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Romania:

Children in Public Care

2014

Coordinators:
Manuela Sofia Stănculescu, Vlad Grigoraş, Emil Teşliuc and Voichița Pop

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Authors:

Manuela Sofia Stănculescu (main author)
Vlad Grigoraș
Monica Marin
Cătălina Iamandi-Cioinaru
Emil Teșliuc
Georgiana Blaj (Neculau)
Bogdan Corad
Voichiţa Pop
Andreea Trocea

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The Romanian folk motifs throughout this study on the chapter and subchapter cover pages were inspired by textiles stitched in the centers for children with disabilities that we visited in Arad and Botoșani counties.

Disclaimer:
The findings, interpretations and conclusions expressed in this study do not necessarily reflect the views and position of the World Bank Executive Directors, UNICEF, the European Union, or the Government of Romania.

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I. Stănculescu, Manuela Sofia (main author)
II. Grigoraş, Vlad (coord.)
III. Teşliuc, Emil (coord.)
IV. Pop, Voichița (coord.)

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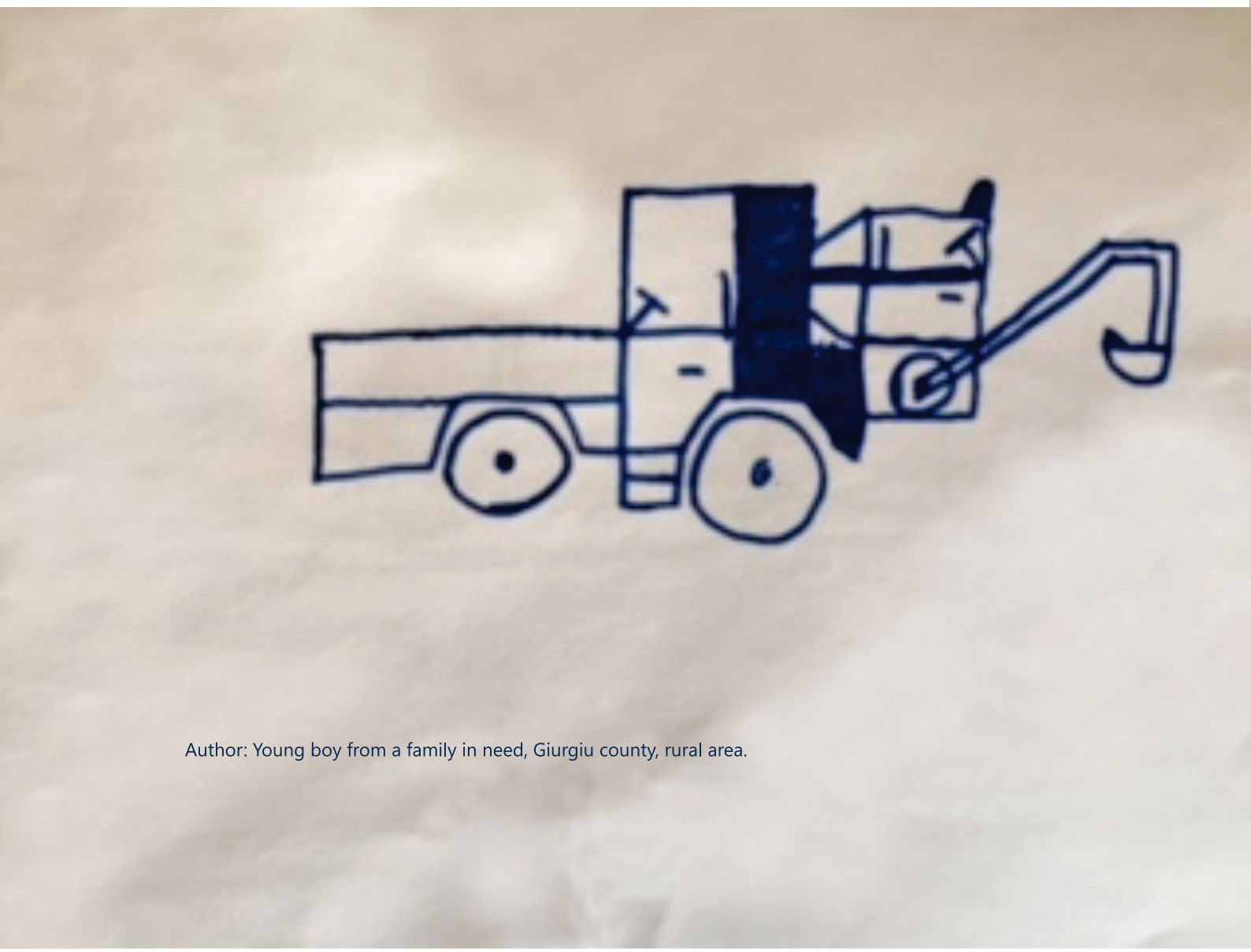
List of Acronyms

ALIAT	Alliance for Fighting Against Alcoholism and Drug Addiction
AMP	Professional foster carer
ANP	National Administration of Penitentiaries
ANPD	National Authority for People with Disabilities
ANPDCA	National Authority for the Protection of Children's Rights and Adoption
AROP	At Risk of Poverty
CEE/CIS	Central and Eastern Europe/Commonwealth of Independent States
CJRAE	Center for Educational Resources and Assistance (at the county level)
CM	Maternal center
CMTIS	Child Monitoring and Tracking Information System
CP	Placement center
CPC	Child Protection Commision
CPRU	Emergency reception center
CTF	Small group homes
DAS	Directorate for Social Assistance
DGASPC	General Directorate for Social Assistance and Child Protection
DPA	Opening the adoption procedure
DSP	Public Health Directorate
EC	European Commission
EEG	The European Expert Group on the Transition from Institutional to Community-based Care
EU	European Union
Eurostat	Statistical Office of the European Union
EU-SILC	EU Survey on Income and Living Conditions
FONPC	Federation of Child Protection NGOs
FRA	European Union Agency for Fundamental Rights
GIS	Geographic Information System
GMI	Guaranteed Minimum Income
HHC	Hope and Homes for Children Romania
ICCV	Research Institute for Quality of Life
ICT/IT	Information and Communications Technology/ Information Technology
IOMC	'Alfred Rusescu' Institute of Mother and Child Care
ISJ	County School Inspectorate
ISR	Social reference indicator

IVA	Entrusting the child for adoption
MDRAP	Ministry of Regional Development and Public Administration
MEN	Ministry of National Education
MIS	Management Information System
MMFPSPV	Ministry of Labor, Family, Social Protection, and the Elderly
MS	Ministry of Health
MSII	Minimum Social Insertion Income
NGO	Non-governmental Organization
NIS	National Institute of Statistics
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPA	Accredited private organizations providing child protection services
ORA	The Romanian Office for Adoptions
PIP	Individualized protection plan
PIS	Specific intervention program
PPA	Practical matching with the aim of adoption
PODCA	ESF/Administrative Capacity Development Operational Programme
POSDRU	ESF/Human Resources Development Sectoral Operational Programme
PTA	Theoretical matching with the aim of adoption
SCC	Community Consultative Structure
SEN	Special Educational Needs
SPAS	Public Social Assistance Service
SPS	Special Protection System
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization



Author: Young boy from a family in need, Giurgiu county, rural area.

Introduction

At the beginning of the 1990s, Romania inherited a disastrous child protection system from the communist regime. As a result of pro-birth policies and of the economic depression in the 1980s, the traditional models of child care in the family, especially for children in need (in particular those with disabilities) were undermined. According to estimates, in 1989, over 100,000 children were living in large residential institutions in extremely poor conditions, which had a strong negative impact on their health, development, and psychological status.

The Government of Romania has made significant progress in the past 25 years in terms of reducing the number of children in public care. [1] At the present time Romania's rate of children placed in public care, compared to its entire population of children is about average among the countries of Central and Eastern Europe and those in the Commonwealth of Independent States (CEE/CIS).[2] However, in absolute numbers, the child protection system in Romania is still one of the largest in the region, having to provide an adequate response to the needs of about 60,000 children.

Despite the large number of children placed in public care, the Government of Romania has acknowledged the fact that the residential type of care has negative effects, especially on the development of young children, and has managed to improve child protection services substantially by developing family-type care alternatives. Therefore, at present, two-thirds of the children in the protection system are placed in family-type care services (Introgaph Chart 1).

However, following the global crisis, which affected the situation of children in the entire CEE/CIS region, the process of reducing the number of institutionalized children slowed down significantly, both in Romania and in other countries in the region. The reasons for this are twofold. First, many families have been leaving their children in institutions either temporarily or permanently because of their declining living conditions and severe poverty. Second, the system's capacity has decreased as a result of the hiring freeze in the public sector and of the limited budget, particularly the budget for family-type care services.

Consequently, decreasing the number of children in public care remains a priority for the foreseeable future. In response to the recent trends, the government has committed to speeding up the deinstitutionalization process and has acknowledged this as a priority in various strategic documents including the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*, *the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, and the *Romanian Partnership Agreement for the 2014-2020 Programming Period*.

In line with the European Commission's Social Investment Package and Recommendation "Investing in Children: Breaking the Cycle of Disadvantage," the National Authority for the Protection of Children's Rights and Adoption (ANPDCA) has set its priorities for 2014-2020 with regard to the need to transition from institutional care to community-based services and to provide children with early and preventive interventions that enforce their right to grow up in a family environment and help them to achieve their full potential and exercise their rights.

In order to strategically prioritize reform measures, the ANPDCA together with the World Bank and UNICEF embarked on a complex process of analysis of the child protection system in Romania.[3] This implies an analysis that goes beyond the numbers - interpreting new data and information on children

[1] See Chapter 3.3.2.

[2] Romania has a rate of between 1,600 and 1,700 children in public care aged between 0 and 17 years old as compared with 1,850 children per 100,000 children, which is the average rate in CEE/CIS region, as well as in the countries of Eastern Europe and Central Asia. TransMonEE 2015 database, Table 6.1.22.

[3] In this study, the child protection system refers to the entire set of services aimed at protecting and promoting children's rights organized at different levels (local, county, and national).

in public care, understanding the circumstances of those children who are cared for outside of their birth families and receive alternative care,[4] and identifying the root causes of child-family separation. The study aims to strengthen the social services related to child protection by: (i) reorganizing existing child special protection services to enhance the quality of care provided while reducing the duration of stay in public care to the minimum necessary; (ii) developing and strengthening the capacity of community-based prevention and support services; and (iii) reconsidering the ways and means of providing family support in order to prevent child-family separations.

This book presents the results of this research on more than 52,000 children placed in public care in Romania (in special protection[5]) who receive family or residential-type protection services, as shown in Introgaph Chart 1, as well as on the children at risk of separation from their families from the source communities.[6] In order to fulfill the research objectives, various quantitative and qualitative data were collected[7] by means of: (i) a survey of households with children in public care in rural source communities; (ii) case studies in urban source communities; (iii) an analysis of the case files of children in public care (in the special protection system), including adoption forms; (iv) a survey of case managers; and (v) focus groups with specialists and with children in public care.

The whole analysis in this volume is child-centered, encompassing both children in the special protection system and children at risk of separation from their family. We attempt to answer the following questions. What is their profile? What families do they come from? By which routes do they enter the system? Which are the root causes of their separation from the family? What kind of community support have they received, if any, before entering the system? How does the transition from family to public care occur? How are children placed in different types of services? How are individualized plans of intervention developed? By which routes do they leave the system? What are their chances of being reintegrated into the family? The themes addressed are organized according to the ANPDCA's vision in three phases: (1) before entering the system; (2) within the system; and (3) leaving the system.

In addition to the data used in this volume, data on institutional practices were also collected, such as transfers within the system, protection measures, case management, and the effects of special protection services on children's development. These results will be presented in a separate volume, which is currently being written.

The results presented in this book have been and will be discussed with the central and local authorities in Romania in order to identify the priority steps required to advance the reform of and increase investments to the child protection system reform. Some of the study's preliminary data were presented in meetings[8] organized in 2014 and 2015 with the representatives of the General Directorates for Social Assistance and Child Protection and of non-governmental organizations.

[4] Alternative care refers to care provided to children deprived of parental care. It does not refer exclusively to alternatives to institutional care and may include placement with relatives or people outside the family, formal foster care placement, other forms of family-based or family-type care placements, safe facilities for emergency child care, emergency transit centers, and other short- and long-term residential care facilities including small group homes and supervised independent living arrangements for children.

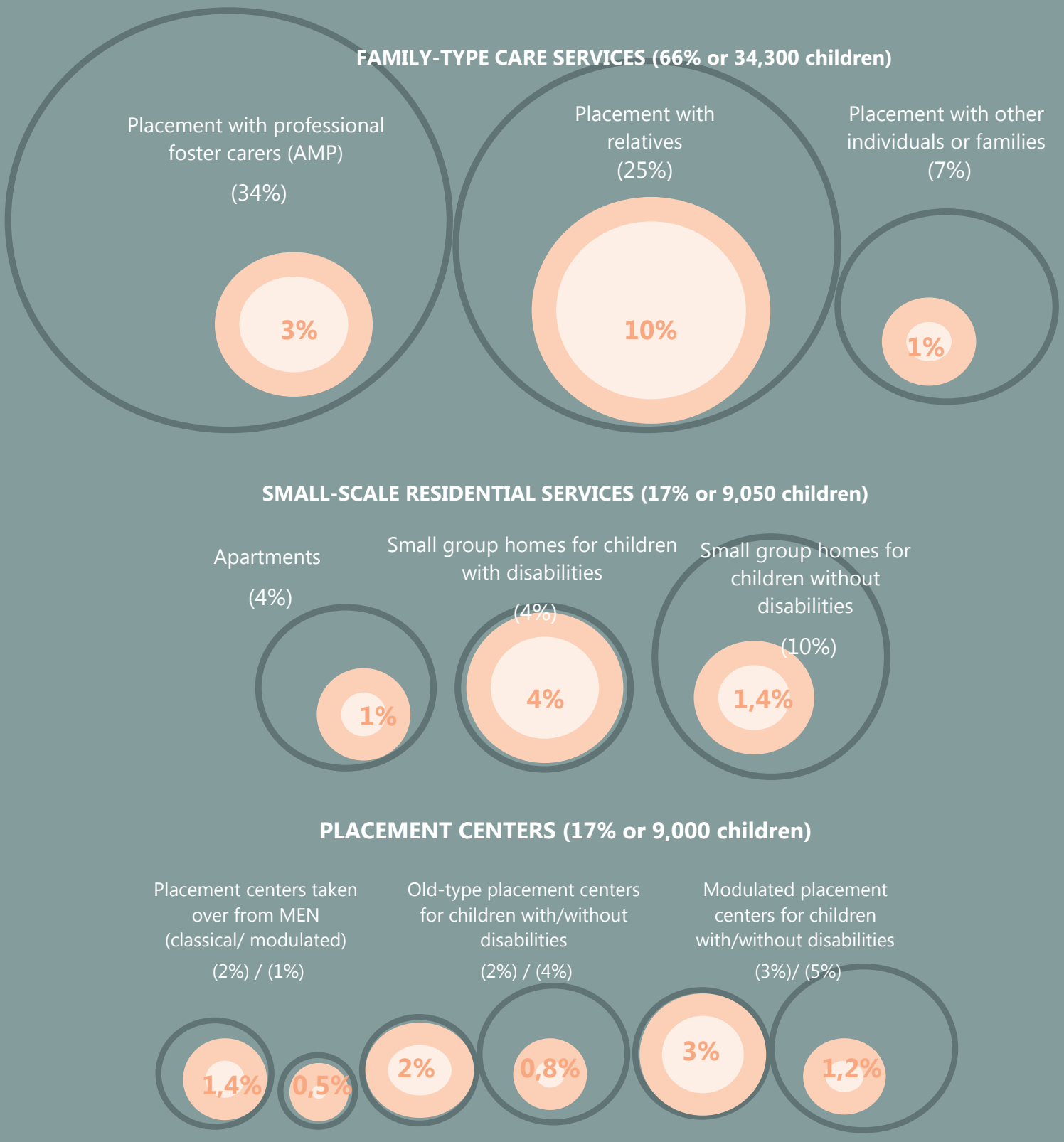
[5] In this volume, special protection refers to the set of measures, benefits, and services aimed at ensuring the care and development of children deprived, either temporarily or permanently, of parental care and of the children who cannot be left in their parents' care if their best interests are to be protected.

[6] By definition, "source communities" (rural and urban) are areas at the sub-locality level from where, compared to other communities, a significantly larger number of children enter public care. Sub-locality areas may refer to a neighborhood, a street, or a group of houses and/or blocks in urban areas or an entire village, hamlet, or just a group of houses in rural areas.

[7] See Chapter 2.

[8] Constanța, 2-5 September 2014; Snagov, 7-8 May 2015; Bucharest, 18-19 November 2015.

Introgaph Chart 1: Children with disabilities and all children in public care, by type of services received, November-December 2014 (% all children in special protection)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighed (N=52,350).

Note: The distribution of all children in public care appears in dark grey, of which the percentage in pink refers to children with disabilities.

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1 Policy Context

1 Policy Context

In the context of drafting the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020,* the Ministry of Labor, Family, Social Protection, and the Elderly (MMFPSPV) through the National Authority for the Protection of Children's Rights and Adoption (ANPDCA) is committed to reviewing and adjusting the current policies of the Government of Romania related to the wellbeing of children and their families, with a special focus on children who are deprived of parental care or are at risk of being separated from their families.

The MMFPSPV has requested the World Bank's support in preparing a draft *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* and an accompanying Action Plan. Also, together with the ANPDCA, the MMFPSPV asked UNICEF for technical assistance to collect information on the child protection system in Romania. The World Bank team has analyzed these newly collected data with a view to improving Romania's policies on child rights and social protection for children who are deprived of parental care or are at risk of being separated from their families.

1.1. The Problem: Children and Youths at High Risk of Poverty

In Romania, there are nearly 3.8 million children under 18 living in 3.2 million households.[9] From 2007, the year when Romania joined the European Union, to 2015, children and youths consistently registered by far the highest risk of poverty of all age groups (Table 1).

Table 1: Relative Poverty Rates, by Age, 2007-2015 (%)

Age (years)	2007	2008	2009	2010	2011	2012	2013	2014	2015
0-17	33,0	33,3	31,9	32,1	33,0	33,3	34,7	39,3	38,1
18-24	21,7	21,9	23,3	24,9	29,2	29,3	30,1	33,8	34,9
25-49	21,0	20,7	20,4	20,8	22,1	23,3	22,6	24,0	23,9
50-64	19,4	17,1	15,7	14,6	15,3	16,3	16,4	18,1	17,4
65 or over	29,4	26,5	21,4	17,6	14,8	14,4	14,5	15,7	19,3
All population	24,6	23,6	22,1	21,6	22,3	22,9	23,0	25,1	25,4

Source: Eurostat.

Note: The share of people with an annual disposable income (after receiving social transfers) below 60 percent of the median income, as expressed per adult equivalent (the AROP indicator).

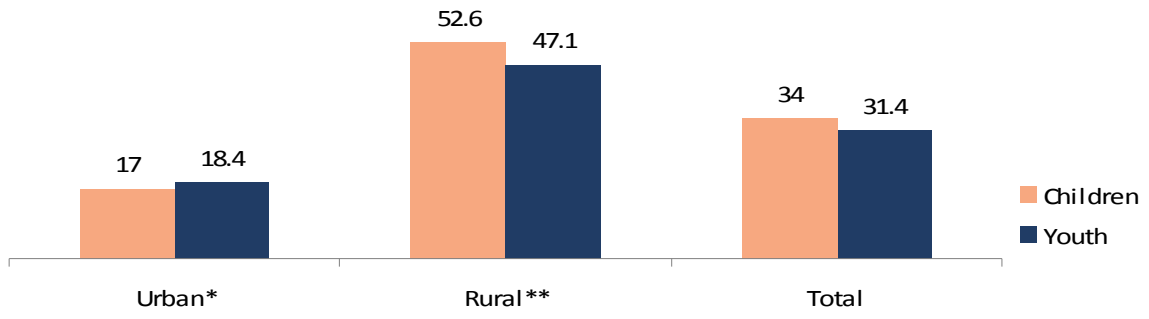
Thus, according to Eurostat data, in 2015, over 38 percent of children aged 0 to 17 in Romania lived in poverty, versus nearly 20 percent in the EU-15. Moreover, the poverty rate increased between 2007 and 2015 (Table 1), a trend registered mostly among children and youths (aged 18 to 24 years old) and to a much lesser degree or not at all among the other age groups.

One in every two children living in rural areas is poor. In 2012, about 53 percent of children in rural areas were living in poverty, while the rate for children in urban areas was only 17 percent. This large

[9] Most children come from nuclear families (58 percent of households with children) or multigenerational households including grandparents and/or other relatives, with or without parents (36 percent). The other children live in single-parent families, accounting for nearly 6 percent of all households with children (NIS data as of 1 January 2012).

disparity coupled with an approximately even distribution of children between urban and rural areas means that over 74 percent of poor children live in rural areas. What is alarming is that income poverty coupled with the lack of access to basic social services (including health and education) and an inefficient labor market increases the vulnerability of these children to persistent poverty even after they become adults.

Figure 1: Relative Poverty Rates for Children (0-17 years old) and Youths (18-24 years old), by Area of Residence, 2012 (%)



Source: World Bank calculations based on 2012 EU-SILC data.

Note: *Rural = thinly populated areas. **Urban = densely populated areas and intermediary areas.

Child poverty in Romania tends to be persistent and accompanied by severe material deprivation. Thus, the persistent poverty rate (for three to four years long) is nearly 30 percent among children, a percentage which, since 2010, has put Romania consistently among the worst EU countries. At the same time, according to Eurostat 2014 data,[10] 29 percent of children in Romania live in households affected by severe material deprivation. Even more worrying is the fact that, according to previous child-focused research conducted by independent teams,[11] 72 to 78 percent of Romanian children suffer from severe material deprivation even in terms of basic needs,[12] which is significantly greater than in all of the other European states (see Figure 2).

The World Bank's background study[13] for the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* showed that the type of household that is most likely to be materially deprived consists of two adults and three or more children. Basically, all people living in this type of household (96 percent) cannot afford a one-week holiday away from home, while more than half also cannot afford to pay for any unexpected expenses, to have a meal with meat every other day, to avoid arrears, or to have a car. Two other types of households – single-parent households and households composed of three adults and at least one child – also have to struggle a great deal to avoid material deprivation.

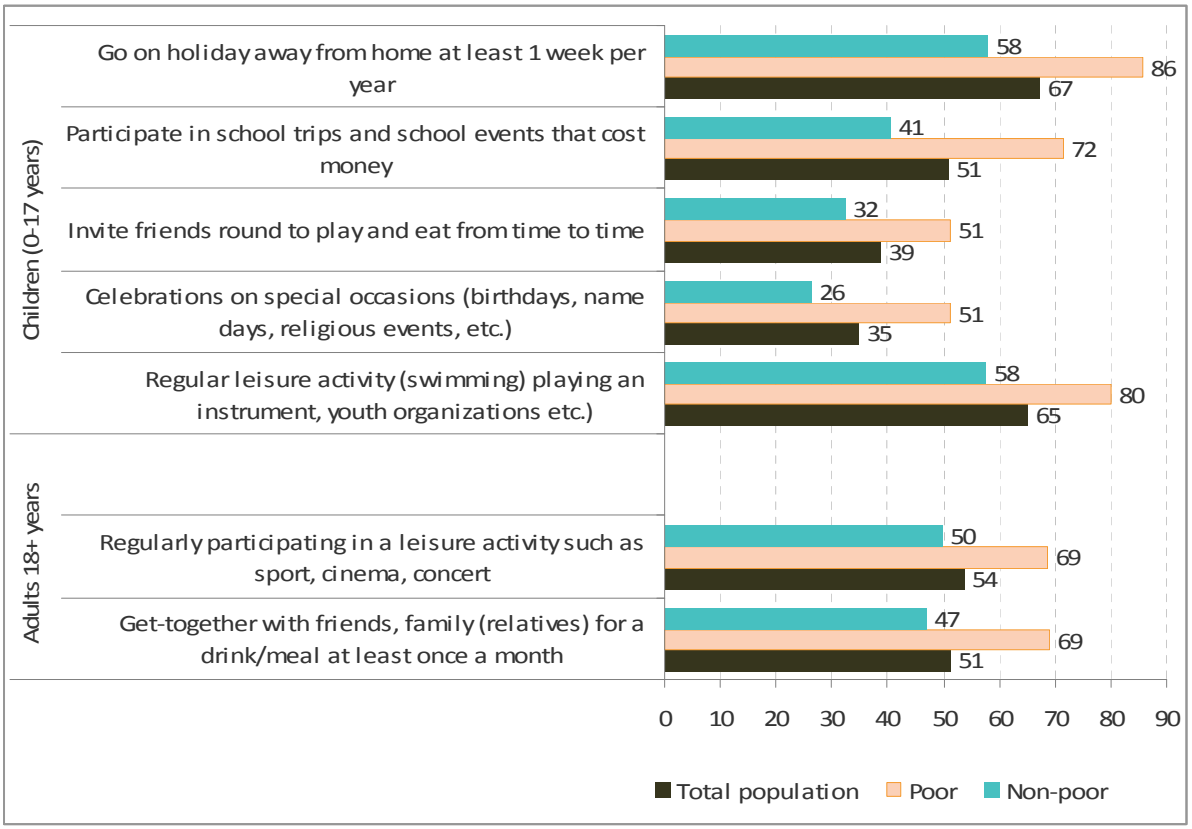
[10] The indicator adopted by the Social Protection Committee (the EU advisory policy committee for the Employment and Social Affairs Ministers in the Employment and Social Affairs Council) measures the percentage of the population that meets at least four of the following nine criteria: (1) they cannot afford to pay their rent, mortgage, or utility bills; (2) they cannot afford to keep their home adequately warm; (3) they face unexpected expenses; (4) they cannot afford to eat meat or other protein regularly; (5) they cannot afford to go on holiday; (6) they cannot afford to purchase a television set; (7) they cannot afford to purchase a washing machine; (8) they cannot afford to run a car; and (9) they do not have a telephone. The indicator distinguishes between individuals who cannot afford a certain item or service and those who do not have this item or service for another reason, for example, because they do not want or need it.

[11] UNICEF Innocenti Research Center (2012), European Commission (2012), and Frazer and Marlier (2014).

[12] This group of children lacks (because of a lack of money) *to an especially great extent*, indoor games, outdoor equipment, and participation in school trips and events that cost money; *to a very great extent*, children's books and a family car; and *to a great extent*, fresh fruit and vegetables as well as a meat-based or fish-based meal every day, celebrations, the possibility of inviting friends over from time to time, regular leisure activities (such as sports or organizations for children and young people), new clothes and two good pairs of shoes, a computer and Internet access, and a desk or adequate space to do their homework.

[13] Teșliuc, Grigoraș, and Stănculescu (coord.) (2015) using data from the 2012 EU-SILC.

Figure 2: Proportion of Children and Adults Who Cannot Afford Various Activities (%)



Source: World Bank calculations based on data from the 2012 EU-SILC for adults and 2009 EU-SILC for children.

Households with many children are also more prone to poverty. The larger the number of children in a family, the higher the poverty incidence, both in rural and urban areas (Table 2). Thus, out of all children in Romania, the approximately 20 percent of children who live in households with three or more children have a risk of poverty of 57 percent, with a high of over 65 percent for those who live in thinly populated (rural) areas.

Table 2: Poverty Rate for Households with Different Numbers of Children, 2012 (%)

Households with…	Total	Urban*	Rural**
0 children	16.5	8.2	29.0
1 child	22.6	12.3	41.8
2 children	33.8	16.1	52.0
3+ children	56.6	39.2	65.2

Source: World Bank calculations based on 2012 EU-SILC data.

Note: *Rural = thinly populated areas. **Urban = densely populated areas and intermediate areas.

Young people have the second highest poverty rate and are the age group who were most affected by the economic crisis. In 2015, youths aged between 18 and 24 years old faced an extremely high poverty rate (about 35 percent),[14] very close to the high risk-of-poverty rate for children. What is particularly worrying is that, in the case of young people, the poverty rate has increased significantly over time. For example, the poverty rate for those aged 18 to 24 increased by over 13 percentage points between 2007 and 2015, while, for children, it increased by about 5 percentage points, and, for the total population, by 1 percentage point over the same period of time (Table 1). This increase may have been due to the growing vulnerability and risk faced by young people on the labor market, particularly during the economic crisis.

[14] The same conclusions apply to the 16 to 26 age group.

In Romania, too many children continue to be separated from their natural families or subjected to various forms of violence or social exclusion. By way of its 2004 legislation for the protection and promotion of children's rights, Romania is already part of the group of countries forbidding violence against children, namely any physical punishment or humiliating or degrading treatment against children. Nevertheless, the government acknowledged the fact that, unless the legislation is implemented consistently and efficiently, its impact will be rather limited, and children (especially those from vulnerable groups) will continue to be frequently exposed to various forms of violence, both in their family and in school.

From the statistical point of view, it is a fact that violence against children remains to a large extent an invisible phenomenon. The most recent statistics and empirical evidence show that reported violence is increasing at all levels. Given the various awareness-raising campaigns conducted nationwide and the increasing access to a growing and varied volume of information, some forms of violence are reported more frequently, while others are overlooked or embraced as natural manifestations, though it is well known that one form of violence can lead to other forms of violence.

In 2015, over 13,500 cases of various forms of neglect abuse, and exploitation (up from 11,232 cases in 2010) were registed by the National Authority for the Protection of Child Rights and Adoption (ANPDCA). Out of all of the reported cases, most were cases of emotional abuse (1,740) and neglect (9,625). The number of reported cases of physical abuse was 1,164. In cases of abuse and emotional neglect, the victims were largely children aged 0 to 9 years old (7,698 children). Only 4,403 children aged 10 to 17 were victims of abuse and emotional neglect. At the same time, and most importantly, ANPDCA data showed that most cases of violence against children occurred in a family environment (12,616 out of a total of 13,546 cases).

Substantial efforts are still needed to increase the level of awareness among the population and decision-makers about violence and to persuade them that zero tolerance against any form of violence must become not only a priority at the policy level but must become a way of life. There are no data on abuse that leaves no traces or scars, yet they are still etched into a child's heart and mind.

1.2. The Policy Response

In 2013, the European Commission (EC) recommended[15] that all of its members should draft and implement policies to reduce child poverty and social exclusion, using multidimensional strategies aimed at ensuring child wellbeing and fostering equal opportunities so that all children can realize their full potential. The Commission also recommended maintaining an appropriate balance between universal policies, aimed at promoting the wellbeing of all children, and targeted approaches, aimed at supporting the most disadvantaged of children, particularly children at high risk due to multiple disadvantages such as those with special needs or disabilities, those in alternative care, Roma children, and those living in low-income households. Such strategies for promoting the wellbeing of children will require sustained investment in order to ensure policy continuity and allow for long-term planning and will have to be designed on the basis of rigorous analyses of how they will affect the most disadvantaged, while including actions to mitigate any adverse effects.

In line with these recommendations, the Government of Romania developed the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020,*[16] which aims to promote investment in child development and wellbeing and to ensure respect for children's rights, coverage of children's needs, and universal access to services. This national strategy was designed to be a catalyst for the national implementation of the principles laid down in the UN Convention on the Rights of the Child.[17] At the same time, it is based on an approach that allows for creating synergies and coherent links with the National Reform Program and with other national strategic documents covering the next five years, particularly those related to the social protection, education, and health sectors.

In accordance with the country's national targets for reducing poverty and social exclusion developed as part of the Europe 2020 Strategy, the Government of Romania has developed a *National Strategy on Social Inclusion and Poverty Reduction 2015-2020.*[18] According to this national strategy, the government has committed to putting in place a set of policies and programs by 2020 to: (i) raise at least 580,000 more people out of relative income poverty by 2020 than in 2008; (ii) break the intergenerational cycle of poverty; (iii) prevent the recurrence of poverty and social exclusion; and (iv) ensure equal access to social assistance, cash transfers, and services to strengthen social cohesion.

Children who grow up in poor households face a higher risk of poverty in the future. To break the intergenerational cycle of poverty, the government needs to adopt programs that can tackle both child and adult poverty in the same household simultaneously. Particularly in the case of the persistent poor and the Roma population, the various dimensions of exclusion tend to be mutually reinforcing and perpetuated from generation to generation. The intergenerational cycle of exclusion is perpetuated when the adults' low educational achievement and poor health are passed on to their children, eventually seriously limiting their chances to access the labor market. Breaking the intergenerational cycle of poverty and exclusion will require targeted interventions designed to address the multiple drivers of inequality.

As a response to the problem of the disproportionately high risk of poverty among children and youths, both national strategies mentioned above made developing social services (increasing coverage and access and improving quality) a major priority for the next phase. Providing cash assistance to the most vulnerable families is necessary but not sufficient. It will also be necessary to focus on preventing children from being separated from their families. This can be achieved only by

[15] The European Commission's Social Investment Package and Recommendation "Investing in Children: Breaking the Cycle of Disadvantage", February 2013, and the EC Communication on Early Childhood Education and Care: "Providing all our children with the best start for the world of tomorrow", February 2011. The Council of Europe Strategy for the Rights of the Child 2012-2015 also provides Member States with guidance and support on child protection policies.

[16] Government Decision 1.113/2014.

[17] United Nations (1989).

[18] Government Decision 383/May 27, 2015.

developing family support services and providing increased access to health, education, employment, proper housing, and other public services. To this end, integrated social services should be developed and properly financed in order to ensure the harmonization and alignment of all of the various interventions and programs carried out both at the individual and the community level by empowered and well-trained social workers and other professionals. Accomplishing such comprehensive reforms will depend on the country's capacity to coordinate many different actors, both public and private, and central and local authorities and on the government's ability to identify and willingness to allocate the necessary funds to cover the costs of these reforms.

The *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* advances the following key interventions in the area of social services:

> Ensure that public funds are available for the development of the social services sector in parallel with funding from the European Union.
>
> (*Flagship Initiative #3*)
>
> Strengthen and enhance social assistance at the community level by: (i) developing a minimum intervention package as a mandatory responsibility for each local authority; (ii) financing from the state budget a national program - Social Program Opportunity and Responsibility (SPOR) - to ensure that in each locality at least one full-time employee does social work, has consistent outreach tasks in their job description, and works one-to-one with people in vulnerable situations and their families, as well as providing the minimum intervention package; (iii) financing from the state budget a national program to train all employees with social assistance duties and to draft methodologies, guidelines, and tools to strengthen the implementation of case management at the level of the SPAS, especially in rural and small urban areas; and (iv) developing a strong system for monitoring and evaluating social assistance services at the community level.
>
> Develop integrated intervention community teams within SPOR to provide social services (in education, employment, healthcare, social protection, and other public services) and social intermediation and facilitation programs at the local level, especially in poor and marginalized areas, rural and urban areas, and Roma and non-Roma communities by: (i) developing clear methodologies, protocols, and work procedures for community-based workers and (ii) developing, in the larger marginalized areas, multi-functional community centers to provide integrated services, primarily though not exclusively to families in extreme poverty.
>
> (*Flagship Initiative #5*)
>
> Strengthen social services for child protection by: (i) developing and strengthening the capacity of community-based prevention and support services; (ii) reconsidering the ways and means (including cash benefits) of providing family support in order to prevent child-family separations; and (iii) revising the existing child protection services to enhance the quality of care provided, while reducing the duration of children's stay in the public care system to the minimum necessary.
>
> Develop social services for vulnerable groups by: (i) increasing the financing of social services and improving the procedures for contracting out social services to non-government and private providers and (ii) strengthening the role played by the County Directorates of Social Assistance and Child Protection (DGASPC) in strategic planning and methodological coordination, in supporting SPAS at the community level, and in monitoring and evaluating service providers within the county.

The *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* focuses on social services for children and their families as follows:

General Objective #1: Increase children's access to quality services	
Specific Objectives:	Increase service coverage at the local level Increase the quality of services provided to children Increase beneficiaries' capacity to access and use child and family services Build the capacity of the public institutions involved in promoting child rights to monitor and evaluate children's rights and social circumstances
General Objective #2: Observe the rights and promote the social inclusion of children in the most vulnerable circumstances	
Specific Objectives:	Secure a minimum level of resources for children by way of a national anti-poverty program that places special emphasis on children Reduce existing gaps between outcomes for rural and urban children Remove attitude and environmental barriers to the rehabilitation and social reintegration of children with disabilities Reduce the opportunity gap between Roma and non-Roma children Continue the transition from institutional child care to community-based care Curb the street child phenomenon Foster the social and family reintegration of children who are in conflict with the law and prevent them from re-offending Reduce the influence of risk factors and increase the influence of protective factors regarding children's use of drugs or other harmful substances Offer adequate support to children whose parents work abroad and to their caregivers Promote a healthy lifestyle among adolescents
General Objective #3: Prevent and combat any form of violence	
Specific Objectives:	Promote non-violence and raise awareness of all forms of violence Reduce violence among children
General Objective #4: Encourage children's participation in relevant decision-making	
Specific Objectives:	Develop mechanisms to ensure children participate in the decisions that directly affect them

Thus, two out of the four general objectives of the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* aim to strengthen social services for children:

- ☐ General Objective #1 sets out priorities for developing and strengthening the capacity of community-based prevention and support services – one of the main responsibilities of public local authorities – while also aiming to avoid separating children from their families and thus preventing new entries into the public care system. It also focuses on enhancing support for families in their role as primary caregivers and helping them to develop parenting skills in a non-stigmatizing way[19] in order to prevent child-family separations.
- ☐ General Objective #2 includes a special focus on children deprived of parental care and protected in the special protection system as well as on children living in poverty, Roma children, children with disabilities, and other children in need.

[19] In line with the EC recommendation on "Investing in Children: Breaking the Cycle of Disadvantage".

2

Analyzing the Child Care System

The Research

2 Analyzing the Child Care System: The Research

The World Bank and UNICEF are providing technical assistance to support the MMFPSPV and the ANPDCA in identifying the priority steps to be taken in order to move ahead with the reforms aimed at the establishment of a good child care system.

Box 1: The Principles of a Good Child Protection System

(1) **The system should be child-centred**: everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about them in line with their age and maturity.

(2) **The family is usually the best place for bringing up children and young people**, but difficult judgments are sometimes needed in balancing the right of a child to be with their birth family with their right to protection from abuse and neglect.

(3) **Helping children and families involves working with them** and therefore the quality of the relationship between the child and family and professionals directly impacts on the effectiveness of help given.

(4) **Early help is better for children**: it minimises the period of adverse experiences and improves outcomes for children.

(5) **Children's needs and circumstances are varied, so the system needs to offer them equal variety in its response**.

(6) **Good professional practice is informed by knowledge of the latest theory and research**.

(7) **Uncertainty and risk are features of child protection work**: risk management can only reduce risks, not eliminate them.

(8) **The measure of the success of child protection systems, both local and national, is whether children are receiving effective help.**

Source: Munro (2011b:23).

As part of this technical assistance, extensive research was carried out between November 2014 and August 2015. The study titled *Analyzing and Reorganizing the Child Protection System in Romania* is based on an in-depth analysis of quantitative and qualitative data on the wellbeing of children and their families, with a particular focus on children deprived of parental care or at risk of being separated from their family. This chapter presents the research methodology, developed by the World Bank and UNICEF with feedback from the MMFPSPV and the ANPDCA.

In the present volume, the child protection system is defined as the set of services aimed at protecting and promoting children's rights, organized at various levels (local, county, and national). The child special protection system (child public care) is the set of measures, benefits, and services aimed at

ensuring the care and development of children deprived, temporary or permanently, of parental care or of children who cannot be left in their parents' care, if the best interests of those children are to be protected.

2.1. The Objectives and Expected Results

Goal: This study aims to analyze the current state of the child protection system in Romania and to identify priorities for improving the quality and increasing the effectiveness and efficiency of public care (special protection) services. In the context of operationalizing the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020,* the study focuses on:

(a) the transition from institutional care to community-based services, and

(b) the provision of sustainable solutions for children separated from their parents.

In line with the European Expert Group on the Transition from Institutional to Community-Based Care (EEG), in this report, the terms "community-based services" or "community-based care" refer to the spectrum of services that enable children to grow up in a family environment as opposed to an institution. "It encompasses mainstream services, such as housing, healthcare, education, employment, culture, and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support. It also refers to specialized services, such as personal assistance for people with disabilities, respite care and others. In addition, the term includes family-based and family-like care for children, including substitute family care and preventative measures for early intervention and family support."[20]

Objectives: To improve the method of information gathering and diagnosis related to the current child protection system in Romania, with a special focus on children deprived of parental care or at risk of being separated from their family.

Scope of research: The study is focused on children protected in public care and children at risk of separation from their families.

Expected outputs:

- An analysis of the causes for separating children from their families and the mapping and analysis of the "source communities" (rural and urban) from where a disproportionate number of children are taken into public care (special protection services)
- An analysis of the circumstances of the children who are beneficiaries of the child special protection services, with a particular focus on residential services (institutions) and placement with extended family members (family-type services)
- A list of actions to be taken in order to improve the quality and increase the effectiveness and efficiency of child care services to be discussed with partners within the central and local authorities in order to identify the priority steps needed to reform the child protection system.

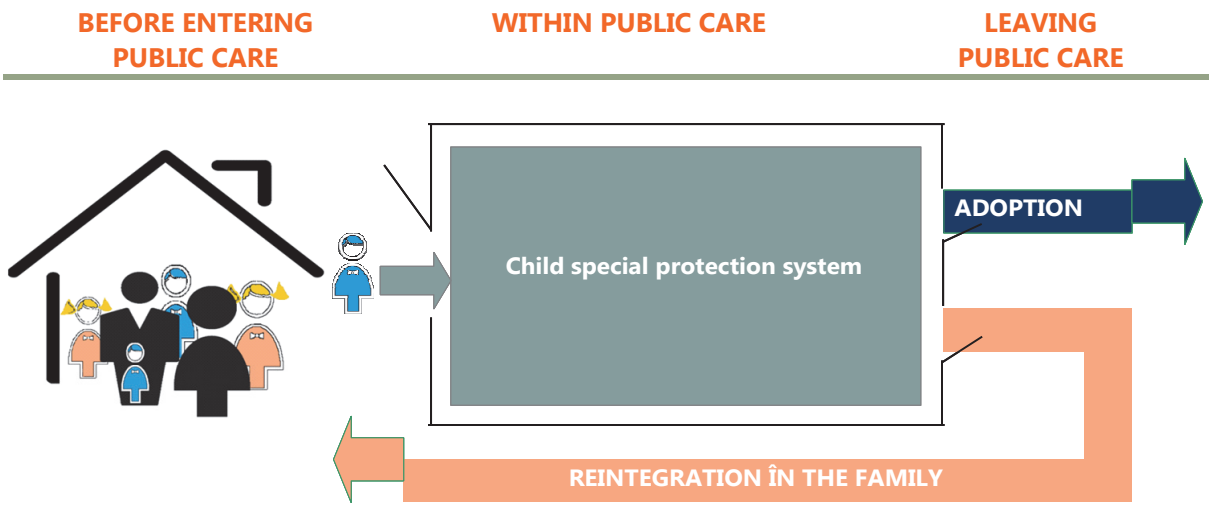
Equal opportunities and equity: All project activities associated with the study were designed and implemented for the equal benefit of girls and boys and women and men. Project staff and experts have been treated equally, regardless of their sex, ethnicity, or other characteristics.

[20] EEG (2016) Deinstitutionalization Terminology.

2.2. The Approach and Research Questions

The approach taken in this study was aligned with the ANPDCA's vision for a new wave of reforms, as illustrated in Figure 3 below.

Figure 3: ANPDCA's Vision for a New Wave of Reforms of the Child Protection System



Guiding principle: To always pursue the best interest of the child.

Main pillars of the new wave of reforms:

Fewer children should enter the system:	Children should only be in the system temporarily:	Children should leave the system with long-term sustainable solutions:
Decreasing the number of children entering public care by enhancing prevention through developing community-based, integrated services for vulnerable children and their families.	Reorganizing the existing child protection services to enhance the quality of care provided while reducing the duration of stay in the special protection system to the minimum necessary. Strengthening monitoring activities/mechanisms and promoting deinstitutionalization by improving and developing family-based and family-like alternative care.	Developing a more systematic reform, including appropriate processes and services to ensure the provision of adequate alternative care, including "permanency" or long-term options.

Source: Interview with Gabriela Coman, President of the National Agency for the Protection of Child Rights and Adoption, 2014.

Thus, this study provides useful analysis to inform this new wave of reforms aimed at developing a good child protection system, centered on children's rights and promoting the best interest of the child. In line with the recommendations of the 2010 UNICEF study for Central and Eastern Europe and the Commonwealth of Independent Countries, this reform wave could aim to ensure "permanency"[21] for the children in public care (special protection), which means establishing family connections and

[21] Better Care Network, Glossary of Key Terms.

placement options that will provide children with a lifetime of commitment, continuity of care, a sense of belonging, and a legal and social status that goes beyond their temporary foster care placements.

According to the approach of the study, the research questions were organized in three groups corresponding to these three phases: before entering public care, within public care, and leaving public care.

BEFORE ENTERING PUBLIC CARE (IN SPECIAL PROTECTION SERVICES)

Research questions:

- ☐ What causes children to be separated from their families? To what extent are the current data on these causes[22] recorded in a disaggregated manner in order for them to be fully understood and effectively addressed?
- ☐ What has been done to reduce the risk of child separation from the family at the community level? To what extent were these interventions specifically related to a given cause of separation or vulnerability?
- ☐ What authority takes the final decision to put a child in public care (special protection)? To what extent does this differ depending on the cause of the separation or vulnerability?
- ☐ Overall, what are the main bottlenecks encountered in trying to address the causes of child-family separation? The analysis includes determinants related to the enabling environment (such as policies, laws, the budget, and social norms), the supply and quality of services (such as the availability of services, the adequacy of staff, the accessibility of services, and quality standards), and demand (such as financial, cultural, and individual or family barriers).

WITHIN PUBLIC CARE

Research questions:

- ☐ What is the profile of children in public care by type of special protection service according to their gender, age, ethnicity, special needs and county of origin?
- ☐ What is the current practice for developing and implementing Individualized Protection Plans (PIP) for children in public care (special protection), as analyzed by category of children, by type of PIP, and by county?
- ☐ What factors (bottlenecks) prevent the implementation of the recommendations contained in the PIP?
- ☐ To what extent are PIPs effectively implemented?
- ☐ What is the average length of stay in public care, by category of children, by type of PIP, by type of service, and by county?

LEAVING PUBLIC CARE

Research questions:

- ☐ Overall, what are the bottlenecks to ensuring that children can safely and sustainably leave public care? The study analyzes determinants related to the enabling environment (such as policies, laws, the budget, and social norms), the supply and quality of services (such as the availability of services, the adequacy of staff, the accessibility of services, and quality standards), and demand (such as financial, cultural, and individual or family barriers).

[22] Currently, the ANPDCA collects data on these causes using a quarterly data sheet/form (*fișă trimestrială*), but other instruments are also used for demonstration purposes or for testing in a particular geographic region.

2.3. Data and Method

This report puts data on children in public care (special protection system) in Romania under the microscope. To provide answers to the research questions, the study team collected quantitative and qualitative data from various different sources as presented in Figure 4.

Child Monitoring and Tracking Information System (CMTIS)

The Child Monitoring and Tracking Information System (CMTIS) is the management information system of the child protection system in Romania.[23] The CMTIS is a relational database system (in MYSQL). The system was developed in 2003 and has not been upgraded since.[24] The structural design of the CMTIS involves hosting the database on a server in Bucharest and making it accessible to users via web-based connections. It is presently connected via a VPN to only 30 counties. To be able to access the CMTIS, users (the DGASPCs at the county level and for Bucharest at the sector level) need to have a basic working knowledge of SQL.[25] This has limited the number of counties who actively use the system, although according to the current regulations: "the general/ executive director of the DGASPC at the county/ sector level has a formal obligation to designate the people responsible for entering into the CMTIS the data on the children registered with the DGASPC" and, for the designated people, "it is mandatory to provide the required training" so they can perform such duties accordingly.[26]

Only about 20 counties use the CMTIS in their daily activities, while the other DGASPCs have developed alternative ICT systems (which are not interconnected and differ from one county to another).[27] According to the survey of case managers that was conducted for this study, 26 percent of all case managers have no knowledge of the CMTIS, and only 27 percent reported having used the system between 2010 and 2015.

Those counties that are not currently connected to the CMTIS are not able to enter in the database the details of the children who are in their protection system records. Even for those DGASPCs that are connected to the CMTIS, there is no structured plan to ensure the accuracy of the local data that they upload or the consistency of that data and the reports that are uploaded to the CMTIS. As a result, the data in the CMTIS are of rather poor quality and have limited coverage.

The list of counties included in data collection (based on CMTIS data) is presented in Annex 6 Table 1. The territorial coverage of the quantitative data is discussed below.

[23] Within the ANPDCA, ICT-related responsibilities are assigned to two staff members (one for child protection and one for adoption) who also have other non-ICT responsibilities. The Romanian Office for Adoptions (currently, part of the ANPDCA) has a separate ICT system that is not connected to the CMTIS. There is no inter-connectivity between the CMTIS and the systems of other institutions.

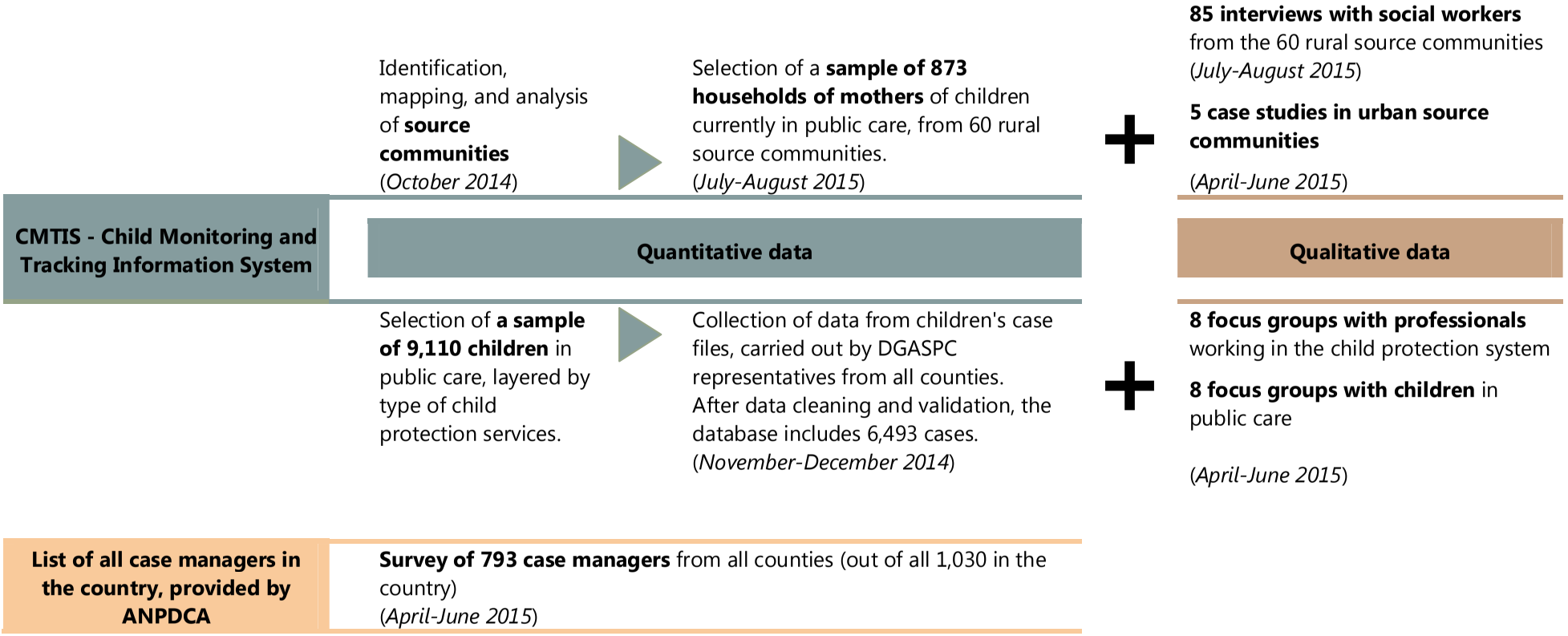
[24] As a result, the CMTIS has no available source code and no disaster recovery system.

[25] Structured Query Language - a specific language used in programming and designed for creating, using and managing data held in a relational database management system.

[26] Currently, there is no structured training on SQL (or on operating the CMTIS) available to users, and there are no plans to extend the use of the system to those counties that are not currently connected. The quotation is from Order 286/2006 for the approval of the methodological norms regarding the development of Individualized Protection Plans.

[27] The ANPDCA does not keep a register of the different software applications used by the DGASPCs at the county level. There are no standards to guide the development of such software.

Figure 4: Data Used in the Study



RECOMMENDATION

A functional child monitoring and tracking information system is vital for ensuring an efficient child protection system. This management information system should be child-centerd, should have national coverage, should include clear procedures to ensure the consistency and accuracy of data between the county and national levels, should be available and user friendly to enable all case managers and professionals working with children and their families to use it in their daily activities, and should be accompanied by a training plan for all types of users.

Also, the inter-connectivity between this management information system (MIS) and other national databases and the databases of other institutions should be ensured.

Source Communities

In the first phase, the CMTIS (Child Monitoring and Tracking Information System) was used in order to identify and analyze the "source communities" (rural and urban). By definition, "source communities" (rural and urban) are areas at the sub-locality level from where a significantly larger number of children enter public care than from other communities. Sub-locality areas may refer to a neighborhood, or a street, or a group of houses and/or blocks in urban areas and an entire village, a hamlet, or just a group of houses in rural areas.

The Source communities are discussed in Chapter 3.2.5.3 *Neighborhood/Community Characteristics: Source communities*. At a later stage, a set of 60 rural source communities and five urban source communities were randomly selected for in-depth case studies.

Study in the Rural Source Communities

Out of all of the identified source communities, the team selected 60 rural localities (communes) within which they found 1,191 mothers with one or more children in public care in the CMTIS. At the time when the fieldwork was conducted, only in 736 households was either the mother (in 455 cases) or a caregiver (in 281 cases) of the children actually identified. The remaining 455 addresses were not used because in 445 cases the families of children in public care no longer lived in the commune, in eight cases the households in the commune no longer included either the biological mother or the children's caretaker, and in two cases the biological mother was present in the household but refused to answer the interviewer's questions.

However, 139 additional women who had children in public care were found and interviewed in the same communities (137 cases), even though they had not been reported in the CMTIS. These additional data are provided in Annex 1 (A 1.1).

In addition to the household survey, 85 social workers or people with social assistance responsibilities at the SPAS level from the same 60 rural communes with source communities were interviewed for the survey.

The research tools used to study these rural source communities were developed by the World Bank in collaboration with UNICEF and are presented in Annexes A 1.2 and A 1.3. Data collection was conducted by the Metro Media Transilvania company in July-August 2015.

Case Studies in Urban Source Communities

At the same time, five case studies were carried out in urban source communities from five cities, namely Arad, Bacău, Bârlad, Craiova, and Piatra Neamţ. These case studies included a mapping of the home addresses of mothers with children in public care and a total of 38 interviews with specialists and parents of children at risk of separation from their families or parents of children protected in public care. Data collection was carried out by the Metro Media Transilvania company during April-June 2015. More details are available in Annex 2.

Analysis of Case Files of Children in Public Care

This study considers the following types of special protection services:

(1) **Family-type services:** (1a) Placement with a relative up to the 4th degree; (1a) Placement with other families/people and (1c) Placement with foster parents.
(2) **Residential services**: (2a) Apartments; (2b) Small group homes[28] for children with disabilities, and for children without disabilities, respectively; (2c) Placement centers grouped into:[29] (2c-1) Placement centers taken over from MEN (Ministry of National Education) (former dormitories of special schools), which can be the old/classical type [30] or restructured/modulated[31]; (2c-2) Classical placement centers (other than MEN centers), which can be for children with disabilities and for children without disabilities, respectively; (2c-3) Modulated placement centers (other than MEN centers), which can be for children with disabilities, and for children without disabilities, respectively.
(3) **Other services**, such as maternal centers, emergency reception centers, guardianship, specialized supervision, day and night shelters are, by convention, outside the scope of the research.[32]

The team extracted from the CMTIS a random sample of 9,110 children in public care. In order to enable an analysis by the type of child special protection service provided, the sample was designed to consist of sub-samples of about 1,000 children randomly selected for each type of the services listed above. Another sub-sample of about 1,000 children in public care was also randomly selected from the rural source communities. In addition, three other sub-samples of over 500 cases each were selected consisting of children aged 0 to 2 years, children with disabilities, and children whose Individualized Protection Plan (PIP) goal was adoption.

Based on the data collected from the children's case files, a data sheet/form for each child was filled in (Annex A 3.2.). The data were collected by more than 900 representatives of all DGASPCs across the country (Annex A 3.1. Table 1), most of whom were inspectors, social workers, or counselors (Annex A 3.1. Figure 1). A World Bank team comprising Bogdan Corad, Cătălina Iamandi-Cioinaru, and Andreea Trocea provided them with training and constant support.

This data collection exercise took place in November and December of 2014. After the research team cleaned and validated the data, only 6,493 forms were included in the analysis (Table 3). The other questionnaires were excluded because the children were not eligible for the study, because the children's case files were not available, or because of partial non-responses on different variables relevant for weighting.

Table 3 shows that out of all 9,110 selected cases, only 71.3 percent (or 6,493) had a corresponding valid form. Sampling errors represented less than 1 percent.

Although the sample was extracted from the CMTIS in November 2014, about 16 percent of the cases were out of scope (not eligible for the study), either because they were using special protection services that were not being analyzed by the study (such as emergency reception centers, shelters for homeless children, or maternal centers), or because they had left the system. In addition, about 2 percent of the sampled children's case files were not available. Therefore, one in every five or six active

[28] According to HHC (2012), a small group home is a residential unit organized based on a family model, with living room, kitchen and bathroom.

[29] The classification of each placement center by type was made by the ANPDCA together with the DGASPCs.

[30] According to HHC (2012), an "old-type," "traditional," or "classical" institution refers to a residential center with over 12 children/young people, with at least four children/young people in a bedroom, and with shared bathrooms for the residents living on the same floor.

[31] According to HHC (2012), a "refurbished," "restructured," or "modulated" institution refers to a residential center with over 12 children/young people, organized in units, with each unit typically consisting of a bedroom, a living room and a bathroom.

[32] In other words, children in the study sample who received only these services were not included in the analysis so they are, by convention, "cases outside the scope" of the research (see Annex 6 Table 1).

cases in the CMTIS was is in fact a child who is not in any special protection service (whether residential or family-type). Thus, the quality of data from CMTIS used as sampling framework was rather limited.

Table 3: Data Sheets/Forms for Children in Public Care in Romania, Based on Their Case Files

	Percent
Valid forms	71.3
Excluded due to partial non-responses	10.9
Services not included in the analysis, of which:	2.7
- Guardianship	0.9
- Other services	1.9
Children left the system:	12.9
- Reintegration into the family	3.6
- Adoption	1.4
- 18+ years	4.8
- Moved to an institution for adults	0.5
- Detention, others, or not mentioned	2.7
Case files not available, of which:	2.0
- Empty files (very little information)	0.3
- Files not available	1.3
- Files transferred to other counties	0.1
- Files of deceased children	0.2
Sampling errors	0.3
Total	**100**

"We have no access to the archive" or "the archive is scattered among several locations" or "the archive is in a different locality." "The institution is under renovation or is moving to different premises and the file cannot be found."

Source: Survey of the Case Files of Children in Public Care (November-December 2014).

Note: Other services refer to emergency reception centers, maternal centers, shelters, day centers and others.

In addition, the share of forms excluded due to partial non-responses was as high as 11 percent of the sample. Given the training and continuous assistance available to the staff of the DGASPCs who completed the forms, this high share of incomplete forms seems to have been due mainly to the fact that the information contained in the children's case files is focused on administrative requirements rather than on the children's situation, circumstances, opinions, experiences, or history.

In fact, the survey of case managers showed that they regard children's case files as an administrative task rather than a working tool. In 73 percent of cases, the case files were not even available at the DGASPC premises. Children's case files are dispersed in various buildings and kept by different people, in different offices. There is no uniform procedure for organizing, keeping, or archiving these files. As a result, case managers generally stated that finding the case file for a child in the sample required, on average, a full working day. However, while 70 percent of case managers declared that they had participated in the data collection activities, our data show that only about 10 percent of all forms were filled in by a case manager or a case responsible officer (see Annex 3, A 3.1. Figure 1 and A 3.1. Table 1).[33]

Adoption Forms

For all children in public care whose Individualized Protection Plan (PIP) goal was adoption at the time of the research (November-December 2014), the DGASPC staff were supposed to fill in an adoption form (see Annex A 3.3). The separation between the child protection and adoption departments within the DGASPCs led to a 90 percent rate of completion of the adoption forms (see Chapter 3.4.2 on

[33] Nevertheless, it should be mentioned that the job title of the DGASPC specialists who filled in the forms was identified based on an open question. Hence, in some counties, the specialists who declared themselves to be social workers or inspectors or counselors may also have been undeclared case managers or case responsible officers.

adoption). The problem was mainly caused by the fact that, once the adoption procedure is initiated, the child's case file is transferred from the child protection department to the adoption department. As a result, the staff of the child protection department have limited access to the file, and only some staff within the adoption departments agreed to participate in the study.

In total, 914 adoption forms were filled in for 913 children (see Annex A.3.1 Table 2).[34] While some DGASPC staff completed adoption forms only for the children who were in the system at the time when the study was carried out (November-December 2014), others also filled in forms for those who had left the system. Thus, the analysis covers 685 valid forms (75 percent), completed for children who were still in public care and had a PIP whose goal was adoption. A share of 17 percent of the forms were excluded from the analysis due to the partial non-responses on the general questionnaire (the child form) for a set of variables relevant for weighting. The other 83 forms (9 percent) were excluded from the analysis because they were filled in for children who had left the system.

Two hundred and fifty two DGASPC specialists took part in filling in the adoption forms, most of them as inspectors or counselors (or "referent" which is another Romanian job title for a specialist or counselor) (Annex A 3.1 Figure 2). The data analysis and the key findings are presented in Chapter 3.4.2. Too Few Adoptions.

Territorial Coverage of the Quantitative Data

Given the characteristics of the CMTIS discussed above, most of the data used in the case file survey were derived from 24 counties. Thus, 82 percent of the entire sample (9,110 cases) and 97 percent of the valid forms (6,493 cases) were from those counties, as shown in Annex 6 Table 1. In addition, the quality of data varied widely across counties, with only eight counties having at least 90 percent valid forms, namely Constanţa, Hunedoara, Mehedinţi, Olt, Satu Mare, Suceava, Vâlcea, and Vrancea.

As expected, the counties that use the CMTIS only occasionally or not at all had very low rates of valid forms, since in their cases, the children selected in the sample were more likely to not be in the system or to have files that lacked the relevant data.

Weighting and Extending Data from Children's Case Files

The data from children's case files analyzed in this report, including those in the adoption forms, were weighted. As already mentioned, the data were previously cleaned and validated. Imputation was not used on the non-responses, as these were considered relevant for the quality of the information in children's case files, on which decisions regarding the prevention services plan and the Individualized Protection Plan (PIP) for each child are based. The data were weighted based on the national distribution of children in the special protection system, by: county, type of special protection service (according to the categories presented above), children's age groups, and children with and without disabilities. Based on this weighting, coefficients for extending the sample data were established. Therefore, the data presented in this report are representative of the entire population of children in public care (special protection system) in Romania.

Because of the rounding of the last decimal part of the extension coefficients to four decimals, there are sometimes small differences (about 1 percent) between some of the total sums estimated in the different tables and figures and the corresponding sums resulting from the computation.

Focus Groups with Professionals and Children in Public Care

A total of 16 regional focus group discussions were held by the Metro Media Transilvania company between April and June 2015 (see Annex 4). Eight focus groups were conducted with professionals working in the child protection system and an additional eight focus groups involved children in public care, including children with disabilities.

[34] For one child, two forms were completed because the adoption procedure was renewed following a revoking of the decision to entrust the child for adoption.

Table 4: Focus Group Participants

Location	Number of focus groups	Number of participants	
		Children	Professionals
Iaşi	2	8	8
Focşani	2	7	13
Ploieşti	2	9	10
Craiova	2	8	10
Timişoara	2	10	11
Cluj-Napoca	2	11	9
Braşov	2	9	8
Bucharest	2	12	7
Total	16	74	76

Children in public care:

Boys and girls aged 7-18 years

1-2 children with disabilities per group

Professionals in child protection:

Representatives of services provided in residential centers

DGASPC representatives

Social workers from SPAS

Case managers

Experts of NGOs providing child protection services

Source: Focus groups with professionals and children in public care (April-June 2015).

Survey of Case Managers

The ANPDCA provided the study team with a database of all case managers working in child protection services in Romania,[35] namely 1,030 people. A random sample of 800 case managers was selected, 793 of whom participated in a survey carried out by the Metro Media Transilvania company in April-June 2015. The questionnaire used in the survey was developed by the UNICEF and World Bank team (see Annex 5).

Data Processing

A substantial effort was needed to clean, validate, and analyze all of the quantitative and qualitative data of to ensure the highest quality standards. The process of data cleaning involved six researchers working for three months. This cleaning process was difficult because of the non-standardized working practices at the DGASPC level as well as the different understanding and interpretation of the legislation among DGASPCs.

In total, the following data were analyzed: (i) almost 2,000 variables from the database of children's case files (830 initial variables and over 1,000 newly created variables); (ii) over 1,000 variables from the database of adoption forms (450 initial variables and over 600 newly created variables); and (iii) almost 2,000 pages of transcripts (805 pages of focus group information and 1,120 pages of interview information).

[35] Ilfov county was not included in this database.

3

Analyzing the Child Care System

The Findings

3 Analyzing the Child Care System: The Findings

Executive Summary

The current study examines the situation of children in public care in Romania and of their families and focuses on three phases: before entering the protection system, the period within the system and leaving the system.

3.1 Children in Public Care and their Families

This discussion of the main characteristics of the children in public care and of their families is drawn mainly from the information on the representative sample of children extracted from the CMTIS in November 2014. In the case of these children's mothers, additional information was gathered from the Household Survey in Rural Source Communities.

Profile of Children in Public Care

The children in public care in Romania (either in institutions or in alternative family-based care) are girls and boys of all ages between 0 and 26 years old (and over). Boys constitute a slightly higher share of children in care than girls (53 percent versus 47 percent). Out of all children placed in public care, more than half (56 percent) are aged between 10 and 17 years. Young people aged 18 years or older who are full-time students (or in other special circumstances) are entitled to protection in a foster home or in residential care until they turn 26 years old. This group accounts for a consistent 12 percent share.

Children in public care come from all counties in Romania, 43 percent from rural areas and 56 percent from urban areas. Children from all ethnic groups are found in the child protection system, but their distribution by ethnicity differs considerably from that of the general young population. The share of children with undeclared ethnicity is more than three times higher in the child protection system than among the general population aged 0 to 29 years (31.3 percent versus 9 percent, according to the 2011 census data). The proportion of Roma children is double the general rate (10.3 percent versus 5.3 percent), while that of Romanians is substantially lower (54 percent versus 79.1 percent).

Children with disabilities represent a significant proportion (almost 29 percent) of all children in public care. The proportion of children with disabilities increases incrementally from about 6 percent of infants under the age of 1 year to over 43 percent of young people aged 18 to 26 years (and over).

The Children's Families

Contrary to common belief, most children placed in public care are not orphans. Over 90 percent of all children in public care have a mother who is alive and known. Therefore, most children in the special

protection system are social rather than biological orphans. Their mothers tend to be young, with an average age of 36.3 years compared to the average age of 42.1 years for the national female population. They gave birth at an earlier age than the general population, at an average 23.4 years old versus 27.8 for all Romania mothers. This average is even lower for mothers from rural areas and for Roma mothers.

The circumstances of these mothers are poorly documented in their children's files, with only sparse information about their marital, health, education, and employment status. However, the available data indicate that many of these mothers have little if any education, are disconnected from the labor market, have undeclared marital status, and suffer from mental health problems and/or from a physical disability. Therefore, any plan to reunite these children with their mothers will require substantial efforts and consistent support not only from child protection professionals but also from other sectors to ensure that the family environment is stable and fosters the child's development.

There was even less information in the children's files on their fathers' circumstances than on those of their mothers, but only 48 percent of children in public care appear to have fathers who are alive and known. Only for very few children does the father seem to be in a position to provide them with a decent life, though not necessarily a stable family environment.

About one-third of the children (32 percent) come from single-mother families where no information is available about the father. Another third (31 percent) come from typical nuclear families, including a mother and a father and possibly other children. The last third (37 percent) come from a variety of atypical families, the most common of which are: (i) a single-mother living with another adult (usually the grandmother) who takes care of the child (9 percent) and (ii) a couple living together with the child in a multigenerational household, in which an adult (usually a grandparent) takes care of the child (8 percent). The pattern of unstable relationships, divorce, and separation means that, before entering the system, 28 percent of the children depended on a caregiver other than their parents.

Routes Followed by Children before Entering Public Care

There are three routes by which most children in public care enter the system. The first category relates to the occurrence of some disruptive event that results in the child being placed in the child special protection system. This is the case for about 65 percent of children in public care. In the second category, children come into care via other institutions, usually when they are relinquished in a hospital maternity ward at birth. This applies to more than 31 percent of children in public care. Children in the third category enter care because their family is homeless or because the children have been relinquished. This route is rare, comprising just over 3 percent of all children in public care. This highlights the need for a national program of social housing for the most vulnerable, especially single-mothers with children, as well as community-based preventive and support services for children and their families.

Young Age of Most Children in Public Care

More than one-third (35 percent) of children in public care went into the system before they reached their first birthday. An additional 17 percent were only between 1 and 2 years old when they entered the system. Therefore, reducing new entries into the system will be strongly dependent on reducing the number of children relinquished in medical institutions, especially just after birth.

Children's Development Status before Entering the Child Protection System

When children first enter the child special protection system, many face serious health problems, have little education, either have no memories of their family or have only distressing memories, and display risky behaviors. All of these factors are critical for understanding the child's history, development status, and specific needs.

Health. There is no procedure for documenting children's development status at the point when they enter the child protection system so their files often lack information on their height, weight, vaccinations, level of nourishment, and baseline psychological state. However, the available data indicate that many children in care are characterized by the so-called "double burden of disease," which is the coexistence of over-nutrition and obesity with under-nutrition, as well as disabilities and

various other chronic diseases. The study found that one in every ten children had signs of malnourishment or undernourishment, which is associated with low resistance to infections and stunted growth. About 11 percent of children in public care have had a disability since their arrival in the protection system. Fewer than half of the children had been given a baseline psychological evaluation, but for those who had, the evaluations showed that many of them had various emotional, cognitive, behavioral, psycho-physiological, personality and interpersonal relationship issues. In addition, many children had not had the appropriate vaccines for their age.

Identity documents. Over 15 percent of children in public care either had no identity papers upon entry (8 percent) or their case files did not contain any information in this regard. This is an issue because children who lack identity papers are not eligible for social benefits and services.

Education. Of all children in care, only about half (46 to 64 percent) of each age cohort were attending school without being at risk of dropping out. The others were either out of school (had never been in school or were dropouts) or were at risk of dropping out. Of all of the children who had ever attended school, about 3 to 5 percent in each age cohort were in a special school, while the large majority of them were in a mainstream school. The school dropout rate was around 9 percent among children who were aged 11 to 17 years when they entered the system, and the rate was higher for children with disabilities (15 percent) and Roma children (19 percent). Also, among the same cohort, the proportion of children who had never attended school before entering the child protection system was higher among Roma children (12 percent) and reached over 23 percent of children with disabilities (versus the average of 7 percent).

Relationship with family of origin. Almost 40 percent of all children in public care either have no memories of their family or have only distressing memories. Although nearly all children knew their main caretaker, only 39 percent of them had a "good" relationship with that person, whereas for 33 percent of them, the relationship was "problematic." The relationship with the parents or caretaker does not vary according to child's age, gender, ethnicity, or health status, but it does vary depending on the type of the family of origin and the route via which the child arrived in the protection system. Children with one or more siblings who either live together or are placed in public care are considerably more likely than average to have a problematic relationship with their parents or caretaker. The proportion of children with problematic relationships increases from 25 percent of children with no siblings to 40 percent of children living together with siblings or with two or more siblings in public care. The best relationships seem to have been where children came from extended families or where their main caretaker was a relative, usually a grandparent.

Children's Risky Behavior. Of children who were between 7 and 17 years old when they joined the protection system, 14 percent had already been exposed to one or more type of risky behavior before entering the system. Running away from home was the most common, with some children running away repeatedly before entering the system. Risky behavior is more frequent among adolescents, boys, and children from urban areas, particularly those from families with no support from a kinship network, as well as those with older mothers or parents (those aged over 40 years at the time of the child's entry). Children who had a problematic relationship with their parents were five times more likely to have been exposed to risky behavior than children with good relationships with their family of origin (29 percent versus 6 percent). The majority of children who had been exposed to risky behavior arrived in the system either through the street routes or, in the case of older parents, directly from their families.

3.2 Entering Public Care in Romania: the Causes of Separation

The study found that there are many different reasons why children enter the child special protection system. The children's case files often gave "poverty" as the sole reason when in fact the separation from their families was due to a much more complex mixture of vulnerabilities within the family, as revealed by the study's other data collection activities. These vulnerabilities included extreme poverty, parental unemployment, poor quality housing or homelessness, poor school attendance or dropout, poor parenting, domestic violence, a high risk of child neglect and abuse (sometimes associated with parental alcohol abuse), young or single parenthood, unstable marriages, low expectations and/or self-esteem, and learned helplessness. In addition, significant life events may happen, such as the

death of a parent, a serious accident, the imprisonment of a parent, or the destruction of a home by fire, which affect children both directly and indirectly, while presenting parents with practical and emotional problems that diminish further their capacity to meet their children's needs.

Broadly, the analysis revealed three main categories of reasons why children are separated from their families and taken into the protection system: (i) unfortunate life events such as the death or institutionalization of their parent(s); (ii) the parents' behavior or attitudes that are directly or indirectly harmful to their child; and (iii) structural causes such as poverty, lack of services, and unstable housing. The three categories are not mutually exclusive as some causes may fall under two categories, but generally they each require specific responses. The unfortunate life events usually require long-term mitigation measures, while the harmful behavior and attitudes of parents require targeted information, education, and counseling programs, intensive support and monitoring, and, when needed, the enforcement of existing regulations. The structural causes require the improvement or development of policies and awareness campaigns aimed at the entire population and not just the at-risk population.

Unfortunate Life Events

The death of one or both parents is the main cause of separation for 6 percent of children in public care. Another 6 percent of children in public care have one or both parents in detention, and affected families confirmed in the study that the imprisonment either of the main income earner or caretaker led to severe hardship and finally to the decision of the child's institutionalization.

Children with parents who are in social or medical institutions represent 0.5 percent of all children in public care. Most of these children were younger than 3 years old when they entered the system and a disproportionately high percentage were underweight, had disabilities, and/or were the children of teenage or young mothers with no support from their kinship network.

The intergenerational cycle of institutionalization of children is a major concern. Although this phenomenon may seem insignificant in statistical terms, it is much more significant when defined as the proportion of affected children in public care. Some specialists believe that at least 50 percent of the young people who leave the system send their own children back into the system.

Child Neglect, Abuse, and Exploitation

Thirty-two percent of children in public care were separated from their family due to neglect, abuse, exploitation, and other forms of violence, or a combination thereof. Overall, the case files of 51 percent of children in public care record some evidence of neglect, abuse, or exploitation. This proportion rises to 60 percent if those babies relinquished immediately after birth in maternity hospitals are not considered, of whom 54 percent faced various forms of neglect, 15 percent were abused, and 4 percent experienced exploitation. Thus, one in every seven children in care was maltreated in various ways before entering the child protection system.

The adverse effects of neglect and abuse on the child are similar irrespective of the causes and involve feelings of betrayal, guilt, loneliness, and a lack of self-esteem. Nonetheless, each child's long-term care plan should be customized according to their specific experiences, circumstances, and personality. There is also a need to improve the way in which child neglect, abuse, and exploitation is understood, categorized, and recorded in children's case files.

Individual (Parental) Risk Factors

A large body of literature has shown that risk factors associated with abuse and neglect in families involved with child protection services include certain characteristics and types of behavior by parents. These include alcohol and drug abuse, domestic violence, disability, mental health problems, behavioral problems, early childbearing, and promiscuous and/or criminal behavior. These are all individual-level risk factors that can be targeted by both population-based policies and targeted interventions.

Many children in care have come from dysfunctional families, which in this study are defined as families in which one or more of the following events have occurred: divorce, separation, infidelity, parental disinterest, desertion of family, unacknowledged paternity, and birth out of wedlock.

Seventeen percent of children in public care were part of such a dysfunctional family when they entered the child special protection system.

Disability

Out of all children in public care, 11 percent have had a disability (physical and/or mental health problems) since before entering the system. This includes children with physical disabilities, developmental delays, special educational needs, and behavioral problems, as well as premature and/or underweight infants. Almost one-third of those aged over 3 years old have a disability so severe that they are not self-sufficient.

Children with disabilities seem to be placed in the protection service not on the grounds of neglect, abuse, or unfortunate events but because the tradition of placing children with disabilities in institutions continues in Romania. However, the qualitative study showed the lack of medical, rehabilitation and support services for people with disabilities (both children and adults) also played a big role in parents' decision to let their children go into the protection service, particularly in the case of children with severe disabilities.

The link between childhood disorders and child abuse and neglect is not only controversial but also difficult to assess based on a rigorous methodology. Nevertheless, some research has suggested that children with a physical and/or mental disability can be at a higher risk of abuse and neglect than healthy children. The qualitative study showed that some parents neglected their children with disabilities because they were not able to understand and meet their children's needs, mainly because of prejudice and lack of education. In the absence of professional support and guidance, poorly educated parents often find it very difficult to cope with a child with disabilities, especially if they have other children as well.

Structural Risk Factors

There are several kinds of structural factors that increase the risk of children being taken from their families into the special protection system. The first type encompasses cultural values and traditions, social inertia related to the pre-1989 situation, economic poverty, and weak governance, including corruption. Thus, the social context within which the family lives influences the likelihood of child abuse or neglect and the associated individual-level risk factors.

The second type of structural risk is the absence of adequate preventive or early intervention services at the community level to avoid abuse, and family break-down. These services could also act as referral systems for cases of neglect, abuse, or domestic violence.

The third structural risk is poverty. While poverty is overused in the children's case files as an explanation for the separation of children from their families, it is also rarely documented in the files because it is taken for granted. The available data indicate that only 4 percent of children in care come from non-poor households (with a monthly income per capita higher than 400 lei), and an additional 6 percent are at risk of poverty (relative poverty), while the other 90 percent are poor or extremely poor. This is a very strong result, albeit based on very weak data.

Another key structural risk factor is unstable family accommodation, home evictions and homelessness. Most children in the special protection system come from households living in only one or two rooms in very poor and overcrowded conditions. The eligibility criteria for social housing are rather lax and are not applied consistently across localities. Out of all social housing units in urban areas, only 57 percent are rented to low-income families.

A final structural risk factor is being located in a community that has a disproportionate number of children in the child special protection system – the "source communities" of this study's analysis. Fourteen percent of children in public care come from these source communities. Based on the CMTIS data, the majority of them are from rural areas (60 percent), from all counties but with a massive over-representation of Brașov, Constanța, Covasna, Sibiu, Vâlcea, and Vaslui. Child protection professionals in the DGASPCs described the source communities as marginalized, consisting of improvised houses or former dormitories, often not connected to utilities, with very poor roads, and deficient in basic social services.

3.3. In Public Care

This section discusses the key issues related to life within the child special protection system.

Moving from Family to Public Care

There are three main ways in which the DGASPC can be informed about a child who may need to be taken into the protection system: (i) the SPAS (responsible for 24 percent of total entries); (ii) other institutions, mostly maternity wards or neonatal units (30 percent); and (iii) the child's family (28 percent of total entries). In addition, the DGASPC can take its own initiatives, and notifications can be made by other people and also by the children themselves.

When it comes to removing the child from the family, there are clear methodological norms. The decision to separate a child from the family may be taken: (i) by the DGASPC director; (ii) by a court; (iii) by the Child Protection Commission (CPC); or (iv) based on a Presidential Ordinance if there is an emergency intervention. Based on the initial assessment, the DGASPC multidisciplinary team will suggest a solution for the child's care. If there is an imminent risk, especially in cases of child abuse, the team will suggest an immediate placement, and the DGASPC director will issue a decision in this respect. If the parents or caretakers object to this, the file is sent to court in an expedited manner in order to get a Presidential Ordinance based on which DGASPC representatives can remove the child from the family and place him or her in public care.

Out of all entries into the child protection system (as of November-December 2014), most had no imminent risk and entered the system with a CPC decision or a court ruling (52 percent), while about 42 percent were high-risk cases with an emergency placement ruled by the DGASPC director and, very seldom, through a Presidential Ordinance. However, a different pattern prevailed between 2010 and 2014 when most entries (54 percent) were emergency placements, usually through a decision of the DGASPC director, and in only 42 percent of the cases was there a CPC decision or a court ruling. Entries with parental consent (decided by the CPC) increased, whereas those without the parents' consent (ruled by the Courts) decreased.

The main problem highlighted by the DGASPC specialists is not being able to provide support fast enough to children once they have been identified. Even in emergency cases (such as those involving abuse or abandonment), the "emergency" might take more than two months during which the child is left with the abusing parent or adult and with no external support.

All Types of Children in All Categories of Care

The child protection system cares for children within residential institutions as well as in family-type services. The residential centers include placement centers, whether the old-type or the restructured type, small group homes, or apartments. The family-type services include placements with the child's relatives, with other families, or with foster parents.

Referring to their most recent admission to the system (as some children are admitted and leave several times during their childhood), 52 percent of children in the system were placed in family-type services, 46 percent in residential-type services, and 1 percent received other types of services, such as counseling or recovery day care centers. The children in the protection service as of November-December 2014 may have been admitted into the system at any time between 1989 and 2014. Since the structure of the service recently underwent major changes, the manner in which the children were placed was also altered. As a result, the children who were admitted to the system during 2013 and 2014 were more likely than their predecessors to be placed, at least initially, in family-type services (65 percent) than in residential institutions (34 percent).

Closing down the old-style/classical institutions is a priority for the government as part of the deinstitutionalization process targeted by the new wave of reform in the child protection sector. In November 2014, there were 111 such old placement centers all over the country. Speeding up the process by which all classical residential institutions for children will be closed down is a priority objective in both the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020*.

The First Individualized Protection Plan (PIP)

According to Romanian law, as soon as a child has been referred to the child protection system, the case manager must develop an Individualized Protection Plan (PIP) for the child. Depending on the case in question, the PIP may have one of the following goals: (i) reintegrating the child within their family of origin; (ii) facilitating and supporting the socio-professional integration of young adults over 18 years old who are about to leave the child protection system; or (iii) pursuing a domestic adoption.

Reintegration within the family is the main goal chosen for all categories of children. The proportion of children for whom the goal was reintegration with their families increased from 69 percent in 2005 to 92 percent in 2014 (among those who entered the protection system between 2005 and 2014). Adoption was the goal for 9 to 10 percent of the children, but this suddenly dropped to 3 percent after Law 273/2004 on adoption was updated in 2014.

Adoption is most likely to be chosen as the goal for children who were under 1 year old when they entered the system, children with no extended family support, children with teenage mothers, and those who were relinquished in health units. Children who are less likely to be given the goal of adoption are those with disabilities, those aged between 7 and 17 with behavioral disorders, and those with siblings in the system.

According to the DGASPC experts, the goal chosen in the initial PIP is adequate and relevant for almost three-quarters of the children in the protection system. However, this is not usually the case for children with behavioral disorders and children with disabilities. The system does not provide children with behavioral disorders with the most appropriate services to prepare them for independent life or to be reintegrated within their families. For children with disabilities, especially for those with severe disabilities, the experts acknowledge that long-term solutions are needed. If no other permanent solution is possible, then these children should be allowed to go on living in their small group homes after they come of age (18 years old).

Too Much Time Spent in the System

According to the UN guidelines regarding child alternative care: "Removal of a child from the care of the family should be seen as a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration." On average, a child spends 7.5 years in the Romanian protection system. Children with extended families (especially grandparents) have the shortest stays (6.2 years), while children from single-parent families, especially single-mothers, have the longest (8.35 years). Children with disabilities, especially severe disabilities, and children with parents who have disabilities and/or mental health problems spend longer in the system than the average.

The study analyzed the length of time that children spent in the system by age of entry into the system and by current age (as of November-December 2014). This analysis showed that: (i) in all age groups, there was a significant percentage of children who had entered the system when they were less than 1 year old (usually after they were relinquished in the maternity ward) and (ii) in all age groups, the average length of stay dropped to half or even one-third for children who had entered the system at the age of 3 or older.

As a result, the study found that one in every five children aged between 15 and 26 who were in the system as of November-December 2014 had spent their entire lives in the system, and almost one in every three had spent 90 percent of their lives. Therefore, the "system" is the only family they know. This shows that there is an urgent need to ensure that they are taught independent life skills and given solid support as they transition into society.

Children's Opinions about the Protection System

Two out of every three children in the special protection system are not consulted about their opinions and preferences. The one-third who were consulted were satisfied with the material and housing conditions in the protection system, which were even better than at home in most cases. The children confessed that, although they want to keep in touch with their natural family, they would only wish to go back to them if the violence and alcohol and drug consumption would stop and if the family's living conditions were good.

At the same time, the children taking part in the focus group discussions organized for the present study, spoke of their need for affection, understanding, and communication from the main carers and staff. Their primary need is to have their voice heard, to have somebody they can talk to, a person to whom they can tell anything and whom they can trust. Therefore, the staff working directly with children in the protection system should spend time with children on a daily basis, listening to their stories, dissatisfactions, joys, opinions, needs, and desires. The children should also be consulted and actively involved in deciding on their daily activities and in preparing their own intervention plans in order to develop the decision-making and planning skills needed to live an independent life.

3.4 Leaving the Child Protection System

Other than reaching the age when they are no longer entitled to support**,** there are several ways in which a child can leave the protection system: they can be reintegrated into their families, they can be adopted, or they can be transferred to an institution for adult care. The PIP goal for the vast majority of children in care is to reintegrate them in their families. However, it can be difficult for specialists to determine whether this is the most appropriate solution and whether the family's circumstances reach the necessary standards to warrant returning the child to his or her home.

The System's Children

Many children arrive in the child protection system when they are under the age of 3. These are the children, particularly those who entered before the age of 1, who face a serious risk of becoming the "system's children." Of those who are currently in care**,** more than 18,000 children entered when they were less than 12 months old and over 9,100 children entered when they were between 1 and 2 years old. About one-third of them are children with mild, medium, or severe disabilities.

The very short time that these children spent with their parents was not enough to build a relationship strong enough to motivate the parent to wish to reclaim the child. This is usually exacerbated by the lack of any support or counseling for these parents, many of whom stop communicating with the child. With every passing day, the child's chances of being reintegrated into his or her family decrease. After three years of separation, their chances of leaving the system drop dramatically. After six or seven years of separation, if no adoption takes place, their chances of exiting the system diminish even further, while the likelihood of being reintegrated into their own family is reduced to virtually zero.

Just setting reintegration in the family as an objective is not enough if it is not based on an analysis of the real chances of reintegration for each and every child and if it does not trigger a specific sequence of actions related to children and their families. For this reason, this group of potential "system's children" needs to be acknowledged as such and treated accordingly. Efforts for their adoption should be intensified, and the regulations governing adoption should be revised to increase the chances of finding them a permanent solution. If a safe, stable, and secure parenting relationship has not been found by the time they reach the age of 10, the potential "system's children" should be able to enter an "institutional pathway" to independent living to help them to integrate into the community when they reach the age of 18. This would include life skills education and would involve growing up in a family-type setting or in a small group home in a small community in which they can build friendships and a social network where they can meet people and be known. This pathway should also include the provision of either social housing or a sheltered house (supervised independent living arrangements) once the young adult leaves the system. In the absence of this pathway, these young people will have no real chance of building a sustainable life.

Too Few Adoptions

Adoption is considered by specialists to be the best solution for children who can no longer be reintegrated within their birth families. This may mean adoption by a family within Romania or a family from another country.

Since 2004, the numbers and rates of adoptions within Romania have either maintained their level or decreased. According to UNICEF, the main reason for this is that so many families have been affected by poverty. In other cases, extended families members have chosen to take the children into their care, either formally or informally, rather than letting them be adopted. Moreover, in Romania there is still a

stigma associated with raising children from outside families, which is why adoptive parents often prefer to adopt very young children, under the age of 1 year old, if possible, and to keep the adoption secret from both the child and the community.

On average, it takes five and a half years for a child in the protection system to obtain an adoption objective in their Individualized Protection Plans. This is because of the many steps that need to be followed to comply with the law. During the first step, the case worker tries to reintegrate the child within his or her birth family since this is usually considered to be the best long-term solution for the child. Only if this cannot be accomplished (because the family is unknown or because even relatives up to the fourth degree are not willing or able to take the child) does the adoption procedure go ahead. The legal requirement to obtain the consent of the parents can present another obstacle to the adoption process, but the legislation in force since 2012 makes it legal to disregard the refusal of one or both parents to consent to the adoption of their child if there is proof that the refusal is abusive.

Most children whose PIP goal is adoption are those who entered the system when they were under 1 year old because they were relinquished in the maternity hospital (61 percent), are biological orphans with no extended family (12 percent), come from single-mother families (62 percent), were born to adolescent mothers (6 percent), or have mothers with disabilities and/or mental health problems and with little education (21 percent). Generally, these adoptable children come from small, poor families with fewer children than the average family with children in the protection system (40 percent).

The children of families with parental risk factors (such as parents who have gone abroad to work, dysfunctional families, and those with abusive alcohol consumption, promiscuous behavior, problems with the law, and/or criminal history) are much less likely than other children in the system to enter the adoption process. Consequently, few children with avoidable entries in the system – children entering the system for social reasons – receive adoption as a PIP goal**.**

Family Reintegration for Children from Source Communities

Although the stated objective for most children in the protection system is to reunite them with their parents, the study's analysis of their families did not reveal a very optimistic picture. More than half of the separated children never contacted their parents or other former caregivers again after the separation, and the percentage was closer to 70 percent when the analysis focused on the previous year. Children who were separated when they were less than 2 years old are more than four times more likely not to have interacted at all with their parents or caregivers in the previous year than children separated at the age of 6 or older.

The frequency of the children's interactions with their family also decreases significantly if there is no stable relationship with the mother, the mother has little education, or if the household is located in a marginalized community. The more of these factors that apply, the lower the chances of the separated child to reunite with his or her family of origin.

The interviews conducted in source communities showed that, for 64 percent of children in care, their parents or caregivers declared that they were not at all willing to take them back, the most important predictor being the amount of interaction they had had with the children in the previous year. Moreover, interviews with the mothers of children in care showed that only 8 percent rated the chances of family reintegration as "high" or "very high." The vast majority of the mothers (80 percent) either could not predict when the family reintegration would take place or said that the reintegration would happen in three years or more.

It is also important to understand the conditions that prevail in these households to be able to judge whether they are likely to be favorable to a child's development and wellbeing. Many of the households with children in public care live in extremely bad housing conditions, which make the children's reintegration improbable in the absence of any immediate measures. What is worrying is that other children (siblings of the children in public care) still live in the vast majority of these households where the living conditions are unacceptable. Overcrowding is also a problem, while many households are not connected to any kind of utilities.

As for consumption, half of the surveyed households stated that their income was not enough to cover even the minimum necessities. Yet these families were receiving very little if any social benefits or other support to enable them to improve their living situation. A quarter of the households with very low incomes told the interviewers that they had not received any means-tested benefits (which are specifically targeted at the poor, by law) during the year of the survey. The percentage of those who did not get any aid was even lower for households with children than for all households. Nor were they receiving regular visits from a social assistant.

The reintegration of most children into families will require not only financial support, where needed, but also continuous monitoring by a social worker or a person with social assistance responsibilities to provide constant guidance and support to these families to help them cope with their multiple challenges and to facilitate the reintegration of their separated children.

4. Recommendations

The study has revealed the many efforts being made to improve Romania's child protection system both at the legislative level and in terms of working practices. Nevertheless, many challenges must still be addressed in order to ensure that the system is truly focused on supporting children and families. The current system faces numerous internal issues that require in many cases both a short-term and a medium-term resolution. Yet many solutions are dependent on coordination with other systems, such as the social assistance system, the social benefit system, the education system, the health system, and the labor market. Therefore, the recommendations in this section are intended not only for professionals within the child protection system at all levels but also for those in the other social sectors.

The conclusions and recommendations below are based on several themes that represent the guiding principles for a good child protection system.

Theme 1: Coordinating all interventions at the local level including health, education, social work, and social benefits to ensure prevention, early identification and intervention

Preventing children from going into protective care should be deemed a priority and should be properly funded. As the child protection system cannot and should not have to solve the inefficiencies of the social benefits system, the gaps in the education and healthcare systems, the absence of services for people with disabilities or other vulnerabilities, or the lack of policies and investments in social housing, what is needed is for the Government of Romania to develop, at the highest level, a multi-sectoral strategy for prevention services.

The system needs to be changed from being geared towards emergency responses to focusing on preventing the child-parent separation. A good protection system is one that focuses on reducing the number of entries into the system, while continuing the deinstitutionalization process and finding suitable permanent family care alternatives for those children who are already in the system or who may enter the system in the future.

Prevention can best be done by providing a wide range of community-based services that serve as a filter to reduce entries into the system and to increase the opportunities to reintegrate children within their families (thus increasing the number of exits). There is a need to conduct a national assessment to identify what services are a priority so that the available resources are invested in the most efficient and equitable way to have the maximum positive impact on the children.

This type of national plan for developing community-based prevention services should be designed by the ANPDCA in close coordination with all stakeholders and professionals, including NGOs and local authorities who are major service providers for children and families. Given that preventing children from being separated from their families is a cross-cutting issue, the plan should be funded from the budgets of several relevant ministries and agreed on with the Ministry of Finance.

Theme 2: Supporting families and children involves working directly with them

Most of the children placed in institutions are not orphans but still have one or even both of their parents. Over 90 percent of the mothers of the children in the child protection system are alive and

known. The results of the study make it clear that, given the dominant profile of parents with children in the protection system, these parents will need parental education and intensive support to be able to fulfill their parental obligations in a responsible manner. Therefore, any plan to reintegrate these children in their family will require professionals to provide the mothers/parents with significant and consistent support in order to ensure that the family environment is one in which the child will thrive. This reintegration should be done based on a medium-term plan, which should be prepared with the input of both the mother and the child.

At present, very few households who relinquished their children receive regular visits from a social worker. Taking into account the wide geographical dispersal of families and the amount of effort required to support them and keep records, it is obvious that case managers need to share this burden with the social workers who are close to these families and are in a good position to monitor their development.

In line with the current legislation, the *National Strategy for the Protection and Promotion of Children's Rights* 2014-2020 includes the following objectives: (i) providing a minimum package of social services for children and their families and (ii) developing integrated community-based services. The *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* also proposes introducing a minimum intervention package whose implementation should be a mandatory responsibility in each rural and urban community and should contain the following: (i) fieldwork, which is essential for identifying potential beneficiaries and for providing early intervention services; (ii) assessment of the needs of communities, households, and individuals who are vulnerable or exposed to social risks, as well as planning of the necessary services based on an approach focused on families and individuals; (iii) information and counseling services for people who are vulnerable or exposed to social risks, people experiencing domestic violence or neglect, drug users and problem former convicts, single-parent families with low incomes, and young people at risk (delinquents, school dropouts, and children from low-income families); (iv) administrative support (such as helping people to fill in application forms for any type of benefits) and social, medical, and legal assistance; (v) referral to specialized services; and (vi) monitoring and home visitation of all people in vulnerable situations within the community.

Theme 3: Youths and children have rights, including the right to participate in decisions that affect them

Two out of three children in the child protection system are not consulted about their opinions and preferences. Children need to have their voices heard and to have somebody they can talk to, a person to whom they can tell anything, and whom they can trust. Staff in the special protection system who work with children should spend time with them on a daily basis, listening to their stories, dissatisfactions, joys, opinions, needs, and desires. The children should be consulted and actively involved in planning daily activities, in the preparation of their intervention plans, and in all aspects of their lives, such as education, health, and leisure. In order to develop independent life skills, it is very important that they learn to make decisions (including about issues that seem of little importance to children living in a family) and to manage their life.

Theme 4: The system needs to provide solutions which are tailored to children's different needs and situations

The diversity of children's needs was reflected in the case files both in terms of their circumstances at the time of their entry into the system and of the causes for separating them from their families. Therefore, it is vital to carry out a thorough analysis of each child's situation because the needs of children vary significantly depending on their age, gender, area of residence, and health. This means that the child protection system needs to offer an equally wide range of services in response to such needs, as do the social assistance, education, and health systems.

Not only do children in public care vary among themselves, but many of them also suffer from a range of different concurrent issues. Over two-thirds (65 percent) of the case files record a multitude of vulnerabilities that the children and their families faced prior to the children entering the protection system, particularly the disabled children, children with developmental delays, children with special

educational needs, children with behavioral disorders, and infants born prematurely and/or underweight.

Also, the case files indicated that for 76 percent of the children in the protection system, there was more than one reason for the separation, including unfortunate events (parents' death or institutionalization), neglect, abuse or exploitation, child relinquishment, and/or the parents were deprived of their parental rights. The other 24 percent of children were defined as avoidable entries, whose causes for separation are related to parental risk factors (parents who work abroad, dysfunctional families, teen mothers, parents' excessive alcohol and/or drug consumption, domestic violence, or parents with disabilities and/or with mental health problems) or structural risk factors (poverty/ low socioeconomic status, dependence on social benefits, insecure or inadequate housing, or evictions). Since the community-based services recommended by this study would address many of these issues, a decrease in the avoidable entries into the child protection system would be an encouraging indicator of the effectiveness of those prevention measures.

The study has revealed that adoption is currently a solution that is open to only a very few children. There are not enough parents willing to adopt and of those who are willing, many have a particular child in mind, often the child who has already been placed with them. Therefore, it will be vital to increase the number of adopting parents by initiating education and communication campaigns at the community level to promote adoption and foster inclusive attitudes towards all children, irrespective of their gender, age, ethnic origin, health condition, or parents. It will also be necessary to improve the training provided to individuals or families willing to adopt a child, as well as the professional training of the DGASPC staff on how to communicate with potential adopting parents, particularly with regard to the needs of children with disabilities.

Theme 5: The success of a child protection system is determined by the effectiveness of the actual support children receive

Services for independent living represent a distinctive and important category that must be developed, especially for the post-institutionalization integration of young people with disabilities, as well as for the transition from residential care to community-based services.

Many children end up in the protection system before they are three years old and live in the system until they reach the legal age to leave. Although the aim of the system is to reunite children with their parents, the chances of this happening are not great. More than half of all separated children have never had any contact with their parents since the separation, and the percentage is closer to 70 percent for those who have had no contact in the year prior to separation. In the case of 64 percent of the separated children, their parents say they do not wish to take them home.

A child spends, on average, 7.5 years in the Romanian child protection system. However, one in every five children aged 15 to 26 years who are now in the system has spent all his or her life in the system, and almost one in every three children has spent 90 percent of his or her life. This shows that there is a pressing need to develop mechanisms to help children as they grow old enough to exit the system, which is the only family they have known. The social and professional integration of these children into society will be very difficult if the system simply disappears once they reach a certain age, leaving them without the skills that they need to live an independent life, without enough education to earn a living, and without any prospect of housing.

There are two main solutions to this transition from childhood to adulthood for children in care. The first is to provide options for those capable of living independently, not only alternative familial care but also social houses and sheltered houses. The second solution focuses on young adults with severe disabilities, who cannot manage on their own and have no support from their families. These options would address a wide range of needs specific to young people: (i) the need to obtain and keep an affordable dwelling, to live independently, and, in some cases, to manage financial and personal goods; (ii) the need for habilitation and rehabilitation adapted to the specific needs of adults with disabilities and provided in the context of an independent life; (iii) the need for professional training, education, professional mentoring, and support to find employment; (iv) the need to access other community services (such as medical assistance, legal services, outdoor activities, cultural activities,

and leisure centers); and (v) the need for a balanced family life (including, for instance, family counseling and sexual education).

Theme 6: Improving and systematizing working practices

Working practices need to be improved and systematized at all stages of the child protection system. The study has highlighted certain specific issues that need to be addressed.

First, there is a need for child protection workers to be more accurate in identifying the reasons for separating a child from his or her family. The study found that "poverty" is often given as a cause in the records when in fact the separation was also due to child neglect or abuse or to the death of his or her parents. This distorts the data and makes it difficult for the child's case worker to draw up an effective and relevant Individualized Protection Plan for the child.

A second issue is the need to develop a consistent process to follow in cases where children enter care at their family's request or as a result of a decision of the Child Protection Commission. This process should start with a thorough initial assessment of the child's case based on comprehensive documentation and end with the fulfillment of all steps prior to the placement of a child in the protection system. Such procedures should be applied consistently throughout the country.

The study revealed that it is crucial for all communes to have at least one SPAS staff member with social assistance duties who has a higher education. Universities, service providers, and the National College of Social Assistants in Romania should draw up child- and family-centered methodologies for the adoption, assessment, planning, design, implementation, monitoring, and evaluation of social services, and a continuous training program should be developed to teach these methodologies to all social assistance staff at the local level.

Theme 7: Developing a high performance management information system

There is an urgent need to develop an effective, nationwide, computerized management information system (MIS) for the child protection system. If used daily in the work of all case managers and specialists within the system, this MIS would significantly increase the accuracy and consistency of data at both the local and national levels. The data entered into this MIS should reflect each child's full history and should contain enough information to enable child protection professionals to provide efficient support to children and their families. This theme is fundamental and is connected to all the other themes because in the absence of reliable and comprehensive data about the child and their family, all child protection system interventions meant to serve the child's best interest will fail.

Developing a computerized management information system would reduce bureaucracy, increase transparency and accountability, ensure a harmonized approach at the national level, facilitate real-time coordination of the SPAS and DGASPC specialists, enable monitoring of the activities carried out by all relevant stakeholders, and provide the ANPDCA with sufficient information to be able to change or adjust the legislation, programs, and support or corrective measures on the basis of relevant evidence.

3.1. Children in Public Care and Their Families

Story Bag

Do you remember why you had to go to a center?

"- I think I was abandoned at birth. I don't know. So basically, I think I've been here for about 14 years. My father would not acknowledge me, I know nothing about my mom. So, I don't know."

(Focus group with children, Craiova)

"- I don't know why.

- Because Mom and Dad didn't have a house or money to raise me.

- I got here because my mom left me with Dad and he didn't have enough money to support me.

- She couldn't afford to raise me and she said she would bring me here to this center so that I would be closer to her, but she doesn't come to see me. ...

- We were told that we were abandoned and that it's a good thing that we got here because there is someone to take care of us, to take us to school, to feed us, we have electricity and a place to live. We have a place to live and there is someone to look after us."

(Focus group with children, Braşov)

"- Because our parents have to work.

Where do they work?

- My parents take care of a girl at home and my aunt looks after a child whose mother has to go to work. [...]

- My mom goes to Italy on a regular basis to earn money for a small house, for flowers for Grandma, for my uncle, for us."

(Focus group with children, Bucharest)

"- Because my folks moved to another country and they left me at the center."

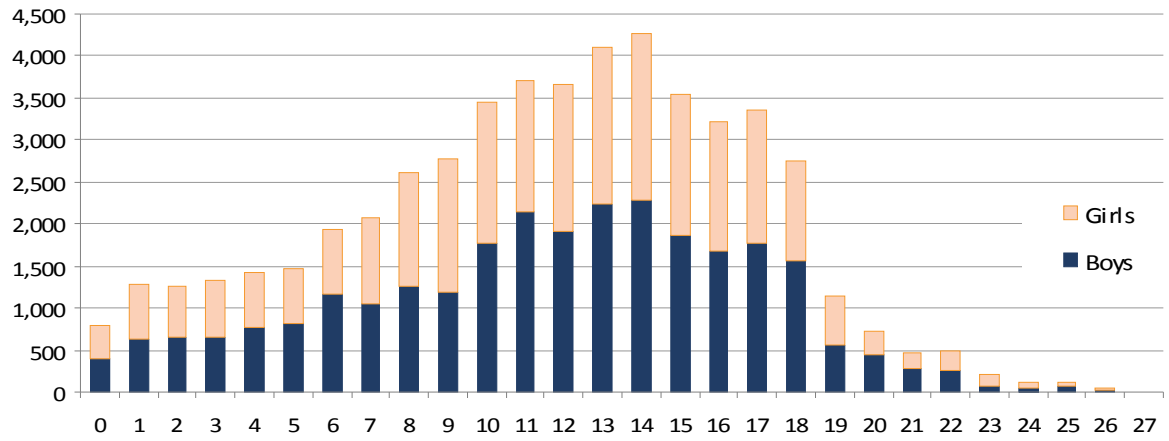
(Focus group with children, Cluj-Napoca)

This section discusses the main characteristics of children in public care in Romania and of their families, mainly on the basis of the representative sample of children extracted from the CMTIS in November 2014.[36] Regarding the mothers of these children, additional information was drawn from the Household Survey in Rural Source Communities.

3.1.1 Profile of Children in Public Care

The children in public care (whether in institutions or in alternative family-type care) are girls and boys of all ages, between 0 and 26 years old (though there are also some young people aged over 26 still in the system). There are slightly more boys than girls (53 percent versus 47 percent). Out of all of the children in public care services, most are aged between 10 and 17 years old. This age group accounts for more than half of the children in protection (56 percent), and its total number and proportion have been constantly increasing over the last four years.

Figure 5: Children in Public Care, by Gender and Age Groups (number)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Young people aged 18 years or older who are full-time students (or in other special conditions) are eligible for protection within any type of public care service, until they turn 26 years old.[37] This group represents a consistent share of 12 percent.

Children in public care come from all counties in the country, 43 percent from rural localities and 56 percent from urban settlements. The predominance of children from cities is due to the large share of children relinquished in maternity homes among those aged 0 to 2 years old.

There are children from all ethnic groups in the child special protection system (Annex 6 Table 2). According to the data available in the children's case files, the distribution by ethnicity of children in public care differs considerably from that in the general young population. The share of children with undeclared ethnicity in the child protection system is three times higher than in the young population aged 0 to 29 years (31.3 percent versus 9 percent, according to the 2011 census). At the same time, the proportion of Roma children is double the proportion in the general youth population (10.3 percent versus 5.3 percent), while that of Romanians is substantially lower (54 percent versus 79.1 percent).[38]

[36] Data are weighted.

[37] In special circumstances, the period may be extended for another three years.

[38] The structure of the resident population in Romania, by age groups and ethnicity, 2011 Census, vol2_t5.xls, http://www.recensamantromania.ro/noutati/volumul-ii-populatia-stabila-rezidenta-structura-etnica-si-confesionala.

Children with disabilities represent a significant share (almost 29 percent) of all children in public care (see Annex 6 Table 3), while the files for over 9 percent of children in protection contain no relevant data on disability. Fewer than two-thirds (62 percent) of children in public care have no disability at all, according to the information in their files. The proportion of children with disabilities increases incrementally from about 6 percent of infants under 1 year old to over 43 percent of young people aged between 18 and 26 years.[39] At the same time, the probability of a child in public care having had a disability is higher among boys than among girls, higher among Roma and other ethnic groups than among Romanians and Hungarians, and higher among children from cities than among those from rural areas.

In conclusion, the needs of children in the protection system vary considerably according to their age, gender, residence of origin, and health condition, which means that the child protection system has to offer a wide variety of services to meet those needs.

3.1.2 The Large Majority of Children in Public Care in Romania Have a Family

As highlighted in the book *Deinstitutionalization Myth Buster*:[40] "Contrary to common belief, the large majority of children placed in institutions are not orphans, but have one or even both parents." This is also the case in Romania, for all children in public care, whether placed in institutions or family-type care. This section focuses on the analysis of data from the children's files regarding their parents and the families who took care of them before they entered the protection system.

3.1.2.1 The Moms

In the Romanian child protection system, only for about 9 percent of all children is the mother not known or not alive.

Table 5: Information about the Mothers of Children in Public Care, by Age Groups of Children, as of November-December 2014 (%)

	<1 year	1-2 years	3-6 years	7-10 years	11-14 years	15-17 years	18-26 years*	Total
Mother is unknown	0.4	0.2	0.3	0.7	1.1	0.7	0.9	0.8
Mother died before child entered the system	0.0	1.6	2.6	4.2	6.1	9.0	10.9	6.1
Mother died while child was in the system	0.0	0.2	1.3	1.4	2.5	3.7	4.6	2.4
Mother is alive, but no information is available	1.3	1.9	1.5	3.0	2.5	2.1	5.2	2.7
Mother is alive, but she is deprived of parental rights	0.8	1.0	1.1	1.6	1.1	1.4	1.8	1.3
Mother is alive and information is available	97.6	95.2	93.2	89.2	86.7	83.1	76.7	86.7
Total %	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
N	**790**	**2,547**	**6,166**	**10,912**	**15,755**	**10,092**	**6,082**	**52,344**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: *Including youth aged over 26 who were still in the system when the research was conducted.

Most children in public care are social rather than biological orphans. The mothers of over 90 percent of all children in public care are alive and known. In most cases, information about the mother's current marital status, occupation, education, health status, or address is available in the files, but in a few cases (fewer than 3 percent) there is no such information in the child's file. The proportion of children whose mothers are well-documented in their files decreases considerably from over 95

[39] The 18-26 age group also includes the youth aged over 26 who are still in public care.

[40] Eurochild and HHC (2014:3)

percent among young children to less than 77 percent among young people aged 18 to 26. This is probably because, for this age group who by law should have left the child protection system, child protection professionals have shifted their focus from reintegration in the family to "integration in society."

Table 6: Mothers' Ethnicity (% valid data)

	Romanian	Hungarian	Roma	Other	Undeclared	Total
General female population*	83.4	6.2	3.0	1.1	6.3	100
Mothers of children in public care	51.4	3.6	11.8	0.4	32.8	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=30,940 mothers). Unknown mothers are not considered. Data on ethnicity are missing for 3 percent of the known mothers.

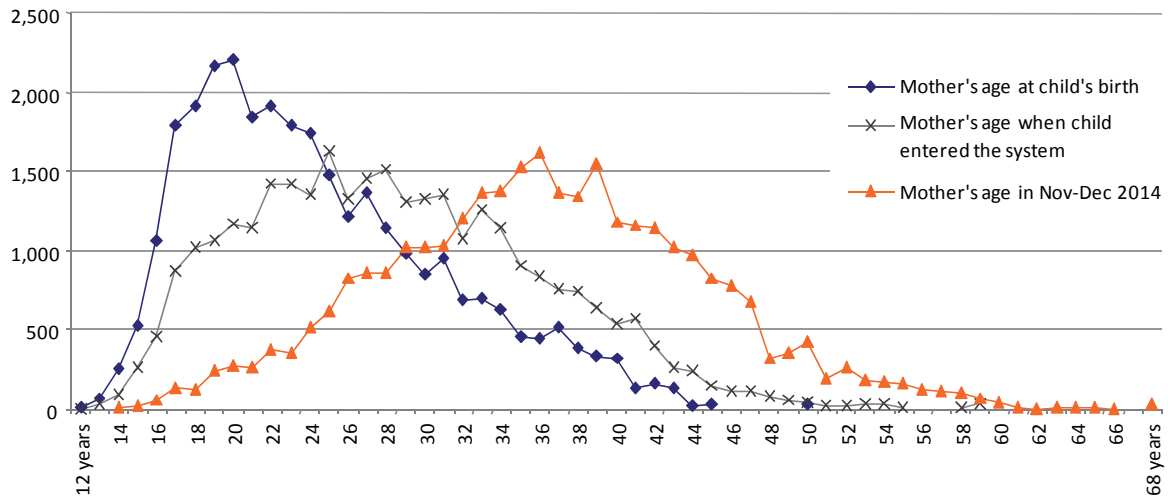
Note: *Structure of resident population in Romania, by age groups and ethnicity, 2011 Census, vol2_t5.xls, http://www.recensamantromania.ro/noutati/volumul-ii-populatia-stabila-rezidenta-structura-etnica-si-confesionala.

Much like their children, the proportion of mothers with an undeclared ethnicity is more than five times higher than the proportion in the general female population. At the same time, Roma mothers are almost four times more numerous than in the general female population, while the proportion of Romanian mothers is much lower (Table 6).

Overall, the children's files contain information on 32,100 mothers aged between 14 and 68 (as of November-December 2014). The population of mothers is young, with an average age of 36.3 years[41] versus an average age of 42.1 years for the national female population, according to the 2011 census.

Most of these mothers gave birth to the child in public care before the age of 25, with 19 percent giving birth between 12 and 18 years old and 39 percent between the ages of 19 and 24. Forty-nine percent were 19 to 29 years old when the child entered the system, and as of November-December 2014, they were over 35 years old (48 percent were between 30 and 40 years old and 30 percent were 40 to 68 years old.

Figure 6: Mother's Age at Different Moments in Time (Number)



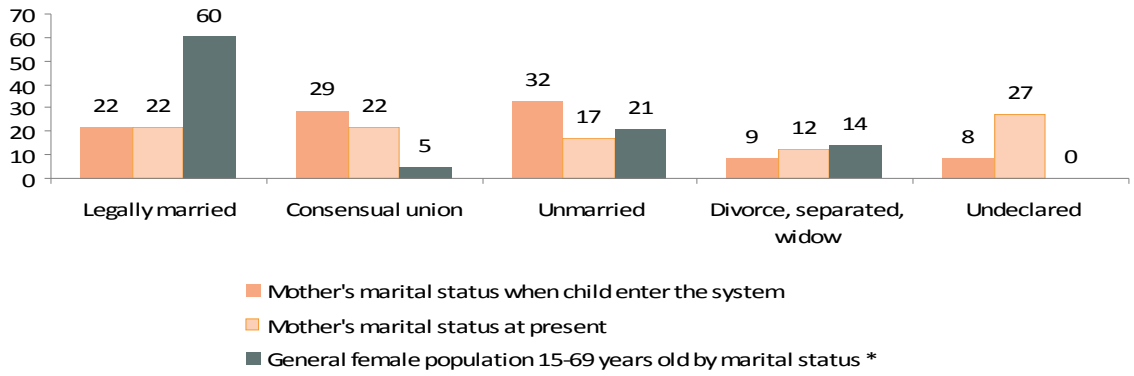
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=30,330 mothers). Unknown mothers are not considered. Data on birth date are missing for 5 percent of known mothers.

[41] Standard deviation of 8.4 years, and a median age of 36 years old.

Hence, they gave birth at an early age, on average 23.4 years old versus 27.8 years for all Romanian women. The average age of the mother at the time of the child's birth is lower for mothers from rural areas (on average, 22.9 years versus 23.8 years for mothers from urban areas) and for Roma women (on average, 22.9 years old).

The mothers of children in public care have an atypical demographic profile. In addition to the early average age at child birth, Figure 7 shows that, unlike the general female population, they follow a consistent pattern of consensual unions and undeclared marital status, which is usually associated with unstable relationships.

Figure 7: Mothers of Children in Public Care Versus the General Female Population Aged 15-69, with Regard to Marital Status (%)

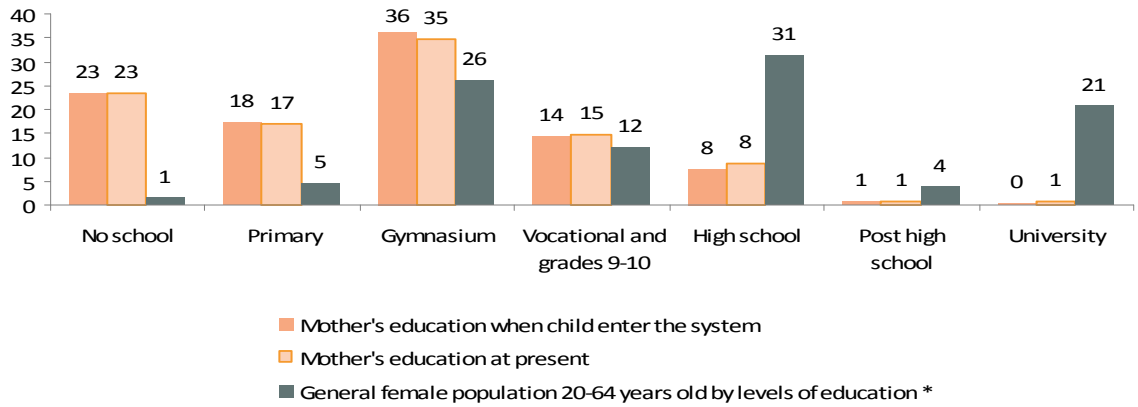


Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=29,037 mothers). Unknown mothers and deceased mothers are not considered.

Note: *Structure of resident population in Romania, by gender, age groups and marital status, 2011 Census, vol1_t12.xls, http://www.recensamantromania.ro/noutati/volumul/

There is little information in the children's files about the state of their mothers' health either at the time when the child entered the system or at the time of the research (Annex 6 Table 4). Based on the available valid data, it appears that around 20 to 23 percent of mothers suffered from mental health problems and/or from a physical disability. Risky health behaviors such as alcohol and drug abuse were also reported in the files for 9 percent and 2 percent of mothers respectively.

Figure 8: Mothers of Children in Public Care Versus the General Female Population Aged 20-64, with Regard to the Level of Education Achieved (% valid data)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=14,700 mothers). Only living mothers aged 20-64 are considered. Data on education are missing for 47 percent of them.

Note: *Structure of resident population in Romania, by gender, age groups and level of education, 2011 Census, vol1_t40.xls, http://www.recensamantromania.ro/noutati/volumul/

The level of education achieved by mothers is poorly documented in children's files. There is no information at all for almost half (47 percent) of all mothers. However, the existing valid data indicate that their level of education is very low. Almost one in every four mothers of children in public care is illiterate. Overall, more than three-quarters of them have completed gymnasium at most.

The employment of mothers is also poorly documented in children's files (Annex 6 Table 5).[42] The existing valid data show that they are disconnected from the labor market, particularly the formal labor market. The proportions of female employees, employers, and consequently of pensioners[43] are extremely low. Their links to the informal or black labor market are also rather low. Only around 23 to 28 percent of mothers do casual work within the country or abroad, are self-employed in agriculture or in non-agricultural activities such as peddling or selling bottles or scrap metal, or make a living from begging, vagrancy, prostitution, or petty theft. Several of the mothers have had occasional episodes of prostitution (2 percent). Associated with this spectrum of activities, over 3 percent of mothers have a criminal record.

However, the majority of mothers are dependants, classified as housepersons, people unable to work, or jobless (around 60 percent). Some of them (2 to 3 percent of all mothers) are institutionalized either in prisons or in various health or social institutions. Under these conditions, especially if no supportive extended family exists, these mothers would only be able to provide their child with a stable and decent living only with consistent support from the state in terms of benefits and varied social services or by finding a partner able to provide for both the mother and her children.

CONCLUSION

More than 90 percent of children in public care have mothers who are known and alive. Nevertheless, the circumstances of these mothers are too poorly documented in the children's files to be very useful for developing a proper plan for reintegrating the child with the mother. Information on the mothers' marital, health, education and employment status is sparse and mostly out of date. The available data indicate that reintegration requires substantial efforts and the provision of consistent support to mothers by both the professionals in the child protection system and other institutions in order to ensure a family environment that can offer the child real chances at developing properly. Otherwise, reintegration will only mean sending the child into a highly unstable and unsuitable environment.

Drafting and implementing a policy targeting young mothers without education and in vulnerable situations (in other words, alone or living in a consensual union, economically dependent, lacking stable accommodation in which to live with the child, and in poor health) is very necessary. If such a policy would exist, the placement measure for children from these families might be reconsidered, as they could return into their families.

[42] There are no data on the employment status for 43 percent of living mothers.

[43] Among the mothers of children in public care, most pensioners receive sickness or disability pensions rather than social insurance pensions.

Box 2: Life Trajectories of Mothers

FROM RURAL SOURCE COMMUNITIES

In general, the mothers of children in public care from rural source communities spent most of their childhood with a mother and father who were most often legally married (about 60 percent). Less frequently, they grew up with a mother and father in a consensual union or with a single-parent (usually the mother) or in an extended family. Their families of origin were large, with a number of children that varied between 1 and 22 and an average number of five children. In addition, about 14 percent of their parents had children from other relationships as well.

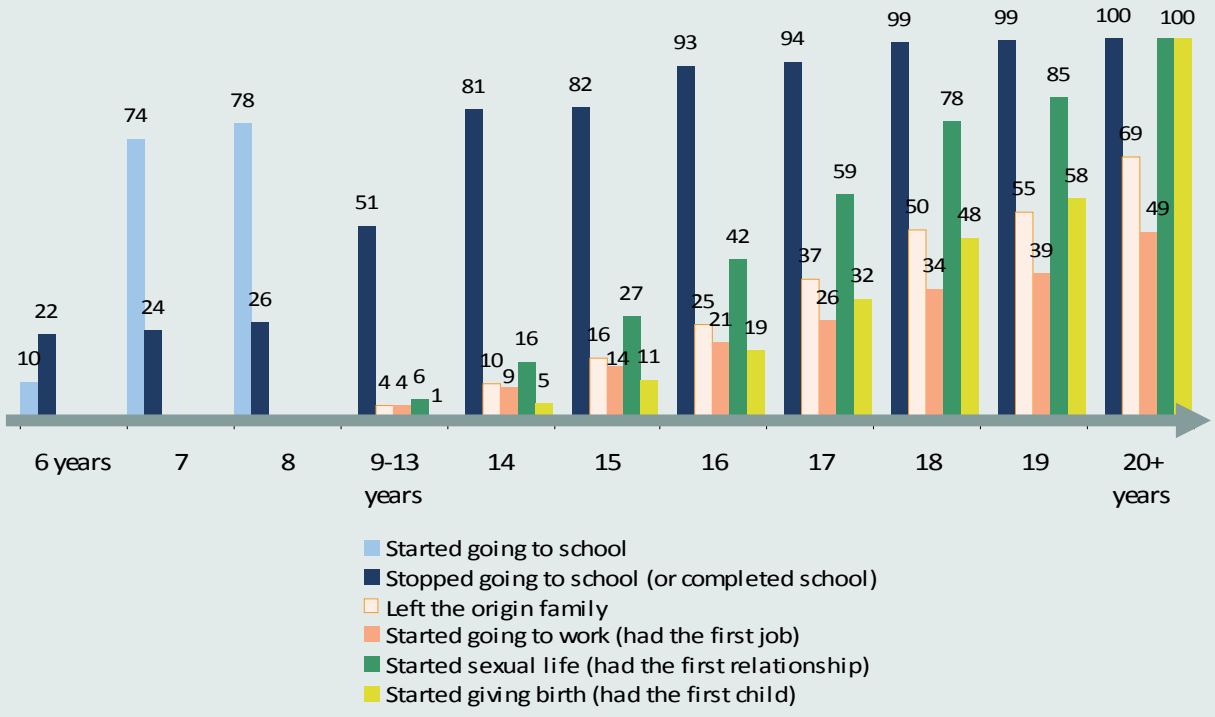
One in every three mothers spent some time in public care herself during her childhood. Three percent spent more time in the child protection system than with their family of origin up to the age of 18 years old. Four percent of these mothers had siblings who were also in public care.

Their parents (the grandparents of the children in public care) were poorly educated, with approximately 20 percent never having attended school, while another 73 percent of grandmothers and 70 percent of grandfathers had completed gymnasium at most. With many children and poorly educated parents, the families were very poor (34 percent) or poor (40 percent).

Like their parents, 22 percent of the current mothers of children in care have never attended school, while 59 percent have completed only primary or gymnasium education. Fewer than 19 percent of the mothers achieved a higher level of education than their parents.

By the age of 18, more than half of them had already left their family of origin, 34 percent had already had a first job (while 51 percent of the mothers never had an income-earning activity), 78 percent were sexually active, and about 48 percent had given birth to their first child (see figure below).

Significant Life Events, by Age (% valid data about mothers from rural source communities)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=685-873 mothers with children in public care).

Consequently, by and large, mothers of children in public care:

- Become sexually active before the age of 17 years old

- Have their first child at an early age - 19.6 years as compared with the average age at the first birth of 26.2 years at the national level (NIS, 2013)

- Tend to have more partners and more children during their lifetime than the general female population. According to the valid data,[44] during their lifetimes, they had an average of 3.8 children (a maximum of 18) with 1 to 10 partners (on average, 1.5), and an average of 1.6 abortions (a maximum of 30). For comparison, the average number of children per woman is 1.5 for the national female population (NIS, 2013).

3.1.2.2 The Dads

Unlike the mothers, the fathers of 52 percent of children in public care are either unknown or dead. The proportion of fatherless children declines from 72 percent among infants under 1 year old to approximately 43 percent of young people of 18 to 26 years old. Conversely, for the same age groups, the share of children with sufficient information about their fathers in their files increases from only 28 percent to almost 52 percent.

Table 7: Information about the Fathers of Children in Public Care, by Age Groups of Children as of November-December 2014 (%)

	<1 year	1-2 years	3-6 years	7-10 years	11-14 years	15-17 years	18-26 years*	Total
Father unknown	71,9	64,3	49,7	49,2	44,9	34,5	25,4	43,4
Father died before child entered the system	0,0	0,5	2,7	4,4	4,9	7,5	7,8	5,1
Father died while child was in the system	0,0	0,4	0,4	1,7	3,5	6,3	10,0	3,9
Father is alive, but no information is available	0,0	0,3	1,3	1,8	0,9	2,1	3,4	1,6
Father is alive, but he is deprived of parental rights	0,0	0,3	0,7	0,9	0,7	0,9	1,1	0,8
Father is alive and information is available	28,1	34,3	45,2	42,0	45,1	48,8	52,2	45,2
Total %	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
N	**790**	**2.547**	**6.166**	**10.912**	**15.755**	**10.092**	**6.082**	**52.344**

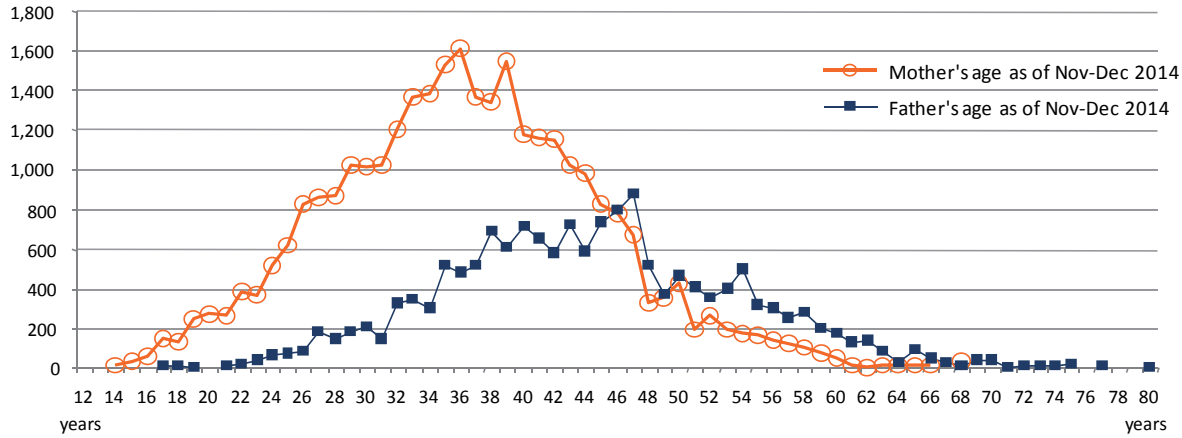
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: * Including youth aged over 26 who were still in the system when the research was conducted.

At the same time, for both girls and boys, the proportion of fatherless children is significantly higher for children from urban areas than from rural areas (59 percent versus 44 percent). It is also higher for Roma children and from other ethnic groups (63 percent) than for Romanian children (48 percent) and Hungarian children (57 percent). Thus, in the children's files, the most information on fathers exists for Romanian children aged over 11 years who come from rural areas.

[44] One-third of the mothers did not declare the number of partners with whom they had had children during their lifetime.

Figure 9: Age Difference between Mothers and Fathers of Children in Public Care (Number)



Source: Survey of Case Files of Children in Public Care (November-December 2014). Data are weighted (N=30,330 mothers and 15,750 fathers). Unknown parents are not considered.

Note: Data on birth date are missing for 5 percent of known mothers and 9 percent of known fathers.

Figure 9 shows that there are considerable age differences between the mothers and fathers of children in public care.[45] Thus, it would seem that many of these couples were atypical, mostly in terms of being formed of a young woman and a much older man. For 46 percent of these couples, the age difference is more than five years, while for 19 percent of them, the father is between 10 and 41 years older than the mother. In over 1 percent of cases, the father is more than five to twelve years younger than the mother. Only about half of the couples (53 percent) have an age difference within the range of five years, and only about a quarter have no more than two years between partners, which is the standard age difference. As with the children and their mothers, the Roma and those with undeclared ethnicity are over-represented among fathers, while Romanians are heavily underepresented compared to the general male population. Also, one in every five couples (mother-father) in which at least one partner declares an ethnic affiliation is ethnically mixed.

Table 8: Fathers' Ethnicity (% valid data)

	Romanian	Hungarian	Roma	Other	Undeclared	Total
General male population*	83,5	6,0	3,2	1,3	6,0	100
Fathers of children in public care	54,4	3,4	7,7	0,5	34,0	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=16,378 fathers). Unknown fathers are not considered. Data on ethnicity are missing for 10 percent of the known fathers.

Note: *Structure of resident population in Romania, by age groups and ethnicity, 2011 Census, vol2_t5.xls, http://www.recensamantromania.ro/noutati/volumul-ii-populatia-stabila-rezidenta-structura-etnica-si-confesionala

The demographic pattern of the fathers deviates from that of the general male population by being characterized by undeclared marital status (usually associated with unstable relationships), divorce, separation, and consensual unions, even more than was the case for the mothers (Annex 6 Table 6).

When it comes to health, the status of the fathers is similar to that of the mothers (Annex 6 Table 4). Their health status is very poorly documented in the children's files. Based on the available valid data, about 11 to 16 percent of the fathers suffer from mental health problems and/or from a physical disability, while risky behavior is quite frequent with 26 percent reported with alcohol abuse and around 4 percent with drug abuse.

[45] The average age difference between mothers and fathers of the children in public care is for the father to be six years older than the mother, with a standard deviation of 6 years.

The fathers of children in public care have somewhat higher levels of education than the mothers but are clear underachievers when compared to the general male population (Annex 6 Table 7). The children's files contain information about education for only about half of the fathers who are known and alive. The available valid data show that 10 percent of the fathers are illiterate (versus 23 percent of the mothers), while approximately 52 percent of the fathers completed gymnasium (versus 25 percent of the general male population). Most of the other fathers underwent vocational training, which offers them certain chances of entering the labor market, mainly as manual workers.

As a consequence, the fathers have more links to the labor market than the mothers (Annex 6 Table 5).[46] Nevertheless, only about 11 percent of the fathers are workers with a labor contract,[47] while 45 to 51 percent of them are employed in the informal or "black" labor market. Specifically for this reason, 10 percent of them are reported to have a criminal record and 6 to 8 percent are in prison, either in Romania or abroad. The share of dependent people among fathers (housepersons, unable to work, or jobless) is lower than for mothers but is much higher than in the general male population (25 to 29 percent). As a result, most of the fathers of children in public care hold insecure, low paid, and/or risky jobs, which cannot provide a stable and decent life for a family.

CONCLUSION

Only 48 percent of children in public care have fathers who are known and alive. In the children's files, the fathers' circumstances are even less well-documented than those of the mothers. Only in the case of very few children does the father seem to be able to provide a decent life, though not necessarily a stable family environment as well.

3.1.2.3 The Families

This section turns from parents to the families who cared for the children before they entered the child protection system. Based on the children's file information on their caretakers, the children in public care can be grouped in three categories according to their family of origin:

- About one-third of children (32 percent) come from single-mother families and there is no information available about the father.
- Another third (31 percent) come from typical nuclear families, including a mother and a father and possibly other children as well.
- The final third of children (37 percent) are from a variety of atypical families among which two types are most common: (i) a single-mother living with another person (usually the grandmother) who takes care of the child (9 percent) and (ii) a couple living together with the child in a multigenerational household, in which a person (usually a grandparent) takes care of the child (8 percent). The other atypical types of families constitute less than 3 percent each and consist of, for example, single-fathers who went to jail, single-mothers who left to work abroad, children relinquished by their parents and taken in by a relative or other person, or children left alone at home after both parents went abroad or after other unfortunate events occurred in the family. These types of families are shown in Infograph Chart 1.

Both for girls and boys in public care, the proportion of children from single-mother families decreases sharply with the child's age at the time of the survey, from 64 percent among children under 1 year old to 52 percent of toddlers aged 1 to 2 years and to a low of 21 percent among young people aged 18 to 26. By contrast, the proportion of children from nuclear families is only 24 percent among babies (younger than 1 year old) and reaches 40 percent of young people between the ages of 18 and 26.

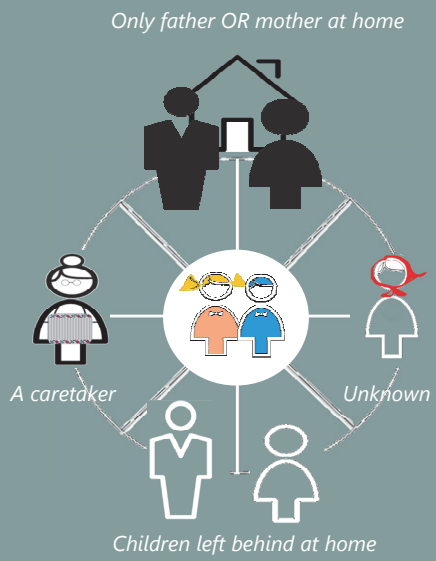
[46] Data on employment status are missing for 50 percent of living fathers.

[47] Correspondingly, among the fathers of children in public care, most pensioners have sickness or disability pensions, while very few have social insurance pensions.

Infograph Chart 1: Types of Families of Origin of Children in Public Care (%)

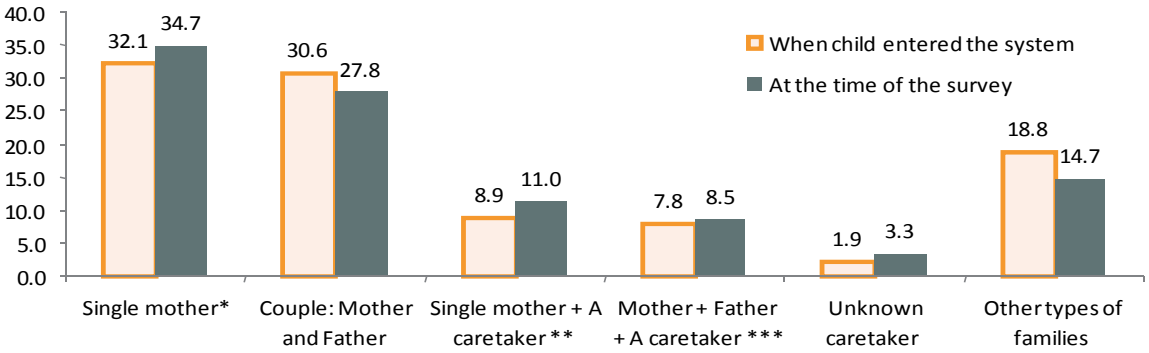
	When child entered the system	At time of survey
Single-mother	32.1	34.7
Couple: Mother and Father	30.6	27.8
Single-mother + A caretaker	8.9	11.0
Mother + Father + A caretaker	7.8	8.5
A caretaker + Mother who left home	2.9	1.3
A caretaker + Both parents left home	2.3	0.5
Single-father + A caretaker	2.3	2.6
Single-mother who left home	2.3	1.3
Unknown caretaker	1.9	3.3
Single-father	1.7	2.7
Mother + Father who left home	1.4	1.3
Father + Mother who left home	1.3	0.8
A caretaker other than parents (relative or not)	1.3	1.5
A caretaker + Mother + Father who left home	1.1	0.9
A caretaker + Father + Mother who left home	0.9	1.0
A caretaker + Father who left home	0.6	0.3
Children left alone by both parents who left home	0.5	0.2
Single-father who left home	0.3	0.2
	100	100

Atypical family structures:



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Figure 10: Structure of the Families of Origin of Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: *No data about the father. The mother was the child's caretaker. **Mother is known and alive, but she lives in the same dwelling with another person (usually the grandmother) who takes care of the child. ***Usually, multigenerational households in which grandparents or other relatives take care of the child although the parents are present as well.

The changes in time within the structure of the family of origin (Figure 10) feature a pattern of unstable relations, divorce, and separation. Between the time when the children entered the system and the time of the study (November-December 2014), the share of children from nuclear families dropped from 31 percent to 28 percent, whereas the share of those with single-mothers slightly increased from 32 percent to 35 percent.

The atypical structure of the families of origin resulted in 28 percent of children who depended on a caretaker other than their parents before they entered the system. Children's file information on caretakers is rather vague. Nonetheless, it shows that the large majority of these caretakers (88 percent) were relatives, of whom more than three-quarters were grandparents (particularly grandmothers on the mother's side). Thus, about 80 percent of these caretakers were women with an average age of 57, legally married (42 percent), poorly educated, and employees, pensioners, or housepersons.

Overall, 34 percent of the children lived with one to fourteen siblings (with an average of two siblings) before entering the system (Annex 6 Figure 1). However, this proportion strongly varies by the structure of the family of origin. Thus, children who lived with siblings prior to entering the system account for a minimum of 12 to 14 percent of the children from families of single mothers who left home or of children with caretakers other than their parents (whether these were relatives or not) and a maximum of 77 percent of children coming from single-father families.

At the time of the data collection (November-December 2014), half of the children had between one and ten siblings (with an average of two siblings) in public care (Annex 6 Figure 1).[48] Generally, the proportion of children with siblings in public care at the time of the study was higher than the proportion of children living with siblings before entering the child protection system. Therefore, one child in public care seems to be a good predictor for new (or other) entries into the protection system from that child's family.

[48] There is no information on whether the siblings entered the child protection system before or after the child under study.

FROM RURAL SOURCE COMMUNITIES

The survey of rural source communities yielded additional information about the "power of the antecedent" - the families of origin of the children in public care. All of the mothers in the sample of households from rural source communities had at least one of their children in public care. Twenty-one percent of them had only one liveborn baby during their lifetime and relinquished that baby to the system. The majority of them were adolescents or younger than 20 years old. The other 79 percent of mothers gave birth to two to eighteen children for a total of almost 3,000 children from about 700 mothers. Of these mothers, 51 percent relinquished only one child to the system during their lifetime, while the other 28 percent of mothers each gave two to ten of their children up to various caretakers. Two-thirds of children were relinquished in maternity wards or were left directly to the child protection services, and one-third were sent to relatives, particularly grandmothers. Overall, more than one in every three children born to mothers from the rural source communities did not grow up with their mother or parents but in the child protection system and, less frequently, with their grandparents.

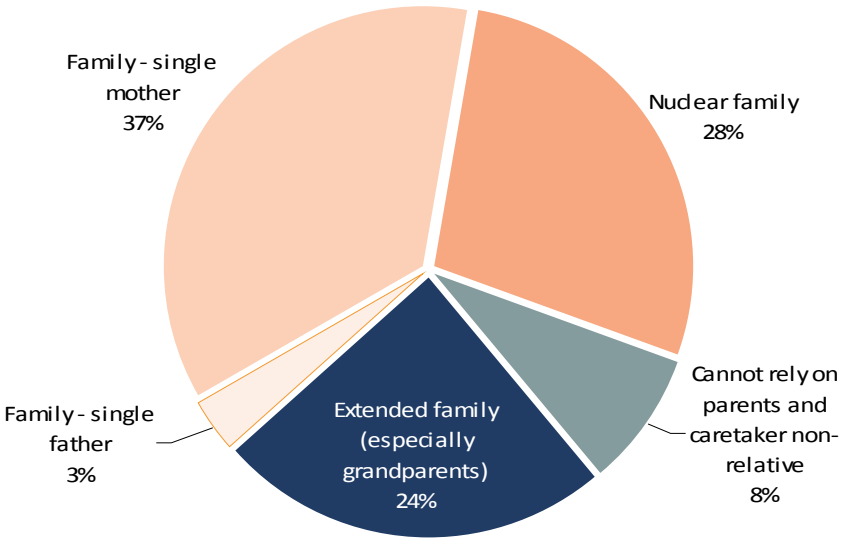
Source: Household Survey in Rural Source Communities (July-August 2015). Data are not weighted (N=873 mothers with children in public care).

Given this information about the current structure of the children's families, it is clear that reintegration has different implications for various categories of children. Thus, only for about 28 percent of children in public care would reintegration into the family mean returning to a nuclear family. For other 37 percent, reintegration into the family would mean returning to a single-mother living in a highly vulnerable situation, as shown in section 3.1.2.1. For the 24 percent who used to be taken care of by their relatives (particularly grandparents), reintegration into the extended family would be the only workable option. Finally, the last 8 percent of children have no parents or relatives to rely on, while 3 percent have only a single-father. In their case, reintegration into their family is very likely to fail.

Boys and girls have an equal chance of falling into any of the categories shown in Figure 11. However, there are significant differences among the children according to their age, residence of origin, ethnicity, and health status. These differences are presented in Annex 6 Table 8. As already mentioned, children under the age of 3 are more likely to belong to a single-mother family, while children over the age of 15 are more likely to have been taken care of by their nuclear and/or extended family. However, the chances for reintegration are not necessarily higher for youths and adolescents from nuclear and/or extended families because it all depends on how long they were separated from their family as the child-parent relationship is often more difficult during adolescence and early youth than in childhood.

Roma children and those with undeclared ethnicity are more likely to belong to a single-mother family. The same is true for children from urban areas, as opposed to those from rural settlements who are more likely to come from a nuclear and/or an extended family. Children with disabilities are more likely than those without a disability to belong to a family, whether a single-mother family or a nuclear family.

Figure 11: Distribution of Children in Public Care According to Current Family Structure (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

RECOMMENDATIONS

More than 4,300 children (8 percent) in public care do not have any family (whether nuclear or extended) to return to. They are boys and girls of all ages, all ethnic groups, with or without disabilities. For them, a new long-term plan should be developed, either one targeting adoption or an Individualized Protection Plan until they reach 18 years of age so as to make sure that, by the time they leave the system, they have the same chances in life as do children with a family. They certainly should no longer spend time in large residential institutions without a plan that takes into account the best interests of the child and that aims for an urgent move to a family-type protection measure.

Over 18,800 children (37 percent) belong to single-mother families. Their reintegration into their families will not succeed unless effective support is offered to their mothers. As we have shown, most of these mothers do not have the resources required to overcome the complex hardships with which they have to deal. Drafting a family policy that targets support to single mothers would improve the chances of a successful child reintegration based on a medium-term plan that should be worked out *in cooperation with* the mother and the child in order to be effective, rather than devised *for* them. This plan should be accompanied by the necessary implementation resources targeted to the child's location as well as the necessary monitoring and support structures to be applied once the child returns in the family and continued for as long as necessary.

More generally, in order to draft a realistic Individualized Protection Plan that would genuinely increase the child's chances of living in a family, it is essential that the situation of both parents is documented in detail and in depth, is constantly updated, and is complemented by information on the extended family, if there is one, as well as on the communities in which these parents live. The fact that, generally, there is less information on the fathers reflects (and reinforces) the social norms according to which the woman (usually the mother) is the child's main caretaker. In any case, the lack of information on parents and the absence of a system for tracking and recording any developments in the status of those parents from whom the child was separated makes the child's reintegration into his or her family a difficult and sometimes impossible mission.

3.1.3 The Routes Followed by Children Before Entering Public Care

Most children in Romania are born in a maternity ward. From there they leave with their mother to join a nuclear family that owns a dwelling and is well integrated in a complex kinship network comprising many relatives with whom, as they grow up, they spend various periods of time, with or without their parents. This may be considered the standard route followed by children in Romania. The children in public care in Romania followed a variety of different routes before entering the system. These routes are visually presented in Infograph Chart 2.

There are broadly three categories of routes that children take before entering the public care system. The first category relates to family and kinship networks: in these cases, children are on the standard route until some disruptive event happens and they end up in the child protection system. This is the case for about 65 percent of children in public care. The second category of routes relates to situations when children are relinquished in institutions, usually medical facilities, which is the route for more than 31 percent of children in public care. The last category is that of street routes and is the least common. The case files contain no information in this respect for fewer than 1 percent of the children in care. The three categories of routes are explored in the next sections.

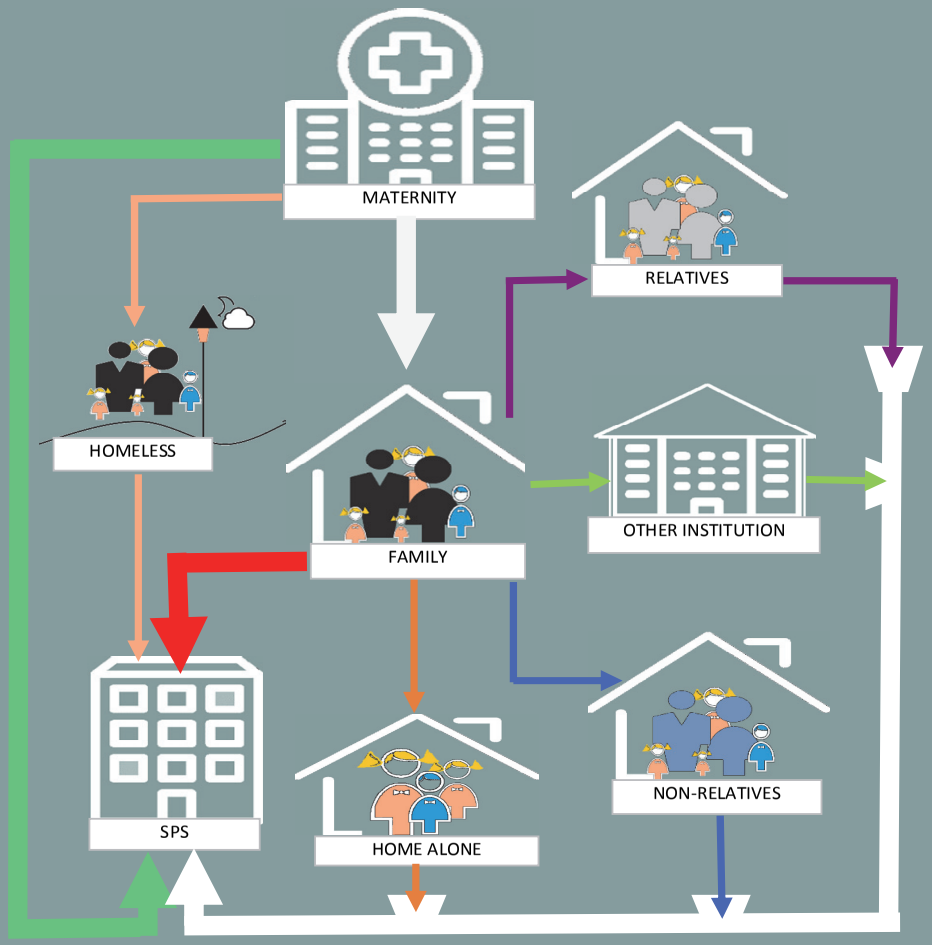
3.1.3.1 Routes Related to the Family and Kinship Network

The route Maternity ward --> Family with stable dwelling --> SPS (Special Protection System, Romanian for public care) was followed by girls and boys of all ages but was more typical of children who entered the system when they were over the age of 3, who therefore were 11 years old or more at the time of the study. They tend to be Romanian or Hungarian children in good health who come from rural areas (Annex 6 Table 9).

Three kinds of family histories are typically associated with this route, namely:

- About half of these children come from a nuclear family and, at the time of the study, still had a nuclear family to return to (sometimes living in a multigenerational household). In most cases, their parents were young adults of 25 to 39 years old when their children entered the system. Nevertheless, about one-third of the children who followed this route have mothers who, at the time of the study, were over 40 and fathers who were over 50 years old.
- Nearly one-third of these children grew up in a single-mother family with an unknown father. In most cases, the mother was young (under 25 years old) and had no support from her kinship network.
- The other children ended up in the system after their mother or father died. In most cases, after the mother's death, they lived for a while with their father who was not able to both provide and care for his children. Thus, the father asked the DGASPC for help and placed his children in public care.

Infograph Chart 2: Routes Followed by Children in Public Care Before Entering the Special Protection System (SPS) (%)



1	Maternity ward --> Family with stable dwelling --> Special Protection System (SPS)	50.9
2	Relinquished after birth in a maternity ward --> SPS	23.9
3	Maternity ward --> Family --> Relatives --> SPS	10.4
4	Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS	7.1
5	Maternity ward --> Family --> Non-Relatives --> SPS	2.0
6	Maternity ward --> Family with unstable accomodation or homeless --> SPS	1.9
7	Maternity ward --> Family --> Children left home alone --> SPS	1.3
8	Maternity ward --> Family --> Children left by parents on the street/ public spaces --> SPS	0.9
9	Maternity ward --> Family --> Children ran away from home/ street children --> SPS	0.5
10	Maternity ward --> Family: Single mother institutionalized --> SPS	0.1
11	No information in the child's file	0.9

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

The route Maternity ward --> Family --> Relatives --> SPS is common when one or both parents die, leave home (to go to prison, to work abroad, or to a "new" family), or are deprived of their parental rights. In some cases, the child's family lived together with other relatives (such as grandparents) in the same dwelling. In other cases, the relatives had different dwellings, but the family ties were strong enough that the relatives were willing to take care of the child for a while. When relatives became unavailable or unwilling to care for the child, either a non-relative person offered temporary support (Maternity ward --> Family --> Non-Relatives --> SPS) or the child remained home alone before being taken into the custody of the child protection services (Maternity ward --> Family --> Children left home alone --> SPS).

> "Do you remember why you had to go to a center?
>
> - Because my folks moved to another country. And my siblings and I were left all alone... and we ended up at the center.
>
> - Actually, being home alone is kind of cool. I was left home alone. Yes. (laughing)" (Focus group with children, Cluj-Napoca)

These three routes (3, 5, and 7 in the Infograp Chart 2) are not associated with any specific characteristics of the children, but being taken in by relatives or other people is more frequent in rural areas where the kinship and social networks are closer and more supportive.

In addition, a small number of children (0.1 percent) (i) arrived in the child public care system after their mothers were institutionalized (most often in a psychiatric hospital); (ii) remained in the system after mother and child had been in a maternal center; or (iii) were born while the mother was in an institution (so, for them going home meant going into an institution).

> "[...] Where I work, there is also a mothers' center... many, about half of the cases are referred to us by this center; they are underage mothers who are not accepted by their family, their pregnancy is not accepted by the family and they want to stay with the child's father during their pregnancy, but they are underage and their family doesn't agree with them getting married, I don't know. Many times, I help the young mother and [she and the child's father] they manage to get married and she goes with the child's father and the child. But, most often, they leave the child and just go away ..." (Focus group with professionals, Timişoara)

Risk is a feature of child protection work that can only be reduced, not eliminated. Although some children arrive in the system via maternal centers,[49] efforts are being made by DGASPCs and NGOs (sometimes in cooperation) to improve the existing services of maternal centers as a way of preventing the separation of children from their mothers and families and ensuring that these centers are not just a mere phase that precedes the separation.

> "- There are mothers' centers under the directorate (DGASPC) acting as residential services and providing mothers with accommodation and specialized interventions from instructors and psychologists to prevent the separation. For the mother and the child or, well, the children, the condition is that one of the children should be under 3, and then they have everything they need for six months, free of charge, in order to keep the child with the mother. So we don't send her to a mothers' center only to later separate the children from the mother and place them in child care. This is an alternative way of preventing child separation.
>
> What happens after six months?
>
> - Then, during that time, of course we work with the mother; normally we don't take mothers off the street because we know that it is difficult to reintegrate them. However, if we are asked, of course we try to see if there is a father, we try to make him accountable and have him acknowledge the child. We also work with the mayoralties, we have a service plan, an aftercare plan, to ensure that a mother never leaves the mothers' center and ends up on the street with her child. The foundation HHC Romania runs a three to six-month financial support scheme that

[49] The case files indicate that fewer than 0.2 percent of children in public care received the services of a maternal center before entering the child special protection system. Another 1 percent of children in public care were initially placed in public maternal centers together with their mothers, but later on they were relinquished by their mothers and transferred to other child care services. This topic is discussed in detail in Chapter 3.3.2.4 (on the first protection service).

allows us to pay the rent, for example, for a mother who was accommodated in a mothers' center provided that she finds a job." (Focus group with professionals, Cluj-Napoca)

The routes related to family and kinship networks are by far the most common (more than 75 percent) among the children in public care from five counties: Gorj, Suceava, Galați, Hunedoara, and Vrancea. By contrast, in counties like Bihor and Harghita, fewer than half of all children in public care have entered the system via these routes (see Annex 6 Table 10).

3.1.3.2 Routes Related to Relinquishment in Health Facilities

Almost 24 percent of children in public care were relinquished after birth in a maternity ward. An additional 7 percent were taken at home for a few months and subsequently deserted in a pediatric hospital or other health unit. These two routes are not associated with specific characteristics of the children and families (Annex 6 Table 11), except for the child's age at entrance in the system.

Relinquishment in health institutions is specific to children under 3 years old (as opposed to older children who are rarely left in a medical institution), girls and boys alike, mostly from urban areas. Children from urban areas are more than seven times more likely than children from rural areas to be relinquished at birth and three times more likely to be left in a health unit.[50] Roma children have a considerably higher probability of being relinquished in these institutions (Annex 6 Table 11). Nevertheless, they represent only 14 to 17 percent of all children who entered the protection system after being relinquished in a maternity ward or medical facility.[51]

Children with disabilities have a high probability of entering the care system after having been relinquished in medical facilities (Annex 6 Table 11). They represent 36 percent of children relinquished straight after birth[52] and over half (51 percent) of those left in a health unit.[53] Premature babies and children with low birth weight (especially those with very low birth weight)[54] have higher odds of being relinquished in a maternity or health facility than children with a normal birth weight.[55]

The majority of these children come from single-mother families (young mothers), an unknown father, and no support from the extended family (approximately 75 percent of children relinquished straight after birth and 50 percent of those relinquished in health units). The others belong to a nuclear family, most often young couples with little or no support from their extended family.

Children of mothers with mental health problems run 1.8 times more risk of being relinquished straight after birth than the average. For children with mothers with both physical disabilities and mental health problems, the odds are 1.5 times higher than average. For children of mothers with physical disabilities and/or with chronic diseases (such as tuberculosis), the risk of relinquishment in the maternity ward is average.

Children of teenage mothers are twice as likely to be relinquished at birth as other children. The odds of being relinquished straight after birth incrementally decrease from 52 percent of all children with adolescent mothers to 35 percent of children with mothers aged 18 to 24 years, to 20 percent of children with mothers between 25 and 39 years old, and to a low of 10 percent for children born to mothers aged 40 or over (Annex 6 Table 11). The probability is even higher if the father is unknown

[50] This result may also be affected by the fact that many children relinquished straight after birth have unknown mothers and fathers. So regardless of where those parents might live, the babies are registered in an urban area because most hospitals are located in urban areas.

[51] The majority of children relinquished in maternity or other health facilities are either Romanians (42 to 44 percent) or have undeclared ethnicity (36 to 37 percent).

[52] In addition, information on health status is not available for about 9 percent of these children. The remaining 55 percent have no disabilities.

[53] Moreover, 12 percent of children left in a medical facility have no information about their health status in their files, while 37 percent have no disability.

[54] Low birth weight for a liveborn infant is less than 2,500 grams. Very low birth weight refers to less than 1,500 grams.

[55] Only 22 percent of all children in public care have any data about their birth weight in their files. Most of those are children who arrived in the system after being relinquished in health facilities.

(and thus does not acknowledge paternity) and/or the teenage mother has no support from her parents or extended family. It is worth noting that the children of adolescent mothers represent only 9 percent of all children that followed the route: Relinquished in a maternity ward --> SPS, and a mere 3 percent of those who followed the route: Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS. For more relevant details, see Chapter 3.2.3.3 on early pregnancies.

> "Normally, the family doesn't accept a child born 'out of wedlock,' as they say; this is a problem for university and high school students who place their children in public care. They secretly give birth to their child, they come from a different county, they get accommodated in a student residence, they happen to get [pregnant] without the family finding out about it … They do this, they travel from one county to another to give birth, to hide their pregnancy and they relinquish their child." (Focus group with professionals, Braşov)

The rates of these two routes vary substantially across counties. Out of the 24 counties with solid data in the CMTIS (see Annex 6 Table 1), six counties have particularly large numbers of children who arrived in public care after being relinquished in health institutions (Figure 15 and Annex 6 Table 12).

The counties with an above average incidence of relinquishment in health facilities are Bihor, Dolj, Harghita, Neamț, Sibiu, Vaslui, and Vâlcea. However, there are other counties, such as Gorj or Suceava, in which both routes are quite rare, while in others both routes are common, such as Bihor and Harghita. At the same time, there are counties such as Caraș-Severin with a high rate of relinquishment in maternity wards but a very low rate of relinquishment in pediatric or other health units.

The mothers of 90 percent of children relinquished straight after birth and 88 percent of those relinquished in health units are alive and known to the child protection professionals (data on the father is available in only 23 percent and 37 percent of the cases respectively). Therefore, when drafting an Individualized Protection Plan for reintegrating the family, data are available on the parents, but, as many of them have been separated from the child for more than 10 years, the chances of reintegration are in reality very low for over half of these children.

However, a large proportion of these parents were aged over 40 at the time when the study data were collected (as of November 2014). Also, little or no information is available about their relatives or extended family as these parents had no support from their kinship networks.

The qualitative study showed that:

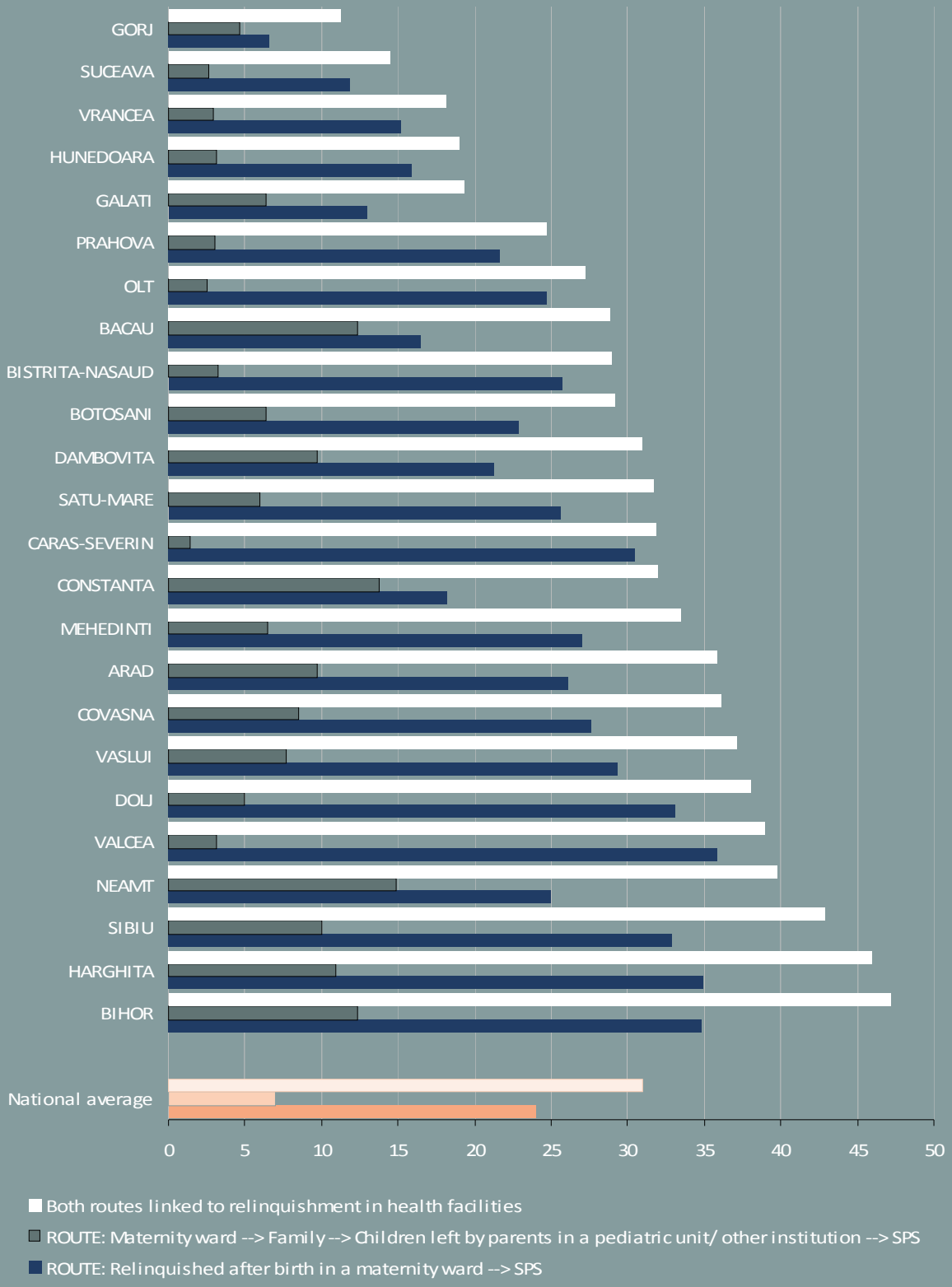
- Often, families do not formally relinquish their child but instead leave them temporarily in public care during difficult times (such as winter). Then, as the separation period gets longer, the chances that the family will come to take the child out of the public care system are weaker.

> "[In a project implemented by UNICEF in the County of Bihor, they identified...] Places where parents were convinced that it was a good thing for the child, to keep them warm during winter. And they would use the hospital as a boarding house, as a place to keep them warm. And after a couple of months they would go and take them back home. And some of them would forget about them [the children]. [...] Yes. They'd get used to being without them. They would say: I did the child a favor, it is warm there, s/he has food every day, s/he won't get bitten by rats, s/he is not shoeless in the cold and mud and so s/he will be better off there. And in the meantime they would have another baby." (Focus group with professionals, Cluj-Napoca)

- For some parents, relinquishment in health units "has become a habit."

> "And here, in the city of Bacău and in other cities with maternity hospitals, most children in public care come from the maternity hospitals, pediatric wards, or other medical facilities. I mean, from the places where children are relinquished, where the mothers known for having a baby every year go to. And the medical staff know that the other children are already in child care. So we do have such cases. We have a mother who already has seven children in public care. Each year, we know that, at some point, we'll get a call to pick up another child from the maternity hospital." (Interview with a specialist, Bacău)

Figure 12: Rates of Children Arriving in the Special Protection System (SPS) Via Relinquishment in Health Facilities, by County (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=50,668). Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

- In some communities, the relinquishment of children in health units is socially acceptable as long as it happens because the mother or the family does not have the means to care for that child. This belief is reinforced by the fact that most health units receive the child without any questions and in the absence of any counselling or other preventive measures, as well as with no referral to child protection professionals.

> "As I've told you, they leave their children in the pediatric ward; they learn this bad practice from one another. I mean, for example they come and tell you 'I can't feed my kids anymore' or things like that and they come and bring them here. 'Take them from me, you take them!' It's left to us to handle them, the children, their child." (Interview with a specialist, Bacău).
>
> "I wanted to ask you who suggested the separation? Did you contact the social services yourself or did someone come to you?
>
> - I contacted them, I went to the maternity ward and I told them that I had no means; I told them I had no means when I gave birth. [...] They asked: 'Do you have a place where you can take him, what will you do with him?' And I said that I had no means and that I couldn't leave him but I couldn't take him home either because I had nowhere to take him. And they understood. So, they understood." (Interview with a parent of institutionalized children, Arad)

- Ocasionally, hospital and maternity ward staff as well as some of the child protection specialists encourage or even direct the parents to relinquish their children straight after delivery. This is particularly the case for children with disabilities or homeless mothers.[56]

> "- No, they came to the maternity ward. [...] So I gave birth and just three days later Child Protection came, the maternity staff called them, they were supposed to discharge me with the girl and I said: where am I to go? So Child Protection came at 8 in the morning, they talked to me, I talked to them, they had me sign a piece of paper, it was a statement, I don't remember exactly. And I knew they were supposed to come and take her from me and they took her but I wasn't present. No. I'm telling you the truth. I went out to buy her clothes, she needed clothes and on my way back to the maternity ward I ran into the Child Protection people and I told them 'I hope you'll let me know when you come to take her from me.' I knew I had to give her up, I did sign everything after all, I was aware of it, but I knew that they could only take her in my presence. That's what I knew. Yes, and that's when they dropped the bomb that they had already taken her, otherwise I would have gone there only to find her gone. And the next day I went straight to Child Protection to see her, they told me where to go, I cried, that was that. Now I thank God because, in a way, they wanted to help me but right then I didn't...
>
> And what was the reason? Did the girl have health problems?
>
> - No, the girl wasn't sick, but I didn't have a place to live." (Interview with a parent of institutionalized children, Bacău)

- In other cases, the request and decision to place the child in public care is based on incomplete information or on the prejudices of the hospital and maternity ward staff or even of the child protection specialists, particularly in relation to Roma mothers and children.

> "Look, talking about children from maternity wards, I know a few cases and situations like that, mothers from Pata Rât [source community from Cluj-Napoca] who left their newborn child at the maternity ward and a protection measure was needed. We got things straight when everybody realized that actually the mother had another child at home and she had gone home to take care of him or her because, well, that's what she thought she should do. For other mothers, the ending is not so happy." (Focus group with professionals, Cluj-Napoca)

- In addition, to ensure the accuracy of the official data and a correct understanding of the phenomenon of child-family separation, the interviewed professionals considered it important to distinguish between causes and effect. They stressed that child relinquishment in health institutions is an effect and should not be reported as the cause of separation. One should look into the causes associated with mothers' or parents' specific circumstances, with labeling or

[56] There are no recent studies in this respect, but it would seem this particular practice now takes place to a lesser extent than it used to at the beginning of the 1990s, as described in the first study on the causes of child institutionalization in Romania (MS, IOMC and UNICEF, 1991)

prejudice such as "underage mothers, mentally retarded mothers, [and] mothers who use drugs and alcohol." (Focus group with professionals, Ploieşti).

Given the large numbers of children who entered the system as a result of being relinquished in maternity wards or health facilities, it is essential to limit these two routes in order to reduce the total number of children in public care in the future. To this end, many measures have been established. The government adopted an action plan in March 2007. However, at the time of the research (November-December 2014), several of its measures had not been developed or implemented nationwide or their implementation had been uneven. These measures included: (i) setting up a coherent system for reporting and monitoring data on child relinquishment and the risk of relinquishment; (ii) standardizing the written forms and the procedures for registering women admitted into maternity wards to give birth; (iii) hiring social workers in all health units proportional to the number of doctors in the unit; and (iv) developing procedures for keeping records of mothers and children with no identity papers and creating a database of these records. In 2014, the government adopted Government Decision 1103/2014 approving the methodology for implementing the responsibilities assigned to the local public authorities, institutions, and professionals involved in preventing and responding in cases of children at risk of relinquishment or relinquished in medical units, a decision that came into force in March 2015, after our research data had been collected.

In the present context, cross-sectoral mechanisms are needed on the frontline that combine health care and social services. Improved monitoring of the health status of all pregnant women is clearly needed, particularly for single mothers and teenage mothers who are the most likely to relinquish their children straight after birth. This falls under the responsibility of the health services, both primary care and community-based ones, but should be combined with a clear mechanism and protocols for the early identification of pregnant women who are highly likely to relinquish their newborns and for a timely referral of these women to the social services. This would enable the social services to provide pregnant women with counseling and support services as early as possible and to develop a permanency plan, if necessary, by the time the child is born.

Since "nowadays, it is too easy to leave a child in a hospital,"[57] coordination and referral between health units (especially maternity and pediatric units) and social services at the local level (especially the community health nurse and SPAS social worker) need to be improved. The professionals interviewed for the study (both from the child protection system and from NGOs) insisted that on the preventive side:

- Social workers should be available in all health units that have maternity and/or pediatric wards in accordance with the legislative provisions on protecting and promoting children's rights.[58]
- When mothers (parents) show up at a health unit with no identity papers, this should be considered without exception as a high-risk situation for child relinquishment and should be treated accordingly.[59] This will require the development of reporting and response mechanisms involving the social services (child protection services) and the police (for identification purposes) in conjunction with the medical units. Otherwise, for the relinquished children, "the father is a fiction and the mother is only probable."

> "Yes, the mother doesn't give us her [*identity*] papers and then ... Then, we are flick-flaking around to find the identity documents that are nowhere to be found. The father is just a story and the mother is only probable. And so the child is placed in public care where they stay for a year until you find the papers. Yes, this is the problem, the fact that they have to stay in child care for a year until you find their parent. Anyway, the parent has forgotten, the mother has forgotten, I suppose she's forgotten, it's all in the past and she actually doesn't want the child anymore. But, if right when it happens the people at the hospital said: 'come and see, there is a mother who was over there and now she has one foot out the door, come and see quickly, let's do something.

[57] Focus group with professionals, Craiova.

[58] Law 272/2004 on the protection and promotion of children's rights, republished in 2014, Art. 10.

[59] This measure is already provided for in the methology approved in 2014.

Let's find the relatives, let's talk to the grandmother, to someone who could support her,' then... But they also have other things to take care of." (Focus group with professionals, Timişoara)

- Work procedures in hospitals and maternity wards preventing the possibility of a mother leaving her child alone in the hospital for several days should be rigorously applied.

"In my opinion, the collaboration with the hospitals is very deficient because we are talking about very young children whom we place in public care and if you don't reintegrate them within a year they will never reintegrate again, that's common knowledge. Hospitals should be more responsible for these children and not let the mother leave the child and wait for her to come back maybe a week later. So I find it unthinkable to let a mother leave the child for a week hoping she will come back. There's no such thing, you need to take action, have staff there working on this..." (Focus group with professionals, Timişoara)

FROM RURAL SOURCE COMMUNITIES

The survey of rural source communities confirms the concern of child protection professionals about children who are left alone in hospital by their mothers for seven days or more. These children have an 81 percent likelihood of ending up in public care compared to only 28 percent for children who stay together with their mothers in maternity wards for more than seven days (for instance, because of low birth weight) and to only 14 percent for those who spend less than seven days in the maternity ward after birth. Consequently, a consistent and uniform use of the relevant work procedures in hospitals would have the potential to prevent at least part of the high rates of child relinquishment in maternity wards.

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=1,140 children).

At the community level, it is necessary to improve social assistance work, particularly with regard to providing all potential beneficiaries with information and counseling services, support in obtaining identity papers, and equal access to proper benefits and services. Also of use would be sexual education and family planning programs targeted to at-risk groups such as single-mothers and adolescent or teenage parents, though these would not immediately or directly reduce the number of children relinquished in health facilities.

"In general, some Roma women have six, seven, eight children and maybe two or three in public care, they may have a disabled child at home, they have young daughters of fifteen, sixteen who also end up having children and just don't use contraception, either because of ethnic beliefs, that the man is there for her and the man refuses contraception, or .... if we manage to empower them, as current laws don't stipulate contraception for uninsured social cases [without health insurance].[60] We have doctors who help us out of their kindness and they actually volunteer to insert the IUD for free. We get the IUDs from the Sera foundation in Bucharest. But, unfortunately, we cannot push things. And there are women – they're famous at the directorate – who give birth to a child every year or every year and a half." (Focus group with professionals, Cluj-Napoca).

[60] In accordance with Order 386 of March 31, 2015 on approving the Technical Norms for implementing national public health programs for 2015 and 2016 (page 214), the population groups who have access to free contraception include: pupils, students, unemployed, people living on the Guaranteed Minimum Income, individuals from rural areas, any person self-declaring before the family doctor that he or she does not have the necessary income to buy contraceptives, and women who have had an abortion for one year after the intervention. At the same time, the framework contract from 2015 and 2016 states that the minimum package of primary health care services includes family planning consultations, therefore these are delivered also to the un-insured population (page 1, Annex 1).

Box 3: Example of Good Practice - First Step in Life

The "First Step in Life" Program is being jointly implemented in the town of Bârlad (County of Vaslui) by the local Directorate for Social Assistance (DAS), the local hospital, and the DGASPC. The program is funded by private donors from the Netherlands.

As part of the program, a baby starter set is given to each newborn irrespective of their mother's and parents' financial means. The set consists of at least seven items, including between five and seven pieces of newborn clothing, hygiene products for the mother, and hygiene products for the baby.

"- This contributes greatly to preventing child abandonment, the part that you are interested in.

Please explain.

- The hospital-based social worker is responsible for social assistance activities. We drafted a questionnaire for social inquiry purposes that actually identifies any problem and any risk of child abandonment in that environment. Indeed, we have children who are exposed to a great risk of being abandoned. When that happens, the hospital-based social worker contacts the social worker from the Directorate [DAS] and then the Directorate comes ... and takes over the case saying 'this could be a problem because these people don't have a home, I don't know, the financial situation, the family situation could pose a risk'. So they take over and, how should I say, they follow up on the case from that time on. And prevention is done from then on...

So the program has a real impact as regards the prevention of child-family separation?

- Absolutely because, when the mother and the family were encouraged and effectively supported with shelter, food, and everything they needed for their daily life, with information to make her [the mother] more balanced as a person, child abandonment was prevented by default.

Moreover, also with Chance Life Association we run another project related to this, which carries forward the Directorate's initiative of providing all new mothers with a sort of starter set for the child and even for the mother. The set includes about eight or nine good quality clothing items. I mean, if she is a mother with no sources of income, she gets everything she needs to be discharged from the hospital with the baby, to be able to take care of the baby for up to three months, since the clothing sizes are for ages 0 to 3 months. And they get bodysuits, one-pieces, jumpsuits, and so on, even a blanket or some sort of a cover; hygiene products, shampoo, and good soap for the baby in enough quantities to last for up to one year. There, the project is implemented in partnership with the Directorate, the local council, and the hospital. The hospital has made its social worker available for this and ....upon discharge all the mothers are informed that they can go and get that starter set. When they do that, a social inquiry is carried out and at-risk mothers are identified, but practically all the mothers are given the package without exception. All the mothers who show up there get it, provided that they agree to that social inquiry and to having their photo taken with the products, which we send to the donors as proof that they received them. The social worker informs the mother about the use of the products because we had mothers who didn't know how to use them. We have, for example, mosquito or insect repellents, some even with sunscreen, which we normally offer in the spring, summer and autumn when there is a high risk of mosquitoes, fleas, and other such things and the mother is informed about how to use the products, how to keep the child safe.

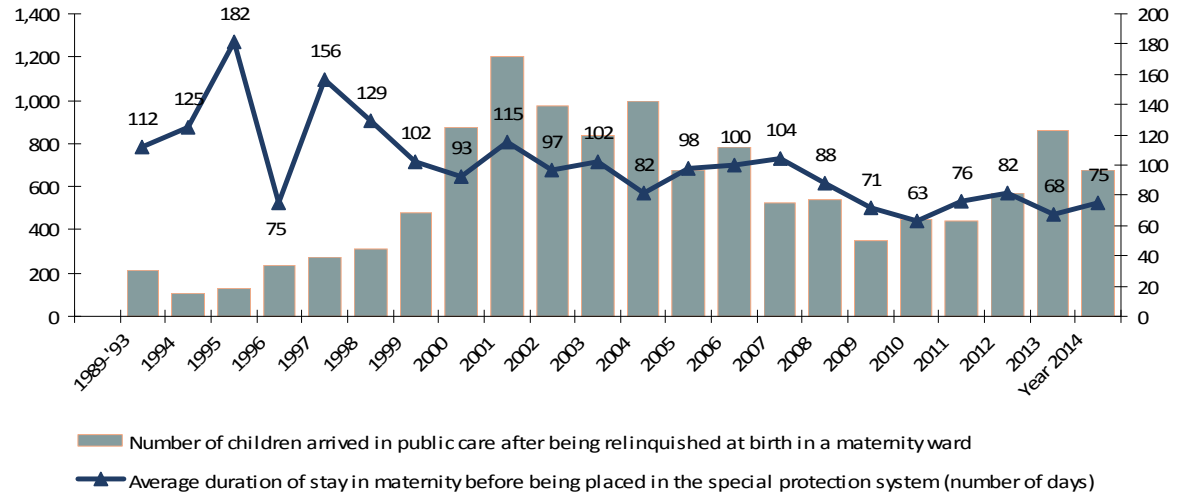
And if they identify at-risk cases, they refer them to the mothers' center where we also provide support in the so-called 'next step' where the mother can come regularly and take clothing and hygiene products as the child grows up and even for the other children in the family so that she doesn't feel all alone or say that she doesn't have the means and eventually choose to abandon the child. When she sees that she gets material support and information, this impacts her as a mother and she is no longer likely to give her child up."

(Interview with a professional, Bârlad)

Besides preventing child relinquishment in medical units, it is also important to consider ways of improving the outcomes for those children who experience this relinquishment. The key to improving those outcomes is to minimize the time spent by the relinquished child in the medical facility. This situation has improved since 2007. Figure 13 shows the number of children at the national level who arrived in public care via the route: Relinquished in a maternity ward --> SPS, as well as the average length of stay in a maternity ward by year. The data from the children's files indicate that the national average length of stay in health units during the 1990s abruptly increased and then decreased, reaching about 100 days just before the year 2000. Subsequently, it fluctuated between 90 to 100 days during 1999 to 2008 and declined to around 63 to 81 days since 2008.

The number of children who entered the public care system due to relinquishment straight after birth and who still were in the system by November-December 2014 followed a different trend. It sharply increased during the 1990s, reaching a peak of over 1,200 children in 2001. Thereafter, it declined to a minimum of around 350 children during the time of the global crisis in 2009, after which it increased again to over 850 children in 2013.

Figure 13: Children Arriving in Public Care via the Route: Relinquished in a Maternity Ward --> SPS - Number of Children and Average Length of Stay in the Maternity Ward, by Year



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=12,501).

The most recent data, for 2014, shed some light on how to interpret these statistics. Thus, in 2014, the children who arrived in the system after being relinquished in maternity wards formed two distinct groups: (i) a majority (80 percent) of babies transferred and placed by the DGASPC in about 46 days and (ii) a small group (20 percent) of babies born in 2013 who had spent an average of nearly 200 days (6 to 7 months) in maternity units before being taken by the DGASPC. Consequently, the statistics for a given year may be affected by a particular policy decision or regulation or by the resources available to the DGASPC in the previous year(s). For example, hypothetically in one year, a lower number of children entering the system than in the previous year may mean that fewer children were relinquished in medical units, but it might also be the result of the fact that only some of the relinquished children were taken in by the DGASPC, while many other children remained behind in the maternity ward without being transferred to a child protection service. In the hypothetical following year, the enforcement of a new regulation requiring shorter deadlines for transferring children from maternity wards to the child protection system and/or an increase in the number of available foster parents may lead to an increase in the average length of stay in maternity because the children who remained behind in the previous year (who thus spent a long time in the hospital) would be also transferred into the system.

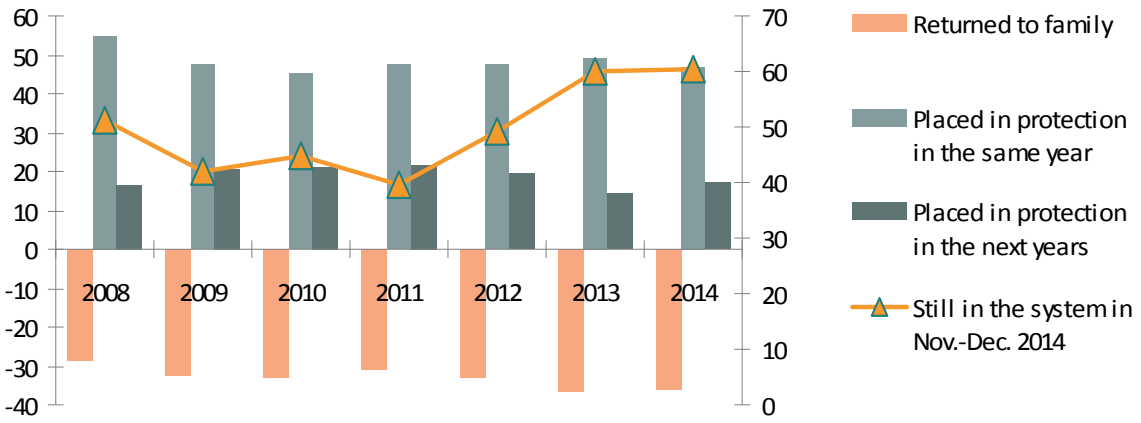
The official reports on children relinquished in maternity wards and other medical units during 2008 to 2014 reinforce this. As Figure 14 shows, every year, out of all relinquished children, about one-third are returned to their families, around half are placed in the protection service in the same year, while the other 15 to 20 percent remain in the hospital and are not transferred to the protection service until the following year or even later.

Girls and boys have similar average lengths of stay in maternity wards after being relinquished and before being taken into the protection service. However, the following categories of children tend to have longer stays in maternity wards:

- Children with disabilities
- Children with very low birth weight (less than 1,500 grams)
- Roma children
- Children of mothers who died in hospital
- Children of mothers who ran away from hospital.

This is most likely because these children have no identification papers, but it may also be a result of the lack of readily available response services (such as dedicated foster care families, including for emergency situations) for children aged 0 to 2 years old.[61]

Figure 14: Children Relinquished in Maternity or Other Health Facilities (2008-2014), Their Placement in Protection (2008-2014) and the Situation as of Nov-Dec 2014 (%)



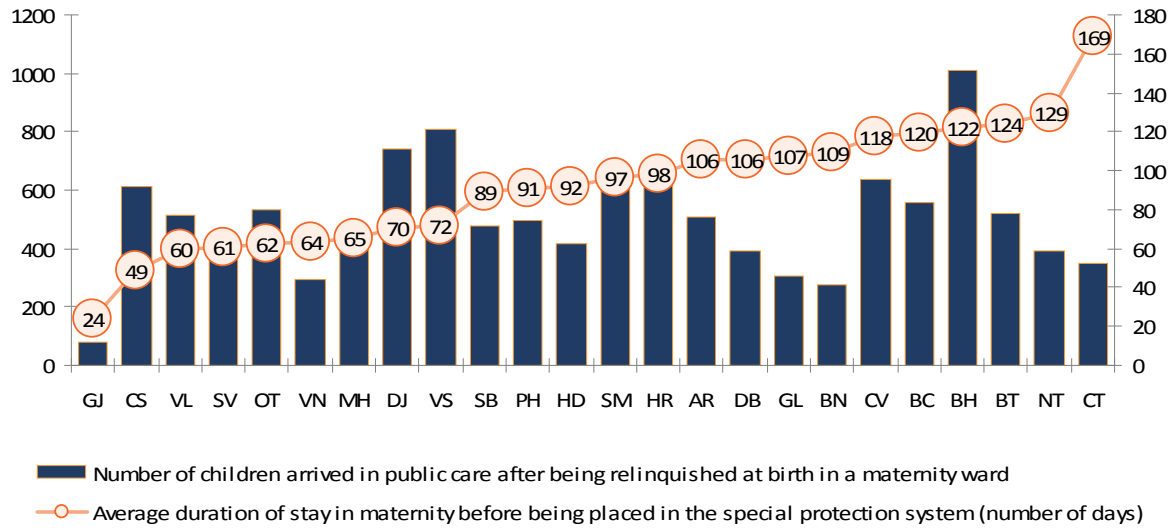
Source: ANPDCA, Official Reports on Children Relinquished in Maternity or Other Health Facilities (DGASPC reports 2008-2014, www.copii.ro) and Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=16,214).

Note: Official reports before 2008 are not available. Also, the available reports do not distinguish between the placement of children relinquished in maternity wards and those relinquished in pediatric or other health units. For this reason, the figure refers to both kinds of relinquishment in institutions and does not limit its coverage to children relinquished straight after birth.

The average length of stay in maternity wards varies widely across counties, irrespective of the year or period considered. It also varies widely within any given county from one year to another (Annex 6 Table 13). For the entire period 1989 to 2014, it ranges from a minimum of 24 days in Gorj to a maximum of 169 days in Constanța (with a national average of 94 days), as shown in Figure 15. This sizable disparity, both in terms of territory and between different years, might be determined by specific characteristics of the child population or by the way in which the county institutions - DGASPCs and medical units - are organized and cooperate with each other with regard to children relinquished in maternity wards.

[61] The institutionalization of children 0 to 2 years old was legally banned starting 2005. In 2014, it was extended to children under 3 years old (with the exception of severely disabled children who may be placed in residential services).

Figure 15: Average Length of Stay in Health Facilities of Children in Public Care after Being Relinquished in a Maternity Ward During 1989-2014, by County



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=11,990). Only the 24 counties with solid data in the CMTIS are considered.

In order to test the significance of the above mentioned determinants of the average length of stay in maternity wards before being placed in the child protection service, we used a regression model. This is presented in Annex 6 Table 14. This exercise shows that:

- All other things being equal or held constant, the most powerful determinant is the year in which the child joined the protection system. The longer ago that was, the longer the time the child spent in the maternity ward before being placed in the system.
- The characteristics of the child are also significant determinants. Having a disability, being left behind by a mother who died or ran away from the hospital, and, especially, having a very low birth weight (under 1,500 grams) are individual circumstances that increase a child's length of stay in the maternity ward before being taken by the DGASPC.
- However, only one individual characteristic is not significant, all other things being equal or held constant, namely ethnicity. This means that the fact that Roma children have longer average stays in maternity wards is not because of their ethnicity, but because of the other factors such as the child's disability, low birth weight or mother's disappearance (deceased or left[62]).
- The institutional factors - how well the DGASPCs and the medical units at the county level are organized and cooperate - are also significant. The county effect shows that, *ceteris paribus*, compared to Constanța (the reference county), the other counties perform better in this area, with a few exceptions, namely Botoșani, Galați, Neamț, and, to a lesser extent, Covasna and Bistrița-Năsăud.

[62] It may be that, at least in some cases, the mother's departure from the maternity ward is reported differently for Roma women than for women of other ethnicity, but this research found no data to support this theory.

CONCLUSIONS & RECOMMENDATIONS

Of the children in public care in November-December 2014, over 9,500 children were placed in public care straight after their birth. An additional 6,700 children were taken home with their mothers but a few months later were relinquished in a health unit. These two categories of children differ only regarding the age at which they entered the system.

Children with disabilities and those with low birth weight have a significant higher likelihood of being relinquished in medical units and of spending a longer period of time in maternity wards before being taken into the child special protection system. Children from urban areas and Roma children are statistically over-represented among children relinquished in a health unit and in particular among those relinquished in maternity wards (14 percent of children relinquished in a maternity ward and 17 percent of those relinquished in another medical unit respectively) The likelihood that the mothers of children relinquished straight after birth are teenagers is of 52 percent. Data are available on the mothers of most of these children.

The efforts to prevent child relinquishment in health units should be substantially strengthened and monitored, as follows:

- Although children are most often relinquished in health units, efforts and services for preventing this phenomenon should be intensified firstly in the community. Social workers or people with social assistance duties together with community health workers and family doctors should be more active and better prepared to early identify and monitor the at-risk situations for child and mother.
- The health monitoring of all pregnancies by community workers (especially by community health workers) is strongly needed along with clear mechanisms and protocols to enable the early identification of pregnant mothers who are highly likely to relinquish their newborns and their immediate referral to the local social services.
- Sexual education and family planning programs for at-risk groups such as single-mothers and teenage parents should be developed or resumed, particularly in source communities. Free contraceptives should be made available to vulnerable groups, whether these groups are covered by health insurance or not. Information, education, and communication campaigns on family planning and its benefits are also needed. In addition, support should be provided to vulnerable groups to reduce the cost of transportation to reach the family planning centers.
- In order to prevent the consequences of teenage pregancies, we also recommend prevention programs that can include: (i) classes on health, sexual education, and contraceptive education initiated as early as possible and implemented on a permanent basis in both schools and communities (available to those who do not attend school) and (ii) awareness and social norm changing campaigns on the relations between parents/adults and children, decision-making autonomy for youths, and youth participation in decisions that affect their life.
- The coordination and referral system between health units (especially maternity and pediatric wards) and social services should be improved in accordance with the legislative provisions that are currently in force.
- Social workers should be available in all health units with maternity and/or pediatric wards according to the legal provisions that are currently in force. Other specialists should also be available, for instance, psychologists working with mothers in special situations (for example, with post-partum depression).
- According to the methodology on prevention and response in cases of children at risk of relinquishment or relinquished in health units (Government Decision 1103/2014), cases when mothers (or parents) show up at medical units with no identity papers should be considered without exception as a high-risk situation for relinquishment and therefore should be addressed urgently, with speedy resolution for both mother (parents) and child.
- All hospital and maternity ward work procedures aimed at preventing mothers from leaving their children alone in the hospital for several days should be strictly implemented.
- Adequate special protection response services for 0 to 3-year-old children should be developed and strenghtened in all counties of the country (for instance, to increase the availability of foster parents to urgently take these children in), particularly for children with disabilities and/or with very low birth weight.
- All measures should be correlated and integrated with the pregnancy identification and monitoring efforts that should be carried out before birth (as part of the prenatal services) and with the community-based support services for the mother/parents and the newborn child (as part of postnatal services).

3.1.3.3 Street Routes

Street routes are less common, but were followed by 3.3 percent of all children in public care in November-December 2014 (Infograph Chart 2). In most cases, these were the children of single mothers or young families who either had unstable accommodation or were homeless (1.9 percent of children) or who left their children on the street or in a public space such as in a taxi, in a field, or at a post office, department store, railway station, or public lavatory (0.9 percent of children). The others, about 0.5 percent of all children in the child public care system, represent street children or children who ran away from home. These routes are not associated with any other specific characteristics of the child, mother, or family.

However, the proportion of children who followed the street routes is much higher in certain counties. In seven counties (Arad, Bihor, Constanța, Dâmbovița, Dolj, Harghita, and Satu Mare), 5 to 8 percent of children in public care come from the streets, whereas in others (such as Bistrița-Năsăud, Galați or Hunedoara) the proportion is less than 1 percent.

The lack of effective preventive measures and support services for children and families at the community level is a strong explanatory factor for these cases in the opinion of the professionals who were interviewed for the study. Mothers or parents in need often ask the various local institutions for help, but when they get no actual support, the only solution they can think of is to leave their child in public care.

Alternatively, adolescents from families in need decide to strike out on their own and "they start running away from home at the age of 12 and continue until they turn 14 when they end up in the system ..."

> "... the eldest [child] would repeatedly run away from home, he would be found by the police and brought back home ... No other services. This went on for about two years, then she took the child to the Directorate for Social Assistance and then there was nothing she could do because he would teach the other two kids at home bad things: 'I can't take care of him anymore, I don't know what to do anymore.' And then the family felt overwhelmed and the child ended up in child care." (Interview with a professional, Bacău)

CONCLUSIONS & RECOMMENDATIONS

Street routes into the child protection system are not common but are the case for an average of over 3 percent of all children in public care, with this share reaching as high as 8 percent of all children in public care in some counties.

Most of these children come from single mother families with no stable accommodation or homeless who stay wherever they can. And precisely because they are not able to find any support from their extended families and because the relationships they have without being married provide them with accommodation but are not stable, they eventually end up on the street with their children for shorter or longer periods. Therefore, this route shows the fact that some children are separated from their family because of the lack of a national program of social housing services for the most vulnerable population, especially single mothers with children and because of the lack of preventive and support services for children and families at the community level. This shows once again the need to draft and implement a policy targeting young mothers with no education and in vulnerable situations (in other words, living alone or within a consensual union, being economically dependent, lacking a stable dwelling in which to live with their child, and in poor health).

The second category of children following this route – street children and/or children who ran away from home – represent only 0.5 percent of all children in the child protection system (about 300 children). Nevertheless, special attention needs to be paid to them as there are likely to be other children in this situation who are not yet in the system. Little is known about the number and the real situation of street children and youths as the available data are few and of poor quality.[63] However, previous studies show that

[63] In 2009, Save the Children estimated these numbers for three large cities – Bucharest, Brașov, and Constanța. The number of children identified varied between 800 and 1,700. Most of them live in the capital city (approximately 1,150). In the seaside town of Constanța, their number varies by season. Over half of them are children (0 to 17 years old), while the rest of them are youths aged between 18 and 35. Children living on the streets generally have little education (most

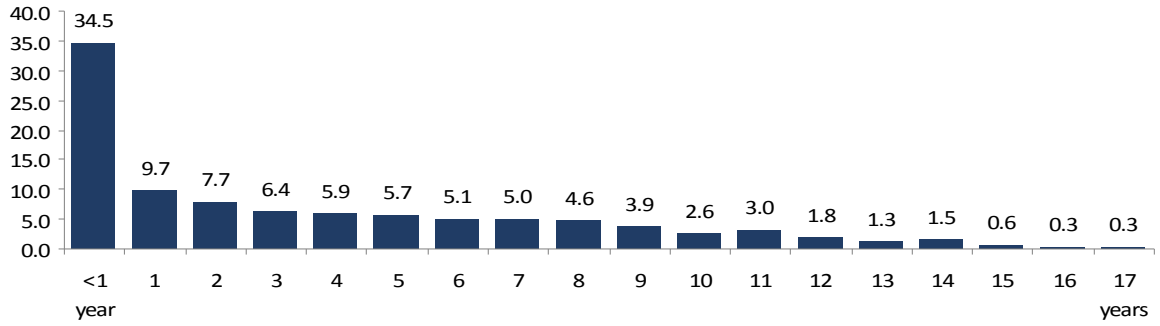
street children and youths are denied most of their rights and are excluded from society.[64] Consequently, the development of a system for monitoring street children and the services available to meet their needs should be a priority in order to ensure their integration in society and to prevent them from ending up on the street in the future.[65]

In order to prevent street routes, as described above, early identification and early intervention are essential. In the absence of any proactive actions to prevent separation, interventions after the child has entered the system are likely to be detrimental not only to the child but also to the family, community, and the child protection system.

3.1.4 The Age of Entry into the System

The current population of children in public care consists of children aged 0 to 26[66] who entered the child protection system between 1989 and 2014. However, more than one-third (35 percent) of them came into the system when they were less than 1 year old (Figure 16). An additional 17 percent were 1 to 2 years old when they entered the system. Much lower proportions of children in public care entered the system at other ages.

Figure 16: Distribution of Children in Public Care, by Age at Entry into the Child Protection System (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

However, this is a snapshot of the population of children in public care at one moment in time. Child protection is a dynamic system, with entries and exits on a daily basis, and children who enter or leave the system may belong to any age group. Annex 6 Figure 2 illustrates the distribution of children in public care by age groups and age at entry.

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of them finished primary school at most), with begging being their main source of income, followed by daily casual work and car or windscreen washing. Generally, they have little or no access to services. Although in Bucharest the situation is better, with over half of the respondents (56 percent) receiving services at one time or another, in Brașov and Constanța very few received these services (Lazăr and Grigoraș, 2009).

[64] For instance, Alexandrescu (2002) or Lazăr and Grigoraș (2009). Living on the streets is accompanied by severe health problems, chronic malnutrition, school dropout and illiteracy (approximately 50 percent), physical abuse (sometimes from the police), sexual abuse (usually started within the family and continued on the streets), stigmatization and discrimination, limited access to social services (education, health services, and social assistance), drug, diluent, or solvent consumption, and even prostitution.

[65] Even though there are national policies meant to reduce the numbers of homeless children (and adults), the current initiatives are limited to providing social support, access to emergency and temporary housing and health services. NGOs, on the other hand, offer health assistance, education, psychosocial support and, sometimes houses, using street techniques and implementing campaigns to increase public awareness of this phenomenon. Nevertheless, their actions have only limited coverage and they are highly dependent on availability of funding, especially from international donors.

[66] It also includes young people over the age of 26 years old who are still in the system.

Table 9: Distribution of Children in Public Care, by Age Group and Age at Entry (%)

	Arrived in child protection system at the age of:					
Children's age at time of survey:	<1 year	1-2 years	3-6 years	7-10 years	11-17 years	Total
0-14 years	43	19	23	13	3	100
15 years	23	18	17	20	22	100
16 years	15	18	22	22	24	100
17 years	12	14	26	27	20	100
18 years	15	10	25	23	27	100
15-19 years	16	15	23	23	23	100
15-26 years*	17	14	24	23	23	100
All children in public care	35	17	23	16	9	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344). *Includes the youth over the age of 26 who were still in the system at the time of the research.

If we confine the analysis to the "complete" age groups, Table 9 shows that children aged 15 to 19 who entered the system some time between 1989 and 2014 and were still in the system in 2014 have a fairly balanced distribution by age of entry into the system. Nevertheless, children who entered the child protection system when they were under 3 years old still account for about one-third of those entries.

CONCLUSION

Early childhood, the period between 0 and 3 years of age, is the most important development phase for a child. Therefore, being separated from their parents, particularly during this phase, can have devastating and long-term effects on the child.

Over half of the children placed in public care entered the system at early ages (0 to 3 years old), mostly under 12 months old. As a consequence, most of them spent their early childhood within the system. Since a large share entered the system through the two routes related to relinquishment in health facilities, preventing and narrowing these two routes is essential (see the conclusions and recommendations in section 3.1.3.2).

3.1.5 Child Development Status Before Entering the Child Protection System

This final section on the period before entering child protection system focuses on children's development status along four dimensions: health, education, family relationships, and risky behavior. The socioeconomic status of these children is analyzed in section 3.2.5.1.

3.1.5.1 Children's Identity Documents

Without identity papers, a child cannot benefit from any available social benefits or services, including some rights such as the placement allocation. Therefore, it is relevant whether a child has a personal identification number (CNP) before entering the system or not. The vast majority (84 percent) had a CNP when they joined the system. However, over 15 percent of children in public care either had no identity papers at entry (8 percent) or their case files did not contain any information in this regard (more than 7 percent).

Table 10: Existence of an Identification Number, by Routes Followed by Children Before Entering the System (%)

Routes followed before entering the system	Identification number				Total
	Yes, before entry	Not at entry, but obtained subsequently	Not at entry, in process to be obtained	Don't know	
No information in the child's file	76.6	4.7	0.0	18.7	100
Routes related to family and kinship network: All	88.7	4.1	0.1	7.1	100
Routes linked to relinquishment in institutions:					
Relinquished in a maternity ward --> SPS	76.6	16.1	0.0	7.3	100
Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS	72.6	18.1	0.5	8.9	100
Street routes:					
Maternity ward --> Family with unstable accommodation or homeless --> SPS	79.2	9.2	0.6	11.0	100
Maternity ward --> Family --> Children left by parents on the street/in public spaces --> SPS	78.9	13.6	0.0	7.5	100
Maternity ward --> Family --> Children who ran away from home/ street children --> SPS	70.6	27.2	0.0	2.2	100
Total - N	44,080	4,335	49	3,879	52,344
- %	84.2	8.3	0.1	7.4	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Most children with no identification number at entry entered the system either after being relinquished in health units or via one of the street routes.

3.1.5.2 Children's Health

There is no procedure for documenting the development status of children when they first enter the child protection system. As a result, most children's case files contain no relevant data on their health status at the time of entry, with 84 percent missing data on weight and height for age, 56 percent having no information on vaccinations, 43 percent making no mention of nourishment, and 54 percent having no baseline psychological assessment (see Table 11).

However, the available data indicate that child protection professionals have to manage a population of children characterized by the so-called "double burden of disease,"[67] that is the coexistence of over-nutrition and obesity with under-nutrition as well as disabilities and various other chronic diseases. Although only 57 percent of the children's files contain information on nutrition, the study team found that one in every ten children showed signs of malnourishment or undernourishment at the time of entry. Accordingly, some children were underweight,[68] while others were overweight or obese.[69]

[67] UNICEF (2006c:26).

[68] Having a low body mass that is below minus two standard deviations from the median for the age or gender of standard population. According to a UNICEF study, in Romania, all other things being equal or held constant, belonging to a severely poor household significantly increases the probability of a child having a low body mass and, thus, of being underweight. On the other hand, the older the child and the longer she or he is exclusively breastfed, the less likely she or he is to be underweight regardless of where they live, of whether the child is a boy or a girl, of how much she or he weighed at birth, of how good or bad the health of the mother is, of how many children there are in the household, and how much food comes from the household's production in their own garden or on their own land. (Stănculescu et al., 2012:40)

[69] A national study of the population aged 0 to 2 showed that the prevalence of overweight (including obese) children had increased to 5.4 percent in 2010 versus 4.2 percent in 2004 (Nanu et al., 2011:22). The corresponding proportion of children in care who were overweight when they entered the system was about 17 percent when taking into account only valid data.

Table 11: Children's Development Status Before Entering the Special Protection System

Indicators		Entry Age				Total
		<1 year	1-2 years	3-10 years	11+ years	
Total	N	18,066	9,130	20,562	4,586	**52,344**
	%	100	100	100	100	**100**
HEALTH						
Body mass for age/ Gender	- underweight	2	3	1	1	**2**
	- normal	16	5	10	11	**11**
	- overweight	6	0	1	0	**2**
	- obese	0.0	0.2	0.7	0.3	**0.3**
	Missing data	76	91	88	87	**84**
Signs of malnourishment or undernourishment	- yes	11	15	10	4	**10**
	- no	47	34	49	62	**47**
	Missing data	43	51	41	34	**43**
Scabies, lice or other diseases related to poor hygiene	- yes	2	8	10	7	**7**
	- no	58	39	48	59	**51**
	Missing data	40	53	42	34	**42**
Vaccinations by age	- all vaccinations	36	25	26	33	**30**
	- only some	13	12	13	11	**13**
	- none	2	2	1	1	**1**
	Missing data	49	61	60	56	**56**
Registered with a family doctor	- yes	27	49	69	83	**52**
	- no	37	11	6	3	**17**
	Missing data	36	40	25	14	**31**
Disability at entry	- yes	9	12	11	14	**11**
	- no	76	71	77	79	**76**
	Missing data	15	17	12	7	**14**
Self-sufficiency	- autonomous	2	11	57	85	**32**
	- needed help	10	33	26	7	**20**
	- totally dependent	79	45	6	4	**38**
	Missing data	9	11	11	4	**10**
Psychological evaluation at entry	- delays/ disorders in all dimensions	9	12	11	10	**10**
	- delays/ disorders in some dimensions	3	6	9	13	**7**
	- normal standard in all dimensions	15	14	25	30	**20**
	- evaluation was done, but no other data	2	3	3	2	**2**
	- no psychological evaluation	63	57	47	40	**54**
	Missing data	8	8	6	5	**7**
EDUCATION						
Children 3-6 years old at entry who had attended Kindergarten	- yes	-	-	45	56	**47**
	- no	-	-	38	18	**35**
	Missing data	-	-	16	26	**18**
Children 6-17 years old at entry who had attended School	- out of school: never in school	-	-	26	7	**21**
	- out of school: school dropout	-	-	3	9	**5**
	- in school and no risk of dropout	-	-	39	53	**43**
	- in school with risk of dropout	-	-	11	14	**12**
	- in school, no other information	-	-	13	15	**14**
	Missing data	-	-	8	3	**6**
Children 6-17 years old at entry who had repeated a grade	- yes	-	-	3	8	**5**
	- no	-	-	49	60	**52**
	Missing data	-	-	48	32	**43**
Special educational needs	- yes	-	-	9	10	**9**
	- no	-	-	68	75	**70**
	Missing data	-	-	23	15	**21**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Specifically due to poor nutrition, many children arrive in the protection system with a legacy of low resistance to infections and prone to "the vicious cycle of recurring sickness and faltering growth, often with irreversible damage to their cognitive and social development."[70] Furthermore, for children in public care, malnourishment is highly correlated with illnesses related to poor hygiene (such as scabies or lice). The children most exposed to these risks are premature babies relinquished in maternity wards, children from rural areas with a single-father and less frequently from a nuclear family, and children who arrived in the system via street routes.

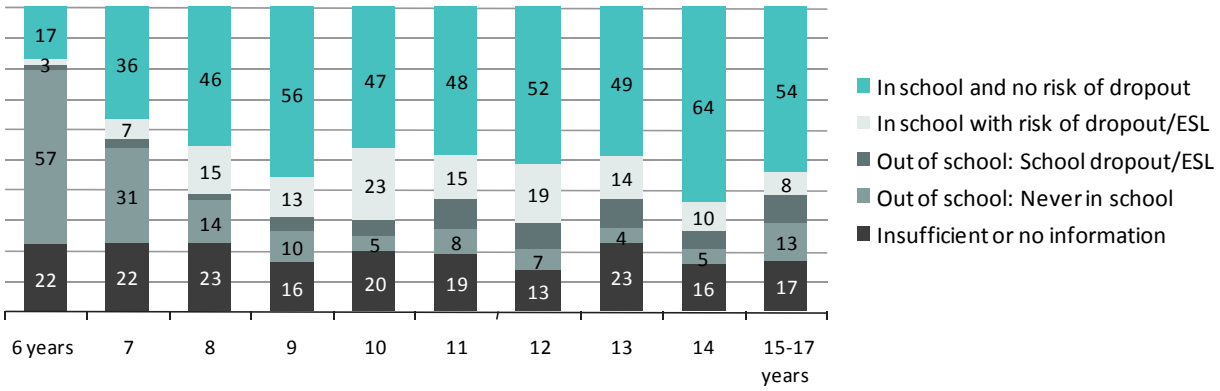
About 11 percent of children in public care had a disability before their arrival in the protection system. Almost one-third of those over the age of 3 at the time of entry had a disability that was severe enough that they could not be self-sufficient in their basic daily activities and another third needed support. However, evaluations conducted on children after they entered the system showed that many other children had serious health problems, so that the share of children with disabilities (upon entry into the system or identified afterwards) increases to 29 percent of all children in the system.

Fewer than half of the children received a baseline psychological evaluation. For those who did receive such an evaluation, many were judged to have various delays or disorders in one or more of the following dimensions: emotional, cognitive, behavioral, psychophysiological, or personality, as well as a lack of interpersonal relationship skills. In addition, many children in public care had to be registered with a family doctor in order to receive the appropriate vaccinations for their age.

3.1.5.3 Children's Education

There is more information in the case files on children's education before they entered the system than on their health, but there are no comprehensive assessments of their education-related challenges or performance (Figure 17). Only about half (46 to 64 percent) of children in each age group were attending school with no risk of dropping out. The others were either out of school (never in school or school dropouts) or were at risk of dropping out.[71] Out of all children who had ever attended school, about 3 to 5 percent in each age group were in a special school, while the vast majority of them were in a mainstream school. For about 20 percent of children in each age group, the files contain little or no information on education.

Figure 17: Distribution of Children Aged 6-17 at Entry, by Educational Status before Entry (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=15.742)

Note: ESL = Early school leaving.

[70] UNICEF (2006c:2).

[71] Comprehensive information on school dropouts or the risk of dropping out is very rare in the files.

Around 9 percent of children who were 11 to 17 years old at entry were dropouts, and this figure is even higher for children with disabilities (15 percent) and for Roma children (19 percent). Dropouts are divided more or less equally between girls and boys and those from urban and rural areas. Also, among children aged between 11 and 17 at entry, the proportion of children who had never attended school before entering the child protection system was higher than average (7 percent) among Roma children (12 percent) and children with disabilities (over 23 percent). The probability of being out of school (never in school or a school dropout) was considerably higher for children who arrived in the system via the following routes: Maternity ward --> Family --> Children left home alone --> SPS, Maternity ward --> Family --> Non-Relatives --> SPS, and the three street routes.

The risk of school dropout is mentioned most often in the files for children aged 11 to 17 years old, particularly boys from rural areas who belong to a family with a stable dwelling (either with a single-mother or a nuclear family).

At the time of entering the protection system, children with special educational needs (SEN) represented 9 percent of all those of school age (6 to 17 years old). However, this share may be even higher (Annex 6 Table 15) because children are not given a baseline assessment when they enter the system. The proportion of children with SEN is considerably higher among adolescents (aged 15 to 17 at entry) and among children with disabilities (38 percent). Almost half of all children with SEN (aged 6 to 17 at entry) were not in school before they entered the protection system (23 percent had never attended school and 8 percent had dropped out of school) or were at risk of dropping out of school (18 percent). Thus, fewer children with SEN had been in school than children without SEN, and this applied to kindergarten as well. Furthermore, a significantly large proportion of children with SEN (25 percent) had gone to special schools rather than mainstream schools, and more than 10 percent had repeated grades. A comparison between children with SEN and the other children is presented in Annex 6 Table 16.

3.1.5.4 Children's Relationship with their Family of Origin

Although the main caretaker of nearly all the children in care is known, only some of the children had spent enough time at home to build a relationship with their parents or caretaker. This relationship was "good" for only 39 percent of children in care aged 4 to 17 years old at entry, while it was "problematic" for 33 percent of them. As for the other 28 percent, there was no information in their files regarding their relationship with their parents or caretaker.

The relationship with the parents or caretaker does not vary according to a child's age, gender, ethnicity, or health status. Instead, it varies depending on the type of family of origin[72] and the route[73] by which the child arrived in the protection system (see Annex 6 Figures 3 and 4). Children with one or more siblings who either live together or are also in public care are considerably more likely to have a problematic relationship with their parents or caretaker. Thus, the proportion of children with problematic relationships increases from 25 percent of children without siblings to 40 percent of children living together with siblings or with two or more siblings in public care.

Children left home alone and children relinquished in health units, public spaces, or on the street are the most likely to have a "problematic" relationship with their parents or caretaker. The children who have the best relationships are those who come from extended families or those whose main caretaker was a relative, usually their grandmother or grandparents.

In conclusion, almost 40 percent of all children in public care[74] had sad or no memories of the time spent with their families prior to entering the system.

[72] See section 3.1.2.3.

[73] See Chapter 3.1.3.

[74] We refer to children relinquished straight after birth (24 percent), those with an unknown caretaker (1.9 percent), and children aged 4 to 17 at entry who have problematic relationships with their parents or caretaker (14 percent).

3.1.5.5 Children's Risky Behavior

Fourteen percent of children who were 7 to 17 years old when they entered the protection system had already been exposed to one or more kinds of risky behaviors before entering the system.

Running away from home is the most common risky behavior (Table 12). Some children ran away from home repeatedly before entering the system.

Table 12: Children Aged 7-17 Years Old at Entry, by Type of Risky Behavior before Entering the Special Protection System (%)

		Entry Age			
	Indicators	7-10 years	11-14 years	15-17 years	Total
Total	N	8,483	3,961	625	13,069
	%	100	100	100	100
Risk behavior:	- yes, any risk behavior	10	21	24	14
	- no	75	69	60	72
	Missing data	15	11	16	14
Of which:	- yes, started sexual activity	0.1	2.6	6.9	1.2
	- yes, minor mother or pregnant	-	0.6	2.1	0.7
	- yes, use of alcohol, tobacco, drugs	1.4	2.7	1.8	1.8
	- yes, bullying or fights	2.0	3.1	3.4	2.4
	- yes, gang member or at-risk peers	1.5	4.6	3.4	2.6
	- yes, ran away from home	4.5	12.2	18.2	7.5
	- yes, problems with police	2.1	9.2	4.6	4.4
	- yes, street work or begging	5.2	8.6	1.6	6.0

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=13,069)

Risky behavior is more frequent among adolescents, boys, and children from urban areas, particularly those from families with no support from their kinship network as well as those with a mother or parents who were more than 40 years old at the time of the child's entry. Children with a problematic relationship with their parents are five times more likely to have been exposed to risky behavior than children with good relationships with their parents (29 percent versus 6 percent). The majority of children exposed to risky behavior arrive in the system either from the street or, for those with older parents, directly from their family.

RECOMMENDATIONS

When they first enter the child protection system, many children have serious health problems, little education, have either no memories or distressing memories of their families, and have experienced various kinds of risky behavior. All of these factors are critical for understanding the child's history, development status, and specific needs.

Therefore, when entering the system:

- 10 percent of children in public care showed signs of malnutrition or undernutrition, but only 57 percent of children's files include information on nutrition. In addition, malnutrition is strongly associated with diseases caused by poor hygiene (such as scabies or lice).
- 11 percent had a disability, and among those over 3 years old, only one-third were self-sufficient in their daily basic activities. The evaluations conducted after entering the system show that children with disabilities represent almost 29 percent of all children in the system.
- 17 percent were facing various disorders or delays, but less than half of them received an initial psychological assessment.
- 17 percent of them were not registered with a family doctor, and 31 percent of the children's files do not include information on this.
- 30 percent had received all of the vaccines for their age, but 56 percent of the children's files contain no information on vaccinations.
- Only approximately half (46 to 64 percent) of the children within each age group aged from 6 to 17 years old went to school and did not present any risk of school dropout. The others were either out of school (never went to school or had dropped out of school) or were at risk of school dropout.
- A school dropout rate of approximately 9 percent was registered among children aged 11 to 17 years when entering the system, up to 15 percent among children with disabilities, and 19 percent for Roma children, both for boys and girls in both urban and rural areas.
- 14 percent of children aged 7 to 17 years old when entering the system had been exposed to risky behaviors before their entry into the system. Having a problematic relationship with their parents increases fivefold the likelihood of a child being exposed to risky behaviors (29 percent versus 6 percent of children in good relationships).
- 28 percent of the files for children aged 4 to 17 do not include any information on the relationship with the parents or caretaker, which influences plans for maintaining a relationship with the family,
- 39 percent of children aged 4 to 17 years old in public care are separated from their parents or family despite having a "good" relationship with them.

Consequently, upon entering the protection system, all children should receive a comprehensive baseline assessment of their health (including medical tests, birth weight, weight at time of assessment, height, body mass, breastfeeding, and any other relevant indicators), education, family relations, and risky behavior. All of these data should be thoroughly recorded in the children's files and made available to all professionals who will work with them. In the absence of such data, it will not be possible to base the child's individualized protection plan (PIP) on evidence or to establish a connection between the protection services and the specific history, development stage, and needs of each child. Neither it will be possible to measure outcomes with the aim of developing and improving protection services from a child-centered perspective.

3.2. Entering Public Care in Romania: the Causes of Separation

Story Bag

"Why is it that some of the children are living with you while others are in public care?

- I didn't have the means for them [the children in public care], I didn't have a place to stay, I didn't have this house, which belonged to some Christian brothers. And they built it in the name of the Lord for children. We lived in a log store, there used to be a log store over here and we moved it for them to build me a house. But I had no means for them [the children in public care] and that's why I took them to the placement center.

So the reason was lack of space?

- I didn't have enough space, yes.

And was this also the reason why you relinquished the child in the maternity ward?

- I didn't have a place to bring them to. And I needed … a father; if he were there, but he wasn't there either.

I see, the reason was lack of space and of a father?

- Yes, these ones [the children at home] have a father, the others [the children in public care] didn't. That's why they got there because I had no one to raise them with. I couldn't do it alone and I also didn't have a place to bring them to. But these ones have a father, he's done things for his children.

Would you like it if these children came back to you?

- If they want to come, I will take them back any time... So, I won't say 'No' to them because I can't."

(Interview with a parent of institutionalized children, Arad)

This section analyzes the process by which children transition from their family to protection services. It focuses on the main causes of the separation of children from their families and the main bottlenecks to the effective prevention of such separations.

According to official data collected by the National Agency for the Protection of Child Rights and Adoption (ANPDCA), the three main causes of children being separated from their families and entering public care have consistently been poverty (42 percent), abuse and neglect (25 percent), and disability (10 percent).

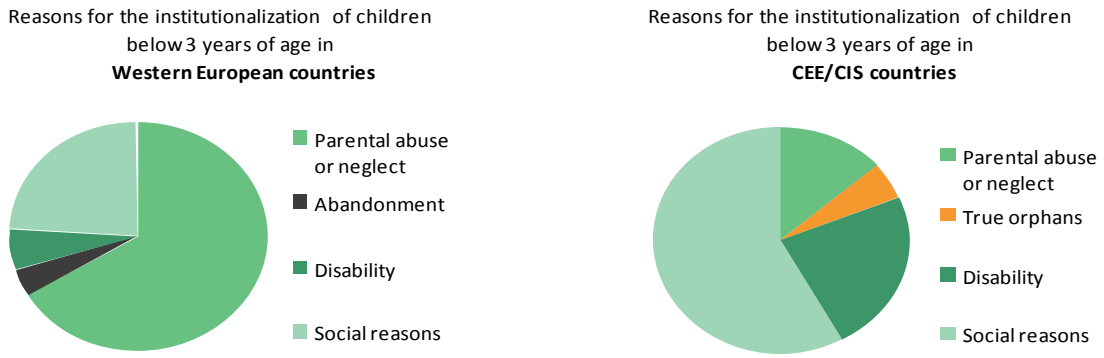
Table 13: Officially Reported Causes of Child-Family Separation

	% of all children separated from their families				
	2010	2011	2012	2013	2014
Death of parents	7.32	7.14	6.71	6.30	6.06
Disappearance of parents	1.75	1.52	1.48	1.41	1.36
Deprivation of parental rights	0.98	0.81	1.00	0.72	0.64
Poverty	44.10	42.72	41.96	42.30	41.66
Neglect, abuse, exploitation, any form of violence	22.23	23.37	25.12	26.82	28.05
Disability of the child	10.42	10.69	10.14	9.54	9.50
Disability of the parent(s)	3.91	3.74	3.66	3.68	3.61
Other causes	9.29	10.01	9.93	9.23	9.12
Total	100	100	100	100	100

Source: ANPDCA - National Agency for the Protection of Children's Rights and Adoption.

With poverty officially stated as being the most frequent cause of separation, Romania is like the other CEE/CIS countries where "social reasons" prevail as opposed to developed countries in which neglect and various forms of abuse in the family of origin represent the main cause of children being separated from their parents (Figure 18).[75] Across the CEE/CIS region, the "social reasons" albeit described in different terms (for example "poverty" in Romania and "parents' temporary inability to take care of the child" in Hungary), are often recorded with no further specific information about the child's circumstances. In some CEE/CIS countries (Montenegro and Kazakhstan), the main cause is registered as "abandonment" while other countries (such as Ukraine, Moldova, and Belarus) use the term "orphan" for children in public care even if 90 percent of them have living parents. Thus, not only do the countries have different causes for children being taken into care but also use widely different practices for registering those causes.[76]

Figure 18: Causes of Separation - A Comparison between Western European & CEE/CIS countries



Source: Browne et al. (2004)
Note: Data from Croatia, Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Romania, Slovakia, and Turkey.

[75] In developed countries, parental rights are often terminated by the judicial system (Groza and Bunkers, 2014: 167).

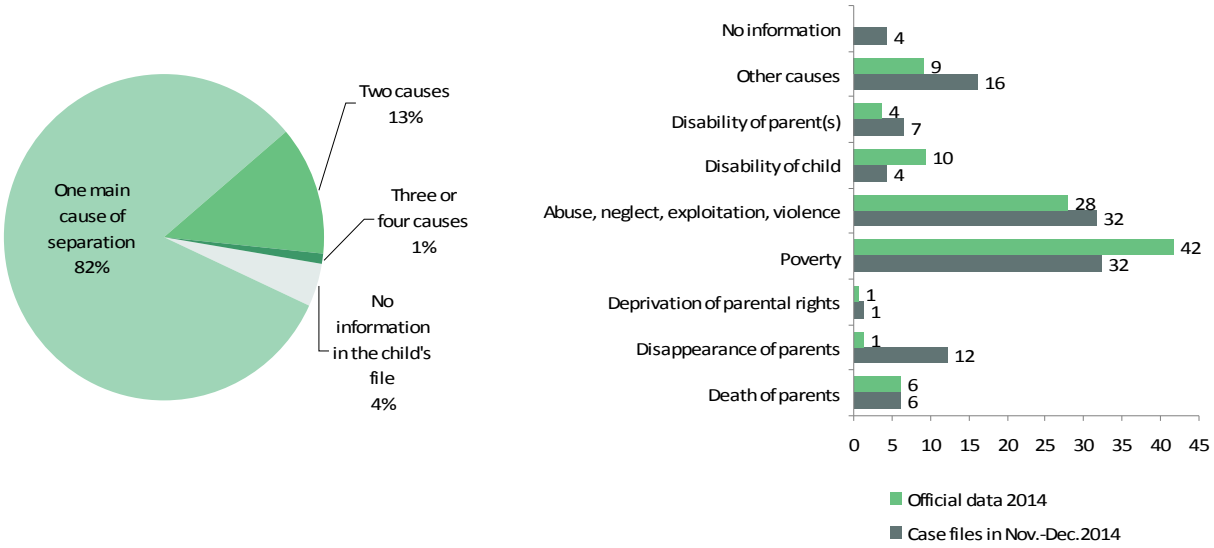
[76] Currently, in Romania, the ANPDCA collects data on causes using a quarterly data sheet (*fișă trimestrială*), but other pilot instruments are also used in related fields of expertise.

Research has shown, however, that most cases of separation cannot be reduced to one sole cause. In fact, evidence suggests that separation is determined by multiple and complex vulnerabilities.[77] In most cases, these complex vulnerabilities consist of a varying mixture of extreme poverty, parental unemployment, poor quality housing or homelessness, poor school attendance or dropout, poor parenting, domestic violence, a high risk of child neglect and abuse (associated with parents' alcohol abuse), young or single parenthood, unstable marriages, low expectations and/or self-esteem, and learned helplessness. In addition, significant life events may happen, such as the death of a parent, a serious accident, the imprisonment of a parent, or a house fire, affecting children both directly and indirectly, while posing both practical and emotional problems for the parents or caretaker that make it harder for them to respond to their children's needs.

The case files of children in care in Romania provide between one and four causes of separation (Figure 19). According to these data, two causes – "poverty" on the one hand and "neglect, abuse, exploitation, or any form of violence," on the other – are mentioned most frequently, both accounting for the same proportion of 32 percent. In other words, there are differences between the causes of separation recorded in the children's case files and those in the ANPDCA official records.

The biggest disparities appear in relation to the following causes: "disappearance of parents", "poverty" and "other causes." The case files also offer more comprehensive information than the ANPDCA report with regard to the types of situations that the DGASPCs include in each of these three categories of causes of separation. "Disappearance of parents" includes parents who left to work abroad, parents who deserted their homes, parents who are imprisoned, parents who do not acknowledge their paternity, and unknown parents. "Poverty" includes not only the family's income but also their housing conditions. "Other causes" include various situations such as substance abuse, divorce, separation, unstable relationships, infidelity, teenage mothers/parents, (extended) family not accepting the newborn, child being relinquished, unwanted pregnancies, low birth weight, children with behavioral disorders, and prostitution, begging, vagrancy, and other criminal behavior by the parents and/or the children.

Figure 19: Main Causes of Separation of Children in Public Care, according to Children's Case Files and the ANPDCA Official Report (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014) and the ANPDCA Official Report for 2013 based on the DGASPCs' answers to the quarterly data sheet (*fișa trimestrială*).

Note: For survey data on the case files, the sum of the bars is 115 percent because some case files provide two to four causes of separation as shown in the pie graph. Survey data are weighted (N=52,344).

[77] Stănculescu, Marin and Popp (2012).

Besides answers to the specific questions on the causes of separation, the current study[78] has yielded a rich set of data that can help analysts to understand the context and determinants of separation, including factual information and observations from the social inquiries completed by social workers before the children enter public care, information from the children's case files, the results of a survey of mothers and caretakers from rural source communities, and the professional opinions of SPAS staff who work in the rural source communities. Also, the qualitative study (interviews and focus groups) has brought to light some causes that were not mentioned in the surveys (either the household survey or the social worker survey).

3.2.1 Unfortunate Life Events

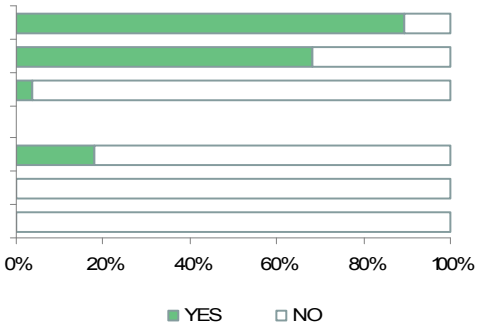
In this study, unfortunate events refer to the parents' death or institutionalization. Thus, this section focuses on true orphans, the children of inmates, and the children of mothers institutionalized in social institutions or psychiatric hospitals.

3.2.1.1 Death of Parents: True Orphans

The DGASPC specialists recorded the death of parents as the main cause of separation for 6 percent of children in public care (Figure 19). According to the factual data presented in Table 14, orphans of both parents represent about 3 percent of all children in the special protection system (1.4 percent since their entry into the system and 1.6 percent became orphans of both parents while they were in the system). Furthermore, 6 percent of children in public care are motherless (4.4 percent since they entered the system) and 49 percent are fatherless (45 percent had no father since they entered the system). The figure next to Table 14 shows that the DGASPC specialists recorded the death of a parent(s) as the main cause of separation not only for true orphans but also for children who have one parent still living. However, there are cases of orphans of both parents for which the main cause of separation registered was not the death of their parents. At the same time, the death of the mother, who is the main caretaker, is often registered as the main cause of separation, whereas the death of the father is less frequently considered as such, specifically because he is unknown or undeclared in many cases.

Table 14: Death of Parents: Facts and Registration as the Main Cause of Separation in the Case File (%)

	Death of parents stated as main cause of separation:		
	NO	YES	Total
At entry into protection system			
- True orphans	0.1	1.2	1.4
- Motherless and living father	1.4	3.0	4.4
- Fatherless and living mother	43.6	1.7	45.3
While in protection system			
- True orphans	1.3	0.3	1.6
- Motherless and living father	1.2	0.0	1.2
- Fatherless and living mother	3.4	0.0	3.4
- Living mother and father	42.0	0.0	42.0
Unknown mother and father	0.8	0.0	0.8
TOTAL	93.8	6.2	100



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

[78] See Chapter 2.3.

A similar practice of recording the causes of separation can be observed in the social inquiries completed by SPAS social workers before the children enter into public care. However, social workers rarely mention this cause of separation (just for 1.1 percent of children), with the death of the parents being recorded in the social inquiries of fewer than one-third of the children who were true orphans at the time of their entry into the system.

3.2.1.2 Imprisoned Parents

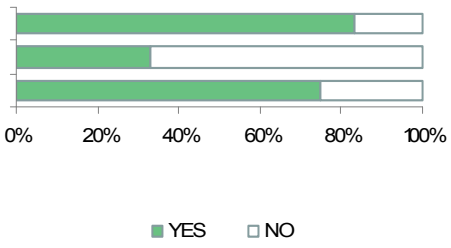
About 6 percent of children in public care have one or both of their parents in detention, most of them since their entry into the protection system (Table 15). As a general practice, the detention of the parents is only declared the main cause of separation when it refers to the mother. The father's imprisonment is often seen rather as "a fact of life... he should provide a life for his family."

> "Normally, all these problems are due to broken families, for example when both parents are in detention, when there is drug use or the father has killed the mother, or the other way around, the mother in prison for prostitution, the father for theft and so on... So, in general, well, the father goes to prison and the mother thus becomes the main provider for the family; and then she finds it impossible to support her children within the family and this leads either to the children's institutionalization or to their placement with another family." (Focus group with professionals, Ploieşti)

Specialists tend to record parents' detention under various categories of causes, namely "disappearance of parents," "deprivation of parental rights," or "other causes."

Table 15: Imprisonment of Parents: Facts and Registration as the Main Cause of Separation in the Case File (%)

	Imprisonment of parents stated as main cause of separation:		
	NO	YES	Total
At entry into protection system			
- Mother in prison	0.4	1.2	1.6
- Father in prison	1.8	0.9	2.7
- Mother and father in prison	0.1	0.3	0.3
While in protection system			
- Mother in prison	0.4	0.0	0.4
- Father in prison	0.6	0.0	0.6
No imprisoned parent	92.2	0.0	92.3
No information in the child's file	2.1	0.0	2.1
TOTAL	97.6	2.4	100



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=48,760). Children with unknown parents and true orphans are not included.

Social inquiries completed by SPAS social workers before children enter the protection system rarely mention inmate parents in the family's needs assessment (included in the case file). They do so only in one in every ten cases. Social workers tend to focus on the disappearance of the income earner and on criminal cases that involve both the mother and the father. Nonetheless, study data from the rural source communities indicate that social workers consider the detention of a parent as a main cause of separation, particularly as there is no social program targeted to the children and families of inmates. Affected families confirm that the imprisonment either of the main income earner or of the main caretaker has led to severe hardship and thus to the decision to separate the children from the family.

Most of the children with inmate parents arrived in the system at the ages of 1 to 6 years old.[79] They are both boys and girls, and the majority are of a normal development standard, with no disabilities or

[79] At the time of the research, they were 3 to 14 years old.

special educational needs. They tend to belong to families with many children and to have "good" relationships with their mother or parents. Before entering the system, they spent some time alone at home or lived with relatives in various families with an atypical structure, from where they entered the system together with their siblings. Roma children and those with undeclared ethnicity are over-represented in this category. Considerably higher than average proportions of children with inmate parents (8 to 12 percent) are registered in Olt, Gorj, Galați, Hunedoara, and Bucharest (Annex 6 Table 21).

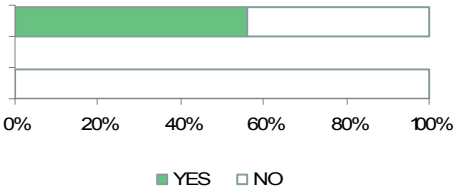
For more details, see also section 3.2.3.5 on promiscuous and/or criminal behavior by the parents.

3.2.1.3 Institutionalized Mother or Parents

Children with mothers or parents institutionalized in social or health institutions (especially psychiatric hospitals) represent 0.5 percent of all children in public care (Table 16). These children were separated from the family when they were under 3 years of age, and most of them are boys of Romanian ethnicity from urban areas. Disproportionately high shares were underweight and had disabilities, as well as having teenage or young mothers with no support from their kinship network. A larger than average number of such cases is recorded in Bacău, Botoșani, Buzău, Dâmbovița, Harghita, Neamț, Vrancea, and Sibiu.

Table 16: Institutionalized Mother/Parents: Facts and Registration as the Main Cause of Separation in the Case File (%)

	Institutionalized mother/ parents stated as main cause of separation:		
	NO	YES	Total
At entry into the protection system			
- Mother and/or father institutionalized	0.2	0.2	0.4
While in the protection system			
- Mother and/or father institutionalized	0.1	0.00	0.1
No institutionalized parent	97.3	0.00	97.3
No information in the child's file	2.2	0.00	2.2
TOTAL	99.8	0.2	100



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=48,760). Children with unknown parents and true orphans are not included.

Section 3.1.3.1 has already addressed the route: Maternity ward --> Family: institutionalized single-mother --> SPS. However, only about a quarter of children with institutionalized parents arrived in the system via this route. The majority were separated from their mother straight after birth in a maternity ward or were relinquished by her a few months later in a health unit.

Also, section 3.1.2.1 (Box 2) and section 3.1.2.3 have highlighted the significance of institutionalization in the mother's life history. One in every ten mothers from the rural source communities spent some time in public care during their childhood, and once they became mothers themselves, they followed the same pattern as they had experienced during their own childhood by relinquishing their children to be brought up in institutions or by other people (usually the grandparents).

The vicious intergenerational cycle of the institutionalization of children is a major concern for DGASPC professionals. Although this phenomenon may seem insignificant in statistical terms, if defined as the proportion of affected children in public care, it is much more prominent. According to the estimates of some specialists, "at least 50 percent of the young people who leave the system send their own children back in the system."[80]

[80] Focus group with professionals, Cluj-Napoca.

"From your experience, could you estimate how many young people who leave child care later place their own children in public care?

- At least 50 percent, I think. Considering how many young girls are pregnant...

- I couldn't guess. I mean I have seen many young people from child care who are not necessarily married but they live together and have children of their own... I know a few cases where they keep the children and don't place them in child care, but...

- In 50 percent of the cases the children stay with them, and in 50 percent they are placed in public care...

- What I can tell you is that, over time, I have noticed that if someone in the family was institutionalized as a child 40 years ago, they turn more willingly to that solution as a last resort than those who have never come into contact [with the system] and have never lived that experience, not even indirectly. So those who had a personal or...indirect contact with it are more prone to it.

- Yes, they give the child up more easily... It's hard for me to tell you a number, but from my experience, they get this idea, especially if the mother suffers from mental retardation and maybe associated behavioral disorders, they do it more easily, at least for a certain period of time until the child grows up and is independent. At least for two, three years. This is what I think.

- I currently have a case of parents from the child care system who have certain limitations, let's call them personal functional limitations. They say that they want 'my child not to experience what I experienced,' but, you know, these are actually exceptions." (Focus group with professionals, Cluj-Napoca)

"Children leaving child care have children of their own, and they come and ask for them to be institutionalized. During their stay, they kept complaining about the services provided, but they perpetuate the very same pattern, doing what their parents did to them." (Focus group with professionals, Braşov)

"But we also have cases of former child care beneficiaries, women and men, as you've already been told, who grew up in children's homes; the girls come and give birth, they leave the child in public care and move on. A year or two later, they come back to me with other children or pregnant and they leave the child again and so on. There are many such cases." (Focus group with professionals, Timișoara)

Breaking the vicious intergenerational cycle of children's institutionalization will require the child protection system to tackle the factors that mutually reinforce and perpetuate the relinquishment of children from generation to generation. For example, much more emphasis must be put on how to demonstrate to these parents a model of appropriate family identity and behavior and show them how to develop good parental skills, especially under conditions of poverty and severe material deprivation.

"The lack of a parenting model and attachment disorders... Many of the mothers who abandon, parents who abandon their children are people who grew up in institutions or they are people who grew up in broken or problematic families and without a family model... the tendency is to... avoid taking on the parenting role, [which is another issue] besides poverty." (Focus group with professionals, Cluj-Napoca)

RECOMMENDATION

Some of the children in public care are children of parents who in turn, as children, were brought up and received care in the special protection system. The present system provides care for the children of children brought up in the past system. Many of these parents grew up in the unreformed protection system of late 1980s-early 1990s, which placed children still in their early childhood in large, depersonalized, rigid institutions. The old system characterized by inadequate care in large institutions has created the current generation of parents. Today's system creates a new generation of children who will become parents in the next 20 years. The vicious cycle of institutionalization cannot be broken as long as the system does not provide parenting skills for children and does not promote a family model and an appropriate model of care and upbringing.

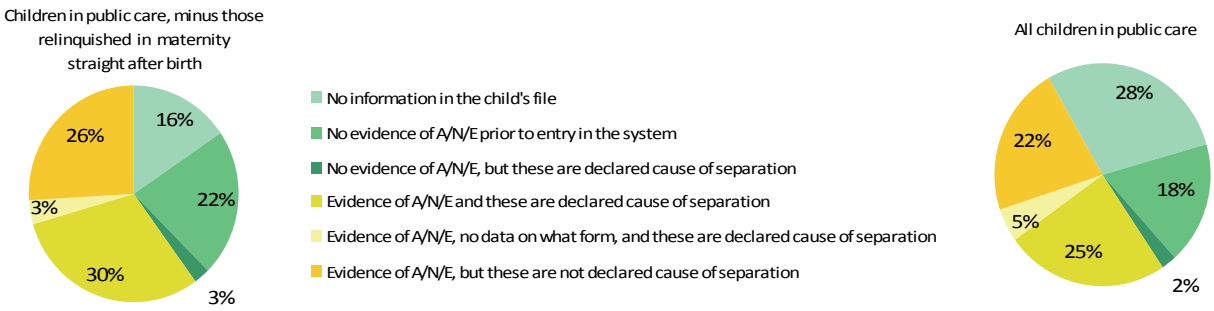
3.2.2 Child Neglect, Abuse, and Exploitation

This section focuses on neglect, abuse, exploitation, and other forms of violence.

In Romania, violence against children, although outlawed since 2004, is still prevalent. Several recent studies show that in everyday practice, corporal punishment is often used[81] and is considered a "necessary evil."[82] Many parents consider beating their child as a child rearing method,[83] because they have no knowledge of parenting strategies based on positive methods.[84]

Children are subject to various forms of violence exercised by their adult caretakers - neglect, physical, verbal, and/or psychological abuse, both in the family and at school.[85] According to the ANPDCA's official statistics, in recent years, there has been an increase in the number of reported cases of violence against children. In 2015, the number of reported cases featuring various forms of neglect, abuse, and exploitation exceeded the number recorded in 2010 by 11,232 cases. Thus, over 13,500 cases were recorded in December 2015. The most frequently reported cases are of neglect (9,625), emotional abuse (1,740), and physical abuse (1,164). In these cases, the victims are mostly children aged 0 to 9 years old and, more rarely, children aged 10 to 17. The phenomenon is reported both in urban and in rural areas. If neglect, sexual abuse, and exploitation for the purpose of perpetrating crime are often reported for rural children, cases of sexual exploitation, child labor, and emotional abuse have a higher incidence in urban areas. Reported cases of physical abuse are distributed equally between rural and urban areas.

Figure 20: Neglect, Abuse, Exploitation: Facts and Registration as the Main Cause of Separation in the Case File (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: A = abuse, N = neglect, E = exploitation.

Let's now turn our attention to the children in the special protection system. As Figure 19 shows, 32 percent of children in public care were separated from their families as a result of one or more causes included in this category (neglect, abuse and exploitation). However, evidence of neglect, abuse, and exploitation prior to entry into the system is recorded in the case files of 51 percent of the children in public care. Figure 20 indicates that the way in which the cause of separation is stated in the children's

[81] By 38 percent of the parents who admit to the abuse and by 68 percent of the parents, according to their children (Grădinaru and Stănculeanu, 2013).

[82] By 30 percent of parents, according to UNICEF (2014).

[83] 20 percent of parents, according to Grădinaru and Stănculeanu (2013).

[84] For example, 11 percent of the parents immediately slap their children or pull them by the hair if they do something wrong (UNICEF, 2014). According to the children, 18 percent say they were beaten with a stick, 13 percent with the belt, and 8 percent with a wooden spoon during the previous year (Grădinaru and Stănculeanu, 2013).

[85] Eighty three percent of children are scolded by teachers when they are mistaken, 33 percent of children are insulted or labeled and 7 percent of children say they are beaten by their teachers, according to Grădinaru and Stănculeanu (2013).

case files varies among professionals and is not always related to the rest of the data contained in the case files.

On the one hand, if we consider all children in the special protection system, we see that a small percentage of children (2 percent) were separated from their families for reasons related to neglect, abuse, or exploitation (according to the DGASPC experts) without any further evidence on this in the child's file (Figure 20). On the other hand, for 22 percent of children in public care, the case files provide evidence of neglect, abuse, or exploitation prior to their entry into the system, but the cause for separation stated by the DGASPC specialists refers to associated risk factors (especially poverty) and not to neglect, abuse, and exploitation *per se*.

A large share of the case files (28 percent) do not include any information on child neglect, abuse, or exploitation, which shows that it is not known whether or not these children had gone through such experience before entering the system (Figure 20). The share goes down to 16 percent if children relinquished in maternity wards straight after birth are not considered. However, this information is not available for more than 71 percent of children relinquished in maternity wards.[86] To obtain a comprehensive picture of the extent of neglect, abuse, and exploitation, we exclude the children relinquished in maternity wards from the analyses presented in the following sections as they were transferred directly from hospital to a protection service without ever reaching their families of origin. Also, the relinquishment of children in health units was extensively discussed in Section 3.1.3.2.

Overall, the case files of 51 percent of children in special protection show evidence of neglect, abuse, or exploitation. The incidence of neglect, abuse, and exploitation increases to 60 percent of children in public care if those relinquished in maternity wards straight after birth are not considered. Of those 60 percent, 54 percent were subject to various forms of neglect, 15 percent were abused, and 4 percent experienced exploitation in various forms. Over 14 percent of children (one in every seven) were subject to various forms of violence (neglect, abuse, and/or exploitation) before entering the child protection system.

The adverse effects of neglect and abuse upon the child are similar irrespective of the causes, including feelings of betrayal, guilt, loneliness and a lack of self-esteem. Nonetheless, the children's post-separation individualized protection plan (PIP) developed in response to the neglect and abuse that they experienced should distinguish between these two and should provide solutions case by case. The underlying causes of child separation, any risk factors, the child's age, any disabilities of the child or the parents, and the nature of their prior relationship should all be taken into account by the case workers when deciding on the most appropriate protection measure for the child (adoption, special guardianship, placement with a kinship or foster family, or placement in a residential unit). For this reason, the next sections present the underlying causes and the risk factors associated with neglect and abuse.

3.2.2.1 Various Forms of Neglect

The case files of 55 percent of children in public care[87] contain evidence of child neglect (Figure 21). Children from rural areas (not necessarily from the source communities) are more exposed to child neglect than those from urban areas (60 percent versus 50 percent). The experience of neglect is more frequent than average among children over the age of 3 years, particularly from families with many children and/or from families in which the father (or the mother's partner) is present while the

[86] The other 29 percent of children relinquished in a maternity ward have information on child neglect, abuse, or expoitation in their files. With respect to the relation between the evidence in case file and how the DGASPC specialists register the main cause of separation, these children fall into all of the categories featured in Figure 20 (other than no information), with about 5 percent of them being in each category.

[87] Not considering the children relinquished in maternity wards. If all children in public care are considered, the proportion is 41 percent.

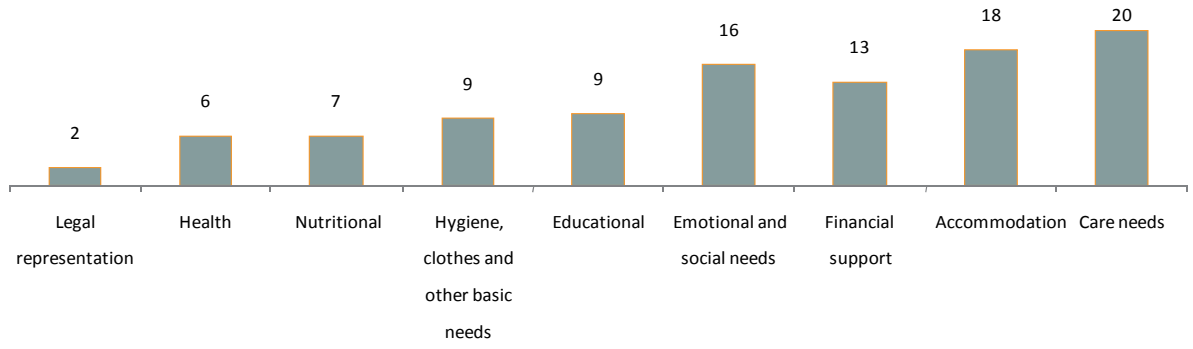
grandmother or grandparents are not.[88] Hence, at the time of our research, many of these children were 7 to 14 years old, with siblings also in the system (62 percent).

A lower than average incidence of neglect is found among children with disabilities,[89] those with special educational needs,[90] and those with low birth weight.[91]

For the majority of neglected children, both parents are alive and known, as are their extended family. Nonetheless, child neglect is strongly associated with bad prior relationships with the family and with risky behavior, especially running away from home. At the same time, children subject to neglect are at a higher than average risk of developing problems such as delays in their psychological development, with 22 percent of the neglected children having such problems versus 13 percent of the other children in public care.

Child neglect is poorly documented in the children's case files. The case files of 21 percent of the children in public care do not contain any information in this regard (Figure 22). This proportion is significantly higher for children who entered the system before 2005. There are also large differences across counties. The differences between counties are not due to the different proportions of children who arrived in the system more than ten years before. Therefore, there is a need to improve the way in which child neglect is understood and recorded in children's case files, especially in some counties, in order to develop well-documented long-term protection plans that adequately respond to the neglect issue.

Figure 21: Needs of Children Who Were Neglected in Their Families of Origin, According to SPAS Social Workers (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=21,040). Children who entered public care after being relinquished in maternity wards straight after birth are not included.

Neglect can be both physical and emotional. In the family's needs assessment prepared by SPAS social workers (and included in the children's case files), neglect was associated with a wide range of child's needs (Figure 21). For example, among the neglected children, the proportion of those recorded, when entering the system, as having illnesses related to poor hygiene (such as scabies or lice) is almost double the average for all children in care (13 percent versus 7 percent). As was shown in the previous section 3.1.5, such illnesses are also highly correlated with malnourishment and are found more frequently in children from rural areas with a single-father and less frequently among those who came from a nuclear family or those who arrived in the system via street routes.

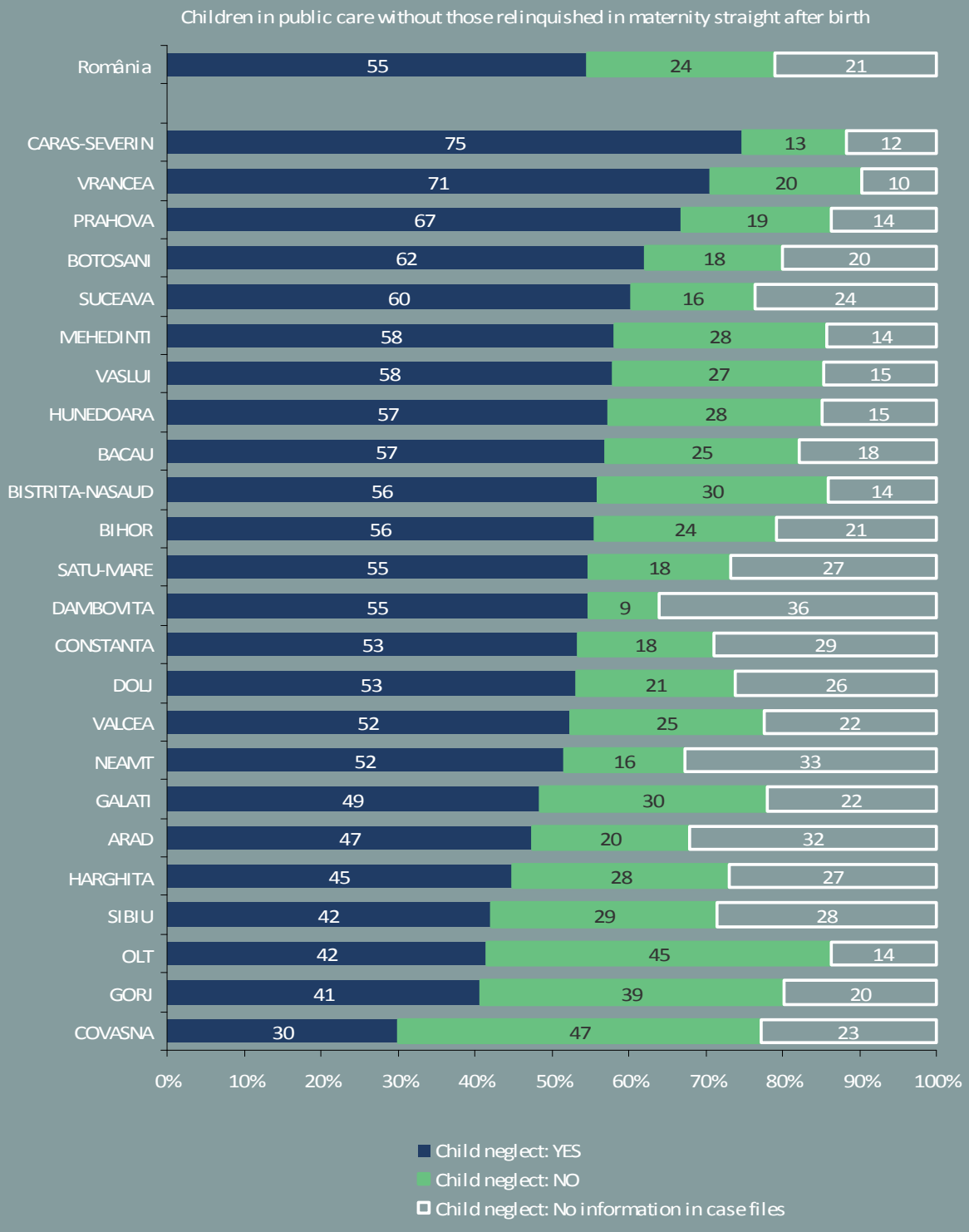
[88] Irrespective of whether the mother is home or not.

[89] An incidence of child neglect of 41 percent versus 58 percent of children with no disabilities.

[90] An incidence of child neglect of 50 percent versus 60 percent of children without SEN.

[91] An incidence of child neglect of 27 percent of children with very low birth weight (less than 1,500 grams).

Figure 22: Rates of Child Neglect, by County (Percentage of Case Files with/without Evidence of Child Neglect before Entering the System)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=38,688). Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

In interviews and group discussions, the DGASPC professionals tended to describe and emphasize the extreme cases related to malnourishment in particular and, more generally, to issues that pose a threat to the child's health. Most discussions were focused on the problem and the efforts to correct the harm done by parents but did not mention any work (activity, service, or intervention) to be done with the parents themselves. Such support measures and services are rarely available at the community level. Given the prevailing profile of the parents and families of children in public care (section 3.1.2), it is obvious that they need intensive parental education and substantial support to fulfil their parental duties in a responsible manner.

> "But we also have cases, like I've told you, the 8-month-old little girl that they brought to us weighing 3 kg because they hadn't fed her. Taking the child back to that family poses a risk because you might later find them the same way. The mother was not even aware of the abandonment, so the child could have died. She said that she had already given her a corn puff and she didn't see why she should give her food as well. I mean, you take action; clearly that little girl needs to be sent to another family, I mean once she recovers we should take her to an actual family, but not to her biological family which hasn't improved and has taken no action to prove to us that they can look after her." (Interview with a professional, Bârlad)

> "We even had a case where they brought us the children – a father did – because they couldn't wash them as they had been disconnected from the water supply for a very long time." (Interview with a professional, Piatra Neamţ)

> "Home hygiene is very poor and this affects the child's health; when they are admitted to the hospital's pediatric ward, social workers inform us about the case." (Interview with a professional, Arad)

Most specialists emphasized that the parents' lack of or deficient parenting skills was a result of their low general level of education but also of their own life history of childhood abuse and neglect. The lack of parenting skills is even more apparent with regard to children with special needs, such as infants in their first months of life, children with disabilities (especially with severe ones), and adolescents with behavioral issues.

> "Regarding the causes, there is also a small number of children with health issues whose parents cannot cope anymore. In general, they stay with their family, [...] but we're talking about severe physical or associated disabilities, which require more specialized care and this is also paired with the fact that, in the family, parents lack the needed skills and sometimes even the means to do that. And another cause could also be – for healthy children, so to speak – parents' lack of skills to raise and educate them because this poses a risk which, in time, leads to behavioral changes in the child and, when they reach puberty, the parent might come to us and say 'I want to send him to a center because I can't... I don't know what to do with him anymore,' so..." (Focus group with professionals, Ploieşti)

> "Other child separation issues emerge, you know, at the age of 12 or 13 years old when they run away from home. They leave home, they run away with their stuff, they become vagrants and then the family can't cope with it anymore and of course they turn to the authorities." (Interview with a professional, Bacău)

An extreme form of child neglect is the relinquishment of children,[92] which may stem from a wide range of causes, including parents leaving to go abroad, family dissolution, parents' unstable relationships, infidelity, and birth out of wedlock as well as parental disinterest.[93] Accordingly, in these cases of child neglect,[94] the DGASPC specialists record as the main cause of separation either the abuse and neglect category (58 percent), poverty[95] (24 percent), or one or more of the above-mentioned underlying causes of neglect (21 percent). In about 10 percent of cases, they also add risk factors associated with neglect, such as alcohol abuse, childhood disability, behavioral problems,

[92] For relinquishment in medical units, see section 3.1.3.2.

[93] Currently, all of these causes of separation are often recorded in the official reports under the category of "disappearance of parents" or "others."

[94] Excluding children abandoned in maternity wards. If all children in public care are considered, the proportion declines to 12 percent.

[95] Poverty is addressed in section 3.2.5.1 on structural causes.

mental health problems of the parents, or promiscuous and/or criminal behavior by the parents (see the analysis in Chapter 3.2.3).

RECOMMENDATIONS

There is a need to improve the way in which child neglect is recorded in children's case files, especially in some counties. Also, it is necessary to understand the underlying causes of neglect so as to ensure well-documented individualized protection plans that address these causes. These individualized protection plans should focus on the child and the family together, not separately, so that the child's return to the family can be a real, feasible option.

Intervention and the provision of services for parents/families and children in the community prior to their separation on grounds of neglect or abuse is vital. In this regard, early identification and early intervention, before risk situations become critical, are key to preventing child-family separations.

It is necessary to raise awareness of the harmful effects of child neglect, especially in source communities.

3.2.2.2 Various Forms of Abuse

The case files of 15 percent of children in public care[96] show evidence of child abuse (Figure 23). Emotional abuse is the most frequent form of abuse recorded in the files (12 percent), followed by physical and sexual abuse (9 percent and 1 percent respectively). Six percent of all children in public care had been subject to two or all three forms of abuse before entering the system.

FROM RURAL SOURCE COMMUNITIES

The household survey in the rural source communities yielded additional evidence of the intergenerational transmission of abusive parenting behavior. The data show that about 8 percent of mothers were emotionally and/or psychologically abused during their own childhood, while 8 percent of them faced physical abuse, and about 1 percent were victims of sexual abuse. Five percent of mothers were subject to at least two or all three forms of abuse in their families of origin.

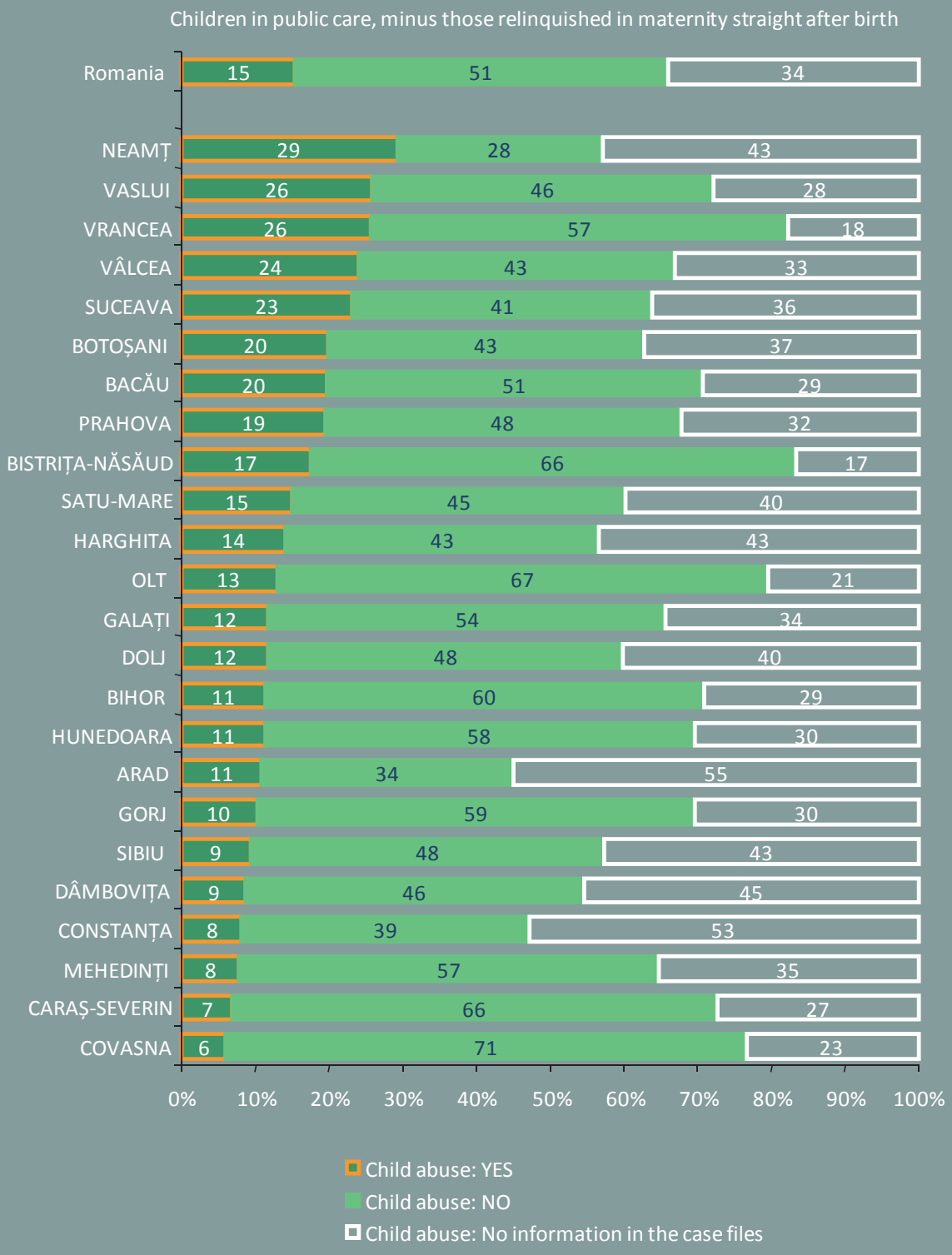
Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=754 mothers who were brought up in a family).

Boys and girls are equally exposed to the risk of emotional abuse before entering the system. Children from rural areas, particularly from source communities, have a higher than average risk of emotional abuse than those from urban areas (14 percent versus 9 percent). Children aged over 3 years old at the time of entry experience emotional abuse more frequently than average, particularly if they are from families with many children and/or from families in which the father (or the mother's partner) is present while the grandmother or grandparents are not.[97] At the time of the research, many of these children were 11 years old, with siblings in the system (71 percent versus the average of 53 percent).

[96] Excluding children relinquished in maternity wards.

[97] Irrespective of whether the mother is home or not.

Figure 23: Rates of Child Abuse, by County (Percentage of Case Files with/without Evidence of Child Abuse before Entering the System)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=38,688). Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

The risk of physical abuse is also evenly distributed among girls and boys, between urban and rural areas, and between source and non-source communities. Thus, children all over the country have a comparable risk of physical abuse regardless of their location. Children over 7 years old at the time of their entry into the system experience physical abuse more frequently than average. The odds of physical abuse are the highest for children from nuclear families (with both parents at home),[98] especially those that include three or more children[99] with no help from their kinship network. These children are at risk of becoming abusers themselves as the majority of them have not had a positive relationship with their grandmother, for instance, which might have countered the influence of the risk factors and thus might have reduced the odds of the child victim becoming a perpetrator.[100]

Emotional and/or physical abuse was reported less than average for children with disabilities,[101] those with special educational needs,[102] and those with low birth weight.[103]

Like child neglect, emotional and/or physical abuse is strongly associated with bad prior relationships with family and with risky behavior, especially running away from home. Researchers who study abuse victims agree that the impact of abuse can last a lifetime. Abuse causes a feeling of shame, and many victims may suffer from countless mental health problems including addictions, depression, and dissociative disorders. According to the children's case files, the baseline psychological evaluations showed that one in every three[104] children in public care who suffered emotional and/or physical abuse was assessed with developmental delays in one or more of the emotional, cognitive, behavioral, psychophysiological, or personality areas and with difficulties in conducting interpersonal relationships.

The risk of sexual abuse is three times higher for girls than for boys, particularly among children aged 11 years old or more when entering the system.[105] Among children in public care who had experienced sexual abuse, the proportion with delays in development is very high, namely about 60 percent.[106]

The causes of sexual abuse are of great concern to the DGASPC specialists. It is very difficult to provide effective help to a child victim of sexual abuse given how these cases are prosecuted in penal courts. For example, the experts' reports take a log time to be delivered, the mother can visit the child in special protection during the trial and thus can put pressure on the victim to agree to return home, and the judge can decide to reintegrate the victim within the family (including the abusive father) during the trial regardless of the DGASPC professionals' recommendation. As a result, the child can be forced to relive the trauma for a long period until the trial proceedings are finished. Also, SPAS services at the community level do not have enough capacity to properly monitor the family during this time, meaning that the child victim is left without proper support and protection.

[98] The incidence of physical abuse is 16 percent versus the average of 9 percent.

[99] The rate of physical abuse increases from 6 percent of children from one-child families to 11 percent of those from two-child families and to over 14 percent of children who belong to families with three or more children.

[100] Munro et al. (2013)

[101] The rate of emotional abuse is 8 percent versus 13 percent for children with no disabilities. For physical abuse, the rates are 7 percent for children with disabilities and 10 percent for those with no disabilities.

[102] An incidence of emotional abuse of 9 percent versus 18 percent of children without SEN. For physical abuse, the corresponding rates are 8 percent and 14 percent.

[103] An incidence of emotional abuse of 6 percent of children with very low birth weight (less than 1,500 grams) versus 10 percent among children with low birth weight (more than 1,500 grams and less than 2,500 grams) and 14 percent of children with normal birth weight. The corresponding rates of physical abuse are 4 percent, 8 percent, and 10 percent respectively.

[104] Versus 15 percent of children in public care with no experience of emotional and/or physical abuse.

[105] Compared to the average of 1 percent of children in public care (minus those abandoned in maternity wards), sexual abuse is documented in the case files of 0.4 percent of boys, 1.4 percent of girls, and 3.6 percent of girls with an entry age over 11.

[106] Twenty-three percent of children who experinceed sexual abuse did not receive a psychological examination when they entered the system. Only 17 percent of them were found to meet the normal standards of development.

In the case of sexual abuse, part of Story Bag 3a:

"[...] the girl reported the abuse. It was very difficult to prove the sexual abuse, because this was indirect evidence. It took a while for the samples to be analyzed [...] it is very difficult to have a criminal case only based on the child's request with no evidence. Meanwhile, because of the mother's pressure, the child stays in contact with the family, while she was subject to a protection measure, so mother and daughter meet and maybe the mother expressed her fears and discontent, and the child asked to go back home. And she did it before the judge, so it was agreed to have a family reintegration, with surveillance. The surveillance was done by the authorities, the social protection service, but the period wasn`t that long. [...] Now, [*the girl*] is subject to a protection measure and the father is in jail. Eventually we got the test results as well, and they confirmed everything, because the result was on the underwear." (Focus group with professionals, Focșani)

Child abuse is even more poorly documented in children's case files than child neglect. For 34 percent of children in public care, the case files do not contain any information of this kind (Figure 23). The proportion is significantly higher for children who entered the system before 2005. There are also major differences among counties, which are only partly due to variations in the proportions of children who entered the system longer time ago (Figure 23).

RECOMMENDATIONS

Intervention and the provision of services for parents/ family and children in the community prior to separation on grounds of abuse is vital. In this regard, early identification and early intervention, before risk situations become critical, are key to preventing child-family separation.

It is necessary to continue awareness-raising campaigns on the harmful effects of child abuse, especially in source communities.

Child abuse is not properly documented in the children's case files, and the situation is even more deficient than in the case of neglect. Therefore, there is a need to improve the way in which child abuse is recorded in children's case files, especially in some counties. Also, it is necessary to understand the underlying causes of abuse in order to ensure well-documented individualized protection plans that address these causes.

It is necessary to develop psychological assessment and counseling services, and also specialized services for victims of violence, given that one-third of children in public care who experienced emotional and/or physical abuse had developmental delays. Also, only 17 percent of the sexually abused children were normally developed when they entered the system. As such, 40 percent of the emotionally and/or physically abused children and 23 percent of victims of sexual abuse did not receive a psychological evaluation when they entered the system.

Cases of child victims of sexual abuse should be defined as high priority for all institutions involved. It is necessary to prioritize the introduction of institutional procedures that wil make it possible to take rapid and consistent measures to protect children against the offender. The court decision should take into account the recommendations of the child protection experts as part of the inter-institutional child protection proceedings to prevent the victim from being returned to the abusive environment.

The investigation of child abuse cases must take into account the child's opinion and establish measures to ensure child protection.

3.2.2.3 Various Forms of Exploitation

The case files of about 3.2 percent of children in public care[107] show evidence of child exploitation.[108] It is not very clear how child exploitation cases get recorded by DGASPC specialists since only about half of the child cases that involve street work and beggary and only 41 percent of cases of child trafficking, prior to the children's entering public care, are stated as cases of exploitation. According to the data in the children's case files, the share of children in public care with prior experience of street work and/or beggary is 1.5 percent.[109] Children who were victims of human trafficking prior to their entering public care represent 0.1 percent of all children in public care. Thus, by adding together the acknowledged cases of street work and/or beggary and/or human trafficking, the proportion of children who experienced exploitation before entering the system rises to 4.3 percent,[110] although 42 percent of children have no information in their files in this regard (in other words, it is unknown whether they had been subject to exploitation before entering the system).[111]

> "There have been cases when parents used their kids to beg, and they were taken to the center. Yes, there are such cases, of course." (Interview with a professional, Bacău)
>
> "The cases we come across in Cireșarii Center are related to sexual exploitation. There are teenage girls who end up with the wrong crowd and are recruited or coerced by some guys into prostitution. And this is a major problem." (Focus group with professionals, Ploiești)
>
> "- We see cases where they abandon their kids even when they are very young, at a very tender age, because they run several risks. They end up in the system because of being neglected by the family, seriously neglected, with repeated admissions, the child's life is really in danger and that's when they are temporarily taken out of their family. They don't have the resources, neither material nor emotional, to support the baby during its first two years of life, so they give it to the system.
>
> *And after?*
>
> - They end up back with the family, because this is the goal, a family which, however, in most cases hasn't done anything in the meantime to change the conditions; and here the child will serve their interest, that is, be a source of revenue. After, it's easier. The child no longer runs the risk of premature or infant death so he/she can be sent on the streets to beg; that is, he/she can be used. They are deemed as suitable to beg if they are over two years of age." (Interview with a professional, Brașov)

FROM RURAL SOURCE COMMUNITIES

The Household Survey in Rural Source Communities shows that mothers themselves reported experiencing child exploitation (3 percent), street work and/or beggary (2 percent) in their families of origin during their childhood.

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=754 mothers who were brought up in a family).

[107] Excluding children relinquished in maternity wards.

[108] According to a study conducted by Salvați Copiii and the MMFPSPV, 2 percent of children from the entire child population in Romania say they have been sent to beg, 5 percent say that they go to work instead of going to school, and 8 percent say that they stay at home to look after their younger siblings instead of going to school (Grădinaru and Stănculeanu, 2013).

[109] Table 12 shows that the proportion is four times higher among children aged 7 to 17 years old (6 percent). The highest incidence of street work and/or beggary is recorded for children of 11 to 14 years of age (9 percent).

[110] Excluding children abandoned in maternity wards. If all children in public care are considered, the proportion becomes 3.3 percent.

[111] There are large discrepancies between counties, which are not necessarily related to the proportion of children who entered the system a long time ago. The rates of missing data on child exploitation vary between a minimum of 24 percent in Bistrița-Năsăud, and a maximum of 63 percent in Constanța (see Annex 6 Table 17).

Story Bag

"Together we worked on a case: a girl who, from the age of 11 until 16, was raped by her father. And the girl eventually reported the abuse. It was very difficult to prove the sexual abuse, because this was indirect evidence. It took a while for the samples to be analyzed. And, before the test results got back from Bucharest and things were cleared, the reintegration was made without us [the DGASPC] suggesting it. The judge ruled for the reintegration.

I was sure he would do it again, so I gave the girl my phone number. The father was the perfect abuser. He would disconnect her from everyone, there was a single phone available, so that he could control everyone: mother, daughter, who she talked to, so she wouldn`t interact with people in the community. He would keep a close eye on her schedule: when she left for school, when she came back, he would control the child and even the other family members. The mother was basically terrorized, she grew dependent on him, although she was not aware of the fact that she was the one holding the place together, she worked, had an income, whereas he was just a parasite in that family. But he managed to make the mother believe that she couldn`t live without him. And despite all this, he did it again. The girl also felt some pressure from her mother, who didn't believe her and thought that what she was doing would leave her without a father for her children and without a family support. But he did it again; that is, he walked in on her when she was taking a bath, when he knew she was naked and that's when she called; it was on a Sunday when I got the phone call, and with the police from there, we intervened and took her to the center. Now, [*the girl*] is subject to a protection measure and the father is in jail. Eventually we got the test results as well, and they confirmed everything, because the result was on the underwear."

(Focus group with professionals, Focșani)

Do you remember why you had to go to the center?

"- I've been in the center for 14 years. I got here because of my parents who drink and fight.

- I've been in the center for two years, because of my parents, who drink, fight, argue, and I haven't shared this with anyone. Mom was remarried and my stepfather had an issue with my brother and me."

(Focus group with children, Focșani)

Story Bag

"I had a girl who was sent back to her family. The mother was not there, because she had been deprived of parental rights, but she was reintegrated at her grandmother's. They created a living environment, the grandmother was supported with goods or money, I'm not sure what the case file stated. The idea was great. She gathered all siblings, including the girl that had been here. The girl had ended up with us because her mother scalded her face with hot water. I don't know if this was intentional or by mistake, but she even went to jail because of this, especially since she also used the girl to beg.

Together with a plastic surgeon from Brașov, Dr. Ardean, who supported us a lot, and with a team of UK doctors, we managed to do many surgical interventions on the girl to reshape her face, to save her ears, because she risked losing her hearing. I think that, overall, she was subject to over 10 surgeries. And after this, there was this project idea; the girl was placed with her grandmother, and she was very happy. She was enrolled in school, we paid for her afterschool. The colleagues would help her do her homework, because here she was with the kids, and couldn't have followed the normal educational path. And she was very happy that she was with the family, with her siblings and grandmother. But despite all this, after half a year, when we had scheduled another surgery, we couldn't find her because her mother had been released from jail and had taken her away, and she was last seen in Suceava or some place, begging again. Now how do you explain to a group of people who came from the UK to do a surgery on the child that she's not to be found?"

(Interview with a professional, Bârlad)

Do you remember why you had to go to the center?

"- I ended up in the center because I wanted to. I asked for it, two years ago. My father started to drink and use bad language. And I'd started singing. I took up singing with my uncle at various events. My father, when seeing that I was doing ok, stopped working and started taking all my money. In high school he suspended my year, so I decided it is best to come here. I decided I wanted a different opportunity."

(Focus group with children, Focșani)

Boys are more exposed to exploitation than girls (5 percent versus 4 percent). The probability of child exploitation is evenly distributed among children from urban and rural areas and from all ethnic groups. The incidence of child exploitation among children in public care increases from about 2 percent of children under 7 years of age when entering the system to over 8 percent of children aged 7 to 10 years and to more than 12 percent of those with entry ages between 11 and 14 years old. Thus, one in every eight children who entered the child protection system in adolescence (between 11 and 14 years old) has experienced at least one form of exploitation.

About three-quarters of the exploited children come from nuclear families with three or more children who live together in a stable dwelling. The majority of them have siblings in the child protection system. The other exploited children arrived in the system via street routes either from a homeless family or after running away from home. It is not clear if they ran away from home as a response to being exploited by their parents or if they were exploited after running away from home (during the period of living on the street), but the statistical association between the two events is very strong. Thus, 37 percent of the children with experiences of exploitation and an entry age of 7 and 17 years old ran away from home before entering the system. This percentage is five times higher than average (which is 7.5 percent).

Childhood disabilities are not a risk factor for child maltreatment as children with disabilities have a lower than average rate of exploitation.[112] Nevertheless, maltreatment through exploitation appears to have a significant impact, leading to developmental delays and special educational needs. The incidence of developmental delays among exploited children at the time of their entry into the system is over two times higher than average (39 percent versus 17 percent). The same is true regarding the incidence of special educational needs (16 percent versus 9 percent). However, further research is needed to establish whether this link is causal.

Another form of child exploitation, on which we have data only from the qualitative study, refers to the parents who go abroad taking their children with them only with the aim of using or exploiting them, not for the purpose of keeping the family united.

> "There are families... not from normal families, who leave for begging, prostitution, or other things. And for this they take their children with them." (Focus grup professionals, Brașov)

> "Somehow we need to find a way to get a reaction on the part of the notaries. They should draw the attention of authorities in case they see a case raising suspicion, they should inform an authority, to have that case looked into, because it is not enough when wanting to take the child out of the country to just pay the fee as long as you are about to put that child in harm's way. Therefore, we believe the power of attorney as it is right now, in its current version, is a loophole of the system as a result of which children enter a process of migration and exploitation through work and beggary." (Interview with a professional, Craiova)

However, the DGASPC professionals interviewed in the qualitative study considered that the parents' behavior in having children in order to access various social benefits, particularly parents who live in poverty, is the primary form of child exploitation which, in their opinion, is associated with welfare dependency.

> "Well, they live off social welfare, from the guaranteed minimum income or child state allowance, and this is why they constantly have babies, because for children under 2 years old, the allowance is higher than for the others, so they constantly have babies in order to have a minimum income in the household." (Focus group with professionals, Bucharest)

> "There was a time… at some point when there were many requests to establish protection measures, especially for children over 2 years of age because the parents used that allowance which was slightly higher for kids under 2. The allowance paid for kids from 0 to 2 years old is RON 200, and that, for them, means a lot of money. And then, they asked for special protection measures." (Interview with a professional, Piatra Neamț)

[112] The rate of exploitation is 2 percent versus about 5 percent of children without disabilities.

"I had this case: two kids were neglected, so we suggested that the parents work with us and, for a given time, until things got better, agree to the establishment of a protection measure. And it shocked me to see that they agreed to this for the older child but not for the younger one. Afterwards, they explained the reason. They were willing to give up RON 42 [the monthly allowance for children over 2], but not RON 200 [the monthly allowance for children between 0 and 2 years old]. (Focus group with professionals, Bucharest)

"Mothers don't want the family planning my colleague was mentioning, because after giving birth, they keep the baby for two years, get that RON 200 allowance, and, after two years, they come and ask for the child to be institutionalized, then go back and have another one. For them, the child is a source of revenue. [...] I don`t know, maybe there should be a law according to which ok, you have one, two, three children - the state will help you, or look after them, but beyond that, it's up to you if you want to have more. Not necessarily a limitation, but making the families more accountable." (Focus group with professionals, Brașov)

Table 17: Access to Social Benefits by Families of Origin (% children)

	Households of children with experiences of exploitation			
	Yes	No	Don't know	Total
Family placement allowance	1.1	4.9	3.4	4.2
Allowance for people with disabilities	6.0	10.8	7.1	9.1
Allowance for people living with AIDS	0.3	0.4	0.6	0.5
Family allowance	16.6	13.8	11.4	13.0
Guaranteed Minimum Income (GMI)	30.4	18.6	16.6	18.1
Social canteen	5.7	2.3	1.5	2.1
Emergency aid provided by mayoralties	5.5	1.0	0.7	1.0
Food staples	7.0	1.6	1.3	1.7
Heating subsidy	9.6	2.5	2.4	2.7
Other (non-contributive) benefits	13.4	10.8	9.0	10.2
Any of the above benefits	**49.2**	**42.7**	**34.1**	**39.3**
TOTAL - %	100	100	100	100
- N	1,289	21,701	16,852	39,842

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=39,843). Children relinquished in maternity straight after birth are not included.

Table 17 shows that, before entering the system, more than 60 percent of all children in public care,[113] lived in households that received no social benefits (other than the regular allowance for all children). The most common benefits were the GMI and the family allowance, which are targeted to the poor. However, no benefit was available to more than 20 percent of children in public care prior to their entering the system. It is true that, in the households of the exploited children, the share of beneficiaries was higher for most social benefits, but none was more than 30 percent of children. Thus, these families might have tried to use their children to obtain more benefits, but they were not very successful. In addition, all of these benefits are very low, only at survival level at best. Although there is little information on income in the children's case files,[114] what there is indicates that the main problem faced by families of children in public care is not welfare dependency, but increasing access to benefits.

For more information, see also section 3.2.5.1 on poverty.

[113] Excluding children relinquished in maternity wards.

[114] Between 20 percent and 42 percent of the children's files are missing information on each benefit.

RECOMMENDATIONS

Interventions that provide services for parents and for families and children within the community prior to separation on grounds of exploitation are vital. In this respect, early identification and early intervention before risk situations become critical are key for preventing child-family separation.

There is a need to improve the way in which child exploitation is understood and recorded in children's case files, especially in some counties. There is a need to clearly distinguish between exploitation and what specialists interpret as exploitation based on preconception and prejudice. It is highly necessary to have a real, physical presence within the community, especially in the source communitites, of child protection specialists, together with social workers or people with social work responsibilities within the SPAS in order to understand the context and thus be able to develop interventions that address the causes of child exploitation.

As a protection measure for children taken abroad by their parents for exploitation purposes, child protection professionals considered, at the time of the research, that a system of notification between the DGASPCs and notaries should be developed. At present, there should be support for the enforcement of the new regulations (Government Decision 691/2015) regarding the procedure for monitoring how children with parents who have gone abroad for work are being raised and cared for and what services are available to them, as well as regarding a work methodology for DGASPC-SPAS collaboration and the standard model for the documents produced by these two institutions.

In addition, a solid interinstitutional collaboration is highly necessary at cross-national level. Where such acts (of exploitation) take place or are noticed, the Romanian legislation on revoking parental rights should be immediately applied (or the legislation of the county in which the abuse, neglect, or exploitation is noted), and the children should receive the most suitable form of protection measure, according to the child's best interest, in the country of origin or destination, according to the same principle.

3.2.2.4 Deprivation of Parental Rights

In Romania, the deprivation of parental rights is regulated in the New Civil Code as shown in Box 4 below.

Deprivation of parental rights is closely linked with neglect, abuse, and child exploitation and is rather an instrument for separating children from the abusing family than a cause in itself.

Box 4: Legal Provisions regarding the Deprivation of Parental Rights

The New Civil Code of 2015 includes the following regulations regarding deprivation of parental rights:

Art. 508 Conditions: The guardianship court, at the request of the public authorities responsible for child care, can rule to deprive parents of their parental rights if the parent endangers the child's life, health, or development through mistreatment, alcohol or substance abuse, abusive conduct, or severe neglect in performing their parental duties, or by severely harming the child's best interest.

Art. 509 Scope of deprivation: (1) The deprivation of parental rights is full and is applicable for all children born when the ruling was issued. (2) However, the court can rule on the deprivation of only part of the parental rights or only for particular children provided that this does not harm the children's development, education, learning, and professional training.

Art. 510 Support obligation: Deprivation of parental rights does not relieve the parents from the obligation of providing support for their children.

Art. 511 Introduction of the Guardianship: If after the deprivation of parental rights the child is not in the care of either of the parents, the guardianship shall be introduced.

Art. 512 Restoring parental rights: (1) The court shall restore parental rights if the conditions that led to their removal are no longer present and if the parent no longer endangers the child's life, health, and development. (2) While the request is still awaiting a ruling, the court may allow the parent to be in contact with the child, if this is in the child's best interest.

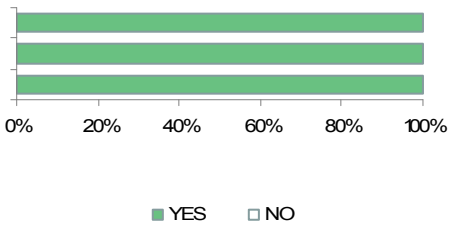
Source: New Civil Code (2015), available on http://legeaz.net/noul-cod-civil.

In the ANPDCA official reports, the deprivation of parental rights is stated as the main cause of separation, as declared by DGASPC specialists, for about 1 percent of children in public care (Figure 19). According to the case files, parental rights have been deprived in the cases of 1.4 percent of children since they entered the system (Table 18). Over time, some parents have regained their rights,[115] while others have lost them, so in November-December 2014 the proportion of children in this situation represented about 1 percent of all children in public care. Consequently, a total of 2.4 percent of children in public care have had their life, health, or development put in danger by their parents.

For children whose parents (one or both) were deprived of exercising their parental rights prior to the child's entering the system, the deprivation of parental rights is stated as the main cause of separation by all parties involved, including DGASPC specialists, parents, and SPAS social workers (see the figure next to Table 18). However, in about half of these cases, they added an underlying cause of the deprivation of parental rights, most often neglect, abuse, violence, and/or the detention of the mother or father. In any event, for all of the cases stated by specialists as being separation on the basis of deprivation of parental rights, the case files show evidence of neglect, abuse, and/or child exploitation.

Table 18: Parents Deprived of Parental Rights - Facts and Registration as the Main Cause of Separation Stated in the Case File (%)

	Deprivation of parental rights reported as main cause of separation:		
	NO	YES	Total
At entry into protection system			
- Mother	0	0.7	0.7
- Father	0	0.2	0.2
- Mother and father	0	0.6	0.6
While in protection system			
- Mother	0.6	0	0.6
- Father	0.3	0	0.3
- Mother and father	0.1	0	0.1
- No parent deprived of parental rights	94.8	0	94.8
No information in the child's file	2.9	0	2.9
TOTAL	98.6	1.4	100



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=48,760). Children with unknown parents and true orphans were not included.

Children in public care whose parents have, at some point during the child's lifetime, been deprived of their parental rights are both boys and girls, most often from families living in source communities,[116] particularly in rural areas. Among them, the share of children who had a personal identification number at the time of their entry into the system was only 71 percent versus 84 percent of the entire population of children in public care. Roma children have higher odds of being in this category (3.7 percent versus 2.4 percent), but they represent only about 17 percent of all children whose life, health, or development was threatened by their parents' behavior. Considerably more cases (around 6 percent) were reported in Harghita and Vaslui counties than in the other counties.

During the qualitative research, some professionals stated that the legal process through which parents are deprived of their parental rights is "too heavy and highly bureaucratic to genuinely and swiftly serve the best interests of the child". [117]

[115] Parental rights have been restored for 31 percent of mothers and 41 percent of fathers who had been deprived of their parental rights when their child entered the system. However, reintegration of their children into the family failed.

[116] The share of children from source communities is 22 percent in this category versus 15 percent of all children in public care.

[117] Interview with a professional, Buzău.

RECOMMENDATION

Considering the fact that the deprivation of parental rights is used as a tool to separate the child from their abusing family rather than a cause in itself and that all the cases stated by specialists as being separation on the grounds of the deprivation of parental rights also document evidence of child neglect, abuse, and/or exploitation, we recommend eliminating the deprivation of parental rights from the list of possible causes of separation and replacing it with the "child neglect, abuse, and exploitation" category.

3.2.3 Individual-level Risk Factors (Associated with Parental Behavior)

The key to preventing child abuse and neglect is resolving the known risk factors. As already mentioned in the previous section, the relinquishment of children[118] is an extreme form of violence[119] that may originate in a variety of underlying causes including parents leaving to work abroad, family dissolution (divorce, separation, or desertion of the family by the parents), parents' unstable relationship, infidelity, and birth out of wedlock, as well as parental disinterest.[120]

A large body of literature[121] has shown that risk factors associated with neglect and abuse in the families of children in child protection include parental behavior and characteristics that can be tackled either by entire population-based policies or by targeted interventions. These risks include alcohol and drug abuse, domestic violence, and parental disability or mental health problems (primarily on the part of the mother). Other risks factors relate to a child's disability, a child's poor health and/or behavior issues, premature birth, and parents' promiscuous and/or criminal behavior. All of these individual-level risk factors are analyzed in this section. Often, the families facing these problems are also exposed to several other vulnerabilities associated with social exclusion, such as poverty or lack of a stable accommodation. These structural factors are discussed in section 3.2.5.

3.2.3.1 Parents Leaving to Work Abroad

Going abroad for work is not in itself a cause of separation. Millions of Romanians work abroad but have not abandoned their children. Going abroad becomes a cause of separation only when it turns into parental neglect, when parents forget about their children who are left behind, cease communicating with them, lose the connection with them, and lack a clear and agreed arrangement of care for the children left home.

> *"You, for instance - why did you have to go to the center? Do you remember?*
>
> - Yes... But I don't want to say why. No, because it's embarrassing.
>
> *Nothing we share here is embarrassing. Please, tell us.*
>
> - Because my grandma kept scolding me; mom would leave for the UK and my grandmother sent me away from home." (Focus group with children, Cluj-Napoca)

[118] For relinquishment in medical units, see section 3.1.3.2.

[119] The definition of violence is the one in Article 19 of the Convention on the Rights of the Child: "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (United Nations, 1989). In addition, it is based on the definition in the World Report on Violence and Health: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug et al., eds., 2002:5).

[120] Currently, all these causes of separation are often recorded in the official reports under the category of "disappearance of parents" or "others."

[121] For example, Munro (2005), Frederick and Goddard (2007), Wood (2008), Jeffreys et al. (2009), and Munro et al. (2013).

> "Parents decide to leave to go abroad just like that, from one day to another. They get a phone call, 'Come, I found this job here!' and they leave their children with other families. The latter [the substitute family,] after a while, starts to wonder: well, they aren't sending me any money, they aren't supporting me in any way, why should I raise their child? And that's when they contact us saying the mom is abroad and left the kid in their care." (Interview with a professional, Arad)

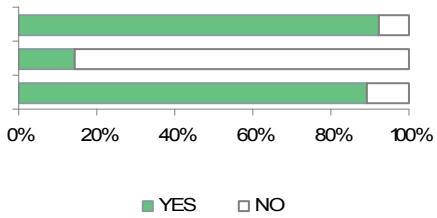
In addition, it can be a cause of separation if the parents take their children abroad with them but only with the aim of using or exploiting them, not for the purpose of keeping the family united.

> "There are families... not from normal families, who leave for begging, prostitution, or other things. And for this they take their children with them." (Focus group with professionals, Brașov)

Thus, leaving to work abroad is a cause of separation only when it constitutes parental abuse or neglect. Accordingly, the vast majority of the DGASPC specialists have reported as the main cause of separation either that parents left to work abroad[122] or neglect, abuse, and exploitation or both. Only for children with just the father working abroad is the main cause of separation stated as "poverty" and rarely as "parent left to go abroad" (figure next to Table 19).

Table 19: Parents Left to Go Abroad (to Work): Facts and Registration as the Main Cause of Separation Stated in the Case File (%)

	Parents abroad stated as main cause of separation:		
	NO	YES	Total
At entry into protection system			
- Mother left to go abroad	0.3	2.8	3.2
- Father left to go abroad	0.6	0.1	0.8
- Mother and father left to go abroad	0.1	0.9	1.0
While in protection system			
- Mother left to go abroad	1.2	0.0	1.2
- Father left to go abroad	0.7	0.0	0.7
- Mother and father left to go abroad	0.2	0.0	0.2
- No parent left to go abroad	90.7	0.0	90.7
No information in the child's file	2.2	0.0	2.2
TOTAL	96.1	3.9	100



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=48,760). Children with unknown parents and true orphans are not included.

Parents going abroad can be a significant risk for child neglect but not for abuse or exploitation. Annex 6 Table 18 shows that the incidence of child neglect recorded in the case files is 52 percent of children with one or both parents abroad versus the average of 42 percent for all children in public care. Also, the chances of children of parents who have gone abroad being relinquished in a maternity ward are eight times lower than the average.

Also, parents going abroad is not associated with any childhood problems such as child disability,[123] special educational needs,[124] developmental delays,[125] or behavioral disorders.[126]

[122] Usually, this was recorded under the category of "other causes" and rarely under "disappearance of parents."

[123] Children with disabilities account for fewer than 8 percent of children with one or both parents gone abroad versus the average of 11 percent for the whole population of children in care.

[124] Among the children with parent(s) abroad, children aged 6 to 17 years with SEN are almost two times fewer (5 percent) than among the whole population of children in public care (9 percent).

[125] Children with developmental delays represent 11 percent of children with parent(s) abroad and 17 percent of all children in public care.

[126] Children aged 7 to 17 with behavioral problems account for 8 percent of children with parent(s) abroad and 11 percent of all children in public care.

The parents of over 7 percent of children in public care left to go abroad (one or both parents), either before the child entered the system (5 percent) or while they were within the system (2 percent), as shown in Table 19.

Most of these children were over 3 years old when they entered the system. They arrived in the system together with their siblings via two main routes: (i) Maternity ward --> Family with a stable dwelling --> SPS, after a parent left to work abroad or (ii) Maternity ward --> Family --> Relatives --> SPS, after the single-parent or both parents left to work abroad. These children are more likely to be girls than boys but come from both rural and urban areas. Most of the cases were reported in the following counties: Botoșani, Caraș-Severin, Hunedoara, Prahova, Suceava, and Vrancea.

RECOMMENDATION

Child protection professionals believe that a notification system between the DGASPC and notaries should be developed to protect children from being taken abroad by their parents for exploitation purposes:

> "Somehow we need to find a way to get a reaction on the part of the notaries. They should draw the attention of authorities in case they see a case raising suspicion, they should inform an authority, to have that case looked into, because it is not enough when wanting to take the child out of the country to just pay the fee as long as you are about to put that child in harm's way. Therefore, we believe the power of attorney as it is right now, in its current version, is a loophole of the system as a result of which children enter a process of migration and exploitation through work and beggary." (Interview with a professional, Craiova)

3.2.3.2 Dysfunctional Families

The atypical demographic behavior of the parents of children in public care, which is characterized by unstable relationships, consensual unions, single-parent families, divorces, and separations, has already been discussed in section 3.1.2. Family breakdowns can be the result of the death, detention, or departure abroad of one or both parents, but it can also be the result of one or both parents deserting their family, of parents getting divorced or separated, of unacknowledged paternity, parental disinterest, infidelity, or birth out of wedlock.

In the present study, the dysfunctional family is defined as a family in which one or more of the following events have occurred: divorce, separation, infidelity, parental disinterest, desertion of the family,[127] unacknowledged paternity, and birth out of wedlock.[128] Seventeen percent of children in public care were part of such a dysfunctional family when they entered the child protection system.

Table 20: Incidence of Child Neglect, Abuse, or Exploitation in Dysfunctional Families and Other Families at the Time of the Child's Entry into the System (% of Children)

	Evidence of:					Total	
Children from...	Neglect	Abuse	Exploitation	Any form of violence	Child relinquished in maternity ward	- %	- N
Dysfunctional families	44	12	3	48	14	100	8,431
Other families	41	12	3	46	27	100	41,061
All children in public care	42	12	3	46	25	100	49,492

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. Children with unknown parents and true orphans are not included.

[127] Does not include detention or the departure abroad of one or both parents, which are discussed in other sections.

[128] Does not refer to teenage mothers, which is discussed in a separate section.

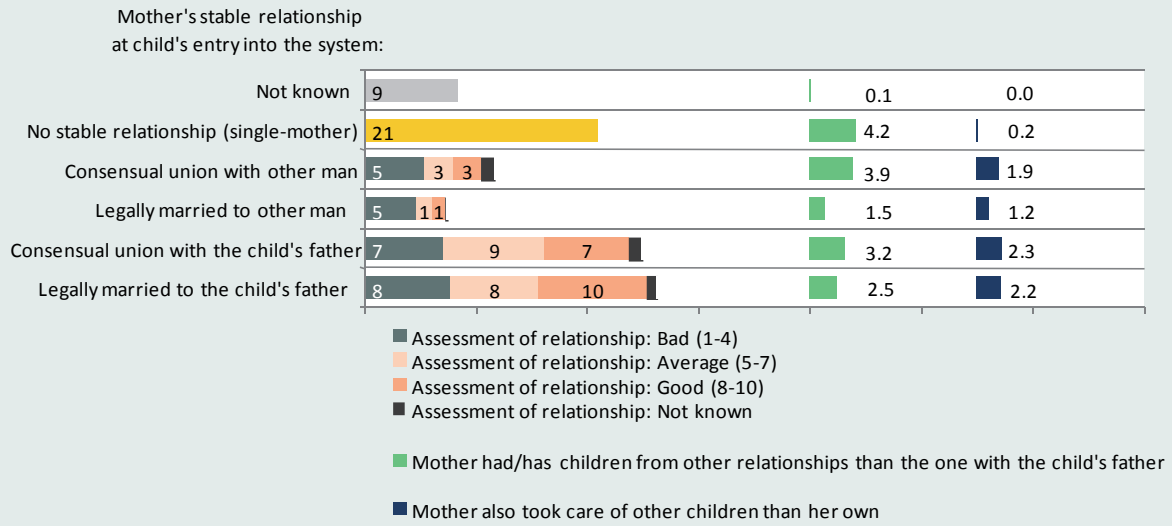
The dysfunctional family, as defined above, represents an important risk factor only for child neglect but not for abuse, exploitation, or relinquishment in maternity wards (Table 20). Also, the dysfunctional family is not associated with children with disabilities,[129] special educational needs,[130] developmental delays,[131] or behavioral disorders.[132]

Among the children in public care who come from dysfunctional families, the following are over-represented: children who entered the system between the ages of 3 and 14 years old, boys (as opposed to girls), children from rural areas, Romanians, and Hungarians. To a large extent (over 43 percent), these children come from families with atypical structures (see Infograph Chart 1), with one or two children and a stable dwelling. The large majority have arrived in public care via the predominant routes related to family and kinship networks.

FROM RURAL SOURCE COMMUNITIES

Data from rural source communities show that the mothers of 70 percent of children in care were in a stable relationship when their children entered the child protection system. However, in only 51 percent of these cases was the mother together with the child's biological father, while the other mothers had a different partner. Even fewer mothers were legally married to the child's father (26 percent of children), and only about 10 percent of children came from a family where the mother and father were legally married and in a "good" relationship (as assessed by the mother).

Figure 24: Relationship Status of Mothers from Rural Source Communities at the Time of Their Child's Entry into Public Care (% of Children)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=1,140 children).

So most of these children came from families where the parents were living in consensual unions or from single-mother families. Only about a half of them lived with their fathers. Many of them had lived in family environments in which the couple had a tense relationship, especially those between the mothers and partners other than the child's father.

[129] Children with disabilities account for 9 percent of children from dysfunctional families versus the average of 11 percent.

[130] Children aged 6 to 17 years with SEN represent 6 percent of children who come from dysfunctional families versus 9 percent of the whole population of children aged 6 to 17 in public care.

[131] Children with developmental delays represent 15 percent of children in public care who come from dysfunctional families and 17 percent of all children in public care.

[132] Children aged 7 to 17 years with behavioral problems represent 9 percent of children in public care who come from dysfunctional families and 11 percent of all children aged 7 to 17 years old in public care.

Many of the mothers or parents of children in public care themselves grew up in dysfunctional families in which they suffered from different types of abuse or neglect. Thus, this is the only type of relationship and parenting that they know. They are just continuing a cycle.

> "- Parents who end up relinquishing their children come from dysfunctional families.
>
> *What do you mean by dysfunctional families*?
>
> - Divorce, poverty, this is somehow perpetuated.... Or simply single-parent families, because many of them don't even get married, they live in consensual unions, after which they break up, have other relations.
>
> - Or very young mothers who simply get pregnant accidentally, but neither they nor their families have the capacity to take the baby in and raise it." (Focus group with professionals, Brașov)

In other cases, the mother has rejected the child. Child protection specialists explained that the main problem in cases of maternal rejection is the lack of procedures for situations in which counselling and/or support services fail. In any case, the absence or underdevelopment of the counseling and support services for mothers/parents in the community cannot be denied.

> "A very concrete example: we have a child who strongly wants to live at home, with his mother. He has a perfectly normal, healthy mother, living in a house with her partner - they are now married. They don't have any children at home; she has other children, older daughters, living in their own homes. The psychologist from the center is making huge efforts to persuade that mother to take in her child. No, no and no. Madam, we will help you, with a job. No, I have a job. Well, if you have a job, and a home, take the child. No, because he causes trouble. Who sanctions her because she does not want to care for the child? Who will sanction her? She has everything she needs. She works without a legal employment contract so that her employment status can't be proven in court. She lived in the home of her partner, which is not her home too, and claims that she can't take in the child. The child wants it, he is fourteen, his opinion is taken into account, he runs away from the center to get to his mother, and his mother lives in Dej, not in Cluj, thus the child's life is put in danger because he travels using all possible means: hitchhiking, by train, by any means he can, it doesn't matter, he wants to be with his mother. He will not stay in the center. So tell me, what can one do to deal with this mother." (Focus group with professionals, Cluj-Napoca)

RECOMMENDATIONS

It is absolutely necessary to develop counseling and support services for children and families as well as parental education training to help families to develop parental skills in a way that avoids stigmatization. Proactive procedures must be developed to identify the reasons why mothers and families reject their children and to devise possible remedial solutions. These might include counseling the mother and father, their life partners, and the wider family in an inclusive and participatory way in the best interests of the child.

It is also vital to develop a specific and accurate tool to collect information, rather than opinions, to inform clear and inclusive interventions for mother and child that take into account the best interests of the child and the core principles regarding the protection of child rights.

3.2.3.3 Teenage Mothers

With regard to early pregnancy, two situations can be distinguished. The first situation involves children whose mothers were teenagers (aged 12 to 17) when they gave birth to the child. The second situation involves children whose mothers were teenagers not only when they gave birth but also when their child entered public care. Of all children in the system, one out of every four or five children (22 percent) has a mother who was a teenager when she gave birth to the child. The vast majority of these children ended up living with their mothers' family (generally in a stable home) from where they were placed in public care at ages between 1 and 17 years old, with the same probability and for similar reasons as for children with mothers aged 18 and over.[133] Only 19 percent of children with teenage mothers at birth entered public care before their mother turned 18 (which represent 4 percent of all children in public care).

Teenage mothers at birth (regardless of how old they were when the child entered public care) represent about 26 percent of all mothers of children in public care.[134] Teenage mothers account for 27 percent in rural areas and 24 percent in urban areas but as high as 35 percent in the source communities. A higher incidence of teenage mothers is also evident among mothers of Roma ethnicity (33 percent versus 25 percent of mothers of Romanian ethnicity and 21 percent of mothers of Hungarian ethnicity).[135]

FROM RURAL SOURCE COMMUNITIES

According to the prevailing demographic model, in rural source communities, one-third of mothers of children in public care had their first child when aged between 13 and 17 years. Thus, early childbearing is widespread in these communities from which a disproportionately large number of children end up in the child protection system.

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=714 mothers).

Mothers who were teenagers (12 to 17 years old) at the time of their child's entry into public care represent approximately 6 percent of all mothers of children in care.[136] The proportions are 4 percent in rural areas, 7 percent in urban areas, and around 8 percent in the source communities. The incidence of teenage mothers is higher than average also among Roma (8 percent) and women of undeclared ethnicity (7 percent). Considerably higher than average shares of teenage mothers of children in public care were recorded in Argeș, Bihor, Brașov, Bistrița-Năsăud, Caraș-Severin, Covasna, Dolj, Olt, Satu Mare, and Vâlcea.

Most teenage mothers were healthy when their child entered the system.[137] The majority were not married, but 22 percent were living in a consensual union and 1 percent were legally married. However, over 82 percent of the teenage mothers stated that the child's father was unknown or that he did not want to acknowledge paternity. Nearly all of the teenage mothers had graduated eight classes at most and only 24 percent were still enrolled in school, while the others were financially

[133] For example, Table 21 shows that the incidence of child neglect, abuse, and/or exploitation is average among the children of teenage mothers. The risk of these children being relinquished in medical units is also average.

[134] Unknown mothers and mothers with unknown birthdays were not incuded. These represent 5.5 percent of all mothers with children in public care.

[135] A high incidence of teenage mothers was evident in the following counties: Bihor, Brașov, Buzău, Călărași, Caraș-Severin, Covasna, Hunedoara, Maramureș, Mehedinți, and Vâlcea.

[136] Unknown mothers and mothers with a missing date of birth are not included. They represent 5.5 percent of the entire population of mothers.

[137] Disabilities and/or mental health problems affected 8 percent of teenage mothers at the time of their child's entry into the system, versus 16 percent of all mothers aged 18 years and over. In the children's files, there is no information on the health status of 27 percent of teenage mothers.

dependent on their families. This low educational level was accompanied by a low level of sexual education, especially in the source communities.

> "It might be the case in single-parent families, maybe there are young girls like in the Roma communities and they are not legally married and they end up alone at some point or they have a relationship; they become sexually active when they are very young... Come to think about it, I think it all starts with the education received. I am educated, I know where to go for my health, I know where to go if I get pregnant, I know it is not good so I use protection to avoid undesired pregnancies so that I don't get pregnant at 13 or 12. At 12 it's more difficult, but at 13 they can have their first pregnancy. It all starts from the education received." (Interview with a professional, Craiova)

> "And there is another situation we are facing: there are a lot of underage girls who live in consensual unions and the parents come to inform us, but they do it when it's already too late, when the parent-child relationship has been long since deteriorated. Not to mention those cases in which the underage girls have babies, they get pregnant. Those are also difficult situations." (Focus group with professionals, Ploiești)

Most children in public care whose mothers were teenagers at the time of the child's entry into the system are healthy: only 6 percent have a disability and fewer than 10 percent have developmental delays.[138] Table 21 shows that the incidence of violence among children of teenage mothers is over two times lower than the average (19 percent versus 46 percent regarding any form of violence). Nonetheless, the risk of being relinquished in a maternity ward immediately after childbirth is doubled (52 percent versus 24 percent). So, the major risk to which these children are exposed is being relinquished in the maternity ward, an issue which is discussed in detail in section 3.1.3.2.

As a result, only about 40 percent of children with mothers who were teenagers at the time of their child's entry into the system have arrived in public care after living with their mother's family. Most often, these mothers gave up their child because the child was rejected by the family on which the mother was financially dependent. In only very few cases, the mother was still in school and gave up her child in order to continue her studies. Based on existing data, it is not possible to assess how many of these mothers currently stay in contact with their child and take their child back at home after they finish their education and find employment.

Table 21: Incidence of Child Neglect, Abuse, or Exploitation in the Case of Teenage Mothers (% of Children)

	Evidence of:					Total	
Children of…	Neglect	Abuse	Exploitation	Any form of violence	Child relinquished in maternity ward	- %	- N
Teenage mothers at childbirth (12-17 years old)	40	8	2	44	23	100	11,363
Teenage mothers at the time of the child's entry into the system	17	*	*	19	52	100	2,174
Mothers aged 18+	43	12	3	47	23	100	47,466
All children in public care	42	12	3	46	24	100	49,640

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. Children with unknown parents and true orphans are not included.

Note: *Cells with a low number of cases.

In cases of teenage mothers at the time of their child's entry into the system, most DGASPC professionals note down as cause of separation "other" often adding explicitly "teenage mother" (or parents) and the rejection of the child by the mother's family and/or by the child's father (Table 22).

[138] Compared to the average values of 11 percent and 17 percent respectively.

As expected, the DGASPC specialists mentioned causes related to neglect, abuse, or exploitation less than average for these children. However, at the same time, "neglect, abuse, or exploitation" was stated as the main cause of child-family separation for only half of the children with teenage mothers who were subject to neglect, abuse, and/or exploitation in the family. In other similar cases, DGASPC specialists mentioned other causes, most frequently poverty or "no information."

Table 22: Teenage Mothers at the Time of Their Child's Entry into the System: Facts and Registration as the Main Cause of Separation Stated in the Case Files (%)

Cause of separation stated in case files by DGASPC specialists:	Teenage mother at the time of child's entry into public care	Mothers aged 18+	All children in public care
Teenage mother (parents) and rejection of child by mother's family and/or by child's father	28	2	3
Disappearance of parents	7	12	12
Neglect, abuse, exploitation	21	33	32
Poverty	29	34	33
Other	52	33	33
No existing information	6	4	4
Total - %	100	100	100
- N	2,174	47,466	49,640

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. Children with unknown parents and true orphans are not included.

Approximately 2 percent of the mothers who were teenagers at the time of their child's entry into public care were institutionalized, which is four times higher than the average (0.5 percent of all children in public care).

RECOMMENDATIONS

Teenage pregnancy is highly associated with child relinquishment straight after birth. Therefore, effectively reducing teenage pregnancies will be vital to substantially strengthen efforts to prevent and monitor child relinquishment in health units. This is also highlighted in the Conclusions and Recommendations box in section 3.1.3.2:

- Although children are most often relinquished in health units, efforts and services for preventing this phenomenon should be intensified first in the community. Social workers or people with social work responsibilities together with community health workers and family doctors should be more active and better prepared to identify and monitor at-risk situations for child and mother at an early stage.
- The health monitoring of all pregnancies by community workers (especially by community health workers) is strongly needed along with clear mechanisms and protocols to enable the early identification of pregnant mothers who are very likely to relinquish their newborns and their immediate referral to the local social services.
- Sexual education and family planning programs for at-risk groups such as single mothers and teenage parents should be developed or resumed, particularly in source communities. Free contraceptives should be made available to vulnerable groups, whether these groups are covered by health insurance or not. Information, education, and communication campaigns on family planning and its benefits are also needed. In addition, support should be provided to vulnerable groups to decrease the cost of transportation to family planning centers.
- In order to prevent the consequences of teenage pregancies, we also recommend prevention programs that can include: (i) classes on health, sexual education, and contraceptive education initiated as early as possible and implemented on a permanent basis in both schools and communities (available to those who do not attend school) and (ii) awareness and social norm changing campaigns on the relations between parents/ adults and children, decision-making autonomy for youths, and youth participation in decisions that affect their life.

- The coordination and referral system between health units (especially maternity and pediatric wards) and social services should be improved in accordance with the legislative provisions that are currently in force.
- Social workers should be available in all health units with maternity and/or pediatric wards according to the legal provisions that are currently in force. In addition, other specialists should also be available, for instance, psychologists working with mothers in special situations (for example, with post-partum depression).
- All hospital and maternity ward work procedures aimed at preventing mothers from leaving their children alone in the hospital for several days should be strictly implemented.
- The existing services provided by maternal centers need to be improved and strenghtened in all counties as a way to prevent the separation of children from their mothers and families.
- Adequate special protection response services for 0 to 3-year-old children should be developed or strenghtened in all counties of the country (for instance, increasing the availability of foster parents to urgently take these children in), particularly for children with disabilities and/or with very low birth weight.
- All these measures should be correlated and integrated with the pregnancy identification and monitoring efforts that should be carried out before birth (as part of the prenatal services) and with the community-based support and assistance services for the mother/ parents and the newborn child (as part of postnatal services).

3.2.3.4 Parental Alcohol and/or Drug Abuse

One in five children in public care had one or both parents who abused alcohol and/or drugs prior to the child's entering the system.[139] In most cases, only the father abused alcohol (9 percent of children). However, 8 percent of children witnessed their mother abusing alcohol or drugs either alone (4 percent) or together with the father (4 percent).

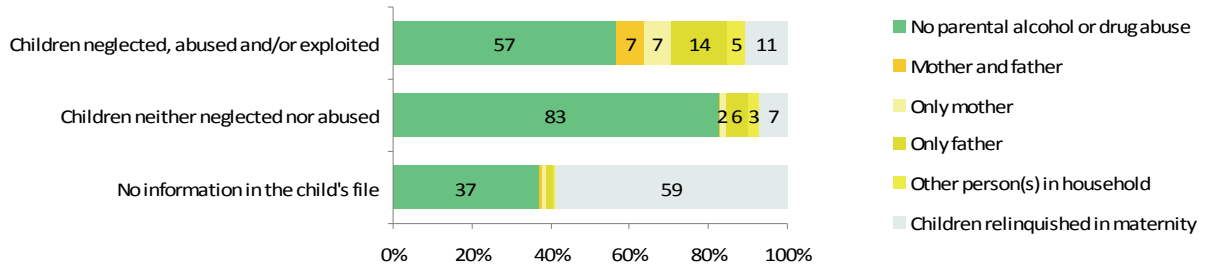
FROM RURAL SOURCE COMMUNITIES

Twenty percent of mothers from rural source communities experienced parental alcohol abuse during their own childhood.

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=754 mothers who were brought up in a family).

The incidence of parental alcohol or drug abuse cases is much higher among children who were neglected, abused, and/or exploited before entering the system (33 percent). Figure 25 illustrates the strong association between the two variables.

Figure 25: Association between Parental Alcohol and/or Drug Abuse and Child Neglect, Abuse, and/or Exploitation (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

[139] The incidence is even higher if children relinquished in maternity wards are not considered (26 percent).

These data confirm the results of previous UNICEF studies[140] that have shown that poor child nutrition, child neglect and abuse, and the separation of children from their families are all correlated with parental alcohol abuse. Table 23 shows that in families in which parents abuse alcohol and/or drugs, the incidence of child neglect is 1.7 times higher than in families in which there is no abuse of alcohol and/or drugs. Cases of child abuse or exploitation are five times more frequent. Overall, before entering the system, 82 percent of children with parents who abuse alcohol and/or drugs have suffered one of more forms of violence versus 48 percent of children with addiction-free parents. However, further research is needed to establish whether this statistical link is causal.

In the majority of cases in which one or both parents abused alcohol or drugs, the DGASPC specialists tended to state child neglect, abuse, or exploitation as the main cause of child-family separation, given that "alcohol leads to domestic violence, which leads to child neglect" (Interview with professional, Bârlad).

The incidence[141] of parental alcohol or drug abuse cases is higher for children aged 3 to 14 years old at entry into the system,[142] higher for girls than for boys, much higher for Romanians and Hungarians than for other ethnic groups, higher for children from rural areas than from urban areas,[143] and higher for those from families with at least three children than from smaller families.[144] Given the last statistic, it is not surprising that 72 percent of children with parents addicted to alcohol and/or other substances have siblings who are also in public care.

Table 23: Incidence of Child Neglect, Abuse, or Exploitation Due to Alcohol/Drug Abuse by One or Both Parents Before the Child Entered the System (% of Children)

	Parental alcohol/drug abuse		
Case file evidence of:	Yes	No	Total
Child neglect	77	47	54
Child abuse (emotional or physical)	37	8	15
Child exploitation	10	2	4
Any form of child violence	82	48	60
Total - %	100	100	100
- N	29,428	10,415	39,843

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. Children relinquished straight after birth in maternity are not included.

Parental alcohol and/or drug abuse is not associated with child disability nor with children with special educational needs. Nonetheless, it appears to be relevant with respect to children's psychological and behavioral problems. Thus, as many as 24 percent of children of addicted parents had developmental delays[145] and over 15 percent had behavioral disorders[146] since their entry into public care.

Parental alcohol and drug abuse is mentioned in at least 40 percent of children's case files in all counties from the Moldova region.

[140] Klingemann (2001), Stănculescu, Marin and Popp (2012).

[141] Not including children relinquished in maternity wards.

[142] Cases of drug/alcohol abuse by one or both parents represent about one-third of all children in public care between 3 and 14 years old versus the average of 26 percent.

[143] The incidence of parental alcohol/drugs abuse is 32 percent among children from rural areas versus 20 percent among children from urban areas.

[144] The incidence of parental alcohol/drugs abuse is 39 percent among children from families with three or more children versus 18 percent of children from one-child families and 28 percent of those from two-children families.

[145] Compared to the average of 18 percent for all children in the system.

[146] This percentage is almost double the one for children whose parents do not abuse drugs/alcohol.

RECOMMENDATIONS

Parental alcohol/drug abuse significantly increases the risk of a child being exposed to neglect, abuse, and/or exploitation and seems to be highly associated with the occurrence of developmental delays and behavioral disorders. Currently, there is no national program designed to address alcohol and drug abuse. Such a program that targeted parents (at least those parents whose children are in the child protection system) could have a significant impact in terms of preventing child-family separation, increasing the chances of family reintegration, and, in general, of respecting the rights of children to full and harmonious development within a family environment.

Furthermore, it is necessary to increase access to existing services and to develop new specialized services for parents who are already suffering from addiction (alcohol or drugs).

3.2.3.5 Parental Promiscuous and/or Criminal Behavior

Before entering the system, 13 percent of children in public care lived in a family in which at least one adult member had been in trouble with the law (had a criminal record, had been in trouble with the police, or had practiced prostitution).[147] In most cases, one or both parents had behaved promiscuously and/or criminally (for around 11 percent of children), while in others, an adult member other than the child's mother or father had behaved promiscuously and/or criminally (over 2 percent).

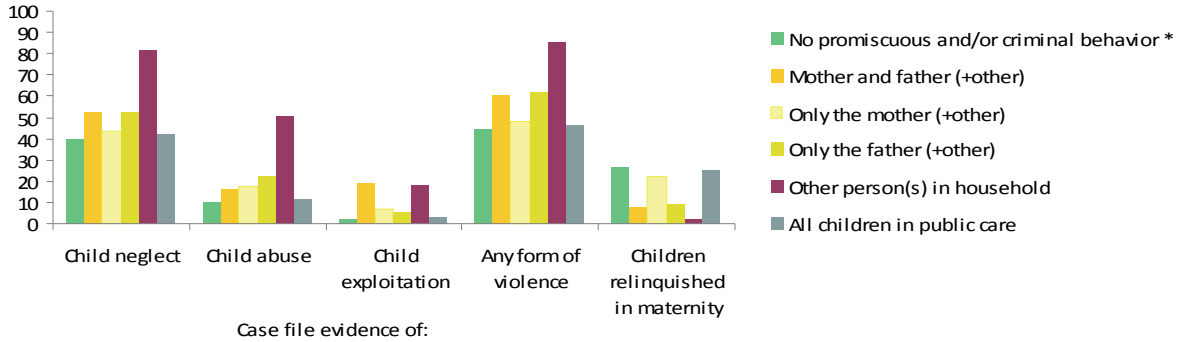
FROM RURAL SOURCE COMMUNITIES

In rural source communities, the mothers of children in public care stated that in their own childhood in their families of origin, 4 percent lived with adults with a criminal record, 3 percent with adults who had had problems with the police, and 2 percent grew up around a woman (or women) who was engaging in sexual relations in exchange for money.

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N=754 mothers who were brought up in a family).

The children's files show that all parents who were imprisoned had demonstrated promiscuous and/or criminal behavior (see Annex 6 Table 19).[148] Therefore, the children of parents who behave in these ways are at a very high risk of being separated from their family due to the imprisonment of one or both of their parents.

Figure 26: Incidence of Child Neglect, Abuse or Exploitation, by the Existence of Promiscuous and/or Criminal Behavior in the Household Before the Child Entered the System (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=49,033). Children with unknown parents and orphans are not included. See also Annex 6 Table 20.

Note: *Have criminal records, problems with the police, and/or engage in sexual relations in exchange for money.

[147] The incidence increases to 15 percent if children relinquished in maternity wards are not considered.

[148] See also section 3.2.1.2.

Parental criminal and/or promiscuous behavior represents a significant risk factor[149] for child neglect, abuse, and exploitation (Figure 26 and Annex 6 Table 20). The risk of one of more types of child maltreatment is especially high in families in which an adult member other than the parents has a criminal record, has had problems with the police, and/or engages in sexual relations in exchange for money. For example, the risk of child exploitation is approximately two times higher than the average if only the mother or the father are in conflict with the law but is around six times higher if both parents or an adult member other than the parents are in that situation.

In the case of children from families in which adults have exhibited promiscuous and/or criminal behavior, Table 24 shows that the DGASPC specialists tend to specify "the disappearance of parents" and/or "deprivation of parental rights" as main causes of separation, while often adding as underlying causes the detention of the parents[150] and parental criminal and/or promiscuous behavior. The neglect, abuse, or exploitation of the child are also frequently mentioned among the causes but not more frequently than average, which does not reflect the significant relationship between criminal behavior and risk of child abuse and neglect. Only for families in which an adult other than the parents has behaved in this way are neglect, abuse, and exploitation usually given as the main cause of separation.

In many case files, poverty is given as the main cause of separation, even for children who have come from families in which parents have exhibited promiscuous/criminal behavior and in which incidents of child abuse or neglect have occurred.

Table 24: Parental Promiscuous and/or Criminal Behavior: Facts and Registration as the Main Cause of Separation Stated in the Case File (%)

Causes of separation stated in case files:	Promiscuous and/or criminal behavior*					All children in public care
	Mother and father (+others)	Only the mother (+others)	Only the father (+others)	Other adult household member	No adult household member	
Detention of parents and/or criminal and/or promiscuous behavior of parents	50	36	26	4	1	4
Disappearance of parents	50	36	39	3	10	12
Deprivation of parental rights	13	4	5	1	1	1
Neglect, abuse, exploitation	23	31	36	68	31	32
Poverty	9	20	24	22	34	32
Other causes	21	33	26	17	34	33
No information in the case file	4	6	4	3	4	4
Total - %	100	100	100	100	100	100
- N	303	2,162	2,694	1,200	45,985	52,344

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: *Have criminal records, problems with police, and/or engage in sexual relations in exchange for money.

There is a strong correlation between the promiscuous and/or criminal behavior of the adults in the family and another risk factor, namely substance (alcohol/drug) abuse.[151]

[149] Further research is needed to establish whether the relation is causal.

[150] As already mentioned in section 3.2.1.2, when the causes of separation are specified in the files, parents' detention is recorded under various categories (disappearance of parents, deprivation of parental rights, other causes, and occasionally the imprisonment of parents).

[151] The incidence of alcohol or drug abuse is of 32 to 35 percent among adults from families in which the father has exhibited criminal and/or promiscuous behavior (whether together with the mother or not) and as high as 55 percent in families in which an adult member other than the parents has exhibited such behavior (versus the average of 20 percent).

Parental promiscuous and/or criminal behavior, especially by the mother, has multiple harmful effects on the child's development:

- Maternal criminal and/or promiscuous behavior increases a child's risk of having special educational needs. The incidence of special educational needs is twice the average among children of mothers with promiscuous and/or criminal behavior (18 percent versus 9 percent).[152] Children from families in which the father has a criminal record and/or problems with police do not have a higher incidence of special educational needs.
- At the same time, maternal criminal and/or promiscuous behavior appears to be extremely relevant to the development of behavioral disorders in children. The percentage of children in care aged 7 to 17 years with behavioral problems is three times higher than average if only the mother has exhibited promiscuous and/or criminal behavior and is five times higher than average if both parents have exhibited such behavior (30 percent and 48 percent respectively versus the average of 10 percent).[153] However, the children from families in which only the father has a criminal record and/or has had problems with the police do not have a higher than average risk of behavioral problems.
- Maternal criminal and/or promiscuous behavior is also associated with developmental delays in children. According to the baseline psychological assessment received by children as they enter public care, the incidence of children with developmental delays (in one or more dimensions) is 21 percent if the mother has exhibited promiscuous and/or criminal behavior, versus an average of 17 percent. [154] Children from families in which only the father has a criminal record and/or has had problems with the police do not have a higher than average risk of developmental delays.

Parental criminal and/or promiscuous behavior is not associated with child disability.

The incidence of parental promiscuous and/or criminal behavior was higher among children aged 1 to 6 years old at their entry into the system,[155] children from rural areas,[156] and those from dysfunctional families, especially those with more than three children.[157] However, it was similar for girls and boys and for children from all ethnic groups (with a slight over-representation of Roma children). Sixty-three percent of children whose parents have exhibited such behavior have siblings in public care.

The vast majority of these children arrived in the system either directly from their family (53 percent) or by one of three other less common routes:[158] (i) Maternity ward --> Family --> Relatives --> SPS; (ii) Maternity ward --> Family --> Children left home alone --> SPS; and (iii) Maternity ward --> Family --> Children who ran away from home/street children --> SPS.

Parental criminal and/or promiscuous behavior was reported in 12 to 16 percent of children's case files in nine counties: Olt, Galați, Bihor, Botoșani, Gorj, Hunedoara, Suceava, Vâlcea, and Bucharest (Annex 6 Table 21).

[152] This risk is also higher in the case of children from families in which an adult member other than the parents has exhibited promiscuous and/or criminal behavior (12 percent).

[153] This risk is also high for children from families in which an adult member other than the parents has exhibited promiscuous and/or criminal behavior (17 percent).

[154] This risk is even higher for families in which an adult member other than the parents has exhibited promiscuous and/or criminal behavior (32 percent).

[155] The incidence of parental promiscuous and/or criminal behavior is 15 to 17 percent versus the average of 12 percent. Most of these children were 3 to 14 years old in November-December 2014.

[156] An incidence of parental promiscuous and/or criminal behavior of 14 percent of children from rural areas versus 11 percent of children from urban areas.

[157] An incidence of parental promiscuous and/or criminal behavior of 18 percent of children from families with three or more children versus 11 percent of children from one-child families and 12 percent of those from two-child families.

[158] The cumulative proportion of children arriving in the protection sysyem by these routes is about 25 percent versus 12 percent of the total population of children in public care.

RECOMMENDATIONS

In order to prevent the separation of children from their families as well as to guarantee the child's right to a safe and full development, we recommend setting up of community-based services to ensure the early identification, support, and continuous monitoring of children from families with promiscuous and/or criminal adults. These services are particularly needed by families headed by single-mothers with no dwelling of their own, thus requiring them to live with relatives or other people, some of whom exhibit behavior that endangers the health and development of the child. In situations where the mother is also abused, both the mother and the children need protection and support to enable them to live in a secure family environment.

Also, a national program should be developed for children whose parents are in prison. Some of these children are in public care, but others are living in families, often with single-mothers who engage in sexual relations in exchange for money in order to make a living. Alternatively, they may live with relatives who exhibit promiscuous and/or criminal behavior. Thus, these children risk being neglected, abused, and/or exploited.

It is also important to develop procedures to ensure continuity of contact between these children and their incarcerated parents as well as with their siblings who are also in public care.

Also, a support program should be developed for young people who leave public care in order to prevent them from sliding back into a cycle of disadvantages and from being victimized by organized crime groups (for example, trafficking and prostitution).

3.2.3.6 Domestic Violence

Data on domestic violence were not systematically collected within the quantitative research component, but the theme was frequently mentioned in the qualitative study. The DGASPC professionals, parents, and children usually mentioned domestic violence in the context of parental alcohol abuse and atypical demographic behavior.

> "There are also problems between the parents; I know this. I refer to domestic violence, although I can't say that this is such a major cause, but it happens, especially after alcohol abuse. The parents fight, hit each other in front of the children, and that's when we have to act. The kids might become victims as well." (Interview with a professional, Bacău)

> "I've had cases when the parents...there was domestic violence. The father killed the mother, and of course we took the children from there into public care." (Interview with a professional, Arad)

> "*How did your kids end up in public care*?

> - Because I left them there. When I left their father, he had beaten me up. I ended up here, in child protection, and I was admitted to hospital because of the wounds. With all three kids, they put me under abused mothers. I was there for four months... He learned of me being there, he came looking for us every day. For four months, he came there every day, promised he'd change; at some point I believed him, I asked to be discharged, I went home on a Monday and the following day after I got home, he beat me up again, and the kids too, because he said they weren't his. And on Wednesday I came back to the Directorate [DGASPC] with all three kids and they told me that, as I filed the request for discharge, they couldn't take me back in. That's the rule. And since I had nowhere to go with them, I left them there and left.... [...] They [DGASPC] were trying to have me reintegrated into the family, but I couldn't live with that man anymore. He would beat me up every day." (Interview with a parent whose children are in the system, Craiova)

> "*How did you end up in the system*?

> - Mom and dad separated and now she is with another man, who kept beating us, my sister and I, and once someone from the child protection called and they came and got us out of there." (Focus group with children, Timișoara)

3.2.3.7 Parents with Disabilities and/or Mental Health Problems

Whether the parents of children in care have a disability or have mental health problems is very relevant to the development of an effective post-separation individualized protection plan (PIP). For example, when a child has been taken into care because his or her disabled single-mother is unable to meet her child's needs, it may be appropriate for the child's PIP to allow for the continuation of contact with the mother (and other family members) while ensuring long-term substitute family care. However, it is less likely (or even desirable) for this to be the case with a parent who has a history of abusive or threatening behavior.

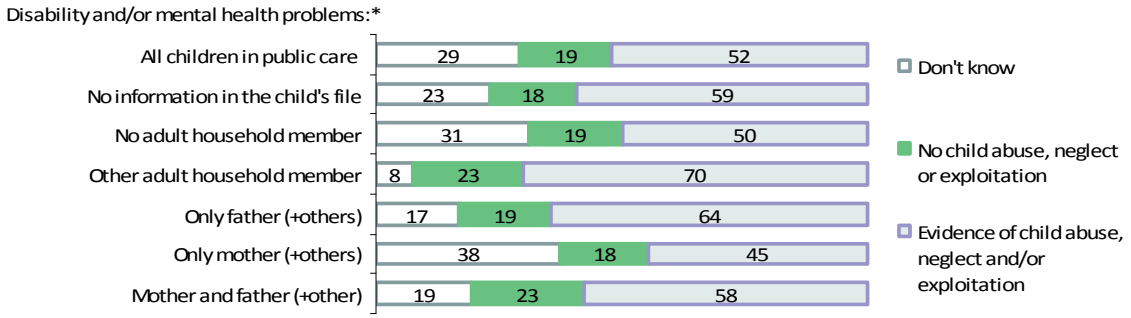
About 18 percent of children have experienced parental disability and/or mental health problems in their family of origin before entering public care (see also Annex 6 Tables 22 and 23). Most often, only the mother has had mental health problems (for about 10 percent of children in care). In addition, about 5 percent of children lived in households in which an adult other than the parents had a mental health problem and/or disability. Overall, over 22 percent of children had experienced living with an adult with disability before entering the system.

> "There are many mothers with mental health problems and also a disability, and since there isn't anyone to support or help them, we took the children in public care." (Interview with a professional, Arad)

> "In many situations there are mothers with medical issues, because there might be someone with a certain degree of disability, or they might have a developmental delay, and not be educated. And many mothers with medical problems don't have documents to prove this [they don't have a disability certificate]. There are many, quite a lot of mothers with developmental delays, that lack a [disability] certificate." (Interview with a professional, Craiova)

Parental disability or mental health problems, usually on the part of the mother, are considered in the international literature to increase the probability of child neglect and abuse. For children in public care in Romania, this seems not to be the case since the incidence of parental disability or mental health problems is lower than average among children who experienced neglect, abuse, or exploitation (see Annex 6 Table 22).

Figure 27: Rates of Child Neglect, Abuse, or Exploitation, by Family Type and Parental Disability and Mental Health Problems (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=48,760). Children with unknown parents and true orphans are not included.

Note: *Includes chronic illnesses such as tuberculosis.

Nonetheless, the data indicate a more nuanced reality. Figure 27 shows that:

- If only the mother has disabilities or mental health problems, the risk of child abuse and neglect (according to the evidence contained in the case files) is significantly lower than average (45 percent versus 52 percent of children). Even so, it should be noted that children of mothers with mental health problems have a very high risk of being relinquished in a maternity ward straight after birth (43 percent versus the average of 24 percent). Thus, many of these children arrived in the system via this route. Consequently, maternal mental health problems can be a risk factor for

child abuse or neglect only if being relinquished in a maternity ward is considered a form of neglect.

- If only the father has disabilities or mental health problems or if both parents have serious health problems, there is a statistically significant association between the presence of parental disability and the child's experiences of neglect and/or abuse. Thus, parental disability appears to be a significant risk factor of child neglect and abuse. An even stronger risk factor is the existence of another household member with disabilities or mental health problems (usually a man other than the father). Thus, the risk of neglect and/or abuse is about 1.5 times higher in families with paternal disabilities and in families with other (male) adult household member with disabilities than in families where only the mother has disabilities or mental health problems. Just to clarify, this does not imply that paternal or other male family member disability leads to child neglect and/or abuse but only that a man with disabilities is more likely to be present in those families where child neglect and/or abuse occurs (see also Annex 6 Table 22).

Paternal disability is strongly associated with another risk factor, namely alcohol abuse.[159]

In accordance with the results presented above, the DGASPC professionals tended to state "disabilities of the parents" as the main cause of separation only if the mother had mental health problems and/or disabilities. Table 25 shows that the chances of parental disability being stated as the cause of separation in the children's files are about five times higher than average for children from families where only the mother or both the mother and the father have disabilities and/or mental health problems. By contrast, if only the father has disabilities and/or mental health problems or if another household member has serious health problems, the main cause of separation is usually stated by DGASPC specialists as neglect, abuse, or exploitation (41 to 42 percent versus an average of 31 percent for all children in care).

Table 25: Parental Disability and/or Mental Health Problems: Facts and Registration as the Main Cause of Separation Stated in the Case File (%)

Causes of separation stated in case files:	Mental health problems and/or physical disability*					
	Mother and father (+others)	Only the mother (+others)	Only the father (+others)	Other adult household member	No adult household member	All children in public care
Parental disability	42	39	9	2	1	8
Neglect, abuse, exploitation	28	23	42	41	31	31
Poverty	15	26	36	28	38	35
Other causes	3	9	9	25	26	22
No information	12	3	5	4	4	4
Total - %	100	100	100	100	100	100
- N	912	6,297	1,350	2,089	31,197	41,844

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. Children with unknown parents and true orphans are not included.

Note: *Includes chronic illnesses such as tuberculosis.

In many case files, poverty is stated as main cause of separation even for families with parental disability in which the child was abused or neglected before entering the system.

Families in which just the mother has mental health problems and/or disabilities are most often single-parent families in urban areas who lack kinship support. Less than half have a stable dwelling, and as a result, many of these mothers live wherever they find a place and sometimes, on a temporary basis, they live in institutions, on the street or with various sexual partners.

[159] The incidence of alcohol or drug abuse is about 32 percent among fathers with disabilities versus the average of 20 percent.

Our analysis shows that there were three main entry routes into the system for children with single-mothers with mental health problems and/or disabilities: (i) some were relinquished in maternity wards by mothers who already had one or two children; (ii) others were relinquished to the public care system by their mothers during periods of homelessness or when they were in between accommodation; and (iii) a small number entered the system at the request of their mother with whom they have a problematic relationship. These relinquished children are both girls and boys with a higher than average risk of having disabilities and/or developmental delays. Forty-four percent of them have siblings who are also in the system (versus the average of 50 percent).

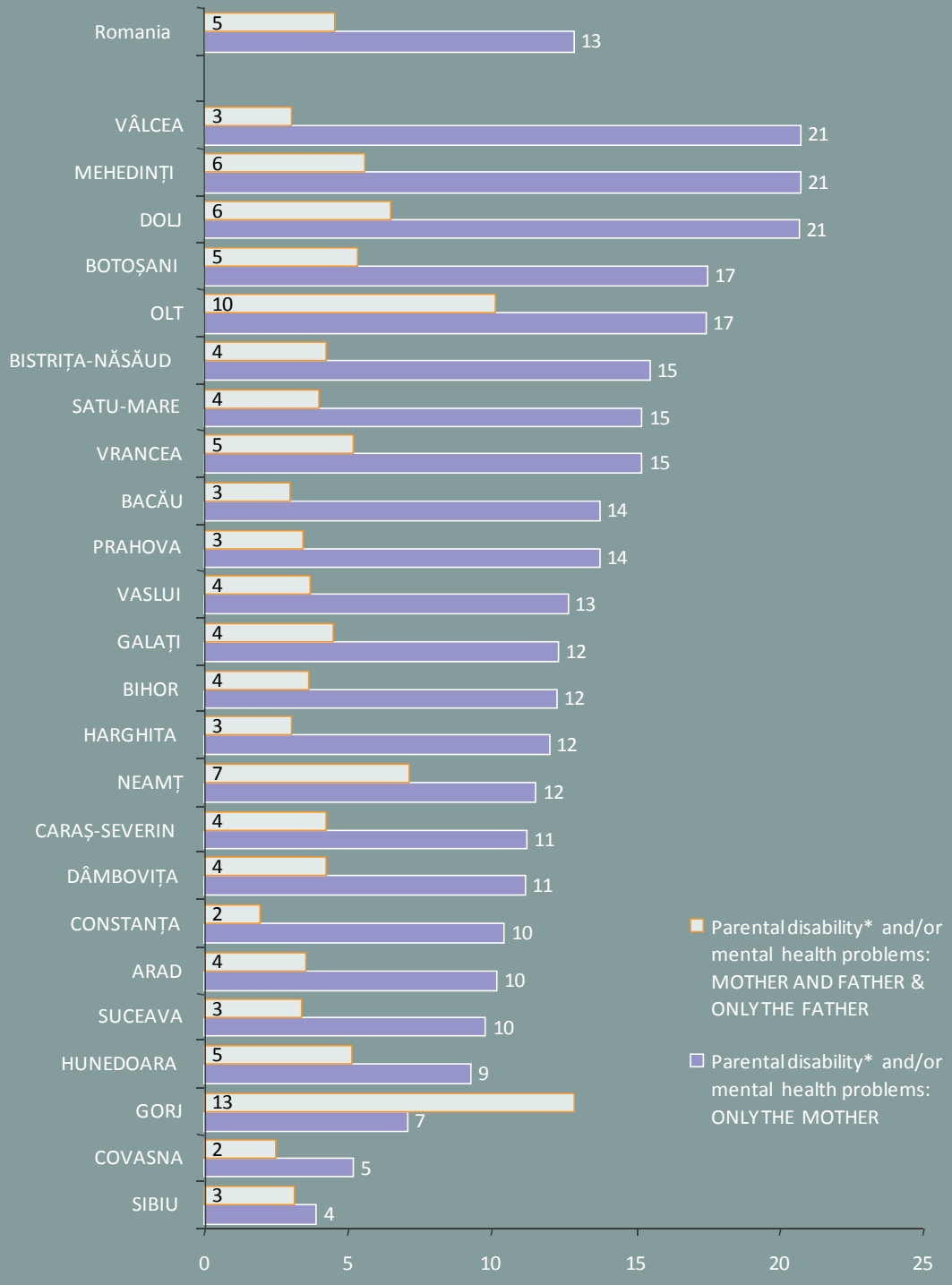
All other families marked by parental (or adulthood) disabilities and/or mental health problems have their own dwellings or live with relatives in large multigenerational households with three or more children.[160] The majority are from rural areas. Children from these households arrive in public care directly from their families, and more than 60 percent of them have brothers and sisters in the system.

- Children who arrive in care from families in which only the father is disabled tend to be mostly girls (56 percent) aged between 3 and 10 years and in good health. Among those over 7 years of age, the risk of running away from home is 1.5 times higher than average (12 percent versus 7.5 percent).
- Children who arrive in care from families in which both parents have disabilities and/or mental health problems are mostly boys (58 percent), and are either between 3 and 10 years of age or are adolescents over 14 years old who have a problematic relation with their parents. Out of these, one in five have disabilities, developmental delays, and/or special educational needs.

The distribution by county of the children with one or both parents with disabilities and/or mental health problems is shown in Figure 28. Rates of children with mothers living with mental health problems and/or disabilities are much higher than average in Dolj, Mehedinți, and Vâlcea counties, while there are disproportionately more children with disabled fathers in Gorj and Olt.

[160] About 7 percent of these are single-parent families with only the father being present.

Figure 28: Children with Parents with Disabilities and/or Mental Health Problems Before They Entered Public Care, by County (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=47,160). Only the 24 counties with solid data in the CMTIS are considered (see Annex Table 1). Children with unknown parents and true orphans are not included.

Note: *Includes chronic illnesses such as tuberculosis.

3.2.4 Children with Special Needs

As of December 2014, the ANPDCA reported that there were over 70,000 children with disabilities in Romania, the vast majority of whom lived with their families (about 80 percent). Nonetheless, not only in Romania but in the entire Central and Eastern European region and the Commonwealth of Independent States (CEE/CIS), the tradition of placing children with disabilities in public care has continued to prevail.[161]

The potential link between children's special needs and child abuse and neglect is not only controversial but also difficult to assess based on a rigorous methodology.[162] Nevertheless, some research[163] has suggested that children with physical disability and/or mental health problem can be at a higher risk of abuse and neglect than healthy children.

To try to understand this link in the context of public care in Romania, this section analyzes five categories of children:

- Infants (0-12 months) born premature and/or underweight
- Children with disabilities
- Children with developmental delays;
- Children with special educational needs (SEN)
- Children with behavioral problems.[164]

Figure 29: Incidence of Different Types of Special Needs among Children in Public Care (All Ages) (%)

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

The distribution of children with special needs in public care by county is presented in Annex 6 Table 24.

[161] UNICEF (2010), see also section 3.3.2.4.

[162] Institute of Medicine and National Research Council (2014:83-84)

[163] For example, Jonson-Reid et al. (2004) and Algood et al. (2011)

[164] Children with behavioral problems are those who, before entering the system, experienced fights or violence with other children or youngsters, being a member of a gang of at-risk peers, running away from home, and/or problems with the police.

Table 26: Incidence of Child Neglect, Abuse, and/or Exploitation among Children with Various Special Needs, Before Entering the System (%)

		Case file evidence of:				Total	
		Neglect	Abuse	Exploitation	Any form of vioence	- %	- N
- Infants 0-12 months old born premature and/or underweight	Yes	10	1	0	10	100	2,685
	No	14	2	1	16	100	15,380
- Children 0-17 years old with disabilities	Yes	41	10	2	47	100	4,307
	No	58	16	5	63	100	30,288
- Children 0-17 years old with developmental delays	Yes	63	26	9	69	100	7,190
	No	55	15	4	60	100	8,512
- Children 6-17 years old with SEN	Yes	50	14	14	55	100	1,457
	No	60	51	49	27	100	11,025
- Children 7-17 years old with behavioral problems	Yes	72	43	42	87	100	1,325
	No	56	18	5	61	100	11,745
All children 0-17 years old in public care	Total	54	15	4	60	100	39,843

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: For the categories of children 0-17 years, children relinquished straight after birth in maternity wards are not included.

Table 26 above shows the relation between the five categories of children with special needs and the forms of violence they were exposed to prior to entry in the system. The following subsections provide a more detailed analysis of this connection and of the profiles of the five categories of children.

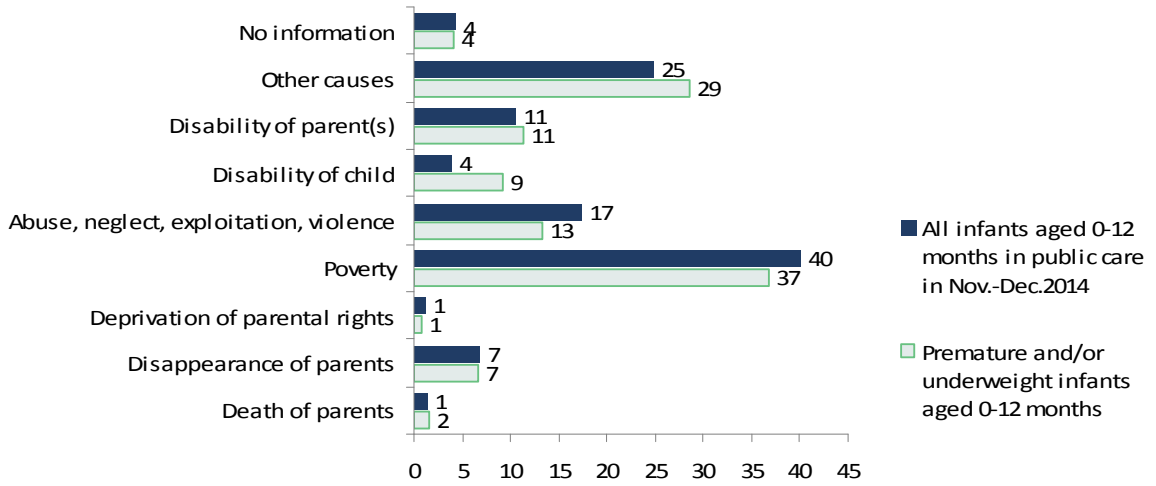
3.2.4.1 Infants 0-12 Months Old Born Premature and/or Underweight

Chapter 3.1.4 revealed that 35 percent of all children in public care were under 12 months old when they entered the system. Fifteen percent of these children were premature and/or underweight babies, who were almost equally divided between boys and girls, mostly from urban areas, and most of which ended up in the system after having been relinquished in maternity hospitals after birth (82 percent). In other words, premature and/or underweight babies are much more likely to be relinquished in maternity wards than full-term and/or normal-weight infants (82 percent versus 67 percent).[165] Only 18 percent of premature and/or underweight babies were taken home with their families and, a few months later, entered public care directly from their families.

To note, underweight and/or premature children come from the same types of families as normal-weight and/or full-term infants. Almost 60 percent of them come from single-parent families (single-mother), with or without other children besides the baby, with no support from their kinship networks. Nevertheless, a significantly higher share of underweight and/or premature children do not appear to have any siblings in the system, which highlights a tendency – even among those mothers who have gained experience by looking after other children at home – to give up on these children who need time to fully develop and grow. This tendency is also reinforced by the statistically significant association between premature and/or underweight babies and disability, as well as developmental delays. Thus, premature and/or underweight infants are three times more likely to have disabilities when they enter public care than normal-weight and/or full-term infants (22 percent versus 7 percent). They are also more likely to have developmental delays when they enter the system (26 percent versus 9 percent).

[165] See also section 3.1.3.2.

Figure 30: Main Cause of Separation Stated in the Case File: Comparison between Premature and/or Underweight Infants and Normal-weight and/or Full-term Infants, at the Time When They Entered Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=18,065 infants aged between 0 and 12 months, of whom 2,685 were premature and/or underweight).

Note: The sum of the bars per category is 110 percent and 112 percent respectively because some case files stated two to four causes of separation.

Table 26 shows that the risk of being neglected, abused, or exploited before entering public care is much lower in infants aged 0 to 12 months than for children who were older than 1 year of age when they were taken into care. Also, among infants (0 to 12 months), exposure to neglect, abuse, or exploitation is even lower in the case of premature and/or underweight babies, which, again, is probably due to the fact that the majority of them entered the system directly from a maternity ward.

Among the premature and/or underweight infants, only 1.2 percent were biological orphans when they entered the system. This percentage is small but it is three times higher than the percentage of biological orphans of full-term and normal weight. Also, they are more likely to come from dysfunctional families (11 percent versus 9 percent) and to have mothers/parents with disabilities and/or mental health problems (28 percent versus 22 percent). However, they have a relatively low risk of having institutionalized parents (in prison or in health or social institutions), parents who are working abroad, or parents deprived of their parental rights. Nor are they likely to have mothers or parents who engage in alcohol abuse or promiscuous behavior or who have problems with the police and/or a criminal record. At the same time, among the babies who were born preterm and/or who were underweight when entering the system, teenage mothers are under-represented while mothers aged between 35 to 45 years at childbirth are over-represented. Only one in ten premature and/or underweight infants who ended up in public care were relinquished by teenage mothers whereas one in five or six had been left behind in the maternity ward by mothers who were 35 to 45 years of age.

The main cause of these infants' separation from their families as reported in the case files by DGASPC specialists (Figure 30) is consistent with our analysis of the risk factors related to children's separation from their families. "Child's disability" shows up more often than for the other infants, while "neglect, abuse, or exploitation" is mentioned more rarely. "Other causes" are reported more frequently and they generally refer to children "relinquished in a maternity ward." Thus, these premature and/or underweight infants were relinquished due to their "disability".

Nonetheless, "poverty" is by far the prevalent cause reported for all the children who entered the system between the ages of 0 to 12 months regardless by which route.

The files specify "poverty" as the main cause of separation for between 37 and 40 percent of these infants (Figure 30). Remarkably, this is close to the rates contained in the official ANPDCA reports, but they are much higher than the average rate for the total population of children in public care based on the case file survey (32 percent, see Figure 19). Nevertheless, the data regarding the income and the housing situations of the families of origin of these infants do not support this assessment. Children who entered the system at the age of 0 to 12 months, regardless of the route taken, come from families with the same socioeconomic status as those of the children who were taken into care at 1 year of age or older.

3.2.4.2 Children with Disabilities

Out of all children in state care, nearly 11 percent had a disability before they entered the protection system.[166] Out of all children with disabilities over 3 years old, around one-third were completely dependent and one-third needed support to carry out their day-to-day activities. The evaluations carried out on each child when they first entered the system highlight the fact that many other children had serious health problems. Thus, the evaluations conducted after the children had entered the system show that children with disabilities represent almost 29 percent of all children (identified either before entering the system or when they entered the system or at a later stage). However, in this section we focus our attention only on children with disabilities at the moment of their entry into public care.

Their case files indicate that neglect, emotional and/or physical abuse, and exploitation have been reported more rarely for children with disabilities than for children with no disabilities (Table 26). The more serious the disability, the weaker the link between child disability and maltreatment.

The qualitative study showed that in some cases, the neglect of children with disabilities is caused by the fact that parents are not able to understand the disabilities and to meet their children's needs, mainly due to their own inadequate education and social prejudice. In the absence of professional support and guidance, poorly educated parents who also have other children can find it seriously difficult to cope with a child with disabilities.

> "Which are the main difficulties you face with the children?
>
> - The girl, the girl, she is… she's never been good. She has brain problems, I have some documents showing this, she has a handicap, has brain problems." (Interview with parent of institutionalized children, Arad)

Children with disabilities have an average risk of being relinquished in maternity wards straight after birth, but double the average risk of being relinquished in a hospital or pediatric unit after several months (15 percent versus the average of 7 percent). Consequently, more than 60 percent of them entered the system at an early age (between 0 and 2 years old).[167]

> "- The children who are most often relinquished to the system are those with serious medical issues, that is children who can't move, with a twisted body,... And the main issue is the psychological barrier. Once the parents of these children relinquish them, to the parent the child ceases to exist... If, say, for the following 3 months, the child hasn't been visited by the parents, then it is clear that they will never be visited again. So we're talking here about ZERO chances of reintegration.
>
> - I have a case. Cases, actually. They ended up in a center for adults with disabilities. And I have raised them since they were 4 years old. Actually, since they were in the orphanage. The old orphanage, that's where I took over and now they're in their 20s." (Focus group with specialists, Bucharest)

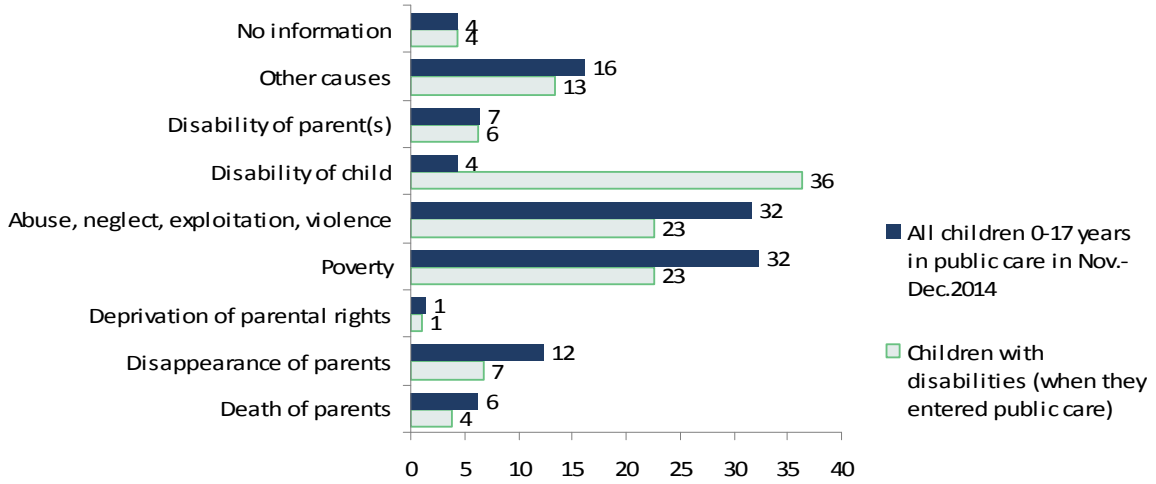
[166] Children with disabilitie represent almost 29 percent of all children in public care. This section refers only to those children who had a disability at the time of their entry into the system, irrespective of whether or not they had a certificate of disability. Children with disabilities when they enter the child protection system are more likely to be boys than girls (57 and 43 percent respectively) and tend to be from urban areas (62 percent).

[167] At present, more than 90 percent of them are aged between 7 and 26+ years.

Only 3 percent of these disabled children are true orphans.[168] For fewer than half, their parents are either abroad or in detention. Child disability is not associated with dysfunctional families or with parental alcohol abuse. Nearly all of them come from single-mother families or nuclear families with one or two children. Child disability is associated only with parental disability and/or mental health problems, particularly in families in which the single-mother or both parents also have health problems. Nonetheless, only about 22 percent of all children with disabilities have parents with disabilities and/or mental health problems.

So it would seem that children with disabilities are often placed in public care based on tradition than because of neglect, abuse, or unfortunate events. However, the qualitative study showed that another equally important reason why parents let their disabled children go into public care, particularly children with severe disabilities, is the lack of health, rehabilitation and support services for people with disabilities (both children and adults). True stories 4a and 4b in the next Story Bag are testimonies to this effect. The lack of health, rehabilitation, and support services for people with disabilities is a structural cause underpinning the separation of children from their families that is discussed in the next section (section 3.2.5.4), which also includes recommendations.

Figure 31: Main Cause of Separation Stated in the Case Files: Comparison Between Children with Disabilities When They Entered the System and All Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care of which 5,620 were children with disabilities).

Note: The sum of the bars per category is 115 percent and 117 percent respectively because some case files gave two to four causes of separation.

The main causes of separation stated in the case files of children with disabilities, other than the disabilities themselves, are neglect, abuse, exploitation, and poverty.

It is worth mentioning that poverty is specified as the main cause of separation for a quarter of children with disabilities who were neglected or abused before entering the system. So, in many cases, the DGASPC professionals selected "poverty" over two other appropriate and relevant causes – "child disability" and "neglect, abuse, and/or exploitation."

[168] Although small, this percentage is higher than average.

3.2.4.3 Children with Developmental Delays

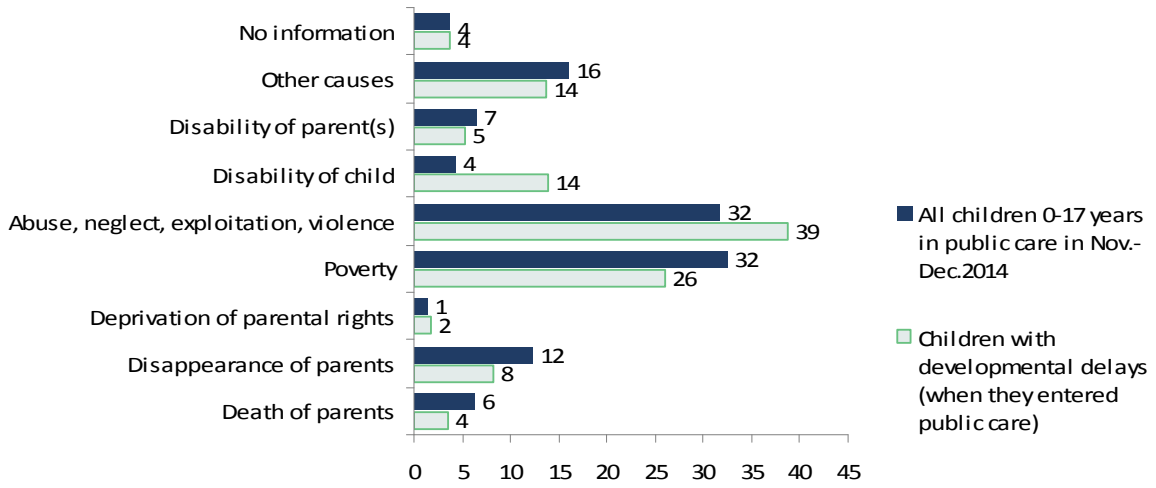
Fewer than half of all children in public care received a baseline psychological evaluation when they entered the system. Actually, only 37 percent were psychologically assessed and had the results entered in their case files. Of these children with such information in their case files, 17 percent had various delays or disorders in one or more dimensions (emotional, cognitive, behavioral, psychophysiological, personality, and interpersonal relationship skills) when they entered in the system. Thirty-six percent of children with recorded developmental delays also had disabilities.

Table 26 indicates that children with developmental delays had a disproportionately high risk of being neglected, abused, and/or exploited before entering the system. The more dimensions of developmental delays were recorded, the more forms of violence the child had suffered.

Children with developmental delays were unlikely to have been relinquished in maternity straight after birth but had a higher than average risk of being subsequently relinquished in a hospital or pediatric unit (12 percent versus the average of 7 percent). So, the majority arrived in the system between the ages of 3 and 17 years. [169]

Among children with recorded developmental delays, there were more boys than girls (57 percent versus 43 percent), more Romanians and Roma than average, and more from rural areas than urban areas. More than half came from nuclear families with three or more children.

Figure 32: Main Cause of Separation Stated in the Case Files: Comparison between Children with Developmental Delays When They Entered the System and All Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care of which 8,881 children with developmental delays).

Note: The sum of the bars per category is 115 percent because some case files gave two to four causes of separation.

As shown in the previous sections, child developmental delays are significantly associated with parental substance abuse, parental disability and/or mental health problems, and parental promiscuous and/or criminal behavior. Children with developmental delays that were recorded when they entered the system have a lower than average probablility of being true orphans (having lost one or both parents), of coming from dysfunctional families, of having teenage mothers, parents abroad, or mothers/parents who are institutionalized (in prison or in social or health units).

In line with the results of the analysis above, the main cause of separation stated by DGASPC specialists in the case files of children with developmental delays is that of neglect, abuse, and exploitation (Figure 32).

[169] At present, about 80 percent of them are between 11 and 26+ years old.

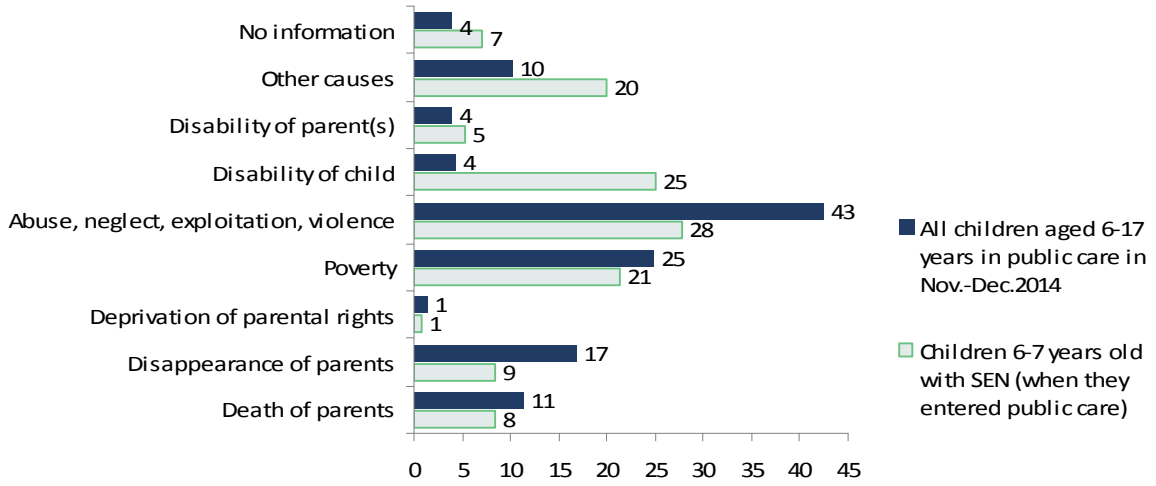
As with children with disabilities, poverty is specified as the main cause of separation for a quarter of the children with developmental delays (and possibly with disabilities) who were neglected or abused before entering the system. So, in many cases, the DGASPC professionals selected "poverty" over two other appropriate and relevant causes – "child disability" and "neglect, abuse, and/or exploitation."

3.2.4.4 Children Aged 6-17 Years with Special Educational Needs

Children with special educational needs (SEN) account for 9 percent of all children aged between 6 and 17 years when they entered the system. Two-thirds of them are children with recorded developmental delays. Also, 68 percent of them have a disability. Thus, around 4 percent of children aged between 6 and 17 years at entry into the protection system had physical disabilities as well as developmental delays and special educational needs, while an additional 6 percent had two of these vulnerabilities.

According to Table 26, children with SEN are disproportionately likely to have been exploited (3.5 times higher than average) prior to entering the system, but not neglected or abused. Nearly all of them arrived in the system between the ages of 6 and 13 years directly from their birth family or relatives. They came from the prevailing types of families (nuclear and single-mother), most with one or two children.

Figure 33: Main Cause of Separation Stated in the Case File: Comparison between Children with SEN When They Entered the System and All Children Aged 6-17 years in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=15,742 children in public care aged 6-17 years, of which 1,456 children with SEN at entry into the system).

Note: The sum of bars per category is 124 percent and 119 percent respectively because some case files stated two to four causes of separation.

Only 5 percent of children with SEN aged 6 to 17 years at the time of their entry into the system were true orphans.[170] Also, these children had a lower than average likelihood of coming from dysfunctional families, having teenage mothers, or having parents who had been deprived of their parental rights, had left to go abroad or were institutionalized (in prison or in social or health units). Nonetheless, as shown in the previous sections, children with SEN are significantly correlated with parental disability and/or mental health problems as well as with maternal criminal and/or promiscuous behavior.

DGASPC specialists tend to specify "child disability" as main cause of separation in six times more cases than average for children with SEN (25 percent compared to 4 percent, see Figure 33). "Other causes" were also mentioned in 20 percent of the cases files of children with SEN. In half of these cases, the DGASPC specialists explained that "other causes" referred to "the need to attend a special

[170] Versus an average of 3 percent of children aged between 6 and 17 when they entered the child protection system.

school" because inclusive education or alternatives to mainstream schools were not available at the community level. The lack of educational services for children with SEN and/or disabilities is a structural cause underpinning the separation of children from their families, as discussed in the next section (3.2.5.4), which also includes recommendations.

Poverty was stated as the cause of separation for one in every five cases of children with SEN (who may also have had disabilities and/or developmental delays) who were neglected or abused before entering the system. So, in many cases, the DGASPC professionals select "poverty" over two other appropriate and relevant causes – "child disability" and "neglect, abuse, and/or exploitation."

3.2.4.5 Children Aged 7-17 Years Old with Behavioral Problems

In this report, children with behavioral problems are defined as those who, before entering the system, had experienced violence with other children or youngsters, being a member of a gang of at-risk peers, running away from home, and/or problems with the police.

> "I would pick on girls and break windows, fight a lot and wouldn't listen to my parents, skip school and my parents and I didn't get along too well, I smoked...now I quit. Yes. I would pick on old ladies, beat them." (Focus group with children, Timișoara)

> "I have many cases of children with behavioral problems, which don't really fall into a disability category. To be brief, the children are bad, they steal, and they can't control them, so the parents or the extended family (if the parents are abroad) can't take the responsibility of looking after them anymore. And they leave them with us." (Focus group with professionals, Timișoara)

One in every ten children in public care who were 7 to 17 years old when they entered the system has such behavioral disorders. Children with disabilities have a lower than average probability of having behavioral problems. In contrast, children with SEN and especially those with developmental delays are two times more likely than average to have had behavioral problems before entering the system.[171]

The data in Table 26 show that children with behavioral disorders were disproportionately likely to have been neglected, abused (almost three times higher than average), and/or exploited (over ten times higher than average) before entering the system.

There were more boys than girls with behavioral problems (60 percent versus 40 percent). They came from the prevailing types of families (nuclear and single-mother), most often with three or more children. About 85 percent of them arrived in public care directly from their family or relatives,[172] but the majority of them had a bad relationship with their family.[173] Out of all children in public care, they were most likely to have arrived in public care via a street route (10 percent versus the average of 3 percent), either by being relinquished on the street or in public spaces or by running away from home. At the same time, they had a higher than average probability of having been taken care of by a non-relative before entering the system.[174]

> "The children who are most often relinquished to the system are those with serious medical issues, that is children who can't move, with a twisted body, [...] But you know, it's even more difficult to deal with children with behavioral problems, because those who are confined to a bed are accepted more easily than those with behavioral problems, who turn the house upside down, who are completely unpredictable, so many parents don't want to recognize them as their own." (Focus group with professionals, Bucharest)

> "Other problems related to separation arise at the age of 12 to 13, when they leave home. They pack up and leave home, become vagrants, and then the family can't cope with this, so, normally, they contact the authorities." (Interview with a professional, Bacău)

[171] Out of all children with recorded behavioral problems when they entered the system, 10 percent had disabilities, 16 percent had special educational needs, and 46 percent had developmental delays.

[172] For comparison, the average is 61 percent (see Infograph Chart 2).

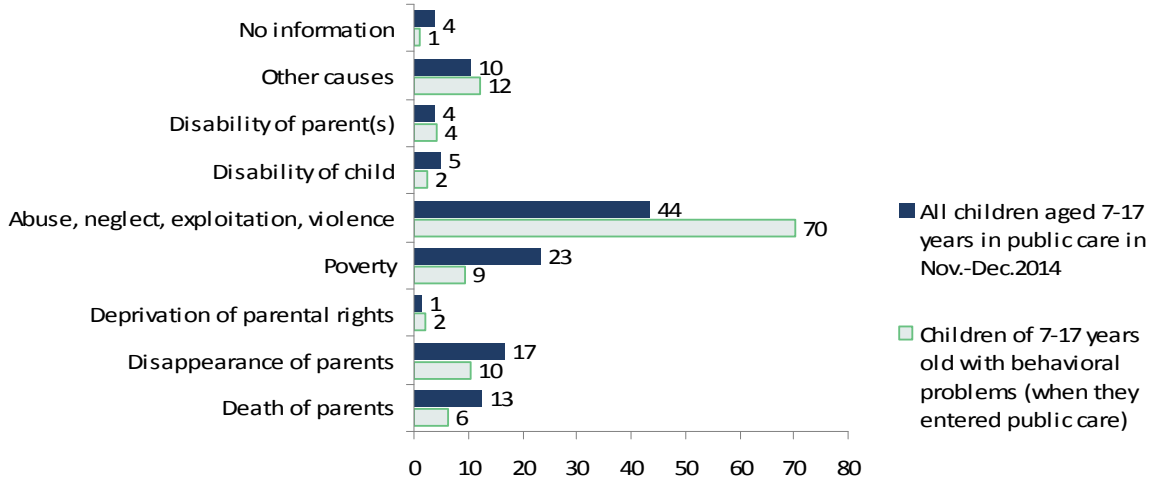
[173] A proportion of 64 percent versus the average of 34 percent.

[174] A proportion of 5 percent versus the average of 2 percent.

"For instance, a child has behavioral problems and the parent comes to the Directorate and says, 'I can't keep him/her in the family.' This is extremely unfair - for a parent to come and say they want to put the child in the institution because he or she has behavioral problems. And if you were to look at the family, at the end of the day, they are the root cause of the behavioral problems. The problems occur usually when they hit puberty. And the thing is that parents basically find it convenient to take this approach, they say 'I don't know what to do to him/her. You handle him/her!'. 'Now, wait a minute! You'll know what to do. We'll tell you what to do!' - this is what making them responsible means." (Focus group with professionals, Ploiești)

Fewer than average children with behavioral disorders are true orphans, come from dysfunctional families, have teenage mothers, or have parents who left to go abroad or are institutionalized (in prison or in social or health units). A proportion of 2.2 percent of them had parents who had been deprived of their parental rights at the time when the child entered the system, which is higher than the average of 1.4 percent for all children in public care.[175] Also, the child's behavioral problems are correlated with the following risk factors: parental alcohol and/or drug abuse, the presence of an adult household member other than the parents with mental health problems, and parental promiscuous and/or criminal behavior.

Figure 34: Main Cause of Separation Stated in the Case File: Comparison between Children with Behavioral Problems at Entry into the System and All Children Aged 7-17 in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=13,069 children in public care aged 7-17 years, of which 1,324 children with behavior disorders).

Note: The sum of the bars per category is 120 percent and 118 percent respectively because some case files gave two to four causes of separation.

The neglect, abuse, and exploitation category is by far the most common cause of separation stated in the children's case files by DGASPC specialists (Figure 34). Only in 9 percent of cases is poverty given as a cause of separation. Among the "other causes" category, the cause that is most frequently stated is parental promiscuous and/or criminal behavior.

[175] Children with unknown parents and true orphans are not included.

Story Bag

"- Harry [the child] has had problems since birth; they told me he would live only for six hours, and now he is 3 years old. What can I say? My husband couldn't deal with it; he said he wouldn't accept it. We divorced, because he found someone else and said that the other woman could give him healthy kids, not like mine. And that's when I took the child and came to Craiova, to my father's. And I live with my father. I stayed at home, with the child, for as long as I could. But when he got close to the age of 3, I started to work. I looked for a job in education, but in the entire county of Dolj you can't find anything related to math; so I started to work as a program tester...

Which are the main problems you are faced with now?

- Time. I don't have time for the kid, for work, for me, for the household... I work from 9 to 6. This means that I leave home at 8:10 or 8:15 and return at a quarter to 7, in the best of cases, or at 7. And when I get home, I don't know what to do first. [...] My father, no...he doesn't take care of the child, he doesn't help or look at him; he can't stand the idea. And he said he would help with anything I ask him, but not with the... The child has a neck cannula, because he can't breathe well, so you have to aspirate it. And there is just one lady helping me look after him. I take him to her place in the morning, and pick him up in the evening. In the beginning, she would come to my place in the morning, and leave when I came back from work. Now I take him there, so she can do her house chores as well...

What are the child's health problems?

- When he was born, the brain did not receive enough oxygen, so he has hypoxic-ischemic encephalopathy. He can't swallow, can't track you visually, can't hold his head up... This is how things are... He needs constant care; I told you he needs aspiration. That's why I keep looking for a place where he can be safe, where I can leave him and stay assured that he is looked after, and pick him up at the end of the week, or when I have more time.... That is, not to have to run away from work all the time and leave things unfinished there....

And you came to the DGASPC hoping to find this service?

- Yes. Because what I had in mind was to admit him to a center for children with disabilities where he is looked after and I know he is safe. To be able to take him home whenever I want to, because I won't sign a document by which I relinquish him to you and not take him back. I don't know, I kept looking, I even inquired in Bucharest. I mean a center, a place...we are many mothers in this situation. So, we could even take turns. We said. Let's get together. Take the children somewhere and take turns. Two stay one day, another two on another day....I don't know, this could be an option. [...] When I was in Bucharest, in intensive care, I talked to other moms in the ward. You can't find one in the entire country...you have them abroad... I mean, a place where you can go and die in peace, without being kicked out. Because this is what they did with us in intensive care, they actually kicked us out because we were occupying a bed for nothing. They used to tell us: others are coming in, and they stand a chance. Yours don't have any chance. You are occupying the bed. That was the idea. A place from where you are not kicked out. You know that there you have people that don't have any chance... But they are looked after and allowed to die in peace. Something like this."

(Interview with the parent of a child at risk of separation, Craiova)

Story Bag

"Which are the pros of the child care system?

- The main advantage is the fact that we create a safe environment for children who can't be looked after at home, this on the one hand. Or if they were to be looked after at home, they would endanger the family, as an institution, as a unit.

What do you mean?

- Children like the ones we have here [in child care] require 24h a day care. In order for a family member to do this, and I refer to the mother or the father, they should not have a job. Moreover, the state provides that allowance for caretakers of children with disabilities, but it doesn't match the salary. Then, the family might have other children. But a child like this requires full attention, so the family tends to neglect the others. So yes, I say it full-heartedly, that the family should be engaged, even for this child we have here, but not as much as to affect the other children or endanger the family in itself or the relationship between spouses.

So this is a positive thing, the fact that they can bring the child with special needs here, and he/she is looked after?

- Exactly. Looked after, because, I told you, in my professional activity I've traveled to disadvantaged areas and come across kids like the ones we have here, and for the sake of the money received as caretaker....I saw a child left on a straw bed, who was not washed, not taken care of, only occasionally fed, just like an animal, but who generated income. So I can't support this, the family could not take care of him. Or I've seen families that split because of a child like this, who cries and screams at night, who has needs you don't know how to meet. I speak of everything from hygiene to the medical side. I had kids who were fed through a tube for some time. It's pretty difficult to do it at home."

(Interview with a professional, Bârlad)

3.2.5 Structural Risk Factors

As shown in the previous chapters, unfortunate events (with otherwise low probability of happening among the general child population) abound in the life of children in public care.[176] This chapter shifts the focus to the macro environment and analyzes the structural risk factors associated with the separation of children from their families.

Although cases of neglect, abuse, exploitation, and any form of violence are difficult to identify, prevent, and properly mitigate, policies and systems in the education, health, and social assistance sectors can provide vital preventive or early support measures that will prevent these events from having any significant negative effects on the child's development. For instance, a family physician who was monitoring an "8 month old baby girl who weighed 3 kilograms"[177] could have notified the DGASPC. At the same time, schools and health clinics can act as referral systems for cases of neglect, abuse, or domestic violence. Last but not least, the capacity of professionals from all levels and institutions to identify sexual abuse cases needs to be strengthened because delays in spotting these cases can lead to negative consequences for the victim from which it is difficult to recover.

Child protection system professionals focus on individual risk factors by tending to blame the parents and holding them responsible for not protecting their children from various vulnerabilities, regardless of any historical and structural barriers that they may face in earning adequate income. The finger is usually pointed at parents' lack of education and disinterest towards their children, while poverty is associated with parents' unwillingness to work or look for a job. However, previous research[178] in Romania has identified four main causes of separation of children from their families that relate to structural risk factors and are embedded in the country's social, economic, political, and cultural processes at macro level: (i) adverse values and norms, including customs and traditions that have influenced behavior that has led to the child's current situation; (ii) social inertia, especially as it relates to the pre-1989 situation, subsequent unclear goals, and weaknesses in the transitional process; (iii) economic poverty, particularly rural, regional, and community poverty, and its influence on children; and (iv) weak governance in the legal, policy, and administrative systems, decentralization, corruption, and budgetary issues. Thus, the social context within which the family lives influences the likelihood of children suffering from the individual-level risk factors discussed in the previous sections.

Accordingly, the chapter is organized in five sections that discuss structural risk factors, four sections tackling poverty, housing vulnerabilities, source communities, and basic social services for vulnerable groups at the community level, and a concluding section on the priority of the development of preventive services.

3.2.5.1 Poverty, Welfare Dependency and Low Socioeconomic Status

In the children's case files, poverty is overused as an explanation for the separation of children from their families. As the previous sections showed, many child protection professionals prefer to use "poverty" rather than other causes that reflect the child's situation, such as "neglect, abuse, and/or exploitation" or "child disability." Despite this, poverty and low household income and expenses is one of the least documented aspects in the children's files because it is taken for granted. Figure 35 shows that as many as 82 percent of all case files of children in public care provide incomplete or no data on the household incomes. In most cases, the files may include brief references to some income sources of some of the family members (for example, a grandmother's pension, occasional income, or a child allowance). However, the available valid data indicate that only 4 percent of children in public care come from non-poor households (with a per capita monthly income higher than 400 lei), and an

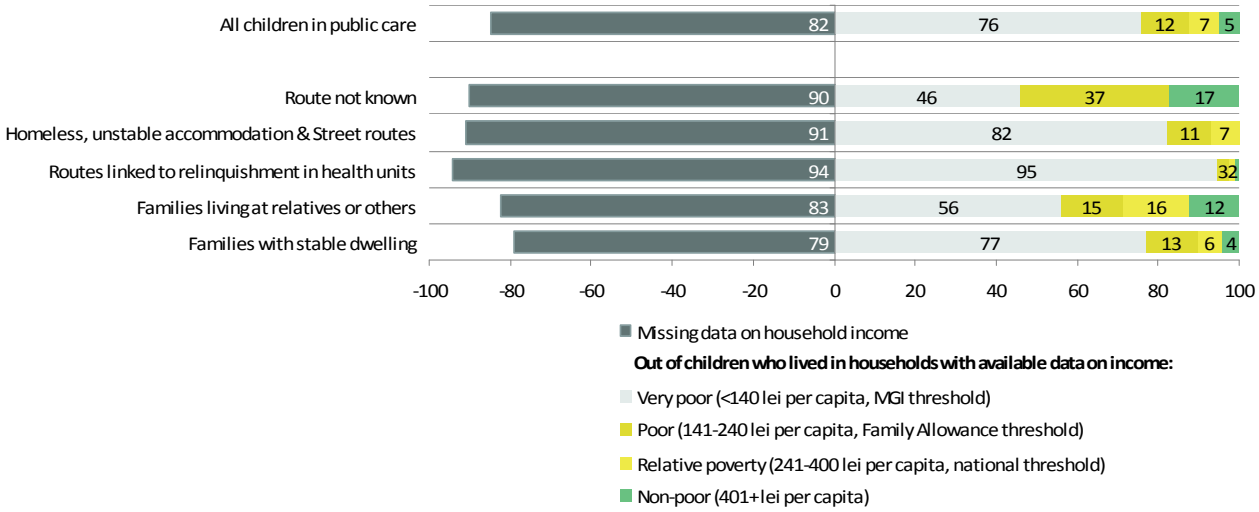
[176] Munro (2010).

[177] Interview with a child protection professional, Bârlad.

[178] UNICEF (2006b).

additional 6 percent are at risk of poverty (relative poverty), while the other 90 percent are from poor or extremely poor families. This is a very strong relevant conclusion, from the perspective of policies for children and families, albeit based on weak data.

Figure 35: The Risk of Poverty of Households in which Children in Public Care Lived Before Entering the System, by Type of Entry Route (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Notes: For details on entry routes, see chapter 3.1.3. Incomes are inflated to reflect their value as of December 2014 in order to ensure comparability.

For a more comprehensive picture, household income data were analyzed by the entry route via which children came into public care (Figure 35 and Annex 6 Table 25). While some data are missing, especially for children relinquished in health units or those who arrived in the system via street routes, even the files for 79 percent of children who came directly from their families of origin contained very little information on income. Based on the available data, we found that children following street routes and those who were relinquished in health units came from extremely poor families. Children who arrived in the system directly from their families of origin (with a stable dwelling) were in a slightly better situation, while children living with relatives or other people were in the best situation, though even for them, 56 percent lived in very poor households before entering the system.

The case files contain some additional data on income sources, though unsystematically recorded[179] and of rather poor quality.[180] These data (see Annex 6 Table 25) reflect the prevailing pattern of joblessness and/or underemployment that characterizes the population of mothers, fathers, and families described in section 3.1.2. Most of these parents or caretakers have poor education and few professional skills and, consequently, they hold marginal or highly vulnerable positions in the labor market. Very few of them are employees in the formal sector, with the majority doing casual work in the "grey" or "black" informal sector. Hence, the most frequent sources of household income are casual work and social benefits (for 34 percent and 38 percent of children respectively).

[179] The case files do not contain information on all of the income sources of each household member, just pieces of information like "the grandmother's pension" or "makes a living from a 500 lei wage." So the available data do not make it possible to analyze income earners or make a comparison between the earnings of workers from source communities and the national average of income earned by workers with the same occupation or in the same sector of activity.

[180] With respect to income sources, the share of missing data varies between 35 percent of the case files regarding wages, about 40 percent related to casual work, pensions or social benefits, and a high 61 percent about the remittances received from household members who left to work abroad (see Annex 6 Table 25).

Wages and pensions were rare in the households where children lived before entering public care, with only about one in every 9 to 10 children's case files indicating that their households received these two income sources (see Annex 6 Table 25). Only 12 percent of children in public care lived in households that received incomes from wages versus a national average of 51 percent (see Table 27).[181] Households where children were living with their relatives and/or other people had higher rates of access to income from wages, but even then this access was very limited (31 percent of children in urban households versus the urban national average of 64 percent and 17 percent of children in rural households versus the rural national average of 30 percent).

Table 27: Households with Incomes from Formal and Informal Work: Comparison Between Households in which the Children in Public Care Lived before Entering the System and All Households in Romania (% of Children)

		Families with stable dwelling	Families living at relatives or others	Routes linked to relinquishment in health units	Homeless, unstable accommodation & street routes	Route not known	All children in public care	National 2014
Wages (formal)	Urban	19	31	5	10	3	13	64
	Rural	11	17	5	18	6	12	30
	Total	14	24	5	12	4	12	51
Casual work (informal)	Urban	33	21	24	31	39	27	-
	Rural	46	32	43	29	49	43	-
	Total	41	27	26	31	41	34	-

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344). For the national level: NIS (2015).

Notes: See the note of Figure 35. Casual work also includes income from informal self-employment.

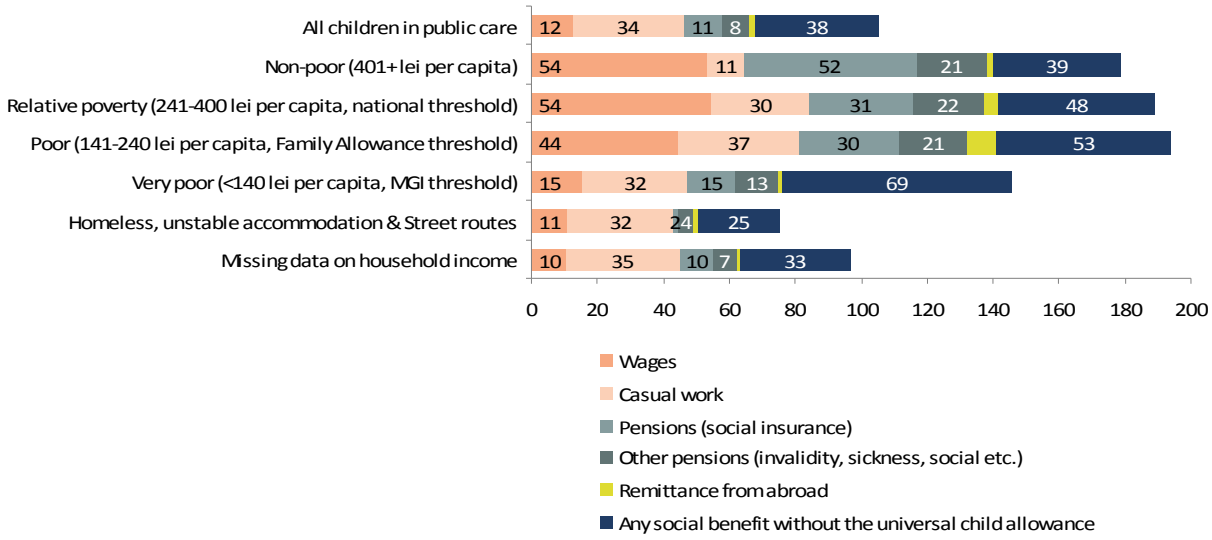
Unlike wages in the formal sector of the economy, income from casual work (including self-employment) in the informal sector is three times more prevalent in the case files, especially for households in rural areas (Table 27). Income from casual work was more often reported for households with stable dwellings. Given the low level of education and skills in these households, it is likely this income from casual work is not sufficient to make a decent living. Compared to wages paid to those on formal work contracts, income from work in the informal sector tends to be irregular and very insecure, making it impossible to properly plan a family budget. This leads families to live from one day to another, focused on the immediate present, concerned with getting through the day: "what am I going to put on the dining table today is what matters, tomorrow is far away."

Out of all households of children in public care, only those of relatives and those with stable dwellings had more than one income source (1.4 sources on average), while the others had either only one cash income source or none at all as in the case of teenage mothers who relinquished their children in maternity wards, mothers in institutions, homeless single-mothers, and street children. The families with more than one income source also tended to have more chances to earn additional in-kind incomes from their gardens or agricultural land and/or other properties, both in urban and rural areas (see Annex 6 Table 26).

The inequalities between poor and non-poor households are highly visible in the studied population. Figure 36 shows plainly that, irrespective of how the child entered the system, extremely poor households had access to fewer income sources, especially wages and pensions. They did casual work to the same or greater extent as the less poor and non-poor households, but had practically no chance to escape poverty. Annex 6 Table 28 shows that they also had fewer chances to obtain additional in-kind incomes, mainly because they owned fewer goods and less property.

[181] A similar situation exists regarding social insurance pensions. Only 24 percent of children in public care came from families that received social insurance pensions (see Annex 6 Table 25), with no significant differences between rural and urban areas.

Figure 36: Income Sources of Households in which the Children in Public Care Lived Before Entering the System, by Total Monthly Per Capita Income (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: Incomes are inflated to December 2014 prices to ensure comparability.

Incomes from social assistance benefits deserve a special discussion, particularly bearing in mind that the majority of the interviewed child protection specialists (either from the DGASPC or from the local SPAS) mentioned the welfare dependency of the families of children in public care as the root of all evil. The specialists believed that many families exploit their children in order to access various benefits, which eventually leads to the child being separated from the family (see section 3.2.2.3). However, as already shown in Table 17, before they entered the system, over 60 percent of all children in public care[182] were living in households that were not receiving any social benefits (other than the universal child benefit allowance). The benefits that were most frequently being received by the families of children in care were the Guaranteed Minimum Income and the Family Allowance, both of which are targeted to poor families. However, before they entered the system, more than 20 percent of the children in public care lived in households that received no social benefit.

Given the poverty and few benefits received by these families, child protection professionals are alarmed about the recent regulations[183] that increased the value of the benefit for family placement and of the allowance granted upon exiting the system, because they regard these as a threat to the proper family reintegration goal rather than as a preventive measure. Considering the assumed tendency of some parents to use their own children as a source of income, professionals are concerned that some parents will take their children home only to bring them back after a while or will leave their children with their relatives just in order to collect the generous placement benefit or exit allowance. This would increase the harm done to the children, exposing them to even more risks. It would also put even more preassure on the public care system, already overloaded, which will have to deal with new entries and temporary false exits.

> "- So, then, the parent leaves the child in the care of one of the grandparents and he finds a job either in the country or abroad. And the child is in the care of his grandparents who come to the Directorate (DGASPC) and request a family placement, given that the placement benefit has

[182] Not including children relinquished in maternity wards.

[183] Starting December 2014, allowances paid for children in placement or for those under guardianship were increased from 97 lei to 600 lei. For children with disabilities, the monthly allowance was increased from 145.5 lei to 900 lei. At the same time, it was agreed to pay a one-off cash allowance equal to the minimum gross salary (900 lei) when a child exits public care (due to adoption or to family reintegration) (Government Emergency Ordinance 65/2014).

increased starting December 1st... and this is a very well-founded concern for us, at present, as we are confronted with an avalanche of such requests.

So, do the new regulations aid the prevention process or not?

- I would not call this a prevention process; this does not look like prevention to me. I mean, since it stimulates the demand for a protection measure and it does not support nor stimulate keeping the child in the family, what else is there to say. It's not about preventing, it's about stimulating..." (Focus group with professionals, Ploiești)

"This money would be good [the reintegration allowance], but many parents use the money when their children are discharged and now want to put the children back into the system ... and at this very moment I have one such case. Here, X, wants to come again. He left from us, from the center, the parents took the money, they used the money given to them when the child was discharged and now they want to bring him back in. So you know what the situation is now, from my point of view, parents are spending the financial support given for the child, and when this financial support is finished, they put the child back into the system." (Interview with a professional, Arad)

FROM RURAL SOURCE COMMUNITIES

The data from the source communities in rural areas do not support the perceptions of DGASPC specialists with regard to the effects of the new regulations as of December 2014 (Government Emergency Ordinance 65/2014). In 57 percent of the 60 communes that contain source communities, there was no registered increase in the number of requests for family placements for children during January-February 2015. In the other communes, the number of requests for placements has risen, but in 20 percent of these communes, the increase was similar to the winter period from previous years and only 26 percent reported a higher increase than in the same period in previous years. In other words, only in approximately one of four analyzed communes did the number of placement requests for children in care increase by almost double (from an average of 2.1 to 3.8 requests per commune) in the period right after the new regulations came into effect.

However, these results must be interpreted with caution given the relatively low number of communes that were included in the sample and the short period of time that had passed since the new regulations came into effect, which has probably limited the extent to which the eligible population has learned about them. As the news spreads, it is likely that the number of placement requests will grow.

Source: Social Assistance Data Sheets from Rural Source Communities (July-August 2015). Data are not weighted. (N=60 communnes with source communities).

"- Maybe we should draw attention to the fact that holding your hand open all the time waiting to get something is also because of the system, because of some laws that don't concretely support...

- Yes, yes, work and responsibility...

- Exactly right!

- But rather too much help, for nothing in return.

- Yes, but we also have to admit that we don't support the parent either, because...

- In my opinion, what should dramatically change in Romania, what should be eliminated, is this thing with welfare for all. I so wish you raised your hands to support me on this…

-Agreed, agreed.

- Yes. First of all, you give someone social welfare, ok, but, at the same time, he/she should be willing to learn and do something in exchange for that money." (Focus group with professionals, Iași)

Child protection professionals tend to believe that the whole system of social assistance benefits distorts the value of work and does not encourage people to search for a job on the formal labor market. While current social benefits may not be well-designed to encourage work, the prevailing

types of families of the children in public care are vulnerable single-mothers (see Infograph Chart 1) of whom three-quarters have completed gymnasium at most and about a quarter of whom are illiterate (see section 3.1.2.1). Many of these single-mothers have themselves a life history of poverty, lack of education, and abuse, and therefore have a difficult time balancing working in insecure and hard conditions in the informal sector and caring for their children. For most of them, the chances of completing their education (for example, through the Second Chance national program) are very low and, consequently, they have restricted access to various other programs such as active labor market measures, social housing (in many localities), or even prevention programs developed by NGOs.

> "The people we work with are usually illiterate. When you take them to the Labor Directorate [the County Agency for Employment], they say nothing. They don't even talk to the civil servants. They don't know how to read or write; there is no point to it because they don't register you. At some point, an NGO started teaching 40-year-old Roma mothers, poor mothers, with five kids at home, but clearly these mothers couldn't attend those classes. They tried to educate them. You know, some people were willing to do that.
>
> There is some sort of a system in place, there is 'A Second Chance' [program] … Yes, but it is unrealistic for parents. Those parents can't go to school and sit there like children … because they have things to do at home. They have children. That's why it is very hard to motivate and support them to go to classes.
>
> In those families with twelve children, what does the woman do? Does she work anywhere? She doesn't. You have no access to social housing unless you work. You definitely don't get any help from HHC [NGO] if you don't have a job." (Focus group with professionals, Cluj-Napoca)

It is clear that under such conditions of extreme poverty, many parents try to access any income opportunity available, whether it is legal or illegal or whether it is a social benefit or not.[184]

> "The child was removed from her at the age of 12, after we strongly intervened. For 2 to 3 years we went and did counseling work with her and the child. She was very lenient, had no rules...we'd say we do things like this, then we left and by the next visit she had already forgotten about the rules we introduced, so the child ended up in child care. [...]
>
> And now [after Government Ordinance no 65/2014 was issued] she filed a request, an impeccable file, everything, all the paperwork was there, and she tells us that the children are her grandchildren, brought from another county, and she wants to take them in placement. And she said I brought three [children] - I'll take two and I'll give my neighbor one, so she has an income too. So this is exactly why she brought the kids from a different county - for the money. She took them from their mother's and brought them here. Now, since we filed for an emergency regime for them, we have to send them home...but for money? She clearly stated this is the reason. [...] When I asked her in and told her that we won't be able to...she started to get angry, to swear, she threatened that she'd go to the media and to the mayor. I told her go ahead, it's your right to contact whomever you want. But in any case, the protection measure should be established at the child's registered home, this is what the law says, that means in the county from where you took the kids; moreover, you already had that child and we don't think... And the woman is already 65 years old..." (Interview with a professional, Arad)

As shown in the previous chapters, it is also clear that the money is not always spent to the benefit of the child as some parents may be drug or alcohol addicts or may smoke or spend money in inappropriate ways while at the same time neglecting their child's needs. Nevertheless, the available data indicate that the main problem is their lack of access to proper support and not their behavior (see Figure 36 and Annex 6 Table 27).

As already mentioned, at the time when the children entered the system, the households from which they came had very little access to social benefits, with fewer than 40 percent of children coming from households that received a social benefit (other than the universal child allowance). Families with unstable accommodation or who were homeless had even less access, given that a stable address is a compulsory prerequisite to receive such benefits. Precisely because of the lack of a stable address, only 28 percent of these families were receiving a social benefit. Mothers with unstable

[184] See also section 3.2.2.3 on various forms of child exploitation.

accommodation live wherever they find a place to stay, moving around together with their children, often from one locality to another, so even if they have identity papers, their residential address is only temporary so they cannot apply for social benefits according to the law, even if they are eligible in terms of low income. As child protection professionals point out, besides lack of a stable home, other circumstances such as separation/divorce can also prevent families from accessing social benefits.

> "Mayoralties grant the family allowances but, unfortunately, practice has shown that this kind of financial aid goes, once again, to better-off families. The families we are talking about have difficult access [to social benefits] because, let's say the couple is only separated, you need a divorce decree and a child support settlement. Or think about these families with problems, they can't go through all these steps. Another example, if child support has been settled, even if the mother doesn't get the money in effect, that income is taken into account when deciding whether she is entitled to that right, which is once again absurd. Therefore, the legislation has some gaps." (Focus group with professionals, Braşov)

FROM RURAL SOURCE COMMUNITIES

The data from the rural source communities survey allowed us to analyze the structural pattern of access to social benefits for families with children in public care to a limited yet useful extent. The analysis has the following limitations: (i) the data in this chapter concern the entire population of children in public care from both urban and rural areas and from both source or other communities, while the comparator refers strictly to the families of children from the rural source communities; (ii) the data in this chapter concern the families' income situation at the time when the children entered the system, which could be any time between 1989 and 2014, while the data from the source communities refer only to 2014; and (iii) the data in this chapter are taken from the children's case files and social inquiries, which provide only partial and unsystematic information about the income of children's families while the data from source communities were systematically collected directly from the social workers of the local SPAS. Despite all of these limitations, the comparison is surprisingly consistent, indicating a stable pattern of low access to benefits. Any differences are due either to the food aid provided by the European Union, a benefit available only after 2007, or to the heating subsidy, a seasonal benefit which can vary slightly unless recorded yearly. Because of these differences, the share of families from rural source communities receiving at least one social benefit was 58 percent versus 38 percent of the entire population of children in public care. Despite these differences, the conclusion is the same, namely that the families of children in public care have a stable pattern of low access to social benefits.

For more information, see section 3.4.3.3 on family reintegration in the source communities.

Source: Survey of Households with Children in Public Care from Rural Source Communities (July-August 2015). Data are not weighted (N=953 households that are still present in the commune and in which children have not yet been reintegrated).

Among the other types of households, the proportion of beneficiaries of social benefits decreases incrementally from 69 percent of the extremely poor to 39 percent of the non-poor. Annex 6 Table 27 shows that, while the non-poor households have benefited mainly from the placement allowance and the allowance for people with disabilities, poor households mainly received the Guaranteed Minimum Income (GMI) and/or the family allowance, programs which are targeted to the poorest.

However, it is useful to analyze the data in another way, from the rights perspective. From a legal point of view, all families in extreme poverty with a per capita monthly income of less than 140 lei are entitled and eligible to the GMI, as well as the family allowance, social canteen, food staples, and/or a heating subsidy during cold seasons as well as other benefits (other than the universal children's allowance). Nonetheless, at the time when the children entered public care, only 37 percent of all families in extreme poverty received the GMI, only 22 percent received the family allowance, and only 2 percent were beneficiaries of the social canteen, heating subsidy, and/or food staples. As a consequence, these families were living in chronic and extremely deep poverty in the absence of adequate support before their children entered the system, as described by a child protection professional:

"Could you tell me what poverty means for these families?

- To support a certain number of people only on the basis of the child allowance. That is 42 lei per month, which is not enough to take care of a child even for a week. And they have many kids, not just one, but many... This would be it." (Interview with a professional, Craiova)

Thus, the poverty that was faced by children and their familires before the children entered public care was (and is) caused by the ineffectiveness of the current policies for children and families, in addition to the limited access that their parents had to the labor market because of their low education, lack of skills, and, in some cases, insufficient personal efforts.

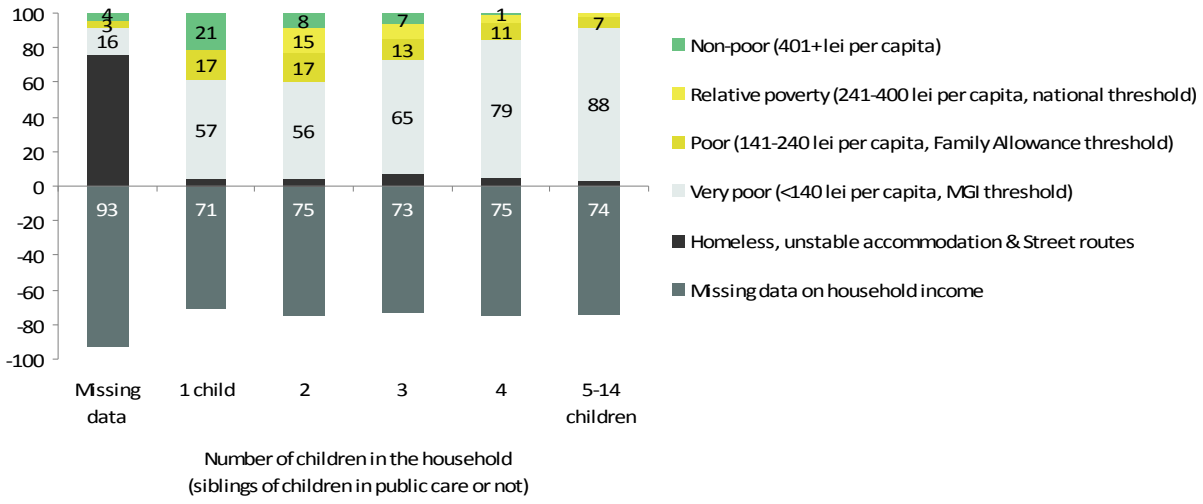
Box 5: Ineffectiveness of Minimum Income Schemes in Many European Countries

A very recent study of the European Commission shows compelling evidence of the fact that minimum income schemes in many countries have been ineffective in alleviating poverty and social exclusion in recent years. The common weaknesses include: (i) inadequate levels of benefit; (ii) failure to cover all of those in need; (iii) low levels of take-up; and (iv) a limited impact in reducing poverty. The main problem has been that these schemes have put insufficient emphasis on developing an integrated and tailored approach to support the beneficiaries and help them to integrate into society and, as far as possible, into the labor market.

Source: Frazer and Marlier (2016).

As expected, households with more children are the most exposed to extreme poverty. Figure 37 shows that the proportion of children from very poor households increases from 57 percent of households with one child (the one now in public care) to 88 percent of those with 5 to 14 children. Correspondingly, the proportion of children with siblings at home before entering the system is 55 percent among extremely poor households, 45 percent of poor households, and 28 to 31 percent of households in the other socioeconomic categories.[185] Children with siblings in the system currently represent 60 percent of very poor and poor children, decreasing to 19 percent of non-poor children.[186] This indicates that more than one child is usually taken into the system from extremely poor and poor households.

Figure 37: Poverty Levels of the Households in which the Children in Public Care Lived Before Entering the System, by Number of Children in the Household (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: Incomes are inflated to December 2014 prices to ensure comparability.

[185] The average value is 34 percent of children in public care.

[186] The average value is 50 percent of children in public care.

Children in public care who came from extremely poor or poor households are more likely to have developmental delays (22 percent versus the average of 17 percent) but not disabilities, special educational needs, or behavioral problems. Also, they are unlikely to have been relinquished in a maternity ward or another health unit (Table 28). Instead, they were highly exposed to the risk of neglect, abuse, and/or exploitation before entering the system. They were also more likely than other children to have faced a series of unfortunate events in their families of origin such as the death of the mother or the imprisonment of the father, or to have experienced risky parental behavior such as parental mental health problems and/or disability, parental alcohol and/or drug abuse, and promiscuous and/or criminal behavior of an adult member other than the parents.

Table 28: Incidence of Child Neglect, Abuse, or Exploitation, by Poverty Level of Households in which the Child Lived before Entering Public Care (%)

Children from households that were…	Children relinquished in maternity	Evidence of:				Total	
		Neglect	Abuse	Exploitation	Any form of violence	- %	- N
Very poor or poor	11	59	20	6	62	100	6,974
All children in public care	24	41	12	3	46	100	52,343

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

The sparse data on income indicate that 73 percent of children in public care came from extremely poor or poor households, not taking into account those from households with unstable accommodation or those who were homeless. If this is the case, then specifying "poverty" as the main cause of separation may be accurate for a large proportion of the children in public care. Nonetheless, the case files specify "poverty" as the cause of separation for only about one-third (32 percent) of all children.

Box 6: More than Poverty as Justification for Removing Children from Parental Care

"Ensure that poverty is never the only justification for removing a child from parental care; aim at enabling children to remain in or return to the care of their parents by, for example, tackling the family's material deprivation."

Source: EC Recommendation "Investing in Children: Breaking the Cycle of Disadvantage" (2013:item 2.2).

How did the DGASPC professionals decide on the 32 percent of children out of the 73 percent of extremely poor or poor children for whom they indicated "poverty" as the cause of their separation from their families, particularly considering that "poverty" should never be the only justification for removing a child from parental care (Box 6)?

- Firstly, there is a certain inconsistency between the facts documented in the case files and the justification for the separation. For all children for whom "poverty" was given as the main cause, 80 percent of case files contain no data on income. In addition, children removed from parental care due to "poverty" represent 33 percent of children from extremely poor households but also 7 percent of children from non-poor households.
- Secondly, and more importantly, "poverty" is usually given as justification for the separation along with neglect, abuse, and exploitation or, less frequently, along with "other causes." Nevertheless, for 12 percent of children in public care, "poverty" represents the sole justification. About half of those are children who were relinquished in maternity wards. As for the other 6 percent of children, the available data in case files do not contain any evidence of unfortunate events, experiences of child abuse or neglect, parental risk factors, or the existence of child special needs. Hence, around 7 percent of children in public care in Romania have been removed from parental care solely on poverty grounds.

CONCLUSIONS & RECOMMENDATIONS

Most children in public care lived with families affected by extreme poverty or poverty before entering the system. This poverty has been (and still is) caused by the ineffectiveness of the current policies for children and families, in addition to the parents' limited access to the labor market. While the children were still with their families, they did not receive proper access to social benefits, let alone support services. It may be that their parents had not applied for these benefits because some of them were illiterate, others could not afford the associated administrative costs, or owed fines or dues to the state. Even so, the support received by the families at the local level aimed at helping the family to keep their child at home was definitely insufficient, irrelevant, and not related to the needs of the family and the child. This has often been the untold part of the separation story.

Due to the absence of appropriate support to family and children, the child protection system either has to contend with the issue of separations by relinquishment or to fill in the gaps left by national policies and community-based services (including the SPAS) by providing protection services for children who have no food or clothes at home or cannot afford heating during winter. Hence, families are separated in order for children to receive "regular meals, accommodation, and shoes to go to school."[187] A ssimilar situation often exists in hospitals when children are temporarily taken in to "treat" poverty rather than a health condition.

For these reasons, there is an urgent need to revise the national policies for combatting poverty as well as the social assistance benefits system to better reach very poor children and their families and to effectively address the challenges that they face. At the same time, public social assistance services at the community level need to be improved and developed so that they can identify these cases and provide effective support to children and families at risk of separation. Only by taking this approach will Romania be able to translate the UN recommendations into practice: "Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family."[188]

What is also needed is an assessment of the impact of the recent law (Government Emergency Ordinance 65/2014) that increased the placement and exit allowances both on the children whom it has affected and on the system as a whole.

Furthermore, other types of integrated and holistic measures and intervention packages for the family are necessary to increase parents' capacity and to strengthen the family (and community) with the purpose of actually reducing their welfare dependency.

3.2.5.2 Unstable Family Accommodation, Evictions and Homelessness

Reliable data on the children's housing conditions before they entered the system were available for 65 percent of children, who represent those who arrived from families with a stable dwelling, or from relatives or other people. The other children (35 percent) were relinquished in maternity wards or hospitals or came from families with unstable accommodation, or those who were homeless, evicted, or institutionalized. Among the latter, data about their last dwelling were available only for 9 percent, while data were missing for the other 26 percent.

Table 29 shows that most children in public care came from households living in overcrowded houses with one or two rooms in conditions associated with medium to major health-related risks. Children who arrived in care after living with relatives or other people had been in better living conditions, while children coming from families with unstable accommodation or who had been evicted or homeless were in the worst situation.

[187] Focus group with children in the child protection system, Braşov.

[188] UN Guidelines for the Alternative Care of Children (2010:4, paragraph 15).

Table 29: Housing Conditions of Children before Entering Public Care (%)

Indicators		Families with stable dwelling	Relatives or other people	Unstable accommodation, homeless, evicted, institutionalized	Total
Total	N	27,655	6,506	4,850	**39,010**
	%	100	100	100	**100**
DWELLING					
Dwelling type	- House	68	49	50	**63**
	- Block of flats	13	14	8	**13**
	- Improvised shelter	7	3	17	**8**
	Missing data	12	34	25	**17**
Housing security	- Partner's ownership	26	12	22	**23**
	- Relatives' ownership	35	33	33	**34**
	- State renting	5	4	5	**5**
	- Social housing	2	1	4	**2**
	- Improvised shelter	7	3	17	**8**
	- Private renting	4	7	3	**4**
	Missing data	21	40	16	**23**
Number of rooms	- 1	26	14	39	**26**
	- 2	37	29	38	**36**
	- 3+	19	16	13	**17**
	Missing data	18	42	10	**21**
Housing conditions	Inside kitchen	34	34	24	**33**
	Inside bathroom/shower	13	15	8	**13**
	Inside toilet	11	13	6	**11**
	Adequate heating	26	29	16	**25**
	A special place for the child	5	8	1	**5**
	Adequate hygiene	22	31	13	**22**
	Adequate endowment with durable goods	20	29	9	**20**
Problems	Roof leaks, rotten floor, damp walls, deteriorated windows etc.	25	7	30	**23**
Health related risks	- Major	32	10	43	**30**
	- Medium	11	6	15	**11**
	- Minor	3	3	2	**3**
	- None, good, very good conditions	7	11	2	**7**
	Missing data	47	71	38	**50**
Overcrowding	Total people per dwelling - average	5.2	4.1	5.2	**5.1**
	Total people per dwelling - max	19	16	20	**20**
	Total people per room - average	3.2	2.3	3.5	**3.1**
	Total people per room - max	16	13	20	**20**
	Total children per dwelling - average	3.0	2.3	3.0	**2.9**
	Total children per dwelling - max	14	14	10	**14**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: The 26 percent of children in public care relinquished in maternity wards or hospitals who are from families with unstable accommodation, from homeless, evicted, or institutionalized families or for whom there were no data on their housing conditions are not included.

In comparison, the living conditions in many social protection facilities may seem truly luxurious. The serious discrepancy between the conditions at home and conditions in public care could represent a risk that should be addressed in the individualized protection plan (PIP). The issue of "good living conditions" and its different meanings for children, families, and professionals was often raised in the qualitative study.

> "I had this case that I always use as an example. I had a mom that I took to a shelter for mothers, with her four kids. Meanwhile, the husband was to refurbish the house. And he did. He painted the outside, fixed the windows (that is, added two more boards so the cold wouldn't get in). And the door...he fixed it as well as he could, he even painted the inside and I said: ok but this is an earthen floor. Yes, lady, but I need cement. With the municipality, we managed to give them cement, he poured it and despite this, we were still unsatisfied. And she said...the lady got really angry, used swear words and said: "What else am I supposed to do to this house?" Put carpets on the walls? Because she felt she had done everything possible; that it's impossible to do more. So this is how things are. So for her it was absolutely great, and that's when we thought that maybe we are the ones with a problem. She had beds, a table, now she had cement floors, it looked nice, she had a stove, pots, plates, her husband had a job, so they could afford food, so for her it was extraordinary. And yet, we were still not happy.
>
> *Do you refer to some standards?*
>
> - Yes. And that's when I told my colleagues to pay attention to how they understand conditions. Because maybe the family think it's extraordinary and they give the children everything they need, because she had other kids and they were in school. So she didn't remove them from school claiming she couldn't afford to keep them there. But still we wanted more, so she got angry. So, we have to think of conditions." (Interview with a professional, Arad)
>
> "Go back to the family? Well, before going back to my family I'd like to know that they have the conditions to keep me, to allow me to go to school, to have a bathroom inside, not in the backyard." (Focus group with children, Craiova)

As with poverty, housing conditions should never be the only justification for removing a child from parental care. Nonetheless, many interviewed parents mentioned "a lack of stable accommodation," "a lack of space," and "improper living conditions" as one of the reasons or the main reason why they agreed to their child being taken into public care. In the family's needs assessments included in case files, SPAS social workers specified as main need: "poor/improper housing conditions" (24 percent of children in public care), "lack of stable accommodation" (7 percent), "lack of heating" (1 percent), and "lack of electricity" (1 percent). In the case files, the DGASPC specialists rarely mentioned "improper and/or unhygienic space" (1 percent) or "evictions" (2 percent), usually next to the justification of "poverty."

The problem of adequate and affordable housing for vulnerable groups, especially single-mothers, is one of the key elements for preventing child-family separation.

> "Lack of housing is another problem. There are mothers who raise two or three children...and they are kicked out of their partners' house, and this is a problem. They can't pay rent. No relationship with the grandmother, or other family members. So we are their last resort." (Focus group with professionals, Timișoara)

At least 4 percent of all children in public care came from families with unstable accommodation or who were homeless or evicted. For these children, the social protection system fills in the gaps of the national housing policies and programs. Many of these children come from dysfunctional families, with a single-mother who is often the victim of domestic violence and who lacks the resources to ensure stable accommodation for her children. These families with unstable accommodation or who were homeless or evicted represent most of the cases in which housing conditions were stated as the cause of separation by the DGASPC professionals (solely or together with poverty).

> "*So you asked for the child placement*?
>
> - Yes, I filed a request and got out of the system [from a shelter for abused mothers]; I couldn't stay there anymore. They [DGASPC] were trying to reintegrate me into the family, but I couldn't live with that man anymore. He would beat me every day. But I didn't have where to go with

three kids, so I left them... I only took the youngest one. Because I thought that, since he was younger, he needed my care and protection more than the others. They all needed me, but since I couldn't take them all, I thought of taking the youngest one... to start with." (Interview with a parent with institutionalized children, Craiova)

Box 7: Example of Good Practice - the Commune of Concești in Botoșani County

The Local Council in the commune of Conceşti in Botoşani County bought and fixed up deserted or unfinished houses in the commune to offer them as social dwellings to needy families with children. First, the Local Council allocated 250,000 lei for the purchase of houses.

> "We can offer the families that will come to our commune a house with very good living conditions, with running water and a bathroom. We also intend to build a bathroom in those houses that currently don't have one to make sure that these social dwellings are in good condition. We have made this decision because the population in our commune has dropped significantly. Each year, [only] five to ten children are born here and this has led to multi-age classrooms in school. We'll start with five houses. We've talked with the owners and they want to sell them. The houses are in excellent shape and if, by any chance, more families came, we could offer up to 10 to 12 houses. [...] The people who will come to our commune will most definitely find a job here. We have jobs. We have also made arrangements at a farm. We have about 50 jobs at the greenhouses and men can work in forestry." (Costel Nazare, Mayor of Concești Commune)

The local initiative was an instant hit. In a matter of days, three families consisting of five adults and 20 children moved there. One family consisted of a single-mother of six - a 19 year old, and five underage children who had never had a home of their own but had lived with relatives or as tenants. Another of the families consisted of a single-mother of seven from another county (Hunedoara) who could not put up with her husband's abuse any more and took her children, the eldest aged 17 and the youngest aged only 2. She said: "We decided [*together with the children*] to go into the wide, wide world". So far, the mayoralty of Concești has received about 35 applications for social housing.

Source: http://www.botosaninecenzurat.ro/20151216-cine-se-muta-la-concesti-primeste-casa-gratis-foto.html

Video sources: http://stirileprotv.ro/stiri/social/primarul-care-ofera-gratuit-case-si-locuri-de-munca-celor-care-se-muta-la-el-in-comuna-cati-oameni-i-au-batut-la-usa.html and http://telembt.ro/proiectul-primarului-din-comuna-concesti-care-ofera-locuinte-gratuite-familiilor-cu-multi-copii-are-succes-peste-asteptari.html

In addition, 8 percent of the children in public care lived in improvised shelters and in living conditions which put their health and development at risk before they entered the system (Table 29). As regards improvised shelters in particular but also social housing or state-rented units, overcrowding has been identified as a major problem because: "there are families with three to four children – two boys and two girls – and they all share a room, they sleep in the same bed, or all the family members live in a single room." (Interview with a professional, Craiova)

Box 8: Preventing Family Separations by Providing Social and Affordable Housing in an Integrated Package of Services for Children and Families

An European Parliament resolution of June 11, 2013 on social housing in the European Union (2012/2293(INI)) "reminds the Commission, the Member States, and local and regional authorities that spending on social and affordable housing is in keeping with fundamental rights, enables urgent social needs to be met, and, as strategic social investment, helps in a sustainable way to provide local jobs that cannot be off-shored, stabilize the economy by reducing the risk of property bubbles and household over-indebtedness, promote labor mobility, counter climate change, combat energy poverty, and alleviate health problems stemming from overcrowding and poor living conditions; insists, therefore, that social housing should not be considered a cost to be cut but an investment that pays off in the long term through better health and social well-being, access to the labor market, and the empowerment of people, especially the aged, to live independent lives."

Only 7 percent of children in public care lived in social housing or state rental housing (with subsidized rent) before they entered the system. They are more in urban areas and only few in rural areas. However, living conditions in social housing, in either houses or apartments in blocks of flats, are as bad as in most other dwellings described in Table 29. Over 50 percent are one-room dwellings, in which live, on average, five people of which three are children. Only about one-third have an inside kitchen, about a quarter have an inside bath and/or restroom, and about a fifth are adequately heated. The 2 percent of children who experienced eviction before entering the system were living in such social housing or state-rented units.

> "In Ploiești, I refer to the town, there are only a few social dwellings. And there are situations when they end up in the social dwellings... and take my word for it, because in the beginning of my career I was in charge of social housing, you should see them now... You should see how they look. Awful, you wouldn't believe your eyes... and they even evict them if they don't pay." (Focus group with professionals, Ploiești)

> "There are some specific cases: parents evicted, they are left without a place to live. They'd keep the children, but don't have where. And I actually have such cases..." (Focus group with professionals, Ploiești)

All the above-mentioned issues point to the same general problems of the social housing and state-owned dwellings sector that are highlighted and analyzed in the *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*.[189] The scarcity of available social housing has been a constant problem since 1990.[190] Local public authorities own and manage housing stock to be rented to the poorest population, but this fund is often not recorded as "social housing" as it does not comply with the legal requirements and standards. Most often this stock consists of nationalized or low-quality houses or apartments with reduced useful floor area, that have been neglected in the past few years and are located in unattractive, difficult to access, and poorly endowed urban areas with a low market price. Nevertheless, the supply of social housing is much lower than the demand.[191]

The eligibility criteria for social housing are rather lax and applied differently from one locality to another. However, one criterion is the existence of a stable residence within the administrative-territorial unit, which often excludes precisely the families that are most in need because of being in unstable accommodation or homeless. Actually, research has shown that many local authorities grant priority access to social housing to families with fewer children and with sufficient income to pay the utilities. The result is that the poorest families and those with the largest numbers of children (especially Roma) are often excluded from social housing. The overall result is that, out of all social housing units in urban areas, only 57 percent are rented to low-income families while the others are let to better-off people. Nonetheless, most urban municipalities have state-owned dwellings of very poor quality, which are not officially registered as social housing units, that are rented to low-income households.

The low quality of the social housing and state-owned dwellings stock is a general problem in Romania

The *Situation of Social Housing* survey confirmed that, in 2014, most social housing units consisted of apartments of one or two rooms covering 10 to 37 square meters that were lived in by numerous families. Common spaces tended to be obsolete, damaged, and/or dirty, and services such as electricity, sewerage, and water supply were either non-existent or had been disconnected because of payment arrears. Massive overcrowding has put serious pressure on the apartment blocks, which are not technically designed to support such a large number of users. As most infrastructure is old and broken, the basements of these blocks are usually flooded with water and dirt. As a result, the walls and roof are eroded and damp, which puts the residents' health at risk. Some of these areas of

[189] Teșliuc, Grigoraș and Stănculescu (coord.) (2015).

[190] Constantinescu and Dan (2005).

[191] The number of applications received by urban mayoralties exceeds 67,000, while the local authorities estimate that the need amounts to 55,000 to 60,000 units. Source: *Situation of Social Housing (SSH)* survey in all urban municipalities (World Bank in collaboration with the Ministry of Regional Development and Public Administration, October 2014).

social housing are at risk of becoming - or have already turned into - pockets of poverty (especially ghettos), with inadequate housing conditions and general unemployment. Local authorities typically act as mere financial managers of the buildings, and existing social housing programs are not designed to include any incentives to encourage or require tenants to participate in the active labor market or in education or to access other social services.

Source: Situation of Social Housing (SSH) survey in all urban municipalities (World Bank in collaboration with the Ministry of Regional Development and Public Administration, October 2014).

Overdue rent and/or utilities is another widespread problem

Social housing units in Romania often have high levels of accumulated arrears on rent and especially public utility payments. This often results in whole buildings being disconnected when they do not have individual consumption meters for each unit. The rent charged by the local authority cannot exceed 10 percent of the income of the occupants, with the difference up to the nominal value of the rent being subsidized from the local budget. Since the residents are typically poor, this level of rent may not even cover the maintenance costs, which makes social housing a major drain on local finances. In the case of social housing, the local authority's accounting system attributes arrears in rent to the unit rather than to the renter, which means that any overdue debt is passed to the next tenant. It is administratively difficult to cancel overdue debts that could not be recuperated so many new social housing tenants are considered liable for the arrears associated with their new home.

Source: Teșliuc, Grigoraș and Stănculescu (coord.) (2015:263-265).

Evicting tenants is the final step in the situation of unsettled arrears. According to the law, the term of a rental is five years, with the possibility of extension. However, cases have been reported where local authorities have decided to lease social housing units for much shorter terms (for as little as three months) to make it easier for them to evict renters who do not pay their rent or utility bills. To prevent renters from building up overdue debts for social housing costs, some municipalities evacuate people to make them "responsible and accountable." Thus, while the mayoralty housing department is just applying the law in evicting people with arrears, the public social assistance service (SPAS) either is not being informed or does not intervene. It is not clear where the evicted families end up, and these vulnerable people, including their children, live through a traumatic life event with no protection at all. In these cases, state institutions are definitely not respecting human and children's rights. Thus, as we have seen above, some of these children end up in public care. In this sense, once again, the child protection system must fill in the gaps in the national policies and programs on social housing, as well as remedying the inaporopriate responses of the staff of SPAS and other community-based services.

> "- I'd focus a lot on prevention, that's for sure.
>
> *How would you focus on prevention?*
>
> - Well, we have an awful relationship with the community; some mayoralties hang up on me... There were times, I couldn't say exactly how often, but there were times when a modest-income family got evicted because of an unpaid electricity bill, and five or six children were placed in public care instead of having their bill paid. Community-based measures means it would have been cheaper and a lot better for the children to cover the bill, it was just one bill..." (Focus group with professionals, Cluj-Napoca).

RECOMMENDATIONS

At the national level, there are no standards for the required housing conditions for families before their children can be released from public care and reintegrated in the family. Nevertheless, as the qualitative study has shown, in specific counties, such standards have been developed and used. A country-wide analysis of the practices used by DGASPCs regarding these housing conditions as well as an evaluation of the impact of these practices on the children and their families are also necessary. It is also important to ensure that common rules are developed and applied in a uniform way by all case managers within the system.

The discrepancy between the child's housing conditions at home and those in public care should be addressed in his or her individualized protection plan to manage the child's expectations and to help him or her to prepare for an independent life.

The public care system cannot and should not separate a child from parental care just on the basis of the parents' lack of access to affordable accommodation. The government should assess the need for social housing for all vulnerable groups (including the homeless, post-institutionalized youth, ex-prisoners, victims of domestic violence, people evicted from restituted houses, and people with drug dependencies). It should then establish a clear national strategic framework for its housing policy involving inter-sectoral coordination and cooperation between the central and local authorities. The range of social housing instruments should be enhanced, and the government should consider awarding housing allowances to very poor people. To achieve this aim, financing for social housing services should be increased.

There is a need for stable and sustained investments in increasing the number of social housing with clear targets for young people leaving public care, families with numerous children, single-parent families, and other categories for whom family separation is an outcome of the lack of housing.

Furthermore, it is necessary to define the way in which social houses are built, allocated, and placed in the community. It is essential to avoid the formation of new "islands" of poverty by building agglomerations of social housing (for example, in blocks of flats or neighborhoods), especially on the outskirts of localities. Precisely for this reason, governments of other European countries encourage the dispersion of social housing throughout each locality.

However, merely building social housing will not reduce extreme poverty and the number of homeless people. The government should gradually shift the emphasis of its housing policy towards prevention, and to this purpose, social housing services should be delivered within an integrated package of social services targeted to families at risk of separation, youths leaving childcare institutions, people leaving prisons, asylums, and hospitals, victims of domestic violence, and those dependent on alcohol and drugs.

A strategy for keeping track of and controlling illegal and improper settlements should be developed and followed by special programs aimed at helping their beneficiaries to access social, health, and educational services as well as available social benefits.

Illegal evictions and evictions in the absence of any alternative accommodation should no longer be carried out, especially when they involve single-parent families with one child or more.

3.2.5.3 Neighborhood/ Community Characteristics: Source Communities

One of the assumptions that is often made when discussing the negative impact on children of being separated from their parents is that preventing children from entering the system is more cost-effective than treating the effects of the separation. No matter how appealing this principle is in theory, the efficacy of measures for preventing children from entering public care depends on how the children at risk of separation are geographically distributed. The resources that the child protection system would have to mobilize and the actions that they would need to take would be completely different if the families at risk were evenly spread throughout the country than if they were clustered in compact communities. The wide range of possible situations across and within counties is one of the key reasons why cost-benefit analyses of preventive measures are difficult to carry out and extrapolate to other territorial contexts. Therefore, how families at risk of separation are either concentrated or spread across and within localities is an essential element to bear in mind in the design and *ex-ante* evaluations of preventive measures.

Two main questions arise in this context. First, are the children at risk of separation concentrated in certain geographic areas or are they spread uniformly between urban and rural localities? Second, if the children are clustered in particular areas, what characteristics of those areas could be used to make it easier to identify and target interventions for families at risk? To answer these questions, we used the CMTIS dataset, which contains records related to children in public care. Although the CMTIS dataset is not ideal, mainly because the information has not been updated in some counties in recent years, it still constitutes an extremely rich information source that has not yet been sufficiently exploited.

To complement the information from the CMTIS, we also used census data, information from the Atlases of Urban[192] and of Rural[193] Marginalized Areas in Romania, and data from the qualitative research conducted for this report.

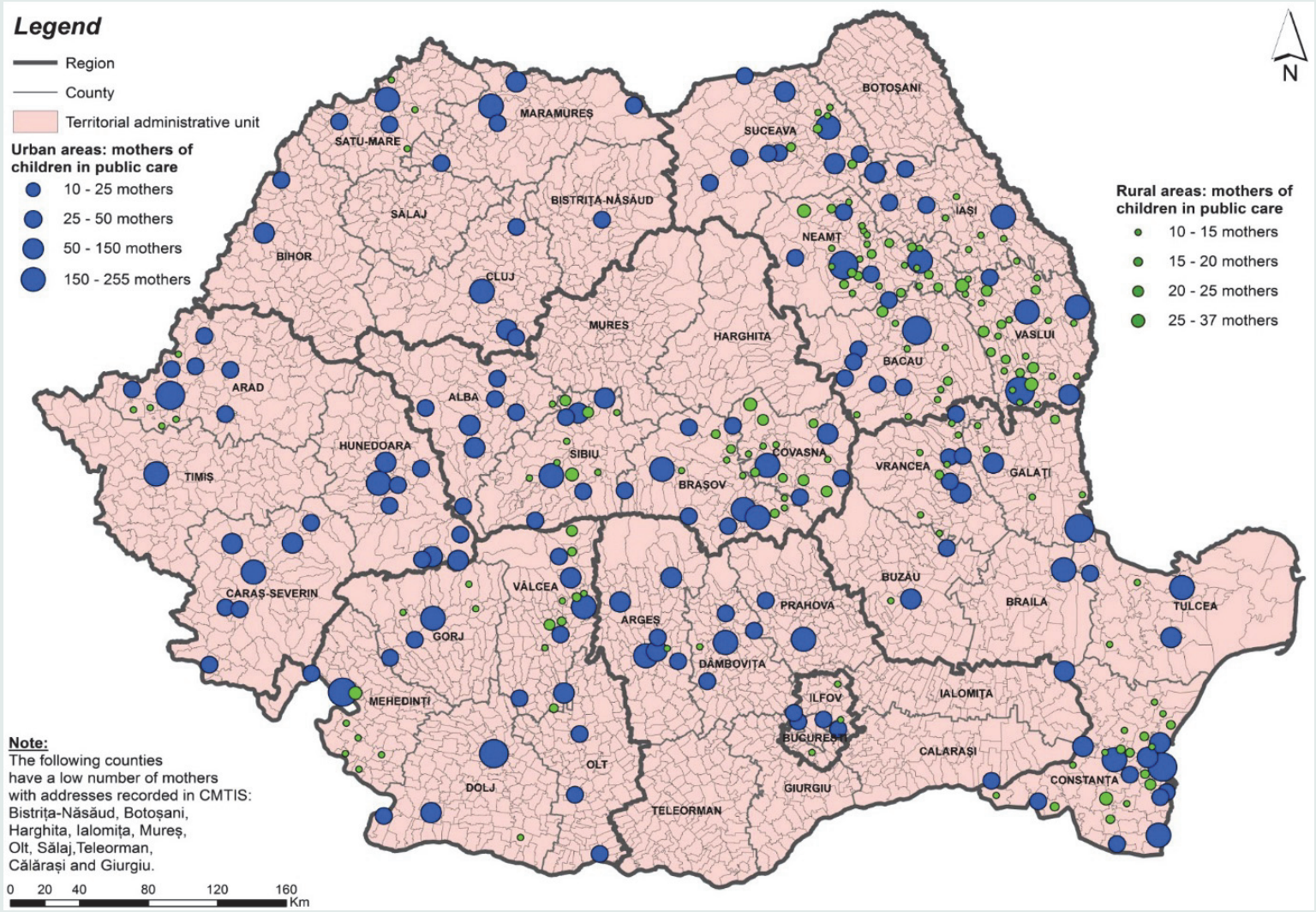
By definition, "source communities" (rural and urban) are sub-locality areas from where a disproportionate number of children end up in public care. Sub-locality areas in urban settings may refer to a neighborhood, as well as a street or a group of houses or blocks of flats, while in rural settings they may refer to a whole village, a hamlet, or just a group of houses.

Map 1 shows the distribution of these urban and rural source communities across the country. The next three sections address our analysis of urban areas, rural areas, and the children in public care who come from source communities.

[192] Swinkels et al. (2014).

[193] Teșliuc, Grigoraș and Stănculescu (coord.) (2016).

Map 1: Urban and Rural Source Communities of Children in Public Care in Romania



Source: CMTIS as at November 2014.

Source Communities in Urban Areas

The CMTIS data on the home addresses of the families with children in public care indicate that there is a concentration of such families in a number of urban localities. Fourteen percent of mothers with children in public care[194] live in only 10 cities (see Annex 6 Table 29). When the focus is restricted just to the urban areas, these 10 urban localities contain more than 30 percent of the mothers with children in public care. The first 20 localities[195] ranked by the number of mothers with children in public care hold one-fifth of all such mothers nationwide; when the analysis is limited just to urban areas, these 20 localities contain 45 percent of mothers of children in public care.

There is no strong correlation between the number of mothers in urban localities and extent of development measured at the locality level. The question that arises is whether there are any factors at the locality level that may predict the concentration of mothers in some localities. The data show no significant correlation between the development level of the localities and the number of mothers in the system when keeping constant the locality size. The apparent absence of a relationship between poverty and the risk of the separation of the child from the family makes sense when we consider that what may matter is not the overall level of poverty of a locality but the number and size of small areas in extreme poverty in a town or city. The Atlas of Urban Marginalized Areas in Romania[196] shows that such extremely poor areas exist in both developed (even in the most developed) and not-so-developed urban communities.

Analyses and qualitative case studies from the Geographic Information System (GIS) suggest that source communities do exist and that they are geographically delimited and contain a higher than average number of families with children in public care. Moving one level below the locality level, with the aim of targeting the preventive interventions as close as possible at those in need, we needed to know whether the existence of source communities is confirmed for urban areas. To answer this question, we carried out GIS analyses of the addresses of the mothers with children in the system in five cities, while at the same time we undertook in-depth case studies in each of the areas that were confirmed as source communities for these five localities.[197]

All five qualitative studies confirmed the existence of source communities in urban areas. Local stakeholders further confirmed the existence of these source areas that had been objectively detected through the aggregation of home addresses of mothers with children in public care. Moreover, the researchers who visited these areas and their interviewees all described the areas as marginalized, consisting of improvised houses or former dormitories, often not connected to utilities, and with roads in extremely poor state (see Story Bags 5a to 5d).

For illustration, the next map (Map 2) shows how the mothers' home addresses are distributed across the city of Arad. The map indicates a few areas where the number of mothers is significantly higher: there are 27 addresses concentrated in one of the areas and 24 and 21 mothers in two others, while others show some degree of concentration as well (although with fewer mothers). Map 3, which zooms in on one of the areas to depict whether or not the home addresses are tightly clustered, indicates that the mothers are concentrated in well-defined areas.

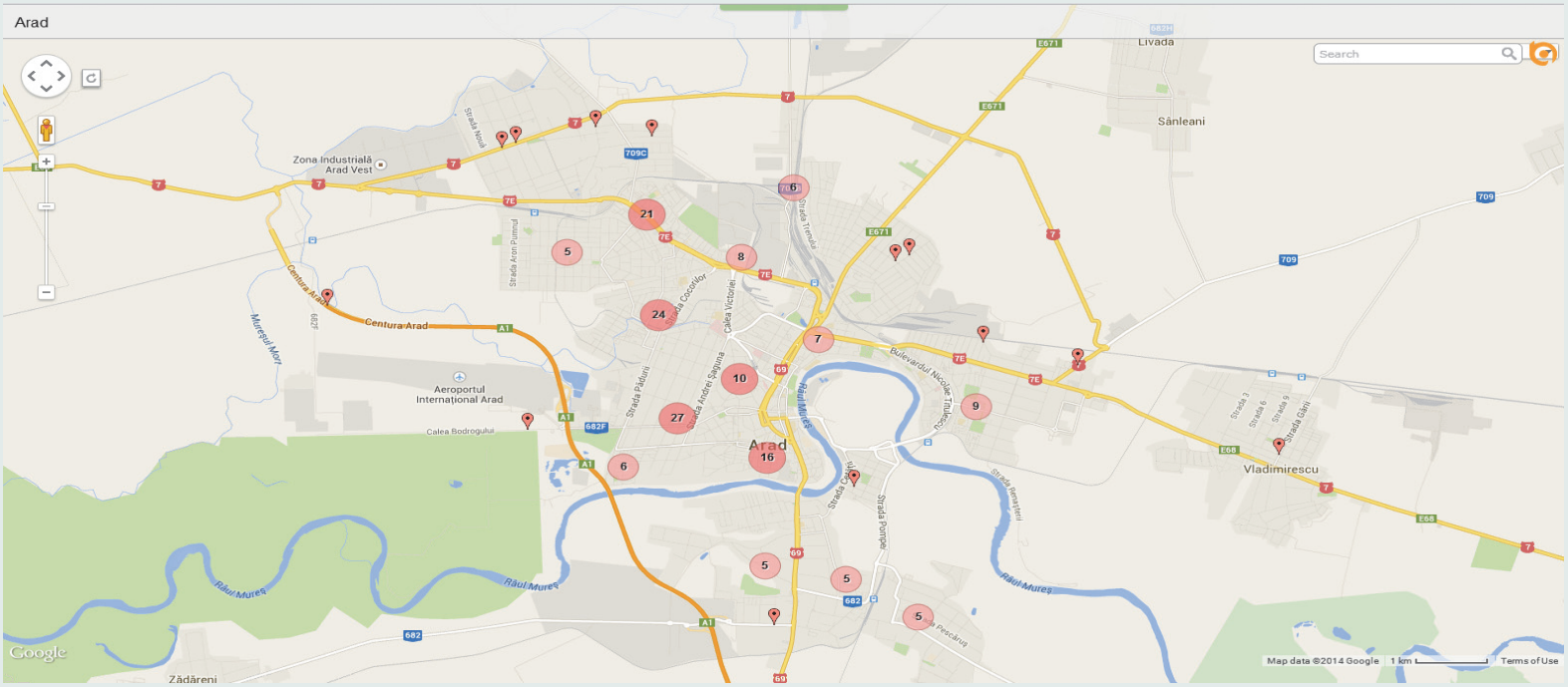
[194] The analysis was conducted only on those counties that systematically entered data into the CMTIS and on the mothers whose addresses were registered. The following counties were not included because the low number of cases in their territories would have made the analysis unreliable: Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu.

[195] Out of all 320 urban administrative-territorial units in the country.

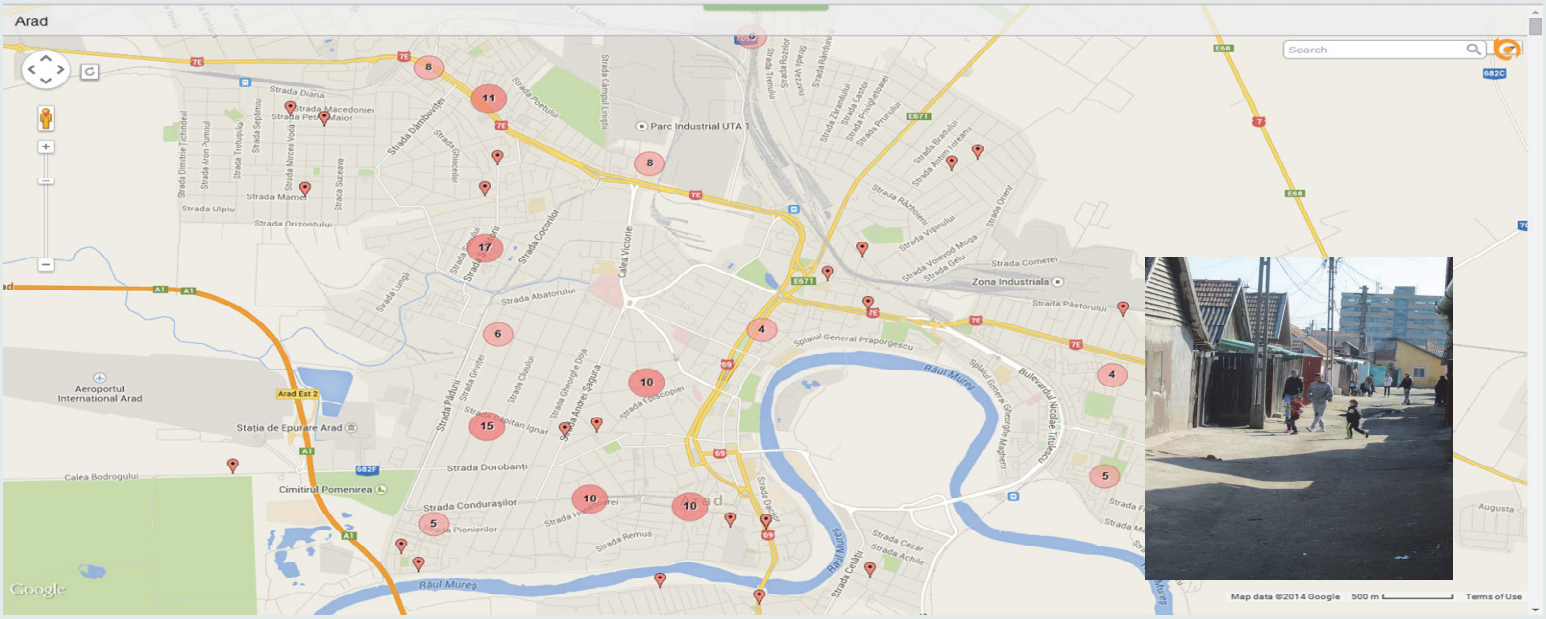
[196] Swinkels et al. (2014).

[197] Five case studies were performed of urban source communities in Arad, Bacău, Bârlad, Craiova, and Piatra Neamț. The case studies included maps and a total of 38 interviews with specialists and parents of children at risk of separation from their families or of children in the child protection system. Data collection was carried out by the Metro Media Transilvania company during April-June 2015. More details are available in Annex 2.

Map 2: Concentration of the Addresses of Mothers with Children in Public Care in Arad City

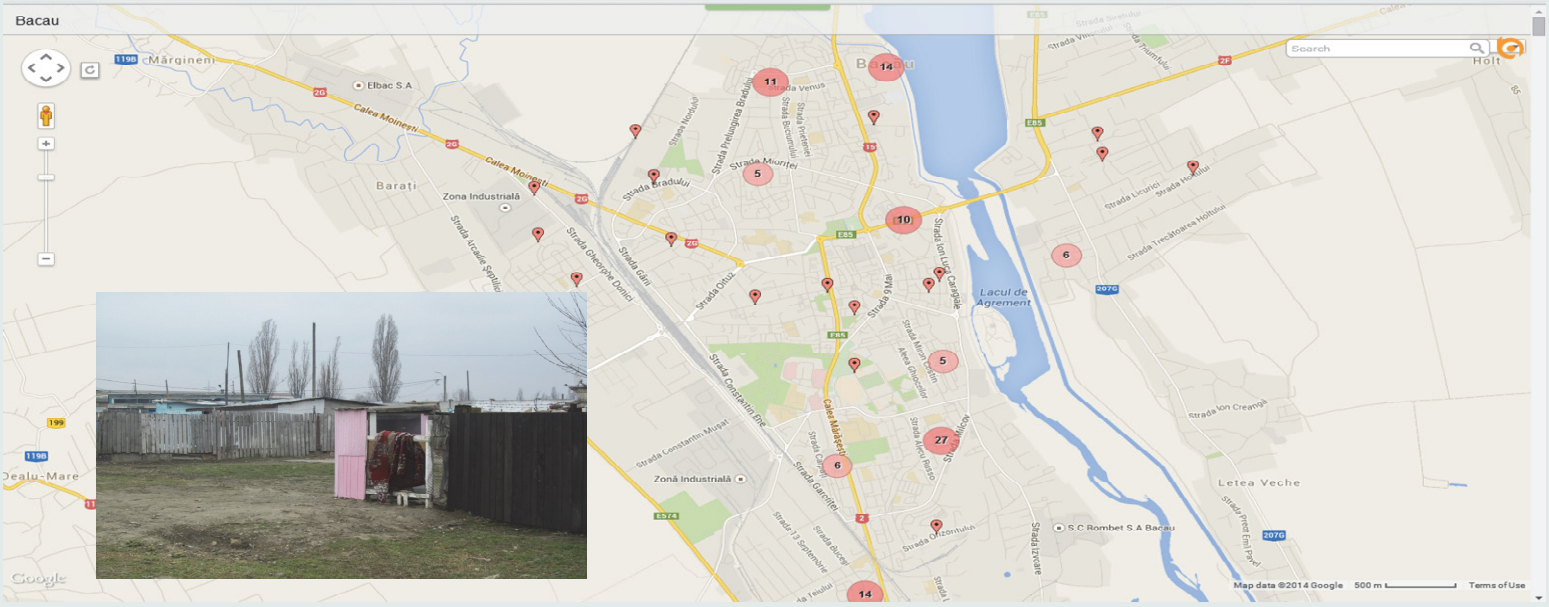


Map 3: Concentration of the Addresses of Mothers with Children in Public Care in Arad City: Close-up of One of the Areas Shown in the Previous Map



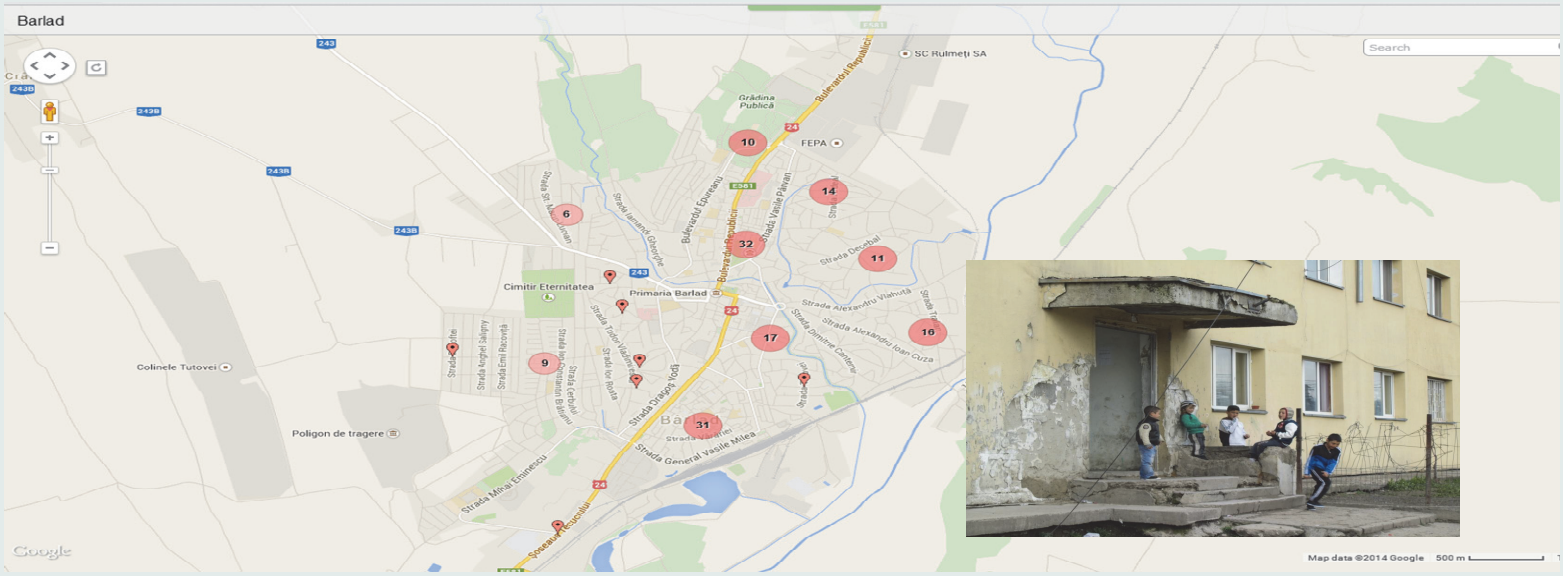
Source: Case study in Arad city: mapping of source communities and in-depth qualitative study (and photo) in Checheci community.

Map 4: Concentration of the Addresses of Mothers with Children in Public Care in Bacău City



Source: Case study in Bacău city: mapping of source communities and in-depth qualitative study in Izvoare (photo) and Vântului communities.

Map 5: Concentration of the Addresses of Mothers with Children in Public Care in Bârlad City



Source: Case study in Bârlad city: mapping of source communities and in-depth qualitative study in Podeni (photo) and Munteni communities.

The qualitative research conducted in Arad confirms that the area that is visible on Map 3 is a source community. This area (known as Checheci) comprises dilapidated houses situated in the center of Arad where a number of buildings were abandoned by their owners a while ago and were then illegally occupied by poor families. Although the community is situated in the middle of the city, most of the houses are not connected to utilities.

Map 4 depicts a similar situation in Bacău. The GIS representation of home addresses indicates the areas where mothers with children in public care are concentrated. These areas were confirmed and profiled through qualitative research. The area with the largest number of mothers (27) was a cluster of former dormitories for workers that had no baths or kitchens and many of which were disconnected from water or electricity because of unpaid debts to utility companies. The second largest community on the map was confirmed during fieldwork as Vântului community, populated mostly with (hetero-identified) Roma where some of the houses were built from cardboard, plastic, and other inadequate materials.

Arad and Bacău are large cities by Romanian standards. Nonetheless, some of the urban source communities are situated in small cities such as Bârlad (with fewer than 50,000 inhabitants as of the 2011 census). Map 5 shows that the situation in Bârlad is similar to that of Arad and Bacău, in that the home addresses of mothers with children in public care are concentrated in just a few areas with the two largest containing over 30 mothers each. One of these two areas used to be a block of flats with social dwellings called by the local people "The Ghetto", which was abandoned due to extreme degradation and the residents were relocated. The other area is a combination of houses occupied by Roma families and another block of flats with social housing. The qualitative research in source communities emphasized the high risk of social housing units becoming source communities for children in public care, specifically because they contain many children with multiple vulnerabilities who receive little help other than some low-level social benefits and accommodation in dreadful housing conditions.

Source Communities in Rural Areas

In the previous section we reported that mothers with children in public care are concentrated in particular urban areas, meaning that these are source communities for children in care. These areas largely overlap with marginalized communities identified as "poverty pockets" on the basis of census data, the occupants of which suffer from many disadvantages including precarious housing conditions and a lack of human capital and formal employment. We now aim to understand whether a similar pattern exists in the rural localities as well.

Our analysis of the data from the CMTIS indicated that mothers who have children in the child protection system are concentrated in a number of rural localities. Table 30 below shows that, of the 2,111 communes included in the analysis, 59 each have 16 or more mothers with children in the system, while there are 11 to 15 such mothers in each of another 103 localities. Although these 162 rural localities represent only 8 percent of the analyzed communes, they accounted for 28 percent of the children in public care as of 2014. Thus, it is clear that source communities for children in the protection system also exist in the rural environment. Furthermore, Table 30 shows that the reason why these source localities sent so many of their children into care is not related to their size as only 13 percent of all rural children live in these localities.

While in urban localities the connection between the number of children going into public care and development indicators at the locality level is not significant, the situation is different in rural areas. Irrespective of the locality's size, the source localities seem to have lower development indicators as measured by the Local Human Development Index (LHDI 2011)[198] as shown in Annex 6 Table 30.

[198] The LHDI measures the total capital of rural and urban administrative units in Romania on four dimensions: (i) human capital; (ii) health capital; (iii) vital capital; and (iv) material capital. Human capital is measured by education stock at the local level (for the population aged 10 years and over). Health capital is measured as life expectancy at birth at the local level. Vital capital is measured by the mean age of the adult population (those aged 18 years and over). Finally, material capital is assessed as a factor score of three specific indicators that focus on living standards: (i) the size of the dwelling

However, the gap in poverty rates between the source localities and other localities is not large, which raises the hypothesis that other factors may be more important than the overall development of the localities in explaining why so many children from these localities end up in the protection system.

Table 30: Distribution of Mothers with Children in Public Care in Rural Localities (Communes)

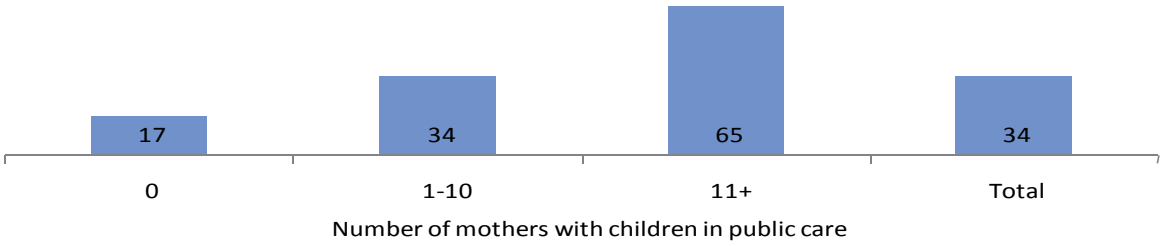
Number of mothers with children in public care	Number of localities	% of localities	% of children in public care	% of all children in rural areas
0	300	14	0	8
1-5	1,313	61	38	55
6-10	395	18	34	24
11-15	103	5	15	8
16+	59	3	13	5
Total	2,111	97	100	100

Source: CMTIS

Notes: The analysis excludes the counties with a low number of mothers with addresses recorded in CMTIS (Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu). Localities refer to administrative-territorial units.

Data at the commune level show a strong connection between the existence of at least one marginalized community within the locality and the number of mothers with children in public care. According to Figure 38, while only 17 percent of localities with no mothers with children in public care have at least one marginalized community, the probability that such a community exists is much higher for the communes with 11 or more of these mothers (65 percent). The relationship is also reinforced by the association between the percentage of people living in marginalized communities aggregated at the commune level and the number of mothers from the CMTIS aggregated at the same level (Annex 6 Table 31). For example, in rural localities with fewer than 2,000 inhabitants and more than 10 mothers with children in the system, an average of 27 percent of people live in marginalized communities, while in the localities of similar size but with no children in the system, the percentage of people who live in marginalized areas is, on average, only 2 percent.

Figure 38: Proportion of Communes with Marginalized Communities, by the Number of Mothers with Children in Public Care in the Commune (%)



Source: CMTIS

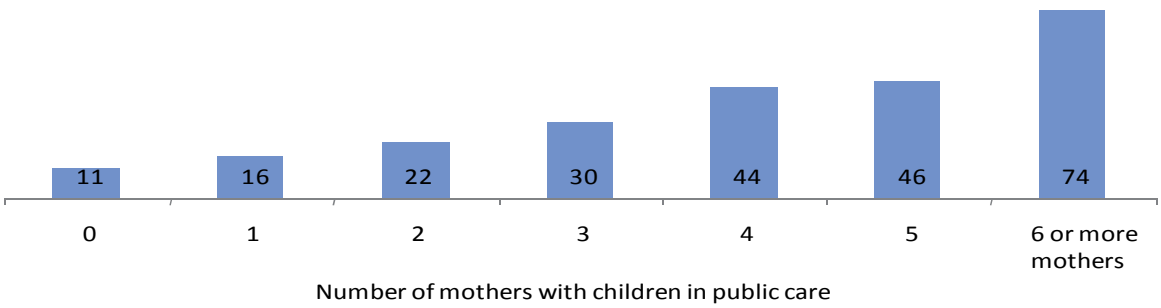
Note: The analysis excludes the counties with a low number of mothers with addresses recorded in CMTIS (Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași and Giurgiu).

The data indicate that the risk of children being separated from their families is concentrated at the village level. Considering that each commune may consist of several villages, it would be relevant to investigate the way in which the risk of separation is concentrated at village level. Sadly, the CMTIS contain data on the names of the villages for only 18 percent of the mothers registered in the

space; (ii) the number of private cars for every 1,000 residents; and (iii) the distribution of the use of gas for household consumption in the particular geographical unit. The four measures of the dimensions of community capital are aggregated by calculating another factor score. The index is determined based mainly on data from the 2011 Census (Ionescu-Heroiu et al., 2013).

database. To overcome this problem, for this specific analysis, we lowered the threshold for identifying the source communities at the village level, meaning that in reality villages with two or three mothers whose addresses are in the CMTIS may well contain many more mothers whose children are in public care. Figure 39 below clearly indicates that the higher the number of mothers with children in public care in a village, the higher the probability of a marginalized community existing there as well.

Figure 39: Proportion of Villages with Marginalized Communities, by Number of Mothers with Children in Public Care in the Village (%)



Source: CMTIS

Note: The analysis excludes the counties with a low number of mothers with addresses recorded in the CMTIS (Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu).

A significant number of rural localities have no social work services (SPAS) aimed at preventing the separation of children from their families. Unfortunately, there are no systematic and nationwide data regarding social services at locality level, but the census of SPAS social workers carried out by the World Bank in 2014 contains some information on the limited availability of services to people from source communities. According to this census data, only 31 percent of the rural localities included in the analysis have access to a professional social worker (Table 31). The percentage is slightly higher in localities where the number of mothers with children in public care is lower, but this may be explained by the fact that these localities are larger and that larger localities are more likely in general to have a social worker within the SPAS.

Table 31: Social Assistance Available at SPAS Level, by the Number of Mothers with Children in Public Care in the Commune (%)

	Number of mothers with children in public care in the commune			
	0	1-10	11+	Total
% of rural localities…				
SPAS with at least one professional social worker (with specialized higher education)	**26**	**33**	**31**	**31**
SPAS with no professional social worker but with a full-time social assistance worker	43	43	55	44
SPAS with no professional social worker and with only part-time social assistance workers	32	24	14	25
Average number of people with social assistance duties (professionals or not, full-time or part-time)	1.2	1.4	1.5	1.3

Source: SPAS Census (*Social Assistance Services at the Community Level*), conducted by the World Bank at the level of all mayoralties in Romania in May 2014 (Teșliuc, Grigoraș and Stănculescu, coord., 2015).

Story Bag

Have you noticed one or several areas in the city from where a higher number of kids come into public care? If yes, please describe the area and its specific features.

"- Yes, there is an area - in our day-to-day language we call it Checheci - it's an area mostly inhabited by Roma people [...] There are several streets and on each of them, several dwellings with unregulated legal status. That is, these houses were abandoned at some point, then illegally occupied by Roma families, and then abandoned again, and others are coming, and so on and so forth and their situation is quite serious, because there are no means to do something with that family and they don't want to leave the area. [...] We have many families from that area, and we had 50 families, with between one and eight or nine kids. [...] It's an area with many kids, Roma people, parents without a job, most of them leave off social welfare that they receive from us [DGASPC]. It's an extremely poor area, with an elevated crime rate, child abuse, children with problematic and eventually criminal behavior. These would be the main features."

(Interview with a local professional, Arad)

"- There are many areas like this [...] The next one is Victor Babeș Street. It's a block of flats comprised of one-room dwellings, that used to be owned by a former enterprise. And there, again, we have people... I mean, families living in a room. The kitchens and bathrooms are on the hallway. And they are overcrowded, all together in a room. The next example is the area of the bus station. The Bacău bus station is on the outskirts of the city. Also former dorms for single individuals, I don't know who used to own them. Nicu Enea street, that's it. These blocks of flats are organized similarly. That is, the bathroom is on the hallway; everything is shared. People who rent, that is, big families, most of them Roma, they rent and can't pay the rent, so the kids are brought here. [...] It's an area where you have people who used to be in prison, with criminal records. Quite often there are fights. So it's quite risky to go in and expose yourself in such a place...

- There is another street close to Nicu Enea, it's Vântului; and here you really have only Roma people who don't do anything, they don't even send their kids to school. These are big families, without jobs, they live from one day to the next, no stability, no future plans. That is, they don't have stability, don't have resources, they depend on social welfare, support from the municipality and this is what they expect in the future as well. These are the areas. They are not people with a stable life."

(Interview with a local professional, Bacău)

Story Bag

Have you noticed one or several areas in the city from where a higher number of kids come into public care? If yes, please describe the area and its specific features.

"There are some built houses, others are improvised, but most of them are made of clay bricks.. [...] The Roma population, because with the others we don't have so many problems. Many big families. Many kids in a family...the fact that...they don't use any contraception and they end up having kids, one every year, they can't take care of them, so they choose to give them to the system...[...] Bad living conditions, no job, no income.... No utilities, none whatsoever. Electricity - I don't know how legal it is, but they are directly connected to the poles. An uneducated population, with a low cultural level - not necessary related to education, because they can go to school - but they have certain ideas about life, hygiene, the moral norms and rules that should be obeyed. [...] Many are working abroad and the kids are left with the grandparents, the uncles, so they are a little out of [control]....for instance, most are criminals. This should also be mentioned. Many of the children who commit criminal deeds, juvenile delinquency, come from that area. They can't be held criminally liable, because they aren't old enough. Now, I don't know if the parents teach them this, or they just replicate their parents' behavior, because their parents also committed crimes and were convicted... These are the main features, in my opinion."

(Interview with a local professional, Craiova)

"You're living in this dorm room provided by the municipality, are you happy with it?

Not really. First of all, because it is not mine, then, it's really small, we share the bathroom, the kitchen... It's hard... Positive things? Hmmm... The area, because I live close to the school and can send the kid to school. I can't take him there in the morning, because I have to leave earlier to get to work. I leave him with a neighbor, who helps him cross the street. The same for the means of transportation - it is close. [...] My biggest problem is that I don't have a place of my own, where I could live and get back my two kids who are in child care. The financial status... I can't afford to pay rent."

(Interview with a parent with children in child care, Craiova)

Children in Public Care from Source Communities

Fourteen percent of children in public care (special protection) come from source communities. Based on the CMTIS data, the majority of them are from rural areas (60 percent). They come from all counties but are massively over-represented in Brașov, Constanța, Covasna, Sibiu, Vâlcea, and Vaslui (Annex 6 Table 32). Children from source communities are more likely to be boys than girls (54 percent) and are from all ethnic groups though with an above average proportion of Roma children (15 percent versus 10 percent).

Table 32: Incidence of Child Neglect, Abuse, or Exploitation in Source and Non-Source Communities (Rural or Urban) Before Children Enter the System (%)

Children from...	Children relinquished in maternity wards	Evidence of:				Total	
		Neglect	Abuse	Exploitation	Any form of violence	- %	- N
Source communities	28	34	11	3	36	100	7,403
Other communities	23	43	12	3	47	100	44,940
All children in public care	24	41	12	3	46	100	52,343

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

The descriptions of the source communities given by DGASPC and SPAS child protection professionals are very much in line with the results of the existing research in Romania on "extreme poverty" and "poor zones" or "marginalized areas" (see for example true stories 5a, 5b, and 5c from the previous Story Bag).[199] Keeping this is mind, the case files of children from source communities yielded surprising results. According to these data, children from source communities in both rural and urban areas have a below average risk of having disabilities, special educational needs, developmental delays, or behavioral problems.[200] There is also less evidence of neglect, abuse, or exploitation in their case files compared with those of children from other (non-source) communities. Child neglect was reported for 34 percent of children from source communities, which is lower than average, while rates of child abuse and child exploitation were at around the average. Overall, fewer children from source communities than average were reported as having experienced maltreatment before entering the system. Also, most individual-level risk factors[201] were not particularly evident among the parents and families of children from source communities.

Part of this is caused by the fact that many of these case files do not provide much information on the situation of the children before they entered the system, and there is even less information available for the children from the source communities. Another factor to be considered is the tendency of the child protection system to respond selectively/unevenly, intervening or accepting parents' requests for child placement only when it comes to children who are less affected by the general context of the ghetto, slum, or other type of marginalized area in which they live. For example, given the source community characteristics presented in the previous sections, it would have been reasonable to expect that the percentage of adolescents with conduct disorders from the source communities is higher than the percentage of adolescents in public care who came from other communities. But, as

[199] For example: Chelcea (2000), Stănculescu and Berevoescu (2004), Constantinescu et al. (2005), Berescu et al. (2007), Preda (2009), Stănculescu et al. (2010), Berescu (2010), Stănculescu and Marin (2012), Stănculescu et al. (2012), Stănculescu et al. (2013), and Swinkels et al. (2014). On Roma and Roma communities: Zamfir and Zamfir (1993), Rughiniş (2000), Zamfir and Preda (2002), Duminică and Preda (2003), Sandu (2005), Berescu et al. (2006), Bădescu et al. (2007), Fleck and Rughiniş (ed., 2008), Preoteasa et al. (2009), ICCV (2010), Botonogu (2011), Daragiu and Daragiu (2012), Giurcă (2012), Tarnovschi (ed., 2012), FRA et al (2012), Anan et al. (2014), Swinkels et al. (2014), and Teșliuc, Grigoraș and Stănculescu (coord.) (2015 and 2016).

[200] The corresponding proportions of children with various special needs are 7, 4, 15, and 7 percent respectively versus the average values of 11, 9, 17, and 10 percent.

[201] Including true orphans, dysfunctional families, parents abroad or institutionalized (in prison or in mental health institutions), parental disabilities and/or mental health problems, and parental promiscuous and/or criminal behavior.

mentioned above, the data shows this was not the case. There are several possible reasons for this unexpected finding. Children with behavioral problems from source communities may already be in jail[202] or they may have escaped the system or have simply not been targeted by specific interventions so they may be living on their own in these areas as homeless people or fugitives. A similar situation might exist with regard to child abuse. The fact that children from source communities do not have higher than average rates of child abuse is likely to be an indication of the system's lack of intervention in these communities as both the existing research and the child protection specialists have shown that abuse and violence (in all forms) is rife in these communities.

The following characteristics are typical of children from source communities who are in the child special protection system:

(i) A predominance of children who are fatherless when they enter the system (51 percent);

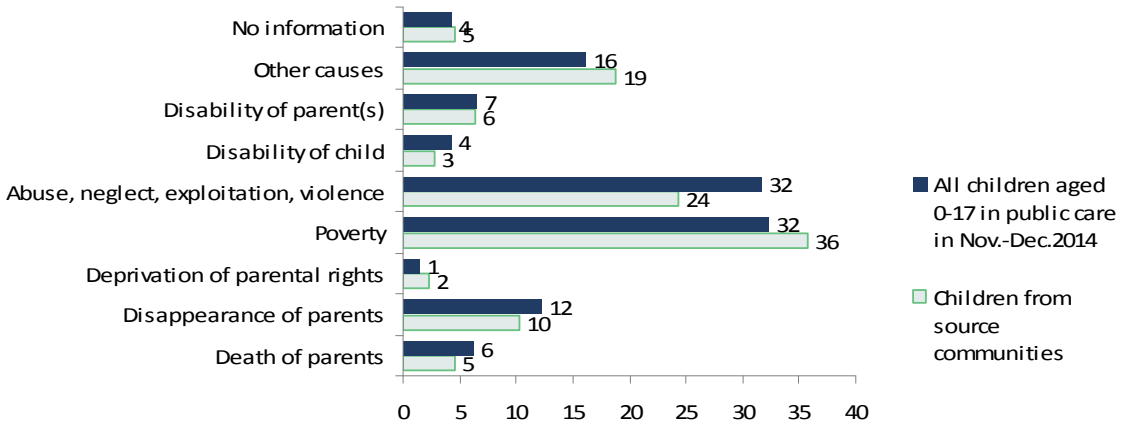
(ii) A relatively high proportion of mothers who are teenagers when their child enters the system (over 6 percent);

(iii) A high rate of parents deprived of their parental rights when the child enters the protection system (2.4 percent) versus the average of 1.4 percent for all children in public care;[203]

(iv) Parental alcohol abuse (primarily maternal and particularly in rural areas).

Children from source communities also have a relatively high risk of being relinquished straight after birth in maternity wards as well as later in other health units. Their families of origin are most often single-mother families living alone or together with relatives in a multigenerational household. However, in contradiction with the main characteristics of the source communities, most children in public care who come from these areas belong to families with one or two children and only 37 percent of them have siblings in the system (versus the average of 50 percent).

Figure 40: Main Cause of Separation in Case Files: Comparison between Children from Source Communities When They Enter the System and All Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care aged 0-17 years old, of which 7,404 children from source communities, rural or urban).

Note: The sum of bars per category is 115 percent and 110 percent respectively because some case files gave two to four causes of separation.

Children from the source communities are no more exposed to poverty than all of the other children in public care, which again is surprising. Eight percent of them had "poverty" recorded as sole cause of separation in their case files.[204]

[202] According to ANP (2014), in the third quarter of 2013, 2,400 children had committed criminal activities but were not imprisoned, and another 1,700 children in detention were counted in the statistics of the National Administration of Penitentiaries. In Romania, there are four prisons for juveniles (Bacău, Craiova, Tichilești, and Târgu Mureș) and three rehabilitation centers (Buziaș, Găiești, and Târgu Ocna).

[203] Children with unknown parents and true orphans were not included.

Nor are children from the source communities exposed to worse housing conditions than all of the other children in public care. Nonetheless, a significantly higher than average percentage of them had either "housing problems" or "housing problems and poverty" recorded as sole cause of separation in their case files.[205]

Accordingly, Figure 40 shows that the distribution of children from source communities by the causes of separation specified by the DGASPC professionals is also average, with one exception - the over-representation of "poverty" (sometimes sole cause, as shown previously).

In conclusion, children from source communities enter public care as a result of a rather selective/uneven process. This fact reinforces our earlier conclusion that the profile and causes of separation of children from the source communities do not accurately reflect their actual difficult and distressing situations but instead reflect the lack of interventions in the source communities and in marginalized areas in particular.

> *"And do you intervene in those communities that place many children in public care?*
>
> - Yes. Usually, we go to other places, as I've told you, where people are more open. In these areas [rural source communities], it's not that we don't work with the local authorities, but, given the economic development of these settlements, they can only do so much. And even if we intervened, the end result would only be taking the children into care." (Interview with a professional, Bacău)
>
> "- In those areas [ghetto], the only criterion based on which you can make, let's say, the decision about whether or not to take them is the emotional connection that the child has with the parent. Because they are all poor, all of them have nothing to eat, all of them are jobless and all of them lack electricity." (Focus group with professionals, Bucharest)

CONCLUSIONS & RECOMMENDATIONS

Five main conclusions can be drawn from the analysis of the source communities.

First, in both rural and urban areas, priority preventive measures can be targeted to communities with a higher risk of children being separated from their parents because such communities do exist and can be identified. There is a considerable need for such interventions in the source communities, which is known to the child protection workers. Nonetheless, this considerable need is somehow overlooked and is not acknowledged as a high priority. The response of the child protection system has been limited to cases of relinquishment in maternity wards or other health units, and there are no intensive interventions directly targeted to these areas. No work is done with parents or the community. Therefore, many children from source communities are not properly protected nor given support to help them break the intergenerational cycle transmitted from their parents. Children living in these source communities are in urgent need of intensive interventions.

Second, the Atlas of Rural Marginalized Areas[206] is proving to be a useful instrument not only for identifying extreme poverty but for identifying source communities as well.

Third, further research is needed to determine if the urban pockets of poverty and exclusion identified within census sectors in the Atlas of Urban Marginalized Areas[207] would be an effective targeting category for the urban source communities for the child protection system. To achieve this aim, data on the home addresses of the mothers or families of children in public care should be improved (updated, supplemented, extended) and should be linked to the census tools used in the 2011 census.

Fourth, preventive measures and targeted interventions for both the rural and urban source communities need to be developed and implemented nationwide. In this respect, it may be feasible and useful to use innovative technology such as the prototype online software Aurora that has been developed by UNICEF for identifying and carrying out needs assessment for children at risk of separation.

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[204] On average, 7 percent of children in public care have poverty as the sole justification for their separation from their families.

[205] On average, 3 percent of children in public care have these sole justifications for their separation from their families.

[206] Teșliuc, Grigoraș and Stănculescu (coord.) (2016).

[207] Swinkels et al. (2014).

Fifth, updating and extending the information in the CMTIS and similar management information systems with regard to the relatives of children in public care and their addresses will significantly improve the targeting of preventive interventions at the community level.

3.2.5.4 Lacking or Under-developed Prevention Services at the Community Level

This section focuses on "community-based services", which, in line with the European Expert Group on the Transition from Institutional to Community-based Care, this report defined as the spectrum of services that enable children to grow up in a family environment as opposed to an institution. "It encompasses mainstream services, such as housing, healthcare, education, employment, culture, and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support. It also refers to specialized services, such as personal assistance for people with disabilities, respite care, and others."[208] Social housing services have been discussed under a previous section so the following sections focus on social assistance, healthcare, and education services as well as on specialized services for vulnerable groups.

Community-based Social Assistance Services

A previous section has shown that the families of children in public care had little access to social benefits before their children's entry into the system. This section looks at their access to social assistance within their communities by analyzing the social assessments that were performed before their entry into the system in the communities from which they were actually taken. These assessments are included in the children's case files.

It is useful to recall that, among all the children in public care, 56 percent come from urban areas, 43 percent come from rural areas, and almost 1 percent come from other countries[209] or from somewhere unspecified within Romania. The case files of most children in public care contain one or two social assessments, but one in every ten children does not have such a social assessment.

Figure 41 shows that almost all children taken into care from rural areas have a social assessment (98 to 99 percent), generally performed by a SPAS representative. When the SPAS representative was just an employee with social assistance duties (with no specialized training in the field), DGASPC professionals tended to add their own social assessment more frequently than when the SPAS representative was an actual social worker (24 percent versus 13 percent). As for the children taken into care from urban areas (in the country or abroad), approximately 85 percent had a social assessment, half of whom only had an assessment conducted by a SPAS representative while the others also had assessments conducted by the DGASPC or accredited private organizations providing child protection services (OPAs).

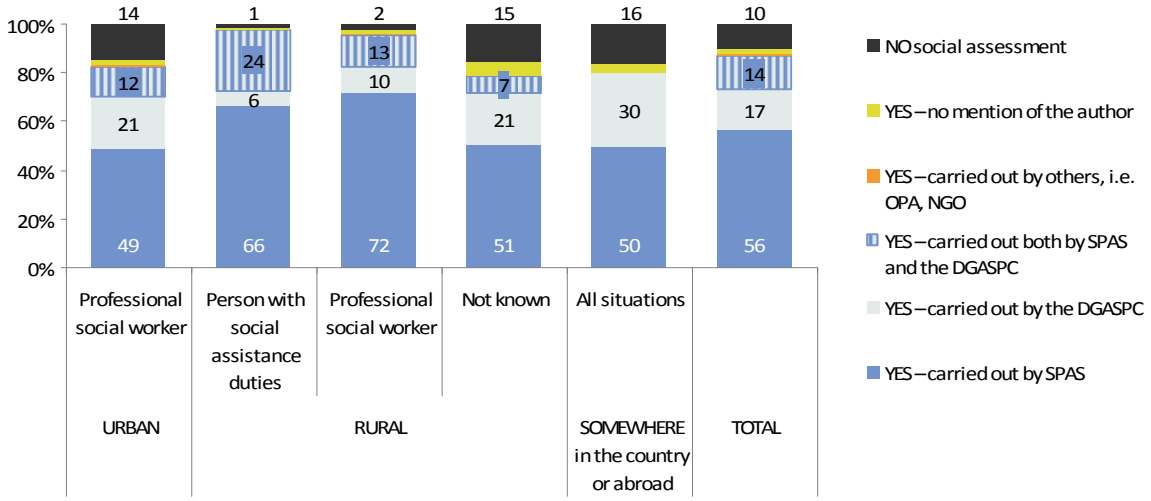
Social assessments carried out by DGASPC representatives (sometimes in addition to those conducted by local SPAS) were more frequent for those children who came from the source communities (see Annex 6 Figure 5). One possible explanation for this is the limited intervention of local SPAS in the source communities, but mostly it is due to the over-representation of children who entered the system after being relinquished in maternity wards or other health facilities among those from these communities in both rural and urban areas. Annex 6 Figure 6 reveals that social assessments conducted by the DGASPC were much more common for children in the case of these very routes and especially street routes. For example, a quarter of the files of the street children who were taken into care do not include a social assessment, a quarter contained a social assessment conducted by the

[208] The term includes family-based or family-like care for children, including substitute family care and preventive measures for early intervention and family support (EEG, Deinstitutionalization Terminology, https://deinstitutionalisation.com/terminology/).

[209] The countries mentioned in the case files include: Italy, Spain, Hungary, Turkey, Serbia, Greece, Poland, and Germany.

SPAS, 31 percent had a DGASPC assessment, 12 percent included assessments carried out by both the SPAS and the DGASPC, and 7 percent featured social assessments whose author is unknown. By comparison, almost all the children (over 95 percent) who ended up in the system straight from their families (with stable dwelling) or from their relatives had social assessments, of which about two-thirds were conducted by the SPAS, 10 to 15 percent by the DGASPC, and the remaining 16 to 19 percent were carried out by both the SPAS and the DGASPC.

Figure 41: Distribution of Children in Public Care, by the Existence of a Social Assessment in the Case File, by Area of Residence, and by the Entity that Carried Out the Assessment(s) (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

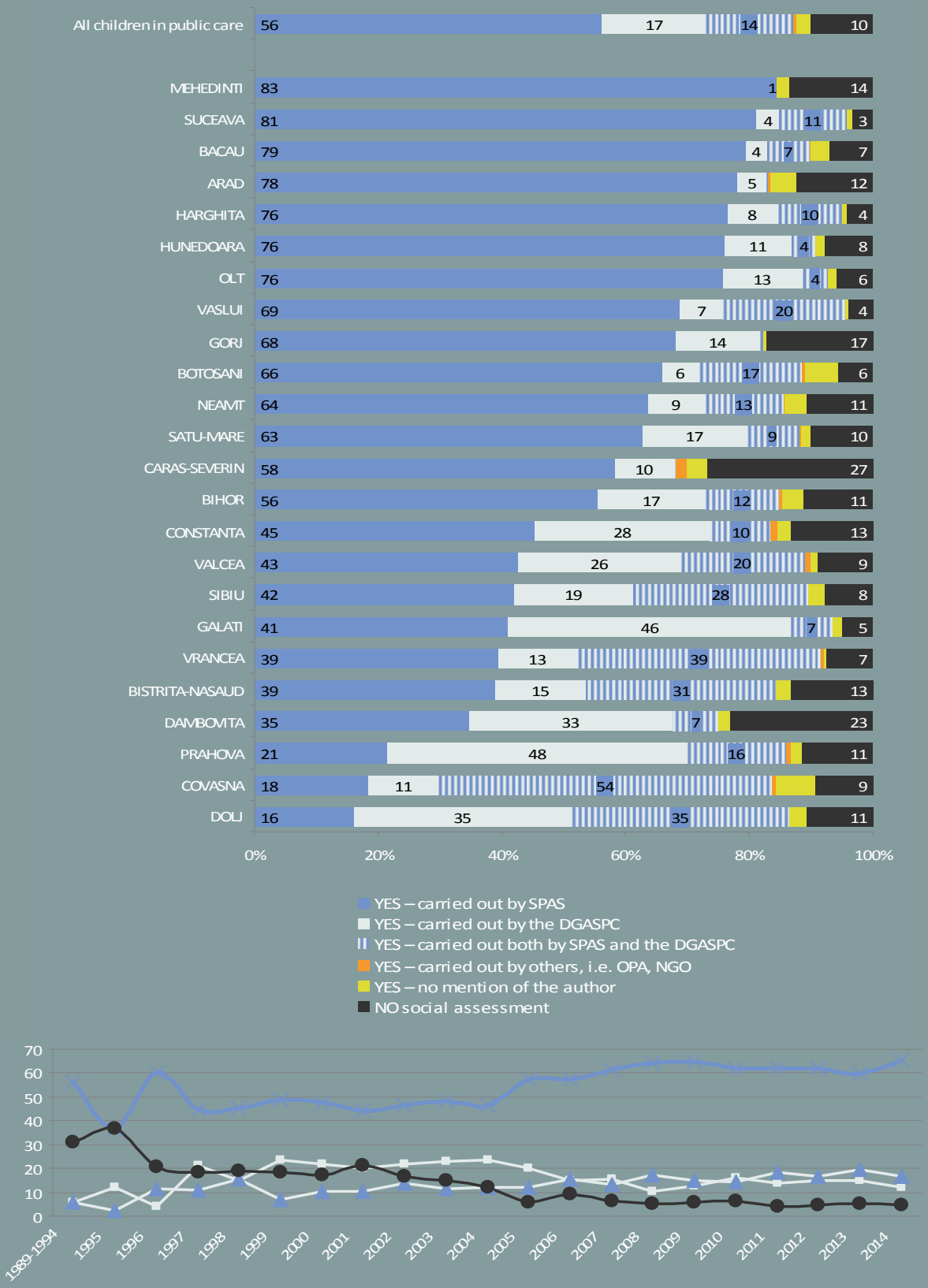
Note: Children from rural areas with no SPAS-related details are mostly children taken into care from urban areas, usually from health units or off the street.

Figure 42 (top chart) shows how the social assessments carried out for children in public care varied considerably between counties. In Mehedinți county, the SPAS produced the social assessment for 83 percent of the cases while the DGASPC produced assessments for only 1 percent of all children, all of which supplemented social assessments conducted by SPAS. However, the situation in the county of Dolj is the opposite, with 16 percent of children having SPAS assessments and 70 percent of children having DGASPC inquiries, half of which supplemented social assessments conducted by the SPAS. In Suceava, Harghita, Vaslui, and Galați, the share of children with no social assessment is less than 5 percent, whereas in Dâmbovița and Caraș-Severin, the corresponding rate is almost five times higher (23 to 27 percent).

Figure 42 (bottom chart) illustrates how the documentation of children's circumstances prior to their entry into public care has changed over time. The share of children with a social assessment conducted by a SPAS (whether or not accompanied by a DGASPC assessment) increased[210] while the share of children with no social assessment in their case file decreased more than fourfold from 20 percent in 1995 to 1999 to 4-5 percent in 2011 to 2014.

[210] The share of children with a social inquiry conducted by SPAS rose from nearly 50 percent in the late 1990s to 65 percent in 2014, and the share of children with social assessments carried out by both SPAS and the DGASPC increased from 10 percent to 16-19 percent over the period 2011 to 2014.

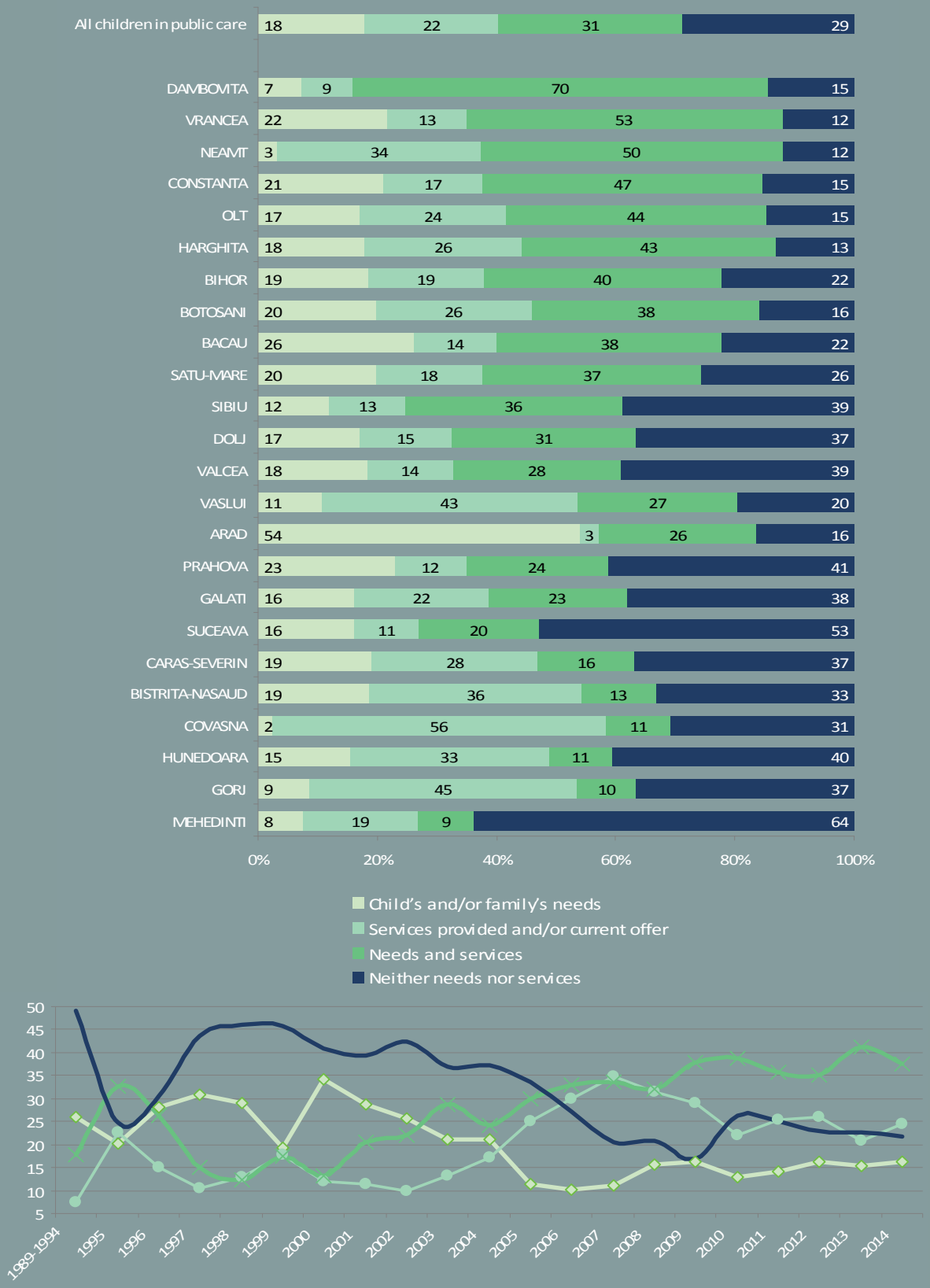
Figure 42: Inclusion of a Social Assessment in Case Files by the Institution that Conducted It, by County (top) and by the Year when the Child Entered Public Care (bottom) (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted; for the top chart, only the 24 counties with solid data in the CMTIS are considered (N=50,670); for the bottom chart (N=52,344).

Note: OPA = Accredited private organization providing child protection services.

Figure 43: Quality of Social Assessments from the Case Files, by County (top) and the Year when the Child Entered Public Care (bottom) (% Children with Social Assessments in their Case Files)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted; for the top chart, only the 24 counties with solid data in the CMTIS are considered (N=45,737 children with social assessment reports in their case files); for the bottom chart, N=47,134 children with social assessment reports in their case files).

The social assessment report should contain data of good quality, meaning that it has to provide the necessary information to give a clear picture of the children's circumstances and those of their families as required to develop an individualized protection plan (PIP) for the child. To this end, the assessment should identify the child's and family's needs and the services that the community offered and the services that it provided before the child was separated from the family and entered public care. Without such information, the social assessment report provides only clues about the child and family, which, as already seen in the previous chapters, are already poorly documented from many perspectives (for example, the health of the children and their mothers and fathers and the family's income and housing) and does not enable the child protection professional to draw up an effective protection plan for the child.

We evaluated the social assessments included in the case files of children in public care based on their quality. In this evaluation, we defined a quality social assessment report as being one that simultaneously covers, even partially, child's and family's needs and the services provided in the community of origin.

We found that, out of all children in public care, 10 percent had no social assessment report and 90 percent had one or two such reports before entering the system. However, for 26 percent of them, their social assessment report provided no key information (either about their needs or about the services available in the community), 36 percent of the social assessments addressed only one component (either needs or services), and only 28 percent of them offered a full picture (even if based on partial information).

We further analyzed the quality of the social assessments and of the information that they provide. Annex 6 Table 33 shows that the quality of these reports varies in several respects.

The share of quality social assessment reports is the highest (42 percent) in those cases where the SPAS assessments are supplemented by DGASPC assessments. In the case of the children with two social assessment reports, a relatively small share (18 percent) of inquiries offer no key information (either about needs or about the response at the community level). With regard to private service providers (NGOs and OPAs), the share of quality social assessments is low (only 13 percent) as they tend to focus exclusively on the child's and/or family's needs (31 percent) or on providing less relevant information (37 percent), though these account for less than 1 percent of all of the social assessment reports from the case files of children in public care.

In terms of quality, there are no significant differences between the social assessment reports conducted within SPAS by social workers and those carried out by the employees with social assistance duties with no specialized training in the field. We believe this surprising finding reflects the absence of a mandate requiring SPAS to conduct comprehensive inquiries into the child's situation, including any support that the child and/or family received within the community before the child was separated from family and entered public care.

Also, there are no significant differences in terms of quality between the assessments carried out in rural and urban areas, although the SPAS in urban areas are much better equipped with human and financial resources and can provide a much wider range of responses than those in rural areas. The rural assessments are more likely to highlight the offer of existing services and/or the services provided at the community level to prevent children from being separated from their families.

Children from source communities are more likely to have quality social assessment reports (32 percent versus 21 percent of children from other communities) as they are more likely to have two assessments, one conducted by the SPAS and another one carried out by DGASPC representatives. On the other hand, the assessments for children from other communities are twice as likely to identify the services provided to the children prior to their entry into public care (38 percent versus 20 percent of children from source communities).

We found significant differences in the quality of social assessment reports according to the route by which the child came into public care. The share of quality reports is above average for the children whose mothers were institutionalized, those with mothers or families with unstable accommodation (homeless, evicted, or living wherever they could), and those from families with a stable home. The

share of poorly documented reports (those offering no information on either needs or services) was above average (35 to 43 percent) for the children who were relinquished in maternity wards or other health units, those who were in the care of people other than their family or relatives before entering the system, and street children.

Figure 43 (top chart) provides additional information and highlights major discrepancies between counties. It shows that the share of quality social assessment reports varies between 70 percent in Dâmbovița and only 10 percent in Mehedinți. In other words, in Mehedinți, SPAS reports are prevalent in the case files of children in public care (80 percent), but only one in ten of them mentions not only the child's and/or the family's needs but also the services offered or provided to them at the community level before the child entered the system. The vast majority (64 percent) give none of the key information needed to develop effective intervention plans.

Nevertheless, the quality of social assessment reports greatly improved from 1989 to 2014. According to Figure 43 (bottom chart), the number of quality assessments more than tripled after 2009 versus the late 1990s. Over the same period, the share of social assessment reports that were missing key information (on either needs or services) dropped by half.

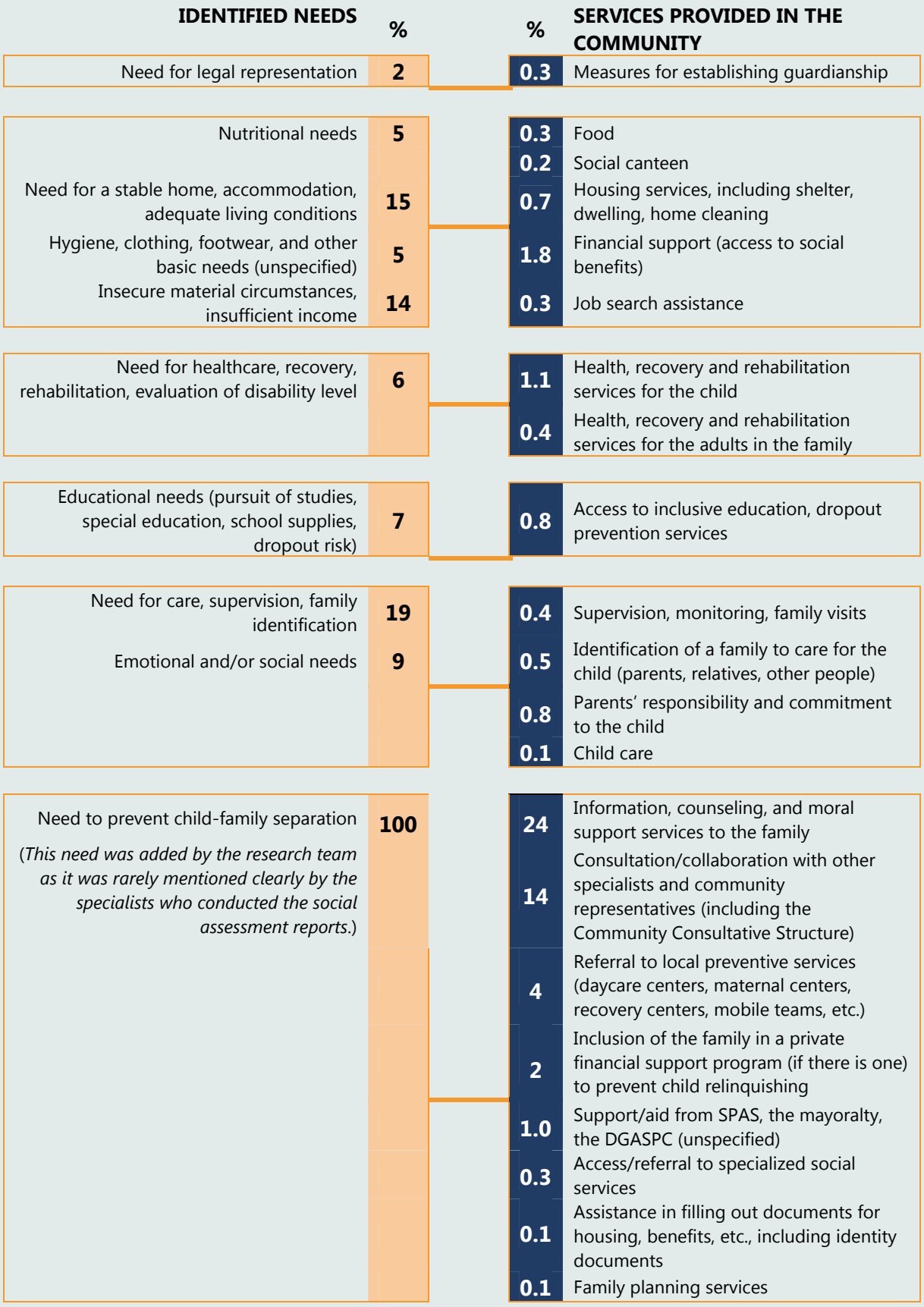
We then moved on to analyze the available information in the social assessment reports. Social assessments are available in the case files of 90 percent of children in public care, but only half of them provide information about the child's and/or family's needs prior to the child's entry into the system, as shown in Annex 6 Table 34. Even where the assessments identified these needs, almost all of them focused on the child and only about half of them also identified the family's needs. This was partly due to a lack of information about the family as often happens in the case of children relinquished in health units or street children.

Others, however, reflect the tendency of many SPAS and DGASPC representatives to look at the child separately from the family. Information about the family's needs is available for only about a quarter of the children taken into care straight from their family (with stable housing). For the children taken into care from relatives, the rate drops to less than 20 percent. The only two situations where family needs are identified in approximately half of the cases are those related to children with institutionalized mothers and those with mothers/families with unstable housing (homeless, evicted, or living wherever they can). Notably, during the qualitative research, some DGASPC professionals drew attention to this tendency to focus on the child separately from the family, an approach which conflicts with the main objective of preventing and addressing children's separation from their family.

> "I just want to add something which I think is very important. Many times, we, all these child protection services, focus exclusively on the child. Very often, we offer services only to the child. I think that, many times, you have to work with the parents in order to get something for the child. As it has been pointed out here, parents are the ones who won't or can't, so it's their failing that things are not going well for the child. Despite this, we don't focus on and we don't have enough services for parents and families like, for example, parenting classes or different forms of support. I mean, so many times we are all asked to be good parents, but no one prepares us for this role. I mean in general, but I'm basically thinking of problematic cases. I don't necessarily think that all parents in Romania should be included in a parenting program; I am talking about at-risk situations or parents who are unable to…" (Focus group with professionals, Cluj-Napoca).

The quality of the information in the social assessments on the needs of the children and/or their families is poor because the specialists or social workers who conducted the assessments had widely different definitions of these "needs." Only about two-thirds of all answers mention needs. The remaining one-third of the answers repeat the reason(s) for the child-family separation, mention a protective measure or service, or give a generic response such as "the need for special protection" or "upbringing, education, and development conditions." The distribution of children with social assessment reports available in their case files based on the identified needs is shown in Figure 44, though the need for preventing the child-family separation was added by the research team as it was very rarely specified in a clear manner by the specialists who conducted the social assessment reports.

Figure 44: The Needs of the Child and/or Family Versus the Services Provided in the Community Before the Child Entered Public Care (% of Children with Social Assessments in their Case Files)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=47,134 children with social assessments in their case files). On this topic, the questionnaire used open-ended questions.

Fewer than one in five assessments indicated what services had been offered or were available in the community that could meet the needs of the child and/or family (Annex 6 Table 34). Moreover, only half of the assessments even referred to services, with the other half referring instead to the reasons for separation, the child or family's needs, or the different protective measures or services in which the children were placed after they entered the system. These results clearly show that, before children are separated from their families and enter public care, either very few services are available (mainly in rural areas) or child protection professionals do not make enough of an effort to identify services in the community that may provide an alternative to the separation (mostly in medium-sized and big towns where various services are available).

About 40 percent of all social assessment reports were accompanied by a service plan (Annex 6 Table 34). According to Order 286/2006,[211] a service plan should be drawn up by a prevention case officer appointed by SPAS and, where applicable, the DGASPC to prevent the child's separation from his or her parents in the following circumstances: (i) for children at risk of being relinquished by their parents; (ii) for children reintegrated into their families after the termination of the protective measure; and (iii) in any situation requiring the delivery of benefits and/or services to ensure the fulfillment of children's rights. Under these circumstances, the fact that a preventive service plan was prepared for only 40 percent of children before entering the system shows that the applicable regulations are not being fully enforced.

Service plans were more common for rural children than for urban children (46 percent versus 35 percent, with an average of 40 percent) as well as being more common for children from source communities than for those from other communities (49 percent versus 34 percent). Furthermore, service plans were more likely to accompany the social assessments conducted by employees with social assistance duties (within commune-level SPAS) than those carried out by social workers (46 percent versus 39 percent). Also, service plans existed for more than half of the children who had two assessments, one carried out by SPAS and one by the DGASPC.

The greatest number of service plans existed for children taken into care straight from their families (with stable housing) or from relatives, and the fewest were for children taken into care from other caregivers and for street children.

As the service plan only became a requirement starting 2006, fewer than 20 percent of the children who entered the system prior to that year had a service plan while the rate went up to 50-55 percent after 2006. However, starting 2010, the share of children with a service plan dropped to 45-50 percent (Annex 6 Figure 7). In general, the service plan regulation is selectively enforced at the county level, with rates varying from around 20 percent of children in Arad, Dâmbovița, and Suceava to rates that are more than three times higher in Harghita, Vaslui, and, especially, Neamț (Annex 6 Table 35). The absence of a preventive service plan before the child's entry into the system was also discussed by the professionals who took part in the qualitative research.

> "- In urban areas, I think that the mayoralties..., as far as I could see from our collaboration with them, don't comply with the law regarding the service plan.
>
> - They don't have specialists.
>
> - They don't abide by the law, so no... The service plan is a plan whereby I, as mayor, set... take some measures to prevent children's institutionalization. Well, I don't know if there are ten mayoralties across the county, well, except for Ploiești where things are as they should be, especially in urban areas they are not adequately trained and there is no...
>
> - They lack specialized staff.
>
> - And interest. Some cases have been known for years and are referred to us as emergencies. So, you can't get your head around this, the mayor, the counselors and the secretary, everybody in the community... the schoolteacher, the priest, and everybody is aware of that family's circumstances and they come to you, after ten years, and say: "Well, I can't feed my child

[211] Order approving the methodological rules for service plan development and the methodological rules for individualized protection plan development, published in the Official Gazette, Part I No. 656 of 28/07/2006.

anymore". And I think those parents are not informed about the available benefits or given any aid. I mean, they take no action, not even measures that require nothing from the mayoralty.

- No. On the contrary, they send them straight to us. So, lately, we have been dealing with many cases like that where mayoralties refer all the social cases to the Directorate for Social Assistance and Child Protection. They know how to send that person to us. They don't offer adequate information and instead they immediately give them our address for us to handle the case.

- Well, they don't offer information because they don't know it, they really don't know it. Some mayoralties called and asked us. This is a fortunate case because they called and asked, but most of the times they refer the cases to us even if they are not within our area of expertise. Even in the communities where the mayoralties have specialists, there are two to three specialists like trained social workers, but they don't necessarily know what the're supposed to be doing." (Focus group with professionals, Ploieşti)

Let us now move from the service offer and the service plan to the services actually provided to children in public care and to their families prior to the child's separation from the family and entry into care. Annex 6 Table 34 shows that only 33 percent of all children with social assessments received any (one to five) preventive services, and most children received counseling and information or collaborative support from different social stakeholders such as medical staff, teachers, the police, the priest, and other representatives of the Community Consultative Structure. Therefore, only one in three children and their families received any support from the services available in their communities before ending up in public care. If we consider all children in public care, with or without a social assessment in their case file, the share of children who received some kind of preventive service goes down to 29 percent.[212]

First, we found a major gap between the child's/family's needs and the preventive services provided in the community, even when we narrowed our focus down to the identified needs as shown in Figure 44. Five percent of the children with social assessments in their case files were identified as having nutritional needs, but only 0.5 percent of the children, that is just one-tenth of those in need, received any food aid or free/cheap meals at a social canteen.[213] Nearly 15 percent of children had housing needs and only 0.7 percent received support, which is less than the 20th percentile. About 14 percent were identified as being at risk of income poverty (because of being in a household in insecure material circumstances and with insufficient income). Although most of these children were eligible for social benefits, as discussed in a previous section, only very few of them were given any help to access the benefits and/or get a job.

Second, we looked at the main characteristics of those children and families who benefited from services provided within the community to prevent children's separation from their families. According to their social assessments, rural children received preventive services more frequently than those living in urban areas (36 percent versus 30 percent). Other categories of children/families who were commonly reported to have benefited from preventive services were:

- Children with institutionalized mothers, those with mothers/families with unstable housing (homeless, evicted, or living wherever they could), and those taken into care straight from their families (with stable dwelling);
- Children who were older than 10 years when they entered the system, and their families;
- Children and families of Romanian or Hungarian ethnicity and, to a lesser extent, those of Roma or undeclared ethnicity (over 35 percent versus about 27-30 percent);
- Families with both parents at home, who were older than 25 years of age when the child entered the system, and who had at least three children;

[212] These data match the findings of a study conducted by the Federation of Child Protection NGOs (FONPC) in 2012 according to which in 2010, of all children assisted by SPAS, only 24 percent received services, while the others received only cash benefits, despite their being children at risk of separation from their family.

[213] The data on social benefits included in Figure 44 do not match the data on social benefits that emerged from the income analysis (see Annex 6 Table 25).

- Mothers with average educational attainment (the share of children whose case files show that they received community-based preventive services goes up from 33 percent for those whose mothers completed primary education at most to 36 percent for those whose mothers have 5 to 8 grades of schooling, and to about 40 percent for those whose mothers completed a vocational/apprentice school or 9 to 10 grades of schooling);
- Children with no disabilities or developmental delays;
- Children aged 6 to 17 years with special educational needs (SEN), as well as those with behavioral disorders (45 percent and 51 percent respectively, versus an average of 41 percent for all children aged 6-17);
- Children exposed to neglect, abuse, and/or exploitation;
- Dysfunctional families (as defined in Section 3.2.3.2) affected by the alcohol abuse of one or both parents;
- Families that include an adult member other than the parent who had troubles with the police and/or a criminal record;
- Families where both parents and/or an adult member other than the parent have disabilities, a chronic illness, and/or mental health problems.

Third, as Annex 6 Table 34 shows, we found that a quality social assessment report, especially if accompanied by a service plan, increased the likelihood that the family and child had received help and support within the community. This is because the process of conducting a social assessment for a particular child makes local stakeholders more aware of the need to step in before referring the case to the DGASPC.[214] At present, not only is there little interest in conducting a quality social assessment and designing a preventive service plan, but also "mayoralties and institutions play fast and loose"[215] and ask the DGASPC for an emergency placement in order to renege, as much as possible, on their own responsibility to intervene.

> "- But mayoralties and institutions play fast and loose; they come to us with the emergency. So, if we do the math and consider all things, in the past years I think that a share of… I don't want to exaggerate because I don't have any statistics, but I think that only ten percent of the cases get to us after an attempt to deliver some services to keep the child with the family. No, most of them get here as an emergency and we are caught off guard. Why? After you place your child in care you can no longer..., the family is no longer motivated unless they really couldn't keep the child.
>
> *But then efforts should be made to reintegrate the child immediately after his or her entry into public care, right?*
>
> - Yes, but the damage has already been done, the child has been separated from the family. You see what happens, once the parents get rid of the child, some parents don't want to give them up for adoption either, most cases are like that, you know, they don't want to take them home and they let the state take care of them for as long as possible." (Focus group with professionals, Cluj-Napoca)

More generally, the child protection specialists stated that, within the communities, social assistance is too often strictly limited to the provision of financial benefits[216] with no preventive or counseling activities targeted to people or families with social vulnerabilities. In the opinion of many DGASPC representatives, this is one of the structural causes of children's separation from their families.

[214] For example, in the case of children with two social assessments (by the SPAS and the DGASPC), the likelihood of the family/child having received community-based preventive services before the child entered the system goes up to 51 percent from an average of 33 percent. Also, in the case of children with service plans, the likelihood of the family/child having received community-based preventive services before entering public care is 56 percent.

[215] Focus group with professionals, Cluj-Napoca.

[216] This usually involves preparing the files, keeping track of monthly payments, and making house visits, generally in order to cross-check the information in the case files.

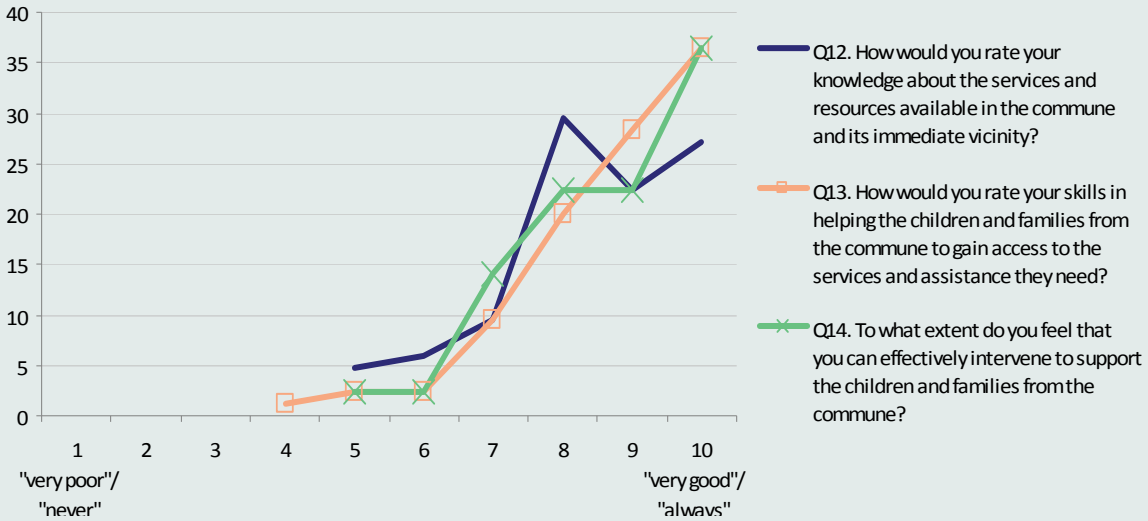
"And, again, I go back to what I initially said: specialized public services, other than filling in some papers related to benefits, don't provide any kind of social assistance. This is our starting point. And, to a great extent, this is why county directorates, especially those from Bucharest districts, are working at full capacity or have exceeded their capacity by 50 percent." (Focus group with professionals, Bucharest)

"I believe a distinction should be made: social assistance comprises both benefits and social services. Unfortunately, I think that sometimes a lot of focus has been placed on benefits, which are useful up to a certain point, but then they [the beneficiaries] may become dependent on social support and many of them, just like Mrs. A was saying, without those services provided by the mayoralty which should somewhat motivate, counsel, and lift them out of that social incapacity, remain trapped in their deprivation and that's how children end up in the system. The idea is to get them out of that situation because as years go by, if we look at the statistics we can see that, at the Caritas level and in the DGASPC law, the figures are consistent, nothing has changed." (Focus group with professionals, Timișoara)

FROM RURAL SOURCE COMMUNITIES

SPAS representatives (whether professional social workers or not), at least those from the communes with source communities, seemed to disagree with these opinions expressed by the DGASPC representatives. They believed that their knowledge of the households with children in public care are "good" or "very good." On a scale of 1 to 10, 72 percent of the SPAS representatives rated their knowledge of these households as between 8 and 10 (in other words "very good"). This percentage varied from 89 percent for children from households where the mother or the main caregiver is still present,[217] 87 percent for children from households still present in the community,[218] 53 percent for children whose households of origin are still present but the mother is absent and only 39 percent for the children whose family members have left the commune (data according to the Social assistance data sheets from rural source communities, July-August 2015. Data are not weighted – N=85 SPAS representatives from the 60 communes with source communities, regarding 1,263 children in public care).

Figure 45: Self-evaluation of SPAS Representatives on Social Assistance Activities in Rural Source Communities (%)



Source: Social Assistance Data Sheets from Rural Source Communities (July-August 2015). Data are not weighted (N=85 SPAS representatives from the 60 communes with source communities).

[217] The mother or the main caregiver of the child/children in public care was present in the household for 53 percent of children and was absent or had left the household for the other 47 percent of children.

[218] The household of origin still existed in the commune for 72 percent of children in public care.

Also, on a scale of 1 to 10, the vast majority of SPAS representatives from all of the communes with source communities rated the following items with an average score of 8.5 ("good"): (i) their knowledge of the services and resources available in the commune and its immediate vicinity and (ii) their skills in helping children and families from the commune to gain access to the services and assistance they need. Moreover, they stated that they almost "always" (an average score of 8.7) felt that they could effectively intervene to support the children and families from the commune. This distribution by scores from 1 to 10 is shown in Figure 45.

Based on their experience, the SPAS representatives considered the Guaranteed Minimum Income (GMI) and the family allowance to be the most efficient cash benefits in preventing child-family separation. As regards services, the SPAS respresentatives mentioned parental counseling as the most efficient service for preventing separation. Other services that were named, though much less frequently, included (access to) jobs, family monitoring, and "School after School" programs for children.

In any case, all of the professionals agreed that there are problems related to both supply and demand. Although some social benefits (mainly the GMI and the family allowance) and parental counseling services are considered to be efficient in preventing children's separation from their families, we have already shown that only a small number of children in public care (and their families) actually received them before entering the system. The professionals explained that this coverage will not increase since local social workers are insufficiently professional and show a certain "lack of interest", while the beneficiaries tend to be illiterate or poorly educated and reluctant to take any initiative.

> "*What do you do to prevent child-family separation*?
>
> - I can't do much more than offer social and educational counseling. Yes, this is what we do out there, on the ground, and at the office too; practically, whoever come in receives social and educational counseling. I mean, I am entitled to do this with any client who comes in if I realize they need it. I can inform you about your obligation to send your child to school, to register the child with the family physician, to keep an eye on them to avoid vagrancy or antisocial behavior; I do that and sometimes I can do it on and on as you do with benefits. For example, we have cases that we discuss with our colleagues from the DGASPC and they tell me "but why don't you counsel them?"; but if they don't ask for it, should I coerce them? That person has to submit an application, I tell them hundreds of times 'come here and I'll help you' but they don't come. What can I do?!
>
> *Are there also families who don't receive the benefits they are entitled to*?
>
> - Of course there are, I'm sure of it. If a person doesn't ask for it, you can't give it to them by force. I inform them, but you are bound by law to give them the benefit, because there is a law with a very clear article, and they say "ah, really, OK, bye!" If they have a preschooler, I tell them about the CASTAN center, but they refuse to take their child there. What can I do? Then that child sits in front of the house all day long, clearly s/he is at risk of not starting first grade.
>
> *But is there a risk of separation from the family*?
>
> - This is the problem. Yes, if I identify that risk, the only thing I can do is to submit a proposal to the DGASPC, there is no other measure I can take, and the DGASPC is in charge of reviewing the case and taking it to the committee or to court." (Interview with a professional, Piatra-Neamț)

On the other hand, as seen in Figure 44, the amount of social assistance, including information and parent counseling, offered to families in need in their communities is entirely insufficient. For example, only 24 percent of children in public care and their families received any information or counseling before the child entered the system.[219] This is why professionals stated that services such as counseling, information, and "parenting classes" need to be scaled up nationwide.

[219] The share rose to over 30 percent for the children who entered the system after 2007.

"*What actions should be targeted to parents in particular to mitigate the risk of separation*?

- Parental education. Depending on how one decides to meet with the parents, twice or four times a month... And I'm telling you this because I participated in many [such activities]. I don't know, parents learn about themselves and they put themselves in children's shoes, it's fantastic. (Focus group with professionals, Craiova)

- Parenting classes... This is how services can develop because you identify needs in a better and clearer manner. They can come up with solutions themselves!" (Interview with a professional, Piatra-Neamţ)

- Parenting classes for parents to learn how to be a role model for their children because the child actually learns from the parent. If the parent cannot be educated and does not set an example for the child, then the child can't get the information s/he needs in life, right? (Interview with a professional, Bârlad)

- I think I'd stick to the same idea, helping parents in their very own environment and giving due consideration to their culture so that they can understand why things are a certain way and not the other way around. Because I can see some discrepancy here… when we pursue the child's best interest, we define it based on our way of thinking, of being, on how we were raised. They come from a different environment, with other traditions and other… and then we have to realize how we can help these people to understand why it is important to keep their child, by understanding them and not based on our concepts. (Focus group with professionals, Cluj-Napoca)

- Some sort of parental education. Exactly, for those who work with us and those who are open to receive this information because not every parent can get that, for example legal counseling... (Focus group with professionals, Ploiești)

- Only parental counseling and information about the service network... If only they came because they receive child benefits and they also get social support for families in difficulty, what interest would they still have in coming to counseling? 'Well, wait, I already get all of them and I still live in abject poverty'." (Focus group with professionals, Timișoara)

However, many parents from the families who are caring for children at risk of separation refuse to participate in counseling or parental education activities. The professionals believed that the greatest issue is a lack of sanctions to enforce the existing regulations, as well as the absence of any regulations regarding parents who violate the rights of their own children. In order to boost parents' participation in counseling, they suggest that counseling should be set as a condition for receiving social benefits (especially the GMI) and benefits should be cut or even discontinued for those parents who do not comply with this condition.

"*What else is missing? What else should be done*?

- Constraints for parents. Penalties.

- Yes, penalties.

- For parents, but not only. Also for institutions...

- There are constraints, right? But they are not being implemented.

- Implementing mechanisms are missing. That is the problem. Leverages to help us …

- We don't have the legal basis. Civil judgments specify the amounts the parent … parents must pay to the tax office, but nothing happens. The parent doesn't pay, they are not investigated, no… [...]

- I was thinking about what could be done; maybe a more drastic measure if, for example, a parent already has two institutionalized children. In order to prevent the institutionalization of the other children, you should coerce them in some way, I don't know how... because you can't break human rights either.

- Yes, the human right to relinquish yet another child with us. [...]

- Or it would be better… since we're talking about legal amendments, to somehow compel parents to participate in a counseling program.

- And they would do it just for the sake of it.

- They either want it or they don't … no, no. Not all the time.

- Not all the time. You have no one to work with. And you've seen it, you go to get them, you chase them, you bring them back, the next day they'll stop coming anyway. No, something to make them or to … some sort of applicable penalties. Sir, have you attended the counseling program? I haven't. Aha, OK, well, there's your fine or something. You pay or you do the counseling… [...]

- Good, and if not, all these things should lead to a court ruling on… child relinquishment.

- The law on relinquishment.

- Yes, because relinquishment is no longer an option. We only have termination of legal … parental rights.

And what is the difference? What are the consequences for parents or children?

- Well, in the case of relinquishment, you don't resume the proceedings, the child becomes adoptable. With the termination of parental rights, we must support the family to regain their parental rights.

- Now, related to what you've said and based on my experience, in general people like that need to communicate. They need to talk. True, some of them may complain, let's say, about their problems in order to get some money. But starting from the idea that they, like everyone else around us, need to communicate, the programs you mentioned… and, starting with the second child, based on age, material circumstances, you should somehow connect them with the benefit, with the welfare, with the guaranteed minimum income, the obligation to go to counseling for a period of time, that is something that can be done. And then, I always say a good farmer makes a good farm. If those who develop such programs want and know how to empower their beneficiaries, then their beneficiaries will come back the next day to take part in the program. If we are not really interested in the work we do, then they won't be willing to come either... and this is also connected to the social workers' continuing education…

Ah, but do they still do that?

- Well, no, but they should …" (Focus group with professionals, Bucharest)

The specialists' discussions about penalties and accountability revolved not only around parents but also around local authorities, which have not developed enough services for the population in need.

"- It is very clear, you will never find priorities related to these children in difficulty on a mayor's agenda. They have political priorities of a different kind: roads, schools, things that generate money. You see? Therefore, this is a matter that should be pushed forward through a law so that communities are funded, but also controlled to make it more difficult for them to evade it, to make it so expensive that it would actually be more profitable for them to keep the child there. I would raise the tax from five to fifteen million, this is how much it costs you as a mayoralty if you place more children in public care. The things the service could do with that money!

- So that suits them. They pay five million a month, then they are carefree, they all prefer it that way, right? But why don't you take the money you've received from the budget, because these are citizens of your commune, and develop services and help them. You see, things should happen at a political level. Because it's clear that everything is due to lack of resources." (Focus group with professionals, Cluj-Napoca)

Nevertheless, the problem is not a lack of regulations.[220] Most of the professionals who were interviewed agreed that Law 272/2004, as subsequently amended, currently includes enough provisions for carrying out preventive activities. However, there are no concrete implementing methodologies (manuals or guides) nor are there any mechanisms for monitoring the implementation of these preventive activities by key local institutions. For example, the service plan, which we have previously mentioned, is stipulated by the current legislation as a way to prevent children from being separated from their families and yet very few SPAS produce them.

[220] For example, see Annex 6 Box 1 on the social worker's role and responsibilities in the protection and promotion of children's rights.

However, there is one positive trend: the incidence of preventive services increased considerably over time, from less than 20 percent of children who entered the system in the 1990s to 40-43 percent after 2007 (Annex 6 Figure 8). Nonetheless, there are still significant gaps between counties (Annex 6 Table 36), with rates ranging between approximately 20 percent of children in Arad, Caraș-Severin, and Suceava and 72 percent of children in the County of Neamț.

Despite last years' progress, it is obvious that neither public community-based social assistance services nor Community Consultative Structures (SCC)[221] provide enough services to prevent the separation of children from their families. Furthermore, they are not active enough nor effective in supporting the children's reintegration into their families.

> "There are those community consultative committees that work inadequately in many communes. If they existed and worked as they should, many cases would probably not even get to us in need of protective measures." (Interview with professionals, Piatra Neamț)

> "Local authorities are willing to intervene, but often they are overwhelmed in practice when it comes to emergency interventions. And volunteering is not very well-developed in our local communities. For example, the problem of contraception or other issues… I mean, the local community doesn't understand that it is first of all its problem, not necessarily the problem of the county or of others. Mobilizing the local community this way, not necessarily the mayoralty, formal and informal leaders, be it the police, be it the … I don't want to label, don't get me wrong, but there are people who could actually help to find local solutions to local problems." (Focus group with professionals, Cluj-Napoca)

Moreover, the case file data showed that only 11 percent of children in public care and their families received any support from a person, group, or organization in the community before entering the system. Two-thirds of them were helped by individuals, especially grandparents, aunts, uncles and other relatives, whereas only one-third received support from local professionals, NGOs, or informal groups. It is worth mentioning that most of the children and families who received support in the community were the very ones who also benefited from services. The share of children who were supported is three times higher among those who received services than the other children (24 percent versus 8 percent). Therefore, the "aid" provided within communities tends to be concentrated on the families who also benefit from services (partly as a result of being referred by the representatives of the SPAS or SCC).

The main structural causes of the shortage and limited effectiveness of preventive services are synthesized in the first quote from the next Professionals' Bag below and include:

- The very low wages paid to social workers.

> "You can't overwork a colleague who gets paid RON 800. And this is what happens in our case because there are only a few of us at the city level and I suppose we are not the only ones dealing with this problem; I suppose it's the same all over the country." (Interview with a professional, DAS Piatra Neamț)

- Understaffed SPAS, especially in rural communities and small towns,[222] and health units. Given the number of children at risk of separation from their families, child protection professionals believe that there is a major lack of staff even in the big cities.

> "Even in the city of Cluj, we currently consist of five people, so that is definitely not enough. I have to handle forty cases at once. I don't know how one can be effective with every single case and offer them services to meet their needs, besides the fact that we only have one psychologist. So, you don't have enough resources to refer the cases to. Many of them need counseling

[221] Law 272/2004 and Government Decision 49/2011 lay down the obligation for local authorities to create informal groups meant to support social protection activities by identifying community needs and finding local solutions to children's social problems. Members of these SCCs include local decision-makers such as the mayor or deputy mayor, the mayoralty secretary, social workers, doctors, police officers, school representatives, and priests.

[222] According to the census of SPAS carried out by the World Bank in 2014 ("Social Assistance Services at Community Level," May 2014), the shortage of staff in the SPAS in rural and small urban communities is estimated to be between 2,300 and 3,600 people (Tesliuc, Grigoraș and Stănculescu, coord., 2015).

support. You visit the family, but it's not enough, despite all our goodwill and professionalism …" (Focus group with professionals, Cluj-Napoca)

- The lack of clearly defined responsibilities at the SPAS level (not only regarding child protection) and excessive office work and other activities unrelated to social assistance.[223]

  "Most mayoralties…, though indeed, some of them have a social worker who knows what social assistance is all about because they have university education, but most of the times there are employees who are assigned social assistance duties and who have other activities to take care of, like the guaranteed minimum income or taxes and levies. In practice, they don't know what to do first, but in general… Anyway, the Craiova City Hall is not doing great either because I know they are understaffed too; there are just a few people handling the entire city, with a population which is quite large." (Interview with a professional, Craiova)

  "If the employee with social assistance duties has to do land measurements and sometimes run an inquiry, they will do it hastily just to get it over with." (Interview with professionals, Piatra Neamț)

- Insufficient training of social assistance staff within the SPAS.

- Lack of protocols and regulations concerning inter-institutional cooperation between local and county agencies, including the DGASPC. However, after the completion of the present study, a new regulation came into force (Government Decision 691/2015) starting September 2015 that established a procedure for monitoring the raising and caring of children with parents who have left to work abroad and the services that would benefit these children, as well as a working methodology for the collaboration between the DGASPCs and the SPAS and a standard model for documents drawn up by both institutions.

  "So, what I want to tell you is that the law on health units has been amended along with their obligation to conclude cooperation agreements with social assistance directorates. So far, we haven't received any cooperation agreements from those units. Actually, we received two: from the maternity hospital in Ploieşti and from Câmpina. Otherwise... We have other maternity hospitals in the county; none of them have made any effort in this respect. Well, we haven't concluded the protocol yet as we are only in the phase of setting the responsibilities. But what I'm trying to say is that there is no interest. And the only one interested was the maternity hospital from Ploieşti. The other maternity hospitals don't have social workers, as required by law. Also, we have a very difficult collaboration with all the units in the county, except for the Ploieşti Maternity Hospital, where there are no problems." (Focus group with professionals, Ploiești)

  "There is an abundance of legislation in the social field and on child protection, it is an extraordinarily vast area. In my opinion, as long as the law only lays out obligations and responsibilities, we cannot expect great things! [...] At the inter-institutional level, we need child protection rules, more that just 'teachers must do this or that…!'. And if they don't? Who monitors that, who reports that? If I inform the police that the school didn't tell me, [...] ok, so what? It looks like it's personal, I've ruined my relationship with them for good because there is no rule based on which you can say 'Madam, this is your duty!'. [...] For example, I know someone at the inspectorate and I was very curious to see the job description of a school principal. And you find out that the job description doesn't stipulate that they have to inform DAS [Directorate for Social Assistance] or follow any of the other legal provisions. What can I do? With all the legislation on education, it's hard to tell her: 'Madam, read the child protection law!' (Interview with a professional, Piatra Neamț)

- The lack of any concrete implementing methodologies (manuals or guides) and of mechanisms for monitoring the implementation of preventive activities by all key local institutions.

- The lack of a methodology for the early identification of children at risk of being separated from their families, especially in medium-sized and big towns.

- A "lack of interest" on the part of some of the SPAS representatives.

[223] See also IRECSON (2011), MMFPSPV and SERA Romania (2012), Teșliuc, Grigoraș and Stănculescu (coord.) (2015).

The main recommendation made by the DGASPC specialists that we interviewed was to intensify efforts to provide continuous training and support to SPAS representatives in order to increase their capacity to provide services aimed at preventing children from being separated from their families.

> "- Regarding this, I wanted to tell you that we, at the directorate level [DGASPC], have offered indirect services for many years, I mean we tried to share our expertise in the field of prevention with the mayoralty. They often recruit unqualified staff or they delegate duties to people like the agricultural officer or others. Commune mayoralties. Yes, commune mayoralties, because those from Cluj-Napoca have never worked with us although they should have on many occasions. When in crisis, they would say 'take that child'; and we'd say let's see what you've done and we'd go there to train them, to explain to them the legal leverages available, the funds they could access, the NGOs that could help and how they should intervene; many times, we went with them on the ground even if there were no cases in the records of the directorate, we created commune groups, we would train them. We don't do that anymore, but we used to do it for years, training the social workers from the mayoralties and, often, we even tried to get the mayors to participate in our meetings to see what they were all about; it's not that easy to take five children and leave them with the directorate, if they don't want to.
>
> - Yes, we teamed up with them, we went on the ground and delivered preventive services, working with the family, trying to help them manage the local resources, to access those they hadn't thought about, including social housing. For many of them it was just a thing: well, the mayoralty has that building, let's see how we can fix it. And you should know that sometimes it worked. We should invest in this sort of activities!" (Focus group with professionals, Cluj-Napoca)

Box 9: Example of Good Practice: Area Center-Based Organization and Close Cooperation with the NGOs

"- The Child Protection Directorate from Iași has six area centers in the community, which are parent support and counseling centers for parents. Their role is precisely to support the family, alongside local authorities, to identify parents' and children's needs, and to run a targeted intervention where needed. As their name says, they provide parent counseling and support but also actual support to the family and child so as to prevent the child's entry into public care. We work with NGOs, providing specific support where needed. All sort of services are provided, including training to the local community consultative structures under each local authority, which are operational in Iași. We also hold meetings with community social workers for their professional development and training so that we can become a functional network, carry out our own specific interventions, support each other and join forces in delivering social services. We don't overlook the role played by NGOs. NGOs have supported our – the Directorate's – actions many times; not only those meant to prevent children's placement in the system but also those aiming at their reintegration, including that of young people leaving public care. [...] (DGASPC representative)

- Yes, we have received a lot of support and we complement each other. The Child Protection Directorate from Iași trains our volunteers so that they can do a good job and be able to efficiently respond to certain cases at our centers, thus ensuring that the child develops properly thanks to our volunteers' contribution." (NGO representative)

(Focus group with professionals, Iași)

Building and strengthening local capacity to provide services that may prevent child-family separation is essential to extending social services designed to meet a wide array of needs, including child protection. However, preventing children's separation from their families requires much more than that, namely the effort of the entire community, other universal services (such as education and healthcare), and community-based services or informal support groups like SCC, as well as the SPAS and the DGASPC. Therefore, the following sections examine these other community-based services.

Professionals' Bag

6a

"*What are the main obstacles that your institution [the DGASPC] comes across as regards the prevention of children's separation from their families*?

- Lack of professionalized services [SPAS] in the communities.

What do you mean by "professionalize"?

- The professionalization of the people who actually work there. They are not professional.

Meaning that they are not trained in the field or what?

- They don't have any kind of training like legal training, work experience in the social field, experience in working with people, they are way too overburdened with other tasks, they are tasked with calculating and collecting taxes, as well as with granting social benefits…

- The biggest problem is that they don't want this...

- They are just a few and they [the mayors] won't let them. We trained some of them and they were really open. And they told us: I have to handle many heating subsidy claims. If I get something wrong there, I'm in big trouble. I can't focus on your case, go there, talk to people, be kind to the mother, loosen up, counsel her, intervene. I don't have time for that, I also work at night."

(Focus group with professionals, Cluj-Napoca)

6b

"This is obvious from the very definition of the institution – Child Protection Directorate. So, they work with children who have already left their families, they are no longer with their families, they are already in a protective setting. Work should be done when the child is still with the family, trying to support it, to identify their resources as well as community resources in order to help that family. And you should do that when the child is still with the family, not when... It's absurd! Lots of money and human resources are allocated for children when they have already left their families, yet nothing is allocated when they are still with their families! SPAS are underdeveloped, there is a shortage of social workers, they don't have money, they don't have... they can't visit those families, they don't know what to do..."

(Interview with a professional, Craiova)

Community-based Educational Services

Figure 44 reveals that at least[224] 7 percent of the children in public care whose case files include social assessments had educational needs that led to their institutionalization in the absence of services at the community level. These needs were mostly related to special education, particularly in the case of children with special educational needs (SEN) and/or disabilities, and to the pursuit of studies or dropout risk, especially among rural children.

Child protection professionals pointed out that problems arise starting with early childhood education. The case file data indicated that only 49 percent of the children who entered the system between the ages of 4-6 years have attended preschool versus 86 percent of children aged 4 to 6 years from the general population.[225] Thus, one key preventive measures would be to increase access to early childhood education for the children from families at risk of separation, which would not only benefit the child but also the family as it would allow the mother or one parent to get a job. The professionals interviewed for this study did not recommend a benefit such as the social vouchers for kindergarten, which was recently introduced by the government,[226] but rather propse that local authorities subsidize kindergarten and crèche fees for low-income families as already happens in some urban settlements or in certain projects.[227]

> "You find solutions. For example, regarding crèches, there is a daycare center – The Protection of the Mother of God – for children aged 0 to 3 years, which covers demand only to some extent; and then for crèches there is a legislative loophole whereby a child with a service plan can go to a crèche for free with the mayor's approval. As far as kindergarten goes, we don't have that option unless we find the financial resources for it. And what does that mean? The parent has to be eligible for welfare, which however is just a small amount of money, and we have to find an NGO to help them; so basically, you have to go here and there." (Focus group with professionals, Cluj-Napoca)

The second major problem is the non-participation in school of many children who end up in public care. The data available in the children's case files revealed that, upon entering the system, 19 percent of primary school-age children (7 to 9 years old) and 6 percent of secondary school-age children (10 to 14 years old) had never been to school.[228] This is a combined effect of a lack of resources, the parents' attitude and decisions, and a lack of accountability from educational services at the community level. Generally, in urban and rural areas, teachers and educational establishments tend to limit the extent of their responsibility to the schoolyard perimeter. This situation is particularly serious for urban children, Roma children, and children with disabilities.[229]

> "I'll give you a real example, an actual case of mine. I have the case of five siblings from a village, aged between 4 and 11 years, all out of school. So, it got to the point that an 11-year-old child was out of school, no one in the community took an interest in him, he was living in the community and no one inquired about him. So, a lack of collaboration and of interest. Still, you have to know what people... We [DGASPC] received a report of suspected child trafficking, that's how we got to this family." (Focus group with professionals, Timișoara)

[224] We say "at least" because the social assessments identify the needs of fewer than half of the children in public care, consequently the share and the number of those with educational needs may actually be greater.

[225] Eurostat data for 2012.

[226] Law 248/2015 published in the Official Gazette in November 2015. Social vouchers for kindergarten amount to RON 50 per month and are given to families earning less than RON 284 per family member. The amount may be spent only on food, clothes, or footwear for the little ones. The family receives the vouchers if the child attends at least 50 percent of the kindergarten program.

[227] Focus group with professionals, Timișoara.

[228] By comparison, the rates reported for children living with their families are 6 percent and 3 percent respectively, according to the 2011 Census data.

[229] See also Stănculescu, Marin and Popp (2012).

Box 10: Out-of-School Children: A Comparison between Children in Public Care and Children Living with Their Families

The total rate of out-of-school children aged 7 to 14 years who have never been to school or have dropped out is 4 percent for those who live with their families and almost five times higher for children in public care before they entered the system.

The 2011 Census data show that, among children aged 7 to 14 who live with their families, children with disabilities, Roma children, and poor children are at extremely high risk of being out of school. The groups of children most at risk of not attending or completing compulsory education are:

- Children who are totally incapacitated (55.4 percent) and those who are significantly incapacitated (20.4 percent);
- Children whose mothers have no formal education (22.7 percent) or completed only primary education (10.6 percent);
- Roma children (18.7 percent). Although the mother's educational attainment is a relevant predictor for school participation, there is a great gap between the Roma and the non-Roma even if the mothers' educational attainment is held constant. The gap between Roma and non-Roma children is significant even if their parents' educational attainment is the same and they come from the same geographical area;
- Children with many siblings in families with three or more children (6.8 percent);
- Children deprived of parental care, in other words whose parents are absent (5.4 percent).

Source: Teșliuc, Grigoraș and Stănculescu (coord.) (2015:192-193).

Because the concept of inclusive education is not well developed in Romania, many educational establishments do not integrate children with SEN and/or disabilities into regular schools.[230] For this reason, many of these children need to enter public care in order to gain access to special education, regardless of the relationship that they have with their family. In practice in their case, entering public care often means leaving home and going to a boarding school and not an actual separation from their family. In this case, success is measured by the extent of the child's ability to live independently rather than by the family reintegration, which is not an issue here.

Box 11: Need for a Law on Inclusive Education to Enable Children with Disabilities to Attend School in their Communities

"Through inclusive education laws, States should establish an inclusive education system under the aegis of their respective ministries of education that prohibits rejection from mainstream schools on the basis of disability and provides for reasonable accommodation. A transformation plan should provide the framework for the implementation of an inclusive education system with measurable goals. States should put in place training programs for teachers, create reasonable accommodation funds, provide for accessible materials, promote inclusive environments, improve testing methods, promote the transfer from special schools to mainstream schools, promote monitoring through indicators on inclusive education, provide adequate support to students, and use appropriate communication means and formats. Schools need to be properly funded, while at the same time availability of resources should not be a basis for denying access to the right to education for a student with disability."

Source: OHCHR (2013).

In other cases, children from poor rural families who cannot afford to continue their education in urban schools are referred by the social worker to the special school and vocational guidance and assessment service (working under the CJRAE). Parents contact the school and vocational guidance committee and their children are often accepted into special education since they have two-year developmental delays as a result of living in poverty with little stimulation. Thus, for many children

[230] Different research studies, reports, and interviews with the families of children with disabilities have illustrated the key problems that these families face when their children with disabilities are enrolled in the education system. They have sounded the alarm about the inappropriate enrollment methods currently used by many (mainstream and special) schools for different groups of children with SEN and/or disabilities. See, for example, Horga and Jigău (2010), Gherguț (2011), Toth (2013), the European Center for the Rights of Children with Disabilities (2013), and Chiriacescu (2014).

who enter the system for causes like "child disability" and/or "poverty," public care actually offers the only accessible solution to receive an education.

Teachers also play a very important role in the preventive services aimed at other groups of at-risk children. The early identification of at-risk children[231] whose parents work abroad (and the subsequent provision of support) is much more effective when it is done by the SPAS in cooperation with the school. The DGASPC specialists interviewed for this study stressed that the following actions are necessary to make this cooperation work effectively: (i) improving and strengthening monitoring and reporting mechanisms at the local level (within SPAS) for the children who need support; (ii) building the capacity of schools to compensate for parents' absence by providing children with counseling; and (iii) carrying out more health education activities as well as activities meant to prevent risk behavior,[232] including risky sexual behavior,[233] among adolescents.[234]

Preventing child-family separation is related to preventing dropout. The activities run in some schools to prevent dropouts contribute indirectly to reducing the risk of child-family separation, especially if those activities also involve parents as well as their children.

After-school services along with daycare centers are deemed to have the greatest impact in preventing both children's separation from their families and dropouts from school. Almost all of the participants in the interviews and group discussions held during our qualitative research referred at least once to this service and its positive effects. Most of their recommendations or suggestions for improvement in terms of prevention supported the development of such services with free access for children in difficult circumstances who are at risk of being separated from their families.

> "In the after-school program, we noticed that the meal was an incentive for children. There are days when many children have nothing to eat at home, let alone a hot or meat-based meal. Well, in the after-school program, they get a hot meal every day, on a regular basis, with sufficient protein for their normal development. So, we can sign them up for an after-school program where they would first eat, because this is what they are looking for to begin with, and then they take part in the activities because they get interested; they come here for the meal, but slowly they get interested in the educational program and you gradually win them over... After-school programs should be available in every school. The law stipulates their establishment without making it mandatory to actually run them. And if 'may' turned into 'shall' in the law, we would find the required funds and this would greatly benefit the children." (Interview with an NGO representative, Case study, Craiova)

Community-based Health Services

Figure 44 shows that at least[235] 6 percent of the children in public care whose case files include social assessments have health-related needs that have led to their institutionalization because of the absence of services at the community level. With regard to the healthcare services available in the community, we identified two potential structural causes of children's separation from their families. The first concerns primary and community healthcare, while the second relates to health services for adults and children with disabilities and/or mental health problems. This section focuses on primary

[231] Especially those with both parents abroad and/or who are facing psychological trauma due to their prolonged separation from their parents.

[232] These are associated with the reduction of drug use, of harmful tobacco and alcohol use, as well as with behavioral disorders among adolescents.

[233] Adolescents' risky sexual behavior is directly linked to teenage pregnancies and teenage mothers.

[234] Some of these measures are already contained in Government Decision 691/2015 for the approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and for the approval of the Work Methodology for DGASPC-SPAS collaboration and of the standard model for the documents developed by these two institutions. This regulation only recently entered into force in September 2015.

[235] We say "at least" because social assessments identify the needs of fewer than half of the children in public care, consequently the share and number of those with medical needs may actually be greater.

and community healthcare, while the following two sections look at the health and social services intended for people with disabilities or exposed to other types of vulnerabilities.

Based on the analyses presented in the previous chapters, families caring for children at risk of separation are undoubtedly a vulnerable group. Few of them are included in the health insurance system,[236] and they are usually poorer, less educated, and less informed than the general population. The data in Section 3.1.5.2 showed that only about half of all children in public care were registered with a family physician before entering the system. Even among children taken into care straight from a family (including relatives or other people), the share of children registered with a family physician does not exceed 80 percent.

The *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*[237] highlighted the need to increase the access of vulnerable groups to quality healthcare services. At present, Romania's primary healthcare network does not provide efficient healthcare services to the poor, and the emerging community nurses network is still not sufficiently extended and strenghtened. The national mapping exercise for the background study[238] indicated that most urban and rural settlements in Romania have at least one family physician and one or more pharmacies. Nonetheless, over 6 percent of all settlements have no family physicians, community health nurses, or Roma health mediators.[239] Therefore, service delivery is polarized between small and poor rural communities that lack all types of social services and larger and better developed rural communities and cities, which have developed more and better services at the local level.

The DGASPC professionals who were interviewed for this study added the fact that the family physician, even when available, is often not familiar with and thus does not implement the provisions of Law 272/2004 and its subsequent amendments. Thus, in many cases, neither the family physician nor community health workers get involved in the effort to prevent child-family separation.

> "In order to identify a problem, the doctor from the community, the family physician should know the community health nurse and go there, like they did in the past. I'm going back to the old times, maybe I'm too nostalgic. But they need to get involved, I keep going back to that because I am both a doctor and a social worker. You sit in your chair and you don't know which pregnant woman in your community is at risk and you just say 'I don't have to.' Yes, you have to. So, [Law] 272 says that you have to make house calls until the child is one year old, but they don't know that. Or if there is a child they visit them or the mother or someone else brings the child to the doctor's office and the child is very sick, the doctor calls me, the Child Protection services, what to do? Well, Madam, what else is there to do? Call 112, call the ambulance, you take the child to the hospital no matter what the mother, the father, whoever is there says. The child is seriously ill, you act like a doctor. You don't have to call me at the Child Protection because there's nothing I can do, but you make sure you do what's best for that child. And this happens with other specialists, too. At the mayoralty, they say 'it's none of my business, I don't have time, I can't go, the social worker should, why should I go and monitor that?' Lack of responsibility, to put it plainly." (Interview with a professional, Craiova)

The involvement of doctors and other healthcare staff is also essential for the development of preventive services for reducing teenage pregnancies, by improving the health monitoring of adolescent girls with the aim of identifying pregnancies early, and by increasing the access of adolescents to health counseling and family planning services. However, current shortcomings in the healthcare system make it impossible to prevent children's separation from their families as well as other adverse outcomes such as infant mortality. In Romania:

[236] Children and pregnant women receive free healthcare by law. Also, GMI recipients are covered by health insurance.

[237] Teșliuc, Grigoraș and Stănculescu (coord.) (2015).

[238] Based on data for September-November 2014.

[239] These "blank areas" lacking primary and community health services tend to be rural settlements that spread throughout the country (with a higher prevalence in Buzău, Ialomița, Caraş-Severin, Vrancea, and Hunedoara), most of which are small communes with fewer than 2,000 inhabitants, generally located on county borders and lacking any social workers.

- One in ten births is registered to a teenage mother (aged between 15 and 19), and the percentage of unwanted pregnancies exceeds 50 percent among adolescents.[240] Early motherhood, especially when the pregnancy is unwanted, can lead to child relinquishment, school dropout, and even social exclusion. Therefore, it is important to reduce the rate of unwanted pregnancies.
- Eleven percent of newborns are premature, with preterm birth being one of the risk factors for children's separation from their families (and causing more than half of all neonatal deaths). Most premature and/or underweight infants are born to teenage mothers and/or to mothers in the lowest socioeconomic groups and/or of Roma ethnicity, to those with low educational attainment, and those living in rural areas. Mothers in these groups either do not seek prenatal care services or use them inadequately, while 40 percent of women who give birth prematurely do not receive any systematic or regular prenatal visits.[241]

There is evidence that there are no or few effective family planning services at the community level, especially for poor and vulnerable women who are most at risk of child relinquishment. Both healthcare and child protection experts also underlined the need to increase access to family planning services for the groups that are most at risk of relinquishing their children.

> "Underage mothers are registered by the family physician and are monitored during pregnancy, and their children are also registered. Monitoring means that the mother receives services but only if and when she comes to see the doctor... The family physician won't go to her home to say: "Come see me, please." So, although they are insured because they are underage, many of them do not receive services precisely because they don't go to a family physician's office. And she comes when she is already nine months pregnant and very close to giving birth. Why hasn't she come earlier? Lack of information, shame, poverty, she doesn't have clothes to wear, or she can't get there, who knows? And at this first visit, I give her a laboratory referral, an ultrasound scanner referral, and another one to a gynecologist for a consultation. She has to travel for every one of these three referrals. The nearest hospital, the Botoșani Maternity Hospital, is 70 to 80 kilometers away. She doesn't have the money to travel, so she won't go. Moreover, she will not come to me the second time because all I do is give her unrealistic tasks instead of real solutions to her problem." (Group discussions with the College of Family Physicians, the Association of Family Physicians, and the Association of Family Physician Employers, Botoşani County, July 2014. Qualitative research conducted by the World Bank in July-August 2014, as part of the Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020).

> "Family planning services should also be developed as, currently, I can't say that they are available. Not even in Câmpina, which is a municipality. There used to be an office but it was closed down. It's no longer available. I've been working in the system for a long time and I haven't come across any clinic offering this sort of services. They don't even talk to the patients." (Focus group with professionals, Ploiești)

However, the child protection specialists whom we interviewed for this study drew attention to the fact that the lack of family planning services on offer is accompanied by demand-side issues. The problem is not only a lack of money to pay for medical tests or transportation but also other factors that can result in at-risk women refusing to participate in, say, sex education, factors such as low levels of education (illiteracy), religion, customs, and, sometimes, the views of the person's spouse or life partner.

> "We are running a program together with Sera Romania precisely on the prevention of unwanted pregnancies and it is going quite well in the sense that women are pretty open. The problem has to do with the traditions. In a Roma community, a woman who doesn't have children is worth nothing and will be chased away. So … this is what makes a man proud. It is a way for him to prove his…" (Focus group with professionals, Braşov)

> "You can't do anything against someone's will. It is their right. And then, there are factors like education, religion, innocence..." (Focus group with professionals, Bucharest)

[240] Reproductive Health Survey carried out in Romania in 2004 jointly by the Ministry of Health, the World Bank, UNFPA, USAID and UNICEF.

[241] Stativă and Stoicescu (2011)

Box 12: Urgent Need to Improve and Increase Access to Reproductive and Mother and Child Health Services for Vulnerable Groups

Affordable and high-quality sexual and reproductive health services[242] are not available in Romania, especially to poor and vulnerable women. The number of reproductive health interventions conducted by the Ministry of Health (MS) targeted to the vulnerable population has gradually decreased since 2008, as have the relevant budgets.[243] The regulations, methodologies, and tools of the MS's National Program (such as the criteria governing which vulnerable groups are eligible for free reproductive health services, the logistic management information system regarding contraceptives and their distribution, and the list of free contraceptives) have not been updated. The network of family physicians' offices providing reproductive health services has been dismantled due to lack of training, budgets, and interest in this program from decision-makers at the national and county levels. There are no sustainable continuing medical education programs on reproductive health for family physicians. Only few family physicians – far fewer than are needed nationwide – have agreed to distribute free contraceptives, and the effectiveness of this free contraception program also suffers from a low budget and a high degree of inconsistency in procurement and distribution. There is a lack of accurate data on the activities carried out by community health workers (community health nurses and health mediators from Roma communities) in the area of reproductive health and, since these workers no longer benefit from training programs or any guidelines or educational materials, it is very likely that these services are infrequent and/or of poor quality. The decentralization of healthcare services, which was poorly coordinated and insufficiently regulated, coupled with the recent economic crisis have led to the current situation.

The priority actions recommended, among others, in the *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020* are:

- Revise the criteria for the free distribution of contraceptives;
- Specify priority beneficiaries (such as rural areas, poor and deprived communities, and specific age groups);
- Ensure continuity of access to a range of free contraceptives for vulnerable women of reproductive age;
- Expand the network of family physicians who are willing to deliver free contraceptives and ensure widespread geographical coverage;
- Train and retrain community healthcare providers (family physicians, community health nurses, and Roma health mediators) in delivering quality sexual and reproductive health services;
- Establish partnerships with specialized and grassroots NGOs to deliver reproductive health services and interventions;
- Plan, implement, monitor, and evaluate information-education-communication (IEC) campaigns and outreach interventions in the field of reproductive health tailored to the particular needs, beliefs, and traditions of the most vulnerable communities;
- Increase the local coverage of basic healthcare service providers (family physicians, community nurses, and Roma mediators) countrywide;
- Train or retrain community healthcare providers (family physicians, community nurses, and Roma health mediators) in delivering quality prenatal, postnatal, and child care;
- Monitor, evaluate, and control the delivery and quality of services.

Source: Teșliuc, Grigoraș and Stănculescu (coord.) (2015:236-241).

[242] A comprehensive definition of reproductive health services includes other priority public health areas such as: (i) family planning; (ii) sexual health; (iii) safe motherhood; (iv) unsafe abortions and sexually transmitted diseases, including HIV; and (v) cervical cancer.

[243] In 2014, the National Mother and Child Health Program (which includes all reproductive health interventions) was allocated a budget of RON 10,330,000, which was less than 50 percent of the 2013 budget and was, for example, five times less than the amount budgeted for the National Organ, Tissue, and Cell Transplantation Program. In fact, ever since preventive and curative programs merged into "national public health programs" funded from the state budget, the programs that included a significant prevention component started getting increasingly lower budgets, while the budgets for curative programs increased.

Community-based Health and Social Services for Children with Disabilities

Although, by law, children are entitled to free healthcare, many do not have access to the necessary health services. In these cases, public care has to take over some of the responsibilities of the healthcare system and support the families of children with serious health problems by separating those children from the family to provide them with the health services they need. Due to the lack of health, recovery, habilitation, rehabilitation, or palliative care services for these children, the public care system is often the only way by which some children in difficult situations can access the services that they need. This is usually the case for children with severe disabilities. One example is the case of the child with hypoxic ischemic encephalopathy in Story Bag 4a.

> "I told you, we have families that have not relinquished the child, they placed him with us for care and recovery because they couldn't take care of him. We now have a case of cleft lip and palate, pretty nasty; we will have the child operated on and after this, we will ensure that the child can be cared for in a family environment, and we will send him back." (Interview with a professional, Bârlad).

> "There are children who started by using our recovery services – they would come here daily, with their parents, grandparents, or caretakers, and eventually they became residents. But this is because the grandparents were very old, had medical problems, the child had also major problems so they couldn't take care of him anymore. However, the child is visited almost every week and whenever the grandparents can take him home, they remove him for short periods, like for the weekend. Based on my knowledge of the parents I see in the recovery, most cases are not relinquishment, the parents use these recovery services, but you can't speak of relinquishment." (Interview with a professional, Piatra Neamț).

There are very few services available at the community level for children with disabilities or for the parents who look after these children. It is difficult if not impossible to prevent children with disabilities from being separated from their families when parents with severe health problems get no support within the community or close by and children have no access to appropriate services before being separated and placed into public care. The child care specialists interviewed for this study considered that, of all types of services for children with disabilities, priority should be given to: (i) developing community service centers that include habilitation and rehabilitation services and (ii) ensuring that children with disabilities and their families have access to those habilitation and rehabilitation services.

The type of services that are not available at the community level include (see also Box 12):

- Early identification and intervention services[244]
- Medical habilitation and rehabilitation services
- Mobile multi-disciplinary teams
- Counseling and psychosocial support services
- Psychiatric and psychosocial habilitation and rehabilitation services
- Respite centers
- Community support services for young people and adults with disabilities
- Social economy structures for young people with disabilities

[244] Early identification is a *screening* and diagnostic process, designed to identify risks of deficiency, developmental delays, and/or functional limitations in babies and toddlers. Early intervention is a set of full inter-disciplinary services that contribute to the development of babies and toddlers with disabilities (0-3 years old) and reduce the risk of physical, psychological, or developmental delays to a minimum.

- Facilitation and counseling services aimed at enabling the employment of young people with disabilities in the labor market
- Day care centers and day care centers with an educational focus on children with disabilities.

The child protection specialists who took part in the qualitative research also mentioned these services often and highlighted how important they are for the child's wellbeing and keeping him/her in the family.

> "We have a recovery center for children with disabilities who live with their families, and priority is given to children from families with high risk of relinquishment. That is, they receive a therapy program that spares the family from all of the expenses that they would incur at home, with tailored services. So every child receives a full, free-of-charge tailored program. And at the same time, they receive counseling. There is a psychologist. Usually, it's at the family's request, but if there is a need, they receive this, both the family and the children, if they are of an appropriate age." (Focus group with professionals, Craiova)

> "We set up a mobile team that travels in the county so that these children from families facing problems, who cannot get to us, can receive a disability certificate so that these children who need the financial or health support are not relinquished but can be looked after by their family. On the basis of that support. We mainly focus on children with a severe disability. So we prefer to go and see them in their community because they will not come to us." (Focus group with specialists, Cluj-Napoca).

Moreover, all of these services are vital to enable the eventual reinsertion of children and young people with disabilities into their families.

Box 13: Services Needed at the Community Level for Children and Adults with Disabilities

The *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020* made a comprehensive inventory of services that need to be developed for children and adults with disabilities so that they have full access to care and support in their communities.

Early Identification and Early Intervention Services

A greater range of early identification and early intervention services that should cover the entire country is critical for ensuring that children with disabilities receive proper care.

- ☐ Each pediatric hospital should have an early identification unit that is staffed by professionals who are trained to deal with the entire spectrum of conditions that can lead to a potential disability.
- ☐ Each maternity ward and pediatric hospital should have a counseling unit to support families after a diagnosis of a current or potential disability. This family counseling should aim to offer guidance, concrete support, practical solutions, and information during the early stages of the habilitation or rehabilitation process.
- ☐ Each city should have at least one early intervention unit or specific services for people with various types of functional limitations (physical, sensory, intellectual, and behavioral).

Currently, early intervention services are usually located in the main city of a county, which means that they tend to be inaccessible to many families living in smaller towns or rural areas as appropriate transportation is often scarce or unaffordable.[245]

[245] Over the past decade, some NGOs started to develop early intervention and support services for at-risk children and their families in cooperation with local authorities and/or existing public services (such as hospitals, kindergartens, and counseling services). Some examples are: Alpha Transilvană in Târgu Mureș (for children with neuromotor disabilities); Speranța in Timișoara (for children with developmental problems); the Center for Motor Rehabilitation (*Centrul Pentru Reabilitare Motorie*) in Cluj; Thysia and Albin in Oradea; Sense International in Bucharest, Oradea, Tmișoara, and Iași (for children with hearing and sight impairments); World Vision in Cluj, Craiova, and Bucharest; Help Autism in Bucharest; Iulia Pantazi Center in Bucharest, and the Inocenți Foundation in Bistrița.

Habilitation and Rehabilitation Services

The development of mobile teams for early intervention is very much needed, especially for children with complex medical conditions and those living in rural or isolated areas. Currently, the use of this kind of mobile teams for early intervention is rare in Romania.[246]

More habilitation/rehabilitation centers and services are needed in small communities, including mobile teams that are able to provide integrated services in rural and remote areas and to people with mobility difficulties.

Habilitation/rehabilitation services are not limited to health care but comprise a wider range of activities and a variety of support services for community living and daily life activities. During the past years, these services have been provided more and more by local authorities or by accredited NGOs. The Ministry of Health is supporting this positive trend. Moreover, there is a need for more medical equipment, medical consumables, and free or reimbursable medicines for people with disabilities.

Services for People with Mental Health Problems

People with mental health problems are at risk of poverty and social exclusion.[247] In order to break the cycle of poverty and discrimination, it is necessary to introduce more income-generating and community empowerment programs for people with mental health problems. Many fear being "labeled" with a mental health problem, which is why they delay or avoid seeking treatment. This self-stigmatization combined with previous negative experiences with the health care system (for example, discriminatory behavior by medical personnel, high costs, and a lack of health literacy skills on the part of the patient) often cause the person with mental health problems to postpone seeking professional help.[248] As a result, many mental health problems remain under-diagnosed or untreated. Education and advocacy programs are needed to promote mental health and to challenge the myths surrounding mental health problems that prevail not only among the general population but also among health specialists. Also, free counseling and psychosocial support services within the community are needed for the families of people with mental health problems.

Psychiatric and Psychosocial Habilitation and Rehabilitation Services

The number of psychiatric and psychosocial habilitation and rehabilitation services[249] should also increase, and their geographical distribution should reflect the distribution of needs across the country. Currently, this type of service is provided in the following way. First, general services are provided for children in a small number of mainstream schools and kindergartens, in public and private after-school programs, and in public and private habilitation/rehabilitation centers. Secondly, specialized services for people with disabilities are provided in residential facilities for children with disabilities, in public and private daycare centers for people with disabilities, and in public and private habilitation/rehabilitation centers that are specifically for people with disabilities or mental health problems.

Support Services within Communities

Support services for people with disabilities designed to enable them to benefit from independent or supported living are crucial for their successful inclusion in society. Most people with disabilities in Romania live with their families and are not able to access affordable housing or support services for independent living. Adapting houses to take account of a person's disability is expensive since state subsidies cover only the interest on a bank loan for such purposes. Many families of people with disabilities do not have high enough incomes to qualify for a bank loan, which makes the subsidized interest irrelevant. Furthermore, local authorities do not always give priority to requests for social housing submitted by families of people with disabilities, as stipulated in Law 448/2006. Various group homes and supported living arrangements are emerging, mostly for children. In-home support, legal assistance, and accessible leisure, culture, and sports programs are all very limited at the national level but are gradually increasing. To accelerate this process,

[246] In 2011, the MMFPSPV set up 20 mobile teams to support the families of children with disabilities in 18 counties and two sectors of Bucharest. Each mobile team consists of a speech therapist, a physiotherapist, a psychologist, a social worker, a pediatrician, an occupational therapist, and a special educator.

http://www.mmuncii.ro/j33/index.php/ro/transparenta/comunicare/comunicate-de-presa/2009-rezultatele-implementarii-proiectului-cresterea-capacitatii-autoritatilor-publice-locale-din-romania-in-vederea-sprijinirii-copiilor-cu-dizabilitati-in-cadrul-propriilor-familii.

[247] Lunda et al (2010) and WHO (2012)

[248] Wahlbeck and Huber (2009)

[249] Psychiatric and psychosocial habilitation and rehabilitation is governed by quality standards set jointly by the MMFPSPV, the Ministry of Health, and the Ministry of Education and is provided by psychologists, special educators, psychiatrists, and occupational therapists.

policymakers could consider:

- Increasing the number of respite centers for children with disabilities and their parents. These centers offer a break for families who are providing 24/7 care for people with disabilities, and thus make it possible for these people to remain with their families.
- Strengthening and developing SPAS at the community level, to provide professional and peer support to families and carers of people with disabilities, including counseling, self-support groups, and help with administrative procedures and with applying for relevant benefits or social services. It is particularly important to help parents and carers of people with disabilities to obtain a disability certificate as a first step towards accessing a series of entitlements (cash benefits and services). In practice, families in rural areas or deprived communities are often not keen to ask for a disability certificate. According to UNICEF and several NGOs,[250] there is a high number of undeclared disabled children in these areas, for three main reasons: (i) a lack of information about the application procedures; (ii) the stigma that is often attached to disability in these communities; and (iii) the costs involved, including the transportation costs from the person's city of residence to the county Child Protection Commission (CPC) or the DGASPC office.
- Developing housing adapted to people with disabilities within the community (available as social housing as appartments or family-type homes).
- Increasing control over the implementation of legislation, mainly because numerous families of people with disabilities have drawn attention to abuses and irregularities.

Source: Teșliuc, Grigoraș and Stănculescu (coord.) (2015:153-166).

Community-based Services Designed to Prevent Child-Family Separation

The services that were most often mentioned during our qualitative research as being most effective in preventing child-family separation were daycare centers. Daycare centers "for children in need, who can have a warm meal there and are helped with their homework by a good teacher"[251] were unanimously mentioned by the specialists who were interviewed as a more important priority than all other types of services.

> "Opening the day center from the complex [set up by the DGASPC under a project] had some impact. Not a major one, let's not dream now, but kids, when seeing that those around them have a different way of living, they automatically feel inclined to make a change too... Many children from that area were encouraged to access the service and they were actually eager to come. I remember that on the first day when the center was opened, the first group that came, although they were children from Bârlad, didn't understand why water was falling from the shower. It was beyond their understanding. And we're talking here about years 2004-2005, not other times." (Interview with a professional, Bârlad)

Daycare centers for children with disabilities, including those with an educational focus, are also included among the most effective preventive services.

Some specialists explained that, because of the compulsory standards set in the current regulations for these day centers, the services are quite expensive. In big or medium-size towns or in localities with active private providers, these centers might be available. However, in the rural environment and in small urban areas where there are no private providers and where the local budget is not even enough to pay for salaries, there is little capacity to apply for EU funding or other project-based funding, and thus the likelihood of setting up and operating a day center is quite small. Reassessing the current quality standards or regulating for less expensive daycare services would have a significant impact on children from small and disadvantaged localities at risk of separation from their families.

[250] Save the Children, World Vision, and Alpha Transilvană.

[251] Interview with professionals, Piatra Neamț.

"*How are you doing in terms of prevention? What projects or activities are there*?

- Counseling, financial support, through foundations, day centers... Unfortunately only Brașov still has daycare centers; the others were closed because of lack of funds.

- And the one in the county capital is only for children in grades 1-4. So, here, daycare services are missing.

- It's good that there still are some NGOs that provide support, like Diaconia." (Focus group with professionals, Brașov)

Another problem is that very few services exist that target other categories of families at risk of child-family separation, as discussed in section 3.2.3. Thus, in many communities, the following services are either poorly developed or are missing completely:

- Juvenile delinquency prevention services, involving the education and social assistance sectors.
- Early identification and appropriate support services for children whose parents are working abroad (especially those whose mother and father are both working abroad and/or those who experience psychological trauma as a result of the long separation from their parents) and for the adults looking after these children.[252] It is essential to build the capacity of local institutions to tackle this phenomenon because there are no signs that this workforce migration will be reduced in the near future, and many migrants hardly ever come home, if at all.
- Prevention, recovery, and social reintegration measures related to alcohol consumption and abuse,[253] both for teenagers and young people and for adults (their parents). Apart from the limited availability of services, access to the existing services is hindered by a series of factors including the lack of specialist staff and of information as well as the fear of stigmatization.[254] These interventions are even more necessary since, according to WHO, for every person who has an alcohol problem, seven others are affected on average (family, relatives, and friends).
- Because of the lack of preventive services to reduce substance abuse, especially in the education and health care sectors, and the limited capacity of the existing health, psychological, and social assistance services for people with addictions, in many cases, children and young adults with these problems do not receive any community support or receive support that does not meet their needs, even after they enter public care.

"- I think that another reason is that there are insufficient prevention services: we don't have enough prevention services, and I think that there aren't enough day centers either. We can't cover, I'm thinking about the fact that we don't have services for substance abuse.

In your experience, have you encountered this reason for children being separated from their families?

- Personally I haven't had cases in which the child ended up in public care because of this reason, but I've come across requests made by parents or children at risk, with parents who don't know how to handle things... and, unfortunately, the services we can provide are also limited. I mean, there are counseling centers and rehab centers... But it seems that for some these are not enough, both in terms of numbers and type of actual services offered.

[252] Currently, for most children in the records of the DGASPCs, the child's caretaker (one of the parents or a relative) does not receive any specialized support. For instance, in December 2013, this was the situation of 95 percent of children who had one or both parents working abroad and 88 percent of the children with a single parent working abroad.

[253] Alcohol abuse refers to chronic consumption with health, psychological, and social consequences for the individual, as well as to alcohol addiction (WHO, 2014:232).

[254] On the one hand, 80 percent of people with alcohol problems have not used the services that are currently available because they do not know that they exist. On the other hand, general physicians often do not identify early-onset alcohol-related conditions but only when these are already advanced (ALIAT, 2011).

When you say substance abuse, what do you refer to mostly?

- Ethnobotanicals and drugs. Here, there is also a legal issue related to the consumption of psychoactive substances, because we had the same problem with our kids, the ones we have in the system, with their substance consumption; unfortunately, the law does not ban all types of psychoactive substances from consumption. Because I had to take a child with mental troubles to be diagnosed, and these troubles resulted from the consumption - I actually took that substance from the child. The procedure states that first of all you call the emergency service, but I also contacted the unit fighting organized crime and asked for their support. They took the substance, sent it for lab tests and the result is that it is not in the category of pure psychoactive substances banned by law. Unfortunately, there are many such substances with an unbelievable impact on the child's health, especially on teenagers, with long-term consequences, which later affect the child's social integration and interaction." (Focus group with professionals, Cluj-Napoca)

- Services designed to reduce the risk of becoming a victim of human trafficking.
- Services for preventing and combating domestic violence and those for violence victims (for example, crisis centers).

According to the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020,* the availability of services seems to be the main determining factor of the reporting level of cases of violence against children. Notifications to the DGASPCs about children whose physical, mental, spiritual, and psychological development is at risk within their families and require DGASPC intervention increased in municipalities to 16 percent in 2010 compared to 2009, while in other cities the increase was not significant and in rural areas it declined slightly. The strategy also highlights that interventions for preventing and fighting against domestic violence are insufficiently developed, with only slightly more than half of all DGASPCs having a special methodology in place for dealing with and monitoring cases of violence, while only 27 percent have a coordination and support plan for activities carried out in this field by local public administration authorities. At the local SPAS level, the use of specific methodologies and procedures is limited, while specialized services are available only in few places.

Services in Source Communities

Apart from the sectoral analysis of the deficit of community-based services, which is a structural cause of child-family separation, it is useful to have an overall picture of some communities. Unfortunately, at the national level, there are no data on community-based services in urban or rural localities. However, the data collected for this study in communes with source communities can offer an idea, although these territorial administrative units in rural areas probably have very few existing services, even when compared to other rural localities.

Table 31 (section 3.2.5.3) has already shown that only 31 percent of communes that contain a source community have a professional social worker. The remaining 69 percent of communes have a person responsible for social assistance, but most of these personnel have a range of other responsibilities within city hall. Moreover, Figure 46 shows that only 43 percent of communes that contain a source community have a community health nurse, and only one-third also have a Roma health mediator, a school mediator, and/or a school counselor. One out of every five communes that contain source communities has only one SPAS representative, whereas the others have two to five community workers (who might be social workers, staff with social work responsibilities, community health nurses, Roma health mediators, school mediators, or school counselors). In the places with two to five community workers, the most frequent combination involves one or more SPAS representatives (a social worker and/or a staff member with social work responsibilities) and a community health nurse.

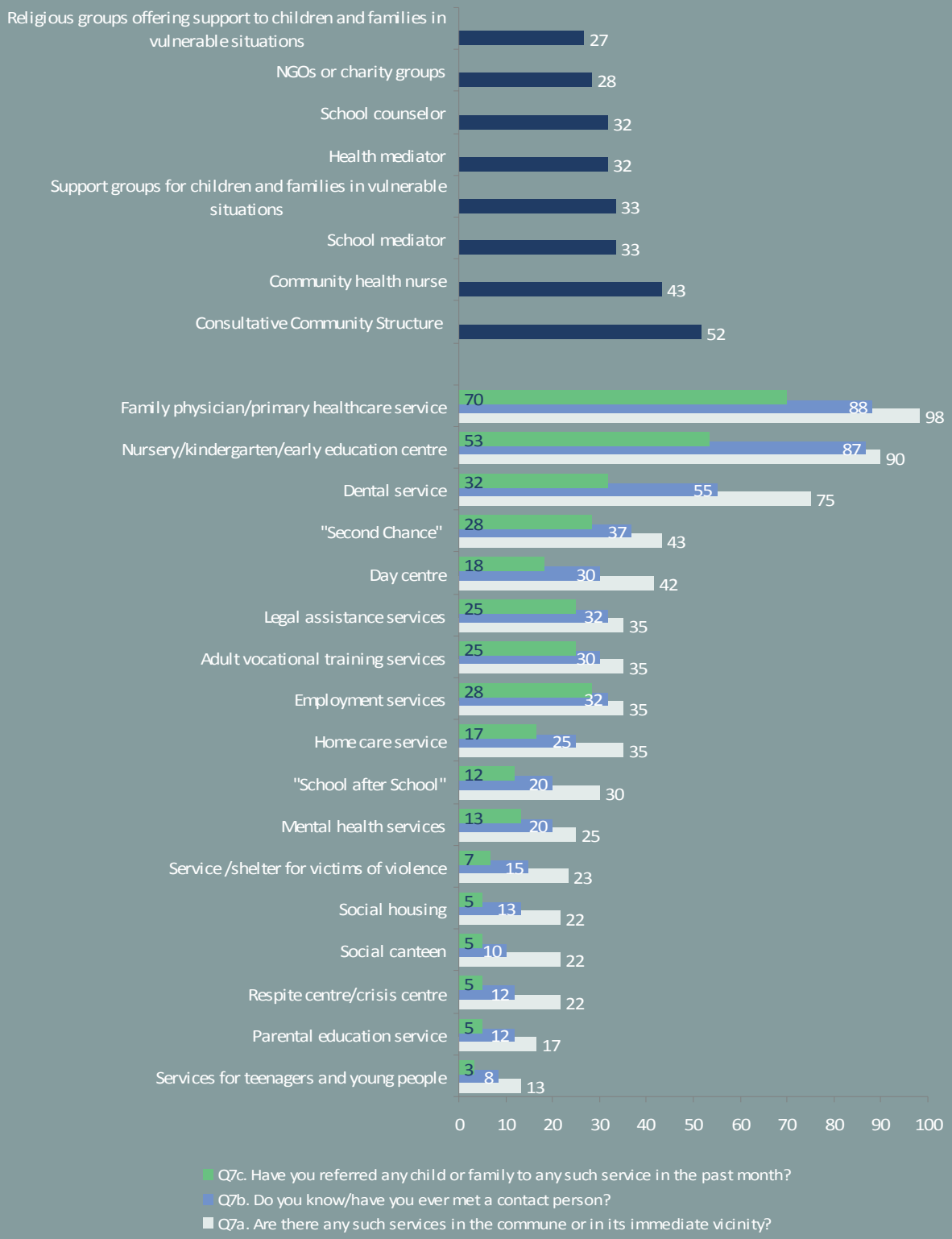
Apart from the community workers, communes with source communities also have informal support groups for children and families in vulnerable situations, NGOs**,** and, in half of these communes, a Community Consultative Structure (SCC). It is worth mentioning that the more social workers there are in a commune, the greater the number of informal support groups and NGO service providers. In those communities where the entire responsibility for social assistance rests on a single person from the municipality, informal groups are rare (and are usually religious) while service providers are virtually nonexistent. Thus, services, community workers, and informal support groups are unevenly distributed even among the communes that contain source communities.

Figure 46 also shows the services that are available in these communities. As expected, the most common are primary healthcare and education services (there is a school in each of these communes). Next in line are "Second Chance"-type services and day centers (43 and 42 percent of communes, respectively). It should be mentioned that these services are usually provided in the neighboring town or commune rather than in the commune included in the study, and transportation to these centers is neither provided nor free in most cases. Daycare centers for children exist in one out of every ten communes that we studied, but they are often just empty premises because they are unable to operate due to lack of staff or funds or for some other reason. Overall, in the 60 communes that we analyzed, only five centers are actually operational, with a total number of 28 employees serving about 200 children. Even among these five centers there are striking differences - from a center with a single employee and 17 beneficiaries, to one with 10 employees and 50 beneficiaries. This is mainly why there is a limited number of referrals that SPAS employees make to daycare centers for children from source communities.

A similar situation prevails in the case of "School after School" services. Thirty percent of the 60 communes have this kind of service within the commune, or in a neighboring commune. However, since transport to the neighboring commune is not provided and is usually not free, we considered only those available within the commune. On that basis, only 10 of the communes that were analyzed have "School after School" services that serve an average of 20 to 30 kids (the minimum number is 3 and the maximum is 40), most of which are financially supported by an NGO. Only in two communes are "School after School" classes paid for by the local authorities, while the remainder are financed by parents. As a result, these services are seldom available to children from source communities (the most vulnerable). This explains the limited number of referrals to "School after School" services.

In conclusion, although the statistics in Figure 46 might paint a positive picture in terms of the available services, the need for daycare services, which have the greatest impact in terms of preventing child-family separation (and school dropouts), is not being met by the currently available supply of services.

Figure 46: Services and Social Workers/Service Providers Available in Communes Containing Source Communities or in Their Immediate Proximity (% of Communes)



Source: Social Assistance Data Sheets from Rural Source Communities (July - August 2015). Date are not weighted (N=60 communes with source communities).

Note: Given the small number of cases, shares below 10 percent are not reliable data.

Making Prevention a Priority with Sufficient Funding

The previous chapter on structural causes showed that cash benefits, social services, education, and health services are still ineffective in preventing child-family separation. In fact, certain deficiencies are structural causes of children being separated from their families. All of these services need to be strengthened, developed, and improved, both in terms of quantity and of quality, affordability, and geographical distribution. While there are problems with supply, there are also problems with demand, particularly because early identification and intervention services, which are by far the most effective and least costly ways to prevent child separation, are missing or are only in the early stage of development in all relevant sectors. Thus, communities cannot yet properly mitigate many of the risk factors for child-family separation.

Box 14: Early Intervention – the Key to an Effective Child Protection System

The first form of early intervention seeks to counter the adverse effects of socioeconomic disadvantage by providing a rich and stimulating environment for children and ensuring that their parents have easy access to advice and support.

The second form of early intervention aims to increase the involvement of all those working with children, young people, and families in observing and responding to low level signs of difficulty. A specific objective of the policy should be to motivate the contribution of several different services in helping children, young people, and their families.

Professionals in universal services such as healthcare and education cannot and should not replace the function of social work, but they do need to be able to understand, engage with, and think professionally about the children, young people, and families with whom they are working. This necessarily entails trying to understand the circumstances of families and children at the point they seek help or when they are identified as needing help while using a service (such as education services, accident and emergency departments, during pre-and post-birth health visiting, during police visits to investigate an incident of violence, or drug and alcohol support). It also entails an understanding of what services social workers can be expected to provide.

Source: Munro (2011a:25).

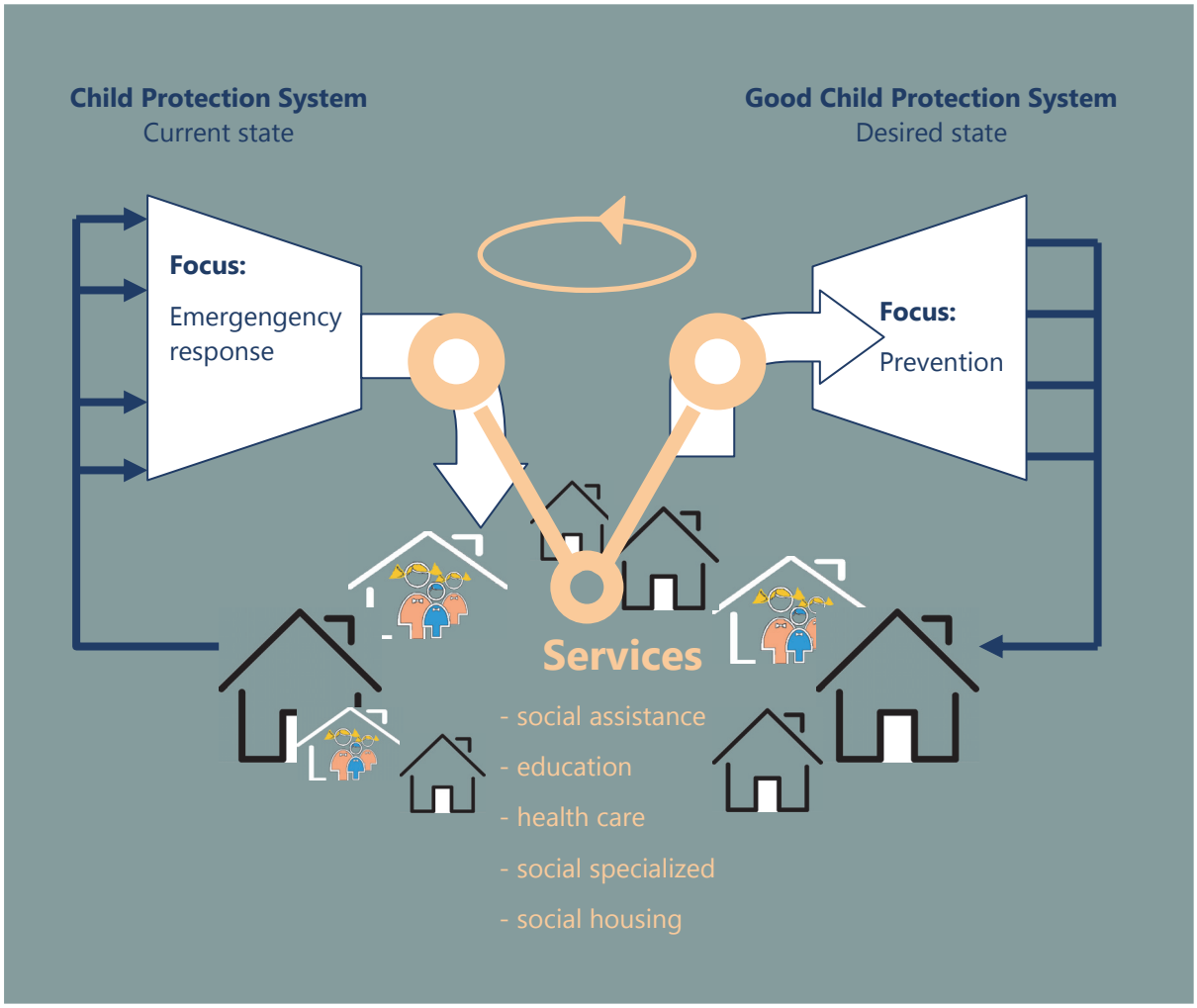
The Romanian child protection system is incapable of preventing child-family separation, and sometimes it wrongfully separates some children from their families. This is no surprise given the context described in the previous sections. So the child protection system cannot and should not have to make up for the inefficiencies of the social benefits system, the gaps in the education and health care systems, the weak development of specialized services for people with disabilities and other vulnerable groups, or the lack of policies and investments in social housing. Public care seems to be called upon to mitigate the adverse effects that all of these shortcomings have on children. The system is designed to be reactive and to be focused on solving "emergencies". In Romania, five siblings enter the system because the parents did not pay the electricity bill and the local authorities or community bodies do not step in. Meanwhile three siblings enter the system because their mother is beaten every day by her partner, but nobody intervenes to help her – not her neighbors, the police, or other local stakeholders - so she has to run away but has nowhere to go with three children. A baby only a few days old ends up in the system because his mom is evicted from a squalid social housing room because she has not paid the rent for the previous three months. Other babies enter the system because their mothers are accepted into maternity wards without IDs and they run away and disappear after having their babies. Other children are admitted to hospital because their parents say they cannot feed them and then leave. There are children who enter the system because they need "a place where they can die in peace, without being kicked out," while others end up in public care because they cannot attend a school in their community. There are children who enter the system because their families cannot afford to feed them, and the municipality urgently calls the DGASPC instead of intervening in the source communities and the marginalized areas because: "They are all

poor, all of them have nothing to eat, all of them are jobless and all of them lack electricity"[255] and "the end result would only be taking the children into public care."[256] This is a picture of public care (the special protection system) as it currently exists – finding emergency solutions for the shortcomings in other systems.

A first step towards building a good child protection system[257] would be to shift the focus of the system from "emergency response" to "preventing child-parent separation." As the specialists interviewed in our qualitative research said:

> "- Supposedly we work on prevention but, in fact, we do intervention, in crisis situations, because prevention would mean identifying those situations before they turn into a crisis, that is to work with those children who show some signs and who could end up in a crisis. Unfortunately, although we claim to be doing prevention, what we do is intervention. And we work on critical cases.
>
> - Exactly. Early identification and prevention - this is what's missing. Prevention, so that we are not faced with situations we can no longer solve, or that we solve with a lot of effort. Better act before reaching that point." (Focus group with professionals, Cluj-Napoca)

Infograph Chart 3: Transition from the Current Situation to a Good Child Protection System



[255] Focus group with professionals, Bucharest.

[256] Interview with a professional, Bacău.

[257] As defined by Munro (2011a:23), see Box 1 in this study.

In the context of such extensive need and given the limited and deficient supply of services currently on offer in communities, the only realistic and economically reasonable option is to focus on reducing the number of entries into the system. At the same time, the deinstitutionalization process should be continued, starting with the traditional institutions (those that have not been modernized), and suitable family care alternatives should be found as permanent solutions for those children who are in or will enter the system.

Infograph Chart 3 shows that the only way to shift the focus of the child protection system onto prevention is to expand and strengthen all of the services discussed above at the community level. Because these services are located within the community, they can act as a filter to reduce the number of children entering the system as well as provide the support needed for the reintegration of children with their families, thus increasing the number of exits from the system. For instance, if daycare centers work well, then the likelihood of children from the community being separated from their family decreases, and, at the same time, the chances of children in the system being reintegrated into their families in a sustainable way increase. Therefore, developing community-based services is the main way to improve the current state of affairs in the child protection system. Otherwise, if nothing changes with regard to community services, the system will be unable to provide better solutions to the problems faced by children and their families.

Box 15: Prevention Services Advocated for by DGASPC Managers

Out of the 45 DGASPCs that participated in HHC Romania's audit of Romanian social services, 42 DGASPC managers mentioned prevention services as the most useful tool for child protection. They highlighted the need to develop services aimed at preventing the child-family separation, in tandem with closing down traditional placement centers and continuing to develop family-type alternative care. Twenty-five DGASPCs are currently providing a wide range of prevention services in the form of daycare, recovery, and counseling centers, although this is not their responsibility under the current laws.

Source: HHC Romania (2012).

Two points need to be made. First, the child protection system has its own internal problems, which are analyzed in Chapter 3.3. However, we focus here on change solutions, which are only partially internal to the system. Many of the change solutions are to be found outside the system and are related to coordination with other systems, such as the social assistance system, social benefits, education, health, the labor market.

The second point is related to the fact that the change model presented above does not imply the need to develop every kind of service in every remote hamlet. The previous sections made an inventory of community-based services (including health and education) and highlighted those that are most efficient in preventing child-family separation. Finding the necessary resources to fund these services will require time, while some may need to be preceded by legal amendments. That is why it would be useful to conduct a national assessment of existing services and to prioritize needed services so that the available resources can be invested in the most efficient way to have the greatest positive impact on the children and to be distributed geographically as fairly as possible.

This national assessment is even more necessary considering the overall picture illustrated by the source communities. You will recall that, in the communes containing source communities, the distribution of services, social workers, informal support groups, and NGO service providers tends to follow the principle of St. Matthew: "Whoever has, will be given more; whoever does not have, even what they have will be taken from them." This means that some of these communes have many services and personnel, while in others all of these activities must be performed by a single SPAS staff member with social assistance responsibilities. Nevertheless, source communities exist in both of these kinds of communes. Therefore, we need to have a clearer understanding of the location and extent of existing services in order to develop a national plan for the development of prevention services for families and children.

The most appropriate agency to lead the development of this national plan would be the ANPDCA, which, in fact, already has such a project under preparation. However, it would need to draw up the plan in close collaboration with the Family Policies Directorate and the Social Services Directorate within the MMFPSPV, with the ANPD (National Authority for People with Disabilities), the Ministry of Education, the Ministry of Health, the county institutions that provide methodological guidance for services provided at the local level (the DGASPCs for the SPAS, the DSP for community healthcare, and the CJRAE for school mediators), local authorities, and representatives of relevant associations such as the Association of Communes, the Association of Towns in Romania, the Association of Municipalities in Romania, and the National Federation of Local Action Groups. Romanian NGOs should also be consulted as they are major service providers for children and families and have developed and piloted projects that could be used as best practices and scaled up nationwide. All of these stakeholders should agree on a single plan. Only a coordinated and mutually agreed plan developed by such a wide-ranging partnership stands the chance of being successfully implemented in the medium and long run.[258]

If local authorities are not mobilized, informed and involved throughout the process, there is a high risk of the plan's implementation being random and distorted. This is the view of the child protection specialists interviewed for this study who made the following observations:

> "Preventing child-family separation is not on the political agenda, nor is it on the agenda of communes." "There is no local community initiative." "Preventing child relinquishment is not important to them. It is not important, they are not going to spend resources on it, it's the problem of every family." "It is very clear, you will never find priorities related to these children in need on a mayor's agenda. They have political priorities of a different kind: roads, schools, things that generate money." (Focus group with professionals, Cluj-Napoca)

And the last element, which is just as important, is to ensure funding for the national plan for developing prevention services for families and children. As explained above, the change model is not limited to social services but covers a wide range of services and programs funded by various ministries. Prevention activities are underfunded in all social fields, including education, healthcare, and social assistance, because the focus tends to be on responding to emergencies and crises. This approach opens the door for more and more children to get into difficulties and reach the point when harm has already been done (the child has dropped out of school, the child suffers from health conditions that could have been prevented by vaccines, or the child is separated from his or her family). This is why promoting a national plan for developing prevention services should be supported by the budgets of several ministries and agreed with the Ministry of Finance.

Many of the child protection specialists who participated in the qualitative study highlighted the need to fund prevention services and activities and presented many arguments for this. One example is the second quote from the previous Professionals' Story Bag. Here are some more examples:

> "The rights of a child. The first right of a child is to grow up with his natural family. So much is spent to provide all facilities in the centers. [...] and we give them everything that a child needs...but nothing is spent on prevention, so we are not ensuring their first right granted by law, that of living with their natural family." (Focus group with professionals, Craiova)

> "At the local level, the state, through the SPAS (the Public Social Assistance Service) could allocate enough human resources to manage these cases involving vulnerable families. Then, once you have the local human resources, at least two to three social workers depending on the size of the community, they need to be trained, to do their job, and to have enough financial resources, because it is sad to hear the state say that: 'I don't have money for social assistance, for prevention in the community, so I can't pay anyone to prevent social cases.' But, at the same time, the state pays for emergency support, for child care centers and protection services, for social welfare, so, at the end of the day, the state will give money anyway." (Focus group with professionals, Brașov)

[258] With respect to actual service provision, our qualitative study highlighted a series of issues related to improving and increasing the transparency and dissemination of the procedures for contracting social services, as well as ensuring fair competition between NGOs and public institutions when accessing the available resources.

A 2013 HHC study[259] also provides economic arguments in favor of the prevention model. The study forecasted the costs that would be incurred by the child protection system up to 2020 according to three policy scenarios: (i) a baseline scenario in which nothing changes; (ii) a moderate reform scenario in which traditional residential centers are closed down between 2013 and 2020 and the children are transferred to foster carers or family homes; and (iii) the deinstitutionalization and prevention scenario involving the moderate reform plus investments in the development of community-based prevention services, which is the model supported in this report. The results of the HHC study showed that, in financial terms, although scenarios 2 and 3 incur higher initial capital investments, in time they allow for recurrent savings that will exceed the costs. By 2020, the new prevention-centered system would generate sustainable financial gains as well as benefits for children and their families (a significant reduction in the number of entries into the system and in the number of children that are in the system as well as improvements in the care services for children in the system). In other words, the prevention-centered model is achievable and profitable, both in social and in financial terms.

3.2.5.5 Attitudes and Values that Do Not Support Preventing Child-Family Separations

The structural causes of child-family separations also include some attitudes, values, customs, or practices that act as barriers to preventing children's separation from their family.

The first category of obstacles refers to the discrimination that continues to expose some vulnerable groups to the risk of social exclusion. Although the situation has improved in recent years, the adult population of Romania has shown a very low tolerance for [260] alcoholics, drug addicts, people with criminal records, people suffering from HIV/AIDS, or LGBTQ people.

At the same time, Roma people are still the subject of discrimination based on their ethnicity.[261] A low level of tolerance and understanding is also shown to people with disabilities. The case managers that we interviewed stated that labeling and prejudice prevent children with disabilities in the system from being adopted or reintegrated.

The second category of obstacles refers to a high tolerance of harmful behavior such as alcohol abuse, domestic violence, and begging. Although alcoholics are stigmatized, alcohol abuse is seen as normal (even in the presence of children). Similarly, family violence is seen as common, with 60 percent of the population tolerating violent behavior within the family as they believe that these acts are justified in some situations or, depending on the context, in all situations.[262]

> "Let me tell you something: in most villages everyone knows when a neighbor beats, abuses, or neglects his children on a regular basis. However, since poverty is ubiquitous, alcohol abuse is widely used and violence is perceived as 'normal' or an acceptable educational method, no one takes any measures in this respect. They say: we should focus on our family, and the others on theirs. However, when they fight, let's say for a broken fence, they immediately remember that there is a social worker in the town hall to whom they can go and file a complaint. Or, even better, they use the Children's Hotline and call the DGASPC, denouncing their neighbor's 'wrong' behavior. The conclusion is that we need more broken fences to defend the 'invisible' children." (Supervisor in the 'Helping the invisible children' UNICEF Project, Buzău)[263]

[259] Comșa et al. (2013).

[260] The level of intolerance was measured by the share of the total population who stated that they would not be happy to have someone from these categories as a neighbour. These data come from the European Values Study conducted in 2008.

[261] According to the European Values Study from 2008, 40 percent of the adult Romanians would not want to have a Roma neighbor, which is two times higher than the percentage of people who would reject a neighbour with other characteristics such as Muslims (23 percent), people of a different race (21 percent), immigrants (21 percent), or Jews (19 percent).

[262] Research by the *Mina Minovici* National Institute of Forensic Medicine and the Center for Urban and Regional Sociology on violence-related cases in 2008.

[263] Stănculescu and Marin (2012:40).

Physical punishment, although banned by law since 2004, is still widespread. Several recent studies have shown that, in day-to-day family life, physical punishment is still used quite often,[264] being regarded as a "necessary evil."[265] Many parents feel that it is a good way of educating their children[266] because they are not aware of more positive methods.[267] Children face several types of violences from the adults who look after them, including neglect and physical, verbal, and/or psychological abuse, both within the family and at school.[268]

The third category of obstacles, which is of major importance, is related to the tolerant attitude towards child-parent separations shown by both the general population and the authorities. Some child protection specialists explain that this attitude has historical roots and is closely related to the undervaluation of children in Romanian society. The literature on child care and family separation[269] reinforces this view while arguing that social acceptance of child-family separations is not specific to Romania but is common in all former socialist bloc countries that promoted aggressive pro-birth policies paired, in some countries like Romania, with pro-relinquishment policies.

In Romania, even now children are too often seen as a "burden" or as a "source of income" or as a "risk," not only by their families and communities but even by policymakers. According to a participant in our focus groups with child protection professionals, "We are turning into a gerontocratic society, which focuses a lot on those who have the power, people with the power of money, power of the vote, power to be heard in society, while children remain an unheard voice, a silent voice, and they are ignored."[270]

> "I would like to add something which, in my opinion, is extremely important and which has been neglected, at least since I've been in child protection. We, as a nation, as people, as a country, we have a traumatizing history of separation. And we accept separation way too easily. So, within the community, very seldom do you have people who see the child-family separation as a tragedy or that the child's life is somehow ruined. We have too much tolerance, and even the local authorities see them as a burden. So, on the one hand, in these disadvantaged areas the families accept the idea of separation way too easily and even when they decline it, they do so because the child is a potential source of revenue or of I don't know what, so, in my opinion, in our country, children are not valued as they should be. We don't have long-term thinking, so everyone tries to solve crisis situations, urgently, hastily, like putting out a fire, and we do not have a long-term vision of what will happen to that child in the future; what matters is for the local authority or the family or whoever has the 'problem' child to be rid of it, "problem" in a manner of speaking, because, most often, these children are perfectly healthy and a huge asset, but nobody sees that value anymore." (Focus group with professionals, Cluj-Napoca)

The specialists say about some families and communities that they have turned child relinquishment into a practice. The case file data shows that more than 3 percent of all children in public care have between 5 to 10 siblings in the system, some of whom entered the system at different periods, which means that there are families who constantly send a large number of children into the system. At the same time, the fact that we were able to identify source communities reveals that there are some areas where child-family separation is particularly common. For those families who are willing to make "more babies than the DGASPC can take" and whose approach is "I make as many babies as I want

[264] The percentage ranges from 38 percent of parents who admit to the abuse and 63 percent of parents based on what their children report, according to Grădinaru and Stănculeanu (2013).

[265] Thirty percent of parents, according to UNICEF (2014).

[266] Twenty percent of parents, according to Grădinaru and Stănculeanu (2013).

[267] For instance, 11 percent of parents immediately slap their children or pull them by the hair if they do something wrong (UNICEF, 2014). According to the children, 18 percent say they were beaten with a stick, 13 percent with a belt, and 8 percent with a wooden spoon in the previous year (Grădinaru and Stănculeanu, 2013).

[268] Eighty-three percent of children are scolded by teachers when they make a mistake, 33 percent are insulted and labeled, and 7 percent of children say they are beaten by their teachers (Grădinaru and Stănculeanu, 2013).

[269] For instance, Palayret (2013).

[270] Focus group with professionals, Cluj-Napoca.

and raise as many as I feel like,"[271] the specialists feel that the introduction of constraints or conditionalities is required to discourage such behavior.

> "But if in two, three, four, five years I see that nothing has changed, with all the support and endorsement of the local community the family doesn't want to do anything, some parents refuse. We have a parent who said that he will keep on having more babies than what we can accept in the system. What can I do in this case? We are not used to sanctioning this kind of parental behavior, we as an institution, and other child protection institutions. I don't know how many institutions and how many DGASPCs in the country, when sending a file to court, also ask for the parent to be sanctioned. I mean, hello, the child was neglected, abused. At the end of [Law] 272 there are certain fines envisaged.
>
> *So there are these sanctions in the law?*
>
> Yes, there are. In a way, we are failing to observe the law because we don't propose those sanctions. Because we think that these are social cases, they will never be able to pay for the sanction…but, in the community, they will be on town hall record as having been fined. And? If they don't pay them, they'll keep piling up. I don't know how many of them have been arrested. I was thinking at some point that, for all these people that keep having babies […] we have to come up with a formula, one that would be accepted by judges as well as by us. (Interview with a professional, Bacău)
>
> "If we refer to teenagers, when the going gets rough and the parent can't cope with everything, they come to us and say: he/she is not my responsibility. I've educated him/her so far, now the state should do it, or it should open correctional centers. So they will go to the police, to the child protection directorate, to the town hall and they feel that no one is solving their problem. At the same time, they don't want any counseling, although this might be a good alternative. All they want is to get rid of the responsibility. (Focus group with professionals, Cluj-Napoca).

This kind of behavior by parents is often encouraged by the answers that they received from some authorities or even specialists, like medical staff[272] and is endorsed by the general idea, still quite widespread, that "it's normal for the state to raise my child."

> "For 25 years we kept hearing that it's alright to go on having babies because the state will take them and raise them, an idea which has not been counteracted by a new mainstream campaign to cancel this theory. People still believe that it is better to be in an institution than at home. And although there have been some campaigns like "Children's homes are not at home," they were feeble attempts compared to the intense pro-relinquishment propaganda promoted before 1989." (Focus group with specialists, Cluj-Napoca).

All these attitudes, beliefs, and practices have to be taken into account in all prevention efforts. Community information and awareness campaigns that encourage tolerance for diversity should be part of the development of community-based prevention services as a way of making them more effective. These kinds of activities should target not only the general public but also staff in relevant sectors and decision-makers.

[271] Interview with parents of institutionalized children from a rural source community in the county of Călărași.

[272] MS, IOMC, and UNICEF (1991). See also section 3.1.3.2.

3.2.6 Causes of Child–Family Separation from the Perspective of Families and Specialists

The causes of child-family separations, analyzed in the previous five chapters, include concepts like abuse, neglect, maltreatment, and poverty, which can be interpreted in different ways at different moments in time, in different cultures, and by different people. For instance, poverty might have different meanings for a child who entered the system at the beginning of the 1990s, and one who entered it recently. Abuse and neglect were regulated by law only in 2004, so this cause might have different meanings for children who entered the system before and after that year.

The main method used in the previous sections was to compare facts derived from the data in the case files of children in public care with the causes of separation recorded by the DGASPC specialists. However, we decided that it would also be useful to present additional perspectives on the causes of separation, such as those of the stakeholders involved in the child-family separation process - mothers and/or families, social workers or SPAS representatives, and DGASPC specialists. Our data on the rural source communities gave us this opportunity. Figure 47 shows the results of the comparison.

There are striking differences among the responses of these three types of actors regarding the causes of child-family separations, based on their level of education and their life experience. The mothers and/or families and the SPAS representatives were making retrospective judgments whereas the causes expressed by the DGASPC specialists were made at the time when the child entered the system, so there is also a time delay between these different views.[273]

The share of cases with unknown or forgotten cause of separation according to SPAS representatives is four times higher than that of cases with unknown or forgotten cause of separation according to DGASPC specialists. This finding shows that, for 16 percent of children from source communities who are in the system, no attempt at reintegration has been made at the community level since even the main cause of child-family separation was already forgotten. Also, for 8 percent of these children, even their own families have forgotten the reason for the separation.

Neither the families nor SPAS representatives made any reference to emotional abuse, sexual abuse, or labor exploitation, including human trafficking or the sexual exploitation of the child, although they were asked these questions directly. Child neglect and abuse were evaluations that were specific to DGASPC professionals, whereas the families and the SPAS representatives tended to point to parental behavior that led to the separation (parental risk factors) such as one or both of the parents leaving the family or going abroad to work.

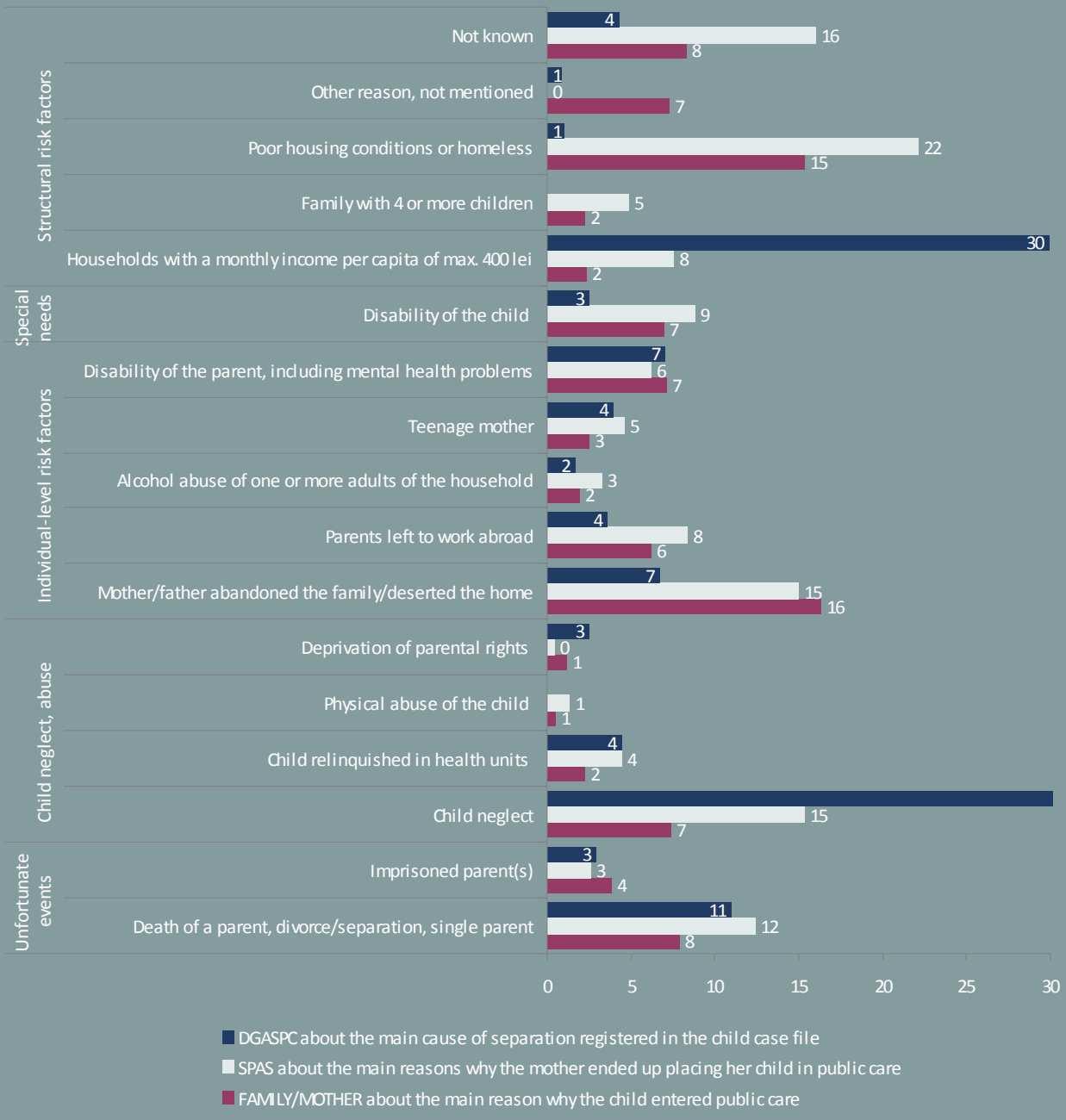
The situation is similar when it comes to SPAS/DGASPC/family views/justification regarding the "child disability" main cause of separation, but here some parents and SPAS representatives added comments regarding the lack of health, recovery, or educational services in the commune.

In terms of structural risk factors, for 15 percent of children in public care, the SPAS representatives mentioned "inadequate housing conditions" as the main reason why the child is now in the state's care, whereas they seldom mentioned reasons like "poverty" or "too many children" (2 percent). The assessments made by SPAS representatives are in line with those of mothers and/or families, who referred to "families with many children who live off benefits in inadequate housing conditions."[274] The DGASPC specialists tended to group these reasons under one label - "poverty" - without any explanation or supporting data, to which they also added "housing problems" for 1 percent of children from rural source communities.

[273] Mothers and/or families tended to offer a single reason (the main one) for the separation, whereas the SPAS representatives sometimes mentioned several reasons related to the mother, most likely referring to her other children. In the case files, DGASPC specialists mentioned between two and four causes of separation for some children.

[274] Social worker in a commune in Constanța county.

Figure 47: Main Cause of Child-Family Separations from the Perspectives of Mothers/Families, SPAS Representatives, and DGASPC Specialists (%)



Source: Social Assistance Data Sheets from Rural Source Communities (July-August 2015). Data are not weighted (for mothers/families, N=1,140 children in public care and for SPAS representatives, N=952 mothers from households still in the commune). The DGASPC specialists' assessments of causes come from the Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=4,484 children from rural source communities).

Note: For comparison purposes, the causes of separation taken from the case files have been regrouped in line with the list of reasons used in the study on source communities. This is why some of the items used to identify dysfunctional families (as defined in section 3.2.3.2) are included in the graph under "unfortunate events" instead of under "individual (parental) risk factors."

If we consider the three perspectives on the causes of separation for a given household, then we can see that these causes overlap in a maximum 60 percent of the cases and are limited to the following: (i) child disability, (ii) parental disability, (iii) imprisoned parents, and (iv) the mother and/or father leaving home.

3.2.7 So What Are the Causes of Separation?

The model[275] that we used in analyzing the causes of child-family separation, which we elaborated on in the previous sections, has four main components:

(1) The child might get separated from his or her family as a result of unfortunate events,[276] such as the death of a parent/parents or their institutionalization, whether in jail or in a social or a health institution (for instance, a psychiatric hospital).

Apart from such unfortunate events, the reasons for separating a child from the family might also include child maltreatment,[277] including neglect, abuse, and/or exploitation or any form of family violence. Child relinquishment in maternity wards or in other health units or abandonment on the street or in a public space can be considered as extreme forms of neglect.[278] This category also includes the deprivation of parental rights, as shown in section 3.2.2.4, since all cases that specialists categorized as being due to the deprivation of parental rights include file evidence of child neglect, abuse, and/or exploitation.

(2) At a more in-depth level, the model also considers the individual (parental) risk factors[279] that can lead to either violence or maltreatment of the child, such as parents leaving to work abroad, dysfunctional families, teen pregnancies, alcohol and substance abuse, promiscuous behavior, problems with the police or criminal record, domestic violence, and parental disability and/or mental health problems.

(3) We analyzed five categories of children at risk[280] when entering public care: (i) infants (0 to 12 months) born prematurely and/or underweight; (ii) children with disabilities; (iii) children aged 6 to 17 years with special educational needs (SEN); (iv) children with developmental delays; and (v) children aged 7 to 17 years with behavioral problems. We found that the disproportionate risk of being separated from their families and entering public care to which these categories of children are exposed stems either from parental risk factors or from structural risk factors.

(4) The model also looks at structural risk factors,[281] which include: (i) poverty and the existence of source communities; (ii) a lack of, the poor development of, or the poor coordination of prevention services and activities in all relevant sectors (including social benefits, housing, general education and healthcare services, and social services targeting specific vulnerable groups) in the community; and (iii) attitudes, values, and general practices that do not support the prevention of child-family separations and may even encourage them.

[275] The model is in line with that proposed by UNICEF for analyzing the (immediate and root) causes behind the institutionalization of children under the age of 3 (Palayret, 2013:65).

[276] See section 3.2.1.

[277] See section 3.2.2.

[278] See subsections 3.1.3.2 and 3.1.3.3.

[279] See section 3.2.3.

[280] See section 3.2.4.

[281] See section 3.2.5.

Infograph Chart 4: Reasons for Child-Family Separation and Cause Analysis Model

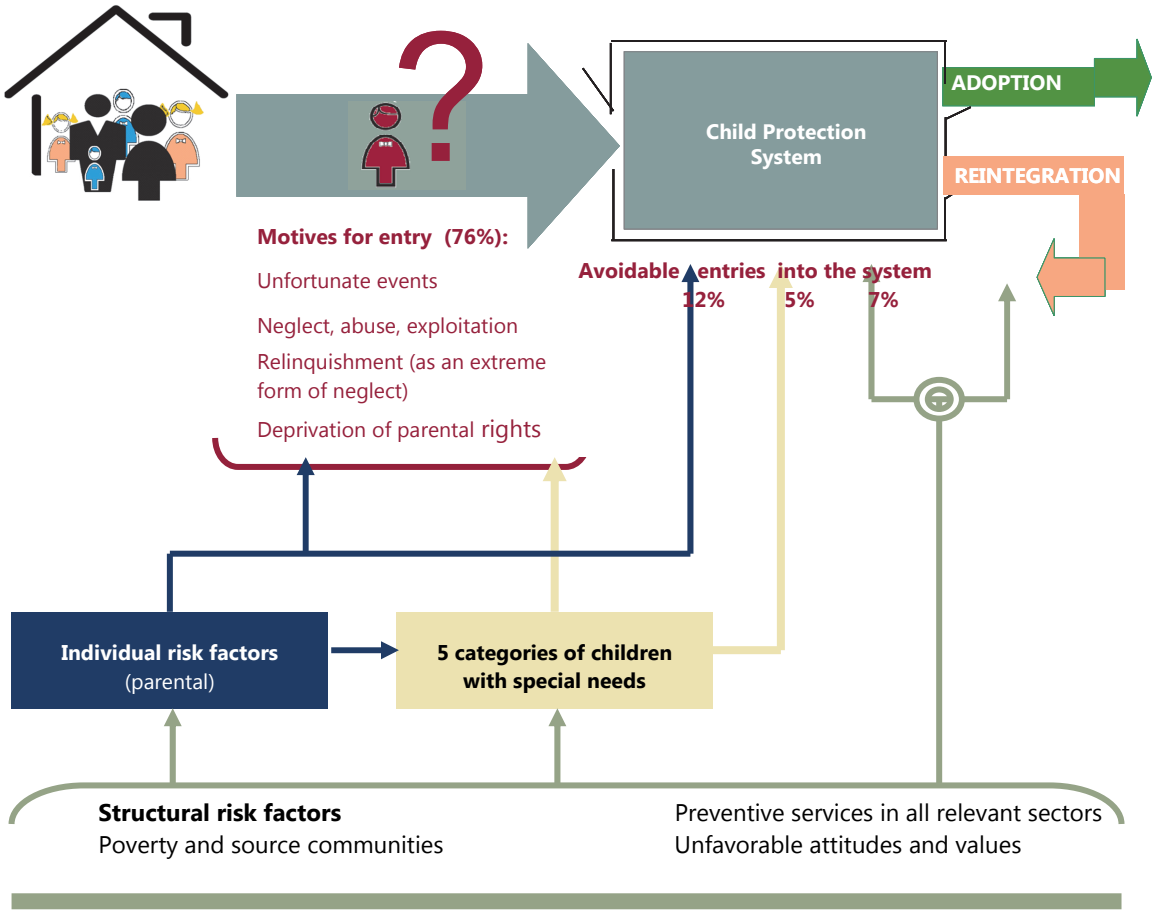
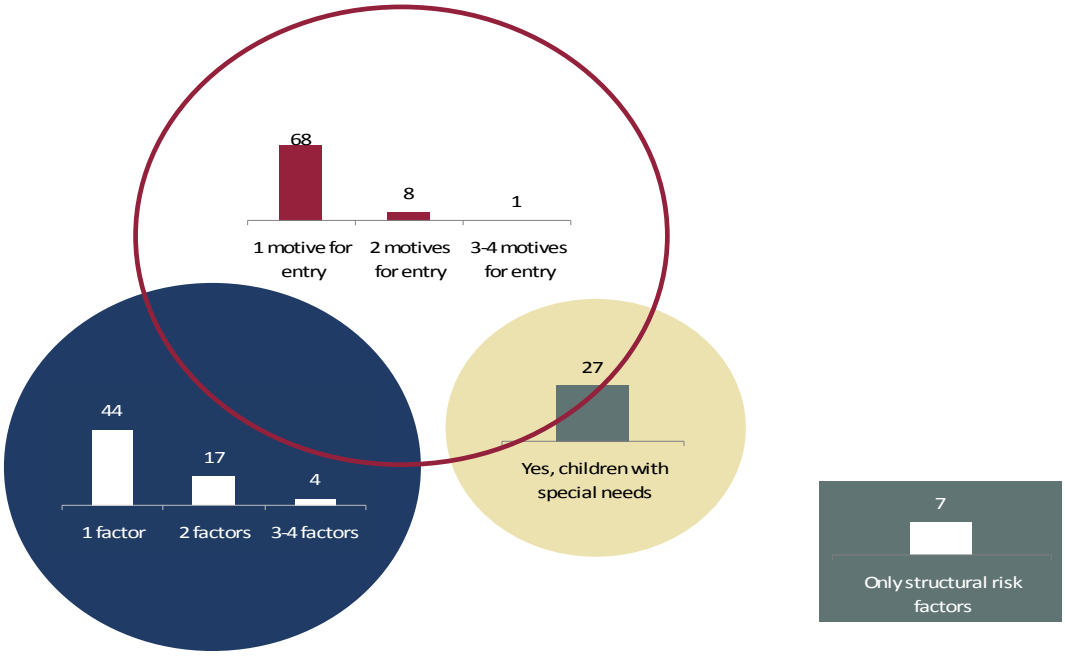


Figure 48: Distribution of Children in Public Care by Reasons for Separation and Risk Factors (% of Total)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Infograph Chart 4 shows a chart of the model used to analyze the causes of child-family separation. The model states that a child can be deprived of parental care only in certain circumstances that are represented by the category called reasons. Child relinquishment, for instance, is a fact and a reason for separation, but it has some underlying causes. These causes of separation can be broken down into three major categories. At the individual level, these are risk factors that lead to parental behavior that are likely to harm the child's health, development, or life, and categories of children with some features that make them vulnerable to a high risk of separation from their family. The third category at the level of the community and society consists of structural risk factors related to the general social and economic environment.

This multi-level analysis model takes a bottom-up approach. Structural risk factors can trigger individual-level factors (related to the parent and/or child) which, in turn, become the reasons for the child entering the system. Moreover, structural factors can work both ways. They can foster child-family separation through the individual-level factors, but at the same time they can ensure or prevent the conditions necessary to reintegrate children into their families and communities. For example, the likelihood of a child with disabilities being separated from their family increases if the community does not have accessible and appropriate recovery services. At the same time, the likelihood of a child with disabilities who is currently in the system returning to their family or being adopted decreases if the community does not have accessible and appropriate recovery services. This dual influence of the structural factors is also presented in Infograph Chart 4. The number of children in public care cannot be significantly reduced and children's rights cannot be fully respected as long as prevention services to address these risk factors are not available at the community level.

No single risk factor is sufficient to explain any given cause of separation (or reason for the child's entry into the system) such as child abuse or neglect. For example, if one or both of a child's parents are alcohol abusers, it is not a given that they will abuse their child or abandon him or her in a public space. Only a combination of individual and structural risk factors (usually alongside other determinants that have not been included in the model)[282] can determine child relinquishment, neglect, abuse,[283] and other reasons for entering the system. Also, protective factors must be factored in as well, such as the support of the extended family or the good relationship that a child might have with their grandmother, which are not included in the model given that its focus is on the causes of separation.

This is exactly why it should not be possible (at least in theory) for a child to enter the system only based on the risk factors (individual and/or structural) or on some characteristics that the child might have. Reasons like "mom and dad didn't have any accommodation and didn't have money to support me" should not exist in a good child protection system. Nor in a good protection system would a child with SEN have to enter the system just so he or she can go to school. Also, cases like the one in which the five siblings ended up in the system because the parents did not pay the electricity bill should not exist. It is clear that the baby that was placed in the system because his mother was evicted from a social housing unit was wrongfully separated from her. Cases like the child with a moderate disability who went into the system because his family did not accept him should also not exist.

In other words, all cases in which children go into the system because of flaws in various systems or because certain services do not exist or cannot be accessed or because of stigmatization and/or other prejudices are wrongful family separations. In the diagram in Infograph Chart 4, the three entry routes (arrows) into the system that are only based on risk factors (either individual or structural) or on child characteristics are considered to be avoidable, meaning their numbers must be decreased in order to improve the child protection system. None of these routes can be completely eliminated since they all exist even in the most developed societies. For instance, for children with severe disabilities who require palliative care, facilities should exist to provide them with appropriate care, and maybe these services cannot be provided at the county level, but can be provided at the regional level. At the same time, separating a child from the family on social grounds cannot always be avoided, and it is not even

[282] For instance, the mothers'/parents' level of education and childhood history.

[283] See, for instance, Munro, Taylor, and Bradbury-Jones (2013).

recommended when the family and/or local community do not take responsibility for their children. However, gradually reducing the numbers of children entering public care via these three entry routes would be a good indicator that the reform of the system is going in the right direction.

It was not possible for us to carry out a rigorous testing using as benchmark a control group of children living with their families with characteristics similar to those of the children in public care. However, based on this model, we were able to analyze the data in the case files of children in public care using only the factual data contained in the case files, without the DGASPC specialists' assessments of the causes of separation.

In total, for 76 percent of children in public care, the case files mentioned one or more reasons for separation: unfortunate events (the death or institutionalization of a parent/parents), neglect, abuse, or exploitation, child relinquishment, and/or the deprivation of parental rights. The other 24 percent of the children were avoidable entries (Infograph Chart 4), whose case files contained no references to any of these reasons for separation. However, their case files did refer to parental risk factors (12 percent) or the child's special needs (5 percent) or the child's entry into the system was strictly due to structural factors (7 percent). Table 33 shows the distribution of children based on factual data in the case files related to the reasons and/or causes (risk factors) of their separation from the family.

> *"What are the main reasons for separating a child from the family?*
>
> - The first one is the economic context. The second, in my opinion, as someone who goes in the field and knows what's happening there, is the fact that there are no prevention programs. And it's true that I am the only forensic doctor around here, there's almost no…and I know what I'm saying…no prevention program. The law states that the management plan should be prepared by the social worker in the commune. Well, the one in the commune usually calls and says "Come here, because I have five families" or picks up the phone when there is an emergency to say: "Come here, because they are killing each other; come and take them away!" Or the maternity or neonatology wards, or the pediatric hospitals, since we were talking about hospitals; kids are born and parents disappear. Or they go there because it's winter, the kids stay and the parents leave. These are the main entry routes. There are also others, but as the most visible areas, these are the main entry routes." (Focus group with professionals, Bucharest)

Table 33 and Figure 50 support the analysis of the DGASPC specialists regarding the causes of child-family separations as does the above quote drawn from one of the focus groups organized under the qualitative research. It is clear that the first priority must be to tackle the structural factors that cause children to be separated from their families, such as poverty and inadequate housing (including a lack of housing, evictions, and a lack of social housing units) while at the same time developing the necessary community-level prevention services and response. These structural factors are poorly documented in the children's case files. For instance, the available data indicate that most children in public care come from families that are poor or at risk of poverty and living in inadequate housing conditions. The answers given by parents and SPAS representatives from the rural source communities in our qualitative research confirmed these statistical results. Despite this, the factual data in the case files show that these structural factors applied to only 36 percent of children in care (Figure 49). However, it is exactly these structural factors that play a key role in keeping the "entry gates" to the system wide open because they often lead to child neglect, abuse, and/or exploitation and relinquishment, especially in maternity wards, but also in other health units or public spaces (see Table 33).

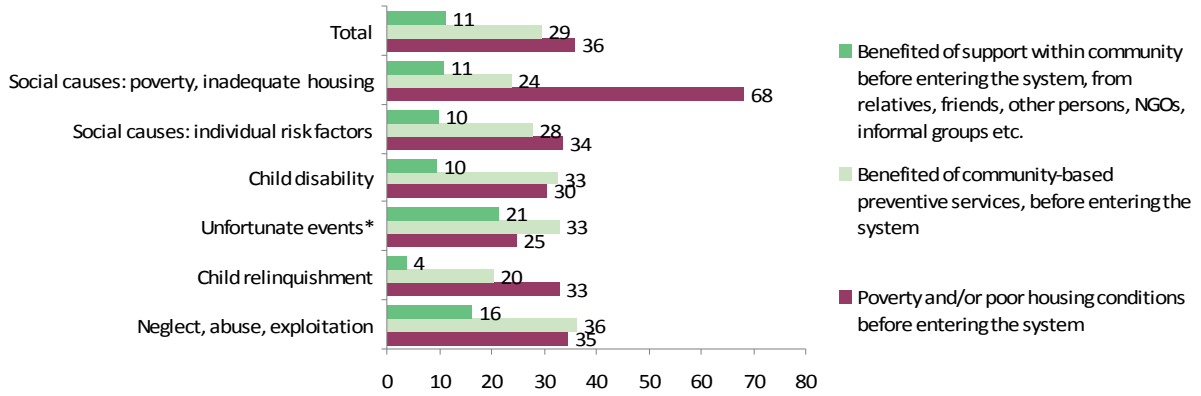
Table 33: Distribution of Children in Public Care by Reasons for Separation (Risk Factors) as Factually Documented in the Case Files (% of Total)

				Avoidable Entries into the System			
	Neglect, abuse, exploitation	Child relinquish-ment	Unfortunate events*	Child disability	Social causes: individual risk factors	Social causes: poverty, inadequate housing	**Total**
Children (0-17 years old) in public care:							
- N	**22,967**	**15,331**	**1,414**	**2,553**	**6,411**	**3,668**	**52,344**
- %	**44**	**29**	**3**	**5**	**12**	**7**	**100**
REASONS FOR SEPARATION							
Total, out of which:	**44**	**29**	**3**	**0**	**0**	**0**	**76**
Neglect, abuse, and/or exploitation, of which:	**43**	**0**	**0**	**0**	**0**	**0**	**43**
- neglect	41	0	0	0	0	0	41
- abuse	12	0	0	0	0	0	12
- exploitation	3	0	0	0	0	0	3
Deprivation of parental rights	**1**	**0**	**0**	**0**	**0**	**0**	**1**
Child relinquishment, of which:	**3**	**29**	**0**	**0**	**0**	**0**	**32**
- immediately after birth in maternity ward	0	24	0	0	0	0	24
- in health institutions	2	5	0	0	0	0	7
- on the street or in public places	0.5	0.5	0	0	0	0	1
Unfortunate events	**3**	**2**	**3**	**0**	**0**	**0**	**8**
PARENTAL RISK FACTORS:							
Total, out of which:	**33**	**15**	**2**	**3**	**12**	**0**	**64**
- going abroad to work	3	0.3	0.2	0.2	1	0	5
- dysfunctional families**	8	3	0.5	1	4	0	16
- teenage mothers (12-17 years old when giving birth)	9	6	0.5	1	5	0	22
- teenage mothers (12-17 years old when the child entered the system)	1	2	0	0.1	1	0	4
- alcohol or substance abuse	16	1	0.2	1	2	0	20
- promiscuous behavior, problems with the police, criminal record	6	2	2	0.1	1	0	10
- parental disability and/or mental health problems	7	6	0.3	1	2	0	16
CATEGORIES OF CHILDREN AT RISK							
Total, out of which:	**12**	**9**	**0**	**5**	**0**	**0**	**27**
- Infants (0-12 months old) born prematurely and/or underweight	1	4	0	0.4	0	0	5
- Children (0-17 years) with disabilities	4	4	0	3	0	0	11
- Children (0-17 years) with developmental delays	9	5	0	3	0	0	17
- Children (6-17 years) with SEN	2	0.1	0	1	0	0	3
- Children (7-17 years) with behavioral problems	2.2	0	0	0.3	0	0	3
TOTAL NUMBER OF REASONS FOR SEPARATION:							
0	0	0	0	0	0	7	**7**
1	8	10	1	1	9	0	**28**
2	16	11	1	2	3	0	**32**
3	12	6	1	1	0	0	**19**
4	6	2	0.4	1	0	0	**9**
5-8 reasons	3	1	0.1	0.1	0	0	**4**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: *Unfortunate events refer to the death or institutionalization of the parent/parents. **Dysfunctional families as defined in section 3.2.3.2. The colored cells highlight prevailing reasons.

Figure 49: Distribution of Children in Public Care by Causes of Separation and Structural Risk Factors as Factually Documented in the Case Files (% of Category)



Source: Survey of the Case Files of children in Public Care (November-December 2014). Data are weighted.
Note: *Unfortunate events refer to the death or institutionalization of parent/parents.

Let us now take a closer look at the "entry gates" into the system in the context of our model of the causes of child-family separation that is described above and is illustrated in Infograph Chart 4.

Child neglect, abuse, and/or exploitation are documented in the case files of 44 percent of children in public care (Table 33). Those cases where the parents were deprived of their parental rights are included in the category of child neglect, abuse, and/or exploitation. The most common is child neglect (41 percent), which is associated with several parental risk factors, especially with alcohol or substance abuse, being a teenage mother when giving birth (not necessarily when the child goes into the system), and dysfunctional families.[284] Children from all risk categories entered the system for this reason, especially those aged between 0 and 17 years with developmental delays.

Child relinquishment is listed in the case files of 29 percent of children in public care (Table 33). It usually takes place in a maternity ward or neonatology unit immediately after birth (24 percent) and is associated with a wide range of parental risk factors, predominantly teenage mothers and parents with disabilities and/or mental health problems. The categories of children at risk include children with disabilities and/or developmental delays, as well as infants (aged 0 to 12 months) born prematurely and/or underweight. Figure 50 shows that for these children there is an even more striking absence of both preventive services in the community and support from kinship networks, NGOs, and informal groups.

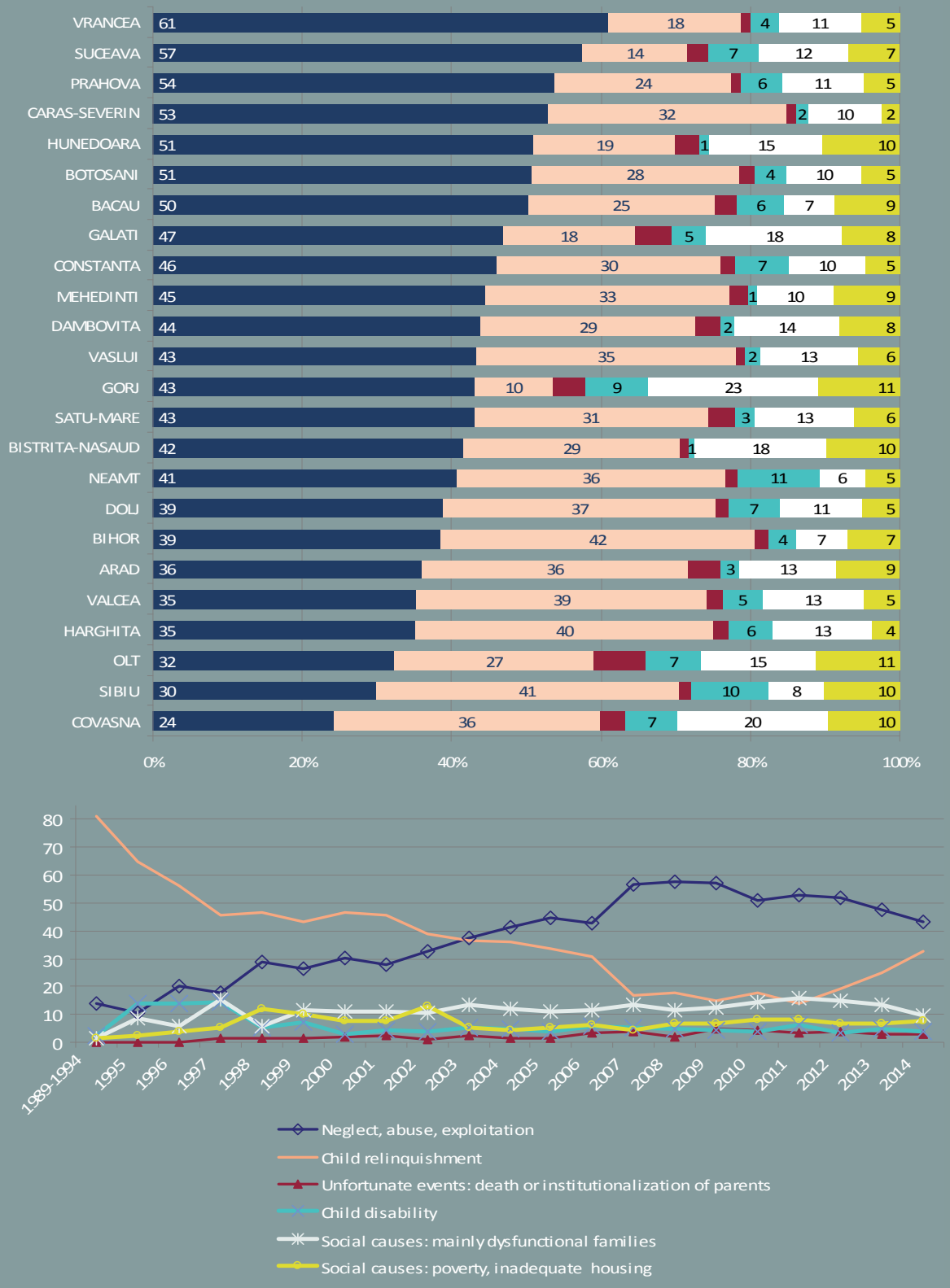
The unfortunate events that most commonly causes children to end up in public care is parental imprisonment, but case files also offer many risk factors with which this is associated.

Avoidable entries on grounds of child disability (5 percent) refer both to children with physical disabilities and to those with developmental delays. Most of these files also refer to various parental risk factors. However, the qualitative research revealed that for some of these cases (we cannot quantify how many) there is a lack not only of preventive services in the community (only 33 percent of these cases received them, according to Figure 50) but also, more importantly, of appropriate recovery and educational services for these children.

Avoidable entries on social grounds refer mainly to dysfunctional families and/or teenage mothers when giving birth. The case files do not provide further data to enable a clearer understanding of the context that leads to these child-family separations, particularly as almost all of these children were taken directly from their families or from relatives.

[284] As shown in section 3.2.3.2, dysfunctional families are defined in this report as families in which one or more of the following events have occurred: divorce, separation, infidelity, parental disinterest, desertion of family (other than going abroad), single-parent family, unacknowledged paternity, and birth out of wedlock.

Figure 50: Distribution of Children in Public Care by Reasons for Separation, as Factually Documented in the Case Files, by County (top graph), and by Year of Entry (bottom graph) (% of Category)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. In the top graph, only the 24 counties with solid data in the CMTIS have been considered (N=50,678). In the bottom graph, N=52,344.

Based on the existing data, one can only speculate that the children were not wanted or were rejected by their family or that the family was unable to create an environment that would foster the development of the child, given the parents' disabilities, in the absence of community-based support and recovery or rehabilitation services for adults.

The avoidable entries on social grounds related to poverty and/or inadequate housing are actually those case files that contained no useful information. This was the case for 7 percent of the children in public care. Even the data on income and housing conditions provided information on only 68 percent of these children (Figure 50).

Although entries in the public care system evolved over time depending on the reason for entering, Figure 50 (bottom graph) shows that avoidable entries represented roughly a quarter of all entries irrespective of the reference year. One big change was the reversal in incidence of relinquishment and child neglect, abuse, and/or exploitation, which occurred after 2004 when the regulations on child neglect, abuse, and exploitation came into force. After the global crisis years, as of 2011, an increase can be seen in the percentage of children who entered the system via relinquishment-related routes and a decrease in the number of those separated from their families because of violence against the child.

There are striking differences among counties as well (Figure 50, top graph). Child neglect, abuse, and/or exploitation are documented in the case files of 61 percent of children in public care from Vrancea county, but only for about a quarter of children in Covasna and for about one-third of those in Harghita, Olt, Sibiu, Vâlcea, and Arad. Similarly, child relinquishment is a major problem, affecting 40 percent of children in public care in the counties of Bihor, Sibiu, Harghita, and Vâlcea but only 10 to 15 percent of children in Gorj and Suceava. Avoidable entries also vary, from a minimum of 14 percent in Caraș-Severin to a maximum three times higher (42 percent) in Gorj county. There might be several reasons for these differences. For example, counties may face different issues related to child-family separation or the training of the local DGASPC staff who filled out the case files may vary, as well as their attitudes towards a case file and how they see, for instance, neglect and/or abuse or poverty.

Overall, out of all of the issues considered in Table 33, more than two-thirds (65 percent) of case files have three to eight possible causes that lead to child-family separation. In other words, there are several vulnerabilities that most children in public care and their families are faced with before the child enters the system, which actually confirms what was found in previous studies.[285] In the absence of a clear methodology and a work algorithm, every DGASPC chooses a main cause of separation from a wide range of possible causes, and this is later also used in the ANPDCA official reports. The relationship between the causes of separation as derived from the model proposed in this chapter (based on factual data in the case files) and the officially stated causes is presented in Table 34 below.

Table 34 shows that the practices used to select and state the causes of separation are, usually, associated with the factual data in case files. However, there are also inconsistencies. For instance, in 30 percent of cases with social causes related to poverty and/or inadequate housing the specialists provided different justifications (usually the death of the parents or child neglect, abuse, and/or exploitation), which are not apparent from the factual information in the file. Also, the DGASPC specialists overuse poverty as a cause, even when there is evidence of child neglect or abuse or of the death of the child's parents. Maybe the overuse of "poverty" as a cause of separation is encouraged by it being listed among eligible justifications, unlike relinquishment. However, in Romania there are almost 1.3 million children living in households at risk of monetary poverty and even more who are affected by severe material deprivation. Most of them live in households so poverty cannot be the only reason for separating the child from the family but must be just one aspect of a wider set of circumstances that also includes individual risk factors as well as a lack of proper support from the community and/or from the child's kinship network or other relevant stakeholders.

[285] Stănculescu, Marin and Popp (2012).

Table 34: Distribution of Children in Public Care, by Causes of Separation as Factually Documented in the Case Files Versus the Causes of Separation Stated by DGASPC Specialists (%)

				Avoidable Entries into the System			
	Neglect, abuse, exploitation	Child relinquish-ment	Unfortunate events*	Child disability	Social causes: individual factors	Social causes: poverty, inadequate housing	**Total**
Children (0-17 years old) in public care:							
- N	22,967	15,331	1,414	2,553	6,411	3,668	52,344
- %	100	100	100	100	100	100	100
Main cause of separation, as stated in the case files:							
Death of parent(s)	5	1	30	4	13	16	**6**
Disappearance of parent(s)	13	7	48	7	24	2	**12**
Deprivation of parental rights	3	0	0	0	0	0	**1**
Poverty	24	37	15	36	35	63	**32**
Neglect, abuse, exploitation, any other form of violence	53	16	8	12	14	13	**32**
Child disability	2	6	1	32	0	0	**4**
Parental disability	5	9	5	6	10	1	**7**
Other causes	9	28	11	9	21	6	**16**
Unknown, there is no information	4	28	2	7	4	7	**4**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: *Unfortunate events refer to death or institutionalization of a parent/parents. The sum of percentages in each column exceeds 100 percent because two to four causes were sometimes mentioned for a child. The colored cells show percentages that are significantly higher.

It is difficult to identify the main reason why a child entered the system, especially if no prevention or support measures were taken for the family or child within the community. This is why the outcome is often more visible than the cause. For instance, here is an example of this child who ran away from home. "The eldest started to do this when he was 12 and kept doing it until 14, when he ended up in the system" (Interview with a professional, Bacău). The case got the attention of the local institutions - "he kept running away from the family, the police would find him and take him back home," but the child's vulnerabilities remained invisible to the social worker, the doctor, and the teacher in the commune. "This lasted for about two years, until [the mother] took the child to DAS, the Social Assistance Directorate, because he was going to influence the other two [children] at home. 'I can't take care of him anymore; I don't know what else to do.' The family felt it was more than they could handle so the child came into the system." (Interview with a professional, Bacău).

Subsequent to the child entering the system, with regard to the causes, this case was associated with poverty. "They live in a consensual union, they all share a single room, the father leaves to work, luckily, he works… in Bucharest, in Brașov… and the mother stays home with the children. Shortages, they don't always have food or othe things they need" (Interview with a professional, Bacău). In other cases in which the child ran away from home, the specialists attributed this to a lack of parental skills for dealing with teenage issues, irrespective of whether the family was poor or not. "Other separation issues arise at the age of 12 to 13 when the child leaves home. They leave home, run away with their luggage, become vagrant, so the family can't deal with this and they contact the authorities" (Interview with a professional, Bacău). In all of these cases of teenagers with behavioral problems that were mentioned during the interviews, there was a combination of factors, including the parents' low level of education (and lack of parental skills), dysfunctional families, many children in the family, monetary poverty, precarious housing conditions, and no proper support within the community. Sometimes, there was also the use of physical punishment against the children or the parents' alcohol abuse and/or poor health. Out of all these, different specialists, or sometimes even the same specialist,

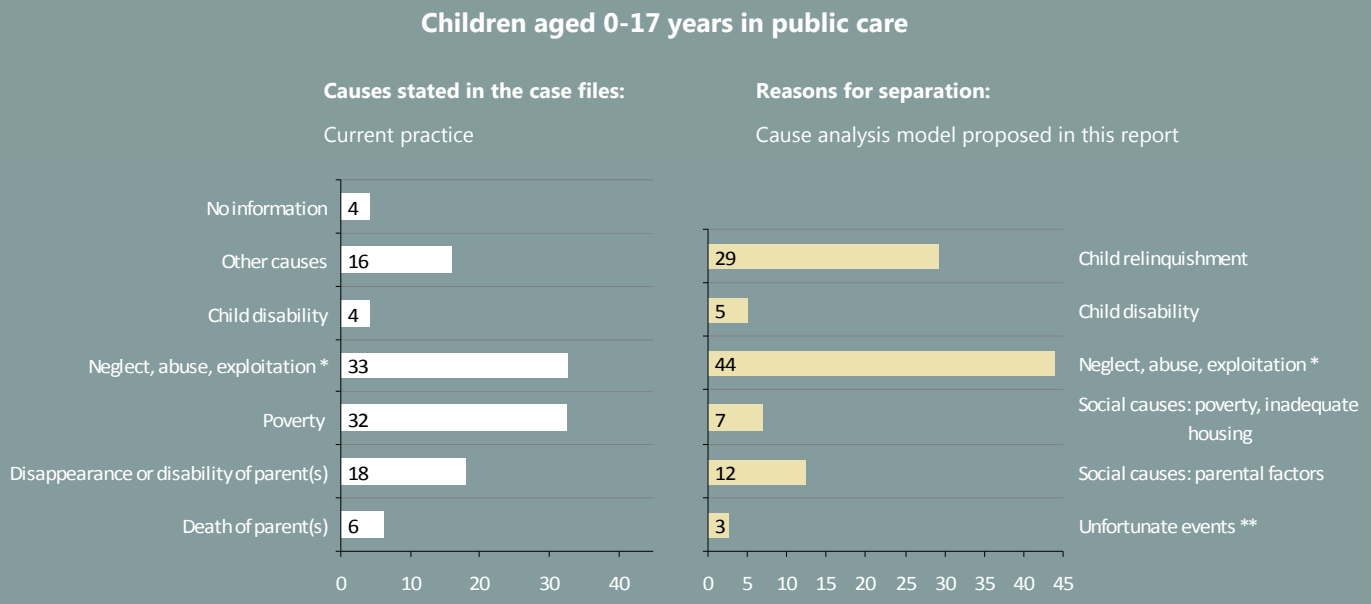
select one main cause that is recorded in the child's case file. In other words, the same type of situation is recorded and reported differently with no logical reason. Even so, none of these so-called causes are either necessary or sufficient to explain why the child ran away from home; only the entire set of factors can reveal the whole story of the child's situation.

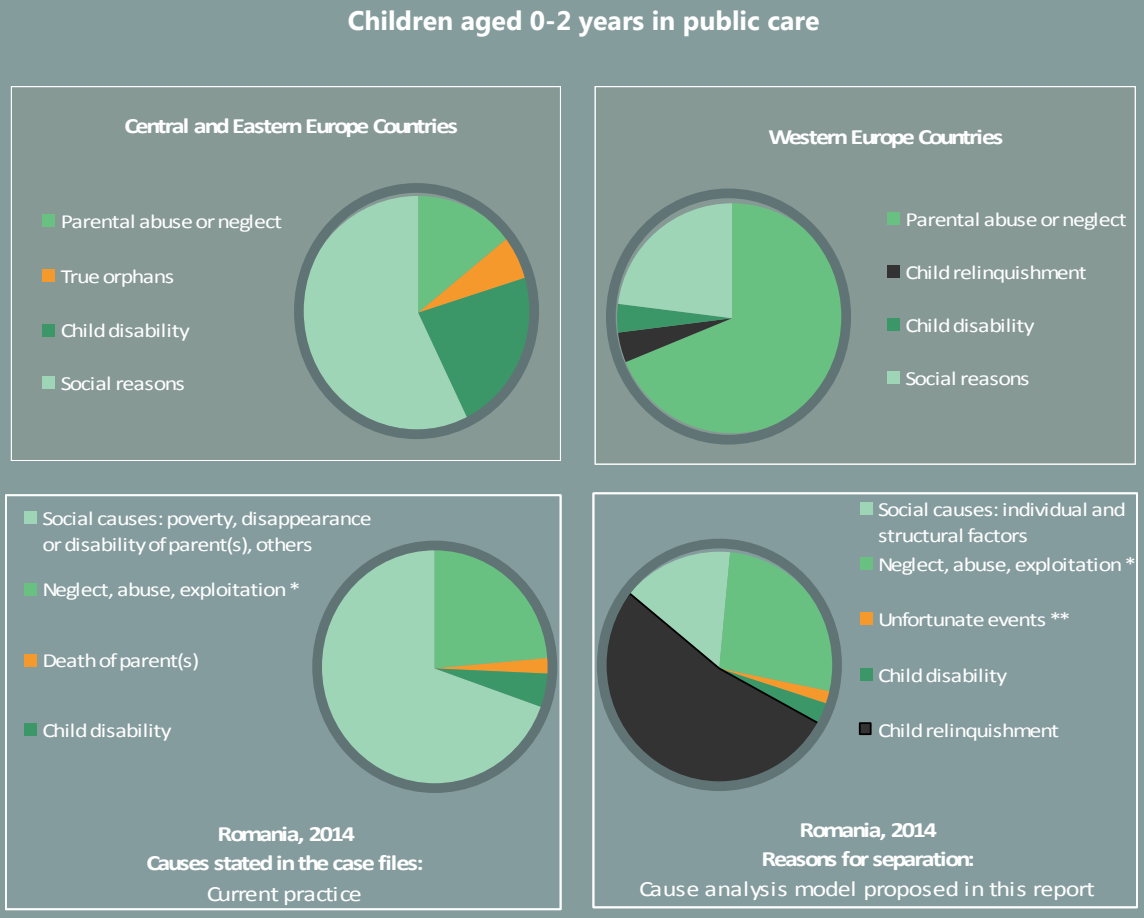
Since most cases of child-family separation involve a range of vulnerabilities, the DGASPC specialists need an information management model to help them decide on the main cause for separation. The analysis model proposed in this chapter could serve this purpose. It would mean that the official reasons for the separation would be stated in the case files together with a thorough factual documentation of all the dimensions suggested in the model: parental risk factors, child's special needs, and structural factors. Figure 51 shows what the statistics on the causes for entering public care would look like (how they would change), both for the entire population of children aged 0 to 17 and for children under the age of 3, if the proposed analysis model were to be applied.

The adoption of this kind of model at the national level would not only change the statistics but would also show the deeper causes of child-family separations, which would help Romania to work towards improving its child protection system in accordance with principles shown in Box 1. Moreover, this model would send a message that child relinquishment is a national problem rather than continuing to use "poverty" as a justification for child-family separations.

To avoid stigmatizing parents, which is anyway emphasized sufficiently, every child's situation should be documented according to the whole range of risk factors, both individual and structural, on the basis of a methodology for identifying and understanding the complex causes of separation. This methodology should be applied nationwide in a consistent way to all children and their families. Also, to avoid the possibility of "relinquishment" becoming an empty label, the list of structural factors needs to be supplemented with a list of all the types of interventions and services received by the family and child before the child entered the system.

Figure 51: Projected Changes in the Statistics on the Causes for Children Entering Public Care, by Applying a Methodology based on the Proposed Cause Analysis Model (%)





Sources: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children of 0-17 years and N=27,197 children of 0 to 2 years). The international data on children under 3 are from Browne et al. (2004).

Note: *Neglect, abuse, and exploitation also includes the deprivation of parental rights. **Unfortunate events refer to the death or institutionalization of the parent(s).

CONCLUSIONS & RECOMMENDATIONS

Analyzing the causes of child-family separation is extremely important because different causes call for different responses. Consequently, in order to understand the needs and the history of a child before preparing an appropriate individualized protection plan, it will be essential to implement Government Decision 691/2015, which lays out a working methodology for the collaboration between the DGASPCs and the SPAS as well as a standard model of documents to be used by both agencies. This methodology includes tools to capture the full range of risks and causes of separation by DGASPCs and by SPAS throughout Romania. Using this methodology based on the analysis model presented in this section would require specialists to:

- State the reason(s) for the child-family separation (to be used when drafting the official ANPDCA report);

- Conduct a full and systematic assessment of all parental risk factors and check if the child have special needs;

- Document all structural factors by providing complete data on income, housing, community of origin, service plan available before entering the system, services received in the community, and support received in the community from relevant stakeholders;

- Extensively justify all avoidable entries by indicating the types of services or activities that are not available within the community such as recovery services or other services for people with disabilities or vulnerable groups and inclusive education (see section 3.2.5.4)

The cause analysis would then be used as input for an individualized protection plan (PIP) that would include not only the services that should be provided to the child in public care, but also a plan for how the SPAS at the community level should work with the child's mother or family.

Also, the analysis would underlie the budget required to implement the services/iinterventions envisaged in the plan.

This methodology should be part of an IT information management system available both to DGASPC specialists and to SPAS representatives as pilot projects have demonstrated that this can be functional and effective. The IT tool would help specialists by simplifying procedures and reducing bureaucracy while at the same time making it possible: (i) to have one unified approach at the national level; (ii) for SPAS and DGASPC specialists to coordinate their activities in real time; (iii) to monitor the activities performed by all relevant stakeholders; and (iv) to provide the ANPDCA with enough data to swiftly adjust the regulations, programs, and measures on the basis of sound evidence.

Moreover, the analysis of existing services (particularly deficient/scarce ones) would become available to local authorities, and, once aggregated at the county and national levels, could be shared with the relevant county and central authorities. In this way, the need for more services that would reduce the number of children entering the system and increase the number of children leaving the system would become more visible and measurable.

It is absolutely vital that sufficient financial resources are made available to enable the local authorities and service providers to intervene consistently and on time and to develop community-based prevention services. Only in this way will there be early and targeted interventions capable of preventing situations in which risk factors can accumulate until they reach a crisis.

3.3. In Public Care

Story Bag

"Do you like the rooms you are in? Would you like for something to change?

- No.

- I would: the windows and the bars. To remove the bars and put insulated glazing windows.

But what do you have against the bars?

- I don't know.

- The windows are really old, the wind blows through the sides and it's cold during the night.

And the bars? Why do they bother you?

- If someone wants to throw me something, I can't catch it. There's not enough room for my hands to go through.

- I don't want anything to change. We have bars, too, but we are ok with them, we even like them.

Why?

- Because for us, having bars is like a game. A role play. For instance, I`m the duck and you`re the drake. We have this team game. We have two teams, one on each side, two flags and two jails. We all have to fight to get the flag of the other team and win. And if caught, you are thrown in jail. And in summer we have many competitions. At school, during the 'Different Week,' which is now, in April, I run. I ran in other races and came second. This kind of strategy game.

- And if we have bars, they can't jump and, God forbid, harm themselves. There are also younger kids who could jump and break their neck or hit their head."

(Focus group with children, Brașov)

This section discusses the key issues related to life within the child protection system in Romania. The analysis is organized into five subsections as follows: (i) moving the child from the family into public care; (ii) the types of children in public care; (iii) the children's individualized protection plans (PIPs); (iv) length of time children spend in the system; and (v) children's opinions about the quality of care that they receive.

3.3.1 Moving from the Family into the Child Special Protection System

This subsection analyses how children actually entered the system. The analysis refers to the entries of children who were in public care in November-December 2014. The total number of entries is higher than the number of children because about 3 percent of children in public care have had multiple entries (between two and four).

There are three main ways in which the DGASPC can be informed about a child who may need to be taken into the protection system: (i) the SPAS (responsible for 24 percent of all entries according to the children's case files); (ii) other institutions, mostly maternity wards or neonatal units (30 percent); and (iii) the child's family (28 percent of all entries). Many specialists claim that family notifications are not so frequent because "no one wants to denounce themselves for not observing their own child's rights."[286] In addition, the DGASPC can take its own initiatives ("we take the initiative most often on cases highlighted in the media or by the community"[287]), and notifications can be made by other people and also by the children themselves, for instance through the Child's Hotline or by going directly to the DGASPC. DGASPC initiatives, notifications made by other people and, especially, notifications made by children account for very small shares, while 6 percent of all entries are not documented in the case files.

Figure 52 (top graph) shows that referrals from SPAS, after increasing during the first part of the 1990s, declined between 1998 and 2001 and then increased again, reaching 27 percent of the entries in 2014. Referrals from other institutions followed the maternity ward relinquishment trend, plummeting from 70 percent to 31 percent of the entries during the 1990s, then increasing at the beginning of 2000 only to decrease again steadily until 2011. At that time, the trend was upward, reaching 35 percent in 2014. Requests from families increased during the first part of the 1990s, then reached a stable level in 1997 at about 30 percent of the entries (27 percent in 2014). The shares of other sources of notification were consistently low. However, notifications made by other people have been slightly increasing in recent years, which was highlighted by DGASPC specialists during the interviews when talking about awareness raising and involving the population in reporting cases of child abuse. It is worth mentioning that the percentage of entries that are not documented in the case files tends to remain at a rather constant level, irrespective of the year.

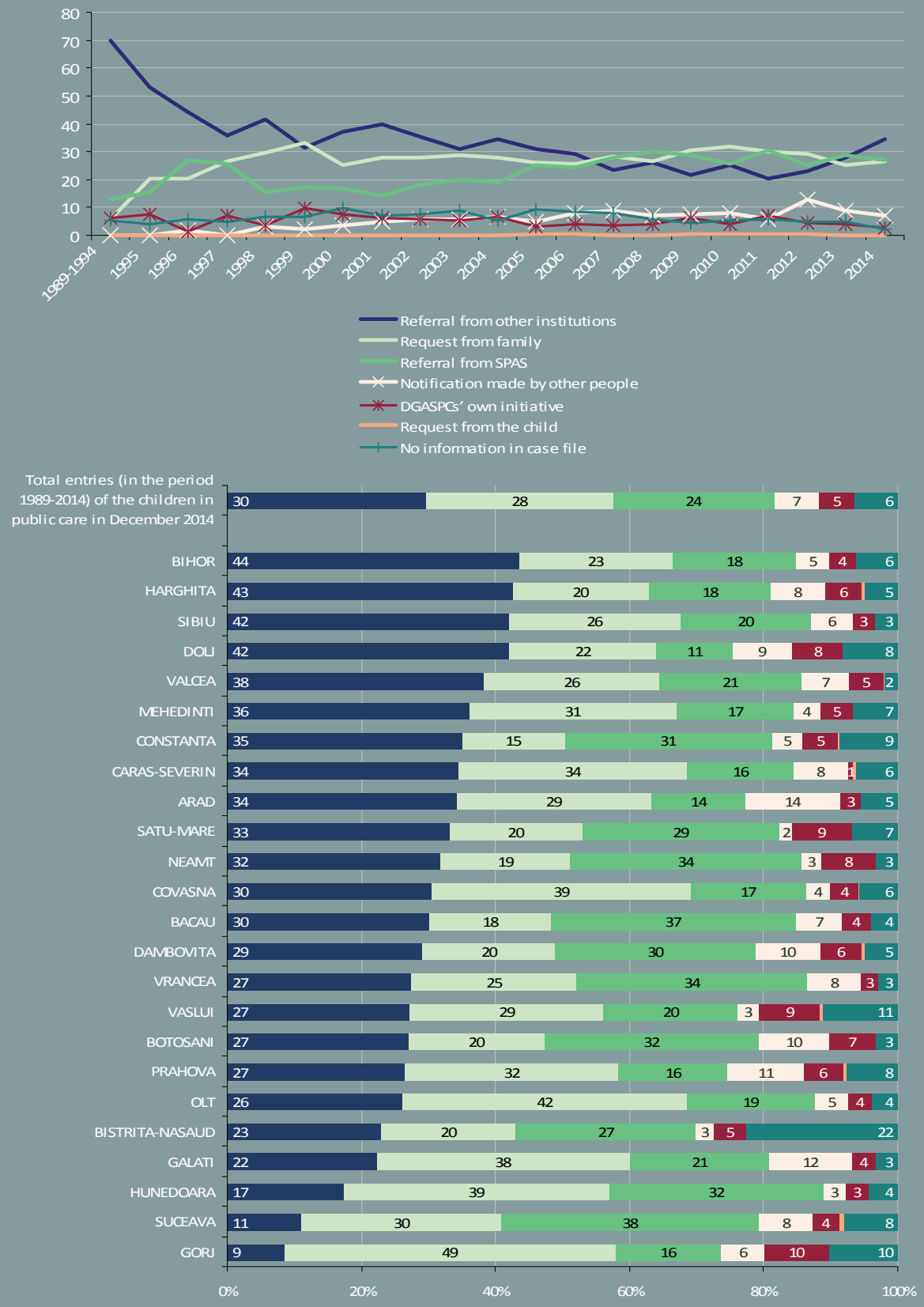
Figure 52 (bottom graph) also shows striking differences from one county to another with respect to children entering public care. The share of SPAS referrals varies from a minimum of 11 percent of the entries (in Dolj) to a maximum that is three times higher (38 percent of all entries in Suceava).[288] The percentage of referrals made by institutions is correlated with that of cases of relinquishment in maternity wards, ranging from 9 percent of the entries (in Gorj county) to a maximum almost five times higher (42 to 44 percent of all entries in Dolj, Sibiu, Harghita, and Bihor counties).

[286] Focus group with professionals, Focșani.

[287] Focus group with professionals, Focșani.

[288] SPAS referrals represent more than one-third of all entries in other counties from Moldavia, too, such as Bacău, Neamț, and Vrancea.

Figure 52: Who Notified the DGASPC of the Case When the Child Entered Public Care, by Entry Year and County (% of Entries)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. For the bottom graph, only the 24 counties with solid data in the CMTIS were considered (N=52,214 entries of the 52,344 children in public care in December 2014). For the top graph, N=53,946 entries of children in public care.

Requests made by families range from a minimum of 15 percent of all entries in Constanța county[289] to a maximum of 49 percent in Gorj county, more than three times higher. The share of entries carried out on the DGASPCs' own initiatives is twice the national average in the counties of Gorj, Vaslui, and Satu-Mare (9 to 10 percent) but almost ten times higher than that of counties like Caraș-Severin (with only 1 percent of all entries at the county level). Similarly, notifications received from third parties represent only 2 percent of all entries at the county level in Satu-Mare but 14 percent in Arad, 12 percent in Galați, 11 percent in Prahova, and 10 percent in Botoșani and Dâmbovița. The percentage of entries that are not documented in the case files also varies, from a minimum of 2 percent of all entries in Vâlcea county to a maximum of 22 percent in Bistrița-Năsăud.

Annex 6 Table 37 presents a profile of cases specific to each type of referral. SPAS referrals relate specifically to children aged 3 to 14 from families with a stable accommodation who were looked after by relatives or were left home alone after their parent(s) left. A large number of cases notified by the SPAS were for families who received prevention and/or support services in the community before the child entered the system.[290] The most frequent cases notified by the SPAS were related to child neglect, abuse, and/or exploitation, especially in the context of parental alcohol abuse and/or the existence of an adult in the household other than the parents who behaved promiscuously, had problems with the police, and/or had a criminal record.

The DGASPCs' own initiatives included children of all ages, especially those relinquished in pediatric units, abandoned on the street or in public places, or from families with no stable dwelling or a place to live or families comprised of single-mothers who were institutionalized. However, most cases in which DGASPC took its own initiative related to cases of child neglect, abuse, and/or exploitation, from families with a stable accommodation, with parental alcohol or substance abuse, in other words, exactly the same cases as notified by the SPAS, except that these families had not received any services or support in the community before the child entered the public care system.

A possible explanation for this overlap between the many cases that the DGASPCs took up on their own initiative and the typical cases notified by the SPAS could be the fact that SPAS have a practice of referring cases to the DGASPC without taking any preliminary steps. According to the current regulations, the social worker in the community is supposed to identify cases of children at risk together with a mixed (multidisciplinary) team, to assess them, and discuss them with the Community Consultative Structure (SCC).[291] Together the SCC and the SPAS are expected to find the best solution given the local context, prepare a service plan, and then provide the child and the family with the services needed to prevent their separation (information and family counseling at a minimum). The DGASPCs are supposed to be the last resort for use only if the community-level intervention fails. The previous section 3.2.5.4 on social assistance services in the community has already shown how infrequently and ineffectively these methodological norms are implemented. The community social worker is often just a person with multiple duties and limited knowledge in the field, while multidisciplinary teams hardly exist outside the DGASPCs, SCCs were set up only in some localities, and the service plan and prevention services are poorly implemented and underdeveloped. According to the DGASPC specialists, this is why many cases are not "handled" at the community level and why SPAS emergency referrals are used more and more: "the social referent immediately makes a referral to our institution [DGASPC], which intervenes within 24 hours after the referral, and within 72 hours there is also an initial full case assessment." (Focus group with professionals, Focșani).

[289] Also in Bacău and Neamț counties, requests made by the families account for less than 20 percent of all entries in the county.

[290] However, although above the average, the families who received prevention services prior to their children entering the system represent only 39 percent of all entries notified by the SPAS, while those who received community support amounted to 16 percent.

[291] Law 272/2004 and Government Decision 49/2011 introduced an obligation for local authorities to create informal support groups for social protection activities to identify community needs and solve social issues related to children at the local level. The members of these SCCs should be local decision-makers like the mayor/deputy mayor, the secretary of the municipality, social workers, doctors, police officers, school representatives, and priests.

> "Quite often, the social worker is also the case manager. Yes, they are everything. The case manager should have a team, but he/she is both social worker and case manager… Yes, they have to work with the police, the school, the doctor, the municipality… and with third parties, the neighbors who know the situation. But without the involvement of all stakeholders… we go there with our own team." (Focus group with professionals, Iași)

> "Truth be told, there is a huge responsibility on the social worker who collects the data for the initial assessment. Because he/she is the one that proposes the case and does field assessment, there is no mixed team; maybe they get some help from colleagues… But in local communities, the social worker goes, discusses, analyses, and… well, he/she suggests some protection measures, and then the case goes before the Commission of the Child Protection Directorate, or the courts, if we speak of emergency placement." (Focus group with professionals, Timișoara)

> "We go back again to the specialized public services, to the social worker from the commune. The law says that the person in charge with drafting the management plan is the social worker at the commune level. Well, this social worker picks up the phone and calls the Child's Phone emergency line: Please come, we have an emergency, take him/her. And the child is taken. In 50 percent of the cases, that child should not be separated from the family, because that is his/her family." (Focus grup with professionals, Bucharest)

> "But the mayoralties and the institutions play fast and loose, they come to us with the emergency. So if we do the math and consider all things, in the past years I think a share of, I don't want to exaggerate because I don't have any statistics, but I think that only 10 percent of the cases get to us after an attempt to deliver some services to keep the child with the family. No, most of them get here as an emergency and we are caught off guard. Why? After you placed your child in care you can no longer…, the family is no longer motivated unless they really couldn't keep the child." (Focus group with professionals, Cluj-Napoca)

Actually, several DGASPC specialists mentioned during the qualitative study that they have to take over some of the responsibilities of local SPAS, either because they are understaffed or because local councils or mayors are not all that interested in social issues. In every county there are municipalities that are supportive of the identification and prevention of child-family separation risks, but also municipalities "with which we have a disastrous collaboration, who hang up on us, who wouldn't even talk to us."[292]

> "Well, the fact that when I ask [SPAS] for a social assessment to identify the relatives, their answer is that they could not find the family at the residence address. All of the letters we had from them said: 'not found at the place of residence.' Well, I don't believe this, if you have 10 people living in that household, how can you not find anyone at home? And how come I can always find someone there?" (Interview with a case manager, Craiova)

As can be seen in Annex 6 Table 37, referrals from other institutions usually involve babies aged 0-12 months relinquished in maternity wards or other health institutions (62 percent of referrals). Premature and/or underweight babies stand a higher chance of being referred to the DGASPC. Of all premature and/or underweight babies, 67 percent entered the public care system following a notification made by health institutions. Also very likely to be referred by health institutions are babies whose mothers/parents have disabilities and/or mental problems.

Requests from families usually involve children aged 3 years or older from families with a stable accommodation or who are being looked after by relatives (Annex 6 Table 37). In this category, there was a very large number of cases that could be seen as avoidable entries[293] that were mostly due to a lack of effective community services to help families cope with their issues and stay together. Out of all of these avoidable entries, half were requests from the family and a quarter were notifications from the SPAS.[294] The parental risk factors associated with the family`s request to place the child in public care were dysfunctional families, the parent(s) leaving to work abroad, and the existence of an adult other than the mother/parents in the household with disabilities and/or mental health problems.

[292] Focus group with professionals, Cluj-Napoca.

[293] See Infograph Chart 4 from previous section 3.2.7.

[294] The other quarter were notifications from other institutions (7 percent), other people (7 percent), or the DGASPCs' own initiative (4 percent). For 7 percent of the avoidable entries, there was no information on who referred the case.

The profile of cases notified by other people is similar to that of the cases notified by the SPAS.

Most requests from children come from those aged 7 to 17 years who were exposed to abuse and exploitation in their families, who have a stable accommodation, live in poverty, and are characterized by multiple parental risk factors, especially alcohol and/or substance abuse, dysfunctional families, and parents who are working abroad and/or have disabilities and/or mental health problems. Out of all children who requested to be placed in public care, those in the 7 to 17 age group with behavioral problems are over-represented. It should be mentioned that the statistical data do not support the impression given by the qualitative study that children with behavioral problems enter the system primarily at their parents' request. Thus, the largest percentage of children with behavioral problems entered the system following a notification made by a SPAS (32 percent) or another institution (34 percent), and only one in ten entered public care at the request of their family or following the notification of another person. The requests made by children represent 2 percent of all children with behavioral problems who entered the system. This percentage might seem small, but it is more than 10 times higher than that of all other children in public care.

When it comes to removing the child from the family, there are clear methodological norms. For children with a stable accommodation, after the DGASPC has received a notification related to the case: "a team from the Office for entries and exits immediately goes there [to the child's location]. If the situation is of high risk, they might even go there at night; it doesn't matter when, the team is ready and available to go at any time. First, we have a field visit and an initial assessment. We listen to and involve the municipality, the SPAS, the local authority, and based on the initial assessment, a solution is proposed. That is, whether the child can still stay with the family, and we will monitor them with the municipality, or if he/she has to be immediately removed. During this initial assessment, we gather information from all social stakeholders, we search for relatives down to the fourth degree, who could get involved to prevent the child-family separation, but this depends on the case. After all these options are exhausted, the child is placed in a public care service depending on his/her age and health. If it's an emergency, the child is immediately removed or, if need be, a president's ordinance[295] is issued." (Interview with a professional, Bacău)

The decision to separate a child from the family may be taken: (i) by the DGASPC director, in cases requiring emergency intervention; (ii) by a court; (iii) by the Child Protection Commission (CPC); or (iv) based on a presidential ordinance, in cases requiring emergency intervention.[296]

If, following their review, the DGASPC representatives conclude that there are sound reasons to believe the child is in a high-risk situation involving abuse and neglect, and unless there is no opposition from the child's caretakers, the DGASPC director establishes an emergency placement measure.

If the child's caretakers refuse or hinder, in any way, the assessments conducted by the DGASPC representatives and the DGASPC has good reasons to believe the child is in a high-risk situation involving abuse and neglect, the DGASPC petitions the court for a presidential ordinance for emergency placement.

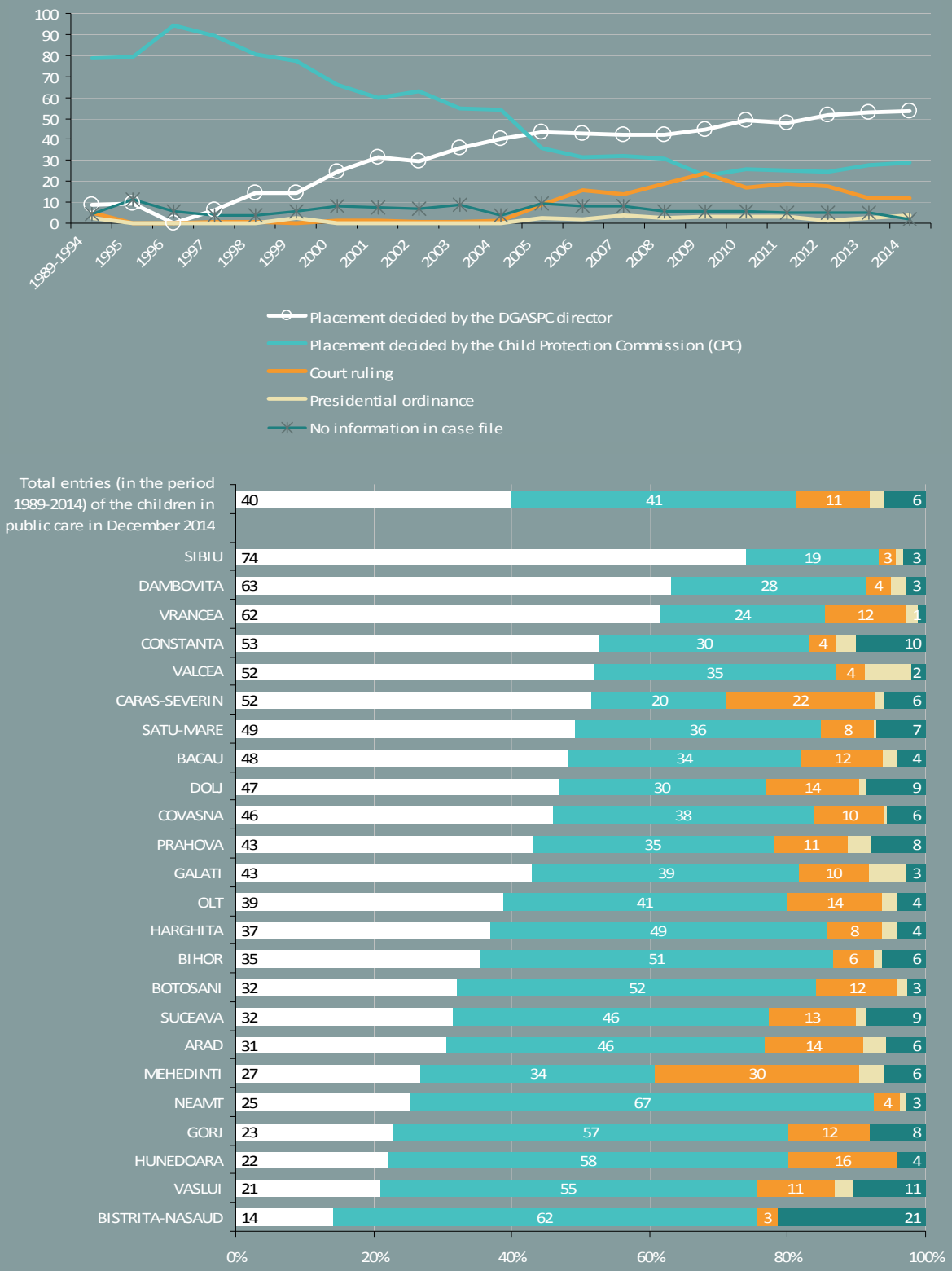
Emergency placements are also enforced for children relinquished in hospitals if they are in good health and can be discharged.[297] Figure 53 shows that children are placed in public care based on a decision of the DGASPC director 20 times more often than based on a presidential ordinance (40 percent versus 2 percent of all entries). The explanation given by the DGASPC specialists for this outcome is that, when they go to see the families, they do so together with the police.

[295] The presidential ordinance is a temporary order for emergency placement which is followed by a court ruling.

[296] Article 94, paragraph 3 of Law 272/2004 introduces two conditions both of which need to be met in order for a presidential ordinance to be issued for an emergency placement. These are: (i) the people who are looking after the child have rejected or hindered the assessments conducted by DGASPC representatives, and (ii) there must be solid evidence of an imminent danger to the child, as a result of child abuse and neglect. See http://legeaz.net/spete-civil/plasament-in-regim-de-urgenta-950-2009 (in Romanian).

[297] Government Decision 1103/12.10.2014 introduced several methodological clarifications regarding children relinquished in maternity wards or other health institutions. See the Official Gazette of Romania no. 37/January 16, 2015.

Figure 53: Who Decided to Place the Child in Public Care, by Entry Year and County (% of Entries)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. For the bottom graph, only the 24 counties with solid data in the CMTIS have been considered (N=52,214 entries of children in public care in December 2014). For the top graph, N=53,946 entries of the 52,344 children in public care.

> "We are quite resourceful these days and we don`t need too many presidential ordinances because we team up with the police. When the child is at risk and our team goes with the police, the parents tend to take one step back and don't come at me to swear or push me aside, or slam the door in my face or hit me to prevent my taking the child. This way, we can immediately remove the child with the emergency provision without the need for a presidential ordinance, which would require some time in court…" (Focus group with professionals, Iași)

If the risk is not imminent and the parents approve, then the case is taken to the Child Protection Commission (CPC) to decide on a special protection measure. The CPC makes its decision based on the proposals made by the DGASPC representative who describes the child's current status to the Commission in the presence of the mother/parents and the child, after which the CPC issues a decision. If the parents do not agree to a protection order being established, then the court is notified and a civil ruling is issued (which is different from a presidential ordinance). Of these two ways of entering the system, Figure 53 shows that decisions by the CPC are almost four times more frequent than decisions made by a court (41 percent versus 11 percent of all entries).

Figure 53 (top graph) shows that placement decisions by the DGASPC director have consistently increased in terms of their share of all entries, from under 10 percent in the early 1990s, to a high of 54 percent in 2014 (the average is 40 percent). On the other hand, placements through a CPC decision steadily decreased until 2009, after which they slowly increased from 23 percent in 2009 to 29 percent in 2014. The shares of the other two methods – court rulings or presidential ordinances – increased after Law 272/2004 came into force. However, the percentage of presidential ordinances has been consistently low (2 to 4 percent of all annual entries into the system), whereas the percentage of entries by court rulings almost tripled from 9 percent in 2005 to 24 percent in 2009, and then dropped to 12 percent in 2014 (with an average of 11 percent between 1989 and 2014).

So, out of all entries in the child protection system (as of November-December 2014), the largest share (52 percent) consisted of cases with no imminent risk for which there was a CPC decision or a court ruling, about 42 percent were high-risk cases with an emergency placement ruled by the DGASPC director and, very seldom, through a presidential ordinance, and for 6 percent of the entries there was no information in the case files. However, looking at the 2010-2014 timeframe, we see a different pattern: most entries (54 percent) were emergency placements, most through a decision of the DGASPC director, and in only 42 percent of the cases was there a CPC decision or a court ruling. Entries with parental consent (decided by the CPC) increased, whereas those without the parents' consent (ruled by the courts) decreased. The share of entries on which there was no information in the case files remained constant regardless of the time period considered.

Figure 53 (bottom graph) shows striking differences from one county to another with regard to who made the decision about a child entering the system. Thus, entries as a result of a DGASPC director's decision varied from a minimum of 14 percent of all entries in Bistrița-Năsăud to a maximum of 74 percent, in Sibiu. Still on emergency placements, there were almost no presidential ordinances in Bistrița-Năsăud, Covasna, Gorj, Hunedoara, and Satu-Mare, but they accounted for more than 5 percent of all entries in Galați and Vâlcea. Entries with parental consent through a CPC decision were quite numerous in some counties – Bistrița-Năsăud and Neamț (62 to 67 percent of all entries) whereas in others they accounted for less than a quarter of all entries (Caraș-Severin, Sibiu, and Vrancea). Entries with no major risk and without parental consent, enforced through court rulings, accounted for a large share in Caraș-Severin (22 percent) and particularly in Mehedinți (30 percent), but they accounted for less than 5 percent of all entries in several other counties. Thus, while emergency entries (especially through a decision of the DGASPC director) prevail in some counties such as Vrancea, Dâmbovița, and Sibiu, in others (Botoșani, Mehedinți, Bistrița-Năsăud, Vaslui, Gorj, Neamț and Hunedoara), between 64 percent and 74 percent of all entries are decided by the CPC or the courts.

Annex 6 Table 38 presents the profile of specific cases for different entry routes into public care. As per the rules described above, entries into the system based on a decision of the DGASPC director usually concern babies (those aged between 0 and 12 months) relinquished in maternity wards and cases of child abuse and/or exploitation.

The categories of children that were significantly more likely to have entered the system through a decision of a DGASPC director were children at risk of separation, especially premature and/or underweight babies [298] but also children with developmental delays and teenagers with behavioral problems. For instance, out of all children with behavioral problems aged 7 to 17 in public care, 61 percent entered based on a decision of the DGASPC director (versus the 40 percent average) and 6 percent were also emergency placements but based on a presidential ordinance (versus the 2 percent average). Other categories of children who were more likely to enter the system based on a decision of the DGASPC director were children left home alone after their parent(s) left, children from families with unstable accommodation or homeless families, children abandoned on the street or in other public spaces, and children who had run away from home (street children). However, these cases represent only 7 percent of all children subject to emergency placement based on a decision of the DGASPC director. Most of these children were neglected by poor families with a stable accommodation.

As discussed above, the presidential ordinance is used when the health, development, or life of a child is being endangered within the family (especially in cases of child abuse) and when parents are against the child being taken by the DGASPC. Annex 6 Table 38 shows that most of these cases involved children from families with stable accommodation living in poverty and/or poor housing conditions and characterized by parental alcohol and/or substance abuse.

CPC decisions tend to be associated with avoidable entries (those that could be avoided if effective community services were available), with 57 percent of all avoidable entries being based on a CPC decision.[299] Entries more likely to have been decided by a CPC decision were those involving children with teenage mothers at the moment of the child's entry, children with institutionalized mothers, and children with disabilities and/or SEN, though they represent only a small share of all CPC decisions.

Entries into the child protection system through a court ruling (other than a presidential ordinance) concerned children 3 and 17 years old from families with stable accommodation or who were in the care of relatives, whose parent(s) had disappeared either because of unfortunate events (death or institutionalization) or because they were abroad, or whose family had broken up (because of divorce or separation, for example). This is why there was no parental consent in the case files (which would allow for the cases to be assessed by the CPC), so the cases were sent before the courts. Cases in which parents are present in the home but disagree with the establishment of a protective measure are rare.

Box 16: UN Guidelines for the Alternative Care of Children

II. General Principles and Perspectives

A. The child and the family

3. The family being the fundamental group of society and the natural environment for the growth, well-being and protection of children, efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members. The State should ensure that families have access to forms of support in the caregiving role.

4. Every child and young person should live in a supportive, protective and caring environment that promotes his/her full potential. Children with inadequate or no parental care are at special risk of being denied such a nurturing environment.

Source: UN Resolution adopted by the General Assembly 64/142, February 24, 2010.[300]

[298] Fifty percent of premature and/or underweight babies were placed in public care based on a DGASPC director's decision.

[299] However, as shown in Annex 6 Table 38, the shares of avoidable entries added up to one-third of all entries based on a CPC decision (versus the 24 percent average).

[300] Excerpt from UN Guidelines for the Alternative Care of Children (2010).

The way in which the decision to separate a child from their family is taken (documentation of the case and justification of the separation) is crucial to ensure that the child's rights are respected. The UN Convention on the Rights of the Child acknowledges the importance of all children growing up in a family: "for the full and harmonious development of his or her personality, the child should grow up in a family environment" (Preamble) and "States Parties shall ensure that a child shall not be separated from his or her parents against their will except when (…) separation is necessary for the best interests of the child" (Article 9).[301]

The information available to those deciding whether or not to separate children from their families should be significantly improved, regardless of how the decision is made or who makes it. In the previous chapters we saw that many elements related to the child's status before entering the system are not properly documented in the case files. Then, in section 3.2.5.4 we analyzed the existence and quality of the social assessments conducted before the child enters the child protection system and found them to be lacking. Furthermore, we have shown that not enough efforts are made to keep children with their families, particularly because of the lack of several types of community-based services. The official audit reports of the ANPDCA found the same types of problems for all DGASPCs across the country.

Common issues associated with placement with substitute or extended families that were noticed during the ANPDCA's audits:

- In only few cases did SPAS provide services aimed at preventing child-family separation prior to the establishment of special protection measures.
- The documents underlying the proposal for emergency placement of the abused/neglected child do not reference the conditions of imminent danger to the child.

Source: 2015 Report produced by the ANPDCA Control Body.

Annex 6 Table 38 provides additional information in this respect, as drawn from the children's case files. According to this data, the best documented files are those prepared for presidential ordinances. It is possible that the files sent to courts that are considering granting the ordinance are more carefully prepared as there is an over-representation among these cases of families and children who received community-based prevention and support services prior to the case reaching the court.[302]

Entries into the system based on a decision of the DGASPC director are associated with requests received by the DGASPC from institutions (particularly the health units where the children were relinquished), the decision being founded on the DGASPC and/or SPAS social assessments whose documentation is of average to good quality.

The worst documented files seem to be those prepared for the Child Protection Commissions, which are associated with requests received from families. This is probably one of the main reasons why entries based on the CPC decision are correlated with avoidable entries: the family makes a request, the case manager (who might be the SPAS social worker) makes a recommendation, and the CPC makes a decision even based on a poor social assessment that has not provided enough information on the case. During the qualitative study, several opinions were expressed related to entries into the system based on a CPC decision:

- ☐ There is a mistaken impression among child protection professionals that the number of these entries is small or constantly decreasing compared to entries based on court rulings (which is contradicted by the data in Figure 53, top graph):

  > "The number [of entries based on a CPC decision] is small, usually two to three cases, not more than three per year, in which the parents come and we have their approval, meaning that we can

[301] United Nations (1989).

[302] Of all children from families who were provided with prevention and support services prior to the child entering the system, only 3 percent entered on the basis of a presidential ordinance (versus the 2 percent average).

have a Commission decision. Usually, decisions are taken by courts." (Focus group with professionals, Focșani)

"The number [of entries based on a CPC decision] is small because most of them come from broken up families, [the parents having] gone to work abroad. They fail to inform the local authorities within the official 40 days' timeframe that they are going to leave, and the children are left in someone else's care. So we have to go through the court, because we don't have the parents' consent." (Focus group with professionals, Craiova)

- Professionals were critical of the CPC, stating that the decision to place the children into public care is taken "too lightly" and that the CPC fails to enforce the requirement to go through all the preliminary steps of working with the family in line with current regulations and with the UN Guidelines for the Alternative Care of Children (Box 16 above).

"I, as the manager of a center, after seeing the children I have there, I think that for some of them the protection measure was established too easily. For instance, a child that came to me, raised by the grandparents, who, at some point, was absent from school, was disobedient with his grandmother, stopped going to football practice, and he came to us with a special protection order. It is possible for the grandparents to refuse [to care for the child], they don't have parental obligations, but…at the end of the day it's a subjective thing, it comes down to the person that was in charge of that case … if someone had worked with the grandparents and the child… or maybe I see things differently." (Focus group with professionals, Cluj-Napoca)

- The professionals also expressed opinions according to which decisions are taken based on a file "which has documents in proof, documents related to income, health status, lack of accommodation, maybe a psychological assessment. Yes, a lot of documents and evidence, but… everyone does what they can… the social worker, the case manager who prepares the case file and presents it before the Commission."[303]

The main problem highlighted by DGASPC specialists is not being able to provide support fast enough to children in vulnerable situations once they have been identified. Some children might have to wait quite some time before receiving services that are not immediately available, whereas emergency cases (especially those involving abuse or relinquishment) require a fast intervention and removing the child from the family/hospital as soon as possible. As one judge has said, "Two months of delay in making decisions in the best interests of a child or young person equates to one percent of childhood that cannot be restored."[304] This is also the opinion of the DGASPC specialists who drew attention to the fact that sometimes it takes too long to get the presidential ordinance, and, in practice, "the emergency" might take even more than two months, during which time the child is left without any support with the abusing parent/adult.

"*It takes some months to remove a child [from the family]…and we speak of abuse?*

- Exactly. Yes, the emergency procedure.

- When we deal with abuse…or even with neglect, but if it is in the long run and things have not improved… But a couple of days ago we had a happy case: the lawyer came with the ordinance, it was accepted, we were awaiting for it to be legalized so that we could start this procedure. But we got a phone call from the child's mother who said that she had thought things over and was willing to cooperate with the Directorate, that she didn't want us to use bailiffs so she would bring the children to us. So together we went and accompanied them to the emergency reception center. This was a happy case.

- And all these deadlines arise because the Civil procedural code sets a maximum deadline of 48 days to prepare the motivation, which is… to have an abused child and leave him/her with the abuser for a month and a half is, in my opinion, really stupid.

- It could be even worse, you could go and pay a visit, witness the child being beaten, and not be able to remove him/her from there. This is the biggest…

[303] Focus group with professionals, Timișoara.

[304] District Judge Nick Crichton, Family Drugs and Alcohol Court, Wells Street, London, quoted in Munro (2011a:90).

- Yes. Or find him/her tied down and starved. And you can't take him/her, you can't do this with a placement decision." (Focus group with professionals, Ploiești)

"There are cases when there is a court decision to remove the child from the family, but we could not do it, although we went with the police, we couldn't take the children from there. There was a big scandal… And the final court ruling was issued in September 2014 and the child was removed from the family only in January 2015 because the final ruling had not been drafted… Which should have been ready in a few days… This is the thing with courts – they entail significant risks for the children, after all, that is why there is a court order in the first place, for special situations, to help us remove the children without delay. I think there should be a courthouse for children, where everyone is specialized in child-related issues."(Focus group with professionals, Timișoara)

RECOMMENDATIONS

In order to reduce the number of avoidable entries into the child public care system, community-based prevention services should be developed, as shown in a previous chapter. At the same time, in the short run, it would be useful to develop a stricter procedure governing children entering the system at the family's request, especially based on a decision of the Child Protection Commission. This should start with the proper case documentation and introduce an obligation that requires the authorities to follow all the steps that precede the placement of a child in public care. The procedure should be enforced in a consistent manner all over the country, and it should involve the DGASPC multidisciplinary teams (for the initial case assessment), together with SPAS representatives, the Community Consultative Structures, and local authorities.

Courts should be created all over the country specifically for minors and their families. At the same time, targeted training on child-specific issues should be provided for judges and clerks.

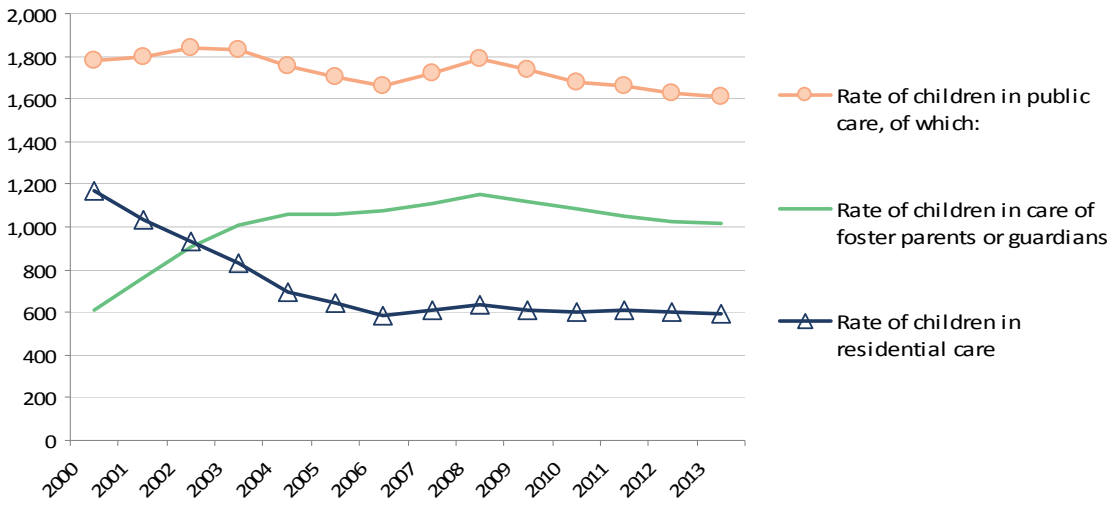
3.3.2 All Categories of Children in All Types of Special Protection Services

From this section on, we will analyze the child public care system, focusing on the types of care available to children temporarily or permanently separated from their family and the process by which children are placed in one of these services. However, before beginning, it is useful to understand the general context in which the data on the current status should be interpreted. The first section will present a brief history of the Romanian child protection system while the second section compares Romania with other countries in Central and Eastern Europe (CEE) and with those in the Commonwealth of Independent States (CIS) at the time of the research. The third section conducts an inventory of the protection services included in this study and their distribution across counties in Romania. The fourth section focuses on how children are placed in one service or another as revealed by the November-December 2014 data in the case files.

3.3.2.1 Developments in the Child Protection System after 2000

The communist regime left Romania with a disastrous child protection system. A network of large institutions was developed between 1945 and 1989, and poor families were encouraged to leave their children (especially those with disabilities) in public care. Traditional child protection methods, like placing a child in distress with extended family members, were undermined. In the context of the pro-birth policies and the economic depression of the 1980s, the results were a catastrophe. It is estimated that in 1989 over 100,000 children were living in institutions in very bad conditions and that more than 16,000 children had died from treatable illnesses or other causes.[305] Moreover, even if the physical conditions had been reasonable, the institutionalization had a strongly negative impact on children's health, development, and psychological status as a result of the depersonalization, rigid routine, and social distance that was prevalent in those institutions.

Figure 54: Rates of Children in Public Care in Romania, 2000-2013 (per 100,000 Children 0-17 Years Old, at the End of the Year)



Source: UNICEF TransMonEE 2015 Database reported by the MMFPSPV (Tables 6.1.22, 6.2.2, and 6.3.2). Data on children in residential institutions include young people aged 18 years and over.

[305] MS, IOMC, and UNICEF (1991).

The government has made significant progress in the past 15 years in terms of reducing the number of institutionalized children and developing family-based care services. The total number of children in child care (in both residential institutions and family-based care) has significantly decreased from almost 89,000 children in 2000 to roughly 60,000 at the end of 2013 and down to almost 59,000 at the end of June 2014.[306] However, at the same time, the total number of children in Romania has also decreased so the ratio of children in child care remained the same after 2005 (about 1,600 to 1,700 out of every 100,000 children aged between 0 and 17 years), which shows that the system failed to reduce the share of children in the public care system. So this is still a priority for the years to come.

Figure 54 shows the structural changes that have happened in the child protection system following the development of family-based services. Starting with the beginning of the 2000s, this has led to a significant reduction in the number of children in residential institutions in favor of family-based care services. The number of children in residential institutions (public and private placement centers, including small group homes) decreased from a maximum of over 58,000 in December 2000 to 21,365 on June 30, 2014. In 2011 the number of institutionalized children increased[307] for the first time in 15 years, a consequence of the population getting poorer and of the country's limited budget. However, the rate began to decrease again after 2011. The government's recent wave of reform of the child protection system has set deinstitutionalization as a top priority, which should continue and accelerate the reduction in the numbers of children in institutions.

3.3.2.2 Romania's Child Protection System in the CEE/CIS Region

The UNICEF Report "At Home or in a Home" shows that the legacy of institutionalizing abused and neglected children, or those with disabilities continues in all Central and Eastern European states (CEE) and in the Commonwealth of Independent States (CIS).[308] In the context of a serious deterioration of the housing conditions and increasing poverty, many families leave their children in institutions either temporarily or permanently. After 2008, the global crisis affected the situation of children in the entire CEE/CIS region. Thus, at the end of 2013, about 1.3 million children in the entire region lived separated from their families in various types of alternative care.[309]

The Romanian child public care system is one of the largest in the CEE/CIS region, caring for about 60,000 children. Only Poland, Ukraine, Kazakhstan, and Russia have larger child care systems. However, according to the ratio of children in public care compared to the total number of children in the country, Romania occupies an average position in the region (with 1,600 to 1,700 children in child care per 100,000 children aged 0 to 17 years versus an average of 1,850 per 100,000 both in the CEE/CIS region and among the countries in Eastern Europe and Central Asia).[310]

The number of institutionalized children in the CEE/CIS region is the highest in the entire world, with about 525,000 children growing up in residential institutions. Despite recent reforms in all of these countries that resulted in more children being cared for by alternative families, over 40 percent of the 525,000 are still in institutions. Thus, the Romanian child protection system is in line with most child protection systems in the region in still depending, to a large extent, on institutionalized care, which inhibits children's development potential (Figure 55).

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[306] UNICEF TransMonEE 2015 Database, data reported by the MMFPSPV (Tables 6.1.21, 6.2.1, and 6.3.1). Data on children in residential institutions include young people aged 18 years and over. Data exist for the 1990-1999 timeframe, but they cannot be compared with those after 2000 because of all the changes in the system.

[307] MMFPSPV, DGPC (2011:1). The number of institutionalized children was 23,240 in 2011 versus 23,103 in 2010.

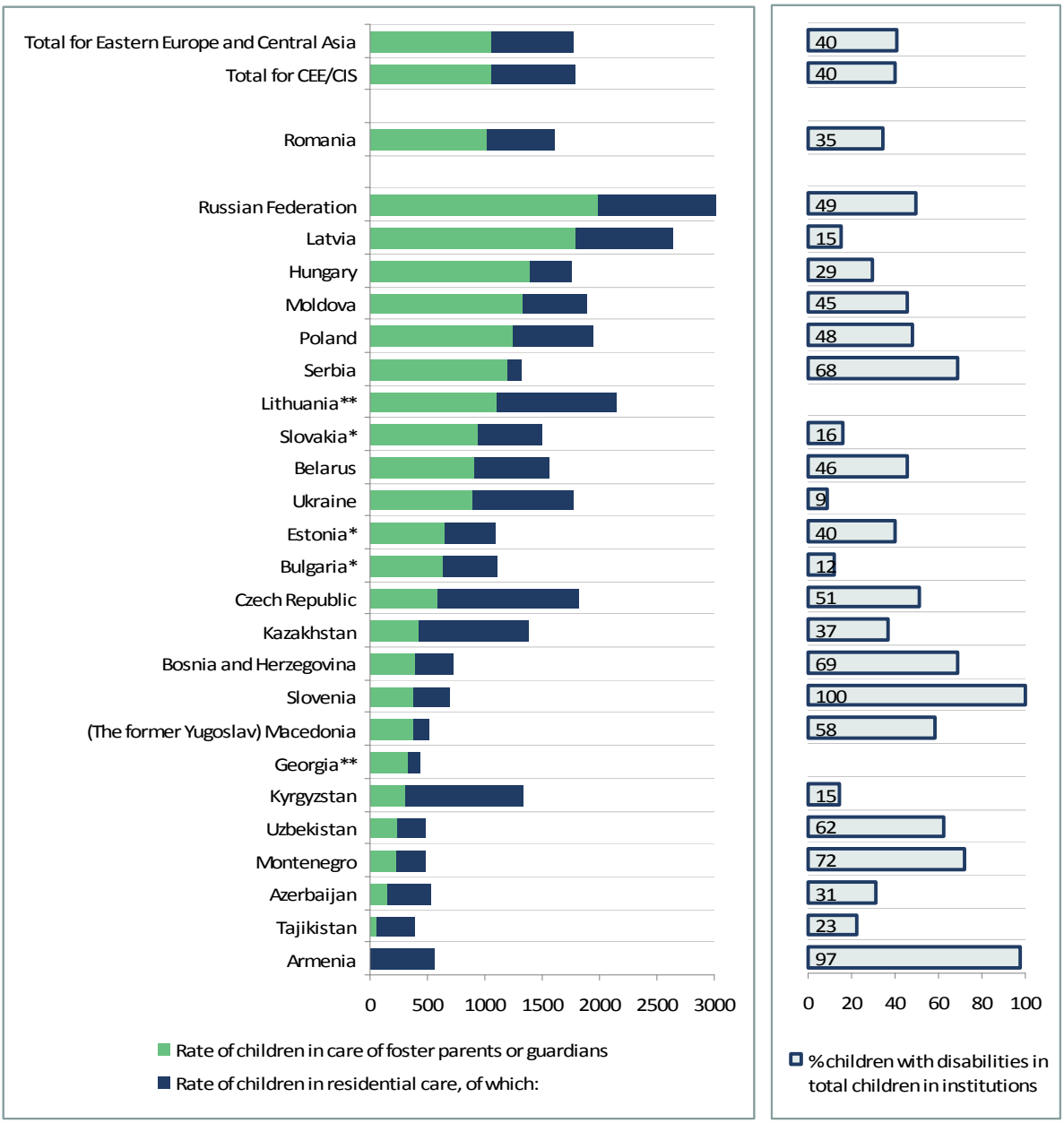
[308] UNICEF (2010).

[309] UNICEF TransMonEE 2015 Database, Table 6.1.21.

[310] UNICEF TransMonEE 2015 Database, Table 6.1.22. Eastern Europe and Central Asia include the following 28 states: Albania, Azerbaijan, Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Macedonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Montenegro, Poland, Romania, Russia, Serbia, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine, Hungary, and Uzbekistan. Out of these, the countries that had more children in public care than Romania (in 2013) were: the Czech Republic, Hungary, Poland, Estonia, Latvia, Lithuania, Ukraine, Moldova, and Russia.

What is even more worrisome is the fact that the child protection system of the region depends heavily on institutions to care for children with disabilities. Across the region, about 212,000 children with disabilities were in institutions in 2013. In several countries, children with disabilities constituted more than half of all institutionalized children. In this respect, too, Romania occupies an average position, as shown in Figure 55.

Figure 55: Rates of Children in Special Protection (per 100,000 children 0-17 years old, at end of year) and Percentage of Children with Disabilities out of All Children in Residential Institutions in the Eastern Europe and Central Asia Region, by Country



Source: UNICEF TransMonEE 2015 Database (Tables 6.2.2, 6.3.2, and 6.2.9). In some countries, Romania included, the data on children in residential institutions include young people aged 18 years and over.

Note: *Data for 2012. **Data on children with disabilities are missing.

At the same time, it is worthwhile mentioning that, in recent years, governments of the CEE/CIS region have been constantly concerned with reducing the number of children under 3 years old in residential institutions because of the devastating effects institutionalization can have on the child's health and development. Since 2005, Romanian law has forbidden the placement of children under 2 years old in a residential service (Law 272/2004). As a result, Romania holds an above average position in the

CEE/CIS region in terms of the number of children under 3 in institutions (93.9 per 100,000 children aged 0 to 3 years).[311]

In 2014, an amendment to Law 272 from 2004 was passed, stating that "the placement of children under the age of 3 can be assigned only to the extended or foster family or to a foster parent, with the placement of these children into residential care being forbidden." However, the amendment also states an exception according to which "a child under the age of 3 can be placed in residential care if he/she has severe disabilities and is dependent on care from the specialized residential services."

In recent years, more and more countries in the region are seeking to ensure a better start in life for very young children and, therefore, Bulgaria, the Czech Republic, Croatia, Serbia, and Slovakia have already adopted or are in the process of adopting a series of legal measures forbidding the institutionalization of children under 3 years old.

3.3.2.3 Types of Protection Services Analyzed

This study considers services provided both in a family-like environment and in residential institutions.

Family-type services:

- (1a) Placement with a relative up to the fourth degree
- (1b) Placement with other families/people
- (1c) Placement with foster parents

Residential services:

- (2a) Apartments
- (2b) Small group homes[312] (CTF) for children with disabilities and for children without disabilities
- (2c) Placement centers grouped into:[313]
  - Placement centers taken over from MEN (the Ministry of National Education) (former dormitories of special schools), which can be either the old/classical type[314] or restructured/modulated[315]
  - Classical placement centers (other than MEN centers), which can be either for children with disabilities or for children without disabilities
  - Modulated placement centers (other than MEN centers), which can be either for children with disabilities or for children without disabilities.

[311] UNICEF TransMonEE 2015 Database.

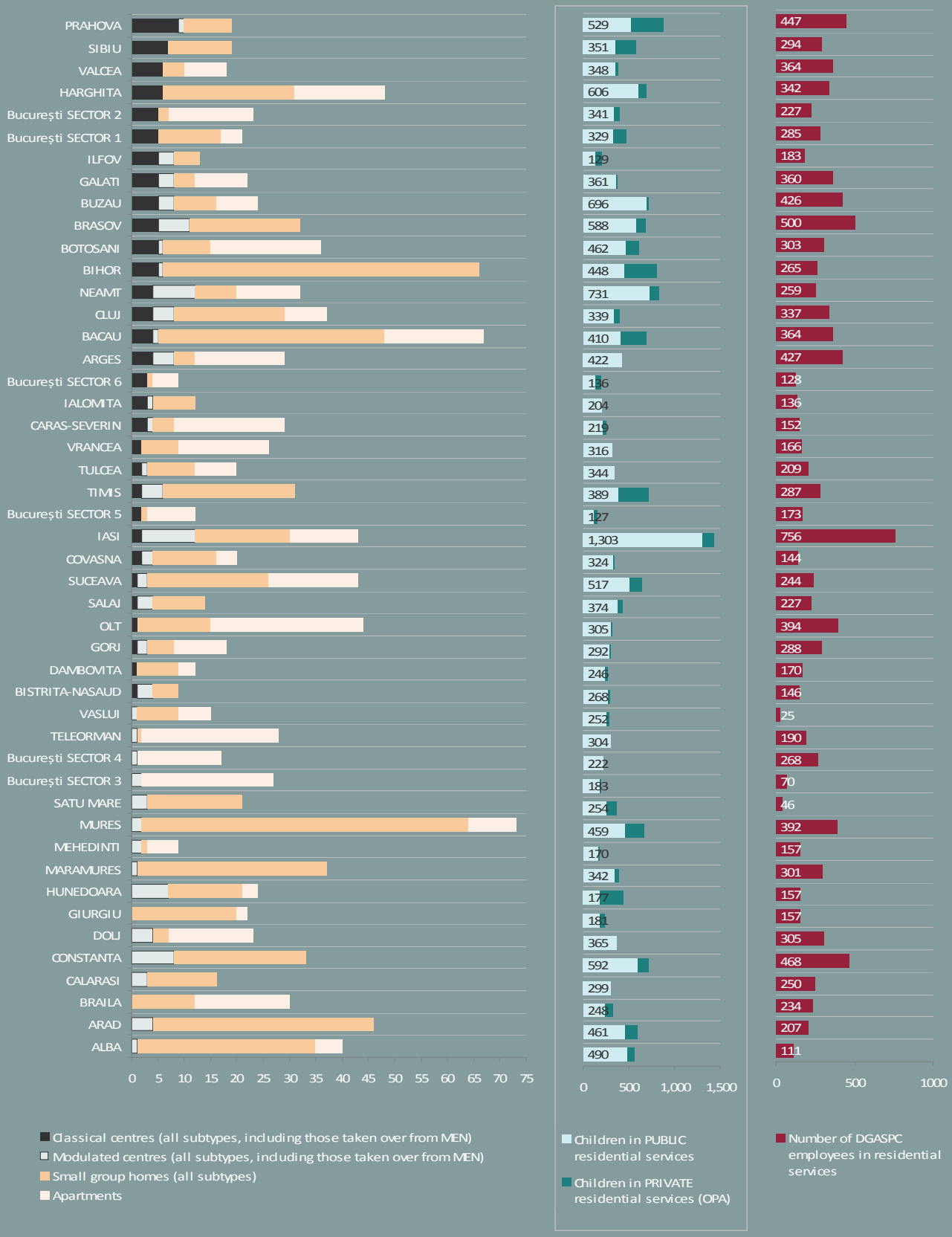
[312] According to HHC (2012), a small group home (CTF) is a residential unit with maximum 12 children, with maximum 4 children in a bedroom, organized based on a family model, with living room, kitchen and bathroom.

[313] The classification of each placement center by type was made by ANPDCA together with DGASPC.

[314] According to HHC (2012), an "old type," "traditional," or "classical" institution refers to a residential center with over 12 children/young people, with at least four children/young people in a bedroom, and with shared bathrooms for the residents living on the same floor.

[315] According to HHC (2012), a "refurbished," "restructured," or "modulated" institution refers to a residential center with over 12 children/young people, organized in units, with each unit typically consisting of a bedroom, a living room and a bathroom.

Figure 56: Number of Public and Private Residential Services, Number of Children in Public and Private Residential Services, Active Cases as of December 31, 2014, and Number of DGASPC Employees in Residential Services, by County



Source: ANPDCA, www.copii.ro/statistici/. See also Annex 6 Table 39.

Other services like maternal centers, emergency reception centers, guardianship, specialized supervision, and day and night shelters are only steps on the way to placements in the system and therefore, by convention, they are outside the scope of this research.[316]

In order to fully understand the analyses presented in the following chapters, we first present a general overview of the child protection system based on ANPDCA data.[317] The way in which child protection services have developed so far differs significantly from one county to another:

- First, while in most counties, children are in family-type care,[318] there are four counties and two sectors in Bucharest where more than half of all children in care are in residential services.[319] At the same time, in eight counties, more than 70 percent of children for whom a protection measure was established were placed in family-type care.[320]
- Second, the way in which residential services have been reformed or developed varies significantly from one county to another, as seen in Figure 56 and in Annex 6 Table 39.

Residential Services

As at November 30, 2014, the DGASPCs reported a nationwide total of 408 apartments, 686 small group homes, and 215 placement centers, which were either public institutions or were managed by accredited private organizations (OPA).[321]

OPA residential services represent about 24 percent of all residential services (according to December 31, 2014 data). Most private residential services are small group homes (41 percent of all small group homes). Only 8 percent of residential services for children with disabilities are managed by OPA. The proportion of private residential services increases every year but varies between counties from a minimum of less than 5 percent of children in residential services in 13 counties and one sector in Bucharest to a maximum that is eight times higher in Bacău, Bihor, Prahova, and Timiș, with the highest value (59 percent) being in Hunedoara county. As of December 31, 2014, at national level, 19 percent of children in residential services were in OPA facilities. For children with disabilities, the percentage drops to 3 percent.

The other residential services are public, in that they are managed by the county DGASPCs. In other words, 76 percent of the residential services in the country are public and they account for 81 percent of the children in residential care (as of December 31, 2014). The equivalent figure for children with disabilities is over 97 percent.

According to November 30, 2014 data, residential services in the form of apartments are available in 27 counties and in the six Bucharest sectors, but their number varies from 2 to 29 per county. Six counties[322] and sector 3 in Bucharest account for 40 percent of all apartments in the country.

Small group homes (CTF) are available across the entire country, except for two sectors in Bucharest (3 and 4). However, their distribution is uneven, varying from 1 to 62 small group homes per county. Homes for children with disabilities represent 30 percent of all small group homes. Altogether, eight counties account for almost half of the CTFs for children with disabilities, and seven counties account

[316] In other words, children in the sample who received only these services were not considered in the analysis, they are, by convention, "cases out of scope" (see Annex 6 Table 1).

[317] www.copii.ro

[318] As of December 31, 2014, at the national level, 63 percent of children in the child protection system were in family-type care, and 37 percent were in public residential institutions or institutions managed by OPAs (accredited private organizations providing child protection services).

[319] As of December 31, 2014, these counties were Alba, Harghita, Sălaj, Sibiu, and sectors 1 and 2 in Bucharest. If we look only at placement centers, the order of the counties changes, with the first three being Iași, Brașov and Prahova.

[320] As of December 31, 2014, these counties were Caraș-Severin, Dâmbovița, Galați, Mehedinți, Olt, Vaslui, Vâlcea, Vrancea, and Sector 5 in Bucharest.

[321] Data provided by the ANPDCA.

[322] These counties are Bacău, Brăila, Botoșani, Caraș-Severin, Olt, and Teleorman.

for about half of all small group homes for children without disabilities. Over 40 percent of all 686 small group homes in the country are located in six counties: Alba, Arad, Bacău, Bihor, Maramureș, and Mureș. Of these, in Bihor and Maramureș the small group homes managed by OPA look after a substantial number of children in residential care, whereas in the other four counties, the small group homes are mainly public services.

Out of the 215 placement centers in the country, most of them (111) are old-type/classical institutions in buildings with at least four children or young people per bedroom and shared bathrooms for the residents living on the same floor. The other 104 centers have been restructured or modulated as units. Both classical and modulated placement centers have, on average about 50 beneficiaries. Placement centers exist in all counties, except for Brăila and Giurgiu, and in the six sectors of Bucharest.

FROM RURAL SOURCE COMMUNITIES

Data gathered from the source communities for the child protection system show that 40 percent of those in rural areas live close to a residential center for children (located in that commune or in a neighboring one).

Further research is needed to test the assumption that placement centers influence nearby communities to be more tolerant towards child-family separation. Proximity to residential centers increase the odds that people will regard the placement of a child in this kind of institution as something "normal", a way of finding somewhere close to home, a place where the child can be accommodated in decent conditions (sometimes better than at home), fed, clothed, sent to school, and supervised.

This assumption is all the more plausible given that the children can pay visits to their homes on weekends or during the holidays. Such an assumption should be tested especially for children from poor families from rural areas who enter the system at their family's request.

Source: Social Assistance Data Sheets from Rural Source Communities (July-August 2015). Data are not weighted (N=60 communes with source communities with 1,140 children in public care, in November-December 2014).

As discussed above, there are several different subtypes of placement centers.[323] There are 45 placement centers taken over from MEN (former dormitories of special schools) nationwide. All of them are public residential services. Most (37) are old-type/classical institutions, and some have been restructured/modulated. These former dormitories of special schools are quite large institutions, with an average of 60 children per center. Placement centers taken over from MEN exist in 20 counties and in two sectors of Bucharest (2 and 6). The counties of Buzău, Neamț, Brașov, and Prahova each have four centers taken over from MEN.[324]

Nationwide, there are 96 refurbished/modulated placement centers, other than MEN centers. The biggest share are centers for children with no disabilities (55), whereas the remaining 41 modulated centers are for children with disabilities. One out of six centers is managed by OPA, but only one of these is for children with disabilities. As a general rule, the OPA modulated centers are usually smaller than those managed by the DGASPCs, with, on average, about 25 beneficiaries versus the average of 45 children in public modulated centers. At the same time, modulated centers for children with disabilities are smaller than those for children with no disabilities (on average 30 beneficiaries versus 60 for modulated centers managed by the DGASPCs and 9 beneficiaries versus 28 for OPA modulated centers). In terms of geographical distribution, modulated placement centers exist in 32 counties and two sectors in Bucharest (3 and 4). Modulated centers for children with disabilities are quite evenly distributed across 23 counties and in sector 3 from Bucharest, whereas there is a strong concentration of modulated centers for children with no disabilities - 9 counties account for about two-thirds of all

[323] ANPDCA data as of November 30, 2014.

[324] Four other counties each have three centers taken over from MEN, namely Harghita, Iași, Ilfov, and sector 2 in Bucharest.

these centers.[325] The counties of Iași and Neamț, followed by Hunedoara and Constanța, have the most modulated centers other than those taken over from MEN (with nine, eight, seven, and six institutions respectively).

Altogether there are 74 classical placement centers other than MEN centers. Most of them (47) are for children with no disabilities, and only 27 are classical centers for children with disabilities. More than one out of four centers are managed by OPA, but very few of them are for children with disabilities. OPA classical centers are usually smaller than those managed by the DGASPCs (on average about 25 beneficiaries versus the average of 50 children in public classical centers). Classical centers for children with disabilities tend to be smaller than those for children without disabilities (with on average 40 beneficiaries versus 60 for the classical centers managed by the DGASPCs). In terms of geographical distribution, classical placement centers other than those taken over from MEN are located in 23 counties and four sectors in Bucharest (1, 2, 5, and 6).[326] Most of these centers are concentrated in seven counties, with over five centers per county in Sibiu, Prahova, Vâlcea, Botoșani, and sector 1 in Bucharest.

The mix of residential child public care services differs significantly from one county to another as shown in Figure 56. While in some counties like Prahova, Sibiu, and Vâlcea, classical and/or modulated placement centers prevail, others counties provide care mainly in small group homes and apartments (such as Mureș, Maramureș, Giurgiu, Brăila, and Alba). This is why the analysis of public care services presented in the following chapters will vary significantly at the county level given the striking differences in the mix of services.

Map 6: Residential Child Protection Services Managed by DGASPCs and the OPA, by Counties, as of November 30, 2014

Source: ANPDCA

[325] Modulated placement centers for children without disabilities other than MEN centers exist in 25 counties and in sectors 3 and 4 of Bucharest.

[326] Classical placement centers for children with disabilities other than MEN centers exist in 15 counties and in sectors 2 and 5 of Bucharest. Classical placement centers for children with no disabilities are located in 19 counties and in sectors 1, 2, 5, and 6 of Bucharest.

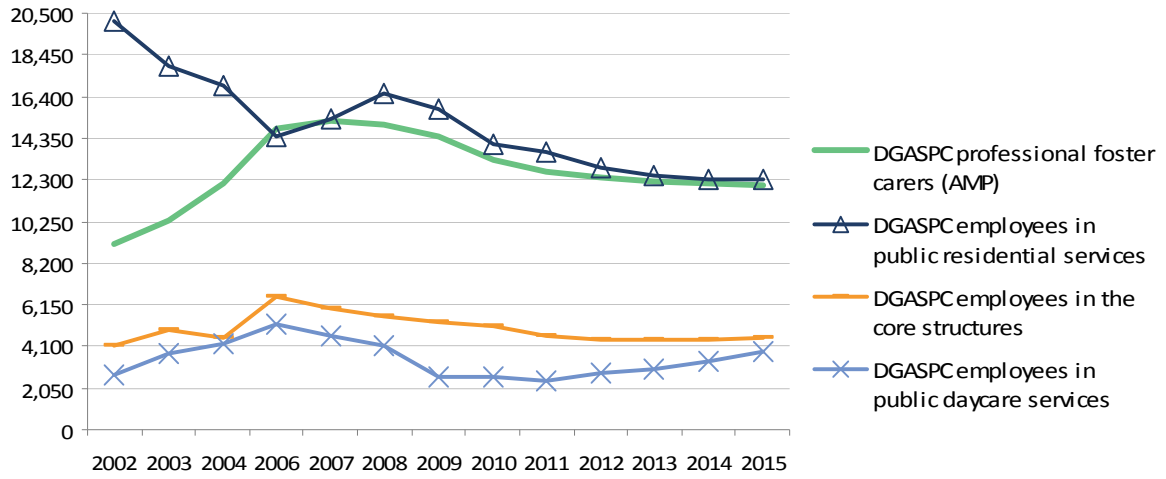
Closing down the old-type/classical institutions (including those taken over from MEN) is a priority for the government as part of the deinstitutionalization process targeted by the new wave of reform in the child protection sector. Speeding up the process by which all classical residential institutions for children will be closed down is a priority objective in both the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* as well as the Romanian Partnership Agreement for the 2014-2020 Programming Period and the EC's 2014 Country Specific Recommendations for Romania. The European Union has specified deinstitutionalization and the transition to community-based care as priorities to be funded from its Structural Funds, and approved, for wide use, the Common European Guidelines on the Transition from Institutional to Community-based Care, which provide practical advice on how to switch sustainably from institutional care to family-based or community-based alternatives for people who are currently in institutions and for those living in the community without appropriate support.[327]

In November 2014, there were 111 such old-type placement centers all over the country (of which, 37 former dormitories taken over from MEN). Figure 56 shows that classical institutions that should be closed down are not evenly distributed in the country. So far, 14 counties and two sectors in Bucharest have completed the process of closing down classical institutions.[328] Map 6 shows the countrywide distribution of residential services, highlighting in red those counties that will require priority interventions in order to close down their classical placement centers.

Human Resources of the Child Protection System

As shown in the previous section, the DGASPCs, which are funded from the state budget and by county councils, are both the main providers and the main contractors of residential child care services. Moreover, when it comes to family-type care services, DGASPCs play an even greater role as fewer than 1 percent of all foster parents are managed by OPA. Consequently, the DGASPCs need sustainable and appropriate financial and human resources in order to develop not only a national network of child public care services but also services targeting other vulnerable groups (especially adults with disabilities).

Figure 57: Number of DGASPC Staff, by Category (as of the end of the year), 2002-2015



Source: ANPDCA

[327] EEG (2012)

[328] These counties are Alba, Arad, Brăila, Călărași, Constanța, Dolj, Giurgiu, Hunedoara, Maramureș, Mehedinți, Mureș, Satu Mare, Teleorman, and Vaslui. The two sectors in Bucharest are sectors 3 and 4.

DGASPCs are big employers of specialized staff. After the structural changes that took place in the beginning of the 2000s, the total DGASPC staff increased from 36,000 in 2002 to over 41,200 in 2008 but started to decrease after the budget cuts in 2009. The downward trend continued until 2012 when staff numbers stabilized at around 32,000 to 33,000 employees (Figure 57 and Annex 6 Table 40). In line with the policy of closing down institutions and developing family-type care services, the number of employees in residential public services continuously decreased (except for a short time between 2006 and 2008) by about 8,000 people between 2002 and 2015. On the other hand, the other staff categories (especially foster parents) significantly increased at the beginning of the period (2002 to 2007) and then gradually their numbers decreased. The development of daycare services started to grow at a faster pace between 2012 and 2015.

The number of the DGASPC staff in public family-based care and in residential services closely followed the trend in the number of children who received these services (Annex 6 Table 41 and Annex 6 Figure 9). However, the number of foster carers decreased faster than the number of beneficiaries,[329] which increased the child/foster carer ratio from 1:1 in 2002 to 1:5 to 1:6 between 2010 and 2015. As for public residential services, the number of beneficiaries decreased faster than the number of staff, so that the child/DGASPC employee ratio was reduced from 1:9 in 2002 to 1:2 in 2008/2009.[330] Later, the number of staff decreased more abruptly, resulting in a 1:4 to 1:5 ratio between 2010 and 2015.[331] The available data do not allow us to estimate the ratio of children to personnel directly involved in child care as they only refer to the total number of employees.

As of December 31, 2014,[332] the DGASPCs employed more than 32,200 people, of whom 37 percent were foster parents, 38 percent worked in residential services, 11 percent worked in daycare services, and 14 percent worked in their core structure. Annex 6 Table 40 shows that there are striking differences from one county to another in terms of the structure of DGASPC staff:

- The number of staff in family-based care varies from 8 percent to 80 percent of all employees across counties (that is, between 64 and 1,456 professional foster parents).[333]
- The share of employees in residential services varies from a low of 1 percent to a high of 64 percent.[334] In 13 counties, more than half of all DGASPC staff work in residential services.
- Daycare services are the most unequally distributed at the county level. Five counties have none of these services[335] and 22 counties employ a very small number of people (under 10 percent) in daycare services, whereas three counties and four sectors of Bucharest each have between 20 and 48 percent of all of their employees working in these services.[336] Altogether, the employees from these counties and from these sectors of Bucharest represent about half of all employees working in public daycare services in the entire country.
- The percentage of staff employed in the core structures of the DGASPCs also varies, from 5 percent to 36 percent. The minimum (5 percent) is in Vaslui, where there are fewer than 100 employees in

[329] From 2008 until 2015, the number of beneficiaries decreased by about 2,100 children, and the number of foster parents employed by the DGASPCs decreased by more than 3,000.

[330] Between 2002 and 2009, the number of children in public residential services decreased by more than 18,000, whereas the number of DGASPC staff working in these services was reduced by less than 4,300.

[331] Between 2009 and 2015, the reduction in the number of children of about 3,100 was similar to the loss in the number of employees in public residential services, which was about 3,500.

[332] As of December 31, 2015, the total number of DGASPC employees was 32,600 people.

[333] Shares of 20 percent or less were found in the Bucharest sectors and in Cluj and Brașov counties. The maximum proportion (80 percent) was found in Vaslui, but rates exceeding 50 percent were also recorded in Dâmbovița, Vrancea, and Caraș-Severin.

[334] The minimum of 1 percent belonged to Vaslui. Shares of under 20 percent were also recorded in sectors 3 and 6 of Bucharest, in Satu-Mare, and in Caraș-Severin. On the other hand, rates exceeding 60 percent were found in Sălaj and Brașov. In absolute values, Iași had the maximum number of employees in residential services, 756 people, which represented 43 percent of the total staff in the county.

[335] These counties are Constanța, Ilfov, Mureș, Prahova, and Sălaj.

[336] These are Dolj, Satu-Mare, Suceava, and sectors 1, 3, 5, and 6 of Bucharest. Sector 6 has the highest number of staff in daycare services (367), which represent 48 percent of all staff.

the core structure to monitor and coordinate a network of over 1,450 foster parents as well as two maternal centers, three emergency reception centers, one modulated center, a shelter, eight small group homes, and six apartments. At the other end, in sector 2 of Bucharest, more than one-third of staff work in the DGASPC core structure (36 percent), which means that there are more than 200 people to coordinate, monitor, and assess five classical placement centers, fewer than 100 foster parents, a small group home, a shelter, an emergency reception center, a maternal center, and 16 apartments. A quarter of the staff in sector 6 of Bucharest and in the counties of Alba and Arad work in the core structure of the DGASPC, whereas less than 10 percent of staff do so in Brăila, Iași, Dolj, and Tulcea.

The DGASPCs reported employing only 1,030 case managers at the national level, either in the core structure or in residential services. Our research included a survey of case managers, but these data will be presented in a separate volume, which is in progress.

As you can see, counties are organized very differently and use a variety of HR policies. DGASPC's county policies comply with the current legislation but do not seem to be correlated with the total number of children in public care in the county or with the specific mix of services that it provides. For example, for a total number of 700-800 children in public care, the number of core DGASPC employees varies between 29 employees in Brăila, 39 in Tulcea, 62 in Sălaj, and 80 in Gorj and 81 in Mehedinți. On the other hand, sector 2 in Bucharest has more than 200 people in its core structure for fewer than 600 beneficiaries, whereas in Iași, which has the highest number of beneficiaries (over 3,600 children), the DGASPC core structure comprises only 122 people.

The next two examples refer to the mix of residential services at the county level (Figure 56) and the numbers of staff employed by the DGASPCs in public residential services (Annex 6 Tables 39 and 40). Thus, the DGASPC in Iași, with over 1,300 children in its public residential services, has succeeded in renovating most placement centers and has built a small number of small group homes and apartments. Meanwhile, the DGASPC in Bihor has five old-type institutions and a large number of small group homes (more than three times the number in Iași), most of which are managed by OPA. As such, out of all of the over 800 children in residential services, only about 450 are in public residential services, and the number of DGASPC employees in residential services is nearly three times lower in Bihor than in Iași (265 versus 756 employees). In contrast, the DGASPC in Mureș closed down all of its classical institutions and now provides residential services in small group homes, about half of which are managed by the DGASPC. Out of all 670 children in residential services in Mureș, the biggest share (over 450) are in services managed by the DGASPC (that is, about one-third of the number of beneficiaries in Iași), with less than half the number of DGASPC staff that Iași has (392 versus 756).

The third example refers to the counties of Alba, Arad and Mureș, which have a similar mix of residential services consisting mainly of public small group homes (Annex 6 Table 39) and have a similar number of beneficiaries of residential services (450 to 490 children). However, the ratio of children to DGASPC employees in public residential services ranges from 1:2 in Mureș, to 2:2 in Arad, and 4:4 in Alba (Annex 6 Table 40).

Irrespective of these differences, all DGASPCs are faced with serious difficulties when it comes to meeting their needs for the human resources and skills necessary to provide the services. According to the social services audit carried out by HHC Romania in 2012, DGASPC general or deputy managers mentioned several problems related to human resources in the child protection system, including: (i) many vacancies given the hiring freeze in the public sector since 2010, leading to understaffing particularly for staff working directly with children (such educators, nursemaids, and nurses); (ii) nepotism in hiring practices; (iii) a lack of performance indicators, making it impossible to produce staff appraisals; (iv) an absence of tools to motivate and sanction staff; (v) declining staff quality in recent years, partly because of low investments in the continuous training of specialized staff;[337] and (vi) the fact that the added value of this type of training is not measured.

[337] Only 20 percent of the DGASPC staff from 45 counties attended any professional development training courses in 2010 (HHC Romania, 2012).

RECOMMENDATION

In the medium and long term, in order to meet the objectives in the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and those in the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, it will be necessary to strengthen DGASPCs' role in strategic planning, methodological coordination, and supporting SPAS at the community level as well as in monitoring and assessing service providers at the county level. At the same time, their role as the main provider of social services should gradually be abolished. If these actions are taken, then DGASPCs will have to be completely reorganized and strengthened in almost all counties by outsourcing their existing services to private providers and by hiring more specialists in strategic planning, monitoring and evaluation, and case management. Therefore, the share of DGASPC employees in residential services can be expected to decrease constantly, while the share of staff in the core structure to increase in order to perform the coordination, SPAS assistance, and monitoring and evaluation functions. Another change to be expected is one concerning the DGASPC staff profiles which will incur a significant drop in the number of cooks, nursemaids, administrators, and drivers and a corresponding rise in the number of staff specializing in the protection of children and other vulnerable groups.

3.3.2.4 The First Stage of the Special Protection Service: How Children Are Placed in the First Stage After Being Admitted in the Public Care System

The analysis presented in this section is based on data from the case files of children in public care on their most recent admission into the system. Among the children in the system as of November-December 2014, 97 percent had only one admission in the system and 3 percent had multiple admissions, meaning that their most recent entry may be their second, third, or fourth. As a general rule, the date of the admission in the public care system is considered by most DGASPC experts as being the date when the first child protection measure was issued (for the admission in question). Therefore, at the time of their most recent admission, 55 percent of the children received a placement measure, 44 percent were admitted with an emergency placement, and only 0.2 percent had specialized supervision (a temporary protection measure established for children who have committed criminal acts and are not criminally liable in which the child stays with the family provided that he or she complies with certain obligations.[338]

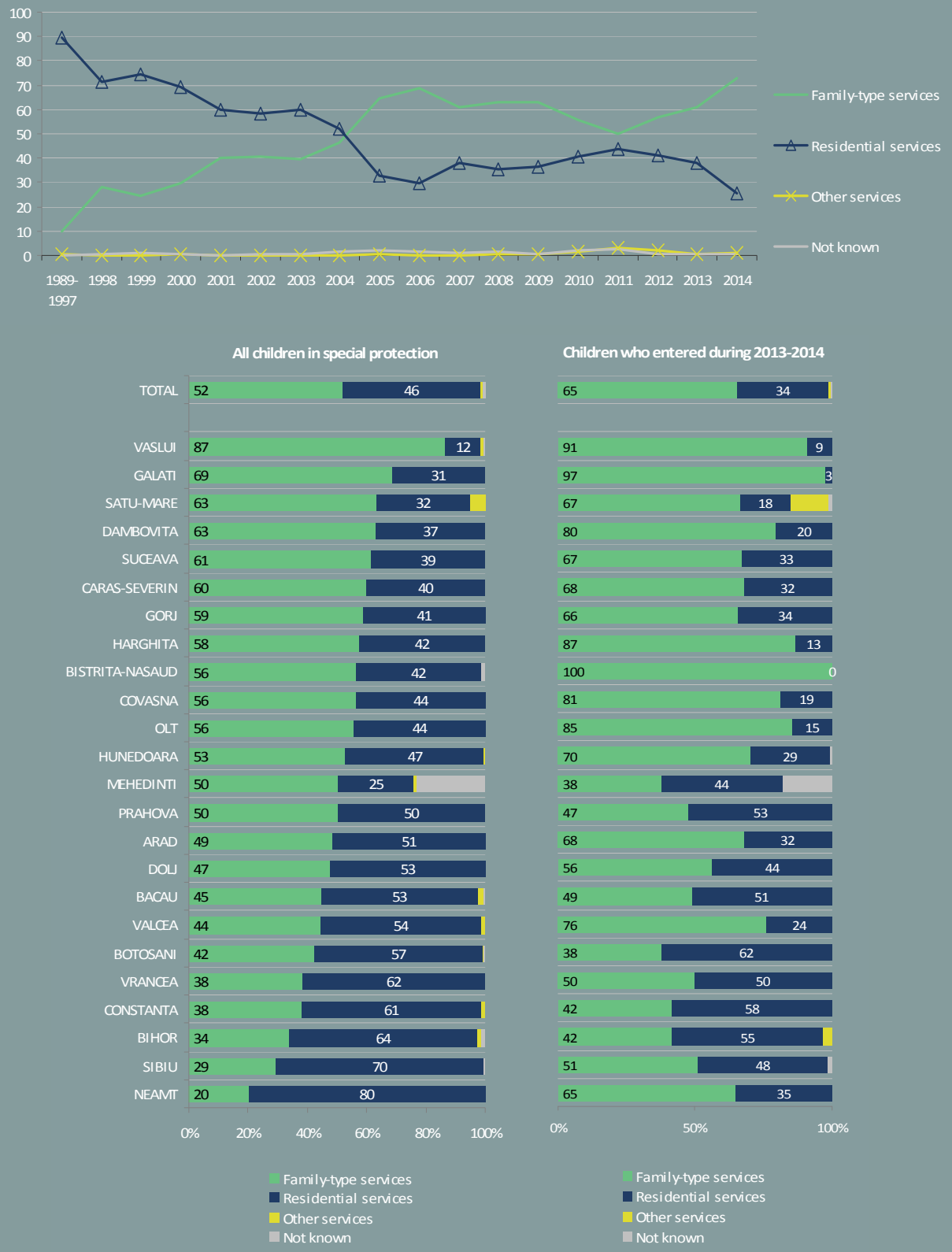
At their most recent admission, in the first stage after the protection measure was issued, 52 percent of the children were placed in family-type services, 46 percent were placed in residential services, and 1 percent were placed in other types of services such as counseling or recovery or daycare centers.[339] This overview refers to the children who were in the public care system as of November-December 2014 but who were admitted in the system at any time between 1989 and 2014. Therefore, the analysis of their information reflects all of the structural changes that had occurred in the child protection system in the previous 25 years. The services recently underwent major changes (see the previous section), and the practices related to the manner in which the children are placed in care were also modified in accordance with the regulations and methodologies introduced in the meantime. As a result, the children admitted into the system during 2013 and 2014 were more likely than before to be placed, at least initially, in family-type services (65 percent) rather than in residential services (34 percent).[340]

[338] For the other children (0.8 percent), there were no data regarding which protection measure was used.

[339] For 1 percent of the children, there was no information in the case files.

[340] The other 1 percent of the children were placed in other services.

Figure 58: Initial Placements of Children on Their Most Recent Admission Into the System, by Admission Year and County (% of Children)



Source: Survey of the Case Files of Children Public Care (November-December 2014). Data are weighted. For the bottom graph, only the 24 counties with solid data in the CMTIS were considered (N=50,668 children, 6,454 admitted during 2013-2014). For the top graph, N=52,344.

Figure 58 (top graph) shows that 2004, when Law 272 on the protection and promotion of children's rights entered into force and 2011, when it was updated, represent turning points. Also, other recent regulations (such as Government Decision 1103/2014) led to a rapid increase of the share of children placed in family-based services, especially for children aged 0 to 3 years.[341] Therefore, while the share of the children placed in residential services decreased from 90 percent at the beginning of the 1990s to 33 percent in 2005 and then to 26 percent in 2014, the share of those placed in family-based services increased from 10 percent to 65 percent in 2005 and then to 73 percent in 2014.[342] These trends were reflected in most counties but not in all. As we can see in Figure 58, in Bihor, Botoșani, Constanța, and Mehedinți counties, the changes were very small or non-existent.

In order to understand the criteria that are used to decide on where the children are placed in the first stage after they are admitted into the public care system, we analyzed a series of factors including: (i) the child's characteristics (such as gender, age, ethnicity, and the environment they come from); (ii) the structure of the family of origin and the child's relation to it; (iii) causes[343] of the child's separation from the family; (iv) the route by which the child was admitted into the system; (v) the family history related to the child protection system (for example, multiple admissions and any siblings in the system); and (vi) the type of protection measure issued when the child was admitted into the system. The results of this analysis are presented in Annex 6 Table 42 and are discussed in this section.

We started by analysing the specific profile of the children with a higher probability than average of being placed in each type of service. Then, we analyzed the groups of children with special needs and the manner in which these children were distributed among the services, as well as how the practices of placing these special groups have evolved in time.

Family-type Services

Of the total of 52 percent of all children in the system who were initially placed in family-type services, 25 percent were placed with professional foster carers, 23 percent with relatives, and 4 percent with other families or people. After 2010, we observed an increase in the placement of children with foster carers and at other families or individuals and a decrease in placements with relatives up to the fourth degree (Annex 6, Figure 10). As a result, 42 percent of the the children who were admitted into the protection system in 2014 were placed with foster parents, and 8 percent with other families or individuals, while the share of those placed with relatives was 23 percent (meaning that a total of 73 percent of all children admitted in 2014 were placed in family-type services).

Placement with foster carers is typical of children aged 0-2 years (particularly those under 1 year old) who were relinquished in maternity wards or other health units (Annex 6, Table 42-A).[344] Among children who were placed with foster carers after their admission in the system, children relinquished in maternity hospitals represent 51 percent, while 34 percent ended up in the system as a result of neglect and/or abuse. Most of these cases were notified by a health unit or were identified on the own initiative of the DGASPC, and their admission into the system was decided by the DGASPC director (56 percent) or by the Child Protection Commission (CPC) (31 percent).[345] Most of the children admitted into foster care had a protection measure of emergency placement (60 percent). Although the case

[341] The placement of children aged 0-2 years in residential care has been prohibited by law since 2005. Starting 2014, this interdiction was extended to all children under the age of 3, except for children under 3 years old with severe disabilities who are dependent on the care provided in specialized residential services.

[342] As an observation, the data from the case files of children in public care are very similar to those reported annually by the ANPDCA to the UNICEF TransMonEE Database.

[343] See Infograph chart 4 and section 3.2.7.

[344] Among children who, after being admitted in the system, were placed in foster care, 58 percent were under one year old and another 21 percent were 1-2 years old. As a result of the association between placement in foster care and children relinquished in hospitals, over two-thirds of the beneficiaries of this service come from urban areas (where the birth was registered).

[345] Admission by presidential ordinance is very rare - only 4 percent out of all children who, after admission in the system, were placed in foster care, a share which, although smaller, is two times the average.

files of most of these children included a social assessment, only 60 percent of the case files contained a list of the child's relatives up to the fourth degree. Premature and/or underweight babies, children of teenage mothers (at the time when the child was admitted in the system), and children of institutionalized mothers all have a higher probability than average of being initially placed with foster carers, but their shares of all children placed in foster care are minor.[346] Placement with foster carers covers 57 percent of the children in public care in Vaslui county, 44 percent in Harghita, but only 6 percent in Hunedoara or 3 percent in Gorj (as compared to the average of 25 percent).

Placement with relatives up to the fourth degree is typical of children over 3 years old who, prior to being admitted into the system, were in the care of a relative (usually their grandmother) who lived together with the child's family and with whom the child had a good relationship (Annex 6, Table 42-A). Among children who, after being admitted into the system, were placed with relatives, two-thirds came from multigenerational households where the grandmother/grandparents lived together with the parent/parents, siblings,[347] and possibly other relatives. In addition, 18 percent lived with relatives (usually grandmother/grandparents) away from the family. Placements with relatives are more frequent in rural areas, and, as a result, 58 percent of the children placed with relatives came from the rural environment and 20 percent came from rural source communities.

FROM RURAL SOURCE COMMUNITIES

The data from the source communities for the children in the protection system show that, at the level of the communes that contain these communities, there is a large number of children in family-based services:

- Children have been placed in foster care in 41 communes (68 percent of the communes included in the sample).[348] In these communes, over 280 foster carers take care of more than 307 children (with an average of 8 foster carers and 9 children in placement per commune) with significant variations from one commune to another (a minimum of one foster carer and one child and a maximum of 50 foster carers and 35 children).
- Children have been placed with relatives in 56 communes (93 percent).[349] In these communes, more than 517 children are in the care of approximately 400 households (with an average number of eight children and six households per commune) with a variation among communes, from a minimum of one child placed in one household to a maximum of 34 children in the care of 25 households.
- Children have been placed with other people or families in 20 communes (36 percent).[350] In these communes, more than 100 children are in the care of over 70 households (with an average of six children and four households per commune), with large differences between communes, from a minimum of one child and one household and a maximum of 33 children placed in 21 households.

Source: Social assistance data sheets in the rural source communities (July-August 2015). Data are not weighted (N=60 communes with source communities with 1,140 children in public care as of November-December 2014).

[346] Premature born and/or underweight babies represent 17 percent, children of teenage mothers 6 percent, and children of institutionalized mothers under 1 percent out of all children placed in foster care.

[347] Thirty percent of the children in placement with relatives lived with siblings before being admitted into the system (versus the average of 34 percent). As of November-December 2014, 37 percent of them had siblings in public care (versus the average of 50 percent).

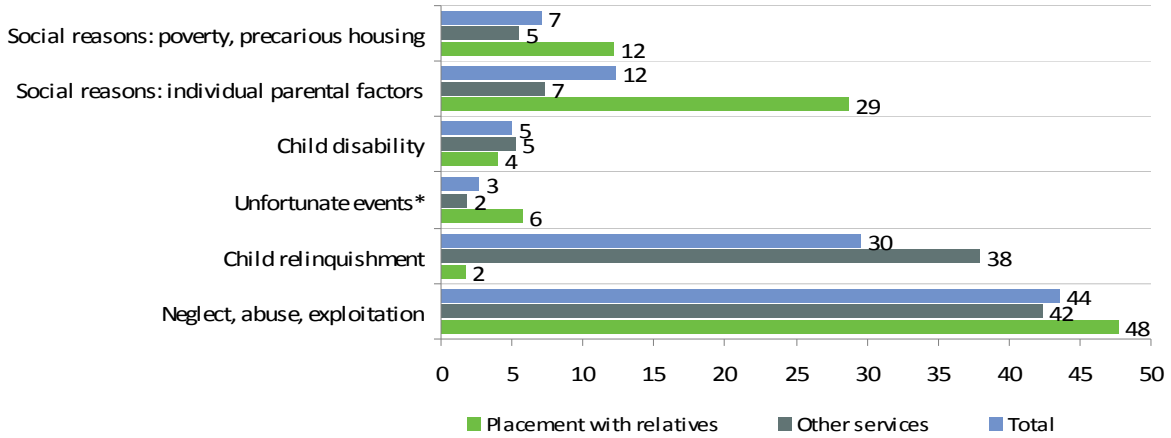
[348] Among these communes, 35 provided us with data on the number of foster parents and the number of children in foster care in the commune.

[349] Among these communes, 50 communes provided us with data on the number of children placed with relatives and the number of households where these children were placed.

[350] Among these communes, 18 communes provided us with data on the number of children placed with other individuals or families and the number of households where these children were placed.

So, in practice, most of the children placed with relatives (over 80 percent) receive a continuity of care, meaning that they are in the care of the same relative whose care they were in before their admission to the system. For 90 percent of them, being admitted into the system meant the establishment of a placement protection order.[351] The reasons why these orders were granted included being part of a dysfunctional family[352] (30 percent versus the average of 17 percent), having parents abroad (11 percent versus the average of 5 percent), having parents who are in prison (12 percent), or another unfortunate event (9 percent). Based on the separation cause analysis model developed for this study, we found that avoidable admissions are massively over-represented among the children placed with relatives (45 percent versus the average of 24 percent) as shown in Figure 59. Among children in placement with relatives, there are, on the one hand, children left with their grandparents for social reasons related to parental risk factors and, on the other hand, children left with their grandparents who do not have enough resources to raise them and who then resort to the placement order.

Figure 59: Reasons for Child-Family Separation: Comparison Between Children Placed with Relatives and Children Placed in Other Types of Services (% of Children)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=51,800 children for which there was data on the type of service in which they were initially placed after their most recent admission in the system).

Note: *Unfortunate events refer to the death or institutionalization of the child's parent(s). For the analysis model, see Infograph Chart 4 and section 3.2.7.

Placement with relatives is usually found in connection with children's case files containing social assessments carried out by SPAS and/or DGASPCs, most of which are accompanied by a plan of services. As a result, among all children in a family placement, the families that received preventive services, mainly information and counseling, before the child's admission into the system, are over-represented. Maybe precisely as a result of this action, most of these families or individuals (almost 60 percent) filed for child placement[353] and the child was admitted into the system based on a decision of the CPC.[354]

[351] Other measures/orders, such as specialized supervision or guardianship, were established for fewer than 1 percent of the cases of placement with relatives. The other children (approximately 9 percent) received emergency placements.

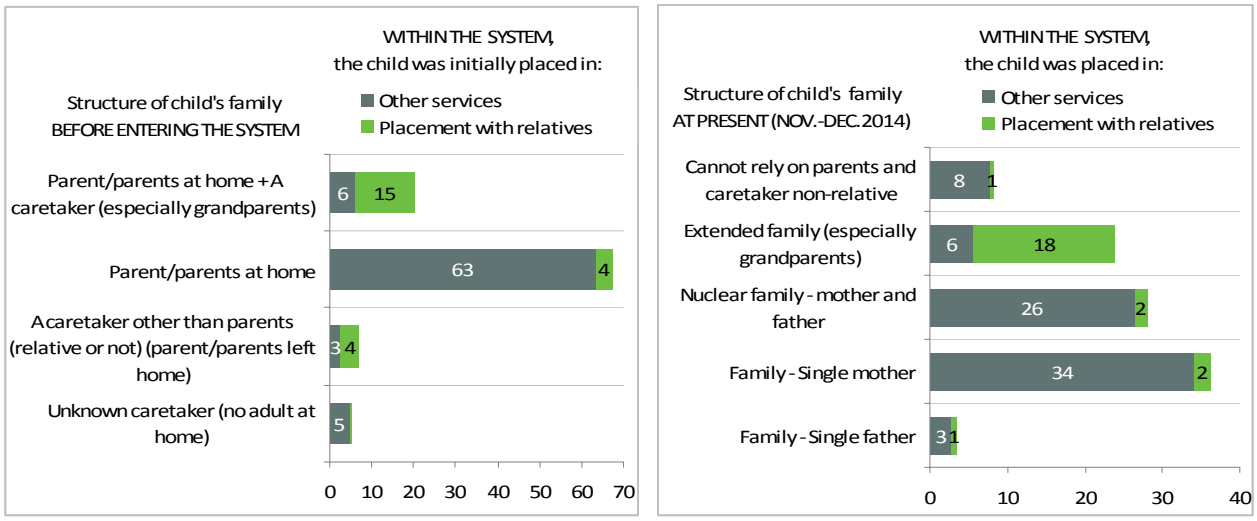
[352] In this report, a dysfunctional family is defined as a family where one or more of the following events have occurred: divorce, separation, infidelity, parental disinterest, desertion of family (other than parents being incarcerated or working abroad), unacknowledged paternity, and birth out of wedlock (other than to teenager mothers). Seventeen percent of the children in public care came from a dysfunctional family when they entered the system.

[353] Another 25 percent of the cases were notified by the SPAS, especially those involving divorce, separation, excessive consumption of alcohol, or parents with disabilities and/or mental health problems.

[354] In other 29 percent of the cases, the decision to admit a child into the system was taken through a court ruling where the parents' approval was missing, mainly if the parents were abroad, were incarcerated, and/or had exhibited promiscuous behavior, had problems with the police and/or a criminal record.

The structure of the families of origin of the children in placement with relatives (Figure 60) and the reasons why these children were admitted in the protection system indicate that many of them continued to be cared for in the family by the same people (usually the grandmother or both grandparents) who were caring for them before but with the addition of a monthly placement allowance.[355]

Figure 60: Structure of Children's Family of Origin Before Entering the System and Afterwards: Comparison Between Children Placed with Relatives and Children Placed in Other Types of Services (% of Children in Public Care in November-December 2014)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=51,800 children for which there was data on the type of service in which they were initially placed after their most recent admission into the system).

Note: The sum of the bars in each panel is 100 percent.

For children in placement with relatives only based on social reasons (especially those related to poverty and precarious housing), the government should consider replacing this special protection measure with a type of special social benefit, possibly as part of the Minimum Social Insertion Income, which is expected to become operational in 2018. Therefore, any family that has in its care one or more children deprived of parental care may have access to adequate support without any additional pressure on the child protection system. This new benefit could be considered a preventive measure that would: (i) provide both the child and the family by providing them with adequate support within the community; (ii) increase coverage of such cases; and (iii) be uniformly applied nationwide.

For the time being, at least in some counties, the DGASPCs have adopted unwritten rules on refusing placements with relatives (for example, in cases of children with parents working abroad) while others accept all parents' requests "for reasons not attributable to the parents, generally, poverty..."[356] According to the current regulations, placement with relatives (as well as in foster care or with other families) calls for quarterly reevaluation and monitoring visits conducted by the DGASPC in cooperation with the local SPAS in order to verify how the order is applied. Nevertheless, even the ANPDCA[357] control reports show that: "The reevaluation of the child's situation and of the reasons having led to his/her separation from the natural family is not carried out within the terms established by the current legislative framework, due to large caseloads and/or lack of transportation."

[355] The monthly placement allowance was increased to 1.2 ISR (Social Reference Indicator) or 600 lei under Government Emergency Ordinance 65/2014.

[356] Focus group with professionals, Ploiești.

[357] ANPDCA Control Body Report (2015) – Common issues regarding child placement with substitute or extended families.

As of November 30, 2014, 50 percent of the children in public care in Gorj and 43 percent in Bistrița-Năsăud county were placed with relatives while only 4 percent in Sibiu and 3 percent in Neamț received such placements (versus the average of 23 percent).

Placements with other individuals or families was the least common and mostly involved children who had been in the care of an unrelated person (such as a neighbor or a friend of their parents) before their admission into the system. In fact, 44 percent of the children cared for by unrelated people before their entering the system were initially placed with other individuals or families.[358] Nevertheless, these cases represent only a quarter of all children placed with other individuals or families. The others were children from families with steady accommodation (around 40 percent) or children relinquished in health units (26 percent).

Placement with other individuals or families is usually done based on social assessments by the SPAS, with the case being notified to the DGASPC by various actors (in 26 percent of the cases the notification was made by a person rather than an institution)[359] and the decision being taken by the CPC (55 percent) or by a court ruling (19 percent). Concerning the distribution by counties, the share of children placed with other families varies between 1 percent (in Bistrița-Năsăud, Harghita, and Vâlcea counties) and a maximum of 8 percent (in Olt).[360]

Children placed with other individuals or families are from all categories and in similar proportions as all of the children in public care. This shows that placements with other individuals or families are a family-type service which, regardless of the purpose for which they were initially created, are not a solution that can be targeted either to a specific group of children or to specific types of difficult situations that the children may go through. Our analysis of the reasons for children being separated from their families shows that avoidable admissions are over-represented also among children placed with other individuals or families (31 percent of beneficiaries versus the average of 24 percent). In other words, this type of protection service seems to be mostly used for children admitted into the system only for social reasons, mainly when their parents are working abroad or if they have teenage mothers.

According to Law 272/2004, "The person or family receiving a child in placement must live in Romania and must be evaluated by the General Directorate for Social Assistance and Child Protection with regard to the moral guarantees and the material conditions that it must meet in order to receive a child in placement" (Article 62, paragraph 2). Families who wish to take a child on a placement must submit an application addressed to their local DGASPC in which they explain their desire to care for and raise a child who is deprived of parental care. A social worker will then be assigned to evaluate the "moral guarantees and material conditions" of the family. If the evaluation report is favorable, then the social worker together with the family petitioning to care for a child decide on what kind of child would be the best fit to be placed with the family, after which the family is put on a waiting list until a child with the right profile is identified. If a person or family have had contact with a child in a residential center and wants to take that child in placement, at least in some counties they can submit a written application to this purpose to the child's local DGASPC. Unlike foster carers or families who want to adopt a child, these families are not required to attend any courses or a special type of training. Instead, they receive free information and counseling from the DGASPC, and after they receive a child in placement, they have the right to meet the child's case manager and be informed about all actions towards the child's integration or reintegration with his or her birth family. Also, they are entitled to support from public and private institutions in taking care of various health-related problems the child may have as well as to parental leave (for children up to 2 years old) and to the monthly placement allowance of 600 lei. In addition, if the child becomes available for adoption, the

[358] Precisely because of the over-representation of children who were cared for by unrelated people before entering the system, in the case files of children placed with other individuals/families there is also an over-representation of information on people in the community who provided support for the child or his/her family (24 percent versus the average of 11 percent).

[359] For comparison, such a notification was submitted only for 7 percent of the children in public care.

[360] High shares are also recorded in Suceava (7 percent), Bihor (6 percent), and Arad (6 percent) counties.

placement family has priority (along with the child's extended family) if they have had the child in their care for longer than six months.

Given this legal framework, an important question that remains to be answered is how this type of service relates to the other family-type services and to the adoption process. There is a pressing need for an analysis of this issue given that the mechanism for selecting these families is less stringent than the mechanism for selecting foster parents and adoptive families and it is applied incompletely and unevenly across the country. These issues were mentioned only sporadically in the qualitative study, but a recent control report[361] from the ANPDCA also found the following problems:

- The detailed case evaluation report most often did not contain an analysis of the reasons that lead to the child's separation from his/her biological family, it merely repeated the information from the initial evaluation.
- Children are placed with substitute families without those families having to undergo an evaluation to ensure that they are capable of meeting the child's needs.
- When filing the placement application, potential substitute families nominate a particular child whom they have already met in various circumstances, which, in the absence of any proper vetting of these families, can lead to the child ending up in an abusive situation.
- The evaluation of individuals or families who want to receive a child in placement is uneven across the country (for example, in some places, a psychologist is involved but not in others).
- The evaluation of the material conditions of the extended or the substitute families records only their incomes with no analysis of any other material resources and without taking into consideration the household's expenses.
- The substitute family and the child are not prepared (either informed or trained) before the social protection measure is established.

CONCLUSIONS & RECOMMENDATIONS

A thorough analysis is necessary of children's placements with relatives. Particularly for those placed with relatives for social reasons only (related to poverty and precarious housing), the government should consider replacing this social protection measure with a special social benefit managed by the SPAS, possibly as part of the Minimum Social Insertion Income (MSII), which is expected to become operational in 2018. This new benefit would be a preventive measure that would: (i) benefit both the child and the family by providing them with adequate support within the community; (ii) increase coverage of such cases; and (iii) be uniformly applied nationwide. Of course, such an initiative would have to be well thought out and designed to minimize fraud and errors, serve the best interests of the child, and ensure that children and the families caring for them receive adequate support within the community.

It will also be necessary to clarify the role played by placements with other individuals or families as well as their relation to other family-based services. For the time being, placements with other individuals or families, regardless of the purpose for which they were initially created, are not a solution that can be targeted either to a specific group of children or to specific types of difficult situations that the children may go through.

The procedure for deciding on the placement as well as the monitoring and post-placement support mechanisms and services need to be revised and standardized.

[361] ANPDCA Control Body Report (2015) – Common issues regarding child placement with substitute or extended families, identified during control actions.

Small-scale Residential Services

As at November 30, 2014, 46 percent of all children in public care were placed in residential services, 8 percent being in small-scale residential care such as apartments and small group homes. After a steep decline between 1999 and 2005 (when it reached a low 4 percent), the share of children in these services increased after 2008 to around 8 to 11 percent, where it remains for the time being (Annex 6 Figure 11). Most of the children in small-scale residential care are placed in small group homes for children with no disabilities (5 percent). The share of children in small group homes for children with disabilities decreased continuously from 5 percent in the early 1990s to 1 percent in 2014 (with an average of 2 percent for the entire period), while the share of children placed in apartments, in the first stage, increased to 3 percent in 2011 and then decreased to 1 percent of the children admitted in the system in 2014 (with an average of 1 percent).

In section 3.3.2.3. and Figure 56, we have already shown how unevenly these services were developed in the field. Consequently, the share of children placed in apartments and small group homes varies accordingly, with the maximum being in those counties that have invested in such services.[362] However, due to the fact that these services were developed in time, there are also counties (such as Alba and Arad) which, despite having a relatively large number of apartments and small group homes, have a relatively small number (and share) of children placed in small-scale residential services in the first stage of their most recent admission into the system. Children ended up in these services only at later stages, after the dissolution of certain placement centers and after the apartments and small group homes became available.

Children over 6 years old (especially those aged 15 to 17) are most likely to be placed in apartments in the first stage after their admission in the system, particularly boys[363] of Romanian ethnicity[364] (Annex, 6 Table 42-B). Most of these children come from nuclear families with a stable dwelling (86 percent) who live in poverty (50 percent) and are dysfunctional (21 percent) and/or where there is parental disability and/or mental health problems (24 percent) as well as alcohol abuse (47 percent). The main cause of child-family separation was neglect and/or abuse (83 percent). Among the children placed in apartments immediately after their admission in the system, certain categories of children are over-represented – those with developmental delays (38 percent versus the average of 17 percent of all children aged 7 to 17 years old in the system) and those with behavioral disorders (14 percent versus the average of 10 percent). More than half of the apartment beneficiaries had their cases documented by the SPAS in a social assessment report of good quality (in that it identified the needs and services in the community), based on which the emergency placement measure was decided by order of the DGASPC director. In the other cases, the notification was made by various factors, including by the child,[365] and the final decision was taken mainly by court ruling or presidential ordinance.

Small group homes (CTFs) for children with no disabilities have a typical profile of the beneficiaries very similar to that for apartments (Annex 6, Table 42-B). Those who are placed in CTFs for children without disabilities in the first stage following their admission into the system are mainly 3 to 17 year-old children who suffered from neglect and/or abuse in their families (55 percent versus the average of 44 percent) or were relinquished in health units at the age of at least 1 year. One out of ten of these

[362] Out of the 24 counties with solid data in the CMTIS, there were high shares of children placed in apartments in Bacău, Botoșani, and Caraș-Severin. As regards children in small group homes, the highest shares (almost 20 percent) are in Bacău and Bihor counties. On the other hand, some counties with a large number of apartments and/or small group homes do not have sufficient CMTIS data to allow for a rigorous analysis, namely Brăila, Maramureș, Mureș, and Teleorman.

[363] Boys represent 68 percent of the children placed in apartments in the first stage following their entry into the system (versus the average of 53 percent).

[364] Children of Romanian ethnicity represent 80 percent of the children placed in apartments in the first stage following their admission into the system (versus the average of 54 percent). Nevertheless, this may partly be an effect of the under-representation in the CMTIS sample of some counties with a relatively large number of apartments.

[365] Two percent of the apartment beneficiaries entered the system due to requests from the children themselves. This share is small, but it is ten times higher than for the children placed in other services.

children was separated from his or her family only because of social reasons such as poverty and precarious housing. Most came from nuclear families (91 percent), with a stable dwelling (70 percent) or who lived in multigenerational households, with many children,[366] or who lived in poverty (45 percent) and had parents who were abusing alcohol (34 percent). Also, among the children placed in small group homes for the non-disabled immediately after their admission into the system, children with behavioral disorders are over-represented (12 percent versus the average of 10 percent children in care aged 7 to 17 years). Most of the cases of children in this type of CTFs were notified by the SPAS (35 percent versus the average of 24 percent), by other institutions (in the case of children relinquished in health units) or were placement requests made by their families (most of which were avoidable admissions for social reasons) or by the children themselves. The decision to issue a placement protection measure (63 percent of admissions versus 37 percent admitted with an emergency placement measure) was taken by CPC (52 percent) or by the DGASPC director.

Small group homes (CTFs) for children with disabilities are very different. Boys and girls of all ages and ethnicities, originating from both rural and urban areas are placed in such services in the first stage after they enter the system, but they all have in common being part of one or more of the following groups with special needs: (i) children with disabilities (67 percent of beneficiaries versus the general average of 11 percent); (ii) children with developmental delays (60 percent versus the average of 17 percent); (iii) children aged 6-17 years with special educational needs (47 percent versus 9 percent); and (iv) rarely, children aged 7-17 years with behavior disorders (16 percent versus 10 percent). A share of 84 percent of the beneficiaries of CTFs for children with disabilities come from nuclear families where both mother and father were present when the child entered the system. The main reasons for these separations were child relinquishment in health units (38 percent versus the average of 29 percent), child neglect (34 percent), or child disability. In fact, avoidable admissions related only to child disability are over four times more frequent in the case of those in CTFs for children with disabilities than in the whole population of children in public care (23 percent versus the average of 5 percent). As shown in section 3.2.7, these admissions in the system have both structural causes, such as the lack of rehabilitation services in the community, and individual causes related to the family's lack of resources, incapacity, or lack of interest in meeting the child's needs.

These cases were generally notified by the SPAS and by the health institutions where the children were relinquished or were requests from the families. Usually, the case ended up with the CPC which issued a placement order (67 percent) based on which children were admitted to a small group home for children with disabilities. For children relinquished in health units, in most cases, the emergency placement measure was established by order of the DGASPC director.

CONCLUSIONS

Small-scale residential services have a clear typical profile. Apartments and most small group homes generally meet the needs of children who have experienced neglect and/or abuse in the family, while some small group homes are dedicated to children with disabilities.

However, there are very few small group homes, especially those for children with disabilities, their numbers are decreasing, and they are unevenly distributed across the country.

[366] As a result, 72 percent of the children placed in CTFs for children without disabilities in the first stage following their admission into the system have siblings in the system.

Placement Centers

Of the total of 46 percent of all children in the system (as at November 30, 2014) who were initially placed in residential services, 24 percent were in placement centers, 8 percent in small-scale residential care (apartments and small group homes), and 14 percent in other services (emergency reception centers and maternal centers). Thus, not only is the proportion of children in public care placed in residential services high, but most of these children have lived in placement centers, the institutions that are the least likely to provide a family environment.

We must take into consideration the fact that this share refers to children who entered the system over a period of 25 years (1989 to 2014) during which many centers were closed or restructured. The share of children in placement centers decreased almost tenfold, from 79 percent in the early 1990s to only 8 percent in 2014 (Annex 6 Figure 12). Nevertheless, out of all children admitted into the system starting 2005, 8 to 14 percent were placed in placement centers in the first stage following admission.

These trends in time reflect the structural changes in the system. Thus, the decrease in the share of children placed in placement centers was due to the closing of some structures and reducing the number of "old type," "traditional," or "classical" centers as well as the number of children in these centers. Meanwhile, the share of children placed in "refurbished," "restructured", or "modulated" centers increased in the 1990s, then slightly decreased and eventually it stabilized to around 6 percent per year. At the same time, the share of children in the centers taken over from the Ministry of National Education (MEN) (former dormitories of special (education) schools[367]) remained relatively steady at approximately 1 percent of all children in public care.

Placement centers are available in almost all counties in the country, but they are strongly concentrated in a few counties, as mentioned in section 3.3.2.3. and Figure 56. Accordingly, the share of children in placement centers in the first stage after their admission in public care closely follows the distribution of these institutions in the field.

Our analysis in this section considers only the centers that were operational at the time of the research, where 17 percent of the children in public care were placed.[368] Most (9 percent) were placed in classical placement centers, among which the centers for children without disabilities accommodate most children (6 percent). Because classical placement centers have been operating for a long time and for many years they were the only type of child protection service available, the typical profile of the children placed in these old-type institutions (as can be seen in Annex 6 Table 42-C) was strongly influenced by the share of children aged 11 to 17 years who were admitted into the system when they were under 1 year old, in other words before Law 272/2014 entered into force. Thus, our analysis shows that classical centers (for children with and without disabilities) were institutions that hosted particularly children aged 0-2 years relinquished in health units (accounting for over 63 percent). As a result, it was more useful to narrow our analysis of these classical centers down to the last five years (2010-2014). The data are presented in Annex 6 Table 43.

Out of all children admitted into the system between 2010 and 2014,[369] 3 percent were placed in classical placement centers in the first stage following their entry into the system, with 2 percent being placed in institutions for children without disabilities and 1 percent in centers for children with disabilities. The following categories of children had an above average probability of being placed in a classical placement center for children without disabilities in the first stage after their admission into the system: (i) children 3 to 17 years old who come from families with three or more children, especially from rural areas; (ii) children who were neglected, abused, and/or exploited within the family (72 percent), mostly by parents who abused alcohol (36 percent); and (iii) children left home alone as a result of their parents' being in detention (13 percent) or having left abroad to work (13

[367] Special schools are part of the special education system for children with disabilities/deficiencies.

[368] Placement centers that were closed down, which were not included in our analysis, were where 7 percent of the children in public care were initially placed.

[369] Children placed in placement centers of all types represent 12 percent of the children who entered public care during 2010-2014.

percent). Very few are children whose mothers are institutionalized, although this share is still ten times above the average. Out of all children placed in the last five years in classical placement centers for children without disabilities, one-third were teenagers with behavior disorders, 27 percent were children with developmental delays, and 71 percent had siblings in the system. Therefore, almost six out of ten beneficiaries of these classical placement centers are children with special needs. More than half of the cases were notified and documented by the SPAS, and the protection measure was decided by a court ruling (22 percent), more frequently than for other children due to parents' absence or refusal to cooperate.

Even though the current legislation forbids the institutionalization of children under 3 years old (except for those with severe disabilities who are dependent on care in residential specialized services), between 2010 and 2014, the classical placement centers for children with disabilities received children of all ages (between 0 and 17 years old) but especially boys (66 percent) and children from rural areas (62 percent). Most of them (85 percent) came from nuclear families made up of a mother, a father, and two to three children. The prevailing reasons for these children's separation from their family were relinquishment in health units (30 percent) and child disability.[370] Among the beneficiaries of classical placement centers for children with disabilities, 20 percent were premature and/or underweight babies, 80 percent were children with disabilities, 66 percent were children with developmental delays, and 62 percent among the children aged 6 to 17 had special educational needs. In addition, 27 percent of the children had at least one parent with disabilities and/or mental health problems. These children entered public care in two ways: those relinquished in hospitals received an emergency placement ordered by the DGASPC director after being notified by the health unit, and the remaining children were admitted with a placement measure ordered by the CPC after a request from the child's family.

Seven percent of all children in public care were placed in modulated placement centers in the first stage after their admission into the system, 4 percent of which in restructured institutions for children without disabilities and 3 percent in centers for children with disabilities (Annex 6 Table 42-C).[371]

The profile of the children admitted to modulated placement centers for children with disabilities has been steady in time (see for comparison Annex 6 Table 42-C and Annex 6 Table 43). As opposed to small group homes and classical placement centers which accommodate children of all ages, modulated placement centers seem typical of children 0 to 2 years old. Both at the level of the entire population of children in public care and of the children admitted in the system between 2010 and 2014, approximately 80 percent of the beneficiaries of modulated placement centers are under 3 years old, particularly infants 0 to 12 months old with health problems. Therefore, the modulated placement centers for children with disabilities are institutions where young children prevail, most of whom were relinquished in health units (60 percent) or separated from their family because of the child's disabilities (11 percent).[372]

The profile of children admitted to modulated placement centers for children without disabilities becomes much clearer when we narrow down the analysis to the period 2010 to 2014 (Annex 6 Table 43). Children 3 to 10 years old have a higher than average probability of being placed in a modulated placement center for children without disabilities in the first stage after entering the system and represent 71 percent of the beneficiaries of these services. Although most of them are of Romanian ethnicity, Roma children are statistically over-represented (15 percent). More than three-quarters of all of these children come from nuclear families with three or more children where both parents live at home, who live in extreme poverty and substandard homes (67 percent). Also, 88 percent of them have siblings who are also in the system.

[370] The share of children in modulated placement centers for children with disabilities separated from their families due to neglect, abuse, and/or exploitation is below average (23 percent versus 44 percent).

[371] Of the children admitted into the system between 2010 and 2014, 6 percent were placed in modulated placement centers - half in those for children without disabilities, and half in those for children with disabilities (Annex 6 Table 43).

[372] The share of children in classical placement centers for children with disabilities separated from their families due to neglect, abuse, and/or exploitation is below average (34 percent versus 44 percent).

The reasons for these children being separated from their families were child negligence, abuse, and/or exploitation (65 percent), social causes related to poverty and precarious housing (18 percent), or parental factors (12 percent).[373] Thus, a large share of avoidable entries into the system can be found in the modulated placement centers for children without disabilities. The great majority (81 percent) of the beneficiaries of these centers entered public care (SPS- special protection system) directly from the family (via route Maternity ward --> Family with stable accommodation --> SPS), but two rare routes are also over-represented: (i) Maternity ward --> Family with no stable accommodation or homeless --> SPS (5 percent) and (ii) Maternity ward --> Family --> Children who ran away from home/street children --> SPS (1 percent). Associated with this, children with behavioral disorders represent 16 percent of the beneficiaries of modulated placement centers for children without disabilities, versus the average of 10 percent. Given the profile of the prevailing share among these centers' beneficiaries, children most often end up in modulated placement centers for children without disabilities based on CPC order after a notification by the SPAS or at the request of the child's family.

The third type of placement centers are former dormitories of special schools taken over from the Ministry of National Education (MEN centers). (See for comparison Annex 6 Table 42-C and Annex 6 Table 43.) These MEN centers can be either the classical type or the modulated type. Given the small number of children in the modulated-type MEN centers, we will limit the discussion to the classical-type ones. Only 1 percent of all children in public care (and 2 percent of those who entered the system between 2010 and 2014) were placed in such institutions in the first stage following their admission into the system. These services were and remained mainly former dormitories/boarding houses of special (or inclusive) education schools. However, in the last few years, they have been taking other types of cases as well. The centers taken over from MEN mainly contain children between 7 and 17 years old, of whom 53 percent are girls and 47 percent are boys. The majority of the beneficiaries are children with disabilities (36 percent), with developmental delays (40 percent) and/or special educational needs (41 percent of the children between 6 and 17 years) who came mostly from nuclear families (82 percent) with many children (61 percent), with whom they have good relations (over 50 percent). Also, 62 percent of the beneficiaries have siblings in the system.

For 40 percent of them, child disability was the reason why they entered the system (versus the average of 5 percent). However, in their case, the child disability actually refers to a structural factor, namely the absence in their community or near their home of any opportunity to attend school. The other 60 percent of the beneficiaries entered the system due to neglect, abuse, and/or exploitation (48 percent) or social causes related to poverty and precarious housing (9 percent) or other causes. Most of the children in classical MEN centers entered the system directly from their families, but one out of every ten children came from a homeless family or one without a stable dwelling. The cases were generally documented by the SPAS based on social assessment reports that largely failed to identify the children's needs or the community services or assistance provided to them before they entered the system. Among those who entered the system in order to attend school, most were taken in following their family's request, usually based on a placement measure established by CPC. The other cases were either notified by the SPAS or the children made their own requests, with the protection measures being emergency placements issued by the DGASPC director.

The present study did not collect data on the quality of the special protection services, or on the equipment or costs of residential services. Nevertheless, during the qualitative study, DGASPC specialists often brought up the fact that most of the residential services, including old-type or restructured placement centers, apartments and small group homes, were noticeably improved over the last ten years. According to the specialists, the main problem is the overcrowding in the centers, at least in those counties with many classical centers.

> "Because our centers are overcrowded with children. We cannot even provide the conditions required by the minimum standards first and foremost because there are many more children [than there are available centers/space]. You know, you are conducting a survey now, but in order

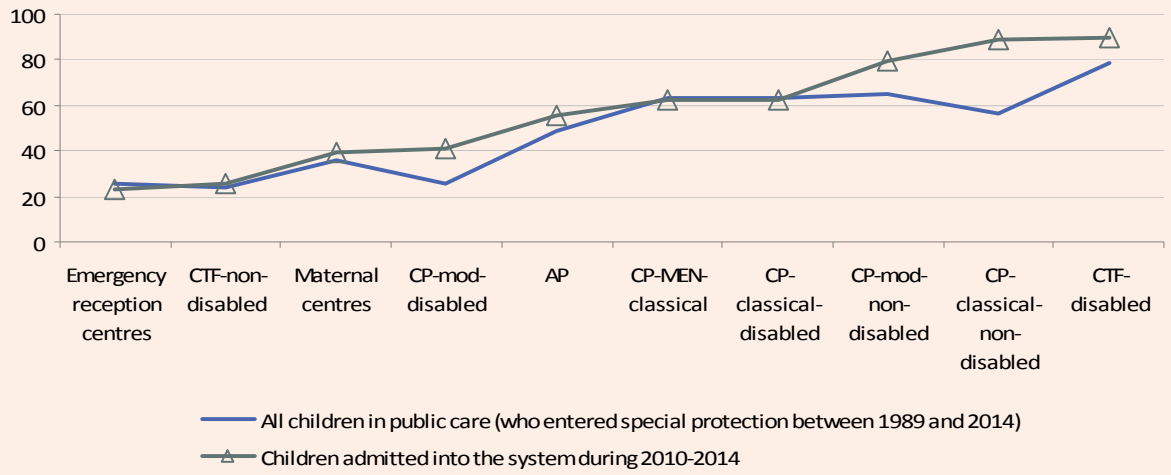
[373] Most frequently, parental factors refer to alcohol abuse and/or promiscuous behavior, problems with the police, and/or having a criminal record.

to understand the real situation, you need to see what the Directorate's centers look like and what these children's homes are like. Because we provide them with all the necessary amenities in the centers. In fact, the children do not want to return home because here they have everything while home they have nothing. We have an obligation by standards and law to provide them with everything any child needs. It's not only about the child, we even provide members of their families with necessary things, but we do not give them the first right granted by the law, the right to live with their natural family." (Focus group with professionals, Craiova)

CONCLUSIONS & RECOMMENDATIONS

The problems of placement centers are strongly related to those of children with special needs. Most residential services, including small-scale ones, were and still are concentrations of children with special needs. As presented in the figure below, the accumulated share of groups with special needs – children with disabilities, children with developmental delays, premature or underweight babies aged 0 to 12 months, children between 6 and 17 years old with special educational needs, and children between 7 and 17 years old with behavioral disorders – represent 56 percent of the children initially placed in apartments and 90 percent of those initially placed in small group homes for children with disabilities. As a comparison, children from these groups represent only 10 to 12 percent of those placed with relatives and less than a quarter of those placed with other individuals or families or with foster parents.

Share of Children with Special Needs, by Types of Residential Service



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, 17,341 children who entered the system during 2010-2014).

Note: CTF = Small group homes, CP = Placement centers, AP = Apartments, mod = Modulated.

There is a rich body of international and national evidence[374] about the importance of the quality of care for child development, especially in the early years. The UN Guidelines for the Alternative Care of Children[375] say that "facilities providing residential care should be small and be organized around the rights and needs of the child, in a setting as close as possible to a family or small group situation." There are studies[376] that prove that reducing the number of children in care from groups of 12 to 14 to groups of 6 to 7 children while also reducing the number of caretakers to two per group has a remarkable positive impact on children's development, even those with severe disabilities, across a wide range of abilities (motor, cognitive, personal-social, adaptive, and communicational), as well as in terms of the relationship between the child and his/her caretaker. Therefore, in order to provide children with adequate support, protection, and care to enable their full intellectual, physical, and mental development, the current placement centers must be replaced with small-scale services.

[374] For example, Legrand et al. (2015) and Nelson et al. (2007).

[375] United Nations (2010:18, paragraph 123).

[376] For example, Groark et al (2008) and Legrand et al. (2015).

Other Residential Services

The other residential services discussed in this section are the emergency reception centers (for neglected, abused and/or exploited children) and the maternal centers (for mothers and their children at risk). In the first stage after they entered the system, 14 percent of the children in public care were placed in these services, 13 percent in emergency reception centers (CPRU) and only 1 percent in maternal centers (CM). Annex 6 Figure 13 shows that these shares followed different trends over time. The percentage of children placed in emergency reception centers increased approximately ten times between the beginning of the 1990s and 2003 (from 2 percent to 19 percent), while these services were being developed, after which it remained relatively constant except for two periods of steep decline, once between 2004 and 2006 and once after 2011 (from 21 percent to 10 percent in 2014). By contrast, the percentage of children placed with their mothers in maternal centers has consistently been around 1 to 2 percent. However, these are children who went into the maternal centers only to remain in public care, which means they are representative of maternal center beneficiaries for whom efforts to prevent child-family separation failed.

As of November 30, 2014, there were 67 emergency reception centers (CPRU) operating in the country, with one to three in each county except for Sălaj county with five and Satu Mare and Ilfov counties with none. Approximately one in every eight children in public care was initially placed in an emergency reception center (Annex 6 Table 42-D). The children most likely to be placed in emergency reception centers were those between 3 and 14 years old, especially those from rural areas (53 percent), from nuclear families with three or more children (63 percent), from families in which one or both parents abused alcohol (36 percent) and/or behaved promiscuously, had problems with the police, and/or had a criminal record (12 percent), and with whom the children did not have good relations before entering the system (53 percent of children aged 6 and over). Most of the beneficiaries entered the emergency reception center directly from their family, but there is an over-representation of children left home alone after their parent's departure (2 percent), children from families who lived wherever they could (4 percent), those in the care of non-relatives (3 percent), children relinquished on the street or in public places (over 1 percent), and children who had run away from home (2 percent). Children with developmental delays (26 percent) and with behavioral disorders (18 percent) are also statistically over-represented. The main reason for these children being separated from their families was child neglect, abuse, and/or exploitation (67 percent of the children placed in emergency reception centers in the first stage after they entered the system). Almost all beneficiaries entered the emergency reception centers based on an emergency placement measure established by order of the DGASPC director, but 8 percent of the beneficiaries had a placement measure.

As of November 30, 2014, there were one to three maternal centers (CM) operating in every county except Caraș-Severin and Covasna as well as in sectors 3 and 6 of Bucharest. These centers provide accommodation and specialized interventions for mother and child with the aim to prevent separation. Annex 6 Table 42-D shows that children with a higher than average probability of being placed in a maternal center are those between 0 and 2 years old (especially those under 1 year old),[377] who come from nuclear families (94 percent), most with two to three children (61 percent). From the groups of children with special needs, premature and/or underweight babies represent almost a quarter of all maternal center beneficiaries aged between 0 and 12 months. The children who received care in maternal centers and remained in the system are more likely than average to have mothers who are teenagers, mothers with disabilities and/or with mental health problems. Also, one out of every eight children remained in the system because their mother was homeless or did not have a stable dwelling. In situations such as these, the preventive services provided by the maternal centers seem to have been less effective.

[377] Children between 0 and 12 months old represent 56 percent of children initially placed in maternal centers and those between 1 and 2 years old represent 23 percent of those children.

RECOMMENDATION

Additional research is needed on the efficiency of maternal centers in preventing child-family separation in order to identify what other services should complement the existing ones or what regulations should be changed to improve the outcomes of maternity centers and to reduce the number of children remaining in the system.

The First Protection Service in Which Children with Special Needs Are Placed When They Enter the System

In this section, instead of looking at services, we shall be focusing on the initial placements of children with special needs and if there have been any modifications in how these placements were made over time. The distribution of groups with special needs over the entire period 1989 to 2014 and over the last five years (2010-2014) are presented in Figure 61.

According to the regulations introduced since 2005, the share of children between 0 and 12 months old who were placed in residential services (of all types) decreased from 46 percent to 16 percent of the children who entered the system between 2010 and 2014. However, even in the last two years, approximately one in every seven babies who enter the system is still placed in residential services (with less than 3 percent being placed in maternal centers). This is probably because of the legal exception (at the time of the research) allowing the institutionalization of children under 3 years old if they have severe disabilities and are dependent on care in specialized residential services. Thirty percent of children who need a great deal of support, such as premature and/or underweight babies, were placed in a residential service, especially in placement centers for children with disabilities, in the period 2010 to 2014. However, this age segment also registers the most progress, with high and increasing shares of children who, at least in the first stage, were placed in a family-type service.

For children aged between 1 and 2 years, the situation improved considerably less, with the share of those initially placed in a residential service decreasing from 43 percent of all children in public care to 34 percent of those who entered between 2010 and 2014. Of these, 8 percent are in placement centers.[378]

As for children who entered the system at the age of 3, the new regulations were too recent to have affected the data from November-December 2014. Thus, over half of the 3 year-olds who entered the system between 2010 and 2014 were placed in residential services, 13 percent of which in placement centers.[379] In other words, even now (at the time of the research), a significant share of children in public care spend their first years of their life, when their brains are developing, in an inappropriate and unstimulating environment.

Children in other groups with special needs were strongly concentrated in residential services. For example, as can be seen in Figure 61, children with disabilities had very little chance of being initially placed with relatives (12 percent versus the average of 23 percent),[380] with a professional foster carer (11 percent versus the average of 25 percent),[381] or with other individuals or families (3 percent versus the average of 4 percent).[382] A similar situation is evident for the other groups with special needs as well.

[378] The others were placed in an emergency reception center (11 percent), in small residential services (11 percent), especially in small group homes for children with disabilities, in maternal centers (3 percent), and in other services (1 percent).

[379] The others were initially placed as follows: 24 percent in emergency reception centers, 9 percent in small group homes for children without disabilities, and 5 percent in apartments or in small group homes for children with disabilities.

[380] Children with disabilities represented fewer than 6 percent of children initially placed with relatives.

[381] Children with disabilities represented fewer than 5 percent of children initially placed with professional foster carers.

[382] Children with disabilities represented fewer than 7 percent of children initially placed with other individuals or families.

Figure 61: The First Service in which Children with Special Needs Are Placed: Comparison Between All Children in the System and the Children Admitted During 2010-2014 (% Category)

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, 17,341 children who entered public care during 2010-2014).

Notes: See also Annex 6 Table 42 and Table 43. *The type of placement center was not specified. CTF = small group homes, CP = placement centers, AP = apartments, mod = modulated, CPRU = emergency reception centers, CM = maternal centers.

Therefore, 70 to 80 percent of children with disabilities, children with developmental delays, children between 6 and 17 years old with special educational needs, and children between 7 and 17 years old with behavioral disorders have been and still are being placed in residential services. Of these children, more than half of the children with disabilities and those with special educational needs were in placement centers. The children with developmental delays were distributed in three approximately equal parts between emergency reception centers, placement centers and other residential services. In contrast, children with behavioral disorders went mostly to emergency reception centers (34 percent) but also to placement centers (20 percent), small residential services (14 percent), maternal centers (2 percent), and other services such as specialized supervision (10 percent).

The subject of specialized supervision and, more generally, of the lack of services for children and young people with behavioral disorders was brought up by the DGASPC specialists in the qualitative research. Some typical opinions on this subject were as follows:

> "*If you were to consider the characteristics of the beneficiaries, are there any barriers to implementing the activities*?
>
> - Many of the beneficiaries in our care show signs of behavioral disorders. They are usually taken into the system at quite an advanced age when it is already too late to intervene and change the way they are.* Recently we took in a lot of trafficked girls. They were trying to create a group of customers and when I introduced them into the system, I was not able to intervene efficiently since there were no specialized centers for certain categories of beneficiaries. The only ones available in my case are those for children with disabillities and those for normal children. Within the group that includes the normal child, I have to deal with different characters and typologies of beneficiaries who interact with other children and lead them to indulge in anti-social behavior, those who are already part of the group in question. At least in residential centers, if we happen to take over some siblings aged, say, 17, 15 and a younger one of 12, it is very difficult to mold them, since they have a certain level of knowledge and their personalities have been shaped already. It is really difficult and I start to wonder whether it was a good thing I took in that young person from the community. And we take in a lot of kids who do not attend school. I try to integrate them into the school system when they are 15, 16, 17 years old by using The Second Chance program, the types of education for those who have not been in school at the proper age. Their reintegration is very difficult to achieve. Considering their behavior, it is extremely hard. We are not prepared to deal with behavior disorders and with young delinquents. I put a delinquent under the same roof with three other children, and if we are talking about a child who has the ability to manipulate others, then one of the other three will definitely end up being a delinquent too.
>
> *So, you are saying that specialized centers or services are required for this type of behavior*?
>
> - Yes. I was thinking at a certain point, I know that I saw a documentary somewhere in Germany about those community corrections. Young people who had committed anti-social crimes were brought somewhere to a village. They were taken over by two or three educators who submitted them to a whole range of physical and intellectual activities. Rehabilitation was achieved by activity. What should I do here in the middle of Bacău? Besides household activities and psychological counseling, there is nothing else that can be done. And the number of children that the Prosecutor's Office sends us for specialized supervision is constantly increasing. I do not have the right place to proceed with this specialized supervision because the required services have not been developed. And across the country, the number of services dedicated to this specific purpose is quite low. I believe that those community correction programs would be beneficial in this regard and that they should be developed. Because the number of these children is increasing and a lot of them choose to leave school. The delusion about leaving the country takes control over them, they come in contact with different kinds of individuals, there are a lot of networks available at the community level that take advantage of the fact that these children are in public care. The thing is that we cannot have full control of a child's life, we cannot do this and we should not do it either..." (Interview with a DGASPC specialist, Bacău)

Note: *We believe these attitudes and stereotypes need to be addressed and actively discouraged.

Before we conclude, we should highlight once again the fact that now, as well as in the past, approximately two-thirds of the children who entered public care for social reasons related to parental factors, and approximately three-quarters admitted for reasons of poverty and precarious housing are in family-type services, particularly placement with relatives. Therefore, in order to address avoidable entries, a reassessment of family-type serviced should first be conducted.

The available data only allow for an analysis of the type of protection service in which the young or older children are placed, whether they are boys or girls, Roma or from other ethnic groups, with or without special educational needs. They do not make it feasible to test hypotheses about the possible existence of discriminatory practices for placing certain groups in "better" or "worse" services.

RECOMMENDATIONS

The legislation in force and the new methodologies prepared by the ANPDCA provide a good regulatory framework, which, however, is only partially implemented. It is particularly necessary to accelerate the implementation of the regulations regarding the placement of children under the age of 3 in family-type care services instead of in residential services.

It is also necessary to eliminate the exception regarding children aged 0-3 with severe disabilities, who for the time being do not have equal opportunities as the other children in the system.

Considering the large-scale concentration of children with special needs in residential services, especially placement centers, there is a pressing need to develop procedures governing the placement of children with disabilities as well as of those with developmental delays and/or special educational needs, in order to provide these children with a real chance of personal development and of living as independent a life as possible.

Also, most counties will need to develop psychological counseling and support services for children with behavioral disorders.

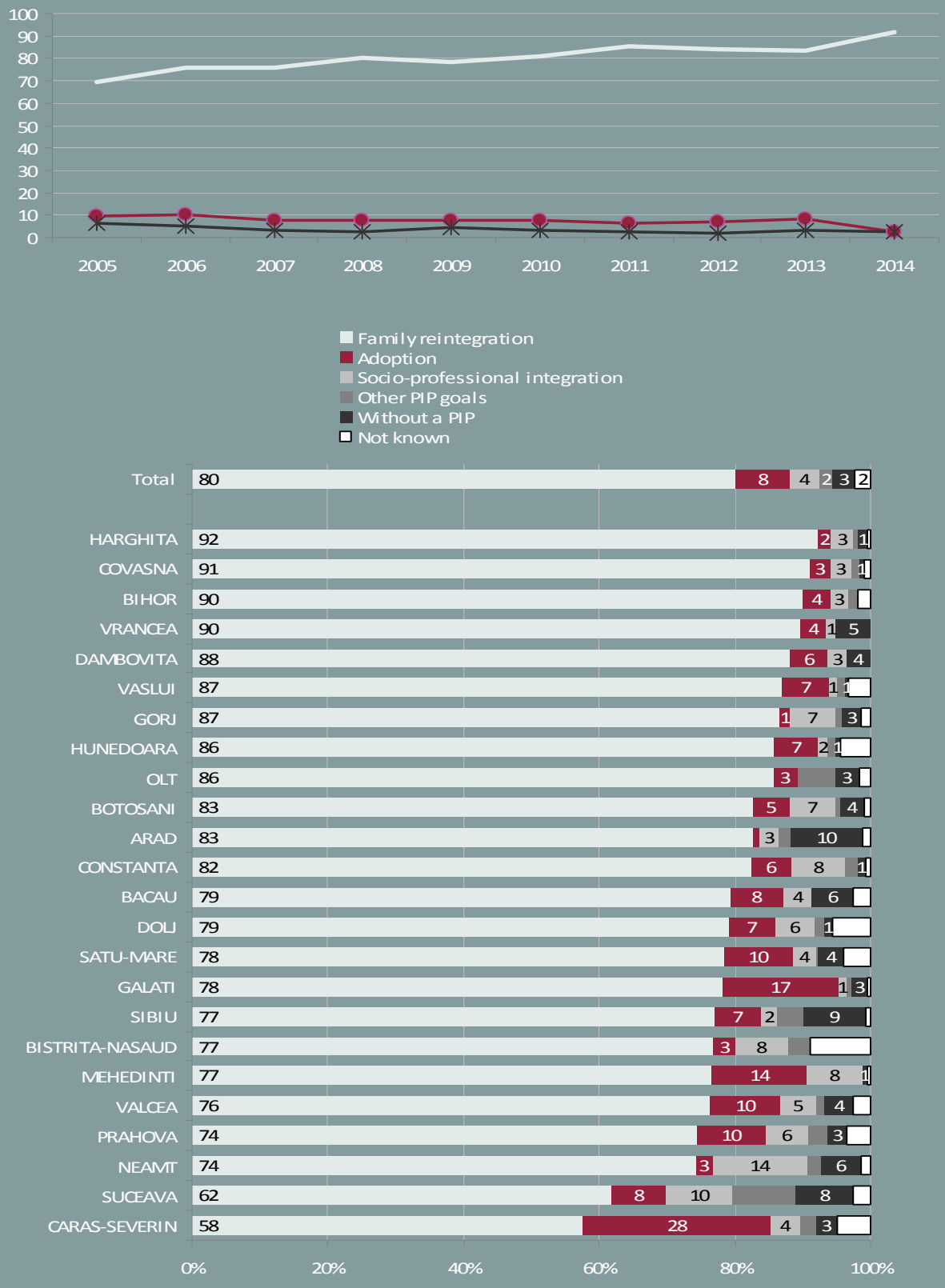
3.3.3 The First Individualized Protection Plan

In Romania, Law 272/2004 introduced the case management principles in the field of child protection, and Order 286/2006[383] set out the detailed methodological rules governing the drawing up of the Individualized Protection Plan (PIP) for each child. According to these regulations, the PIP must be initiated immediately after the case has been referred to the DGASPC by the SPAS (or after the DGASPC director has ordered the emergency placement). Depending on the case in question, the PIP may have one of the following goals: (i) reintegrating the child within their family of origin; (ii) fostering the socio-professional integration of young adults aged 18+ who are about to leave the child protection system; or (iii) pursuing a domestic adoption.

Figure 62 shows the distribution of children who entered public care each year starting 2005 up until 2014, by the PIP goal that was established for them when they first entered the system. The percentage of children whose PIP goal was reintegrating with their family rose from 69 percent of those who entered the system in 2005 to 92 percent in 2014. Adoption was the goal assigned to 9-10 percent of the children who entered the system in 2005, but this dropped abruptly to 3 percent in 2014 after Law 273/2004 on adoption was updated.

[383] Published in the Official Gazette of Romania, Part I no. 656 from 28/07/2006.

Figure 62: The First PIP Goal Received by Children Entering Public Care Starting 2005, by Year and by County (%)



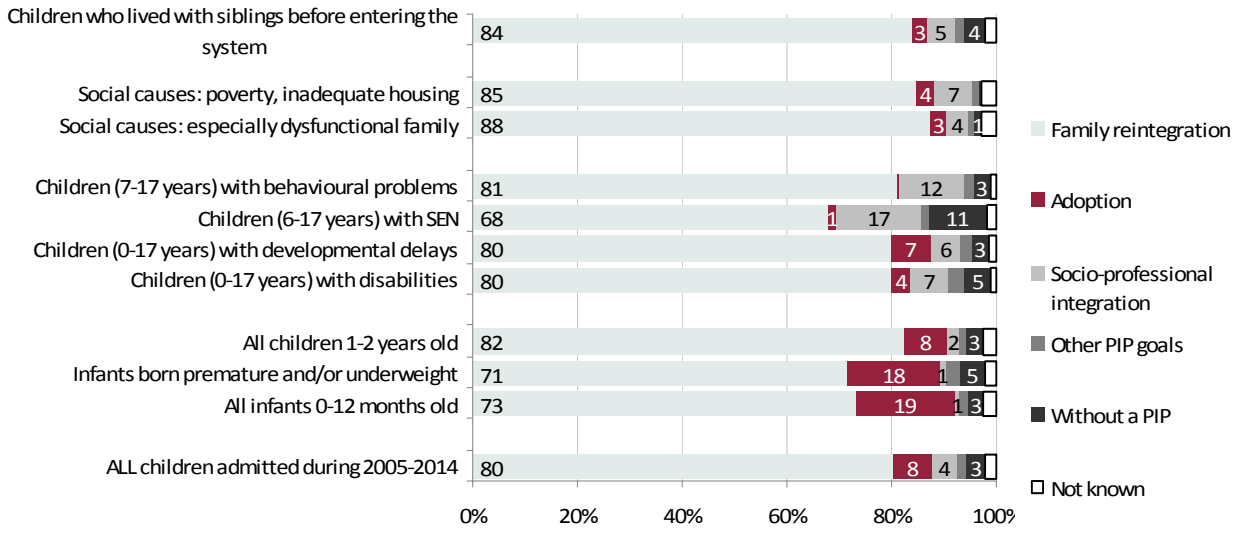
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. For the top graph, N=33,841 children who entered public care during 2005-2014. For the bottom graph, only the 24 counties with solid data in the CMTIS were considered (N=33,217).

The share of children whose PIP goal was socio-professional integration also dropped significantly, from 7 percent of the children who entered public care in 2005 to 1 percent of those who entered in 2014 (with an average percentage of 4 percent over the entire period). This PIP goal is reserved for children who are about to leave the protection system when they come of age (18 years old). As the sample for this analysis is the children who were still in public care in November-December 2014, this means that at least some of the young people who received this PIP goal at the beginning of the period under analysis had left the system by the time of the study. Other than these three goals, for 2 percent of the children the goal as stated in the case files was life skills training, transfer to an adult care center, or other goals. Three percent of the children in public care in 2014 had no PIP goal set in their files (a decline from 6 percent in 2005), and 2 percent of the children had no information at all on this matter in their case files.

There were significant discrepancies between children from different counties in terms of their PIP goals (Figure 62, bottom chart). Reintegration within the family is the prevailing goal for the entire population of children in the special protection system. However, in the PIPs, it varied between 58 percent of the children in Caraș-Severin and 92 percent in Harghita among the 24 counties with solid data in the CMTIS. Adoption was stated as a goal for fewer than 5 percent of the children in several counties (with a minimum of 1 percent in Arad and Gorj), while in other counties it was stated for more than 10 percent of the children (with a maximum of 28 percent in Caraș-Severin).[384] The percentage of children for whom no PIP goal was established also varied between virtually zero in Bihor and Bistrița-Năsăud and approximately one in ten children in Arad, Sibiu, and Suceava. Thus, the way in which the PIP goal is assigned to children seems to vary significantly from one county to another.

Although reintegration within the family was not specified as the goal for all children in public care (Annex 6 Table 44), it was still the prevailing goal for most children, except for teenagers (particularly those between 15 and 17 years old), those with socio-professional integration as their PIP goal (13 percent for those aged 11 to 14 and 3 percent for those aged 15 to 17), children whose parents had died or were institutionalized, children relinquished in health units, children with teenage mothers, and those with multiple entries in public care.

Figure 63: The First PIP Goal Assigned to Children with Special Needs (%)



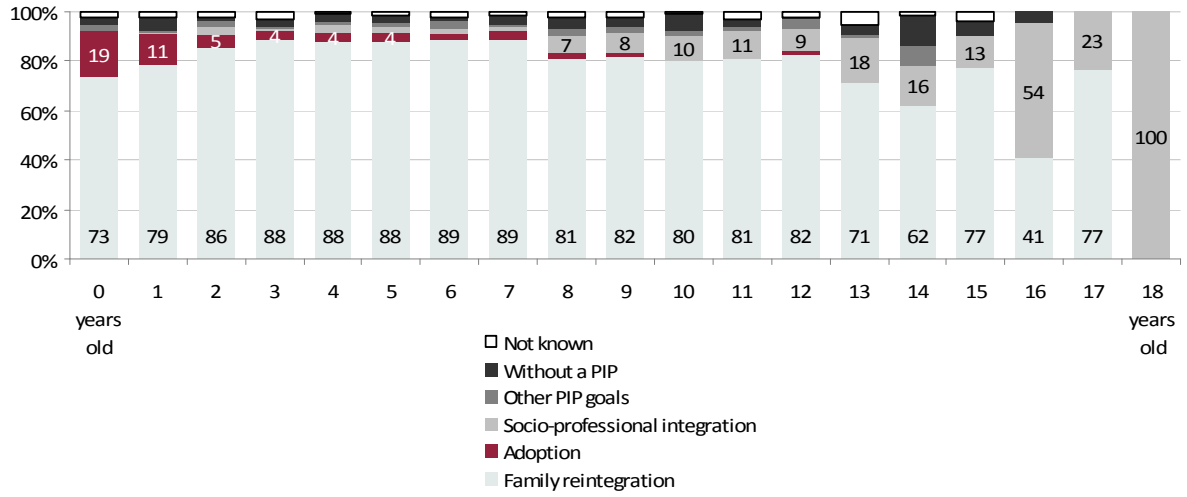
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=33,841 children who entered public care during 2005-2014).

[384] Other counties with quite high percentages of children whose PIP goal was adoption were Prahova (10 percent), Satu Mare (10 percent), Vâlcea (10 percent), Mehedinți (14 percent), and Galați (17 percent).

Adoption was more likely than average to be the first goal specified in the PIP for children under 1 year old, for those from families with no extended family support (whether or not the parent/parents is/are home), for children whose mothers are teenagers when their children entered the system, and for those relinquished in health units.[385] The categories of children who were less likely than average to receive adoption as their first PIP goal were children with disabilities, children aged 7-17 with behavioral disorders, and children with siblings in the system. In contrast, premature and/or underweight babies, children with developmental delays, and those aged 6 to 17 with SEN had an average likelihood of receiving adoption as their PIP goal (see also Annex 6 Table 44).

There is a significant correlation between the first PIP goal and the age of the child upon entering the system (Figure 64). Thus, adoption was the PIP goal assigned to one in every five children aged 0 to 12 months and one in every ten children aged 1 year old, while for children aged 2 years, the adoption share suddenly dropped to 5 percent and was hardly used at all for children over 9 years of age. In contrast, socio-professional integration was stated as the first PIP goal for 2 percent of the children aged between 0 and 7 years old, rising with the children's age, reaching 100 percent of 18 year olds.

Figure 64: The First PIP Goal, by the Child's Age When Entering the System (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=33,841 children who entered public care during 2005-2014).

Socio-professional integration was set as a first PIP goal for about 4 percent of children in public care. Those with a higher than average probability of receiving this goal were children aged 11-17 (when they entered the system), boys and girls alike, children from rural areas (6 percent versus 3 percent from urbans areas), those with good relationships with their parents or family, children with SEN attending special education schools, and children with behavioral disorders. Unlike the goal of family reintegration, the socio-professional integration goal seems to be underused. However, this may be because this analysis is limited to the first PIP goal established for the child as soon as he or she enters public care.

There is very little connection between the first PIP goal assigned to the child and the first service in which the child is placed after entering the system. The only exceptions to this are very young and older children. Young children with the greatest chances of being adopted are mostly placed in family-type services, while the services in which the older children are mainly placed (for example, apartments) are appropriate for the socio-professional integration PIP goal (Annex 6 Table 44).

According to the regulations, the PIP should be preceded by a service plan aimed at preventing the child's separation from their family. This plan is requested by the DGASPC and is drawn up, implemented, and monitored by SPAS or staff with social assistance duties at the community level as

[385] A large number of children from urban areas and of those with undeclared ethnicity also received adoption as their PIP goal.

discussed in section 3.2.5.4. However, Annex 6 Table 44 shows that the only correlation between the first PIP goal and the information underlying it seemed to be for children who were assigned adoption as their PIP goal. Most of these were children taken from hospital units and, therefore, the majority of them had no service plan and/or quality social assessment report.

As far as the way in which the PIP goal is established, a recent control report[386] from the ANPDCA found that:

- The PIPs contain objectives that do not help to achieve the proposed goal (such as counseling for the mother with a view to family reintegration even though the mother's address is unknown).
- Adoption is sometimes established as a child's PIP goal without first having exhausted the options for reintegrating the child with his/her family or without establishing any changes in the family situation at the time the special protection measure is being established.
- Specialists often do not actively look for the children's relatives up to the fourth degree before placing the children with substitute families, usually because the relevant population records do not keep track of the population by degree of kinship.
- The child's relatives are not informed about the steps they need to take to enable the reintegration of the child.

As Table 35 shows, only approximately half of the children in the special protection system had a list of relatives up to the fourth degree in their case file. Only for children whose PIP goal was adoption did specialists make more intensive efforts to find the child's relatives, but even here only for 60 percent of them.

Table 35: The First PIP Goal and the Likelihod of Reaching the Goal (% of Children who Entered Public Care during 2005-2014)

			Is there a list of identified relatives up to the IVth degree for the child?			Considering the data in the file, based on your experience, is the PIP goal relevant and adequate given the child's situation?		
The first PIP goal:	Total - N	Total - %	Yes	No	Unknown	Yes	No	Unknown
Family reintegration	27,220	100	51	44	5	75	11	14
Adoption	2,550	100	60	25	15	68	6	26
Socio-professional integration	1,503	100	38	53	9	76	5	19
Other PIP goal	637	100	44	49	7	66	17	17
There is no PIP	1,161	100	47	50	2	65	17	18
Unknown	769	100	31	52	18	63	10	26
TOTAL	33,841	100	51	43	6	74	10	16

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

According to the DGASPC experts, the PIP goal specified for almost three-quarters of the children in public care is adequate and relevant (Table 35).[387] The percentage drops to 68 percent of those with adoption as their PIP goal. For the other quarter, the experts either mentioned a different goal than the one in the case files (3 percent) or explained the reasons why that goal could not be achieved. For instance, in the case of adoption, the experts mentioned that the reason why no adoptive family was found for some children was because sometimes children were only "given an adoption goal by

[386] ANPDCA Control Body Report (2015) – Common issues regarding child placement with substitute or extended families, identified during control actions.

[387] It is worthwhile mentioning that even for 65 percent of the children with no PIP, DGASPC specialists still considered that the PIP goal was both relevant and adequate given the child's situation.

number without any real chance of being adopted,"[388] because the parents refused to give their consent, or the child refused to be adopted. As far as reintegration within the family is concerned, the experts invoked the various risk factors we have already discussed in this report (parents are deceased, parents are unknown, parents are gone abroad, there are no relatives, grandparents are too old, insufficient financial means, parents have no job, homelessness, parents abuse alcohol, lack of daycare units and community recovery and rehabilitation services), while they believed that socio-professional integration is mainly hindered by the lack of protected jobs.

However, most of the DGASPC experts referred to two groups of children with special needs for which none of the PIP goals is adequate - children with behavioral disorders and children with disabilities. For children with behavioral disorders, the system does not provide the most efficient services to prepare them for an independent life or to reintegrate them within their families. For children with disabilities, especially for those with severe handicaps, long-term placements are necessary. For youths with disabilities who are about to leave the system, the experts said that what is needed is sheltered workshops[389] with permanent surveillance along with ensuring housing to enable some of them to live a (semi)-independent life.

The problem is that there are only three PIP goals to cover a wide variety of children's situations, needs, preferences, and circumstances. Establishing comprehensive and appropriate sub-goals for the various categories of children is absolutely necessary to enable child protection specialists to establish achievable objectives and roadmaps for each child, in connection with the provision of a more diversified package of services for that child.

Besides its goal, the PIP is developed along specific intervention programs (PIS) for each child. These programs should meet a broad range of needs[390] and "should specify short, medium, and long-term objectives, activities appropriate for those objectives, which may be regular, routine, or determined by certain procedures or events, the duration of the activities, the designated responsible specialized staff and other stakeholders, and the methods envisaged for program monitoring and evaluation/reevaluation." (Order 286/2006)

In addition to the challenge of effectively achieving the PIP goal, the implementation of these specific intervention programs (PIS) also involves practical problems that were often brought up in discussions by the DGASPC experts.

> "*To what extent do you consider that the activities set out in the PIP are being followed*?
>
> - We are trying to stick to them because that's why we do them and everything that's in the plan, so we also follow those PIS that we develop... based on the PIP and there are short-term, medium-term, and long-term objectives, there are the formal communications that we send to the person's records department or to the city hall, to the local police to see if the parents have shown up in their area of residence, if they have returned from abroad, and, if they did not, to find a way to contact the parent somehow. Being from different villages, we cannot see from here if they came back home or not, and when they return, the parents do not always come on the first or second day to visit us, sometimes they don't even come to see their child or they come on the last day before they leave again; they say "I'm going to catch the train or to take the bus" or some other transportation from Craiova and in that situation, we submit a formal communication, we submit a lot of them every three months, we come back [to the area] to see if the parent has

[388] Quote from a questionnaire filled in by a case manager.

[389] According to Law 448/2006 on protecting and promoting the rights of people with disabilities, sheltered workshops (which may be located in community facilities, daycare centers, residential centers and special education facilities) are settings adapted to the needs of people with disabilities, enabling them to receive skill training and development and improvement activities.

[390] These needs are: (i) health and health promotion needs; (ii) the need for care, including the provision and promotion of the child's welfare; (iii) physical and emotional needs; (iv) educational needs and the need to ensure that the child achieves school results appropriate to his/her development potential; (v) the need for leisure; (vi) socialization needs; (vii) the need to preserve the child's relationships, as applicable, with his/her parents, extended family, friends, and other people with whom the child has developed affectional bonds; (viii) the need to develop independent life skills; and (ix) the need to reintegrate the child with the family.

returned, or if any relative wishes to take the children and raise them, if their conditions, the house in which they lived, have improved, [following] a welfare report or something.

- Or, for example, we agreed to prepare a contract with the family and if the family has not returned to the country, there is no one to do this with. So, there are reasons why the PIS cannot be implemented." (Focus group with specialists, Craiova)

Moreover, many of the DGASPC specialists believe the PIP reevaluation that is required every three months is a bureaucratic burden that does not benefit the child. This attitude is understandable given that the entire decision-making process is more administrative than child-centerd and is based on poor quality and fragmented information.

"Maybe this PIP should be done initially, but revised only when problems occur, because there are situations in which there is no change in the child's progress and one has to do it every three months, which is nothing but a copy-paste job, you see." (Interview with professionals, Piatra Neamț)

RECOMMENDATIONS

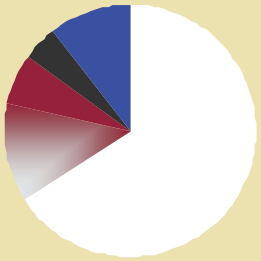
It is necessary to revise the methodological rules regarding the individualized protection plan (PIP) and related specific intervention programs (PIS) to allow for a more comprehensive and effective achievement of the PIP goals. On the other hand, diversifying the choice of public care services provided to children is key to establishing more effective objectives and intervention plans.

A small share of children from public care, particularly children with severe disabilities, have a PIP goal involving being transferred to an adult center. This type of goal should be eliminated because, otherwise, although the child protection system prioritizes deinstitutionalization, it actually prepares some children for institutionalization after they turn 18. This means that, for children between 0 and 17 years old, the Romanian state acknowledges the importance of care in a family environment, but as soon as the child becomes a young adult, the state considers institutionalization as appropriate. Besides the immeasurable negative effects on the young adult, this seems to be wasteful in economic terms.

Of course, too many rules and regulations may limit the work of child protection experts and may require them to shift their attention from the child's interest to the required administrative tasks. However, the entire public care decision-making process needs to be based on more systematic and quality information, which is inevitably time-consuming to gather and record.

Vignette 1

Please describe clearly how you would proceed in the following hypothetical case: you are notified about a 10-year-old little girl, Lavinia, currently in public care (in a residential placement, small group home) who, according to the medical report, suffers from behavioral disorders. Lavinia comes from a deprived family and has another five siblings, two of whom are also covered by a protection measure.



We received answers from 81 case managers, randomly selected from the 793 who participated in the study.

What is the PIP goal proposed by the case managers for this child?

What do case managers think should be done in this case?

Most case managers supported the PIP goal of reintegrating Lavinia into her family (31 out of the 47 who responded). When asked what should be done (according to their own opinions but also within the legal framework), most of the interviewed experts recommended various types of services including psychological counseling and services to assess the causes of her behavioral disorders. However, only a few of them recommended working together with Lavinia and her family in order to support her reintegration into the family or her adoption. Thus, a permanent long-term solution is definitely supported as a PIP goal but less in terms of the courses of action in the PIS (specific intervention plan).

Six case managers oscillated between the PIP goals of family reintegration and adoption depending on the intentions of Lavinia's family. Nevertheless, none of the case managers envisaged adoption as being a "pragmatic" solution with high odds of success in this situation, as was the case for the child relinquished at birth (Vignette 2). This was probably because of the age of the child, which decreases the likeliness of a successful adoption, as well as the fact that Lavinia had a group of siblings inside the system, which some of the managers saw as a difficulty in reaching the adoption goal because "the family may adopt only if they are willing to take all of the siblings" (Interview with a professional, Satu Mare).

In the case managers' opinion, what are the child's chances of being reintegrated into her natural family or of being adopted?

Only eight of the case managers considered that there was a strong chance of a successful family reintegration in this case. Five of the case managers gave a higher chance of success to the adoption solution in this hypothetical situation. Most of those with no experience of similar cases (28 cases workers out of 47) opted for a temporary solution, namely keeping Lavinia into the system and providing her with the necessary specialized services.

On the basis of similar actual cases, the interviewed case managers considered that the most difficult aspects of the case management related to this hypothetical situation would be: (i) establishing a link and collaborating with the family or relatives; (ii) offering specialized services, including psychological counseling and therapy to the child; (iii) family counseling and accountability; (iv) collaborating with the relevant institutions; (v) monitoring and reevaluating the PIP and the PIS; (vi) establishing the PIP; (vii) implementing the PIP and training the multidisciplinary team that contributes to the case management process; and (viii) identifying issues and carrying out an initial and detailed case evaluation.

3.3.4 Too Much Time Spent in the System

According to the UN guidelines for child alternative care: "Removal of a child from the care of the family should be seen as a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration."[391] We analyzed the time spent by children in the Romanian public care from this perspective.

On average, a child spends 7.5 years in public care.[392] Although the variable is quite evenly distributed, there is a range of 0 to 25 years, which means that the data should be analyzed carefully. This section focuses on those categories of children who are more likely than others to spend longer than average periods of time in the system.[393]

Girls spend slightly less time in care than boys (on average, 7.3 years versus 7.6 years). There are small but statistically significant differences related to the child's ethnicity. On average, Romanian children spend 7.2 years in the system, Hungarian children spend 7.8 years, and Roma children spend over 8 years.[394] The structure of the family from which the child comes is also relevant. Children with extended families (especially grandparents) have the shortest stays (6.2 years), while children from single-parent families, especially single-mothers, have the longest (8.35 years).

Before going further, it is worth reflecting on the meaning of the average length of stay in public care for one group of children or another. The analysis was carried out on children who entered the protection system at any time between 1989 and 2014 and at any age between 0 and 17 years. Consequently, most differences between various groups of children, even if statistically significant, are in fact a combined effect of the mix of the ages of those children when they entered the system and the year in which they entered the system. This relationship is not simple. For example, older children do not automatically spend more time in public care because they may have entered the system when they were 1 to 2 months old or when they were 17 years old. At the same time, two children entering public care at the same age may spend very different lenghts of time in the system depending on their entry year. If among Roma children, for instance, there is an over-representation of children relinquished in the maternity hospital[395] who entered the system in the 1990s, then the difference between this group and another in terms of length of stay is not determined by ethnicity but is the result of the combination between their entry ages and the number of years at group level.

Based on this reasoning, we analyzed the length of stay in the system by groups of children based on what age they were when they entered the system and their current age (as of November-December 2014). Results are reported in Figure 65. These showed that:

(i) The average length of stay in public care increases with the age of the child, from 0.1 years for the group aged under 12 months to 12.4 years for those aged 18 and 26 (and over). This monotonous growth is determined by the existence, within all age groups, of a significant percentage of children who entered the system when they were under 1 year old (usually, after they were relinquished in a maternity ward).

[391] UN Guidelines for the Alternative Care of Children (2010:4, B. 14)

[392] Standard deviation of 4.9 years.

[393] The method we used was mainly one-dimensional variance analysis.

[394] For children with undeclared ethnicity, the length of stay is equal to the general average.

[395] Which applies, see section 3.1.3.2.

Figure 65: The Average Length of Time Spent in Public Care, by Child's Age When Entering the Special Protection System and Now (November-December 2014)

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children).

(ii) The average length of stay drops to half or even one-third for children who entered the system at the age of 3 or more, at the level of all age groups. For example, for the group of youths aged between 18 and 26, the average length of stay in the system is 18.1 years for those who entered the system when they were a few months old, but this drops to 17.1 years for those who entered the system when they were 1 to 2 years old and is as low as 10.5 years for the children who entered the system when they were 3-17 years of age. Consequently, the general average of 12.4 years spent in public care by youth groups aged between 18 and 26 is the combined result of these three subgroups. The same pattern can be observed for all age groups.

The analysis refers to children in public care, in other words, the children who have not completed their stay in the system during the period of time under scrutiny. Consequently, it is only a snapshot of a moving target. One year spent in the system may not seem much from the perspective of the adult making the decision to place the children in care, but for a 1 year old, this is equivalent to his/her entire life. To better understand this phenomenon, we need a time reference. For this purpose, we chose the period of time between the child's birth and the present time (Nov-Dec 2014), meaning the entire life of the child, to which we related the length of time spent in the system. As such (see Figure 65, bottom graph), it is obvious that, regardless of their current age, the children who entered the system when they were under 1 year of age stand a very good chance of spending their entire life until they are 18 to 26 years old in the child protection system, including the first years of life, which are crucial for their development. For children who entered the system when they were between 1 and 2 years of age, the situation is somewhat better, but among them, those who were 7 to 10 years old in November-December 2014 had already spent 78 percent of their life in the system, and the equivalent percentage is 88 percent for those young people who were 18 to 26 years of age at the time of the case files survey.

Among the groups of children with special needs, only children with disabilities, especially those with severe or accentuated disabilities, spent a longer than average period of time in public care. Those who spent a shorter than average time in the system (5.5 years) were children with SEN because most of them stay in public care only during the school year.

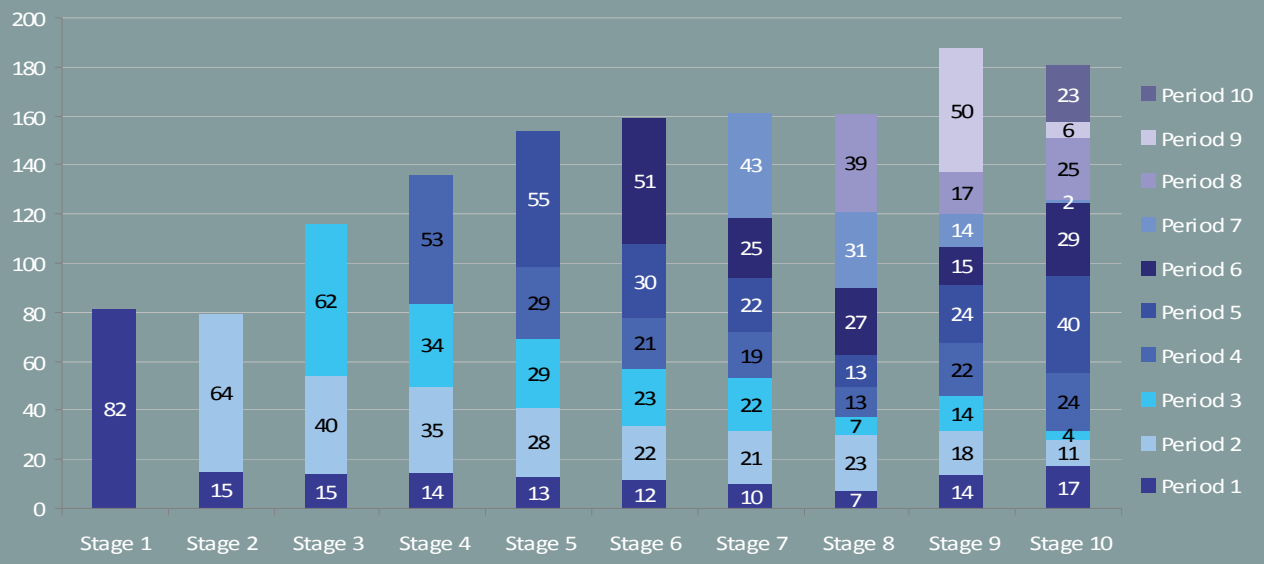
Table 36: Average Length of Time Spent in Public Care by Children with Special Needs (in Years)

Categories of children with special needs:	Average	Maximum	Minimum	Standard deviation	N
Children (0-17 years) with disabilities					
- upon entering the system	8.0	23	0	5.1	5,620
- upon entering and/or now	9.0	25	0	5.1	1.4974
- severe or accentuated disabilities	9.8	25	0	5.3	6,092
Children (0-17 years) with developmental delays	7.3	25	0	5.0	8,881
Children (6-17 years) with SEN					
- upon entering the system	5.5	15	0	3.5	1,456
- upon entering and/or now	5.5	15	0	3.6	782
Children (7-17 years) with behavioral disorders	3.9	10	0	2.6	1,324
Premature, underweight children (0-12 months)	7.8	23	0	5.4	2,685
Reasons for child-family separation:					
Child relinquishment	9.2	25	0	5.3	15,320
Individual risk factors:					
Parents with disabilities and/or mental health problems	8.0	25	0	5.0	8,547

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

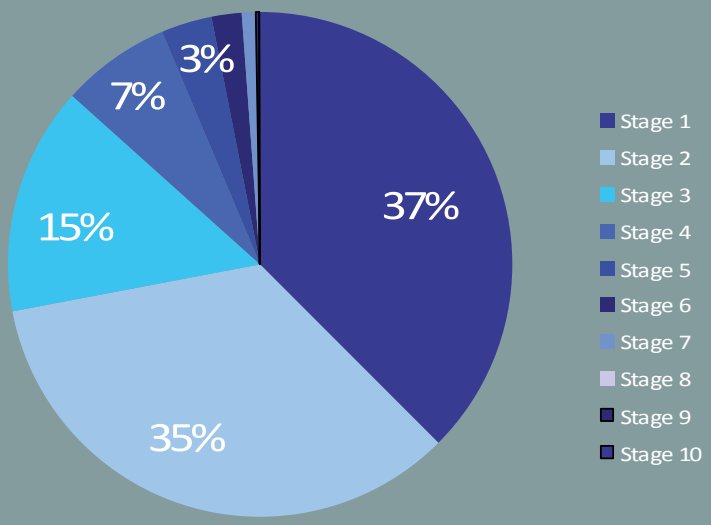
Children who spend a longer than average period of time in public care are also those with parents with disabilities and/or mental health problems. None of the other characteristics of the child and/or family are relevant to the length of stay in the system.

Figure 66: Average Length of Stay in Public Care According to the Number of Stages Experienced in the System (Determined by the Changes in Protection Measures, Services, and/or Service Providers) (in Months)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children).

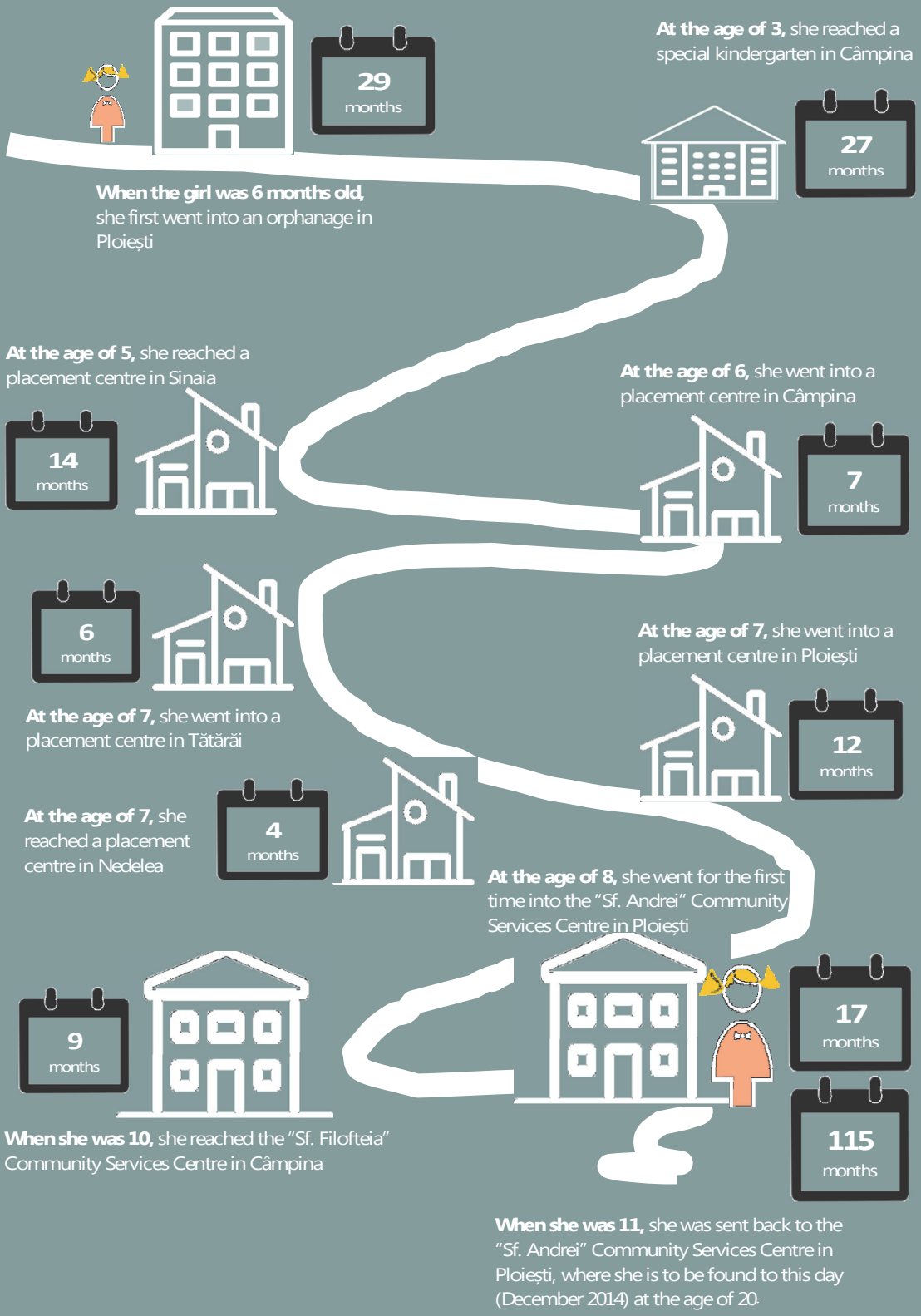
Figure 67: Distribution of Children in Public Care According to the Number of Stages Experienced in the System (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children).

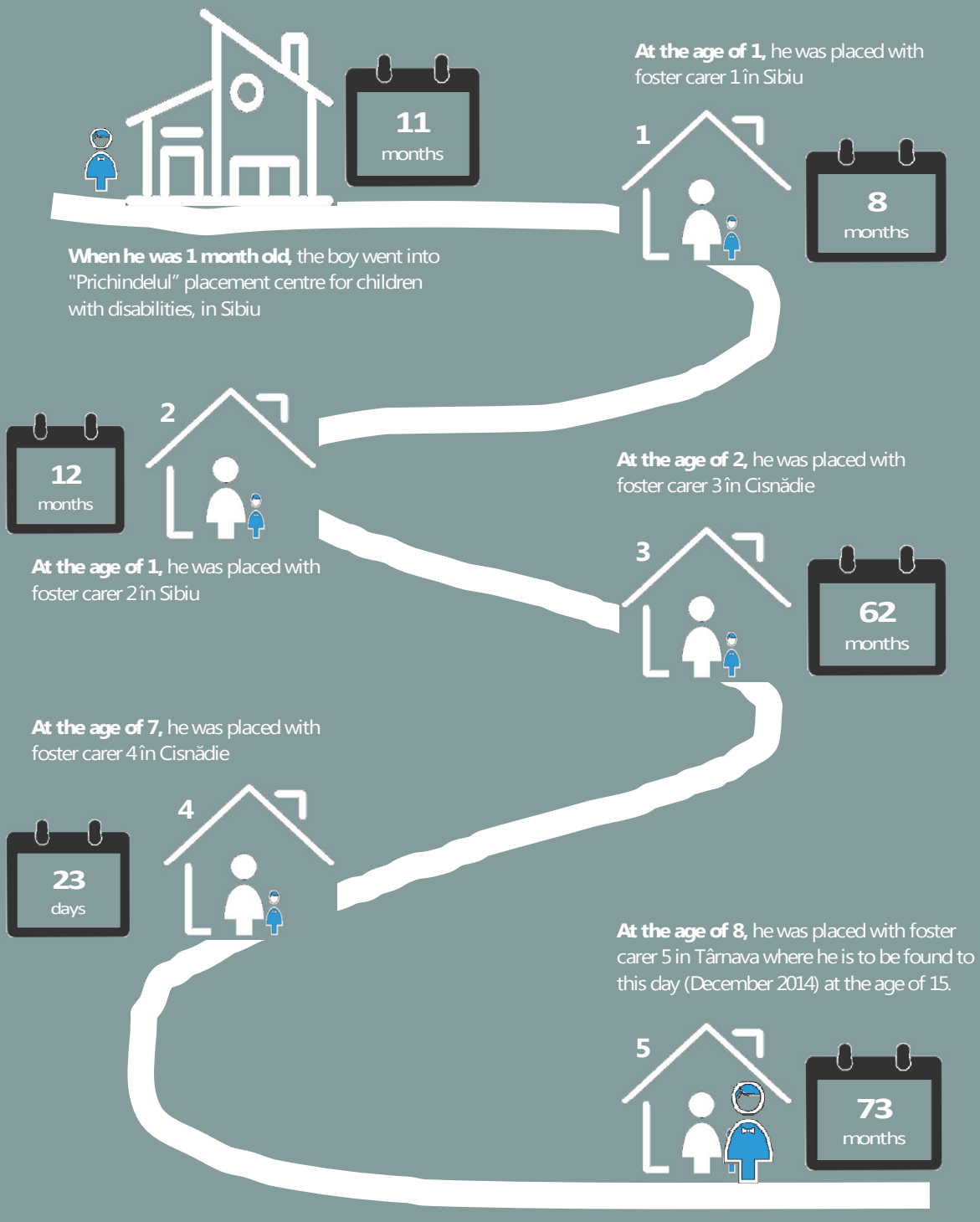
Note: Stages 6-10 involve fewer than 2 percent of the children in public care.

Infograph Chart 5: The Journey through the Child Special Protection System of a Girl Relinquished in the Maternity Hospital



Source: Survey of the Case Files of Children in Public Care (November-December 2014).

Infograph Chart 6: The Journey through the Child Special Protection System of a Boy Relinquished in the Maternity Hospital



Source: Survey of the Case Files of Children in Public Care (November-December 2014).

The particular first protection service in which the child is placed is not relevant either, nor are the protection measure or the child's PIP goal. However, if we further divide the period of time spent in public care into stages determined by changes in the child's protection measure, service, or service provider, significant differences can be noted (Figure 66). Over a quarter of the children in public care passed through three to ten different stages, most of them changing their service provider (for example, being transferred from one professional foster carer to another or from a center to another center of the same type). Such routes within the system are illustrated in Infograph Charts 5 and 6.

Our analysis of the length of stay in public care by the number of stages that the child goes through found that children for whom a stable solution was found (only one stage) had spent an average of 82 months in the system. Most of them were not young children but were 7 to 26 years old and were placed with relatives or foster carers. Among those with two stages, most of them were children aged 3 to 10 who had entered the system with an emergency placement measure after being relinquished in a maternity hospital. Subsequently, their protection measure was changed to placement, and they were placed with professional foster carers. This category of children has also spent only 80 months on average in the system.

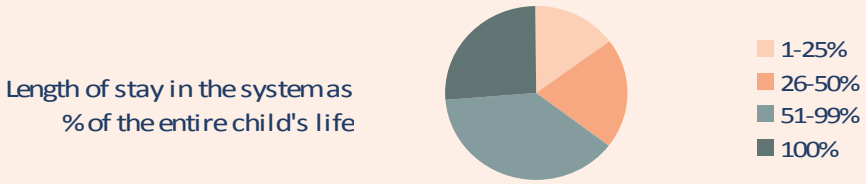
For children who have gone through three stages or more, the average lengths of stay in the system increase (Figure 66 top graph). Variations can be noted also in stage lengths, protection services and service providers. This category includes the children who entered the system before the public care reform process. Figure 68 (bottom graph) shows that, starting 2004, the percentage of children with stable solutions (those who have only gone through one or two stages) has grown significantly, while the percentage of those with frequent changes decreased considerably.

The number of stages that each child goes through is not only determined by changes in the related legislation, but also, to a great extent, by the combination of protection services available at the county level (see section 3.3.2) as well as by the DGASPC strategies for the various categories of children. Figure 68 (top graph) illustrates the current differences between counties. In Mehedinți 90 percent of the children in public care went through only one or two stages regardless of their age, whereas in Sibiu (a county with many placement centers), almost half of the children went through frequent changes/stages.

RECOMMENDATIONS

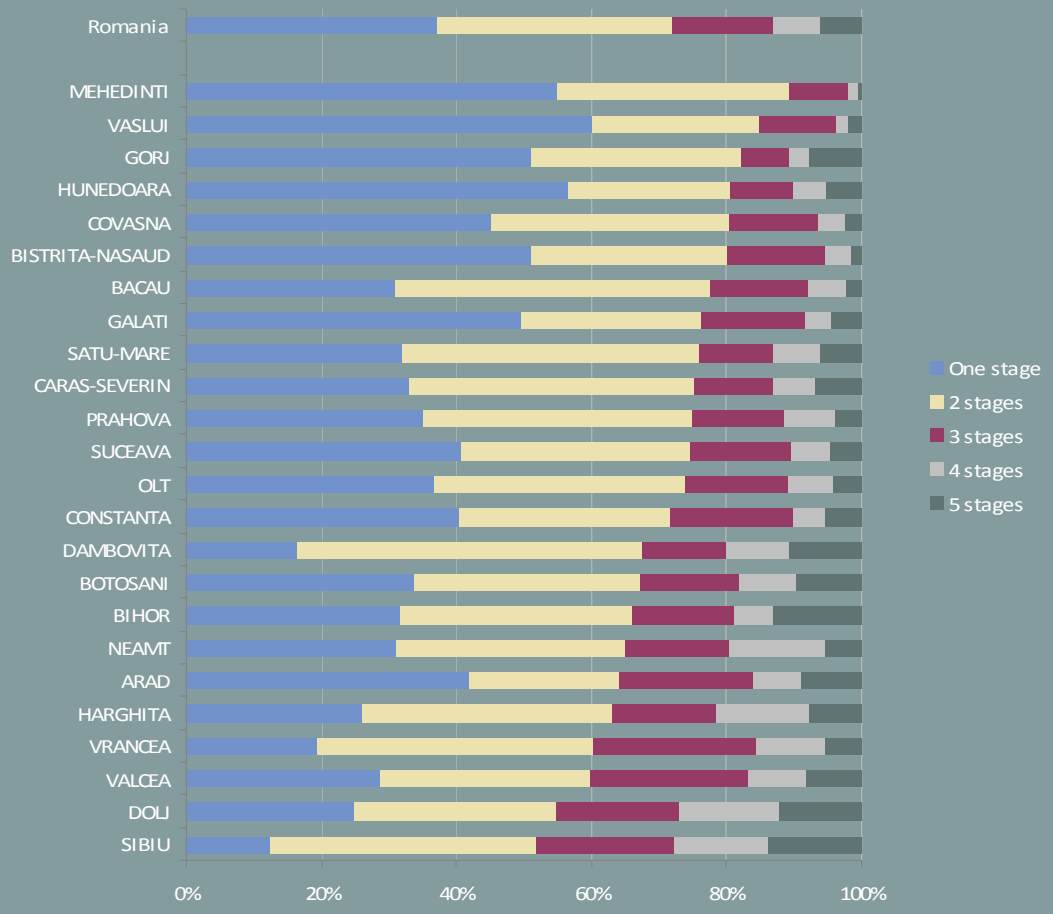
To reduce the length of time spent by children in public care, not only must the number of exits increase but also the number of children who enter the system under the age of 1 (especially after being relinquished in maternity hospitals) must decrease. This section has shown that these children are at a high risk of staying in the system during their entire childhood and adolescence, although they stand a good chance of being adopted if their natural family refuses to reintegrate them.

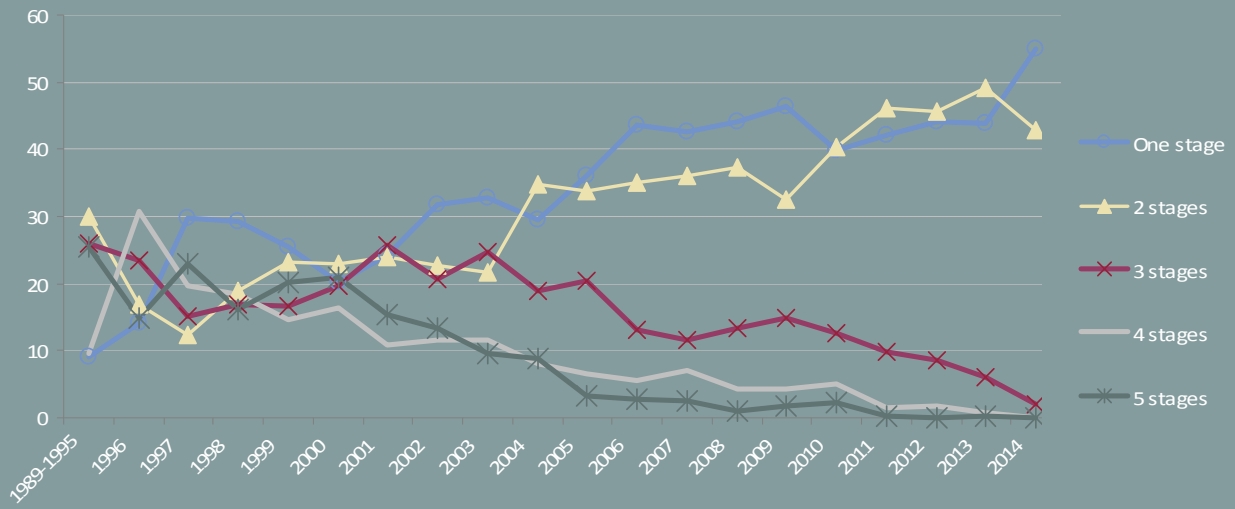
A child spends an average of 7.5 years in public care in Romania. However, over 13,000 children have already spent their entire lives so far only in the system.



The fact that one in every five children aged between 15 and 26 now in public care has spent his or her entire life in the system and almost one in every three has spent 90 percent of their life in the system demonstrates the urgent need to develop exit paths that would offer these children real chances for the future. Because they entered public care 15 to 26 years ago, they are likely to have gone through many centers, but the "system" is the only family they know. When these young adults reach the age when they have to leave, the "system" simply withdraws just as their parents disappeared when they were little, leaving them with no independent life skills, no solid education to enable them to earn their living, and with no housing choices.

Figure 68: The Distribution of Children in Public Care According to the Number of Stages Experienced in the System (Determined by Changes in Protection Measures, Services, and/or Providers), by County and by Year (% of Children)





Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. For the top graph, only the 24 counties with solid data in the CMTIS were considered (N=50,679). For the bottom graph, N=52,344.

RECOMMENDATIONS

Not only do these individuals spend years in the system, but many of them are often moved from one place to another, from one service to another, for periods varying from 2 to 60 months. The situation has improved in the last years, but the consistency of child care is still not a paramount consideration.

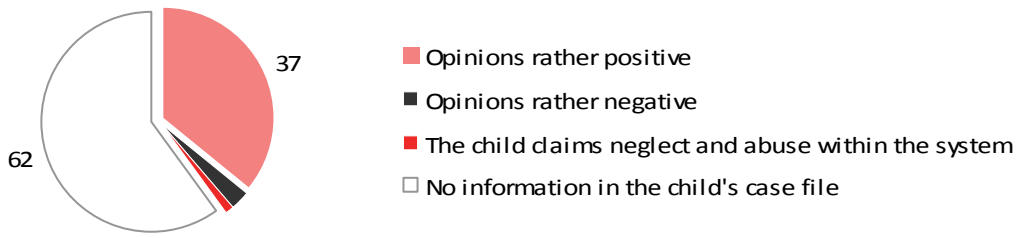
Our key recommendation is to shorten the time spent by children in public care and to shift the focus on the family model, by increasing the capacity and the number of professionals who provide direct care, flexible interventions across multiple needs and, most importantly, who have strong communication skills when working with children. Moreover, it is essential to support the reintegration of children within their families/communities by allocating resources to fund services in the community and focusing interventions on the child, not on the system, so that the child may grow up in a family and break the cycle of disadvantage.

3.3.5 Children's Voice

Only 58 percent of the case files of children in care aged 10 or older mentioned their opinions about the separation from their families and the establishment of the protection measure. The children whose files contained this information were mostly boys over the age of 15, of Romanian or Hungarian ethnicity, with no disabilities or SEN but with behavioral disorders.

For two-thirds of the 10-year-old children and older, there is no mention or statement in their files about their opinions of the quality of the services they have received or their level of satisfaction. In other words, two of every three children in public care do not seem to be consulted as to their opinions and preferences. The one-third who were consulted gave fairly positive opinions. These positive opinions tended to be expressed mostly by female children under 15, of Romanian ethnicity, with no disabilities or developmental delays, while negative opinions tended to be expressed by male children over the age of 14, with disabilities, developmental delays, and/or SEN.

Figure 69: Children's Opinions about the Quality of the Special Protection Services They Experienced Over Time



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=35,358 children 10 years old and older).

Overall, children demonstrated a positive perception of the material and housing conditions in public care, but at the same time those who participated in our focus group discussions spoke of their need for affection, understanding, and communication on the part of the staff. While children emphasize the communicational and emotional side, specialists are mostly concerned with issues related to the material and housing conditions in the centers.

"*What is missing in the center where you are staying? I see some of you have not rated it at 10. The ones who didn't rate it at 10, what is missing? What would make you… what should change for you to rate it at 10*?

- To know that at least one person in that house will take your side and will never betray you, or will… Because I don't trust them… if only a little bit, a fraction if they could love me too. Seriously… there things are…

So they don't love you?

- No.

Why do you say that?

- Because I feel them." (Focus group with children in public care, Craiova)

Even if, in general, the living conditions in the centers have improved in recent years, a recent study[396] showed that the system is deficient in terms of working with the beneficiaries. "Young people have been complaining of the lack of programs designed for their leisure time, for the development of independent life skills, and for socialization activities outside the sheltering institution. Other young people have been complaining that they are not allowed to have a girlfriend or boyfriend, as the case may be, the DGASPC employees' motivation being: 'We are protecting them. They don't understand that, but [otherwise] we can expect to find newborns on our doorstep any time.' Nobody talks to them about sexual and contraceptive education, everything is taboo. This is how young people end up having sexual identity crises, moments of searching for their own identity."

When they were asked what made them happy, children said their siblings who are with them in the system, their parents' visits, telephone conversations with their parents, and the chance to continue their studies.

"- What makes me unhappy is that I wish my parents would visit me a little more often. That's it...

- What makes me happy first of all is that I have my siblings with me and this is what I enjoy most. And what makes me unhappy is that my parents don't visit much.

- I am happy I have got the chance to continue my studies because this is what I wanted – musical studies. And I am happy when at home there is a joyful, very active atmosphere, and unhappy [because] I don't keep in touch with my parents, my mother calls me rather seldom, and that's about it." (Focus group with children in public care, Focșani).

In group discussions, children confessed they wished that violence and the consumption of alcohol and other substances would no longer exist in their birth family, and also that they had good housing conditions. Only if these conditions were met would the children want to return home. Although they want to keep in touch with their families, they are aware that, beyond the lack of affection and parental care, the protection system provides them with better conditions and more opportunities.

"- I wish most bad things could be deleted, that there would no longer be any booze, alcohol, and cigarettes. That everything went back to normal. And that I could be my daddy's little monkey again.

- I for one, no, I wouldn't like to go back [home], because I have discovered another life here, I can say I've become emancipated since I came here. I also don't want to go back because I have more opportunities here than I would have at home. To graduate." (Focus group with children in public care, Focșani)

"- Before going back to my family I'd like to know that they have the conditions to keep me, to allow me to go to school, to have a bathroom inside, not in the backyard." (Focus group with children in public care, Craiova)

Out of all children's needs, the need to have their voice heard, to have somebody they can talk to, a person to whom they can tell anything and whom they can trust is the most important. Therefore, staff working directly with children in public care should communicate with children more, spend

[396] Ciobanu et al. (2016:36)

more time with them every day, listening to their stories, dissatisfactions, joys, opinions, needs, and desires. At the same time, the children should be consulted and actively involved in deciding on their daily activities, in preparing their own intervention plans and in all aspects of life that directly affect them (such as education, health, and leisure) in order to develop the decision-making, planning and management skills needed to live an independent life.

> "*When you are upset, like all teenagers and children are in general, who do you talk to about such things*?
>
> - To my conscience.
>
> - To my best friend.
>
> - I hypnotize myself. I watch YouTube hypnosis videos and I calm down.
>
> - Or I go to sleep.
>
> *How about you*?
>
> - I also go to sleep to calm down…
>
> - I access Facebook.
>
> - I try to talk to the right person. I mean, I study the person first [before I decide to talk].
>
> *And who do you happen to talk to*?
>
> - Nobody. I mean, I don't know, I don't have those kinds of thoughts.
>
> *OK. And you, who do you talk to when you are upset*?
>
> - Nobody and I try to calm down. I mean, sorry. I do talk to somebody. I talk to God." (Focus group with children in public care, Craiova)
>
> "- When I am very angry and upset, the next day I go to tae kwon do, I take the dummy and I kick it until it falls. Even if it weighs two kilos.
>
> *But do you talk to anybody when you are upset*?
>
> - I don't talk, I rather fight." (Focus group with children in public care, Cluj-Napoca)

Our analysis of children's case files showed that 52 percent of the files included some mention or document concerning the child's participation in decisions or their being consulted about relevant issues, such as preparing the PIP, the service plan, and issues related to education or health. These files tend to be for children over 15 years old, of either gender, of Romanian and Hungarian ethnicity, with no disabilities, developmental delays, or SEN. Of all groups of children with special needs, children with behavioral disorders seem to be consulted more frequently than average.

In group discussions, the children said that they would like the following:

- ☐ More pocket money
- ☐ Better food
- ☐ Internet access
- ☐ More money for clothing
- ☐ Nicer clothes of their own choosing.

This shows that it is very important for children to be consulted about their needs, to learn how to prioritize their needs, how to buy clothes, how to prepare the daily menu, and how to manage their pocket money. All these tasks will help them to develop independent life skills.

In order to increase children's participation in the care that they are given, it will be necessary to build the communication skills of the staff involved in working with the children. Training programs should focus more on including children in the decision-making participative process rather than just listening to their views in order to make decisions about them. Moreover, to overcome organizational barriers, it will be necessary to ensure that case management is carried out in a way that is much friendlier to children.

Model of Good Practice for Developing Independent Life Skills

"- Moreover, we have advanced. You see, in the past, a child of normal development living in an institution did not have access to the kitchen and was not able to acquire those kinds of independent life skills because of hygiene regulations. But we, as a Directorate, changed this model and put the family model in place. Consequently, the children in the institution are allocated food money that they are responsible for managing themselves. Thus they learn to manage a budget and to cook a meal, to balance their meals as much as possible so that they should have no gaps. I remember everything about the assistance and support center, it was created in 2004 or maybe in 2005, and I had the chance to oversee the first generation who received this service. And on the first day I brought food to them, I told them to put the food in the fridge, and because the fridges were new, we cleaned them before plugging them in. And then I told each child to put their food in their own fridge. There were three kids who lived in a sort of flat. When I went to plug the fridges in, I luckily looked inside. For them, the fridge was like a wardrobe. The eggs were in the freezer because it was the top shelf, and the meat was in the lower boxes. They didn't know any different because they had no opportunity to learn that anywhere, they only went to the canteen. They were involved in certain activities occasionally with their teachers, but it was not a routine thing. And that's what I wanted to say, much progress has been made, in that young people's integration is no longer as difficult. They know how to manage money. In the past, they didn't know how to determine how much they would need, how much bread they would eat." (Interview with a professional, Bârlad)

Staff working with young people should be skilled and should have the abilities and capacity required to help them to prepare for their exit from public care and to become independent. Specialists believed that nowadays young people develop a certain dependency on the system, which is very detrimental to their future and to their preparation for life.

> "- Because we made the mistake of employing unskilled people and now we don't have the results we would like to have. We can say that they were successful from the point of view of the child's emotional development and of the family environment, while the children were young they made very good progress, but when they became teenagers and realized that, wait a minute, these are not our parents, that, wait a minute, they have their own children, look, we are different and what will happen to us in two years' time, then the truth comes out." (Focus group with professionals, Cluj-Napoca)

> "- We have youths for whom we find employment and after a month we have to have them employed elsewhere, and in another month, again, elsewhere, because they are not used to it [to working/work ethics]. We have to admit that in centers, and come to think of it, even with foster carers, children get used to being at the receiving end rather than being taught how to provide for and manage themselves so when they leave the system and have to live on their own, they cannot manage money, or create a budget for themselves, or create a daily schedule because they were brought up in the system in which the foster carer told them "go to school" or the teachers at the center told them "go to school." The teacher at the center gave them pocket money, the children weren't tought how to manage/spend it. This creates potential problems that need to be corrected. I don't know if this is the case with foster carers, but in the centers they surely need intensive independent life programs, not just to learn how to use the washing machine. So, in practice, give a young person the money and see how he/she manages, clearly they will have nothing left the next day. We [adults] don't have anything left the next day either, but for other reasons. But it should be a more or less independent program, under supervision, to observe what the young person is actually doing because we have children who are able but who don't know to look at the clock and see that they should be at work at 8 o'clock. They don't know that, they were sent to school from 1st grade through to 12th grade, in the same way. It is true that children often don't learn these independent life skills in normal families either, but it seems families are a little bit more responsible." (Focus group with professionals, Timișoara)

Our data do not indicate any mentions by the children, parents, or specialists with regard to any abuse in public care. However, other studies have shown that abuse seems to occur in some institutions.

Box 17: Children's Voices on Life in Public Care

A recent study [397] of placement centers found the following:

- Youths running away from the centers to live on the street because they are beaten by older colleagues and their stuff is stolen.

- The existence of a "torture chamber" called the "isolator" (an isolation ward) in which the youths are confined in pairs when they are late, a technique that the center staff acknowledged using as a disciplinary method.

- Centers with locked gates because the youths are not allowed to leave the building.

- Centers where outsiders are not allowed to access or interact with the youths, the reason being that it doesn't serve the "interests of the child."

- "Nineties style" centers with grey walls and dozens of lonely children nobody listens to, and teenagers saying that "the idea of living in captivity destroys you emotionally, spiritually, and mentally."

- Children wishing for people who understand them, "Who stop treating us like animals" (a 15 year old). "The Headmaster of the center shouldn't be allowed to beat us for any reason" (a 16 year old). "Nobody should swear at us again" (a 16 year old), "We want to be offered a chance to live our lives" (a 17 years old).

- Psychologists seen by the children as "informants," which is the reason children give for not trusting them enough to discuss their problems with them.

Source: Ciobanu et al. (2016).

The main message expressed by children in public care during our focus group interviews was that, in general, the material conditions in the system are satisfactory, even better than at home for most of them, but that what is missing is a person who makes time for them, someone with whom they can build a relationship based on trust, "someone to love me too, man, you know." This is the primary need that the public care system fails to meet. Second, from the point of view of older children, they wish for a certain degree of independence and to participate more actively in all of the decisions that may influence their life, from the clothing they wear to their PIP goal.

Box 18: Children's Voices Reflected in Other Studies

Of all the rights that children now have, the one they rate highest is the right to protection from abuse.

Children and young people told the Munro review that what they value most are good relationships with professionals they can trust and practice that focuses on their needs. Building a trusting relationship with professionals is seen as important as it provides children with ways of getting information, knowing about their rights, having their say and making choices, and finding out how decisions about them are being made.

Children and young people have also said that they do not want social workers who keep leaving them. They want social workers who "are there for them," who talk to them, listen to them, and respect them. They want to deal with professionals whom they can trust (that is, someone who is honest, reliable, and who the child can depend on). They want someone who can offer them the support they need at important times of change in their lives. But, above all, they want social workers who are able to treat them as individuals, with their own unique needs, views and interests.

They have also said that professionals are well placed to help and support a child who may be at risk. Teachers, school counselors, support workers, advocates, children's rights officers, and many others can all play a vital role in creating the right environment for a child to feel that it is "safe to tell."

Source: Munro (2011c:4).

[397] This study was conducted in 2015 by the organization *Desenăm Viitorul Tău (*Drawing Your Future*)* together with Hope and Homes for Children Romania. It examined the placement centers in 22 counties and I five sectors in Bucharest. The aim of the study was to review of what happens when youths reach the age when they have to leave the system, specifically how the protection system prepares them for an independent life and what happens to them after they exit the system. The research target group was 979 institutionalized youths.

3.4. Leaving Public Care

Story Bag

Are there categories of children for whom reintegration within the family proves to be more difficult than for others?

"- Young children want to go home, while older children want to be in a center. Older children, somewhere around 12, 13 years of age, are able to see the difference between the conditions at home and the conditions in centers and to decide that they prefer the conditions in the centers. But this is only the case for older children. Young children want to go home.

- Yes, but the child's expectations of his/her family should be considered as well. We have children who want so much to live with their parents in a single room that it wouldn't matter to them that there'd be nothing for them to eat there all day long but carrots. For them, the fact that at home they don't have a place to wash themselves, except for the basin available in the yard, is not important, whereas the fact that grandma comes to visit them twice a day and that their mother is there is more important than our running water, regular meals, clothes, and all the comfort we can provide. Children come from home crying which makes me go through this constant state of anxiety, wondering what is in the child's best interest, what does the child feel and what are my own feelings and thoughts about the child in question."

(Focus group with professionals, Cluj-Napoca)

" - Yes, the disabled child, my colleagues are right.

- And those with behavioral disorders.

- If the child with disabilities is left in the state's care, that's where he/she'll remain... till the last day of his/her life.

- Yes. Because this becomes a family struggle, an expense, an effort, somebody who needs to take care of the child 24/7. It is very difficult. [...]

- And the main issue is the psychological barrier. Once the parents of these children decide to relinquish them, to the parent that child ceases to exist. If, say, for the following three months, the child has not been visited by the parents, then it is clear they will never be visited again. So we're talking here about ZERO chances of reintegration.

- I have a case. Cases, actually. They've ended up in a center for adults with disabilities. And I have raised them since they were 4 years old. Actually since they were in the orphanage. The old orphanage, that's where I took over and now they're in their 20s."

(Focus group with specialists, Bucharest)

"To what extent can the reintegration of children within their biological families be supported by activities carried out in the community?

- To the extent you are able to make some material resources available for them, but you can't be certain it will work, in my opinion.

Why do you say that?

- Well, we had an actual case here. I had a girl who was sent back to her family. The mother wasn't there, because it was a case of neglect, but the girl was reintegrated at her grandmother's. A living environment was created, the grandmother was supported with goods or money, I'm not sure what the case file stated. The idea was great. She gathered all siblings, including the girl that had been here. The girl had ended up with us because her mother scalded her face with hot water. I don't know if this was intentional or by mistake, but she even went to jail because of this, especially since she also used the girl to beg. Together with a plastic surgeon from Brașov, Dr. Ardean, who supported us a lot, and with a team of UK doctors, we managed to do many surgical interventions on the girl to reshape her face, to save her ears, because she risked losing her hearing. I think that, overall, she was subject to over 10 surgeries. And after this, there was this project idea; the girl was placed with her grandmother, and she was very happy. She was enrolled in school, we paid for her afterschool. The colleagues would help her do her homework, because here she was with the kids, and couldn't have followed the normal educational path. And she was very happy that she was with the family, with her siblings and grandmother. But despite all this, after half a year, when we had scheduled another surgery, we couldn't find her because her mother had been released from jail and had taken her away, and she was last seen in Suceava or some place, begging again. Now how do you explain to a group of people who came from the UK to do a surgery on the child that she's not to be found?

I see. This is a specific case. But, in general, does the reintegration of children into their community families succeed?

- Yes. All necessary steps are being taken. This is a case that came to mind that I knew about, I told you there were risks involved. But it can work just as well, you can't say it doesn't work, the problem is to provide the right conditions, and in our public policies there is no awareness of the fact that the family has to be involved as well, there is no education without coercion."

(Interview with a professional, Bârlad)

The main difficulties encountered by specialists in reintegrating the children into their natural families as shown by the qualitative study, are: (i) the refusal of children to return to their biological family; (ii) the refusal of the parents to reintegrate the children into the family; and (iii) the family finding it difficult to meet the necessary conditions for the reintegration to succeed.

As a rule, young children want to go home, whereas older children prefer to live in centers. As they reach adolescence, children become aware of having been rejected by their family and can develop feelings of hatred towards their parents, no longer wishing to go home. Also, the longer children spend in the protection system, the weaker their connections with their families. A rift occurs between the child and the family, and reintegration becomes more difficult to achieve.

> "Why would anyone aged 18 who has grown up far from their parents want to live with these parents? In our center we have all teenagers. I tell you, this age of adolescence is the age when the young person becomes aware of things. Think about it, we have a psychologist at the center, he is terrified and doesn't know what to do anymore, how to work with them, because this is the moment when youths realize they have been rejected, worst of all, by their own parents. They have school mates. Good, bad, regardless how they are, they're mum and dad. For them, the worst psychic trauma is that someone has cast them away. A hatred develops in them. It's terrible." (Focus group with professionals, Cluj-Napoca)

On the other hand, children often reject being reintegrated into their families because of the expectations about living conditions that they have come to have during the time they have spent in public care. In general, the housing conditions of their natural families do not change while the children are in the system, and the conditions provided in the centers and the lifestyle they have here make them not to want to return home.

> "They were getting closer to their coming of age and had to return to their families. The conditions in their family were the same, I'm speaking about the same as years ago, and by then they were used to a different lifestyle, it was very difficult for them to adapt to the family environment. And as a rule, say rather from what we've heard and less from our own experience, very few of the children grown up in foster care will go back to their family environment. Well, especially now, because the conditions in the family are not the same as the ones they are used to. They were brought up nicely so, if you see them, you think they won't return or that going back to their environment would be difficult." (Interview with professionals, Craiova)

The interviews with specialists have shown that there are various reasons why parents do not want their children to be reintegrated. On the one hand, in the case of dysfunctional families, when the mother has another life partner who does not want the child, the reintegration cannot take place regardless of how much the child might want this and despite all of the necessary conditions for reintegration being met, such as the financial and living conditions.

> "On the one hand, there are parents who did not want to have children in the first place and gave them away. They won't be interested in getting them back. Then there are children who are willing to try, nevertheless. Now, I don't know how confidential this might be, but a 14-year old girl wrote in her diary: "even though you gave me away, when I grow up I will have a job and money and I will be the one to provide for you so we can be together." (Focus group with professionals, Cluj-Napoca)

On the other hand, in the case of children placed with their relatives, reintegration often does not happen because the foster family is not willing to give up the foster care benefit, which is a significant source of income, especially in rural areas.

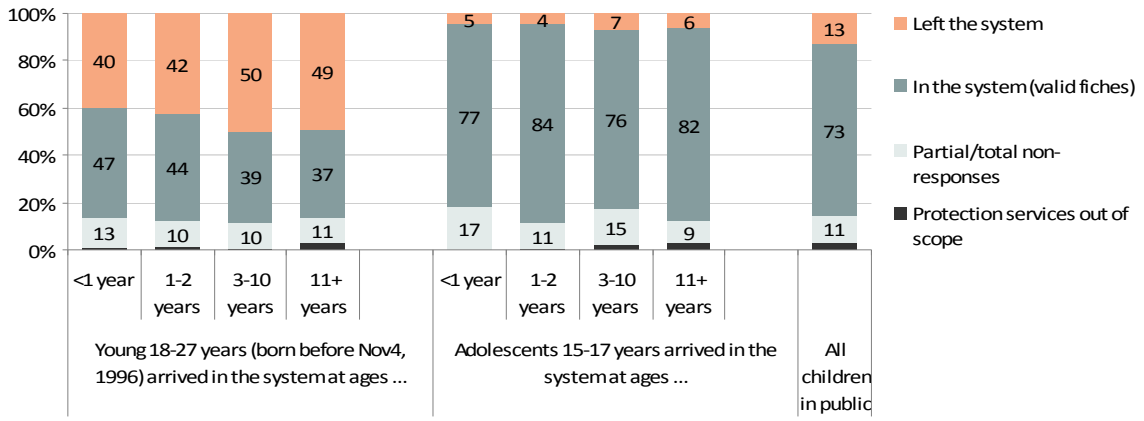
> "I think it is probably a big mistake for Law 272 to have increased the foster care benefit to 600 lei, especially for family foster care. Because we have many children placed with relatives, grandparents, uncles and aunts, we'll never ever be able to reintegrate those children into their biological family, take them from their grandparents and give them to their parents if the grandparents receive a benefit of 6 million and the parents maybe receive an aid of 1 million. So it's clearly impossible, even though we tried... Give the aid to the parent, help the parent bring up the child in the family and then they will leave the protection system." (Interview with professionals, Piatra Neamț)

There are situations when it is hard for specialists to determine whether a child should be reintegrated into their family or not, for example, when the standard conditions are not met but the family wants their child and does everything possible to provide the best for them (see section 3.2.5.2). As recommended in section 3.2.5.2, a careful review is needed of the standards regarding the housing conditions required before the child's reintegration into their family as well as of these conditions' impact on the child and the family.

3.4.1 The System's Children

The population analyzed in this study consists of children who had entered and remained in public care between 1989 and 2014. During this time, many others left the system through reintegration into their families, adoption, "integration in society", or transfer to an institution for adults with disabilities (for young people aged 18 years or older). A few of them (2.8 percent) died while in the protection system.

Figure 70: The Sample of Children in Public Care and Their Situation as of the End of 2014 (%)



Source: Survey of the Case Files of Children in Public Care: Sampling Lists (November-December 2014). Data are not weighted (N=8,954 children with available data sheets out of the total of 9,110 children selected from the CMTIS).

Note: See also Annex 6 Table 45. The 18-26 age category included young people over 26 who were still in the system.

As shown in section 3.1.4, more than half of all children in public care were between 0 and 3 years old at the time of their entry into the system (35 percent were under 12 months old). Not only do children who enter when they are under 3 years old (and especially under 1 year old) prevail among children in public care at any given time, but they also tend to stay longer in the system. To test this hypothesis, we looked at the available information on the current situation of the children in the sample, including those who left the system.

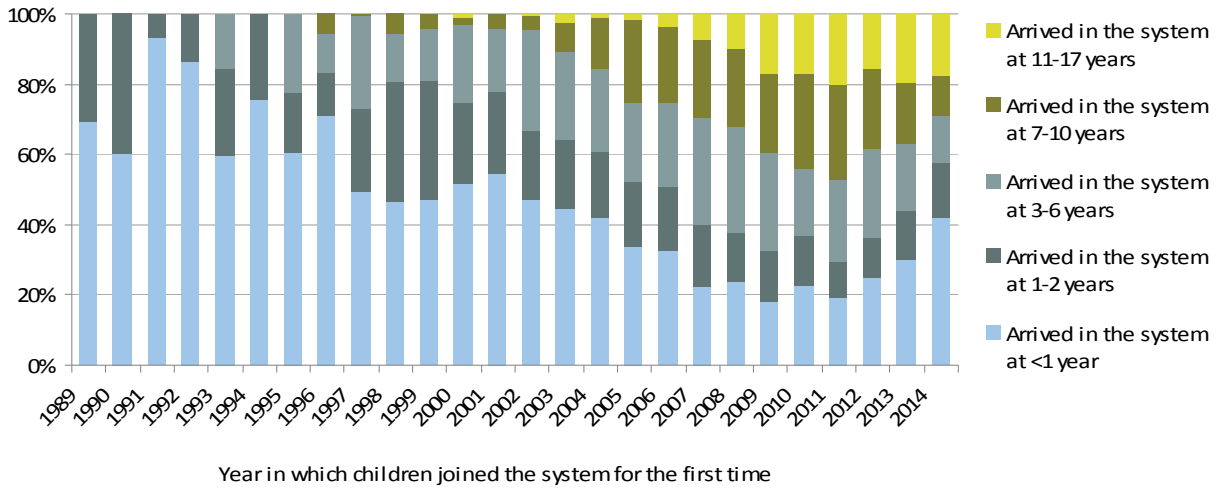
Comparing the current situation of youths aged 18 to 26[398] by the age at which they entered the system shows that the prevalence of children whose entry age was under 3 is not only the effect of a higher number of entries but also the effect of a lower number of exits than among those who entered the system over the age of 3 (Figure 70 and Annex 6 Table 45). Thus, among the youths aged 18 to 26, those who entered the system when they were younger than 3 make up a distinct category. Among these: (i) a significantly larger than average percentage is still in the system (44 to 47 percent); (ii) a significantly larger percentage than average was transferred to institutions for adults with

[398] The 18 to 26 age category also includes youths over 26 who are still in the system.

disabilities (4 to 10 percent); and (iii) a substantially lower percentage left the system upon coming of age (around 25 to 26 percent).[399]

Furthermore, out of all children who entered public care before the end of 1996 (who all turned at least 18 in 2014), those who still were in a protection service in 2014 had entered when they were under 3 years old (especially under 1 year old) (Figure 71). Children who entered when they were under 12 months old represent about 25 percent of all children who entered public care between 2007 and 2014, but also account for almost 71 percent of all those who entered the system between 1989 and 1996.

Figure 71: Distribution of Children in Special Protection, by Entry Age and Year (% of Children per Year)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children).

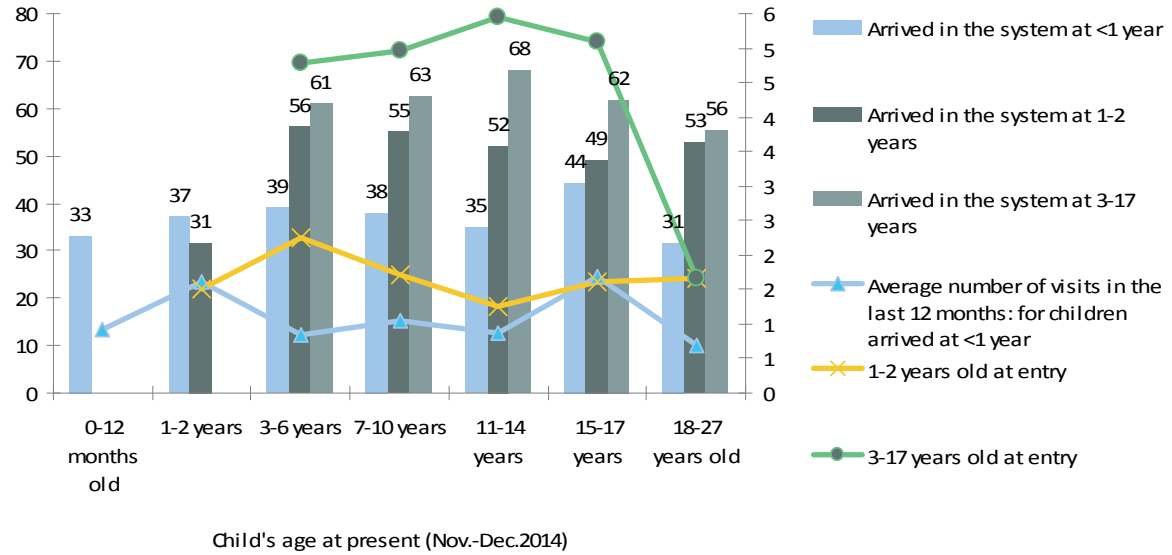
Thus, children who enter the special protection system when they are under 3 years old (and especially those who are under 1 year old) appear to be more likely to become "the system's children" than the other children in public care.[400] There are more than 18,000 children who entered the system when they were less than 12 months old and over 9,100 children who entered at ages between 1 and 2 years. These are all potential "children of the system." About one-third are children with disabilities (mild, medium or severe). Their distribution by age cohorts and by health condition at present is shown in Annex 6 Table 46.

Irrespective of whether these children's parents are alive and known, the very short time that the children spent at home before entering public care was insufficient for a strong enough relationship to grow between the children and their mothers or parents to motivate the mothers or parents to reclaim the child. This is particularly the case when no support or counselling has been made available to these mothers or parents. As a result, most ceased having any communication with their children a long time ago. As Figure 72 shows, regardless of their current age, the children who entered the system when they were under 1 year old had a less than average amount of interaction with their biological family (where interaction is defined as the fact that a relative (regardless of how distant) submited at least one visit request, visited the child, contacted the child by telephone, sent packages, or took the child on vacation. In reality, in 30 percent of cases in which there has been some connection with the family, the children who entered the system before turning 1 year old received, on average, only one visit per year or were contacted by telephone, most frequently by their mother.

[399] For comparison, among the youth aged 18 to 26 who entered the system when they were 3 years old or older, 37 to 39 percent are still in the system, 1 to 2 percent were transferred to institutions for adults with disabilities, and 38 to 39 percent left the system when they came of age.

[400] See also section 3.3.4 about lengths of time spent in the system.

Figure 72: Children in Public Care Who Had Any Relationship with their Natural Family and the Average Number of Visits They Received in the Previous 12 Months, by Child's Current and Entry Age (% of Children as well as Average Number of Visits)



Source: Study of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children).

Every passing day decreases the child's chances of being reintegrated into the family, especially if there is no connection between them. After three years of separation, their chances of leaving the system decline considerably. After six or seven years of separation, if no adoption has been successful, their chances of exiting the system diminish even further, while their chances of being reintegrated into their family are virtually zero. Therefore, this group of potential "system's children" needs to be acknowledged as such and treated properly. Just setting reintegration into the family as a PIP goal for a child is not enough, especially if it is not based on any analysis of the actual chances of reintegration for each and every child and if it does not trigger a specific sequence of actions involving the children and their families.

More efforts should be made to get these children adopted as a permanent solution. If no safe, stable, and secure parenting relationship has been established by the time the child reaches 10 years old, then the potential "system's children" should enter an institutional pathway of independent living that includes life skills education in which they grow up in a small group house, preferably located in a small community in which they can build friendships and social networks until they reach 18 years of age. Furthermore, this pathway should include the provision of either social housing or assisted living facilities for people with disabilities (both supervised independent living arrangements) for when the young person leaves the system. Otherwise, these young people will have no real chance to be integrated into society and to build a sustainable life. This institutional pathway (and the corresponding social housing program) should be designed and implemented as soon as possible so that it may yield visible positive effects starting with those children who are currently (2014) 3 to 6 years old.

> "It is absolutely necessary to create a legal framework for youths leaving public care, whether they are with disabilities or not, because after they leave, their trace is lost and everything that the state invested in them for 18 or 25 years is abandoned... It's like building a house but leaving it without a roof on top. In my opinion, this is what's happening here. And I'm telling you this because I myself spent my childhood in public care, this is what happened to me too. I was simply left hanging in the air, only God guided my steps on one path and saved me..." (Interview with professional, Craiova)

At the same time, experts acknowledge the fact that long-term solutions are necessary for potential "system's children" with severe disabilities and little chance of managing on their own. If no other permanent solution is possible, small group homes should be used for children with disabilities, even after they become adults. Meanwhile, medium to long term plans should be designed for the transition from institutional to community-based care as well as for supervised independent living arrangements, and health (rehabilitation) services.

RECOMMENDATIONS

Many children arrive in public care when they are under 3 years old (and particularly under 1 year old). They face a serious risk of becoming "the system's children." This risk should be acknowledged and counteracted by developing two distinct institutional pathways.

- The first pathway for children should be for independent living including not only family-type alternative care in smaller communities, but also the provision of social housing or assisted living facilities for when the youth (aged 18 to 26) leave the system.
- The other pathway should be for children with severe disabilities who cannot manage on their own.

In the absence of such pathways, the child protection system will only provide care during the childhood stage, without being able to live up to its catchphrase "making all efforts to keep children with their families", by failing to plan for the thousands of young people who leave the system every year without any family support.

We reiterate some of the recommendations of the *Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*,[401] which are relevant for the development of the two institutional pathways recommended above.

There is a special need for support services for young adults with disabilities living in their communities. Apart from such services as in-home support for those with complex dependency needs or help with daily home activities and personal care, there is a wide range of needs specific to young people that must be met. These include:

(i) the need to find and keep accessible housing, live independently and, in some cases, manage financial and personal assets;

(ii) the need for habilitation and rehabilitation services adapted to the specific need of adults with disabilities and provided in the context of independent living;

(iii) the need for vocational education, training, job coaching and employment support (all tailored to people of different ages and at different stages of the professional cycle);

(iv) the need to access other community services such as healthcare, legal services, outdoor activities, cultural activities, and leisure facilities; and

(v) the need to have a balanced family life (requiring, for instance, family counseling and sex education). Services for independent living are a very specific and important category that must be developed in the coming years, particularly to integrate post-institutionalized young adults with disabilities into society as well as to provide a transition from residential care to community-based services.

[401] Teșliuc, Grigoraș and Stănculescu (coord.) (2015:160).

3.4.2 Too Few Adoptions

Story Bag

What are the more difficult cases from the adoption perspective?

"- I have children for whom internal adoption procedures have been opened but who are not considered to be a match because the Romanian Office for Adoptions has the final say and they consider certain lists, criteria... so these children get stuck [at the theoretical matching stage]. They are older, they are 10 to 11 years old and have siblings, so nobody wants to adopt them, there are no families willing to do that... people interested in taking care of a child this age or of more children at once. Or of 14-year-old children... So, even if you open the adoption procedures, you get stuck, and once you open the procedure, children are no longer allowed to stay in touch with their birth families and so, for two years, you basically block their chances of reintegrating with their families and their relationship with their families, and... they do not even get to be adopted. So, for these children those two years are frozen, there is nothing you can do.

- When it comes to children with disabilities, things are even more difficult. It is even harder for him or her to be adopted because we [in Romania] have a different mentality: we only want children with fair hair, blue eyes, and in great health. This is why some of the disabled children defined as adoptable remain in the system with a protection measure as nobody wants to adopt them."

(Interview with professionals, Craiova)

"- I think that the adoption law should be also changed because we have families with many children in the system, they bring them when they are young or relinquish them in the maternity ward and afterwards they say, I'm not giving him or her up, they are mine, I will take them back home, and it is obvious that those who want to adopt a child prefer a young child they can shape. We are forced to open adoption procedures even if the child is 14 years old and we have the duty to contact family to the fourth kinship degree, sometimes the kids are from a family of 11, and then one has to run all over the place to ask for the reintegration of some children whom their extended family may have never seen and/or heard about before.

If the parents do not want to give them up for adoption, what happens?

- One cannot do anything at all. Without the parent's consent, one cannot.

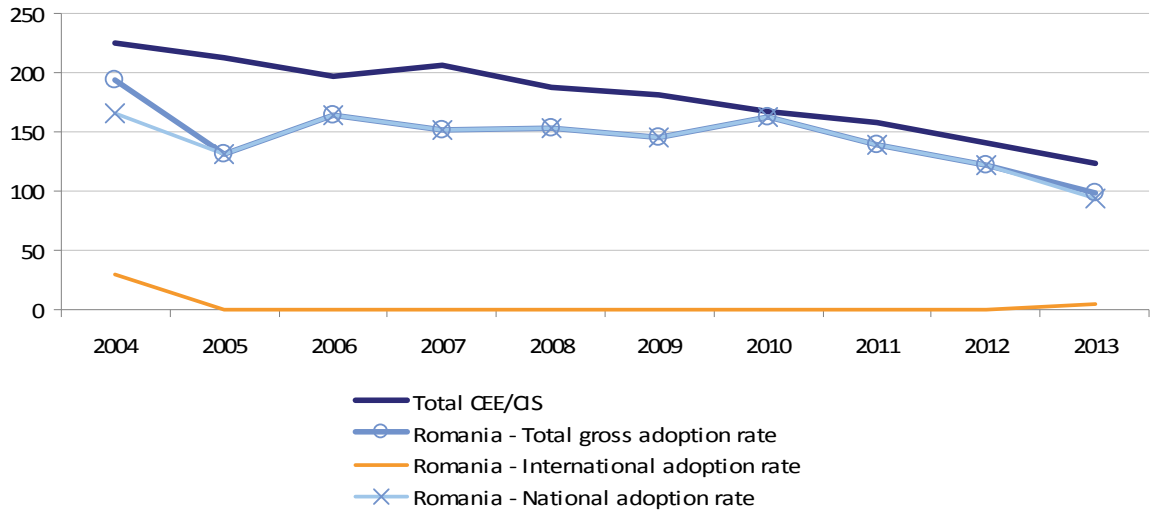
- Despite the fact that maybe all children from those families are in public care. If they do not want to, one cannot do anything."

(Focus group with professionals, Brașov)

3.4.2.1 Adoption of Romanian Children within the Framework of the CEE/CIS

Adoption is considered to be the best solution for children who can no longer be reintegrated into their birth families. Therefore, all efforts must be made to find the most suitable family or individual who wishes to provide parental care to the child in question within their country of origin. According to UNICEF data (Figure 73), in the CEE/CIS region, the adoption rate in Romania is currently below average (98 adoptions per 100,000 children aged 0-3, all throughout 2013, versus the CEE/CIS average of 123, see Annex 6 Figure 14).[402]

Figure 73: Gross Rates of Adoption in Romania and CEE/CIS, 2004-2013 (per 100,000 Children Aged 0-3, During the Year)



Source: UNICEF TransMonEE 2015 database, data for Romania as reported by ORA (Table 6.4.2).

Since 2004, the gross rate of adoption within the CEE/CIS region followed a downward curve. Romania followed the same trend with slight fluctuations, ending up with only 750 adoptions in 2013.[403] The fluctuations in the number of adoptions care mainly due to changes in national regulations. In 2004, a new law on the legal status of adoption (Law 273/2004) was introduced, which came into force as off January 1st 2005. Consequently, between 2006 and 2012, international adoptions were restricted to certain categories of people who could adopt a Romanian child. In 2011, the law was subject to new changes and additions, enforced as of April 2012 (through Law 233/2011). The new provisions broadened the categories of adoptive persons eligible for international adoptions, and as a result, in 2013, seven international adoptions took place. A new law regarding adoption was passed in 2016 (Law 57/2016), which introduced more flexible procedures and shorter deadlines for the adoption process.

[402] Unlike Bulgaria, Poland, Latvia, Lithuania, and Hungary, all of which had higher than average levels for the region.

[403] UNICEF data from the TransMonEE 2015 database as reported by ORA (table 6.4.1).

3.4.2.2 How Children Enter the Adoption Process

Beginning with this section, we go back to the analysis of the data found in the case files of children in public care, specifically the data collected via the Adoption Form designed for the children in public care who, at the time of our research, had adoption as their PIP goal (see section 2.3).[404]

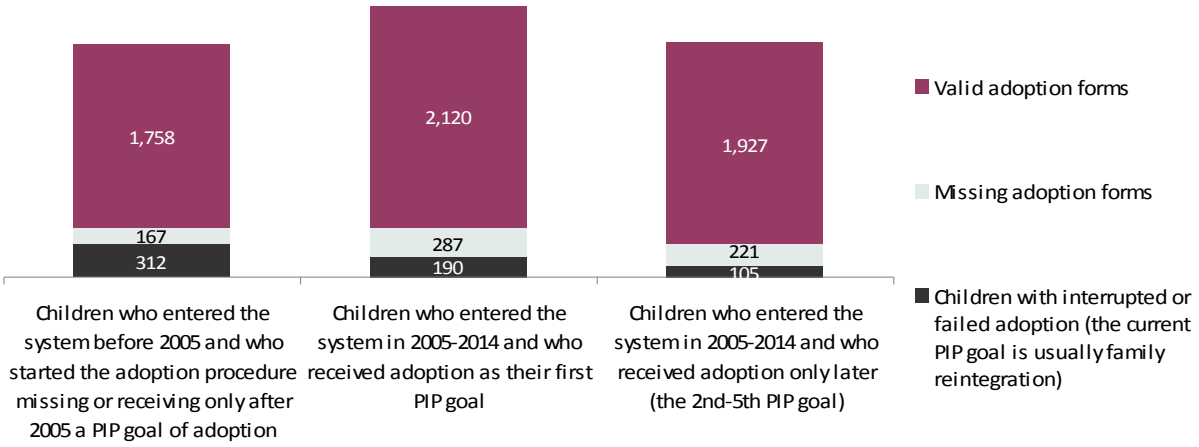
Of all children who were in public care as of November-December 2014, an average of 14 percent had passed through various stages of the adoption process:

- Four percent entered the system before 2005 and started the adoption procedure without having adoption set as their PIP goal (since it was not yet required by law), while other children who entered the system during the same timeframe were provided with adoption as their PIP goal sometime after 2005.
- Five percent entered the system between 2005 and 2014 and received adoption as their first PIP goal immediately after entering the system.
- Five percent entered the system between 2005 and 2014 and received adoption as their PIP goal only after several attempts had been made to reintegrate the child into his or her birth family.

Thus, almost 7,100 children (14 percent of children in public care) had gone through one or more stages of the adoption process which, however, was not completed and these children were still in the system at the time of the study. For more than 1 percent of these children, the adoption was either interrupted or it simply failed, while for three-quarters of them, the PIP was changed from adoption to reintegration into their families. These interrupted or failed adoption cases were unevenly distributed across counties, as shown in Annex 6 Table 47. As expected, the numbers of these cases were significantly higher in those counties with high shares of adoptable children (such as Dolj, for instance), but they were also high in some counties with relatively few adoptable children as a share of all children in public care (such as Arad and Constanța counties, see Figure 76).

Considering all these factors, at the time when the data were collected (November-December 2014), adoption as PIP goal was still valid for approximately 12 percent of the children in public care (namely, about 6,500 children). For all of these children, an Adoption Form should have been filled in, but for the reasons explained in section 2.3, valid forms were prepared for only 90 percent of them (5,805 cases). Figure 74 shows that the missing adoption forms were evenly distributed among the three categories listed above.

Figure 74: Distribution of Valid and Missing Adoption Forms, by the Categories of Children Established According to Entry Year and the Existence of an Adoption PIP Goal (numbers)

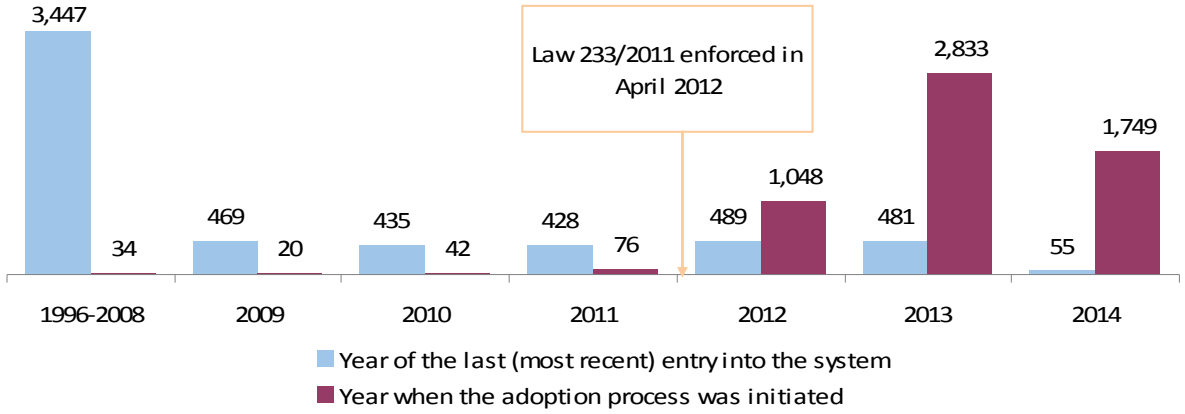


Source: Survey of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted (N=7,087 children who went through stages of the adoption process).

[404] The data on adoption which are analyzed below are weighted.

In this study, an "adoptable child" is defined as a child in public care for whom adoption was established as their PIP goal. Therefore, the valid forms analyzed below refer to adoptable children as of the end of 2014. Of the 82 percent of them who had entered public care between 1996 and 2011, 97 percent had the adoption process initiated in 2012 (Figure 75).

Figure 75: Distribution of Adoptable Children, by Year of Entry in Public Care and Year When the Adoption Process was Initiated (number)



Source: Survey of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted (N=5,805 children with an adoption PIP and a valid form).

On average, it took five and a half years for a child in the special protection system to obtain a PIP proposal for adoption, namely the time between the moment when he or she entered the system to the beginning of the adoption process. In fact, in the population of adoptable children as of the end of 2014, there were major differences between those who entered the system before 2005 and those who entered after 2005. More precisely, for children who entered the system between 1996 and 2004 (30 percent of all adoptable children), it took an average of approximately 10 years to get a PIP that targeted adoption. On the other hand, for the children who entered the system after 2005 (after Law 273/2004), it took an average of only 3.5 years for an adoption file to be opened.

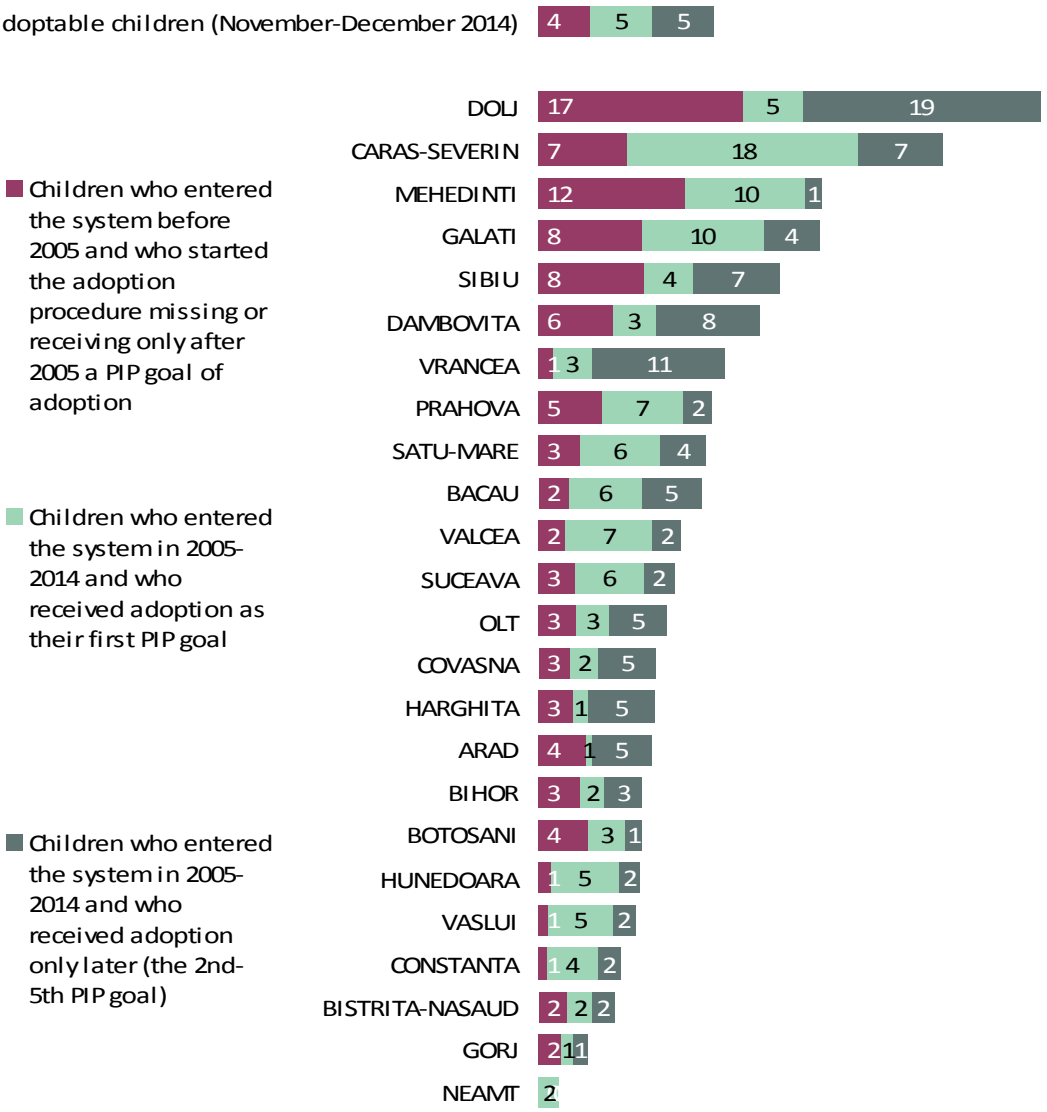
As a result, these averages are strongly influenced by the presence, among the adoptable children at the time of the study, of the many children who entered the system many years before and who received a PIP adoption goal only after the enforcement of Law 233/2011. In fact, although the adoption process began for almost all of these children between 2012 and 2014, if we look at the distribution of adoptable children according to the year of entry into the system, we notice that a roughly equal number of children having entered public care during 2001-2013 were selected as potentially adoptable each year, with a national average of 430 per year (Figure 75).

Figure 76 shows a similar approach underlying the number of adoptable children for whom an adoption procedure was opened in 2012-2014, approach which was followed by most counties in the country, with different shares.

According to the DGASPC specialists, the significant time lag between the child's entry into public care and their being declared adoptable was mainly due to the many steps that need to be taken in order to comply with the law. During the first step, the objective is to reintegrate the child with his/her birth family, since this is considered to be the best long-term solution for the child. The adoption procedure is to be opened only if this objective cannot be accomplished (because the family is unknown) or if it fails to be accomplished (even after consulting the parents or other relatives up to the fourth degree). Therefore, the significant amount of time that passes between the child entering public care and the the adoption file being developed is due to the legal requirement to find the child's parents and/or

relatives up to the fourth degree, to consult them, and to get their consent for the child's adoption, unless they opt for reintegration.[405]

Figure 76: Adoptable Children as of End of 2014, by Categories Established According to the Year They Entered the System and the Existence of an Adoption PIP Goal, and by Counties (% of All Children in Public Care in Each County)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Only the 24 counties with solid data in the CMTIS were considered. Data are weighted (N=50,677 children in public care).

> "The process takes a lot of time... because only after the reintegration process fails, after the parents show no interest and the child cannot be reintegrated into the extended birth family, only then can adoption be proposed as the goal of the child's PIP. When the adoption procedure is initiated, the file is sent to the adoption department which then continues with the fieldwork, proceeds to consult with the parents, if it manages to find them, and with the relatives regarding the consequences of adoption, and takes down their statements. These people have 60 days to change their mind, to reconsider their statement, and if nothing changes, the file is sent to the court with a proposal for initiating the adoption process. If after analyzing the contents of the file, the court decides that reintegration efforts have failed, it summons the parents to verify that they

[405] Law 56/2016 states that the maximum time allowed to search for relatives up to the fourth degree who might be willing to raise and educate the child shall be reduced from one year (as was previously stipuled in Law 233/2011) to six months. If the relatives cannot be traced during this timeframe, the child will be eligible for adoption.

have agreed to giving their child up for adoption even though they have already submitted to us a statement to this effect. If they cannot be found, they are away, nobody can provide information on their whereabouts, and the child cannot be reintegrated within his or her birth family, then the court will also declare the child adoptable and the adoption department can start looking for the most suitable family for the child in question." (Interview with a professional, Piatra Neamț)

Table 37: Case File Documentation of Reintegration Efforts for Adoptable Children versus Other Children in Public Care (%)

	Children with no adoption PIP	Adoptable children (A)	Adoptable children (B)	Adoptable children (C)	Total adoptable children **
List of relatives up to the fourth degree who were identified	47	61	62	64	62
Relatives up to the fourth degree refuse to reintegrate the child within the family*	28	49	65	62	59
Assessment by the case manager or person responsible for implementing the PIP of the chances for reintegrating the child:					
- within the birth family	58	43	47	51	47
- with relatives up to the fourth-degree	38	37	45	48	43
Considering the information available in the file and from your experience, is adoption as PIP goal adequate and relevant for the child's situation? – "Yes" Answers	73	72	67	76	71
Total: - %	100	100	100	100	100
- N	45,258	1,758	2,119	1,927	5,804

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: Adoptable children (A) = Children who entered the system before 2005 and who entered the adoption process without any adoption PIP or with an adoption PIP received after 2005. Adoptable children (B) = Children who entered the system between 2005 and 2014 and whose first PIP goal was adoption. Adoptable children (C) = Children who entered the system between 2005 and 2014 and who entered the adoption process later on (in their second to fifth PIP). *These results were similar when considering both the refusals and the approvals of the relatives regarding the reintegration of the child. **Only adoptable children with valid forms were taken into consideration.

Another factor that is often mentioned as an obstacle to initiating the adoption process is the requirement to obtain the parents' consent to adoption. The parents will often refuse to let their child be considered for adoption although they also make no further efforts to take the child home or to participate in any parenting classes or counseling services aimed at improving the chances of reintegrating the child into the family. In fact, there is no obligation for parents with children in public care to participate in such classes or services, nor are there services developed for this purpose. However, the legislation in force starting 2012 allows the system to disregard the right of one or both parents to consent to or refuse the adoption of one of their children if there is proof that the refusal is abusive.[406]

"Yes. But you see, once the parents got rid of the child, they are the kind of parents who also refuse to give him or her up for adoption or take him or her home, just so that the state may keep him/her as long as possible". (Focus group with specialists, Cluj-Napoca)

"To be declared adoptable, but to also be young enough for adoption, otherwise it is a complete nonsense, there are some that want to be adopted and it can't be done [because their parents won't have it]. And here we are, in the system, always facing their unjustified refusal, because if

[406] Article 8 of Law 273/2004 regarding the legal regulation of adoption, republished in 2012 in the Official Gazette of Romania, part I no. 259 of April 19, 2012.

> you look at it over time, by year, I am right, if you do a statistical analysis, you will find in the system the same children whose parents said no [to adoption] because they said they were going to take the kids home but never did. So the children will turn 14, 15 and still be in the system and when they must exit the system at 18, let's say that they no longer want to attend school and exit the system, you cannot then reintegrate them into their homes because the family will say they are already adults and there's no place home for them anymore. So there's this vicious circle that makes the child stay in the system..." (Focus group with specialists, Brașov)

Regarding the steps that have to be taken prior to initiating the adoption process, the data in the case files shows that specialists make more efforts to identify the parents of adoptable children and to obtain their consent or refusal to reintegrating the child than they make for children who have never had an adoption PIP (Table 37). For example, there is a list of relatives up to the fourth degree in the case files of 62 percent of the adoptable children compared to only 47 percent of the files for other children. However, this accounts for only about two-thirds of adoptable children. For the other one-third, these efforts were not made even though only approximately 10 percent of them have unknown and/or deceased mothers or relatives. Moreover, for fewer than half of the adoptable children (a similar share to the entire sample), the case files had no assessment by the case manager or person in charge with implementing the PIP with regard to their real chances of being reintegrated into their natural families. Overall, the DGASPC experts who filled in the adoption forms felt that adoption as a PIP goal was relevant and appropriate for fewer than three-quarters of the children selected for adoption, with the rest having very limited chances of completing the process successfully. This means that the DGASPC experts admit that their adoption efforts will fail for more than one-quarter of the adoptable children.

Adoption is analyzed in this section as a process through which the child passes from public care to a permanent living solution. However, in order to examine the adoption process, we needed to develop a profile of the children considered eligible for adoption. That is the theme of the next section.

3.4.2.3 The Profile of the Adoptable Child

Data from the case files helped us to identify the profile of those children in public care who enter the adoption process (Annex 6 Table 48). Adoptable children were different from the children without an adoption PIP in several ways. Adoptable children were much more likely than average to have entered the system when they were under 1 year old as a result of being relinquished in maternity wards (61 percent).[407] They were aged between 1 and 10 at the time of the study (68 percent) and were biological orphans with no extended family (12 percent) or came from families of single-mothers (62 percent), adolescent mothers (6 percent), or mothers with disabilities and/or mental health problems (21 percent) who usually had completed primary school at most. This profile is strongly associated with that of the children who received an adoption PIP immediately after entering the system (section 3.3.3).

Generally, adoptable children come from small, poor families (40 percent) that have fewer children than the families of the other children in public care. However, 46 percent of them had siblings in the system, of whom 38 percent had an average of two adoptable siblings among whom a 1.4 siblings could be adopted together.[408] It is worth mentioning that the children from families with parental risk factors had a much lower probability of entering the adoption process than other children. Consequently, avoidable entries into the system (children entering the system only for social reasons) were under-represented among adoptable children.

Children with special needs were significantly under-represented among adoptable children, especially children with severe or marked disabilities (9 percent). However, in certain counties, such as Gorj, Hunedoara, Mehedinți, Dolj, and Olt, children with a handicap or disability in the system accounted for more than 40 percent of adoptable children (versus the average of 29 percent of all children in public

[407] Resulting in high numbers of children from urban areas and with undeclared ethnicity.

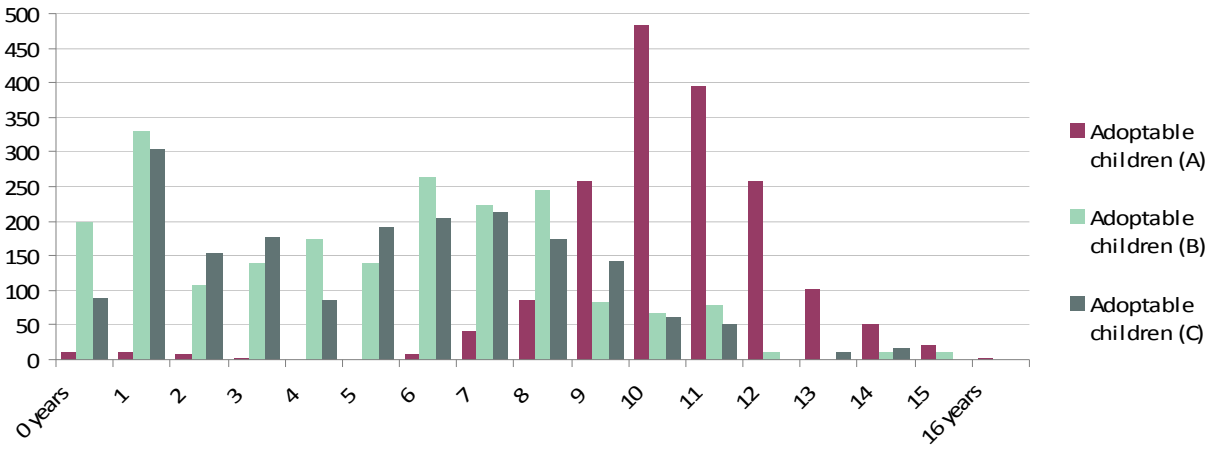
[408] The number of adoptable siblings varies between 1 and 8, and the number of children that can be adopted together varies between 0 and 5.

care). By contrast, these children accounted for under 20 percent of adoptable children in Bihor, Botoșani, Constanța, Covasna, Satu-Mare, Suceava, Vaslui, and Vâlcea counties (of the counties with solid data in the CMTIS, as shown in Annex 6 Table 49).

Children aged 6 to 17 with SEN and children aged 7 to 17 with behavioral disorders were also statistically under-represented among adoptable children (Annex 6 Table 48). However, the absence of these two groups was probably largely due to their age more than to their belonging to a group of children with special needs. By contrast, premature and/or underweight infants were over-represented (12 percent).

Although at the time of the study most adoptable children were between 1 and 10 years old, there were children who had started the adoption process at all ages between 0 and 16 (Figure 77). Young children prevailed among those who had entered the system starting 2005, while those aged 9 to 12 (with an average age of 10) prevailed among the children who entered public care during 1996-2004. Also, there were differences among counties in terms of the age at which the adoptable children had entered public care. In Gorj, Constanța, and Bistrița-Năsăud counties, all adoptable children entered the adoption process at 0 years old. In Vâlcea, Dolj, and Caraș-Severin counties, the percentage of adoptable children who entered the system at the age of 7-10 years was significantly higher than the national average.

Figure 77: Distribution of Adoptable Children, by Age at which They Began the Adoption Process (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=5,805 adoptable children with valid adoption forms, though for two percent of them there is no information about the date when the adoption process was initiated).

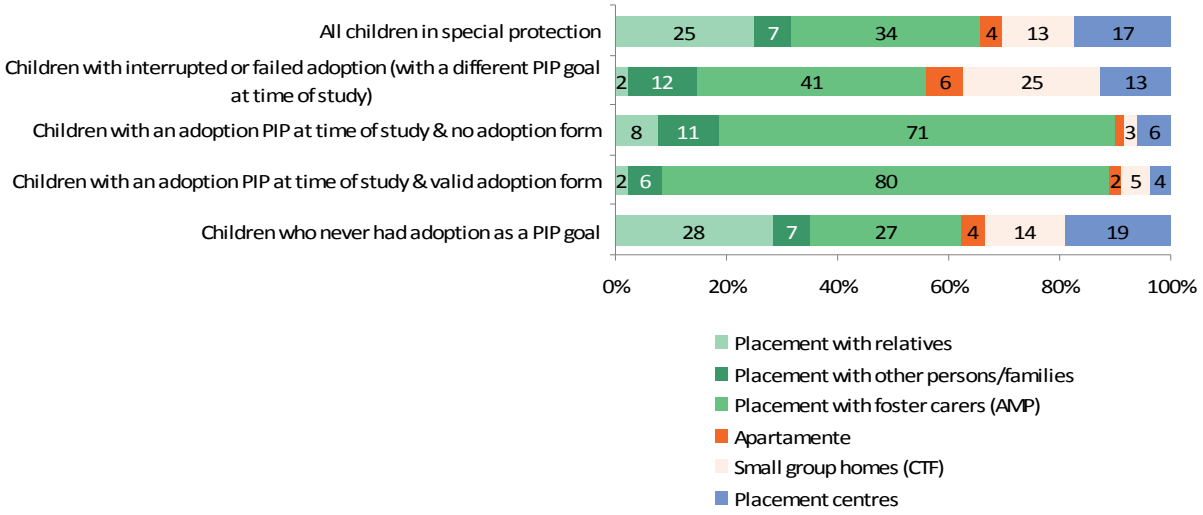
Note: Adoptable children (A) = Children who entered the system before 2005 and who entered the adoption process without any adoption PIP or with an adoption PIP received after 2005. Adoptable children (B) = Children who entered the system between 2005 and 2014 and whose first PIP goal was adoption. Adoptable children (C) = Children who entered the system between 2005 and 2014 and who entered the adoption process later on (in their second to fifth PIP).

Regarding the protection services in which the adoptable children were placed, placement with a professional foster care prevailed (Annex 6 Table 48). Only 4 percent of adoptable children were in placement centers, compared to 19 percent of those who never had an adoption PIP. Also, only 7 percent of adoptable children were in small-scale residential services versus 18 percent of the other children. By contrast, 80 percent of adoptable children were placed in foster care compared to 27 percent of those who had never entered the adoption process (Figure 78).

Adoptable children who had no valid adoption form and are therefore missing from the analysis in the following sections had a different profile than the one reported above. The children for whom the DGAPC experts had never filled out an adoption form (although the children subsequently received adoption as their PIP goal) had a significantly higher probability of being boys, Roma children, children with developmental delays, and children from families with parental risk factors

(mother/parents with promiscuous behavior, or who had problems with the police and/or a criminal record, living in poverty). Also, those children placed with other people or families were over-represented among children with an adoption PIP but no adoption form (11 percent versus an average of 7 percent for all children in the system). This category of children represented over 1 percent of the children in public care, and were unevenly distributed among the counties (Annex 6 Table 47).[409]

Figure 78: The Protection Services in Which Adoptable Children Were Placed Versus Other Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care).

Finally, Annex 6 Table 48 also provides information about the children in public care who experienced a suspended or failed adoption during their stay in the system. First, 92 percent of them were children aged 7 or older. Second, an above average share of them had siblings in the system (54 percent versus the average of 50 percent) and approximately one in every ten had developmental delays. Although children relinquished in maternity wards prevailed (as they did among all the other adoptable children), children who were relinquished in health units at ages over 1 and those who entered the system after running away from home (including street children) were over-represented among children with suspended or failed adoptions. Although they were older than 6 at the time of the study, to a significantly higher than average extent these children were placed in family-type services, especially with other families or individuals or with foster carers, and in small-scale residential services (Figure 78).

As we already stated above, suspended or failed adoption cases were unevenly distributed among counties (Annex 6 Table 47).

We conducted a simultaneous analysis of the factors that influence the allocation of a child into the adoptable or non-adoptable categories using a logistic regression (Table 38). This analysis showed that this selection is largely based on four factors: (i) the age of the child; (ii) the structure of the original family who must give their consent for the adoption of the child; (iii) the route via which the child entered the system; and (iv) the efforts and strategy of the county DGASPC.

All other things being equal, we found that a child aged between 0 and 3 is significantly more likely than a child aged 10+ to be declared adoptable and to not have experienced a failed adoption. A child of 4 to 9 years old in public care is almost four times more likely than a child aged 10+ to enter the adoption process but is also two times more likely to have a failed adoption on file.

[409] Among the 24 counties with solid data in the CMTIS, the share of adoptable children for whom no adoption form had been filled in varied widely, with a maximum of nearly 7 percent of the children in public care in Satu-Mare county.

Table 38: Multinominal Logistic Regression Model Predicting the Allocation of Children (in Public Care) into Various Categories of Adoptable and Non-adoptable Children

	Child with an adoption PIP at time of study & valid adoption form		Child with an adoption PIP at time of study & no adoption form		Children with suspended or failed adoption (with a different PIP goal at time of study)	
	Odds report	Sig.	Odds report	Sig.	Odds report	Sig.
Age of child at time of study:						
Children aged 0-3 versus those aged 10-17	2.9	0.000	3.9	0.000	0.3	0.000
Children aged 4-9 versus those aged 10-17	3.6	0.000	2.8	0.000	1.8	0.000
Family structure at time of study:						
Father only vs. nuclear family (M+F)	0.7	0.021	0.2	0.016	1.3	0.245
Mother only vs. nuclear family (M+F)	1.9	0.000	1.5	0.000	1.6	0.000
Extended family vs. nuclear family (M+F)	0.4	0.000	0.9	0.735	0.6	0.019
No parents or extended family vs. nuclear family (M+F)	1.9	0.000	2.4	0.000	2.3	0.000
Approval/ refusal of the relatives to integrate the child:						
Nothing is known of the relatives vs. No approval or refusal	10.5	0.000	1.4	0.052	0.2	0.001
Relatives' approval of integration vs. No approval or refusal	0.7	0.000	0.8	0.102	0.2	0.000
Relatives' refusal of integration vs. No approval or refusal	5.4	0.000	1.8	0.000	2.2	0.000
System entry routes:						
Relinquished in the maternity ward--> SPS vs Taken directly from family with a stable home	3.8	0.000	7.5	0.000	5.3	0.000
Maternity ward--> Family with no stable home or homeless--> SPS vs Taken directly from family with a stable home	1.3	0.030	2.0	0.026	1.3	0.438
Maternity ward--> Family--> Relatives--> SPS vs Taken directly from family with a stable home	1.1	0.528	1.0	0.948	1.0	0.920
Maternity ward--> Family--> Children relinquished in paediatric units or other institutions--> SPS vs Taken directly from family with a stable home	2.1	0.000	2.2	0.000	2.7	0.000
Maternity ward--> Family--> Children who ran away from home/street children--> SPS vs Taken directly from family with a stable home	1.9	0.001	0.0	.	11.5	0.000
Other minor routes* vs Taken directly from family with a stable home	1.3	0.002	1.1	0.835	0.5	0.015
DGASPC per county:**						
Other counties versus DJ***	0.3	0.000	0.2	0.000	0.1	0.000
AR versus DJ	0.1	0.000	0.3	0.000	0.5	0.000
AR versus DJ	0.2	0.000	0.3	0.000	0.2	0.000
BH versus DJ	0.1	0.000	0.5	0.001	0.0	0.000
BT versus DJ	0.2	0.000	0.1	0.000	0.2	0.000
CS versus DJ	0.9	0.287	0.5	0.008	0.1	0.000
CT versus DJ	0.0	0.000	0.5	0.004	0.5	0.000
DB versus DJ	0.4	0.000	0.1	0.000	0.5	0.000
GL versus DJ	1.0	0.923	0.6	0.101	0.2	0.000
HG versus DJ	0.1	0.000	0.0	0.000	0.1	0.000
HD versus DJ	0.1	0.000	0.1	0.000	0.1	0.000
MH versus DJ	0.6	0.000	0.3	0.000	0.2	0.000
NT versus DJ	0.0	0.000	0.2	0.000	0.0	0.000
SM versus DJ	0.1	0.000	2.2	0.000	0.5	0.000
SB versus DJ	0.2	0.000	0.5	0.001	0.1	0.000
SV versus DJ	0.4	0.000	0.3	0.000	0.3	0.000
VS versus DJ	0.1	0.000	0.4	0.000	0.1	0.000
VL versus DJ	0.1	0.000	0.4	0.000	0.2	0.000

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care).

Note: Nagelkerke Pseudo R2=0.41. *See Infograph Chart 2. **All other counties in the country are grouped together due to the small number of cases in one or more categories. Highlighted values are statistically significant. A value higher than 1 predicts that a child will be allocated into one of the categories of adoptable children while a value lower than 1 predicts that a child will be allocated into the category of non-adoptable children.***DJ = Dolj county. M+F = Mother and Father.

The child's current family structure is also a significant predicting factor. With all other things being equal and controlled for, the children with the greatest chances of entering the adoption process are biological orphans with no supporting relatives or the children of single-mothers. The existence of an extended family lowers the chances of a child being declared adoptable almost threefold in line with the system's emphasis on reintegration into the natural family as the best permanent solution for the child. However, taking into account the limited efforts and underdeveloped community services to identify and support the families at risk of separation (Table 37),[410] it may be that the mere existence of some relatives prevents a child from being considered for adoption even when the child's existing relatives do not want to or cannot care for him or her. As can be seen in the regression model featured in Table 38, when children's files contain statements from their relatives up to the 4th degree refusing to integrate and raise them, it increases fivefold the children's chances of entering the adoption process, whereas statements regarding an integration approval reduce them significantly, which is not unexpected. However, even in cases where nothing is known about a child's relatives (particularly in cases of relinquishment), the chances of the child entering the adoption process are greater than for those who have known relatives and the file does not include any statement of approval or refusal from those relatives. Similarly, children who only have a father tend to have little chance of being declared adoptable, maybe because this situation requires specialists to work with the family a great deal, the father is harder to find, or it requires time and effort to convince him to cooperate.

System entry routes are relevant because they show us that, when all other things are equal, children relinquished in health units, especially those relinquished immediately after birth, are considerably more likely to enter the adoption process than those children who lived with a family first and then taken into the system. On the other hand, children taken into the system after having run away from home (and street children) have relatively high chances of being declared adoptable but few chances of going through the process successfully.

The number of adoptable children is also significantly influenced by the strategies and efforts of the DGASPCs at the county level. Annex 6 Table 47 and Figure 76 show that, while in Dolj county 40 percent of the children in public care were adoptable (4 percent of whom had a suspended or failed adoption), a large share of counties had started an adoption process for fewer than 10 percent of the children in their care. The regression model in Table 38 confirms the fact that children from all counties except Caraș-Severin and Galați were up to 10 times less likely to be declared adoptable than children in the protection system in Dolj County, after reintegration efforts failed.

There were differences not only among county DGASPCs but also among case managers in terms of how children were selected to enter the adoption process. In our survey of case managers, we used, among others, the vignette method, a friendly method for analyzing work practices which compares case workers' reactions to the same hypothetical situation. However, these results must be interpreted with great care because the case managers' answers to fictional situations may differ from how they would react in the real world.[411] In order to illustrate the various approaches taken by case managers in the field of child protection in Romania, we used three vignettes, one of which relates to adoption and is presented below (Vignette 2).

Vignette 2 shows that, for a healthy child relinquished in the maternity ward immediately after birth, the majority of case managers would first try to identify the child's natural family and reintegrate the child with them. Subsequently, "depending on the case developments," they would initiate the adoption process. Consequently, most case managers would focus on finding a permanent solution (a family) for the child, and, depending on what time and resources were available, they would carry out a detailed assessment of the situation, which differs from the "front door decisions."

[410] See section 3.2.5.4.

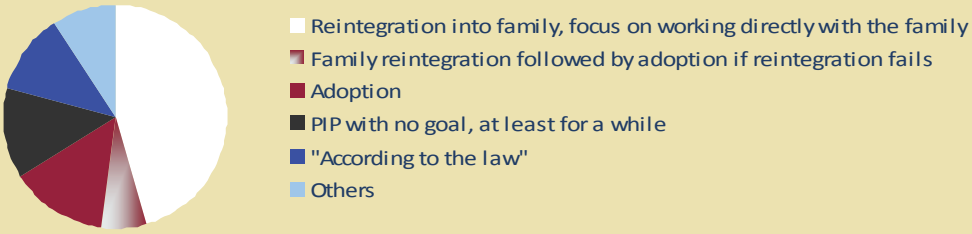
[411] Wilkins (2015).

Vignette 2

Please describe clearly how you would proceed in the following hypothetical case: a request from hospital/ maternity ward X regarding child Andrei, 3 days old, relinquished at birth. Andrei was born at full term, he weighs 3.5 kg, has received an Apgar score 9 at birth, and is of Romanian ethnicity. Andrei's father is unknown. (No information is provided on the mother.)

We received answers from 77 case managers, randomly selected from the 793 who participated in the research.

What is the PIP goal proposed by the case managers for this child?



What do case managers think should be done in this case?

The first group of responses advocated for taking a long-term approach to find a permanent solution for the child, with individualized solutions. Specifically, these case managers recommended family reintegration for the child, possibly followed by adoption. Generally all explanations concerning the necessary actions were detailed and centerd on identifying positive ways and resources that could be used, for example, "the identification of resources and of resource people for the child within the extended family on the mother's side who wish to get involved in raising the child" (Interview with a professional, Bucharest), "identification and counselling of the mother, accommodation in a maternal center, and the identification of family and community resources that may support the reintegration of mother and child" (Interview with a professional, Iași).

The second group of responses also advocated for taking a long-term approach to find a pragmatic and fast permanent solution in the interests of the child. Specifically, these case managers recommended adoption. The hypothetical child had the profile most sought after by adopting parents so they recommended, "placement with an adopting family and adoption of the child without looking for the mother since this is a case of abandonment" (Interview with a professional, Vaslui) and the "immediate initiation of the adoption process to identify an adopting family asap" (Interview with a professional, Hunedoara).

The third group of responses provided short-term, temporary solutions for the child (a PIP with no goal) by placing him in emergency care with a protection service, with no reference to a long-term solution and with no previous assessment of the family situation: "deprivation of parental rights; emergency placement with a foster carer" (Interview with a professional, Satu Mare).

The fourth group of responses were either "according to the law" or did not reveal any clear measures to take in this case: "for such a child, a method, a measure of protection must be found; we would inform competent authorities and specialists will take the best steps" (Alba) or "I think that all efforts being made at present would be efficient in solving the situation of this child" (Dolj).

In the opinion of case managers, what are the child's chances of being reintegrated into his natural family or of being adopted?

Good and very good chances were the answers given by the case managers who focused on finding permanent solutions for the child.

On the basis of similar actual cases, the interviewed case managers considered that the most difficult aspects of the case management related to this hypothetical situation would be: (i) identifying the mother/ extended family and assessing the family situation; (ii) securing an emergency foster care placement; (iii) drafting the relinquishment protocol; and (iv) ensuring the child's right to an ID/ birth certificate.

In addition to this prevailing reaction, there were another four different groups of responses, almost equal in number, among the case managers who provided an answer. The first group referred to pragmatic ways, based on their experience, of reaching a permanent solution for the child as soon as possible. In the opinion of these experts, the child in question had a good chance of being adopted rapidly. Therefore, they said that they would "skip through the stages" of family reintegration because these stages use precious time and they would go directly to "emergency adoption". The responses of this group of case managers seem to back up the findings of recent studies[412] of practices in the field of child protection according to which oftentimes there is little involvement of the family, there is not enough partnership-driven work and the issues raised by the case managers about the family tend to be rather negative.

The second group of responses did not consider the chances of the child being reintegrated or adopted and did not refer to a permanent solution for the child but was limited to the emergency entry of the child after being relinquished in the hospital and the rapid identification of an available foster parent to care for him or her. All attention and efforts of these case managers were directed towards finding a temporary solution, with the operative word being "emergency."

The third group of managers often referred to standards and regulations and answered with the monotonous formula "according to the law", with no assessments or explanations. Adoption was an option to the extent that it was "according to the law." More generally, their answers to the questions were opaque and did not allow for identifying any practices or concrete activities to be applied, at least in theory.

The fourth group of case managers expressed various ("other") opinions and concentrated on experience and the rich caseload as a way to illustrate the unpredictable situations that can occur (and that usually occur) in the field. Their discourse concerned "fieldwork" and various types of obstacles encountered "in real life" (such as parents with no identity documents, mothers with disabilities and/or mental health problems, parents leaving home, and difficulties associated with collaborating with the authorities, such as the failure to comply with legal terms and conditions).

Therefore, it is clear that current practices used in the child protection system result from a combination of national legislation, the various strategies used by the DGASPCs and by the case managers, only some of whom consider permanent solutions for the child and even fewer are concerned about offering family support and about working directly with the families.

Box 19: Profile of People who Adopt in Romania

Most people who adopt in Romania are people with secondary, higher or postgraduate education, are aged over 30, with an average age of over 38. Almost three-quarters are from an urban area. In 88 percent of cases they are families and the other 12 percent of cases are single women. Most couples are in a stable, long-term relationship that has lasted more than five years. The single people who want to adopt are aged over 40, with at least secondary education (almost half with tertiary education or a PhD). Eighty-six percent of adopting people have no biological children of their own, and the decision to adopt has come in most cases after several failed attempts to have their own children.

Source: Buzducea and Lazăr (2011).

[412] For example, Popoviciu et al. (2012).

3.4.2.4 The Stages of the Adoption Process

Adoption is hereby analyzed as a process through which the child passes from public care to a permanent living solution. There are several stages to the adoption process as set out in Law 273/2004 and subsequently amended by Law 233/2011, which introduced a practical matching stage before entrusting a child for adoption. This chapter will analyze the six stages of the adoption process as established by law (at the time of the study):

(I) Submitting the file to the adoption office
(II) Opening the adoption procedure (DPA)
(III) Theoretical matching with the aim of adoption (PTA)
(IV) Practical matching with the aim of adoption (PPA)
(V) Entrusting the child for adoption (IVA)
(VI) Court Approval for/Revocation of the adoption

Of the 5,805 children with an adoption PIP at the time of data collection (November-December 2014) and with valid Adoption Forms, some 1 percent were in the preparation phase at the time of the study, in that their files had not yet been submitted by the DGASPC child protection office to the DGASPC adoption office. These children are not included in the analyses described below because they had not yet entered the actual process.

The data analysis revealed that, out of all children who entered the adoption process, 86 percent were in the first three stages of the process (of whom 68 percent were in stage III involving theoretical matching) and only 5 percent had reached the final stage. At the county level, not only did the number of adoptable children vary widely but also their distribution in each stage (see the top graph of Figure 80 and Annex 6 Table 50). In those counties with larger numbers of adoptable children, most of them were in the theoretical matching stage (stage III), probably because the number of adopting parents was not large enough to increase their chances for a match. Meanwhile, in counties with lower numbers of adoptable children (such as Harghita, Vaslui or Constanța), over one-third of the children had reached the final stages of the process.

In our process analysis that follows, we assumed that any child in a given stage had gone through all the previous stages. For instance, we assumed that children in stage IV of the adoption process (practical matching) had had their files submitted to the adoption office (stage I), had had an official adoption procedure initiated (stage II), and had successfully passed through the theoretical matching process (stage III), which means a list of potential adopters had been identified. Figure 80 (the bottom graph) presents the distribution of adoptable children according to all of the stages they had gone through up to November-December 2014. The process looks very different depending on the perspective chosen for analysis: one that concerns only the situation existing at the time of the study and one that also considers past stages (cumulative perspective), as can be seen in Figure 79 below.

Figure 79: Stages of the Adoption Process from Two Perspectives

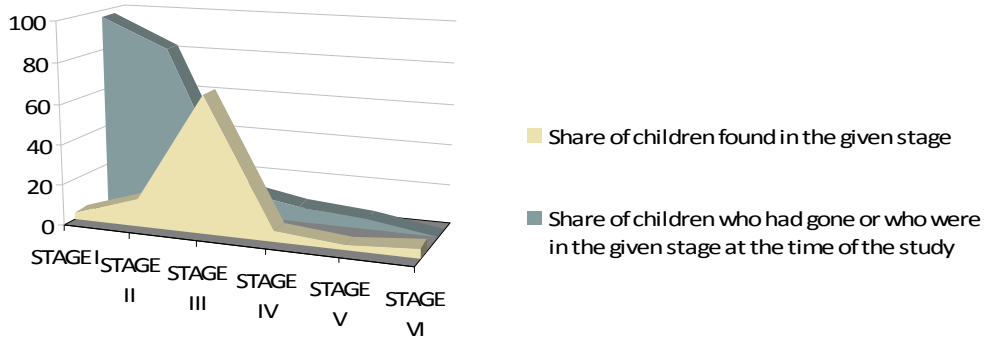
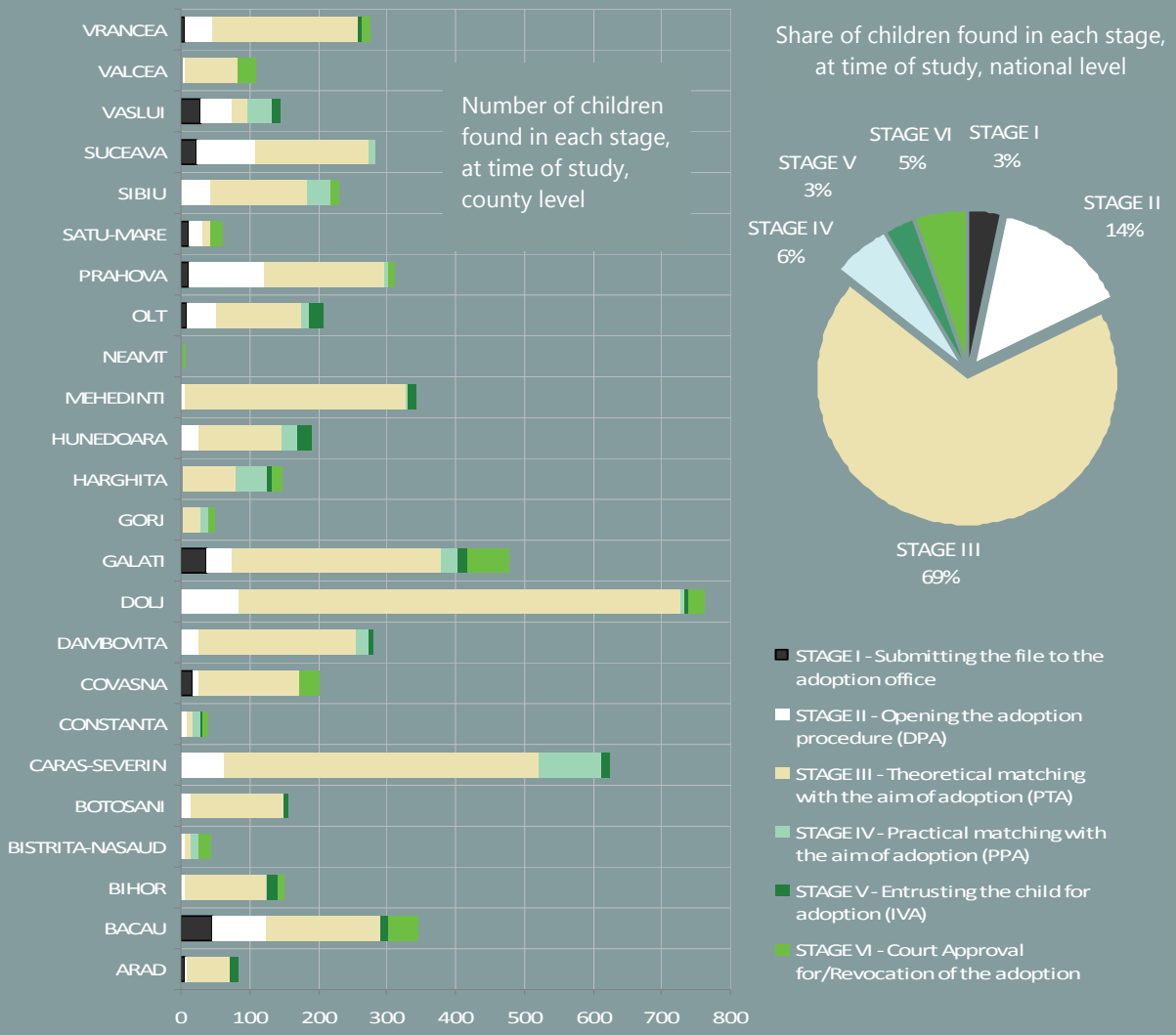
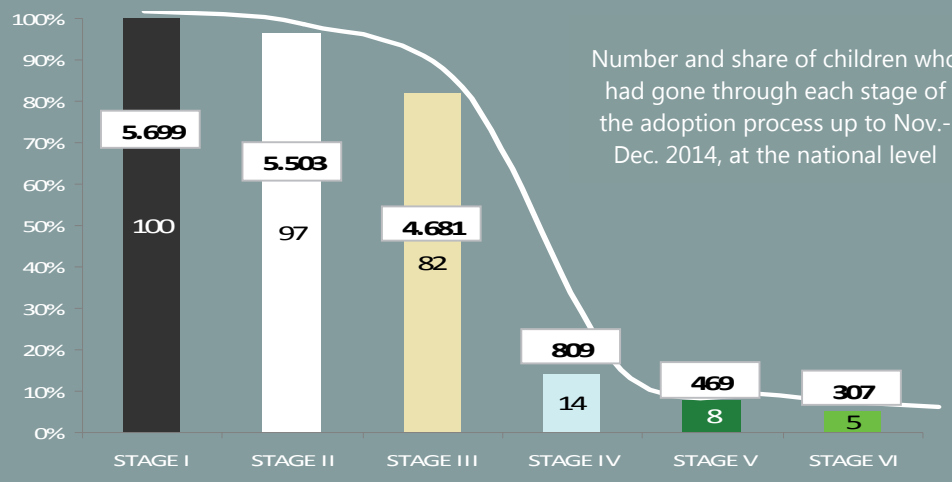


Figure 80 : Distribution of Children Who Entered the Adoption Process, by Stage at Time of Study, at National and County Level (top graph), and by Completed Stages (bottom graph)





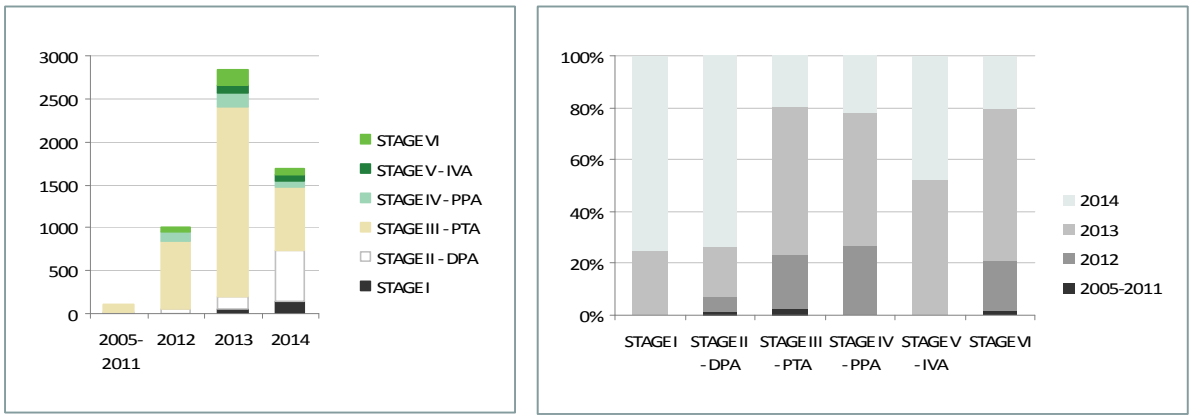
Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted: for the top graph, only the 24 counties with solid data in the CMTIS were considered (N=5,518); for the bottom graph, N=5,699 children who entered the adoption process.

Note: See also Annex 6 Table 50.

The following sections are based on the cumulative perspective. The method we applied compares the profile of the children in each stage of the process at the time of the study with the profile of the children who had already concluded that stage. The aim of the analysis was not only to describe the stages of the adoption process but also to use comparisons to discover whether there are any types of children with an above average probability of remaining stuck in a certain stage.

In order to locate the process in time, the years in which these children began the adoption procedure were those between 2005 and 2014, with 98 percent of children beginning the process between 2012 and 2014. Figure 81 clearly shows that, as might be expected, the more recent the start date, the more likely a child was to be in the first stages of the process. At the same time, Figure 81 shows that there are some obstacles in the process since almost all children who started it between 2005 and 2011 had only reached stage II – opening of the adoption procedure (DPA) or stage III - theoretical matching with the aim of adoption (PTA).

Figure 81: The Distribution of Children Who Entered the Adoption Process, by the Year the Adoption Process Started and the Stage They Had Reached by Nov-Dec 2014 (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=5,624 children).

(I) Submitting the File to the Adoption Office

For almost all adoptable children in public care, the process started when their file was submitted by the case manager to the DGASPC adoption office. In the case of only 1 percent of children, the process began with submitting a request for opening the adoption procedure (DPA) to a court of law, most probably because at that time there was no adoption office in the DGASPC. This first stage had been completed by 97 percent of the children who had entered the adoption process by November-December 2014, with only 3 percent still being in stage I.

The profile of the children who were still in stage I (file submitted to the adoption office) largely resembles the general profile of adoptable children presented in section 3.4.2.3 (see Annex 6 Table 51). Because they were children of a very young age who had recently entered the system, they had the defining characteristics of the adoptable child, namely babies relinquished in a maternity ward[413] for whom all efforts to reunite them with their families had failed, so that one to four years later the adoption process was started. Most of them did not have adoptable siblings and came from families headed by single mothers, especially adolescent mothers (14 percent) and mothers with disabilities and/or mental health problems (41 percent). Few of these children were disabled (21 percent versus the average of 29 percent), but among this group there was an over-representation of children with a severe or marked disability (15 percent). There was also an over-representation of babies born prematurely and/or underweight (18 percent of them).

[413] As a result, children with an undeclared ethnicity and those from urban areas are over-represented.

It is notable that among this group of children at the very beginning of the adoption process, there was a massive over-representation of children who had entered the system only as a result of social causes, either related to the specific profile of their parents (for example, adolescent mothers or parental disabilities) or to poverty and/or precarious housing conditions, though the number of children from families living in poverty was much lower in this group than in other groups or in the overall population of adoptable children (32 percent versus 40 percent).

Children who were in the first stage of the adoption process at the time of the study had had contact with their biological family or relatives up to the IV degree almost twice as much as children in the other stages (30 percent versus 17 percent). Most of them had had contact within the previous year, with the average being six months earlier.

The shares of children in stage I were not distributed equally throughout the whole country. Only 12 counties declared having any such cases, with most being in the counties of Bacău, Galați, Vaslui, and Suceava, as shown in Figure 80 (top graph).

As already stated, all children who entered the adoption process went through this stage. Consequently the date at which the case managers handed over the files of children with an adoption PIP to the DGASPC adoption office is the same with the distribution of children according to the year in which they started the adoption process (Figure 81 left box) as follows: 2 percent in the period 2005 to 2011, 18 percent in 2012, 50 percent in 2013, and 30 percent in 2014.

(II) Opening the Adoption Procedure (DPA)

As of November-December 2014, of the total number of children in the adoption process, 97 percent had reached the stage of opening the procedure (DPA) and 82 percent had passed on to the following stages (Figure 80, bottom graph). Consequently, 15 percent of children were still in this stage.

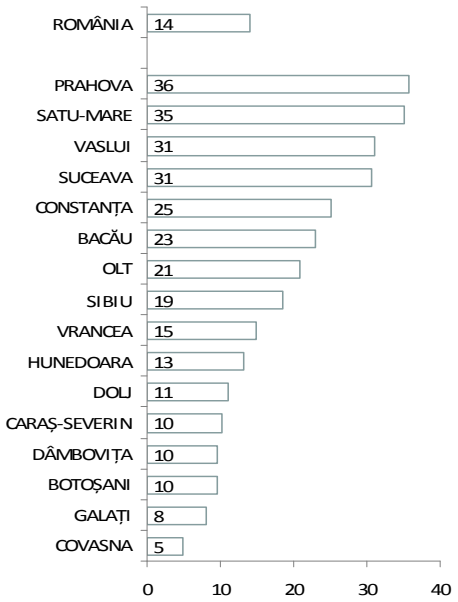
A small group (around 1 percent) of the children in stage II had started the adoption process in 2011-2012, spending more than two years in the DPA stage. These children had disabilities and had entered public care before the age of 1, having been relinquished in the maternity ward. Their adoption files had been prepared when they were between 7 and 14 years old. Only 16 percent of them had adoptable siblings, so they could be included in a group of siblings. Children who spent more than two years in the DPA stage only existed in four counties: Dolj, Galați, Prahova, and Vaslui.

The group of children then in the DPA stage were mainly children of single-mothers who had been relinquished in the maternity ward, a large share of whom were declared adoptable less than one year after entering the system so that a quarter of them were between the ages of 0 and 2 at the time of the study (see Annex 6 Table 51). The specific profile of this group included the following characteristics: an over-representation of children from large families,[414] especially from rural areas (30 percent) and from families living in poverty (49 percent), which for 1 out of every 10 children was the main reason why they had entered the system (9 percent). In total, avoidable entries amounted to 15 percent of this group, a percentage which was almost double the share of children who had completed this stage of the adoption process. In addition, significantly higher shares of the children in stage II (DPA) had entered the system after being left home alone or after living for periods of time with relatives or on the street as a consequence of unhappy events and/or exploitation.

[414] Consequently, a larger than average share of them had siblings in the system, though not adoptable ones.

Figure 82: Children in Stage II (DPA) as a Share of All Children in the Adoption Process, by County (%)

Twenty-five counties had children who were in stage II (DPA). Most cases were in four counties - Prahova, Suceava, Dolj, and Bacău (Figure 80, top graph). However, a comparison between the number of children in stage II and the total number of children in the adoption process shows that there were above average rates in more than those four counties (Figure 82). These rates may indicate a lack of cooperation between the DGASPCs and the county courts (to which the DGASPC adoption office submits the DPA request as required by law).



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only counties with solid information in the CMTIS and 10+ cases in stage II were considered. Data are weighted (N=677).

With regard to the sub-stages within stage II, at the time of the study, a DPA request had been forwarded to the court for 39 percent of the children in stage II and a ruling/decision was expected. Meanwhile, 22 percent of the children were waiting for the court to send its decision officially to the DGASPC, and 36 percent of children were in the phase pending a final DPA court ruling.

Table 39: Children in Stage II (DPA), by Sub-stage Reached and by Year of Submission of the DPA Request to the Court

	2012	2013	2014	Unknown	Total
Pending Court ruling	0	1	36	2	39
Pending Court ruling communicated to the DGASPC	1	1	7	12	22
Pending Final court ruling	1	1	28	5	36
Unknown	0	0	1	3	3
Total	3	4	72	21	100

Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=822 children in the DPA stage).

Our analysis of case files shows that a child who had reached the DPA waited one month[415] on average between the time the case manager handed over the file to the DGASPC adoption office and the time the DGASPC request to open the adoption procedure was submitted to the court, as required by law. There was, however, considerable variation among cases, from a minimum of one week at the most to a maximum of 16 months. Consequently, in some cases the child had to wait for more than a year before the request to open the adoption procedure was submitted to the court.

In order to analyze the duration of the sub-stages within stage II (DPA), we used the information on the children who had concluded this stage. We found out that for those children the whole DPA procedure lasted, on average, 130 days (approximately 3.7 months)[416] from the submission of the DPA request until the final DPA court ruling. Table 40 shows that what takes longest is the court to pronounce its ruling on the DPA request, around 68 days on average. The DPA court ruling was communicated to the DGASPC, on average, in 35 days after it was pronounced, and it became final 59 days after it was pronounced.

[415] Standard deviation is 1.95 months (N=4,392).

[416] Standard deviation of 87 days (or 2.9 months), with a minimum of 19 days and a maximum of 539 days (or around 17 months).

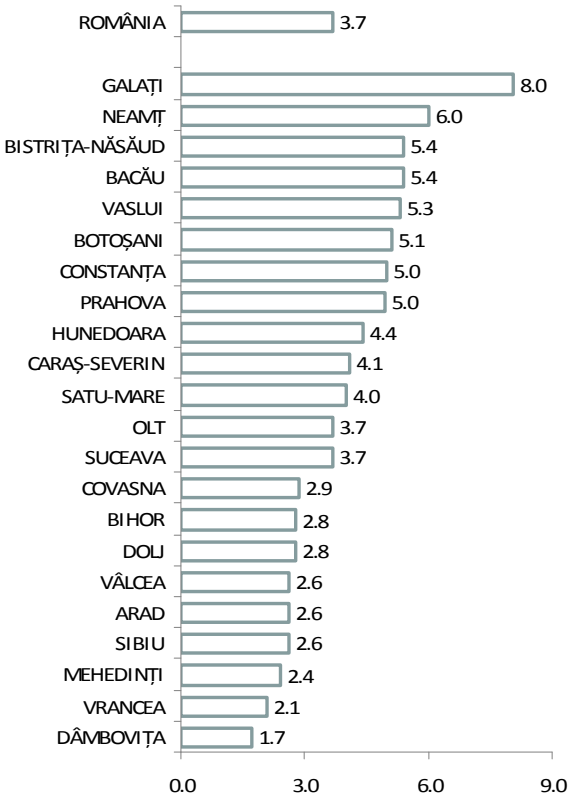
Table 40: Average Duration of the Sub-stages of the Adoption Opening Procedure

DPA sub-stages:	Time between submission of the DPA request and court pronouncing its ruling		Time between court pronouncing its ruling and ruling being communicated to the DGASPC		Time between court pronouncing its ruling and ruling becoming final	
	months	days	months	days	months	days
Average	1.76	67.89	0.76	34.84	1.47	59.42
Standard deviation	2.07	62.69	1.71	51.86	1.53	46.15
Minimum	0	0	0	0	0	0
Maximum	13	421	14	433	13	422
N	4,365	4,365	4,548	4,548	4,525	4,525

Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

The length of time varied substantially between counties depending on the quality of the services provided by the county courts as well as on the quality of the collaboration between the court and the DGASPC. The county of Galați had the longest average duration (eight months), while the county of Dâmbovița had the shortest (1.7 months).

Figure 83: Average Time between DPA Request Submission and Court Ruling Becoming Final, by County (Months)



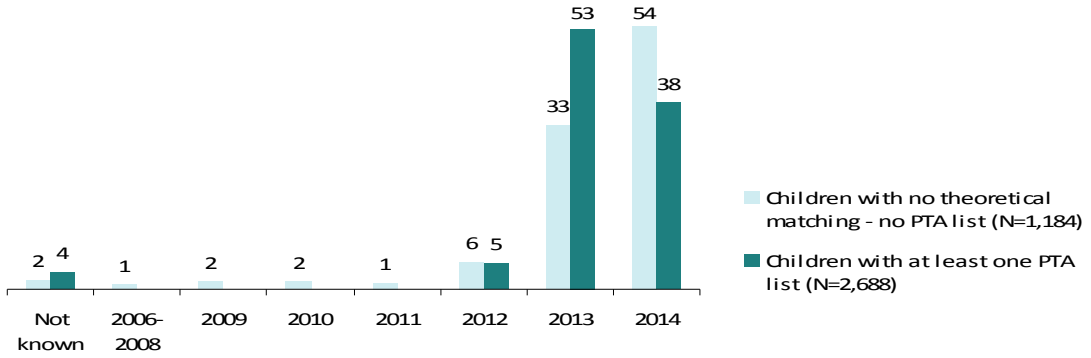
Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only counties with solid information in the CMTIS and with 10+ cases that had concluded stage II were considered. Data are weighted (N=3,916 children with a final DPA court ruling who had gone on to the next stages).

(III) Theoretical Matching (PTA)

The theoretical matching is a critical stage in the adoption process. As many as 82 percent of all children who had entered the adoption process reached this stage, but only 14 percent went on to the following stages (Figure 80, bottom graph). Consequently, in stage III (PTA) we found the largest number of adoptable children.

Of the almost 3,900 children who were in this stage at the time of the analysis, 31 percent had had no theoretical matching up to that point while 69 percent had at least begun the theoretical matching process. The 31 percent of children with no theoretical matching consisted of two sub-groups (Figure 84): the large majority had recently received their final DPA court ruling and were waiting for the adoption offices to start the theoretical matching procedure, while for a smaller group (around 6 percent), the theoretical matching had started but no list of adoptive families had yet been issued, even though the DPA court ruling had been final ever since 2006-2011. This smaller group of children, representing some 2 percent of all children in stage III (PTA), seemed to be stuck in this stage since they had been in stage III for an average of over five years.[417] This group consisted mainly of children with disabilities or children with developmental delays, with no adoptable siblings, who had entered the system before they were 1 year old, had started the adoption process when they were over 3 years old, and were between 7 and 14 years old at the time of the study. They were from Bihor and Prahova counties. This group would appear to have very little chance of going through the adoption process successfully.

Figure 84: Distribution of Children in Stage III (Theoretical Matching), by the Year When Their DPA Court Ruling Was Final and by the Existence of a PTA List (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

As mentioned above, the majority of the children in the theoretical matching stage at the time of the study (69 percent) had had at least one list of potential adoptive parents drawn up by the DGASPC. Table 41 shows that an average of four PTA lists was drawn up for these children, which is more than the number of lists prepared for the children who had continued on to the next stages of the adoption process. The differences were even greater in terms of the maximum number of PTA lists prepared, with a maximum of 14 having been prepared for children then in stage III versus seven lists for the children who had completed this stage. Of all children then in stage III (PTA) for whom the DGASPC had prepared at least one list of adoptive parents, 11 percent had had 8 to 14 lists prepared for them. This means that none of the adoptive parents on the previous list(s) were prepared to take them on. Accordingly, this is a second group with apparently very little chance of going through the adoption process successfully.

[417] The average time between the court's final DPA ruling and the time of the study was 60.5 months, with a standard deviation of 15.6 months. By comparison, for the other children waiting to start stage III (PTA), the average time was 10.3 months, with a standard deviation of 7.2 months.

The largest share of this latter group consisted of boys (69 percent) who had entered the system when they were over 1 year old, had spent more than three years in the system, had reached the point of adoption at the age of 6 or older, and were 7 to 17 years old at the time of the study. Almost all of them were children with no disabilities, from nuclear families, from urban areas, living in poverty and/or precarious housing conditions (52 percent) who had entered the system for reasons of child neglect. Some of these children were relinquished by their parents on the street or in other public spaces.

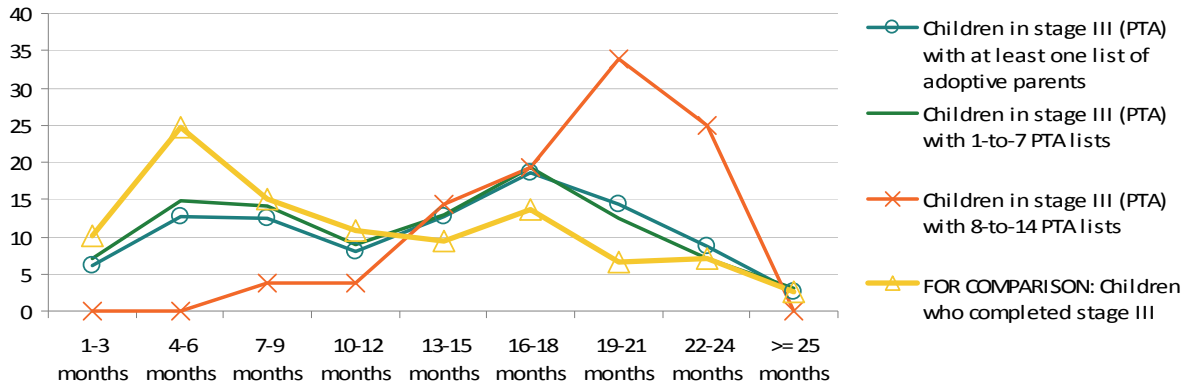
Table 41: Average Number of Theoretical Matching Lists for Children in Stage III (PTA) with at Least One PTA List versus Children Who Completed Stage III

	N	Average	Standard deviation	Minimum	Maximum
STAGE III - Theoretical matching	2,669	4.07	2.55	1	14
STAGE IV - Practical matching	329	3.11	1.88	1	7
STAGE V - Entrusting the child for adoption	151	1.20	0.40	1	2
STAGE VI – Court Approval/Revocation	272	1.94	1.66	1	7
Total	3,421	3.68	2.51	1	14

Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

Another indication that the group of children with 8-14 PTA lists is stuck in stage III is the average time that had passed between the final DPA court ruling and our research phase - an average of 18.5 months versus about 13 months for children with 1-7 lists of adoptive parents.[418] These differences are even more apparent in Figure 85 below.

Figure 85: Time Between DPA Court Ruling Becoming Final and November-December 2014: Children in Stage III (PTA) With At Least One PTA List versus Children Who Completed Stage III, by Number of PTA Lists Issued (% of Children)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=2,592 children with at least one PTA list, of whom 2,300 have 1-7 lists and N=787 children who went on to the next stages of the adoption process).

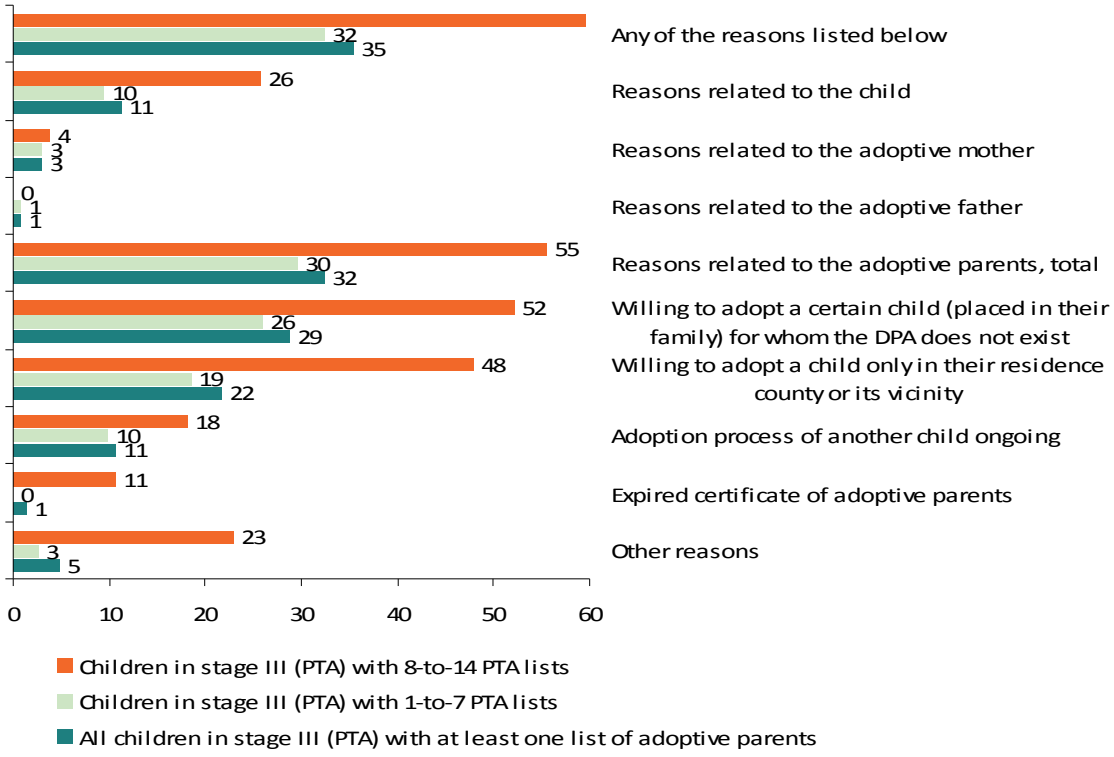
Other than the two groups with little chance of completing this stage, the children in stage III (PTA) at the time of the study tended to consist of (see Annex 6 Table 51): (i) children between 7 and 17 years old who began the adoption process later than other adoptable children; (ii) a slight over-representation of Roma children; (iii) children with one or both parents who had problems of excessive

[418] The standard deviations for the two average lengths of time were 3.9 months and 6.6 months.

alcohol consumption and/or disabilities and/or mental health problems;[419] (iv) a significant proportion of children from rural areas (with no higher a risk of poverty than the average) who received no preventive services or aid in the community before entering the system; (v) children with siblings in the system, of whom most had one to two adoptable siblings (45 percent versus 25 percent of the children who went on to the subsequent stages); and (vi) children with disabilities, including severe and marked disabilities (35 percent of children who were then in stage III and 49 percent of children with no theoretical matching versus 6 percent of all children who went on to the next stages), and/or with developmental delays (14 percent and 16 percent respectively versus 9 percent).

Considering that most children in this stage had at least one PTA list of potential adoptive parents, it was not clear what was preventing these children from moving onto the practical matching stage (stage IV). In this regard, too, it was possible to distinguish a group of children with a large number of lists (60 percent of children had 8 to 14 lists versus 32 percent who had 1 to 7 lists). The reasons given by prospective adoptive parents for not going ahead with a practical match, as shown in Figure 86, are basically even for both categories of children (those with eight toten PTA lists and those with one to seven lists), with one exception, child-related reasons are provided for 26 percent of children with 8 to 14 PTA lists versus only 10 percent of those with 1 to 7 lists. In most cases, the main reason given by adoptive parents was the child's older age (23 percent). Reasons that were rarely mentioned were the child's ethnicity (fewer than 10 percent) or gender (male) as well as the child's "physical features" and his or her "behavioral problems."[420] In very few cases (3 percent), the adoptive parents' reasons for not agreeing to the practical match included the child's medical history (disabilities) or the requirement to adopt a group of siblings.

Figure 86: Reasons Given by the Adoptive Parents on the PTA Lists Why the Practical Matching Could Not Be Initiated, by Number of PTA Lists Issued (1-7 vs. 8-14 Lists) (% of Children)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=2,687 children with at least one PTA list, of whom 2,395 with 1-7 lists).

[419] Children with parents with disabilities and/or mental health problems accounted for 31 percent of children with no theoretical matching versus 21 percent of all children in stage III and 18 percent of children who went on to the next stages.

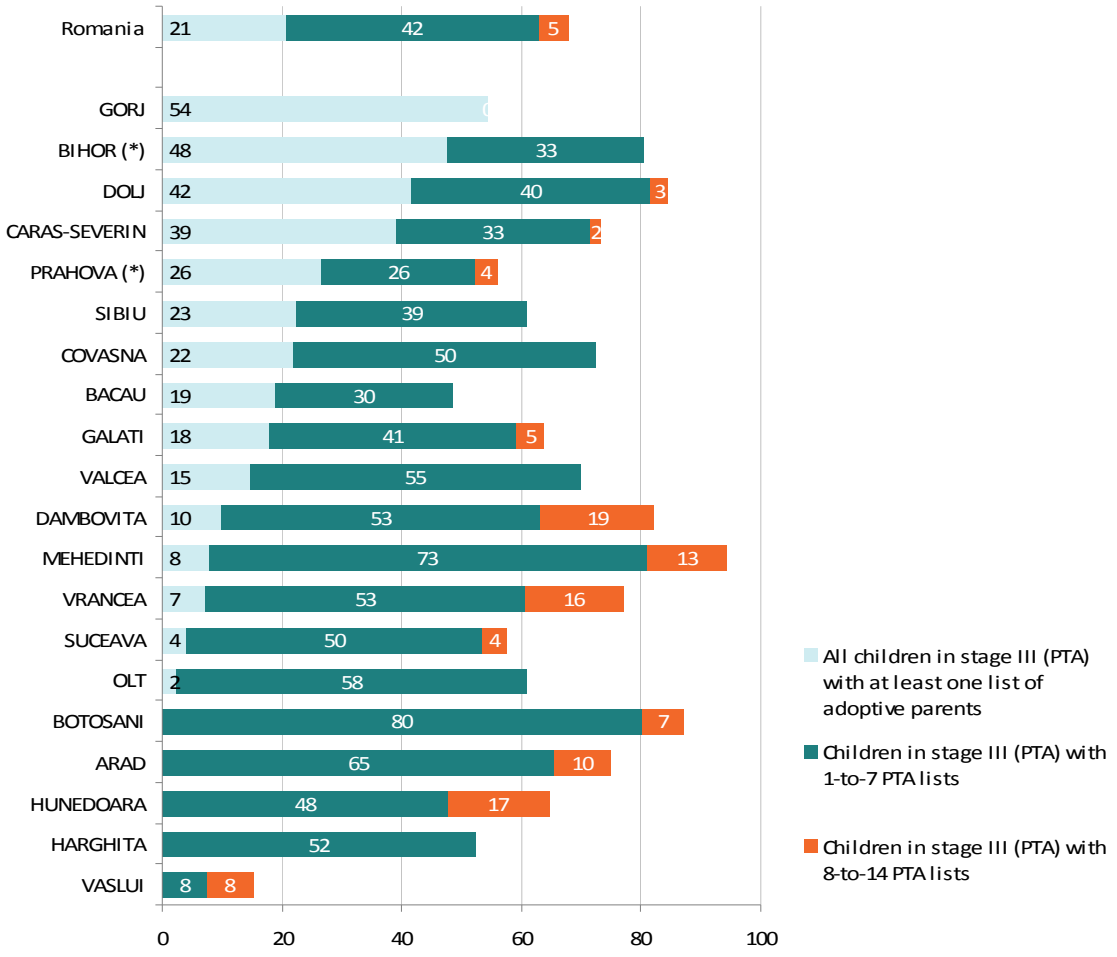
[420] Quotes from the answers to the open question in the questionnaire.

However, for all children who could not go on to the practical matching stage, the reasons were mostly related to their potential adoptive parents. The fact that, in most cases, the adoptive parents wanted to adopt the child who had already been placed with them draws attention once more to the need for an analysis of how placement with other families or individuals influences the adoption process.

These data are consistent with the findings of a study by UNICEF and ORA[421] showing that 72 percent of adoptive families want children under 3 years old and 81 percent of them want children with no medical issues. Also, the study concluded that children who have siblings in the system are harder to adopt. It found that 94 percent of families adopt only one child, and in 40 percent of cases, families prefer a particular child with whom they have had previous contact, usually a child whom they have already fostered.

At the county level, the highest numbers of children in stage III (PTA) at the time of the study were in Dolj, Caraș-Severin and Galați (Figure 80, top graph). However, when we compared children in stage III to all children who had entered the adoption process, we noticed several counties registered rates higher than the national average, with the highest being in Mehedinți and Botoșani (Figure 87). In order to guide potential interventions, it is useful to know that there were also very high percentages of children at serious risk of not completing this stage of the adoption process in Dâmbovița, Hunedoara, Vrancea, Mehedinți, Arad and Bihor.

Figure 87: Children in Stage III (PTA) as a Share of All Children in the Adoption Process, by Number of PTA Lists at the County Level (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only the counties with solid data in the CMTIS and with 20+ cases in stage III were considered. Data are weighted (N=3,761 children).

Note: (*) Also include children with no PTA list who seemed to be stuck in this stage for more than five years.

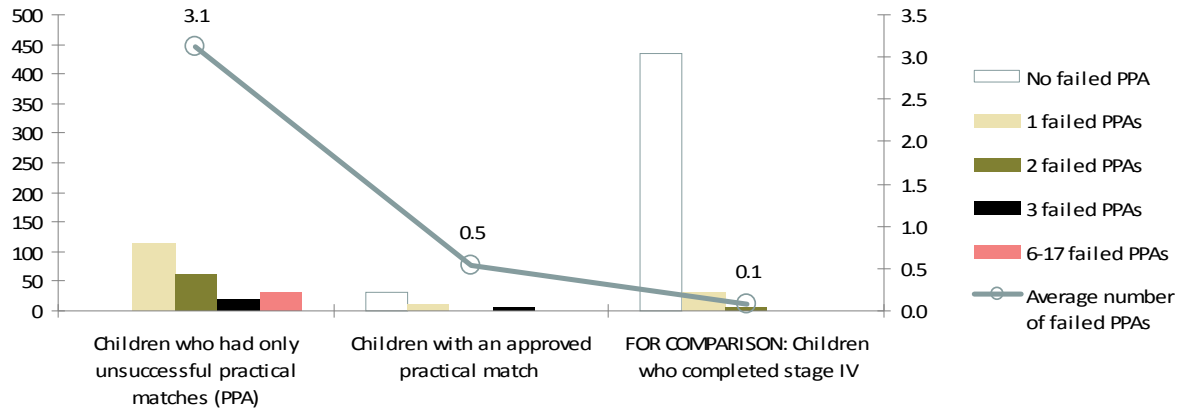
[421] Buzducea and Lazăr (2011).

In conclusion, after an average period of 3.7 months until a final DPA court ruling was obtained, children tended to get stuck in stage III (PTA), particularly if there was a large number of children who started the process at the same time, as was the case with the 2012-2014 wave of children in the adoption process that we analyzed in this study. The high percentage of children in stage III at the time of our study was to be expected given that the wave of children intended for adoption was not accompanied by an increase in the number of prospective adoptive parents. Also, given that a significant number [422] of adoptive parents want to adopt a particular child, namely the child whom they already had in foster care, then the actual number of available adoptive parents is even lower. Therefore, it will not be possible to streamline the process and move more children out of stage III unless measures to increase the number of adoptive parents in Romania and, if possible, abroad are taken. Measures are also required to unblock the process for the two sub-groups identified in this study - children with too few or no PTA lists for too long a time and children with too many PTA lists but no successful outcome - without which these children are likely to spend years in the adoption process, without ever finding a permanent solution for their future.

(IV) Practical Matching (PPA)

About 800 children (14 percent of all children who had entered the adoption process) had reached stage IV, the practical matching stage (PPA). A practical match was approved for 8 percent of these children who then passed on to the subsequent stages, while around 6 percent remained in stage IV at the time of the study (Figure 80). As shown in Figure 81, all of the children in stage IV (PPA) had entered the adoption process between 2012 and 2014.

Figure 88: Number of Failed Practical Matches for Children in Stage IV (PPA) versus Children Who Completed Stage IV (Number of Children)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=267 children of whom 48 have an approved PPA, and N=469 children who completed stage IV).

The children who were in stage IV (PPA) fell into two distinct groups according to the number and outcome of their practical matches. Fourteen percent had an approved practical match so had qualified to pass on to stage V (IVA), but most (67 percent) had only had unsuccessful matches.[423] Figure 88 shows that the children who had only unsuccessful matches can be subdivided into those with one to two failed PPAs (51 percent of the children then in stage IV) and children with 3 to 17 failed PPAs (16 percent). While the first group's number of failed PPAs was similar to that of the children who had completed this stage, the second group was at risk of getting stuck longer at this

[422] Forty percent according to Buzducea and Lazăr (2011).

[423] For 19 percent of the children in stage IV (PPA), the adoption forms did not contain information on the number of practical matches undertaken so far.

stage, especially those who had more than six failed PPAs. All children who had a successful practical match had a maximum of three failed PPAs.

Because of their prevalence, the children who only had failed practical matches determined the specific characteristics of the group of children who were in this stage at the time of the study (Annex 6 Table 51). They were mostly boys (64 percent versus 37 percent of boys who completed this stage), children who had entered the protection system before the age of 1 after having been relinquished in maternity wards, those whose adoption procedure began when they were 1 to 2 years old and who were 3 to 6 years old at the time of the study. The share of children from risk groups (such as children with disabilities) was extremely low. Children from source communities are over-represented in this group (23 percent versus an average of 12 percent) as are those from nuclear families (28 percent versus an average of 10 percent). Ninety-six percent of the children in this group were placed with foster carers compared to 64 percent of those who had received a practical match.

It is noteworthy that the only significant difference between children with one to two failed PPAs and those with 3 to 17 failed PPAs was the children's ethnicity. The share of ethnic Romanian children prevailed among the children who completed the practical matching stage (above the average of the sample) while children with unknown or undeclared ethnicity prevailed among children with 3 to 17 failed PPAs (Table 42).

Table 42: Distribution of Children by Ethnicity: Children in Stage IV (PPA) with Failed PPAs Only (1-2 vs. 3-17) versus Children Who Completed Stage IV (%)

	RO	HU	Roma	Undeclared	Total - %	Total -N
Children with 3 to 17 failed PPAs	21	9	9	61	100	53
Children with 1 to 2 failed PPAs	57	9	9	26	100	175
FOR COMPARISON: Children who went on to the next stages	59	1	10	30	100	469
Total	46	1	11	42	100	5,699

Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

The reasons for the failed PPAs that were expressed by potential adoptive parents and recorded in the children's case files complemented and reinforced this finding (Figure 89). For the children with one to two failed PPAs, the reasons were related to the adoptive parents in almost all cases. Reasons related to the child were mentioned in 55 percent of the cases, most commonly in reference to the child's medical history. For 91 percent of the children with 3 to 17 failed PPAs, the reasons given were related to the child, while in only 40 percent of the cases the reasons given were related to the adoptive parents. In the case of these children, the main child-related reason that was stated was the child's ethnicity (in 60 percent of cases), followed by the child's "unknown origin."

These results confirm the views expressed by DGASPC experts during our interviews, in that the adoption process in Romania is strongly influenced by the sometimes unrealistic expectations that prospective parents have concerning the children they wish to adopt. They do not want just any child but the "perfect" "Romanian" child who is "blonde with blue eyes," a "hale and hearty" child with an "IQ of 147." Therefore, Roma children and children with disabilities are least likely to be adopted. Also, the chances of a child being adopted lower increasingly as the child gets older. Prospective parents want children who can be "shaped," and that window of opportunity, according to experts, closes around the age of 5. The quotes of Story Bag 9 are illustrative in this respect.

> "*Relying on your work experience so far, how much does the ethnicity of a child in child protection matter, I mean, first of all, the ease with which he or she enters the system and the ease with which he or she then exits the system*?
>
> - In adoptions it is taken into account…

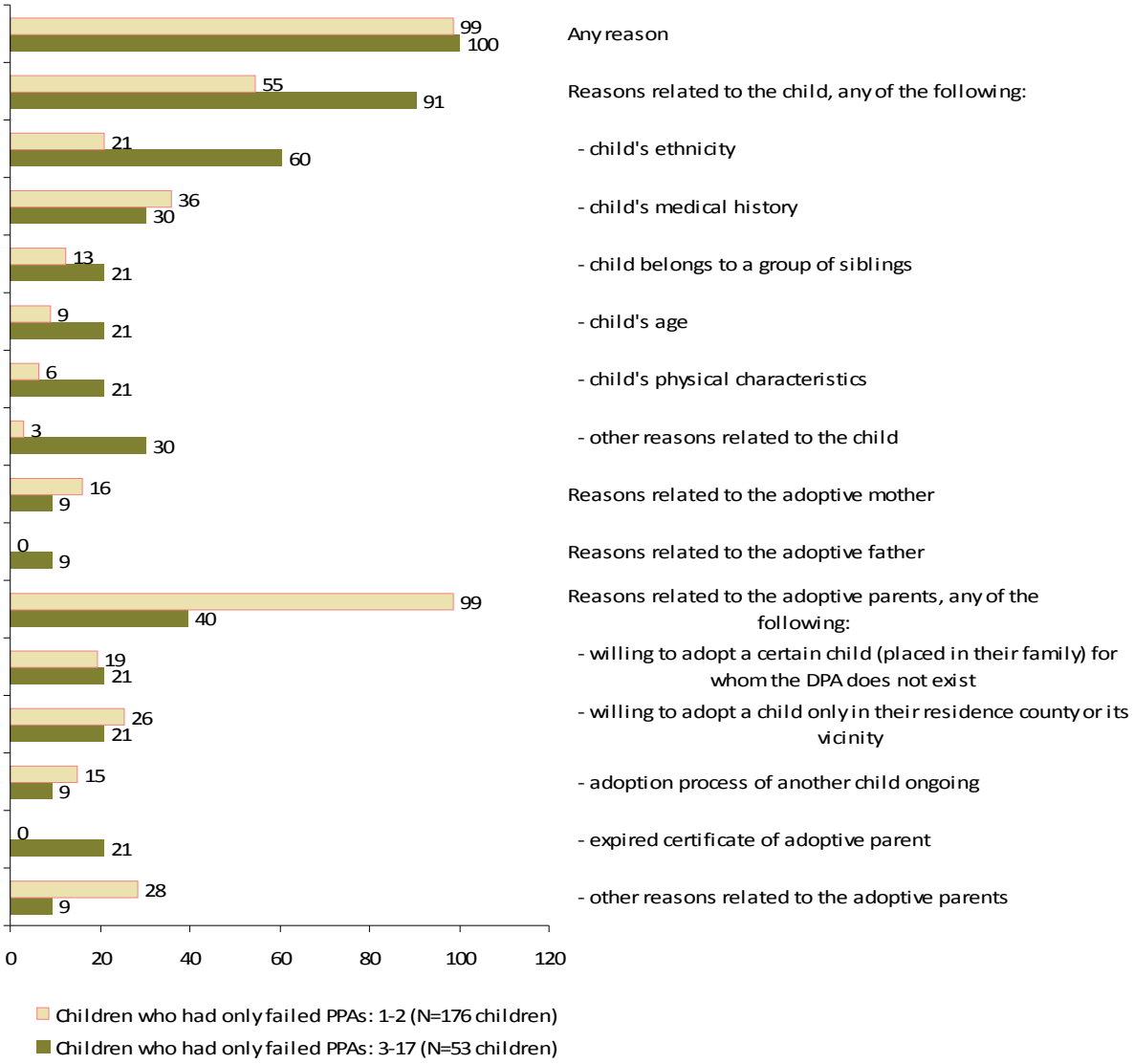
- In adoptions, yes, because everyone wants children who are blonde with blue eyes and an IQ of 147.

So, for adoption, it matters. And other than that…?

-Otherwise no." (Focus group with specialists, Brașov)

"If we talk about adoption, we've found in recent years that most families who want to adopt a child do not adopt children who have passed a certain age, those over the age of 5. Very few people expressed a desire to adopt a child of an older age. Most of them want very young children, and we try to split our efforts somehow [between these two situations]. Ok, what are the chances of adoption for child X. Although it is not fair, but having a very large number of cases, you think which is the most likely child to go, whose adoption is most likely to work. I told you, this is not a fair approach, but neither can I open an adoption procedure for a young man of 14 because I would stand no chance [to make it work]." (Interview with a professional, Bacău)

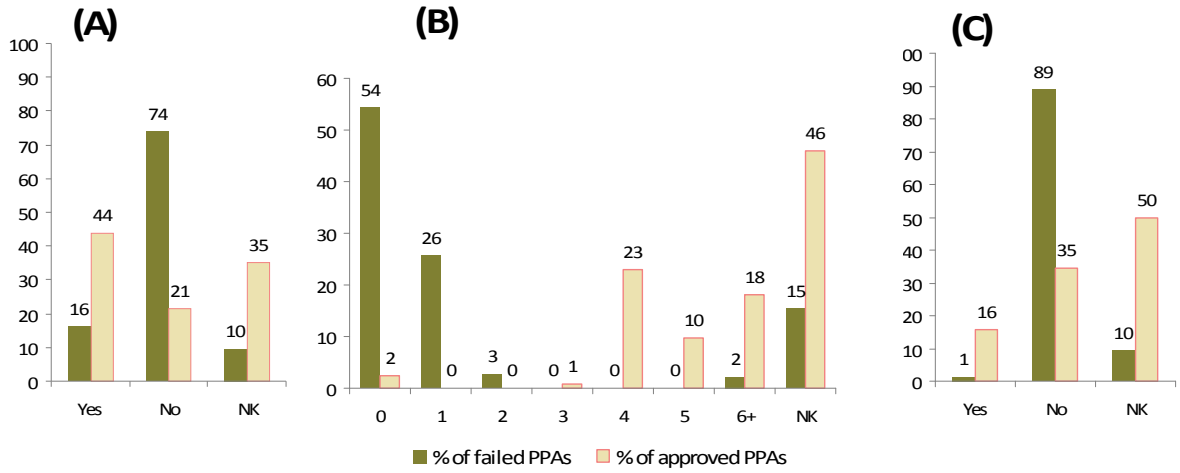
Figure 89: Reasons Given by Adoptive Parents for the Failed Practical Matching, by Number of Failed PPAs (1-2 vs. 3-17) (% of Children)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

The chance of a child receiving an approved practical match increases when the adoptive individual or family lives in the county where the child is under protection (Figure 90). In 74 percent of the failed practical matches, the individuals or families were not resident in the district or county where the child was protected, compared to only 21 percent of those involved in approved practical matches.

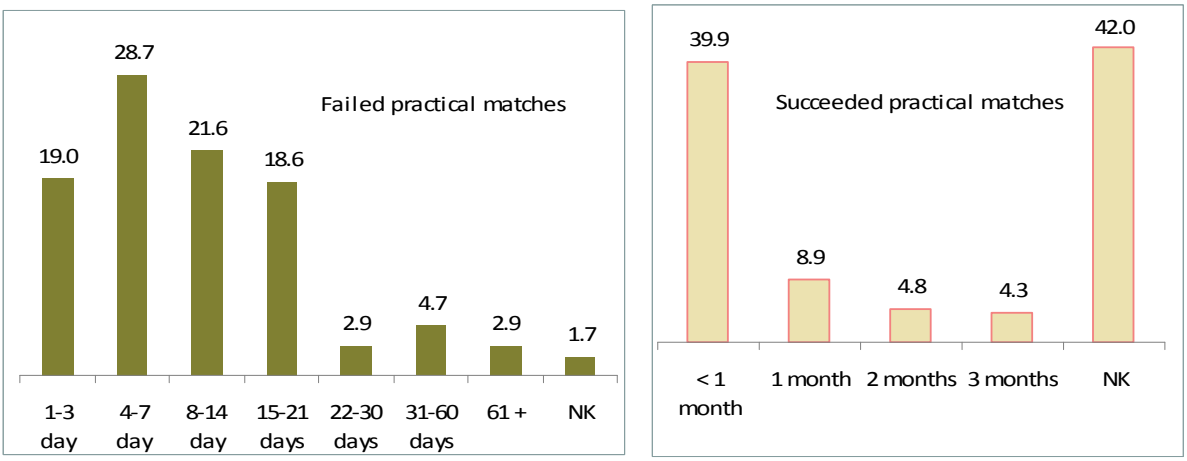
Figure 90: (A) Do the Individuals/Families for whom the PPA Failed/Succeeded Live in the County where the Child is Protected? (B) How Many Meetings/Visits Did the Child Have with the Individuals/Families for whom the PPA Failed or Succeeded? (C) Did the Child Visit the Family?



Source: Survey of Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=782 failed practical matches, and N=518 approved practical matches). NK - Not known.

In 54 percent of the failed practical matches, there was no visit or meeting between the child and the family or individual with whom that match was made, whereas in 51 percent of the approved practical matches, four or more visits or meetings took place (the law requires that a minimum of four meetings must take place between the child and the prospective adoptive parents). The child had permission to visit the family in only 1 percent of the failed practical matches and in 16 percent of the approved practical matches.

Figure 91: Average Duration of Failed Practical Matches (in Days) and of Approved Practical Matches (in Months)



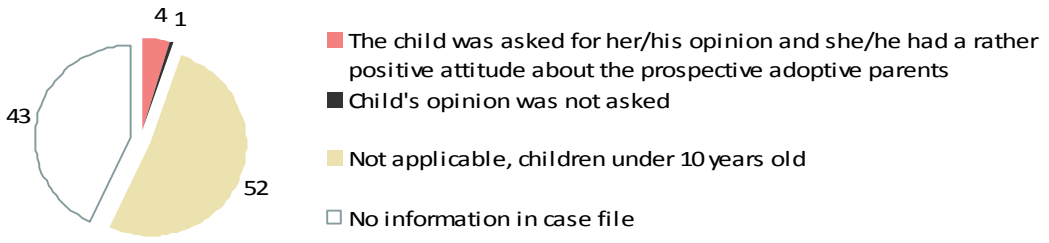
Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=782 failed practical matches; N=518 approved practical matches).

Note: Months were counted between the beginning of the approved practical matching process and the conclusion of the practical matching final report. NK = Not known.

- The average duration from the initiation of the adoption process (the submission of the file to the adoption office) to the beginning of the first practical match (whether failed or approved) was 9.6 months.[424] The minimum period was 3 months and the maximum was 37 months.
- The average duration of a failed practical match was approximately 11 days. However, there is a considerable variation from one failed PPA to another. The longest ones seem to be the first two PPAs, which may take up to nearly five months. As of the third failed PPA, the average durations gradually decrease.
- The average time period between the submission of the file to the adoption office and the beginning of an approved practical match was 10 months.[425] The minimum period was 3 months and the maximum was 37 months.
- The time between the beginning of the approved practical matching process and the conclusion of the practical matching final report ranges from 0 days (when the match was achieved the same day) to 3 months. The average time length is 0.5 months. For most children (40 percent), this process lasted less than a month.

Asking the child for their opinion of the prospective adoptive person or family was found to be an uncommon practice.

Figure 92: Statements Reflecting the Child's Views of the Adoptive Person/Family for Whom the Practical Match was Approved



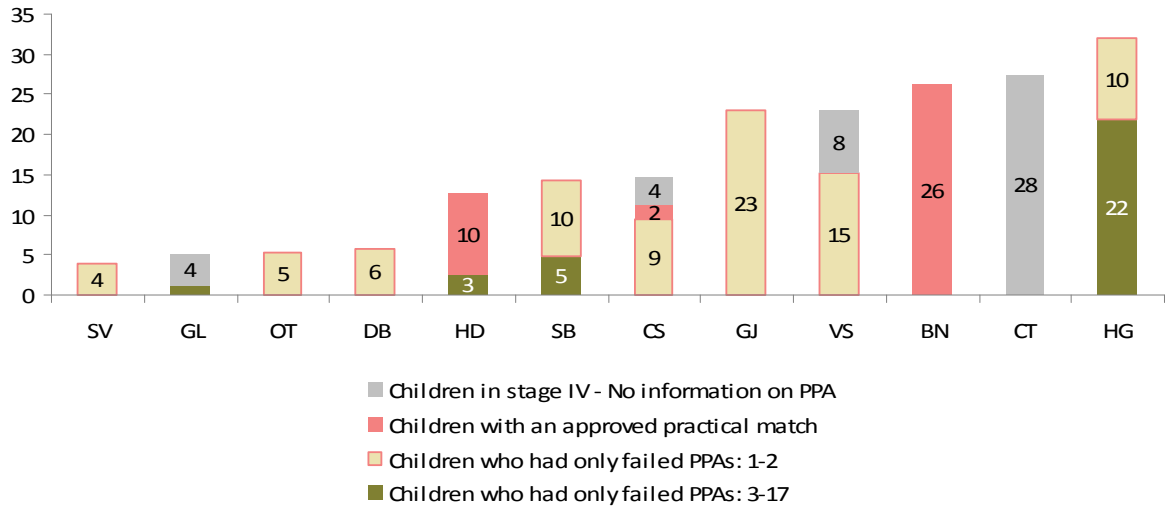
Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=518 approved practical matches).

At the county level, the highest number of children in stage IV (PPA) at the time of the study were in Caraș-Severin and Harghita (Figure 80, top graph). A comparison between children in stage IV and all children who had entered the adoption process showed that several counties registered rates higher than the national average (which is 6 percent), with a maximum of five times higher than the average in Harghita county (32 percent). Moreover, Figure 93 shows that inter-county differences extend to the children's profiles as well. Thus, there were many children in Harghita in the practical matching stage, many of them already having had a large number of failed PPAs. In contrast, Constanța did not provided any data on adoption (because it did not fill in the adoption forms), Bistrița-Năsăud only had a small number of children in this stage but all had approved PPAs, while in Gorj all children had only failed PPAs though these were few (one to two PPAs).

[424] Standard deviation of 5.8 months (N=545). Twenty-seven percent of cases were not included because either the date of the submission of the file or the starting date of the practical matching was not recorded.

[425] Standard deviation of 7 months (N=321). For 38 percent of the cases, the duration could not be calculated because either the date of the submission of the file or the starting date of the approved practical matching was not recorded.

Figure 93: Children in Stage IV (PPA) as a Share of All Children in the Adoption Process, by Type of PPA and Number of Failed PPAs at County Level (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only counties with solid data in the CMTIS and 10+ cases in stage IV were considered. Data are weighted (N=338).

The conclusion of the previous section remains valid, namely that it is vital to increase the number of available adoptive parents in order to increase the chances that practical matches will succeed. Also, it is necessary to increase the effectiveness of the courses attended by those individuals and families who want to adopt a child. In parallel, education and communication campaigns at the community level should focus on raising awareness of adoption and adopted children and changing negative attitudes that reject and undervalue children, regardless of their gender, age, ethnicity, health status or parents.

(V) Entrusting the Child for Adoption (IVA)

Of all children who started the adoption process, 469 children reached this stage (8 percent). Of these, about 1 percent did not have to complete this stage because they had been in foster care for more than two years with the person or family who wanted to adopt them. Therefore, they went directly from PPA to court approval of the adoption. Over 4 percent of all children in the adoption process completed stage V (IVA) and went on to the next stage. Therefore, at the time of the study about 3 percent of the children in the adoption process were in stage V (IVA) (Figure 80).

Children who were very young when they entered the adoption process have a higher than average probability of getting to stage V (IVA) having gone through the previous stages when they were less than 3 years old (Annex 6 Table 51). At the time of the study, the following groups were over-represented in stage V: (i) girls (60 percent); (ii) Romanian children; (iii) those with no siblings; (iv) those from urban areas and not from source communities; and (v) those from a single-mother family (78 percent) who had completed at least secondary school and/or those of teenage mothers. There were some babies born prematurely and/or underweight in stage V, but there were no children from any other group of children with special needs. The main reasons why they entered the system were relinquishment (85 percent) or neglect (12 percent). Twenty-two percent of them (compared to an average of 6 percent) were placed with other families or individuals, and 90 percent of them (compared to an average of 62 percent) had never had any connection with their biological family. Therefore, the children who had reached stage V (IVA) largely corresponded to the "ideal" profile of an adoptable child as described by the potential adoptive parents.

For these children, approximately 9.5 months passed between the submission of the child's file to the adoption office (stage I) and the submission of the IVA request to the court (stage V). It took an average of eight days between the preparation of the practical matching report (stage IV) and the submission of the IVA request to the court (in accordance with the legislation, this is only supposed to take five days).

In stage V (IVA), it took an average of three months between the submission of the IVA request to the court and the court ruling becoming final.

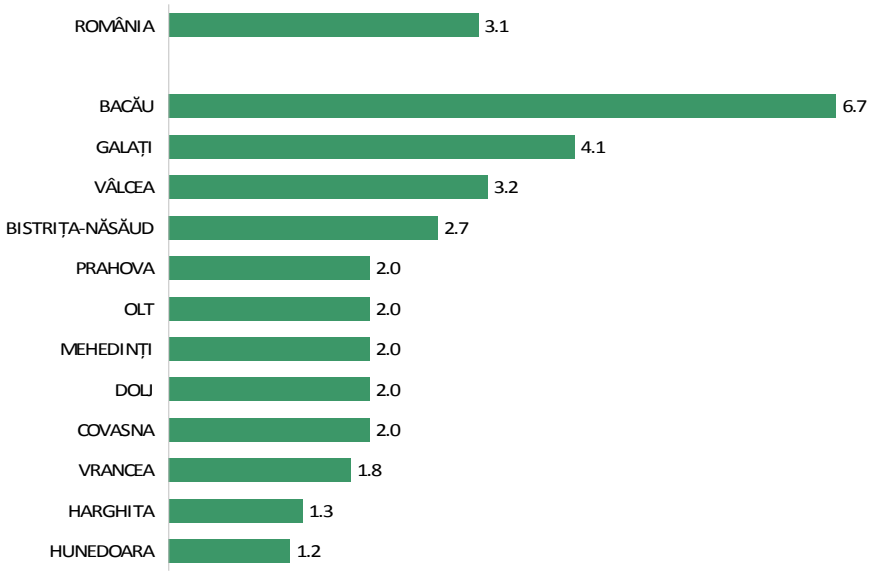
Table 43: Average Duration of the Sub-stages of the Adoption Process until Stage V (IVA)

Sub-stages:	Between delivery of the file to the adoption office and submission of the IVA request to the court		Between conclusion of the practical matching final report and submission of IVA request to the court		Between submission of the IVA request to the court and IVA court ruling becoming final	
	days	months	days	months	days	months
Average	305.9	9.5	8.2	0.1	106.4	3.1
Standard deviation	167.4	5.5	13.6	0.46	84	2.9
Minimum	110	3	1	0	13	0
Maximum	1144	37	62	2	477	15
N	323	323	231	231	253	253

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

As with stage II (DPA), the duration of stage V (IVA) reflects the cooperation between the DGASPCs and the county courts. Only in two counties did stage V (IVA) take longer than the national average - Bacău and Galați - and these same counties also took longer to get children through stage II (DPA).

Figure 94: Average Duration of Stage V (IVA), by County (in Months)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only counties with solid data in the CMTIS and 10+ cases in stage V were considered. Data are weighted (N=253 children in stage V or who completed stage V).

There were few children in stage V (IVA) nationwide. These were distributed among the counties, with most cases being in Hunedoara and Olt (Figure 80, top graph).

(VI) Court Approval/Revocation of Adoption

Of the total sample, 307 children (5.4 percent of all adoptable children) reached the last stage of the process (Figure 80, bottom graph). For 87 percent of them, the IVA court ruling was an approval, while for 13 percent, a revocation.

The small number of children with a revocation court ruling (39 children) allowed for a descriptive analysis only. For 11 of the 39 children, the court revoked the IVA 56 days after the child had moved in with the adoptive family and, for 17 children, 165 days after. For the remaining 11 children, the adoption forms contained no information on the date when the child moved in with the adoptive family. The reasons for revocation according to the adoptive person or family included the ethnicity of the child, the fact that the child's birth had not been attended by healthcare professionals, and the person's or family's personal wish to give up the adoption.

In all 39 cases, the PIP goal remained a domestic adoption, and for 22 of the children the theoretical matching procedure was resumed.

On average, children reached the approval stage 13.5 months after the initiation of the adoption process and 40 days after the IVA court ruling became final. The approval stage took an average of 2.2 months, including 40 days until the delivery of the court's ruling, 30 days for the court ruling to be communicated to the DGASPC, and 30 days until the ruling became final.

Table 44: Duration between Different Sub-stages of the Adoption Process and the Approval

		N	Minimum	Maximum	Mean	Standard deviation
Between initiation of the adoption process and submission of the request for approval	days	146	210	694	426.1	142.6
	months	146	6	22	13.5	4.6
Between IVA court ruling becoming final and submission of request for approval	days	94	1	91	41.3	24.8
	months	94	0	2	0.8	0.7
Between submission of the request for approval and court ruling	days	129	6	111	39.2	31.6
	months	129	0	3	0.7	1
Between court ruling on the approval and communication of ruling to the DGASPC	days	107	5	70	30.1	22.7
	months	107	0	2	0.6	0.8
Between communication of ruling to the DGASPC and ruling becoming final	days	46	7	53	28.7	18
	months	46	0	1	0.6	0.5
Between submission of the request for approval and the ruling becoming final	days	46	59	121	87.7	21.1
	months	46	1	3	2.2	0.5

Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted.

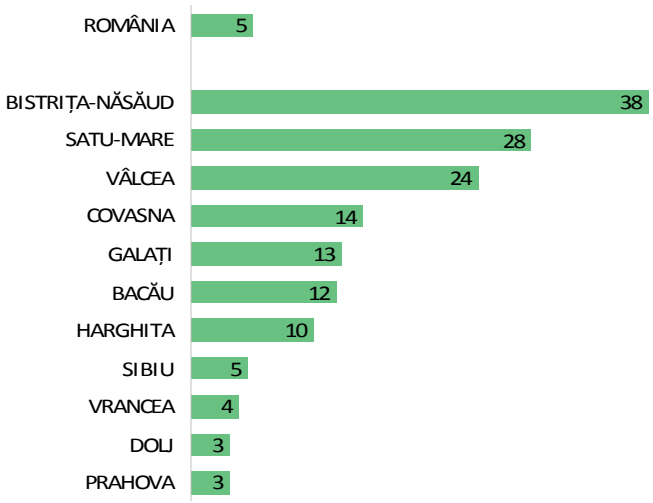
The adoption process took longer for certain groups of children including children older than 3, those with siblings in the system and/or who were adoptable, children with disabilities, those with developmental delays, premature and/or underweight babies, those whose mothers were teenagers when the child entered the system, those with parents abroad, and children with parents with disabilities and/or mental health problems.

Most children who reached the last stage of the adoption process and received the court's approval for adoption (Annex 6 Table 51) had the following characteristics: they were girls, had no siblings in the system or who were adoptable, had only one theoretical match[426] and no failed practical match,[427] entered public care at early ages (38 percent were 0 to 2 years old versus the average of 20 percent), and had no disabilities and/or developmental delays. More than one-third of them had had placements with relatives or other individuals or families.

[426] Of the children who had reached this final stage of the adoption process, 63 percent had only one theoretical match, while of the entire sample of children who had reached the theoretical matching stage, only 17 percent had only one theoretical match.

[427] Of the children who reached the last stage, 94 percent had no failed practical match. For the whole sample, 35 percent of the children had at least one failed practical match.

Figure 95: Children in Stage VI as a Share of All Children in the Adoption Process, by County (%)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Only counties with solid data in the CMTIS and 10+ cases in stage VI at the time of the study were considered. Data are weighted (N=262 children).

At the county level, the counties with the highest number of children in stage VI were Galați and Bacău (Figure 80, top graph). The national average rate is 5 percent of all children in the adoption process, while rates five to six times higher were recorded in Bistrița-Năsăud, Satu-Mare, and Vâlcea.

We were unable to analyze the children's natural parents' motions for a review of the IVA/Approval court ruling because there were very few of these requests.

Overview of the Adoption Process in Romania

Our analysis of the adoption process by stages highlighted the main bottlenecks in the process and identified the children with lower than average chances of overcoming them. Four such bottlenecks were identified:

(1) In stage II (DPA), there were children who had entered the adoption process as early as 2005-2011 and in November-December 2014 were still waiting for the opening of the adoption procedure.

(2) In stage III (PTA), there were children with no PTA list although their DPA court ruling had become final as early as 2006-2011 (in other words, they had had too few PTA lists for too long).

(3) In stage III (PTA), there were children who had had too many lists of adoptive parents (8 to 14 lists) that had not led to any practical matches. Benchmarking them against the children who had completed stage III showed that, after three PTA lists, the chances of reaching the practical matching stage significantly decreased while after seven lists they came close to zero.

(4) In stage IV (PPA), there were children with 3 to 17 failed practical matches. According to our analysis of the progression of children through the higher stages, after a third failed PPA the chances of being adopted decrease considerably.

However, the main limitation of the analysis remains the absence of a counterfactual consisting of national and international finalized adoption cases.[428] As a solution, we built a "moving" pseudo-counterfactual by comparing each stage with the following stages to determine the chances of children becoming stuck or successfully adopted. This methodological choice yielded results but did not allow for a refined observation of certain small groups and/or groups with very specific

[428] Because of the legislation restricting international adoptions, it was not possible to build a counterfactual for international adoptions (see section 3.4.2.1).

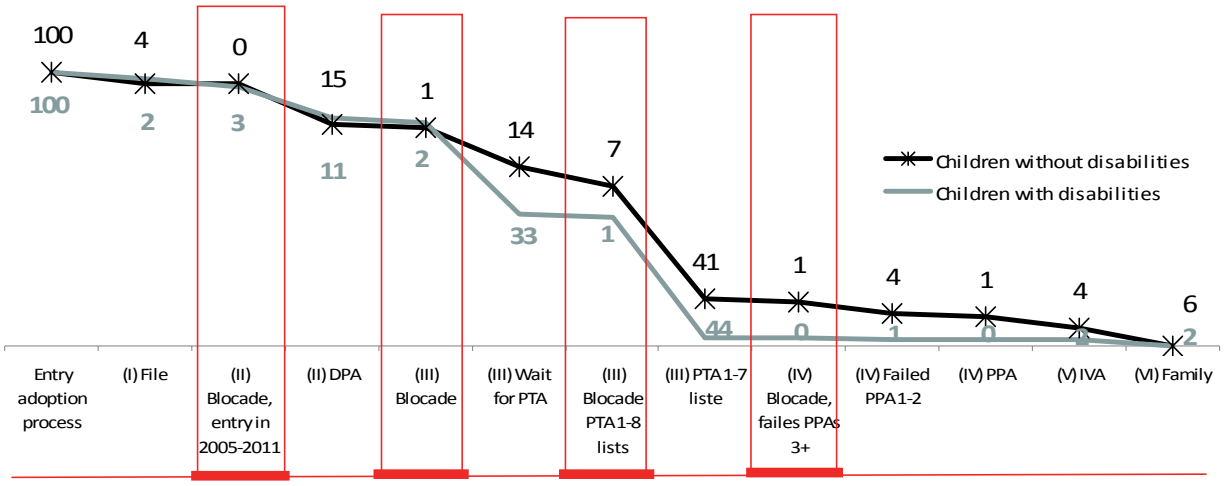
characteristics because usually these are distributed among stages in an erratic or distorted manner. Consider for example the situation of children with disabilities who "artificially" entered or were "forced" to enter the adoption process in the opinion of the DGASPC specialists who were interviewed in the qualitative study.

> "For example, where the reintegration of children is not... for children with severe disabilities who require specialized medical care, permanent medical assistance, who are in specialized centers for children with disabilities in our country. They are vegetables,* for example. Family reintegration is not possible even if the parents would like that, say, hypothetically, you cannot leave them there because they don't have the necessary medical services. You make efforts, because that's how it is, once reintegration fails, you should make the necessary arrangements to quickly open the adoption procedure. You go through the steps, identify relatives up to the fourth degree, using the census, identify them, take interviews, evaluate their living conditions, and open the internal adoption procedure. No one adopts them. Social-professional integration, it's not even an issue. Socio-professional integration is for children over 16. Automatically even if they reach 16, you cannot socio-professionally integrate them. You can't fit the profile. You draw a PIP with an adoption goal, you set out to achieve that goal, but you can't do it." (Interview with a professional, Craiova)

Note: *We believe that such attitudes and stereotypes need to be addressed and actively discouraged.

To better understand the experience of the children with disabilities who entered the adoption process, Figure 96 illustrates the entire process from entry to the court approval or revocation stage (last stage of the process), highlighting potential bottlenecks. To read the results correctly, it is useful to recall that the group of children with disabilities (at the time of their entry into the system and/or at the time of the study) represented 29 percent of all children in the adoption process[429] and entered the process earlier[430] within the wave of children selected for adoption in 2012 to 2014.

Figure 96: From Public Care to Adoption for Children with Disabilities vs. Children without Disabilities (% of Children)



Source: Survey of the Case Files of Children in Public Care: Adoption Forms (November-December 2014). Data are weighted (N=5,130 children).

Notes: The curves in the graph represent the cumulative share of children who had passed that stage out of all children in the adoption process. The numbers in the graph show the percentage of children who were in that stage at the time of the study. Not included were children whose disability status was not known and those whose stage in the process was not known.

[429] Children without disabilities represented 62 percent, while for 9 percent of children, there were no data in their case files.

[430] The distribution of children with disabilities by the year of their entry into the adoption process was as follows: 3 percent entered in 2005-2011, 24 percent in 2012, 51 percent in 2013, 21 percent in 2014, and 1 percent was not known. The corresponding rates for children without disabilities were: 2 percent (2005-2011), 15 percent (2012), 47 percent (2013), 34 percent (2014), and 2 percent (not known).

In total, there are fewer children with disabilities than children without disabilities (6 percent versus 9 percent) within the bottleneck areas (the red quadrants of the figure). Statistically, the difference is significant and leads to the conclusion that children with disabilities have a lower probability of stalling in the adoption process than other children.

Children without disabilities go through the early stages, which are predominantly administrative, at a faster pace and have a 7 percent likelihood of getting stuck in the theoretical matching stage (stage III) when the child's characteristics are weighed against the expectations of the adoptive parents (as they are described in the various studies conducted and as the study results are interpreted by the decision-makers involved in the matching process). Children without disabilities may also get stuck in the practical matching stage (stage IV) where potential adoptive parents play a very important role.

In contrast, children with disabilities go through the early stages very slowly. After they are declared adoptable, they then wait, sometimes for years (3 percent), for their case managers to submit the DPA request to the court. For children with disabilities with an open DPA request, the total time between the submission of the request to the court and the court ruling becoming final was shorter than for children without disabilities (average of 116 days or 3.3 months versus 135 days or four months).[431]

Next, once the DPA court ruling becomes final, the chances of children with disabilities getting stuck or having to wait longer for the issuance of a PTA list are considerably higher. In addition to the 2 percent of the children with disabilities who were stuck, one-third of children with disabilities received no theoretical match (a share over two times higher than for children without disabilities) even though they entered the process earlier than non-disabled children. The most likely explanation for this is that the theoretical matching process did not find any adoptive parents who were capable of "turning a blind eye" to the child's health status.

After this stage, there were very few children with disabilities. However, two facts can be observed. First, children with disabilities represented only 11 percent of children in stage VI. In other words, at the end of the process, the share of children with disabilities as a percentage of all children was almost three times lower than at the beginning of the process (11 percent versus 29 percent). Second, more than two-thirds of the children with disabilities who had reached stage VI had been placed with relatives or other individuals or families (67 percent versus 35 percent of non-disabled children).

Therefore, the chances of children with disabilities being adopted are lower than those for children with no disabilities. Their chances could be increased by reconsidering the theoretical and the practical matching procedures but also by better training DGASPC specialists on how to communicate with potential adoptive parents about the circumstances of children with disabilities, especially as some of them have only minor or moderate disabilities.

[431] The standard deviations are 75 days for children with disabilities and 92 days for those without disabilities, indicating a more homogeneous treatment of children with disabilities by the courts.

CONCLUSIONS AND RECOMMENDATIONS

In our analysis, we looked at the status at the time of the study (November-December 2014) of the wave of children in the protection system who had been declared adoptable between 2012 and 2014.

These children entered the adoption process with a range of very different characteristics, but those who had significantly higher chances of completing the process were: young children, especially those between 0 and 2 years old, girls, children with no siblings in the system, and children without disabilities and/or developmental delays. More than one-third of them came from placements with relatives or other individuals or families.

For the children with the above features who were in the final stage, the adoption process had lasted, on average, 15 to 16 months.

There are four main sources of bottlenecks in the process:

(1) In stage II (DPA), there were children who had been entered the adoption process as early as 2005-2011 and in November-December 2014 were still waiting for the opening of the adoption procedure.

(2) In stage III (PTA), there were children with no PTA list although their DPA court ruling had become final as early as 2006-2011 (in other words, they had had too few PTA lists for too long).

(3) In stage III (PTA), there were children who had had too many lists of adoptive parents (8 to 14 lists) that had not led to any practical matches. Benchmarking them against the children who had completed stage III showed that, after three PTA lists, the chances of reaching the practical matching stage significantly decreased while after seven lists they came close to zero.

(4) In stage IV (PPA), there were children with 3 to 17 failed practical matches. According to our analysis of the progression of children through the higher stages, after a third failed PPA the chances of being adopted decrease considerably.

Increasing the number of available adoptive parents is vital to increase the numbers of successful theoretical matches and accepted practical matches. As of the beginning of the adoption process, after the average of 3.7 months required to receive a final DPA court ruling, children tend to get stuck in stage III (PTA), especially if many children begin the process at the same time. The high percentage of children in stage III at the time of our study was to be expected given that the wave of children intended for adoption registered no response from the prospective adoptive parents. Also, given that a significant number[432] of adoptive parents want to adopt a particular child, namely the child whom they already had in foster care, then the actual number of available adoptive parents is even lower. Therefore, it will not be possible to streamline the process and move more children out of stage III unless measures to increase the number of adoptive parents in Romania and, if possible, abroad are taken.

The fact that, in most cases, the adoptive parents wanted to adopt the child who had already been placed with them draws attention once more to the need for an analysis of how placement with other families or individuals influences the adoption process.

Measures are also required to unblock the process for the two sub-groups identified in this study - children with too few or no PTA lists for too long a time and children with too many PTA lists but no successful outcome - without which these children are likely to spend years in the adoption process, without ever finding a permanent solution for their future.

It is also necessary to increase the effectiveness of the courses attended by those individuals and families who want to adopt a child. In parallel, education and communication campaigns at the community level should focus on raising awareness of adoption and adopted children and changing negative attitudes that reject and undervalue children, regardless of their gender, age, ethnicity, health status or parents.

Therefore, to ensure that all children have a real chance at a successful permanent living solution will require rethinking the theoretical and practical matching procedures and improving the training of specialists on how to communicate with prospective adoptive parents about the circumstances of children with disabilities.

[432] Forty percent according to Buzducea and Lazăr (2011).

3.4.3 Family Reintegration for Children from Source Communities

Story Bag

"It is an apartment building with 100 families I think, I think we are around 100 families. A single building, but mostly of Roma people, I don't know what to call them not to offend them, gipsies. Yes, it is a building of gipsies and there are other families, I don't know if there are 10 Romanian families in all. We also lived with my mother-in-law, when I moved to my husband's apartment I lived with my mother-in-law, but we couldn't live there with the children. This is how we got here... I can't let my child go outside, because you hear only dirty words, because this is what people around you are like, and you basically have nowhere to go. We only go to the park sometimes. I prefer to stay at home, to watch TV, or I don't know, if the child has no place to run a little, to have his own room or I don't know, to play there, do his homework there, later on, which will become neccessary... But we have no choice because we have nowhere to go, we can't financially afford to pay rent.

...

Well, when he comes home, he always says: mom, when can I go play in the yard? Or he tells me: mom I want to play too, but I can't. He's sad when he comes home sometimes. In the morning, he can't wait to go to kindergarten, what can I tell you, he's glad to go play with the children. When he comes home, it's like home, I only have, look, only this much space, one per two square meters, in the middle of the house. ... it's one room, kitchen and bedroom in the same place. And then: don't jump there, don't touch that, don't pull that, be careful not to drop the other, so the poor kid has to sit in a corner, on a bed, to just sit with a toy in his hands and fiddle with it."

(Interview with a parent with a child at risk of separation, in a ghetto building of studios in a source community, Bacău)

This section describes the features of families with children in public care who live in "source communities." In section 3.2.5.3, we demonstrated the existence of such geographical concentrations of mothers/parents with children in public care, both in rural and urban areas. The research that we conducted in the 60 communes that contain such source communities has enabled us to reach a better understanding of the circumstances of families with children in public care. The goal of the assessment was twofold. The first aim was to investigate the extent to which the support system is meeting the needs of these families and thereby facilitating the reintegration of the separated children. The second aim was to understand to what extent the children who are still in the home are being efficiently protected and monitored to ensure not only that they will not need to enter the public care system but also that they are not living in conditions that are unfavorable to their growth and development.

As shown in Chapter 2.3 regarding the data and method used in this study, our survey of households with children in public care in the source communities was based on a sample of mothers identified using the available data in the CMTIS. Among the households living at the addresses given in the CMTIS, only 61 percent still comprised either the mother or another person who had cared for one or more children now in public care. The other 39 percent of the households no longer lived in the commune.[433] Moreover, in the source communities of the 60 communes under analysis, an additional 139 families with children in public care were identified who were not registered in the CMTIS, as shown in Table 45 below.

Table 45: Estimated and Final Samples of Mothers/Families of Children in Public Care from the Rural Source Communities

	Number of people to be interviewed	Of which, number of people interviewed	Of which, number of people present in the household	
			Biological mothers	Other caregivers of the child/children
Initially selected (from the CMTIS)	1,191	736	455	281
Identified during field work	139	137	82	55
Total	1,330	873	537	336

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

RECOMMENDATIONS

The survey (particularly the actual collecting of the survey data) underlined the fact that a significant share of the target families (those into which children might be reintegrated) is unstable. For almost 40 percent of the addresses drawn from the CMTIS for the rural source communities, no member of the child's family could be found. This shows that more systematic and repeated efforts must be made to maintain contact with the families of children in public care, without which it will be impossible to achieve the PIP goal of reintegrating children into their families.

Given the wide geographical dispersion of families, it is clear that such efforts cannot be made by case managers alone. The responsibility for maintaining contact with and monitoring the conditions of the families of children in public care must be shared in fact, not theory with the social workers who are closest to these families. In the absence of any true collaboration between the child protection professionals and the community social services, family reintegration will not only be difficult but may even be unsustainable. It is worth recalling that the case managers who were the most critical of SPAS and of the Community Consultative Structures were precisely those who had managed to reintegrate children into their families.

[433] Only two mothers refused to participate in the survey, and there were eight cases in which households were present but no longer included either the biological mother or any other person who had cared for one or more of the institutionalized children prior to their entering the system.

3.4.3.1 Living Conditions in the Original Households of Children in Public Care in Rural Source Communities

Out of the 873 surveyed households, the assessment in this chapter focused only on households with at least one child under 18 years of age who was separated from the family (772 cases).[434] Of these 772 cases, in 705 at least one child was still separated from the family at the time of the study (interestingly, in 15 cases one or more children had returned in the family, while others had remained in public care). Moreover, out of all households with at least one child still separated from the family, in 63 percent of the cases, the mothers still lived in the home, while in the other 37 percent of cases, at least one other person who had cared for the child (usually, the grandmother) was present.

Table 46: Households in which At Least One Child Was Still Separated from the Family (%)

Households in which at least one child is still separated from the family:	Total	Households with sampled mothers	Households without sampled mothers
- N	705	445	260
- %	100	100	100
Out of which:			
- Households in which at least one child who had been separated was then living in the household	2	1	5
- Households in which none of the separated children had returned to the family	98	99	95
Out of which:			
- At least one other child in the household	68	70	65
- No child in the household	32	30	35
With at least one child of the mother in the household		56	
With no other child of the mother present in the household, but with other children in the household		14	
With no children in the household		30	

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

In at least two-thirds of the households with children in public care at the time of the study (68 percent), there was at least one child who still lived with the family. This was the case even though the child who was in the system was admitted because of the existence of certain factors in the household.

In 70 percent of households where the mother of the children in care is present, at least one other child still lives there. Even though these children were not always the children of the mothers with children in care, in half of these cases at least one of the mother's children lived in the household (Table 46). As might be expected, a reverse relationship can be noticed between the number of children in public care and the number of children still living in the household - the higher the number of children still in care, the higher the likelihood that no other child lived in the household (Annex 6 Table 52).

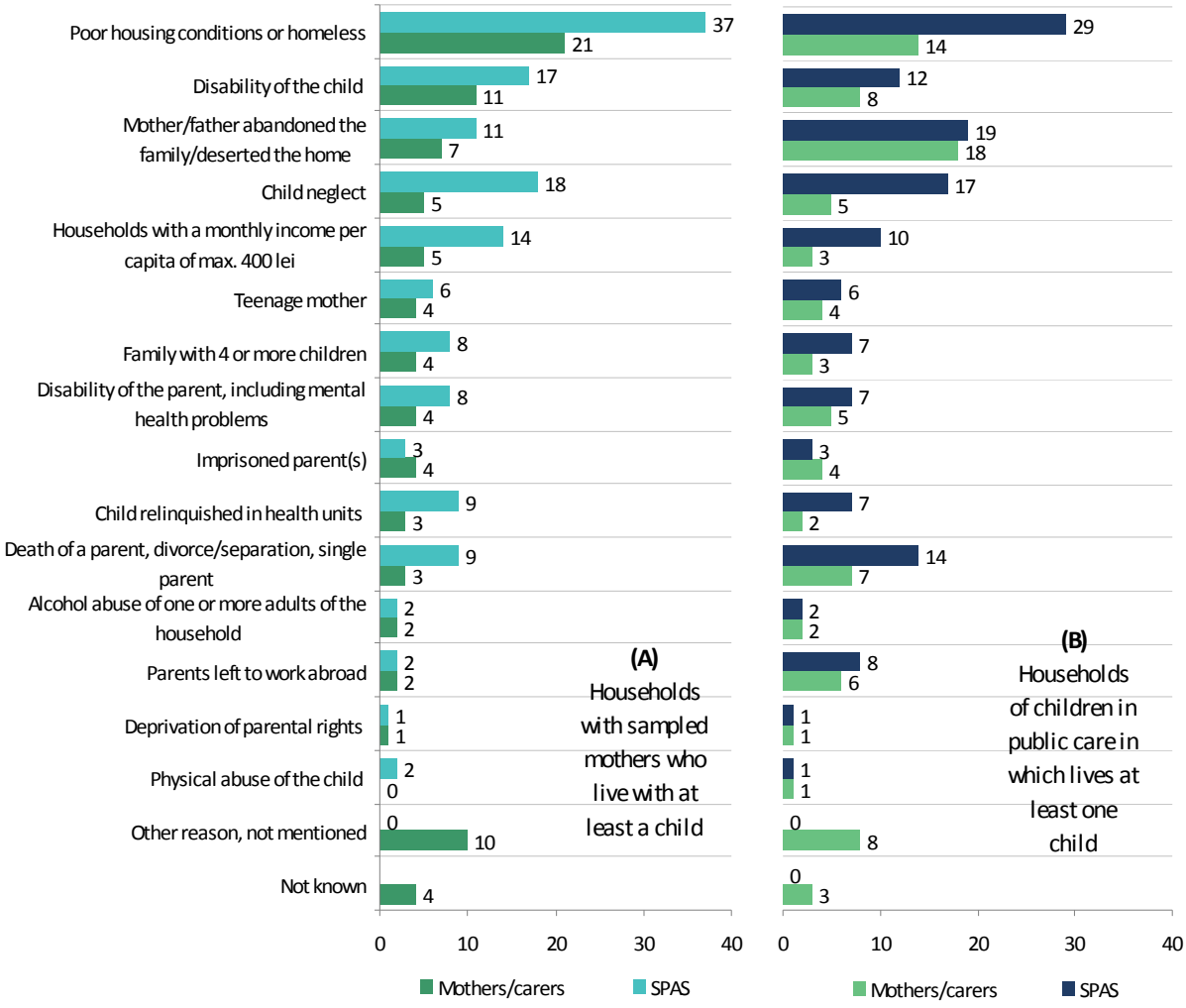
There seems to be no clear relationship between a child's presence in the household and the main cause of separation for the child in public care. Children were found to be still living in households where this should not be the case given the reasons why the children in care were taken out of the household (Figure 97). It is even more difficult to explain why this was allowed to happen in the case

[434] The other 101 cases in the sample refer to children who were separated from their families but who in the meantime had turned 18. They either continued to be in public care (still continuing their education or looking for a job), or were transferred to an institution for adults with disabilities, were reinserted in families, or were socio-professionally integrated.

of households where the mothers of the children in public care were still living with at least one child. For example, some mothers were still living with their children in cases where the reasons for another child being taken into care had been the family's inadequate housing conditions and precarious financial situation.

This situation raises multiple questions. If extreme poverty is addressed only by sending the children into the system, why are there still children living in these households? A family's extreme poverty is obviously not going to be solved automatically just by removing some of the children from the household. On the other hand, if the family's poverty was solved in the meantime, then why were the children still in care? The same questions are relevant when children were separated from their families for other reasons such as neglect or alcoholism. If after careful monitoring and intervention the problem was solved, the separated children should have been reintegrated in the family, and if the problem was still not solved, then why are other children still living in the household? These are particularly relevant questions for avoidable cases, which are those related only to social causes.[435]

Figure 97: Causes of Separation Stated by SPAS Social Workers and the Mothers/Carers of Children in Public Care from Rural Source Communities, by Types of Households (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities and Social Assistance Data Sheets from Rural Source Communities (July-August 2015). Data are not weighted (sample N of children's mothers/carers=307; sample N of children's mothers/carers for which SPAS representatives provided responses=174).

[435] See Infograph Chart 4 and section 3.2.7.

The study carefully examined the characteristics of the households of children in public care in order to better understand the conditions in which they would be living if they were to be reintegrated into their families. Much could be learned from focusing on the children who were still living in these households because they not only represented a good counterfactual but also because some of them could have been in an increasingly vulnerable situation themselves.

The analysis focused on two types of children:

(i) the children of mothers who had at least one other child in the system and

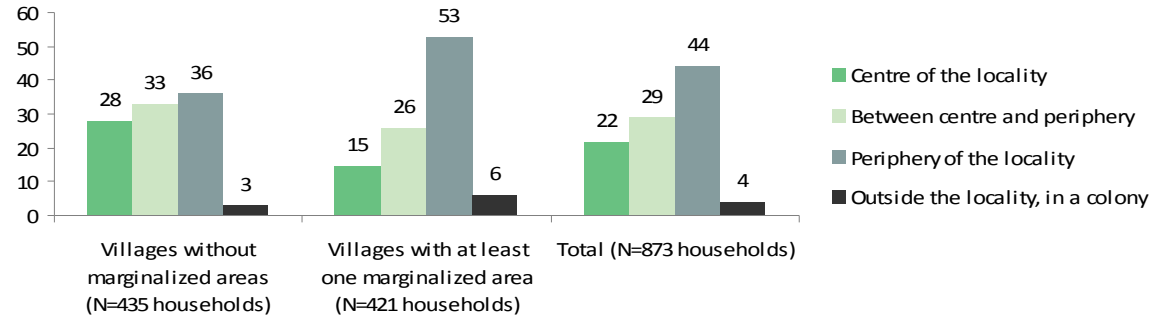
(ii) children who were not the offspring of the mothers but either lived with them or lived in the households from which the mothers had left.

In studying these children, we analyzed multiple facets of social exclusion, including housing, education, child care, health and nutrition, and income.

Housing

Section 3.2.5.3. showed not only that there are source communities from which a disproportionate number of children enter public care but also that these communities overlap to a great extent with marginalized areas.[436] Our analysis showed that, although a significant share of families with separated children is concentrated in marginalized areas, they tend to be widely dispersed among communes (both urban and rural). As the survey collected complete information on the households living at the addresses given for the mothers with separated children, we were able to examine in detail the overlap between extreme poverty at the community level and the risk of children being separated from their families. These data indicated that 50 percent of selected mothers lived (or had lived) in villages that contained marginalized areas. An interesting issue is that, the sample revealed a few villages with concentrations of mothers that were not found as being marginalized. This may have been because it was possible to identify marginalized areas based on the census data only when a minimum number of households in a census sector was reached (50 households), and this minimum number might be too high to make it possible to identify all of the concentrations of families at risk. Approximately half of the families of the separated children lived in clusters on the outskirts or even outside communes (Figure 98). Accordingly, the probability of a household being located on the outskirts or outside of the commune is greater if the village in which it is located has at least one marginalized area.

Figure 98: Distribution of Households between the Center and the Outskirts of a Village, Depending on the Existence of a Marginalized Community within the Village (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

[436] Marginalized areas were identified using 2011 Census microdata and were defined as intra-commune areas characterized by three types of disadvantages - low human capital, lack of formal employment, and precarious housing conditions. See the Atlas of Marginalized Urban Areas (Swinkels et al., 2014) and the Atlas of Marginalized Rural Areas (Teșliuc, Grigoraș and Stănculescu, coord., 2016).

Because they are located on the outskirts of the commune, one-third of the surveyed households are likely to be living in poor housing conditions and to have only limited access to services (Annex 6 Table 53). Nineteen percent of these households have a river, brook, or pond within a radius of 200 meters of their house, which puts them at risk of flooding (or may have already suffered from flooding). Also, 11 percent are located near derelict buildings or ruins, and 22 percent are located near woodland that the household members have to cross in order to reach the commune center on roads that are often impassable at certain times of the year. Fifty-eight percent of the households in these difficult locations are in villages that contain marginalized areas.

In many of the households from which children entered the public care, housing conditions are still inadequate, sometimes extremely so, which makes the children's reintegration unlikely in the absence of measures to counter this problem (Table 47). What is worrying is that other children still live in the vast majority of households where the living conditions are unacceptable. Four percent of the surveyed households live in improvised shelters, huts, or derelict homes, and two-thirds of these households still include at least one child. Overcrowding is also a problem for a high percentage of the surveyed households and is almost entirely associated with the presence of children in the household. A quarter of children living in these households live in homes that are not even connected to the electricity network, the vast majority do not even have a well within the household, and a quarter of households (and a quarter of the children) lacked the means to heat the home over the previous winter at least a few times a month.

Table 47: Housing Conditions of Households in the Rural Source Communities (%)

	% Households with the problem in question	Out of all households with the problem in question, % households with one or more children	% Children
Improvised shelter, hut, derelict home, ruin, tent	4	67	5
Homes where there is a special place designated for children, where they can do their homework or play	33	69	31
Households with more than two people per room	34	97	64
Households with more than two people per bedroom	49	92	77
Households with structural problems (leaks from the roof, damp walls, rotten/damaged floors or windows)	38	74	48
Households not connected to the natural gas network	97	74	97
Households not connected to the electricity network	17	73	23
Households with no running water within the household	70	75	75
Households with no running water or well within the household	55	75	61
Households with no toilet connected to the sewage system	92	74	94
Households unable to heat their home at least one week during the previous winter	11	80	15
Households unable to heat their home at least a few times a month during the previous winter	23	74	26

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

RECOMMENDATIONS

Three recommendations can be made based on the territorial dispersion of the sampled households in the source communities.

The most efficient way to prioritize interventions aimed at preventing child-family separation would be to target the marginalized areas that contain a large number of mothers with children in public care. These areas can be identified using the Atlas of Urban Marginalized Areas[437] and the Atlas of Rural Marginalized Areas.[438]

The second way to target prevention interventions might be to focus on those communities that contain high numbers of mothers or families of the children in public care. The mapping of these areas will require the constant updating of the information in the CMTIS.

Regardless of how they are targeted, systematic interventions are needed in all of these source communities. In the medium term, there is a need for social workers to monitor at-risk cases within each commune as it is impossible to detect these cases using geographical targeting instruments.

Solving the housing problem can contribute to the reintegration of children in care and to keeping other children within the family by eliminating the precarious housing conditions that caused the separation. However, it does not break the cycle of disadvantage, which continues in the source communities and which lead children to be taken into the protection system for other reasons.

Consumption in Households with Children

Housing problems are exacerbated by other difficulties within households that affect the children still living there. Of all children living in households with at least one child in public care, 14 percent had nothing to eat at least once a week in the previous six months, while a quarter of them had faced this problem at least a few times a month (Annex 6 Table 54). Almost half of the children eat a maximum of only two meals per day while 8 percent eat just one meal a day. In relation to their clothing, for only one-third of the children their parents stated they had bought new clothes, while a third have only clothes bought from second hand stores, and the other third have clothes they received from neighbors and relatives. However, these data did not show how often clothes are actually acquired these different ways and if they are sufficient to keep children clothed (Annex 6 Table 55). Half of the surveyed households stated that their income was not enough to cover the minimum necessities, with 62 percent of children living in this type of households (Annex 6 Table 54).

Children's Education

Participation in education is low, most frequently for children with mothers who still live in the household. In relation to kindergarten attendance, for instance, only a little over half of the children between 3 and 6 years old were enrolled in kindergarten or in nursery school (Table 48). Attendance percentage is significantly higher (76 percent) for children who are not the biological offspring of these mothers. This difference in percentages shows a deficiency of the protection system, which should have provided these mothers with services to improve the living conditions of the household in order to prevent the separation of the other children and to ensure the reintegration of the children who had already been taken into care.

[437] Swinkels et al. (2014).

[438] Teșliuc, Grigoraș and Stănculescu (coord.) (2016).

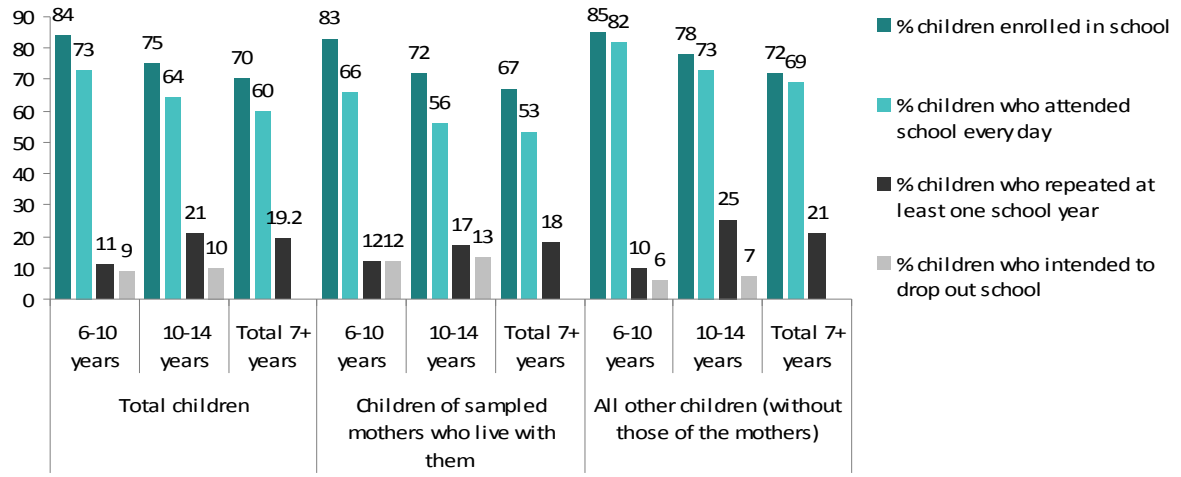
Table 48: Kindergarten Attendance of Children in Households with At Least One Separated Child in Rural Source Communities (%)

	Total children	Children of sampled mothers who live with them	All other children (without those of the mothers)
% children aged 0-6 enrolled in nursery or kindergarten	41	38	48
% children aged 3-6 enrolled in nursery or kindergarten	59	56	76

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Only 70 percent of children over 6 years old are enrolled in school, with the percentage being slightly lower for the children of mothers who have children in public care compared to the other children. Moreover, of the children of mothers who have other children in public care, only half go to school every day, and approximately 20 percent have repeated at least one school year, which leads to a higher probability of dropping out of school later on and of low achievement in the educational system in general. The situation of these children is bad even at the primary level – only 66 percent of children between 6 and 10 years old go to school on a daily basis and more than 10 percent have already repeated at least one school year.

Figure 99: School Attendance of Children from Households with At Least One Separated Child in Rural Source Communities (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

For 41 percent of children who live with their mothers and manage to attend school, their mothers stated that they never know how to help them with homework, and for another 38 percent, the mothers said that they can only help some of the time. The percentage of children whose parents cannot help them with homework is high even for the basic level of education – those for children aged 6 to 10 years old (Table 49). Only for 17 percent of children aged between 7 and 14 who go to school their parents said that they could help with homework most of the time or all the time. The situation appears even worse for the whole sample of children of school age regardless of whether they go to school or not. Only 21 percent of all children aged 6 to 10 go to school and have parents who can help them with homework always or most of the time (the equivalent percentage for children between 7 and 11 years old is only 12 percent).

Table 49: Shares of Children Whose Parents Claim to Know How to Help Them with Homework, Out of All Children Who Attend School, from Households with At Least One Separated Child in Rural Source Communities (%)

	How often do you know how to help your child with their homework…				
	Never	Sometimes	Most of the time	Always	Total
Children aged 6-10 years	37	38	18	7	100
Children aged 7-11 years	43	41	12	4	100
All children who go to school	41	38	14	6	100

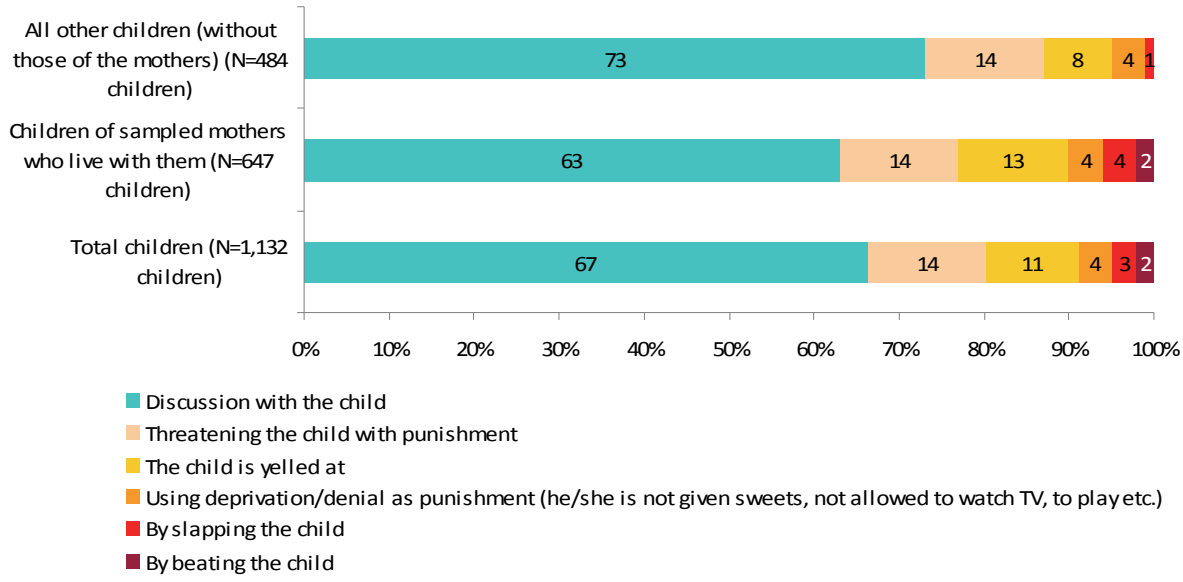
Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Having parents who know how to help their children with homework is strongly linked with the child's learning outcomes. Of the children who go to school but have parents who never know how to help them with homework, a quarter do not attend school every day and 22 percent have repeated at least a year. The percentages are 3 percent and 12 percent respectively for those who have parents who know how to help them always or most of the time (Annex 6 Table 56). For children with extremely low school attendance and parents with little involvement in their academic life, the educational system will need to make major efforts to genuinely include them in the educational system and to make up for the deficit of knowledge and values that most of these children will already have accumulated.

Disciplining Children

Based on statements of the mothers or carers, it was possible to explore the methods used to discipline the children in the surveyed households. According to these statements, 5 percent of children are most often disciplined with a slap or with a beating (Figure 100). Other frequently used methods include threatening with punishment (14 percent of children) or yelling (11 percent).

Figure 100: Most Frequently Used Method of Child Discipline in Households with At Least One Separated Child in Rural Source Communities (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Mothers and carers were also asked "how often do you use physical correction in order to raise and educate children properly?" Only 68 percent of them said they had never used this method and 8 percent said they do this most of the time or always (Annex 6 Table 57). It is important to note that physical punishment was used less frequently on the children who lived with mothers who had children in public care than on the other children who lived in the households. This may indicate that the effectiveness of counselling services for parents of children in the system was rather limited. Moreover, these percentages are probably higher in practice for two reasons: (i) the survey question only asked about which disciplinary methods were used most often but not about the most extreme punishment ever used and (ii) the question measured only the stated practices.

Other Risky Situations in Households with Children in Public Care

In 17 percent of the sampled households, adults are behaving in ways that could negatively impact the children's development if they were to be reinserted into their families. These types of behavior, which include excessive alcohol consumption, abuse and violence, criminal records, and problems with the police, constitute individual risk factors for the separation of the child from the family (Table 50). It is important to note that most of these problems happen in households with at least one child; for example, in 63 percent of the households in which the child's carers have stated there is excessive alcohol consumption, there is at least one child in the household. Fifteen percent of children who live in the surveyed households are affected by these problems. As with the questions referring to disciplinary methods, these problems are likely to occur with a higher frequency in practice than was stated in the survey.

Table 50: Incidence of Individual Risk Factors in Households with At Least One Separated Child in Rural Source Communities (%)

	% Households with the problem in question	Out of the households with the problem in question, % households with one or more children	% Children
Excessive use of alcohol	12	63	10
Criminal record	3	74	3
Experiences of prostitution	1	44	0
Abuse and violence	6	68	6
Work on the street, begging (including by children)	1	88	1
Problems with the police	2	72	2
Infidelity	2	70	2
Death of the main income provider	1	46	1
Any of the above problems	17	64	15

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

3.4.3.2 Support Provided to the Original Households of Children in Public Care in Rural Source Communities

In this section we will analyze to what extent the original households of children in public care receive the necessary support to solve the problems they are facing so that the separated children can be reintegrated into the family and the children who still live in the households are not themselves taken into the system. The support should also ensure that all of these children can live at home in conditions that will not limit their development potential for the rest of their life. The data from the survey of rural source communities can help us to understand which families from the target group receive social benefits that might help them to solve their problems even partially, and to what extent they have had access to a social worker with whom to discuss the situations of all of their children.

Providing Financial Support to Households in Need

A quarter of the sampled households with very low incomes said they had not received any means-tested benefits during the year of the survey. Of those individuals with income under 100 RON, only 67 percent mentioned that they had received the Guaranteed Minimum Income (GMI), the family allowance, or a heating subsidy. One-third of those with incomes under this level said that they had received another type of aid as well (Annex 6 Table 58). The share of beneficiaries declines as household income increases. The percentage of those with low incomes who do not get any type of aid is similar among households that still contain children and also for all households suffering from severe material deprivation (inability to heat the home, lack of electricity in the household, living in improvised shelters, or being unable to feed themselves properly), including those in which children are still living (Table 51).

Table 51: Share of Households Receiving No Social Benefits or Aid, Of All Households Living in Severe Material Deprivation (% of Households)

Households that did not receive any aid as percentage of all households that …	Total households	Households with children living at home
Had income of less than 100 RON per capita	27	24
Could not warm the house at least a few times a month	21	15
Were not connected to the electricity grid	34	24
Lived in makeshift shelters	25	26
Had no food to put on the table at least several times a month	18	12
In the previous two weeks had provided their children with at two meals a day at most	18	18

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

A significant share of households whose children were taken into public care for financial reasons do not receive any of the means-tested social benefits. As noted in Figure 97, the (A) section, according to respondents, precarious housing conditions were the cause of separation for 21 percent of the sampled households while other reasons associated with material deprivation were the cause in another 9 percent of the cases (5 percent consisting of households with monthly per capita incomes of less than 400 lei and 4 percent consisting of families with four or more children). Although one might have expected these households to have received financial support in order to enable the children's reintegration in the family and prevent new entries into public care, nearly a quarter of them had received no aid in the previous year (Table 52). The share of those who do not get any aid is lower for households with children than for the total number of households. The lack of support for these groups was confirmed by the responses of the social workers (which, as we noted in Figure 97, do not overlap perfectly with the responses of the children's mothers/carers). According to their assessments, even though a much larger number of separations occurred for reasons of material deprivation, more

than a quarter of the households that should have been financially supported to enable their child to be reintegrated had not received any support.

Table 52: Share of Households with At Least One Separated Child in Rural Source Communities Receiving No Social Benefits or Aid, by Reason Stated for the Separation (% of Children)

	Households not receiving the GMI, the family allowance or heating aid			Households with no material aid		
	Total	With children	With sampled mothers	Total	With children	With sampled mothers
The reason for child-family separation as stated by mothers/carers:						
Poor living conditions or no home	37	24	33	29	20	25
Households with monthly income per capita <400 lei	33	16	25	29	11	20
Family with 4 children or more	29	29	29	29	29	29
The reason for child-family separation as stated by SPAS social workers:						
Poor living conditions or no home	37	28	33	27	22	23
Households with monthly income per capita <400 lei	43	36	37	38	33	31
Family with 4 children or more	36	36	38	30	28	30

Source: Survey of Households with Children in Public Care in Rural Source Communities and the Social Assistance Data Sheets for the Rural Source Communities (July-August 2015). Data are not weighted (N=85 SPAS representatives of the 60 communes that contain source communities).

CONCLUSION

Those households whose children were taken into care for preventable reasons such as poverty or poor housing conditions[439] are not receiving sufficient support for the family to overcome these difficulties and enable them to bring their children back home. This perpetuates the risky situation even in households where other children continue to live and continues a cycle of disadvantage that can lead to more children entering the system and being separated from their families, with significantly increased costs and significantly worse results.

Research is needed to identify the causes of social and school exclusion and to what extent these are influenced by the households' precarious housing conditions. Helping families to access adequate housing as part of an integrated package of services could offer solutions for the various problems faced by children and families in source communities.

[439] See Infograph Chart 4, section 3.2.7, and section 3.2.5.1.

Interactions with SPAS Social Workers/Staff with Social Work Duties

In order to reintegrate children into their families, it is important to ensure not only financial support where needed but also a regular interaction with a social worker. SPAS social workers should ensure an ongoing monitoring of the sampled households to prevent the situation in which any children still present in the household are taken into public care and to provide constant guidance and support to the families to help them solve their problems and facilitate the reintegration of their separated children.

However, despite the importance of interacting with a social worker, most households do not seem to experience enough of these interactions (Table 53). For example, in households with at least one child in the protection system and other children still in the household, only 15 percent of the children's carers said that they interact monthly with the social worker, while another 24 percent said that they have only one interaction every two to three months. In households where the mothers of the separated children are still present, these interactions are equally infrequent, only increasing slightly when the mothers live with other children in the household.

Table 53: How Often Mothers With At Least One Separated Child in Rural Source Communities Talk with a Municipality Social Worker About Their Children (%)

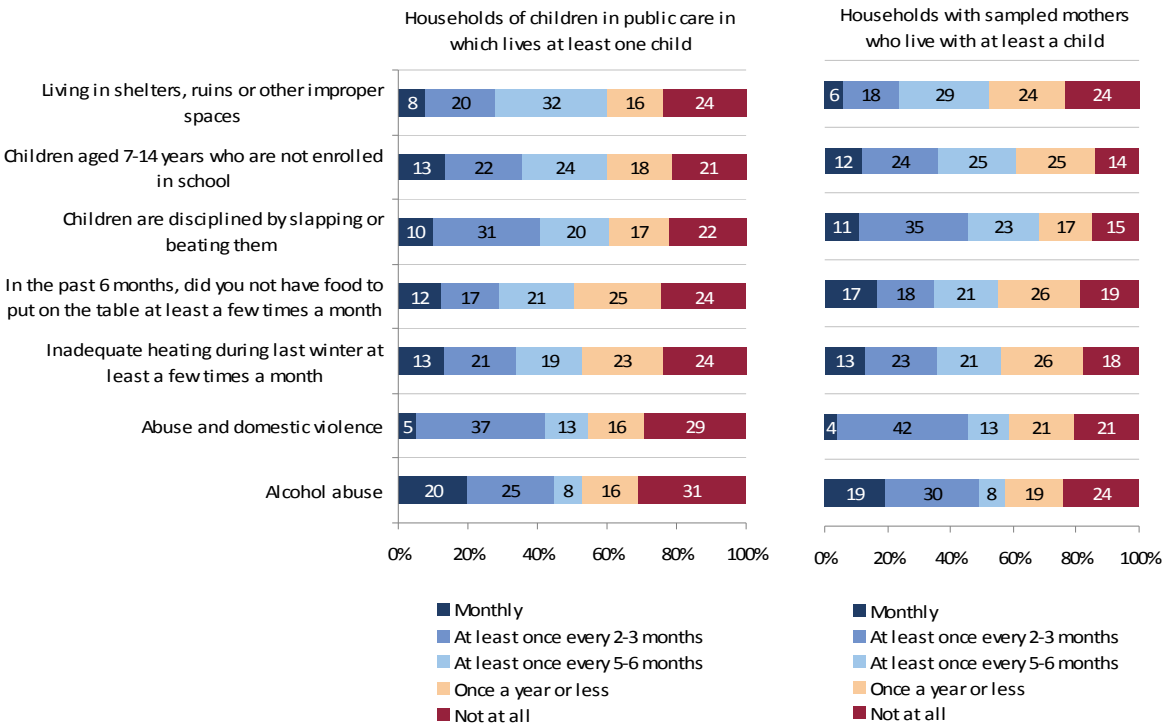
	Total households with children at home	Households with sampled mothers	of which…	
			Sampled mothers living with children	Sampled mothers with no children at home
Monthly	15	15	17	11
Once every 2-3 months	24	26	27	24
Once every 5-6 months	17	19	19	19
Once a year or less	16	16	17	15
Not at all	28	24	19	31
Total - %	100	100	100	100
- N	556	425	263	162

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Even if we narrow down the analysis to households with serious problems in which children are still living, we still find a low frequency of interactions with the local social worker. Figure 101 shows that, regardless of the problem in question, the percentage of households interacting with the social worker on a monthly basis is no higher than 20 percent, and in about a quarter of the cases, the social worker has never met with members of the vulnerable households. For instance, only 19 percent of members of households with children present and with stated alcoholism problems said that they met with a social worker every month. In the case of households with problems of abuse and violence, only 5 percent of households with children have interacted every month with a social worker. Even if some of the problems faced by households are more difficult for a social worker to observe, thus leading to the infrequent interactions, there are equally low percentages for households where the children are not in school or are living in improvised shelters, barracks, or ruins. A low frequency of interactions is also evident for households where mothers continue to live with other children.

Moreover, the low frequency of interactions with a social worker applies even when the cause of separation indicates that the other children present in the household are highly vulnerable to harm, such as neglect or excessive alcohol consumption (Annex 6 Tables 59 and 60).

Figure 101: How Often Mothers With At Least One Separated Child in Rural Source Communities Talk with a SPAS Social Worker About Their Children, by Existing Problems and Type of Household (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

In such households, the risk that another child will be taken into the protection system is higher than in the general population. This is confirmed by the share of the survey respondents from these households who stated that they had thought about the possibility of giving up the children still living in the household to the public care system in the future (Table 54). Among the households with children in the system where other children still live with their mothers, 5 percent stated that they had thought about giving them up to public care. In the case of children who have already been separated from their families at least once in their lifetime, the percentage rises to 21. The link between having been in the protection system in the past and the likelihood that this could happen again is confirmed by the fact that 10 percent of the mothers in the sample had been in public care themselves in the past (the percentage is 12 percent if we include the siblings of mothers with children in public care).[440]

Table 54: Risk of Separation of Children Currently Living in Households with At Least One Separated Child in Rural Source Communities (%)

	%
Children living with sampled mothers who were not separated	5
Children living with sampled mothers who were separated before	21
Children not related to the sampled mothers	2
Children of the sampled mothers who had been separated and were currently living in households without their biological mother	11

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

[440] On "the power of the antecedent," see also section 3.1.2.3.

Why does the frequency of interactions with the social worker (or the person with social assistance responsibilities in the SPAS) vary so much between households? To answer this question we examined the relationship between the frequency of interaction and different types of factors: the social worker's profile, the location of the household within the village, the characteristics of the mother, and those of the separated child.

Regarding the features of the SPAS social worker/person with social work responsibilities, what seems to matter is not the person's type of specialization, but whether this person has a higher education or not. In the case of the respondents living in localities served by SPAS staff with social work responsibilities who do not have higher education, 51 percent have reported interacting with them once a year at most. However, the percentage increases to 41 in the case of respondents in localities served by SPAS staff who had studied social assistance or sociology, 40 percent if they studied economics or law, and 38 percent if they have other specialization (Annex 6 Table 61).

The location of the household within the commune or village, as well as the features of the community to which it belongs, are also significant predictors of the frequency with which the respondents interact with the SPAS social work staff (Annex 6 Table 62). For households in villages at the periphery of the commune, their interaction with a social worker is monthly in only 9 percent of cases, while for villages in the center of the commune, the equivalent percentage is 22. Similarly, the position of the household within the village or outside it is key to predicting the frequency of interactions with the social worker. For households located in the center of the village, the interaction is monthly in 24 percent of cases, while for households located at the outskirts or outside of the village, in only 11 percent of cases.

Mothers with separated children living in households with other children have a slightly higher likelihood of interacting with the social worker every month than mothers with separated children but with no other children in the household. Social workers seem to interact more rarely with households where the mothers are no longer present, even if other children live in these households (in 54 percent of these cases, the frequency is once a year or less) (Annex 6 Table 63).

We used a logistic regression model to carry out a simultaneous analysis of the factors predicting whether the SPAS social worker interacts at least once every two to three months with households with children or households with mothers with separated minor children (Table 55). We found that all of the predictors previously mentioned are significant. Households where mothers of separated children live with other children are more likely to be visited than other households with children. Also, if the social worker has a higher education, the frequency of interactions is higher, which is also the case if the household is located in the center of the commune or village or between center and the outskirts.

Table 55: Logistic Regression Predicting Whether SPAS Social Workers Interact With the Households with Children or With the Mothers of Separated Children "At Least Once Every 2-3 Months" or "Less Than Once Every 3 Months"

	Odds report
"Mothers with separated minors and other children in the household" versus "Other households with children"	1.61**
"Mothers with separated minors and without other children in the household" versus "Other households with children"	1.12
"Mothers without separated minors and with other children in the household" versus "Other households with children"	2.54***
The social worker has a higher education	1.94***
The household is located in the center of the locality or between the center and outskirts	2.3***
Pseudo R2=0.0507; *p<0.1; **p<0.05; ***p<0.01.	

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

The role of these predictors becomes even clearer when the analysis is focused only on households where the mothers still live, as it is possible that, when mothers were not present in the sampled households, the social workers focused their interventions on other households where mothers were present (including those in other localities). To remove this ambiguity, the analysis below covers only households containing mothers with separated children.

Whether the person with social work responsibilities has a higher education or not seems to be important in explaining the frequency of his or her interaction with the mothers (Annex 6 Table 64). The share of mothers reporting having interacted at least two to three times a month with the person with social work duties is over 40 percent if the person has a higher education but only 27 percent if the person has no higher education. Moreover, the percentage of mothers who interacted frequently with that person is only 14 percent when they do not have any other children living with them in the household.

The location of households containing mothers with separated children in a marginalized community and/or within or outside the village is a significant predictor of the frequency of interaction with the social worker. If the household is located in a marginalized area, then mothers with separated children are less likely to interact with a social worker at least once every two or three months (Annex 6 Table 64). The picture is more nuanced when we take into consideration the presence of other children in the household as in this case being located in a marginalized community does not seem to matter. In non-marginalized areas, 52 percent of mothers with children in the household have interacted with a social worker, while in marginalized areas, only 26 percent. The location of a household in the center of a village or commune is also a significant predictor. Forty-eight percent of mothers from households located in the center of these localities interact with a social worker every two to three months, versus only 30 percent of those located at the outskirts or outside the locality (similarly, for mothers who no longer live with the children but live in households located in marginalized communities, the percentage of visits is significantly lower.)

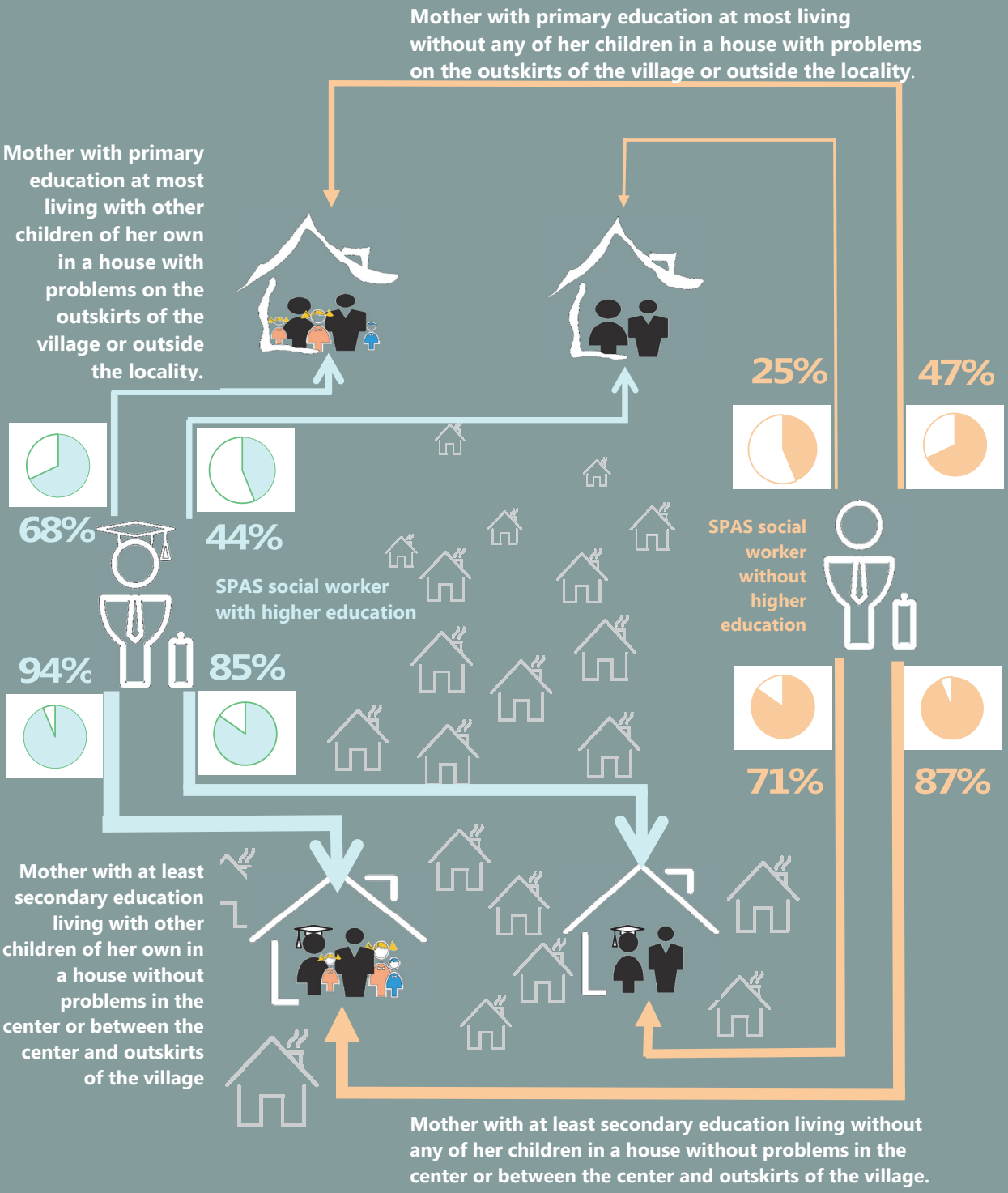
The quality of the house in which mothers live is also a significant predictor, but in the opposite sense than is desirable. Only 32 percent of mothers living in houses with problems (roof leaks, damp walls, rotten/damaged floors or windows) interact with a social worker once every two to three months, while 49 percent of those who do not have such problems interact this frequently with a social worker (Annex 6 Table 64).

The mother's characteristics also count. Mothers who are less educated and older are less likely to interact with the social worker (Annex 6 Table 64). Only 34 percent of mothers with no education and 35 percent of mothers with a primary education interact frequently with the social worker, whereas the percentages are much higher for mothers with a secondary education or an education beyond secondary school (51 percent and 48 percent respectively). We also noticed that these interactions are more frequent for mothers aged under 25 than for other mothers.

The age of the child when last separated from the family and the length of time spent away from the mother are also relevant in predicting the frequency of interactions with social workers (Annex 6 Table 64). If children were separated when they were over 2 years old, then the likelihood of the social worker interacting with the mothers still living in the households is higher than average. Interestingly, this relationship does not seem to apply when there are no longer any children in the household. If the child has been separated from the mother for less than two years, then the likelihood of any interaction with a social worker is higher (39 percent of the mothers who had been separated from their children for more than two years interact frequently with the social worker, versus 48 percent of the mothers for whom the separation occurred more recently).

Because some of these variables are inter-related (for example, the mother's education level is related to the type of the community in which she lives or to her housing problems), it would be helpful to understand the extent of the role played by each of them. The logistic regression model shown in Table 55, which predicted the odds of having interactions with the social worker at least once every 2-3 months in the case of mothers living in the households, allowed us to carry out this type of analysis.

Infograph Chart 7: Likelihood of a Mother Aged Under 25 from a Rural Source Community Who Has At Least One Child Aged 6-17 in Public Care Discussing Her Children's Situation with a SPAS Social Worker At Least Once Every 2-3 Months



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted (N= 348 households still present in the commune and in which children had not yet been reintegrated).

Note: Likelihoods were estimated based on the regression model presented in Table 55, see also Table 56.

A multivariate analysis confirmed the relationship between all the variables discussed above and the likelihood of interacting with the social worker. For instance, in households where the mother lives with her other children, the likelihood of interacting with the social worker is 2.7 times higher than for mothers in households where there are no other children, with all other variables being equal.

Table 56: Logistic Regression Predicting Whether SPAS Social Workers Interact With the Mothers of Separated Children Still Living in the Household "At Least Once Every 2-3 Months" or "Less Than Once Every 3 Months"

	Odds report
The mother lives in the household with her other children	2.7***
The household is in the center of the locality or between the center and the outskirts	2.3***
The social worker has a higher education	2.4***
The household has no problems with the house (roof leaks, damp walls, rotten/damaged windows or floors)	1.8**
The mother has at least a secondary education	1.8**
The mother is less than 25 years old	3.1**
The number of children aged 6-17 who are currently separated	1.7***
Pseudo R2=0.0507; *p<0.1; **p<0.05; ***p<0.01	

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

More importantly, these variables interact with each other so that people with different characteristics have completely different likelihoods of interacting with a social worker. The regression model presented above (Table 55) made it possible for us to estimate the likelihood of interacting with a social worker for people with various characteristics and in different contexts, as shown in Table 56. It can be seen that, for a person under 25 (who therefore has a generally higher than average likelihood of interacting with a social worker), the likelihood of interaction can be very different depending on the person's other characteristics as well as the characteristics of the community in which the person is living and of the social worker serving that community.

For mothers who have favorable characteristics, the likelihood of interacting with a social worker is close to 100 percent. In the case of mothers with children separated when they were over age 5, living with other children of their own, having at least secondary education, not living on the outskirts of villages, living in a house with no major problems, in a locality covered by people with social work duties with a higher education, there is a 94 percent estimated likelihood of interacting with the social worker. Similar percentages occur when social workers have a higher education and mothers have few negative characteristics (for example, in terms of education, location in the community, and housing), even if the children were separated at an early age or if mothers do not live with other children in the household.

If the mother lives on the outskirts of the village/commune in a poor quality house, the likelihood of her interacting with a social worker decreases dramatically. This decrease is even more significant when the social worker does not have a higher education than when he or she does have a higher education (especially in households where children are still present and where children were separated at older ages). Therefore, if the social worker has a higher education and the mother lives with her other children, the percentage decreases by 26 percentage points (from 94 percent to 68 percent) when the characteristics of the mother are worse and by 40 percentage points (from 87 percent to 47 percent) when the characteristics of the mother are similar but the social worker does not have a higher education. Most worrying is the fact that when the mother has a low level of education and she is not living with any other children, the likelihood of frequent interaction decreases to a maximum of 44 percent, even when the social worker has a higher education and the children were separated at older ages.

Table 57: Likelihood of a Mother Aged Under 25 From a Rural Source Community Discussing Her Children's Situation with a SPAS Social Worker At Least Once Every Two to Three Months

		With at least one separated child aged 6-17		With no separated children aged 6-17 (with separated children aged 0-5 only)	
		SPAS SW with higher education	SPAS SW without higher education	SPAS SW with higher education	SPAS SW without higher education
The mother lives with another child of her own	The mother with at least secondary education lives in the center/between the center and outskirts of the village in a house with no problems	94	87	90	79
	The mother with primary education at most lives on the outskirts/outside the locality in a house with problems	68	47	55	34
The mother lives without any of her children	The mother with at least secondary education lives in the center/between the center and outskirts of the village in a house with no problems	85	71	77	59
	The mother with primary education at most lives on the outskirts/outside the locality in a house with problems	44	25	32	16

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: The likelihoods in this table were calculated based on the logistic regression model used in Table 55. SW - Social worker/ person with social assistance duties.

The role of the social worker without higher education varies greatly depending on the characteristics of the household that he or she is supposed to support. For households where there are children present, the living conditions are decent, and the mother has a secondary or higher education, the likelihood of interacting with a social worker with no higher education is similar to when the social worker has a higher education (the difference is only 10 percentage points). However, when the mother lives in unfavourable conditions and has primary education at most, the difference is at least 20 percentage points. In these circumstances, a mother who does not live in the center of the village, has no higher education, does not live with any of her children, lives in a house with problems, and was separated from her children when they were younger than 2 years old has a likelihood of only 16 percent of interacting with a social worker every two to three months or more often.

CONCLUSIONS AND RECOMMENDATIONS

A first conclusion is that, in terms of the characteristics of the social worker, what seems to matter is whether he or she has a higher education or not. In other words, to improve the system's performance and to adequately meet the needs of children and families in difficulty, it is crucial that every commune in Romania (particularly those with source communities and/or marginalized areas) has at least one person with social assistance responsibilities within the SPAS who has higher education. Ideally, this person would be a professional social worker.

In addition, in line with the provisions of the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*, we make the following recommendations: (i) ensuring that there is a functional Public Social Assistance Service (SPAS) in every administrative territorial unit; (ii) filling any vacant positions in the child protection system; (iii) ensuring that each SPAS includes specialized personnel; (iv) combining two or more rural localities under one SPAS in those cases where there are not enough resources to set up one SPAS in each; and (v) establishing a SPAS in each urban locality where none exists at the moment.

In accordance with current legislation[441] and in line with the recommendations of the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and of the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020,*[442] we recommend that the Government of Romania introduces a minimum package of social services for children as part of an integrated package of interventions to be mandatorily implemented in every urban and rural community. This minimum package of interventions should involve the following steps: (i) carrying out field work to identify potential beneficiaries and early intervention services; (ii) assessing the needs of vulnerable or at-risk communities, households, and people and planning the delivery of services and interventions based on an approach centerd on the family and the individual; (iii) providing information and counselling services to vulnerable groups and people at social risk, people who have experienced domestic violence or neglect, drug consumers, former prisoners, single-parent families with low incomes, and young people at risk (such as young offenders, young people who have dropped out of school, and children from families with low incomes); (iv) providing administrative support to clients (for example, to help them fill in application forms for various types of benefits) and social, health and legal assistance; (v) providing referral to specialized services; (vi) monitoring and visiting all people in vulnerable situations within the community; and (viii) developing housing services that meet the needs of poor and vulnerable families.

This minimum package of interventions should be complemented with other preventive services (such as social canteens, daycare centers, or services targeting vulnerable groups) depending on communities' specific needs and resources. For the effective implementation of this minimum package, professionals (especially those from universities, service providers, and the National College of Social Workers in Romania) will need to develop family- and individual-centerd tools and methodologies for the adoption, assessment, planning, design, implementation, monitoring, and evaluation of these services. These tools and methodologies should be taught in a continuous training program for social work personnel at the local level.

According to the analysis presented in this chapter, the greatest challenge will be to increase access to any and all of the community-based services for families with children, especially those at risk of separation from the child, who live on the outskirts of localities, in source communities, and/or in marginalized areas (rural and urban) in homes of poor quality and where the adults have low levels of education. Currently, the children in these families not only live in need and difficulty but also have fewer opportunities than other children to benefit from any support or help at the community level.

[441] Social assistance law 292/2011 and the provisions concerning the minimum package of public services provided by local public governments (Government Decision 1/2013 and the 2014-2020 Strategy for strengthening the public government).

[442] Teșliuc, Grigoraș and Stănculescu (coord.) (2015:126-127). Starting 2011, UNICEF has developed and tested such a package of primary services within its project called "First priority: no 'invisible' children."

3.4.3.3 Chances of Reintegration of Separated Children from Rural Source Communities

This section estimates the chances that children from rural source communities who are separated from their parents will be reintegrated into their families, from the perspective of their family. For that purpose, we will analyze the frequency with which parents and other carers interact with their children in care, their desire to reintegrate the children into their households, and what they think the chances are of this happening in the near future.

More than half of the separated children who come from the rural source communities have not interacted with their parents or other carers since they entered public care. The parents or former carers of 55 percent of all separated children from rural source communities stated that they had not seen or talked to them at al since the separation (Table 58). Although it might be expected that the interactions with the separated children would be more frequent when their mothers were still living in the household, the difference is only 4 percent (54 percent for households where the mother is still living versus 58 percent for households where the mother is absent).

Table 58: Percentage of Children Who Have Interacted with Their Parents or Carers Since Entering Public Care

Type of interaction of the separated child with his or her parent/carer	Separated Children		
	Total	With mothers present in the household	With mothers absent from the household
The child came to visit	16	17	13
The child was visited	36	36	37
The child and the parent/carer met the child by chance	1	1	1
The child was not seen, but they spoke on the phone	2	2	1
The child was not seen and has not spoken with the parent/carer	55	54	58

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

The lower the age of the children at separation, the less likely they are to interact with their parents or carers after entering the system. In the sample of separated children from the rural source communities, 46 percent were less than 1 year old at the time of their last separation, and another 17 percent were between 1 and 2 years old (Annex 6 Table 65). The age at which the child was last separated from the family is a relevant indicator for the probability of interacting at least once with the parent or carer after the last separation. The carers or parents never interacted with the children again in the case of 59 percent of the children separated when they were under 1 year old versus 36 percent of the children older than 10 at the time of the separation (Table 59).

There is a significant difference between the children whose mothers are still living in the surveyed households and those where only the carers were present. In the case of children who were under 1 year old at the time of the last separation, it makes no difference whether the mother was present or absent in the children's households of origin. In both situations, around 60 percent of the children have not seen or talked to their former carers or parents since entering public care. However, the difference becomes visible as the age of the children increases. Among children aged 10 or older when they entered the system whose mothers still live in the household, 24 percent have had no contact with anyone from the household of origin, whereas in the case of children whose mothers no longer live in the household, 50 percent have had no such contact (Annex 6 Table 66).

Table 59: Share of Children Who Interacted with Their Parents or Carers Since Entering Public Care, by Age at the Time of Their Last Separation

Type of interaction of the separated child with his or her parent/carer	Age at the last separation of the child from the mother in order to be taken care of by someone else					
	0	½	3/5	6/9	10/max	Total
The child came to visit	10	17	14	28	36	16
The child was visited	34	35	39	50	54	38
The child and the parent/carer met the child by chance	1	1	2	0	0	1
The child was not seen, but they spoke on the phone	2	3	1	1	0	2
The child was not seen and has not spoken with the parent/carer	59	52	51	43	36	53

Source: Survey of Households with Children in Public Care in Rural Source Communities (July - August 2015). Data are not weighted.

When the analysis focuses only on the previous year, the percentage of children who have not interacted with their parents or former carers increases even more since some of the children have been in the system for a long time and any interactions they might have had with their families shortly after the separation will likely have diminished in time. This can shed light not only on the child's interaction with the family but also on the chances of the child being reintegrated into the family in the near future. Table 60 below indicates the frequency of interaction during the period of one year and shows that 68 percent of the children from the rural source communities did not interact with their parents or carers even once in the previous year and only 18 percent interacted with them at least once a month. The percentages are similar when the analysis focused only on the children whose mothers still live in the sampled households (Annex 6 Table 67).

Table 60: Frequency of Interactions with Separated Children in the Previous Year According to the Statements of Mothers or Carers (%)

In the last year, the children …	weekly or several times a month	once a month	several times a year	once a year	rarely or not at all	Total
a. were visited	8	6	9	6	70	100
b. were contacted by phone	8	5	6	2	78	100
c. received parcels	4	4	4	2	87	100
d. were taken on holiday	4	2	5	3	86	100
Any of the above	12	6	9	5	68	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July - August 2015). Data are not weighted.

In order to understand which children are least likely to be reintegrated into their families we have to analyze the factors that might forecast the frequency of interactions between the separated children and their parents or former carers.

- Separated children who entered public care directly from maternity wards have had much less interaction with their families than those who were taken from their grandparents or other relatives or families. Most children from the rural source communities were sent into public care from maternity wards at their last separation (71 percent) (Annex 6 Table 68). Only 9 percent of these children interact with their parents/former carers a few times a month, versus 22 percent of those who were separated after living with their grandparents or other families (Annex 6 Table 69). The difference between these two groups of separated children (who entered public care from the maternity ward vs. after living with grandparents or other relatives or families) by type of protection measure established for the child is even higher in the situations where the mother still lives in the surveyed household.
- Up to a point, the income of the households is not a significant predictor of the frequency of interactions with separated children. The survey data show that the percentage of separated children who do not interact with their parents is approximately the same regardless of their

income level – between 62 percent and 70 percent of the separated children do not interact at all with their mothers or former carers (Annex 6 Table 70). The only difference is that weekly interactions are much more frequent than average in the case of children whose families have relatively high incomes of more than 540 RON per capita. These percentages do not differ when we analyze just the children whose mothers are still present in the households.

- The characteristics of the mothers, such as the type of the community where they live in, their past experiences with the special protection system, their level of education, and the type of relationship they have with a current partner all predict how likely they are to interact with their separated children from the moment of separation (Annex 6 Table 71). Separated children whose mothers do not live in marginalized communities have a significantly higher probability of interacting with their mothers. While 22 percent of such children interact with their mothers on a weekly basis or several times a month, only 7 percent do so when the households of origin are in marginalized communities. If the mothers themselves were in public care in the past, then the probability that they will interact with their separated children is higher. The lower the mothers' level of education, the lower the probability that they will interact with their separated children. Seventy percent of the separated children whose mothers had only up to four years of schooling had not seen their mothers at all during the previous year, versus less than 57 percent of the separated children whose mothers' level of education was higher. The type of relationship that the mother has with a current partner and had at the time of the separation is also associated with the frequency of interaction. Mothers who are currently in a stable relationship and those who at the time of the separation were not together with a man other than the child's father are more likely to interact with their separated children.
- The age at which the child was separated is a strong predictor of the frequency with which their mothers interacted with them over the previous year. For the children who were separated under the age of 2, the probability of not having interacted with their mothers at all during the previous year is 72 percent, while for those who were aged 6 or older when they were separated, this probability decreases by half (only 37 percent) - see Table 61. Meanwhile, the percentage of children interacting weekly or several times a month increases from 8 percent to 37 percent.

Table 61: Frequency of Contact withTheir Children in the Previous Year by Mothers Still Living in Their Households, by Children's Age at the Time of Their Last Separation (%)

Child's age at the time of the last separation	Frequency with which separated children were contacted by their mothers in the previous year					
	weekly / several times per month	once a month	several times a year	once a year	rarely or not at all	Total
0/1	8	5	11	4	72	100
2/5	18	2	16	6	59	100
6+	37	12	10	3	37	100
Total	16	6	12	4	63	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

- How much time has elapsed since the child's last separation from the family is also associated with the frequency with which children were contacted by their mothers during the previous year. Fifty-one percent of the children whose separation had occurred less than two years before had not been contacted by mothers, versus 67 percent when the separation occurred more than six years earlier (Annex 6 Table 72). An important factor seems to be the dynamics between the age of the child at the time of the last separation and the time that has elapsed since then. Both for children separated when they were under 1 year old and for those separated at the age of 6 or older, the time since the separation does not seem to influence the frequency of interaction with their mothers. For the first category, the probability of the children not having interacted with their mothers in the previous year is high regardless of how long they had spent in the system (about 70 percent), while for the second category, the rate is half (35 percent). However, for

children aged between 2 and 5 when they were separated from their families, the time since the last separation particularly significant. While only 18 percent of these children relinquished for less than two years had not interacted at all with their parents or other former carers in the previous year, 67 percent of those who had already spent six years in the system had not interacted with their families.

Table 62: Share of Separated Children who Interacted with Their Parents or Carers Less than Once a Year, by the Child's Age at the Last Separation and the Time Since the Last Separation (for Households where Mothers are still Present)

	Time from last separation		
Age at last separation	0/1	2/5	6+
0/1	71	75	70
2/5	18	56	67
6+	35	36	36

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

- The interaction of those in the household with someone competent to support the reintegration of the separated children is also a significant predictor of the frequency of interactions between separated children and their parents or other former carers. In the case of 34 percent of separated children, the mothers who were still present in the households said that they had not interacted with anyone to discuss their children's situation, while in 43 percent of cases the mothers stated that they had interacted with someone from the DGASPC, and in 51 percent of cases, the mothers had interacted with a social worker from the municipality (Annex 6 Table 73). Among the separated children whose mothers had spoken with somebody from the DGASPC or a social worker, only about 40 percent of them had not interacted at all with their parents or caregivers in the previous year, while this percentage is almost doubled when no one in the household had talked to anyone about their separated children (Annex 6 Table 74). Even if this association seems to indicate the effectiveness of the actions taken by social workers and other representatives of the DGASPCs, the causal relationship is not clear. It is possible that these representatives have interacted more often with those who were already more likely to contact their separated children.

To test the role played by each of the above characteristics, we used four logistic regression models predicting whether or not separated children had interacted at all with their mothers or other caregivers in the year previous to the survey. The base model was the one in which the only predictor used was the child's age at the time of the last separation, and we found that children separated when they were under 2 years old when separated were 4.3 times more likely not to have interacted with their parents or carers in the previous year than those separated at the age of 6 or over (Annex 6 Table 75).

In the second model, we tested other predictors at the time of the survey and found that the location of the mother's household and the mother's type of current relationship were both statistically significant. The third model added another significant predictor, the type of relationship with a partner that the mother had at the time of the separation. The fourth model added the variable related to interactions with a social worker from the municipality or with someone from the DGASPC, which was proved to be statistically significant even when controlling for all other predictors.

Using the second regression model (which uses only the current characteristics of the household), we found that the predicted likelihood of contact between children and parents was very different depending on the characteristics of the children and their mothers. For instance, if a child was under the age of 2 when he or she was separated and has a mother living in a marginalized community, with four grades of education at most and not in a stable relationship with a partner, the probability of the child not interacting with his or her family in the previous year is over 80 percent (Table 63). On the other hand, if the child was separated at a young age but the household is not located in a marginalized community and the mother has more than four grades of education and a stable relationship, the predicted percentage of no interaction decreases to 54. Even with this low number of

variables, we can notice a profile of those children who are less likely to get in touch with their family - children who were separated at older ages and come from households not located in marginalized communities, with mothers with more than four grades of education and in a stable relationship have an estimated probability of only 27 percent of not having interacted with their families at all in the previous year.

Table 63: Predicted Probabilities of Children Having No Interaction with Their Families of Origin, for Children Whose Mothers Still Live in the Household

	%
Separated at the age of 0-1, from a household located in a marginalized community, with a mother with 4 grades of education at most who is not in a stable relationship	81
Separated at the age of 0-1, from a household located in a non-marginalized community, with a mother with 4 grades of education at most who is not in a stable relationship	54
Separated at the age of 6+, from a household located in a marginalized community, with a mother with 4 grades of education at most who is not in a stable relationship	58
Separated at the age of 6+, from a household located in a non-marginalized community, with a mother with 4 grades of education at most who is not in a stable relationship	27

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: Based on the logistic regression model 2 in Annex 6 Table 75.

Beyond the frequency of interaction between separated children and their families, it is important to see to what extent mothers or other former carers want to take the children back. In the case of 64 percent of separated children from the source communities, parents or other carers said they did not want to take the children back, while for another 21 percent, the carers said they would like to have them back but could not do so at present (Table 64).

As might be expected, if the mother is still present in the household, the percentage of separated children whose mothers or carers refuse to take them back is slightly lower, but the difference is not great (8 percentage points).

Table 64: Share of Separated Children whose Parents or Carers Would Like to Take Them Back from Public Care

"Would you like to take the child back?"	Total separated children	Separated children from households where the mother is still present	Separated children from households where the mother is no longer present
Yes, I would take him/her back any time	15	15	14
Yes, but I cannot take him/her back now	21	23	16
No, I don't want to take him/her back	64	62	70
Total	100	100	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

The variables that predicted the frequency of mothers' and carers' interactions with the child also predict their desire to take the child back home, but the most important predictor is the frequency with which mothers contact their separated children. Most of the previously identified predictors also apply to the desire to get the child back, for example the age at which the children were separated, the number of years since the last separation, the household income level, whether the mother is in a stable relationship or not, whether the mother was in a relationship with a man other than the child's father at the time of the separation, and whether the mothers had discussed their separated children's situation with a representative of the local or county authorities (Annex 6 Table 76). However, the most important predictor (which cancels out the influence of all of these other characteristics) is the frequency of interaction between the separated child and the family in the last year. For 40 percent of children whose mothers interact with them at least a few times a month, the mothers say they would

take back the child any time. However, only for 7 percent of the children who have not been contacted at all by their carers in the last year, their parents stated they would take them back any time.

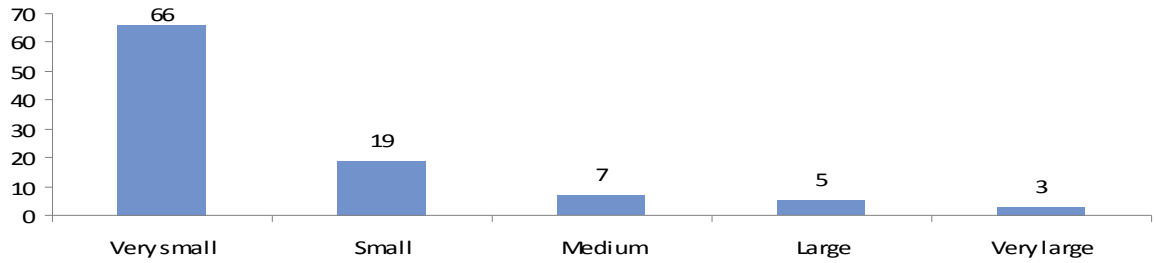
Table 65: Percentage of Separated Children Whose Mothers Still Living in the Household Would Like to Take Them Back, by Frequency of Interaction

	Would you like to take the child back?			
	Yes, I would take him/her back any time	Yes, but I cannot take him/her back now	No, I don't want to take him/her back	Total
Weekly or several times per month	40	36	25	100
Once a month	44	38	19	100
Several times a year	16	39	44	100
Once a year	12	35	53	100
Rarely or not at all	7	15	78	100
Total	15	23	62	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Fewer than 10 percent of the mothers present in the sampled households believed that they had a good or very good chance of taking their children back home. Their desire to reintegrate the separated children does not overlap perfectly with their intention to do so. Even though, for almost 40 percent of the separated children, mothers stated that they would like to take them home (either now or later), the mothers of only 8 percent of the separated children estimated the chance of this happening as good or very good, while for another 7 percent, they estimated the chance as average.

Figure 102: Chances of Getting Separated Children Back as Estimated by Mothers Still Living in the Household (%)



Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: Based on answers to the question "In conclusion, how great do you think are your chances of being able to take the child back?"

When analysing to what degree the chances estimated by the mothers, on the one hand, and their desire to get the children back in the next period, on the other, overlap/match we obtain an even worse picture of the reintegration of separated children.

The mothers of 7 percent of the separated children said that, although they would like to take their children home any time, they thought the chances of this happening in the future were small or very small (Table 66). Similarly, the mothers of 18 percent of the separated children said they would like to take their children back at a later date, but they thought that the probability of that happening was low or very low. The reasons that were most frequently mentioned by the mothers for their low expectations of reintegration were related to their lack of good housing conditions (62 percent), their low incomes (49 percent), and the large number of children already living in the household (29 percent) – see Annex 6 Table 77. A significant number of mothers also mentioned the reason that their separated child would not want to return - a quarter of the cases where the mothers wanted to take their children back immediately but believed that the chances of that happening were small or very small.

Only for 7 percent of the separated children, their mothers who were still living in the household said that they believed there was a good or very good chance of the child being reintegrated and that they would take them back any time. However, even within this small group who potentially has the best chance of reintegration, in two-thirds of cases, the mothers could not estimate when they would be able to take the children home, and in another 7 percent of cases, the mothers said it could take more than three years until reintegration (Annex 6 Table 78). Only the mothers of 16 percent of these children (representing less than 1 percent of the whole sample) estimated that they would be able to take their children home in less than a year.

Table 66: Estimated Chances of Separated Children Returning to their Mothers Still Living in the Household and the Mothers' Desire to Take Them Back

	How great do you think are your chances of being able to take the child back?					
"Would you like to take the child back?"	Very small	Small	Average	Big	Very big	Total
Yes, I would take him/her back any time	4	3	2	3	2	15
Yes, but I cannot take him/her back now	8	10	3	2	1	23
No, I don't want to take him/her back	55	6	1	0	0	62
Total	66	20	7	5	2	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

For another 6 percent of the children (18 cases in the sample), the mothers estimated average, big, and very big chances of reintegration, but also they said they were unable to take the children home right at that point. For 14 out of the 18 cases, the mothers could not estimate when they would be able to take their children back, and only in one case of the 18 did the mother say that she would take her child home in less than one year.

CONCLUSIONS

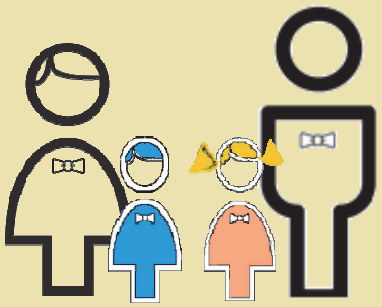
The findings of this chapter reinforce and complete those of sections 3.3.4 and 3.4.1: children who were separated when they were under age 2 are over four times more likely to have had no interactions with their parents or carers in the last year than children separated at the age of 6 or over. Beyond the frequency of interaction between the separated children and their families, it is important to establish the extent to which the mothers or other former carers want to take the children back.

Although the intention is to reintegrate separated children with their parents, their families' assessment of the likelihood of the reintegration reveals a less optimistic picture. More than half of the separated children had no contact with their parents or other former carers after the separation, and the percentage is closer to 70 when the analysis focused solely on the previous year (the percentage is high even if the sample includes children who have been separated for less than a year).

The frequency of children's interactions with their families decreases significantly when the following factors are involved: (i) the child was very young at the time of the separation; (ii) the child has been separated for a long time; (iii) the mother is not in a stable relationship; (iv) the mother's low education level; and (v) the location of the child's household of origin in a marginalized community. The more of these factors that apply to a given separated child, the lower the chance of that child being reintegrated into the family of origin.

In the absence of any intervention to change the household circumstances leading to the separation, for 64 percent of the separated children parents or other carers stated they would no longer take them back home. Moreover, for only 8 percent of children do their mothers consider the likelihood of reintegration as being high or very high (for another 5 percent, the mothers estimate the chances as average). For the vast majority of the children who theoretically stand a good chance of being reintegrated, their mothers either could not predict when they would be reintegrated or said that reintegration would not happen for another three years or more. For fewer than 1 out of every 100 children from source communities, their mothers estimated that the reintegration would occur the following year.

There still are parents who would take back their children even if no intervention were carried out. These parents should be given all necessary support with the utmost urgency in order to reintegrate these children back into their families. Moreover, among the other group of parents, it is very likely that at least some would take home their children provided that they were provided with effective support. Consequently, we underline the urgent need for interventions that would alter the household circumstances leading to the separation, not only to increase the chances of reintegrating separated children but also to prevent separation in the first place by improving the living conditions for all children in the family.



4 Conclusions and Recommendations

4 Conclusions and Recommendations

"The aim is to make it harder for people to do something wrong and easier for them to do it right." [443]

The goal of this study has been to analyze the current status of the Romanian child protection system in order to identify priority actions that would improve the quality and increase the effectiveness and efficiency of public care (special protection) services. These actions would help put into effect the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* regarding: (i) the transition of the system from institutional care to community-based services, and (ii) the identification of sustainable solutions for children separated from their parents. The analysis focused on the children who are temporarily or permanently separated from their parents and in public care or children who are at risk of being separated from their family. The study has generated evidence towards creating a good/effective child protection system.[444]

This report is based on various quantitative and qualitative data: a study of source communities in rural areas, case studies of source communities in urban areas, an analysis of the case files of children in public care, including adoption forms, a survey of case managers, and focus groups with professionals and children in public care.[445]

The public child care system (special protection system) in Romania has to cope with multiple and complex challenges given that it is one of the largest systems in the region and has to provide adequate care solutions for approximately 60,000 children. However, in terms of the number of children in public care as a share of the total child population, Romania holds an average position in the region (with 1,600 to 1,700 children in the state's care per 100,000 children aged 0 to 17 years versus an average of 1,850 per 100,000 both in the CEE/CIS region and among the countries in Eastern Europe and Central Asia).

The study has revealed the many efforts being made to improve Romania's child protection system both at the legislative level and in terms of working practices. Nevertheless, many challenges must still be addressed in order to ensure that the system is truly focused on supporting the rights of children and their families. As the conclusions in this section emphasize, the current system faces several internal issues, many of which require both a short-term and a medium-term solution. Yet many solutions for improvement are to be found outside the child protection system and in its coordination with other systems such as the social assistance system, the social benefits system, the education system, the health system, and the labor market. Therefore, the recommendations in this section are intended not only for professionals within the child protection system at all levels (national, county and local) but also for those in other social sectors. Only by taking a systematic and coordinated approach to the conditionalities that exist outside the system will it be possible to substantially improve the special protection system outcomes for children and their families.

[443] US Institute of Medicine (1999) in Munro (2010:10).

[444] A good child protection system in accordance with the guiding principles highlighted by Munro (2011b).

[445] In total, 16 regional focus groups were held between April and June 2015.

The conclusions and recommendations below are structured according to several themes, which largely represent the key guiding principles of an effective child protection system.[446] The implementation of some of these recommendations will require substantial resources, while others will require fewer resources but more time. Irrespective of the extent and type of the resources required, there are a series of problems that need urgent resolution or implementation.

Theme 1: Coordinating all interventions at the local level including health, education, social work, and social benefits to ensure prevention, early identification, and intervention

Social benefits and services and the health and education systems in Romania are currently unable to prevent the separation of children from their families. The study has revealed that, of all children in public care with or without a social assessment report in their case file, only 29 percent received any prevention service. Prevention activities are poorly funded in the social, education, health, and social work sectors, which tend to be reactive and to focus on effects rather than causes. In order to change this working philosophy, government policy needs to focus on early identification and intervention by coordinating all current services at the community level, including developing and introducing a minimum package of services for children and families. This is a necessary but not sufficient condition. In the longer term, it will be necessary to develop integrated services at the community level, which are much more effective with respect to prevention. At the same time, it will be crucial to find a sustainable mechanism to finance these interventions from the budgets of the many relevant ministries and to ensure that these expenditures are fully reflected in the state budget multiannual programming. For the government to adopt such a policy would be an endorsement of the principle that "the family is usually the best place for bringing up children and young people." Only this change of approach has the potential to substantially reduce new entries into the child protection system.

Preventing children from going into protective care should be deemed a priority and should be properly funded. The Romanian child protection system is currently unable to prevent child-family separations and sometimes it wrongfully separates children from their families. However, this is no surprise in light of the circumstances highlighted in this study.

The study has revealed that the Romanian child protection system allows certain children to enter public care even though the separation could be avoided, they could grow up within their families if early and coordinated interventions were available. The child protection system cannot and should not have to solve the inefficiencies of the social benefits system, fill the gaps in the education and health care systems, substitute for the poor development of services for people with disabilities or vulnerable groups, or operate in the absence of policies and investments in social housing. However, at the present time, the child special protection system seems to be called upon to mitigate all of the negative effects that these deficiencies in other systems have on children. Thus, one could say that the public care system is forced to be mainly reactive and focused on solving "emergencies."

In Romania, the following situations have occurred. Five siblings entered public care because their parents could not pay their electricity bill and the local authorities/community failed to step in to help. Three siblings entered the system because their mother was beaten every day by her partner, and her neighbors, the police, and other locals did not intervene, so she had to run away but had nowhere to go with her three kids. A baby only a few days old ended up in the system because his mom was evicted from a squalid social housing room because she failed to pay the rent for the previous three months. Other babies have ended up in the system because their mothers were accepted into maternity wards without IDs and they ran away after giving birth. Other babies are admitted to hospital because their parents say they cannot afford to keep them and then leave. There are children who enter the system because they need "a place where they can die in peace, without being kicked out,"[447] while others end up in public care because they cannot attend a school in their community. There are children who enter the system because their families cannot afford to feed them and because the municipality, instead of supporting them, calls the DGASPC. Meanwhile, in source

[446] According to the eight principles formulated by Munro (2011b) (see Box 1 in this study).

[447] Story Bag 4a - Interview with the parent of a child at risk of separation, Craiova.

communities and marginalized areas, nobody intervenes because "they are all poor, all of them have nothing to eat, all of them are jobless and all of them lack electricity",[448] and "the end result would only be taking the children into public care."[449] This is the current state of the Romanian public child care system, called upon to find emergency solutions for children who have been let down by the inadequacy of other systems.

A first step towards ensuring that Romania has a good child protection system[450] must be to change its emphasis from "emergency response" to "preventing child-parent separation." In the context of such extensive need and given the limited and deficient supply of services currently on offer in communities, the only realistic and economically reasonable option is to focus on reducing the number of entries into the system. At the same time, the deinstitutionalization process should be continued, starting with the traditional institutions (those that have not been modernized), and suitable family care alternatives should be found as permanent solutions for those children who are in or will enter the system.

The only way to shift the system focus onto preventing child-family separations is by increasing the provision of preventive services, in particular those at the community level. Because these services are located within the community, they can act as a filter to reduce the number of children entering the system as well as provide the support needed for the reintegration of children with their families, thus increasing the number of exits from the system. Unless something changes with regard to community services, the protection system will be unable to enhance its performance or to provide better solutions to the problems faced by children and their families.

The change model proposed in this study does not advocate for the need to develop every kind of service in every remote hamlet in the country. It would be useful to conduct a national assessment of the existing services and to prioritize the needed services so that the available resources can be invested in the most efficient way to have the greatest positive impact on the children and as balanced a geographical distribution as possible.

To enable the system to respond more adequately to the needs of vulnerable children and families, it is essential that every commune in Romania (especially those in source communities and/or marginalized areas) has at least one SPAS person with social work responsibilities and higher education. Ensuring specialized staff within every SPAS is the desired model envisaged in the *National Strategy for the Protection and Promotion of Children's Rights 2014-2020*. In addition, what is needed is for social services at the community level to be integrated, and the World Bank has developed such a tailored operational model in the implementation plan for the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, "Develop integrated social services at the community level".

Mobilizing financial support from the EU could contribute to sustaining this paradigm shift and to initiating a review of some of the policies designed to prevent child-family separations at community level. Also, developing a plan for monitoring and evaluating the transition from institutional care to community care is vital.

The ANPDCA has already made certain steps in this direction, through a project funded under the Administrative Capacity Development Operational Program. Throughout the project implementation, the ANPDCA is collaborating with the relevant officers from the MMFPSPV, the ANPD, the Ministry of National Education and Scientific Research, the Ministry of Health, relevant associations (such as the Romanian Association of Communes, the Romanian Association of Towns, the Romanian Association of Municipalities, and the National Federation of Local Action Groups), as well as institutions at the county level that ensure methodological coordination for the services provided at the local level,[451] and NGOs with experience in the field of child protection. The latter have already developed or piloted projects with high potential for good practices that could be rolled out nationwide. To maximize the

[448] Focus group with professionals, Bucharest.

[449] Interview with a professional, Bacău.

[450] As defined by Munro (2011b:23), see Box 1 in this study.

[451] For example, the DGASPCs for the SPAS and the Public Health Directorates for community health assistance, etc.

chances of a well-coordinated plan being implemented successfully in the medium and long term, it must be developed based on a partnership of all relevant stakeholders.

If local authorities are not mobilized, kept informed and involved throughout the process, there is a high risk that the resulting plan will be implemented in a random and distorted manner, since according to the child protection specialists consulted for this study: "Preventing child-family separation is not on the political agenda, nor is it on the agenda of communes." "There is no local community initiative." "Preventing child relinquishment is not important to them. It is not important, they are not going to spend resources on it, it's the problem of every family." "It is very clear, you will never find priorities related to these children in need on a mayor's agenda. They have political priorities of a different kind: roads, schools, things that generate money." (Focus group with professionals, Cluj-Napoca)

With regard to the health system, an adequate response needs to be developed to the problem of children being relinquished in health units. More than half of the children placed in public care have entered the system at early ages, especially before reaching the age of 1 year. Specifically, the efforts related to the relinquishment of children in medical units need to be strengthened by: (i) monitoring all pregnancies in accordance with clear protocols for active/early identification of mothers at high risk of relinquishing their babies and for prompt referral to social services; (ii) ensuring that social workers are employed in all medical units (especially maternity and pediatric wards); (iii) ensuring sustained enforcement of Government Decision 1103/2014 for approving the methodology for implementing the responsibilities assigned to the local public authorities, institutions and professionals involved in preventing and responding in cases of children at risk of relinquishment or relinquished in medical units; (iv) introducing sexual education and family planning programs targeting risk groups such as single-mothers and teen parents, particularly in source communities; and (v) strengthening adequate child protection response services for children aged between 0 and 3 in all counties of the country, especially for children with disabilities and/or with very low birth weight. In all of these actions, the role played by community health nurses is essential. In the absence of enough community health nurses and Roma health mediators, particularly in marginalized areas, source communities, and in the 6 percent localities lacking family physicians, it will not be possible to break the vicious circle that leads to children being relinquished.

As far as the social assistance system is concerned, first it will be necessary to revise the local level allocation of benefits and human resources intended for the early identification of at-risk children and their families. The study has shown that, prior to their entering the system, over 60 percent of all children in public care[452] lived in families who were not receiving any social benefits. This result contradicts the opinion held by many of the system's specialists who cite dependence on state aid on the part of families with children in the protection system as the main reason for all these families' problems, including the separation from their children. Therefore, the national policies for fighting poverty as well as the system of social assistance benefits need urgent revision in order to better serve very poor children and their families and to respond more efficiently to the challenges that they face. To increase access to social benefits for vulnerable groups, it will be necessary to speed up the consolidation of means-tested social benefits programs into one single program - the Minimum Social Insertion Income (MSII) program. This will reduce the time that social workers have to spend on paperwork, freeing them up to provide the necessary services for families at risk of separation. At the same time, the MSII will reduce the high exclusion rate of poor families for means-tested social benefits.

Every child, mother, and family should receive administrative aid at the local level to obtain all necessary documents, starting with the ID papers. Also, to reduce extreme poverty and the number of homeless people, social housing should be provided as part of an integrated package of social services for children at risk of separation and their families. By ensuring access to basic resources such as water, shelter, heating, electricity, the housing services that are part of an integrated basic package of services would address issues that affect family and child health and education.

[452] Not including children relinquished in maternity wards.

As far as the education system is concerned, it will be necessary to extend the integrated special education system for children with special educational needs (SEN). Measures enabling one to continue education or reducing the risk of school dropout, especially for children in rural areas, are essential. Measures that aim to increase the educational inclusion of children with disabilities and/or SEN should include: (i) promoting the right of children with disabilities and/or SEN integrated in mainstream education to a customized training program, support teachers, and other support services; (ii) developing new resources and teaching materials for pupils with SEN (based on a tailored curriculum) and facilitating their access to these resources; and (iii) developing national training programs for teachers in inclusive education, in particular for those currently working in classrooms that include at least two-three children with disabilities and/or SEN. At least 7 percent of the children in public care who had a social assessment report in their case files had special educational needs that had resulted in their institutionalization in the absence of any appropriate educational services at the community level. Problems related to education start early, with only 49 percent of the children who entered the system when they were between 4 and 6 years of age having attended pre-school compared to 86 percent of the general population of children aged 4 to 6. In this case, early intervention for families at risk of separation could consist of providing their children with access to early education, for example, by subsidizing kindergarten or nursery tuition fees for families with low incomes.

Moreover, according to the recommendations set out in the *National Strategy for the Protection and Promotion of Children's Right*s *2014-2020*, an integrated system of early screening and comprehensive evaluation for children with disabilities should be developed to include: (i) full screening programs for an early identification of disability; and (ii) a simple and low-cost way for the disabled child's family to obtain certification for a disability, the school/vocational guidance certificate, and a service plan.

At the same time, the study conducted in the source communities revealed that it is possible to identify communities with a higher risk of children being separated from their families and that preventive measures for these communities should be prioritized. In the absence of integrated preventive interventions in these source communities the system's response is limited to reacting to emergencies, most often when children are relinquished in maternity wards or health units. Adequate budgetary allocations will be required that will allow for flexible and customized service plans/ interventions to meet the specific needs identified in each community.

Theme 2: Supporting families and children involves working directly with them

Contrary to the general opinion that "the large majority of children placed in institutions are not orphans but have one or even both parents."[453] This is the case for the child protection system in Romania as well for all children in public care, whether in institutions or in family placements. Child protection specialists need to work directly with children's parents and families before the children enter the system, as a primary preventive measure, while they are in the system, to achieve the PIP goals, and after they exit the system, to monitor PIP goal achievement outcome. The study recommendations refer primarily to DGASPC and SPAS professionals but also to specialists in other social sectors who work directly with the child and family such as family physicians, community health nurses, and teaching staff.

With regard to families, the study has found that it is essential to work directly with the mothers since over 90 percent of the children in public care have mothers who are alive and known. Nevertheless, even in the case of these mothers, there is an issue of unsystematic and incomplete information about their situation. Information from CMTIS or the children's case files on the mothers' civil status, health, education, and occupational status is scarce and outdated. The available data indicate that reintegrating children with their families requires substantial efforts and the provision of consistent support to these mothers by both child protection professionals and other institutions in order to ensure a family environment that can offer the child real chances at developing properly. Otherwise, reintegration will only mean sending the child into a highly unstable and unsuitable environment.

[453] Eurochild and HHC (2014:3)

Moreover, over 18,800 children (37 percent) in public care come from single-mother families, so, for them, reintegration will be just another word unless their mothers are provided with actual support. Reintegration should be carried out based on a medium-term plan, which should be prepared with the input of both the mother and the child.

Over 4,300 children (8 percent) of the children in the protection system have no nuclear or extended family to return to. These are boys and girls of all ages, of all ethnic groups, with or without disabilities. For these children, the goal stated in their individualized protection plan should be reviewed to ensure that, from the moment they leave the system, they have the same chances in life as children with a family.

Given the dominant profile of parents with children in public care, it is obvious that they will need parental education and intensive support to be able to fulfill their parental obligations in a responsible manner. Most specialists emphasize the lack of adequate parenting skills among parents of children in care, generally as a result of their low education levels and often due to their own past history of childhood abuse and neglect.[454] The study has also revealed that many cases of avoidable entries into the system are not only the result of poverty and precarious housing but also of a lack of sufficient support to enable families to overcome their difficult circumstances and keep/take their children home.

To increase the effectiveness of the special protection system, in addition to providing parental education services, it will also be necessary to tackle the individual risk factors associated with parental behavior, which would significantly influence the number of new entries into the system as well as the "quality" of the exits from the system via family reintegration. Thus, it is recommended to improve reproductive health medical services and mother and child health and nutrition services, and to increase the access of vulnerable categories to these services, as well as to strengthen services for households/families dealing with parental excessive alcohol and/or drug consumption, promiscuous and/or criminal behavior, disabilities and/or mental health problems, and domestic violence.

Furthermore, the study has found that the current situation in terms of household-social worker interaction does not offer reasons for optimism. For instance, in households with children out of which at least one child was in public care at some point, only 15 percent of the people taking care of the children stated that they had interacted with the SPAS social worker on a monthly basis while another 24 percent stated that they had such interactions only once every two to three months. In households where the mothers of separated children are still present, these interactions are equally rare, with shares being slightly higher when mothers live in households with other children. Irrespective of the type of household involved, no more than 20 percent interacted with social workers every month, and in approximately a quarter of all cases, social workers never met with any members of the vulnerable households.

The other factors that influenced the frequency with which respondents interacted with the SPAS staff with social assistance duties were the education level of the social worker, the characteristics of the communities, the number of children in the household, and the location of the household within the village. If the mother lives in a poor quality dwelling on the outskirts of a village or commune, the likelihood of her having any interaction with the social worker drops dramatically. Yet, there is an even greater drop when the social worker lacks higher education (especially when it comes to households with children present or with children who were separated at older ages).[455]

The recommendations associated with this theme need to be viewed together with those related to *Theme 7: Improving and systematizing working practices,* particularly regarding the inter-institutional collaboration between the DGASPCs, the SPAS, and the Community Consultative Structures (SCC). The study has revealed that no family member could be found at the address recorded in the CMTIS for

[454] This deficit of parenting skills is even more noticeable in the case of children with special needs, such as infants in their first months of life, children with disabilities (especially with severe ones), and teenagers with behavioral problems.

[455] It is of concern that, when a mother has a low level of education and does not live with any other child, the probability of having frequent interactions with a social worker decreases to no more than 44 percent, even when the social worker has higher education and children were separated at older ages.

almost 40 percent of the mothers of children in public care from rural source communities. Given the geographical dispersion of the families of children in public care and the intensive effort that their coverage entails, if only in terms of keeping accurate records of them, it is obvious that this effort cannot be made by case managers alone. Their responsibilities need to be shared with the social workers who are the closest to these families and who are in the best position to monitor their situation.

In line with provisions of the *National Strategy for the Protection and Promotion of Children's Rights 2014-2010* and the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, we recommend the introduction of a minimum package of interventions to be implemented compulsorily in each rural and urban community.[456] This minimum package should include the following child- and family-relevant interventions: (i) outreach activities, key to identifying potential beneficiaries and carrying out early intervention services; (ii) an assessment of the needs of vulnerable or at-risk communities, households, and individuals and the planning of the necessary services that are focused on the family and the individual; (iii) information and counselling services targeted to vulnerable groups, those exposed to social risks, people who have experienced domestic violence or neglect, drug consumers, former convicts, single-parent families with low incomes, and young people in risky situations (such as young delinquents, school dropouts, and children from families with low incomes); (iv) administrative support (such as helping clients to fill in the application forms for benefits of any type) as well as social, health, and legal assistance; (v) referral to specialized services; and (vi) monitoring of and home visits to all people in vulnerable situations within each community.

Theme 3: Youths and children have rights, including the right to participate in decisions that affect them

Children's voices are still insufficiently taken into account in the activities or decisions concerning them. For two-thirds of children in care aged 10 and older, there is no mention or statement in the case file about their opinions of the quality of the services they received and their level of satisfaction. In other words, two out of three children in the child protection system are not consulted about their opinions and preferences. The one third who were consulted generally expressed positive opinions.

Out of all of the needs that children have, the most important is the need to have their voice heard, to have somebody they can talk to, a person to whom they can tell anything and whom they can trust. Intense communication with the child should be one of the key tasks carried out by the staff working with children in public care. They should spend time with children on a daily basis, when they should listen to their stories, dissatisfactions, joys, opinions, needs, and desires. Children should also be consulted and actively involved in planning daily activities, in the preparation of their intervention plans, and in all aspects of their lives, such as education, health, and leisure. In order to develop the skills needed to live an independent life, it is very important that these children learn to make decisions (including about issues that seem of little importance to children living in a family) and to manage their lives.

To increase children's participation in the protection system, besides formal rules, procedures, and guidelines, it will be necessary to build the communication skills of the staff working directly with children and enhance their knowledge of participative processes. The training programs should focus more on encouraging children to participate in the decisions that affect them rather than on listening to their views in order to make decisions about them. Also, to overcome organisational barriers, it will be necessary to ensure that case management is carried out in a way that is much friendlier to children.

[456] MDRAP (2014). Enhancing the administrative capacity to ensure access to quality public services is one of the overall goals of the Strategy for Strengthening the Public Administration 2014-2020 (Goal IV, Annex 1:83-85). The Strategy recommends the development of quality and cost standards for all public services in order to improve their efficiency and quality. It also proposes the development of a minimum package of public services that every territorial administrative unit should supply, as well as an optional package of services that should be provided by the more developed localities.

Theme 4: The system needs to provide solutions which are tailored to children's different needs and situations

The diversity of children's needs was reflected in the case files both in terms of their initial circumstances and of the reasons for separating them from their families. Therefore, it is vital to carry out a thorough analysis of each child's situation because the needs of children vary significantly depending on their age, gender, area of residence, and health. This means that the child protection system needs to offer an equally wide range of services in response to such needs. Specifically, the social assistance, education and health systems need to offer adequate prevention responses in order to decrease the number of new entries into the system and to improve the range of services available at the local level to increase the number of children in public care who are successfully reintegrated into their families.

The analysis of the causes of child-family separation has revealed that the case files of over two-thirds (65 percent) of the children in public care mentioned a multitude of vulnerabilities that these children and their families faced prior to their entering the system. The categories of children with a higher than average risk of being institutionalized were: (i) children who had disabilities when they entered the system; (ii) children with developmental delays when they entered the system; (iii) children between 6 and 17 years of age with special educational needs when they entered the system; (iv) children between 7 and 17 years of age with behavioral disorders when they entered the system; and (v) infants between 0 and 12 months born prematurely and/or underweight.

Overall, the case files indicated that 76 percent of the children in public care had more than one reason for being separated from their families, including unfortunate events (one or both parents' death or institutionalization), neglect, abuse, or exploitation, child relinquishment, and/or the parents being deprived of their parental rights. The other 24 percent of the children represent avoidable entries, whose case files explain the entry into the system either on the basis of parental risk factors[457] (12 percent), or of the child's belonging to one of the groups with special needs (5 percent), or of structural factors[458] (7 percent). In total, avoidable entries represent approximately a quarter of all entries, irrespective of the year of reference. A decrease in avoidable entries into the child protection system is a good indicator of the effectiveness of prevention measures.

Children in public care, whether in institutions or family-type care, are boys and girls of all ages between 0 and 26 (and sometimes older). Most of the children placed in the care of child protection services are between 10 and 17 years of age. This age group represents more than half of the children in public care (56 percent), and their total number and share have constantly increased in the past four years. Children with disabilities represent a significant share (almost 29 percent) of all children in public care. The share of people with disabilities increases gradually from approximately 6 percent of children under 1 year of age to over 43 percent of young people between 18 and 26+ years of age.

With regard to the types of services provided by the system, thorough analyses are necessary of chil'ren's placements with relatives or with other families or individuals.

For children placed with relatives for social reasons only (related to poverty and precarious housing), the government should consider replacing this social protection measure with a special social benefit managed by the SPAS, possibly as part of the Minimum Social Insertion Income (MSII), which is expected to become operational soon. This new benefit would be a preventive measure that would: (i) benefit both the child and the family; (ii) increase coverage of such cases; and (iii) be uniformly applied nationwide. Of course, such an initiative would have to be well thought out and designed to minimize fraud and errors, serve the best interests of the child, and ensure that children and the families caring for them receive adequate support within the community.

[457] The individual risk factors analyzed in this study are: parents who leave to work abroad, dysfunctional families, adolescent mothers, parents' excessive alcohol and/or drug consumption, domestic violence, and parents with disabilities and/or mental health problems.

[458] The structural risk factors analyzed in this study are: poverty/low socioeconomic status, dependence on social benefits, no stable dwelling, homeless families, evictions, vagrancy, characteristics of source communities, lack of services within the community, and attitudes and values that do not support the prevention of child-family separations.

For the time being, placements with other individuals or families, regardless of the purpose for which they were initially created, are not a solution that can be targeted either to a specific group of children or to specific types of difficult situations that the children may go through. It will also be necessary to clarify the relation between placements with other families or individuals and the adoption process since our research has shown that, in most cases, the adoptive parents wanted to adopt the child who had already been placed with them.

Most DGASPC specialists distinguish two specific groups of children with special needs in public care: children with behavioral disorders and children with disabilities. None of the PIP goals are appropriate for these two groups of children. Children with behavioral disorders are not provided, either outside or within the system, with the most effective services to enable them to prepare for an independent life or to be reintegrated in their families. With regard to children with disabilities, particularly those with severe disabilities, it should be acknowledged that they will need long-term placements. Therefore, the methodological norms for the Individualized Protection Plan (PIP) and the specific intervention plans (PIS) should be revised to take the long-term needs of these groups of children into account. On the other hand, it is also important for the system to provide a wide range of services in order to enable the setting of more effective goals and intervention plans for each child in care. Of course, too many norms and regulations can result in child protection specialists having to spend too much time on paperwork and not enough time on working directly with the children. Nevertheless, there needs to be a balance between gathering the necessary information on the children and their circumstances on the one hand and spending time doing right by children on the other.

The study revealed that adoption is a solution open to very few children in public care. The children who enter the adoption process are children with a range of very different characteristics, but those significantly more likely to complete the process are toddlers (between 0 and 2 years old), girls, children with no siblings in the system, and children with no disabilities and/or developmental delays. An adoptable child's actual chances of being adopted depend to a large extent on the number and the outlook of the potential adoptive parents. Since many prospective adoptive parents want to adopt a particular child, often the one who had already been placed with them, the actual number of parents who are open to adoption is in fact much smaller. Therefore, it will be vital to increase the number of prospective adoptive parents in order to increase the chances of successful theoretical and practical matches between the adoptable child and the potential adoptive family. It will also be necessary to increase the effectiveness of the courses attended by those individuals and families who want to adopt a child as well as to improve the professional training of the DGASPC specialists on how to communicate with potential adoptive parents, particularly with regard to the needs of children with disabilities. At the same time, there is a need for education and communication campaigns at the community level that not only foster a positive attitude towards adoption and adopted children but also discourage the rejection and undervaluation of children, irrespective of their gender, age, ethnic origin, health condition, or parents.

Theme 5: The success of a child protection system is determined by the effectiveness of the actual support children receive

Many children end up in public care when they are younger than 3 years, often under 1 year old, and thus face a real risk of becoming "children of the system." Moreover, the absence of any interaction with their family since their separation only increases the chances that these children will spend most of their life in the system until they reach the legal age to leave. Children who were separated when they were less than 2 years old are more than four times more likely not to have interacted at all with their parents or other caregivers in the previous year than children separated at the age of 6 or older. Besides the frequency of interaction between separated children and their families, it is also important to establish to what extent their mothers or other former caretakers want to take their children back.

Although the system's intention is usually to reintegrate children into their families, the study's findings regarding their families' views on their reintegration present a less optimistic picture. More than half of all separated children have never had any contact with their parents since the separation, and close to 70 percent of them have had no contact in the previous year (the percentage is similarly high even if the sample includes children who have been separated for less than a year).

The parents of 64 percent of the separated children say they do not want to take them back home. Furthermore, according to the mothers who were interviewed for this study, the chances of being reintegrated were high or very high for only 8 percent of all children in care (while for another 5 percent, the chances were rated as average). Also, for the majority of these children with chances of being reintegrated, the mothers were not able to estimate when the reintegration was likely to take place or they said that it was unlikely to take place for at least another three years. For fewer than 1 in every 100 children in public care from the source communities, their mothers estimated that their reintegration would take place in the following year. This shows the urgent need for interventions that would improve the circumstances of the source families not only to increase the chances of the child being reintegrated into the family but also to prevent any future separation.

On average, children spend 7.5 years in the Romanian child protection system. However, there are many children who stay in the system much longer than the average, and more than 13,000 of them have spent their entire lives so far in public care. One in every five children aged between 15 and 26 who are now in public care have spent their entire lives in the system, and almost one in every three children has spent 90 percent of their lives there. This means that there is a pressing need to develop exit paths that would offer these children real chances for the future. Because they entered public care 15 to 26 years ago, they are likely to have gone through many centers, but the "system" is the only family they know. Their integration in society or socio-professional integration will be nothing but words on paper if, once these young adults reach the age when they have to leave, the "system" simply withdraws just as their parents disappeared when they were little, leaving them with no skills to live an independent life, no solid education to enable them to earn their living, and with no housing choices.

The system should address this risk by creating two distinctive institutional paths to prepare children for a life after being in care. The first path, for an independent life, would comprise not only family-type alternative care in smaller communities but also social housing or sheltered houses for children when they come of age (18 to 26 years old). The other path should be for children with severe disabilities who are unable to manage on their own. In the absence of these paths, the child protection system provides childhood care, but, despite its aim to make all necessary efforts to keep children with their families, it failes to fulfil its long-term objective for the thousands of young people leaving the system each year with no support from their families. For children with disabilities, especially with severe disabilities, experts acknowledge that long-term placement solutions are needed. If no other permanent solution is possible when they become adults, then they should be able to continue living in the small group homes in which they are currently living as children.

There is a special need for support services for young people with disabilities who live in their communities. First, it will be necessary to remove any attitudinal and environmental obstacles to the habilitation and social reintegration of children with disabilities. Second, it will be necessary to provide a basic package of integrated social services, including all basic health and education services as well as habilitation/rehabilitation services, that are friendly and accessible to children with disabilities and their families. Specialized mobile support teams should also be established to service those children who live in areas in which it is not feasible to develop habilitation/rehabilitation services. In addition to such support services as home help for people with complex dependencies or assistance in performing daily household activities and personal care, there is a wide range of needs that is specific to young people that should be addressed. These include: (i) the need to obtain and keep an affordable dwelling, to live independently, and, in some cases, to manage financial and personal goods; (ii) the need for habilitation and rehabilitation adapted to their specific needs and provided in the context of an independent life; (iii) the need for professional training, education, professional mentoring, and assistance in finding employment (all of which must be capable of being tailored to the needs of people at various ages and at various stages of the professional cycle); (iv) the need to access other community services (such as health care, legal services, outdoor activities, cultural activities, and leisure centers); and (v) the need to have a balanced family life (which implies, for example, family counselling and sexual education). The services that enable independent living represent a distinctive and important category of support that must be developed in the next few

years, especially in the context of the post-institutionalization social integration of young people with disabilities as well as of the system's transition from residential care to community services.

Theme 6: Improving and systematizing working practices

At the time of the study, the practices of DGASPC professionals were found to be unstandardized and not sufficiently or not at all based on reliable data regarding the history of children and/or their families. As has been shown several times in this report, the practices of social workers or people with social assistance duties, as well as of professionals at the local level are also inconsistent and largely depending on circumstances that should not affect one's work. Therefore, working practices need to be improved across all three stages of the child's journey through the protection system - prior to the child's entry (understanding the causes leading to the child's separation from the family), within public care (drafting, implementing, and monitoring the Individualized Protection Plan), and upon exiting the system (monitoring the child and family's welfare after he or she leaves the system).

This study has revealed that the practices used by professionals to select and record the cause of child-family separation are generally based on the factual data contained in the child's case file. However, DGASPC specialists tend to overuse "poverty" as a cause of separation even when there is evidence of child neglect or abuse or the death of the child's parents, for example. This overuse of "poverty" as a cause of separation is encouraged by it being listed among eligible justifications, unlike child relinquishment. Also, it will be essential to improve the way in which neglect, abuse, and other forms of exploitation of children are understood and recorded in order to ensure that relevant long-term, post-separation individualized protection plans can be drawn up for each child in this situation.

Also in the stage prior to the child's entry into public care, it would be useful to develop a stricter procedure governing children entering the system at the family's request, especially based on a decision of the Child Protection Commission. This should start with the proper case documentation and introduce an obligation that requires the authorities to follow all the steps that precede the placement of a child in public care. The procedure should be applied consistently throughout the country, and it should involve the DGASPC multidisciplinary teams (for the initial case assessment), together with SPAS representatives, the Community Consultative Structures, and local authorities.

At the stage when a child enters the system, a comprehensive initial child-focused assessment is essential. In the absence of such an assessment for every child who enters the system, it is impossible to carry out a transparent monitoring of the outcomes of the child protection system.

Even though prevention services focus on offering multiple alternatives in order to avoid new entries in the system, there will still be cases where it will be in a child's best interest to make an urgent intervention with protection measures. Professionals have emphasized the need to make these interventions more quickly in cases of relinquishment or abuse because "two months of delay in making decisions in the best interests of a child or young person equates to 1 percent of childhood that cannot be restored."[459]

The recommendations related to this theme are closely connected with *Theme 7: Developing a high performance management information system*. A work methodology based on an information system would significantly increase the transparency and accountability of the public care system. As a result of using such a methodology, the need to develop services targeting both a decrease in the number of entries into the system and an increase in the number of exists from the system would become measurable. At the same time, by listing types of services or activities not available (and requiring development) in specific communities, it would enable specialists to justify any apparently "avoidable" entries into the system. This methodology would also allow for an enhancement of the interinstitutional collaboration between the DGASPC specialists and the SPAS or SCC staff.

This study has found that the frequency with which a family of a child in public care interacts directly with a SPAS social worker/staff with social assistance duties depends not so much on the social worker's type of specialization as on whether he or she has a higher education or not. Therefore, to

[459] Quotation from District Judge Nick Crichton, Family Drugs and Alcohol Court, Wells St, London, in Munro (2011a:90).

improve the performance of the protection system, it is vital that all communes in Romania (especially those that include source communities and/or marginalized areas) employ within their SPAS at least one person with social assistance duties who has a higher education. Ideally, such a person would be a professional social worker. At the same time, for the efficient implementation of the minimum intervention package recommended under Theme 1, professionals (especially those from universities, service providers, and the National College of Social Workers in Romania) should develop child- and family-centerd tools and methodologies for the adoption, assessment, planning, design, implementation, monitoring, and evaluation of social services.

Theme 7: Developing a high performance management information system

The structural design and use of the current Child Monitoring and Tracking Information System (CMTIS) does not make it possible to extract relevant data regarding the status of children in public care, data that would inform the working practices of professionals, or the assessment of general system outcomes for children and their families. Only about 20 counties use the CMTIS in their daily activities, while the other DGASPCs have developed alternative ICT systems (which are not interconnected and differ from one county to another).[460] According to the survey of case managers that was conducted for this study, 26 percent of all case managers have no knowledge of CMTIS, and only 27 percent reported having used the system during 2010-2015. In addition, there is no clear procedure to ensure the accuracy of the local data entered in the CMTIS.

Second, the information in the CMTIS is not updated. The fact that the study team could not find a high percentage of the households of children in public care from the source communities and that a high percentage of mothers were not present in the selected localities raises a question mark about the quality of the entire information system as such. Even though case managers updated the information "on paper" in the children's case files, it is difficult to access this information and use it in an efficient and integrated way in the absence of a system that is constantly updated in real time both by case managers and by social workers.

Third, the CMTIS is not compatible with other public databases that contain information on families and children and that could be used to identify families at high risk of separation or that could provide rapid alerts in real time about events in the life of families and children that are likely to increase the risk of separation. The World Bank's proposed model of integrated social services developed as part of the implementation plan for the *National Strategy on Social Inclusion and Poverty Reduction 2015-2020* ("Develop integrated social services at the community level"), recommends creating a management information system (MIS) based on the interoperability of public databases.

Identifying the causes for child-family separation and providing early intervention are key to an effective performance of the child protection system. Specific regulations – such as Government Decision 691/2015[461] whose enforcement needs to be supported – should also include a management information system based on one IT program available to both DGASPC specialists and SPAS representatives, using lessons learnt in previous projects. A management information system would help child protection specialists by reducing bureaucracy, while enabling: (i) the use of a consistent approach nationwide, (ii) real-time coordination between the SPAS and DGASPC specialists, (iii) monitoring of the activities carried out by all relevant stakeholders, and (iv) supplying the ANPDCA with sufficient evidence to allow for rapid adjustments to any legislation, programs or measures where necessary.

Moreover, the analysis of existing services (particularly deficient/scarce ones) that would be facilitated by the use of a MIS would become available to local authorities, and, once aggregated at the county and national levels, could be shared with the relevant county and central authorities. In this way, the

[460] The ANPDCA does not keep a register of the different software applications used by the DGASPCs at the county level. There are no standards for the development of such software.

[461] Government Decision 691/2015 for the approval of the Procedure for monitoring the way children with parents gone abroad for work are being raised and cared for and the services available to them, and for the approval of the Work Methodology for DGASPC-SPAS collaboration and of the standard model for the documents developed by these two institutions.

need for more services that would reduce the number of children entering the system and increase the number of children leaving the system would become more visible and measurable.

Therefore, it will be necessary to develop a nationwide child-centerd MIS to substantially increase the current level of data accuracy and consistency at local and national level. This MIS should be a daily working instrument for all local professionals, as well as for case managers and specialists from the public child care system. The data entered into this MIS should reflect each child's full history and should contain enough information to enable child protection professionals to provide efficient support to children in public care and their families/relatives. This theme is connected to all the other six themes because in the absence of reliable and comprehensive data about the child and their family, all child protection system interventions meant to serve the child's best interest will fail.

Reorganizing the System around the Needs of the Children/Young People and their Families

In light of the themes discussed above, this study has identified a few key problems that require urgent solutions, but most of all the political will to completely reform the current configuration of the child protection system, of social assistance and social benefits, and of education, health, social housing, and jobs. Some of the reform objectives that we proposed here are already being undertaken as part of the implementation of two strategic documents – *the National Strategy for the Protection and Promotion of Children's Rights 2014-2020* and *the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*. However, the implementation of a number of them will require a longer time horizon and most likely a substantial financial support. In many cases, this financial support will not necessarily mean an increase in the volume of resources but rather a retargeting of budget allocations, for example, from institutional care to prevention services that should substantially reduce the number of new entries and enable more children to grow up within their families.

Other steps will be necessary to complement all of these recommendations, as described in the previous themes, iso as to demonstrate a long-term vision according to which children and young people are viewed as "an asset" instead of "a problem" as highlighted by one of the specialists interviewed in the qualitative study:

> "[...] so, in my opinion, in our country, children are not valued as they should be. We don't have long-term thinking, so everyone tries to solve crisis situations, urgently, hastily, like putting out a fire, and we do not have a long-term vision of what will happen to that child in the future; what matters is for the local authority or the family or whoever has the "problem" child to be rid of it, "problem" in a manner of speaking, because, most often, these children are perfectly healthy, and a huge asset, but nobody sees that value anymore." (Focus group with professionals, Cluj-Napoca)

Author: Boy from family in need, Giurgiu county, rural area.

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Annex 1. Household Survey in Rural Source Communities

A 1.1. Methodology

The Survey of Households with Children in Public Care in Rural Source Communities was based on a sample of mothers identified using the available data in the CMTIS. Among the households living at the addresses given in the CMTIS, only 61 percent still comprised either the mother or another person who had cared for one or more children now in public care. The other 39 percent of the households no longer lived in the commune.[462] Moreover, in the source communities of the 60 communes under analysis, an additional 139 families with children in public care were identified who were not registered in the CMTIS, as shown in Table below. The analysis of this data will be presented in the sections of this chapter.

A1.1. Table 1: Estimated and Final Samples of Mothers/Families of Children in Public Care from the Rural Source Communities

	Number of people to be interviewed	Of which, number of people interviewed	Of which, number of people present in the household	
			Biological mothers	Other caregivers of the child/children
Initially selected (from CMTIS)	1,191	736	455	281
Identified during field work	139	137	82	55
Total	1,330	873	537	336

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

[462] Only two mothers refused to participate in the survey, and there were eight cases in which households were present but no longer included either the biological mother or any other person who had cared for one or more of the institutionalized children prior to their entering the system.

A 1.2. Household Questionnaire for Rural Source Communities

HOUSEHOLD QUESTIONNAIRE

NRCHEST |__|__|__|__|__|

(Write down the questionnaire number recorded in the Sampling Sheet or the Additional Sheet)

Date when questionnaire is filled in: |__||__| |__||__| 2015	
Time when the interview started: |__|__| : |__|__|	**Time when the interview ended:** |__|__| : |__|__|
County:	COUNTY CODE
Commune:	SIRSUP
Village:	SIRINF
Name of household head:	
Address:	**Phone number:**
Interview operator's name:	**Interview operator's code:**
	Signature:

ID1. The household is located …?	**ID2. Within a perimeter of about 200 meters near the household, is/are there…?**		
1. In the center of the locality	a. One or more inhabited houses	1. Yes	2. No
2. Between the center and the outskirts	b. A forest	1. Yes	2. No
3. On the outskirts	c. A landfill	1. Yes	2. No
4. Outside the locality, in a colony	d. A river, creek, pond	1. Yes	2. No
	e. Disused buildings, ruins	1. Yes	2. No

CODMOM. To which mother does this household correspond?
Write down the same mother's code (CODMOM) recorded in the Social Assistance Sheet.

Attention! *The Sampling Sheet refers both to the main sample and to the reserve samples.*

1. from the Sampling Sheet
2. from the Additional List

CODMOM. |__|__|__|__|__|

KIDS. Number of children of this mother who are in public care
The question refers to the sample data, meaning only to children who are included in the List of Children.

|__| children

CODKID. Code of each child in public care

Use the codes from the List of Children.

Child 1 |__|__|__|__|__|__|
Child 2 |__|__|__|__|__|__|
Child 3 |__|__|__|__|__|__|
Child 4 |__|__|__|__|__|__|
Child 5 |__|__|__|__|__|__|
Child 6 |__|__|__|__|__|__|
Child 7 |__|__|__|__|__|__|
Child 8 |__|__|__|__|__|__|

PREZGG. Is the household/family present in the commune? *Try to check the SPAS information (from the Social Assistance Sheet) against information from the police or other well informed locals*	1. Yes 2. No =► STOP
If YES **PREZMG. Is the selected mother present in the household?** *Check the SPAS information (from the Social Assistance Sheet) directly in the household*	1. Yes =► START QUESTIONNAIRE 2. No
If NO **PREZMR. But are there in the household one or several persons who used to take care of this mother's various children** (from the List of Children) **prior to their last entry into public care?** *Check the SPAS information (from the Social Assistance Sheet) directly in the household*	1. Yes, several persons in the household =► START QUESTIONNAIRE 2. Yes, one person in the household =► START QUESTIONNAIRE 3. Nu =► STOP

Attention!

ALL HOUSEHOLDS SHOULD HAVE AT LEAST ONE FILLED IN QUESTIONNAIRE, AT LEAST THE FIRST SHEET!

Note on presence in the household: persons who left to work (in the country or abroad) who did not form another household or did not establish residence in a different locality and were not absent from the household for more than 12 months are deemed members of the household.

Section 1. HOUSEHOLD STRUCTURE

Attention! Write down all household members. Both parents of all household children under the age of 18 need to be recorded, even if they are absent from the household.

Person's code	**Initials or first name of the person**	**Presence in the household** 1. present person 2. person left to work abroad 3. person left to study or work in the country 4. person in hospital short term stay (max. 45 days) 5. person in hospital/care center etc. - long term stay 6. person in prison 10. person who is divorced/separated and moved out (only for parents absent from the household!) 11. deceased person (only for parents absent from the household!) 12. unknown situation (only for parents absent from the household!) 100. other situation than the ones above	**Did the person live in the household at one time?** *If PREZ>=10* 1. Yes 2. No	**As of what year is the person no longer present in the household?**	**Gender** 1. M 2. F	**Birth date** Use the format: |_|_| |_|_| |_|_|_|_| Day Month Year			*For all children aged 0-17* **Who is the mother of the household children?** Write down the mother's CPERS. If the mother was not entered, go back and enter this person, even if she is absent from the household! If the mother is no longer a member of the household, note 0	*For all children aged 0-17* **Who is the father of this child?** Write down the father's CPERS. If the father was not entered, go back and enter this person, even if he is absent from the household! If the father is no longer a member of the household, note 0
CPERS	**NAME**	**PREZ**	**LOCOD**	**LOCAN**	**SEX**	**BZ**	**BL**	**BY**	**MOM**	**DAD**
01										
02										
03										
...										

Person's code	*For all children aged 0-17* **Who is the main caregiver of the household children?** Write down the CPERS of the main caregiver for each child.	*For all children aged 0-17* **What is the kinship between the caregiver and the child?** 1. father/mother 2. brother/ sister/ brother-in-law/ sister-in-law 3. grandfather/ grandmother 4. uncle/ aunt 5. other relative 0. unrelated 100. himself/ herself	*For everyone* **Nationality** 1. Romanian 2. Hungarian 3. Roma 4. German 5. Other	*For everyone* **Civil status** 1. married 2. concubine 3. divorced 4. widow/ widower 5. unmarried 6. separated	*For everyone* **Highest level of education attained** 1. no school graduated 2. primary school (grades 1 to 4) 3. gymnasium (grades 5 to 8) 4. vocational, apprentice or complementary school 5. first high school stage (grades 9 to 10) 6. high school (grades 9 to 12) 7. specialized or technical post-high school studies 8. short-term university education/college 9. long-term university education (including a master degree) 10. PhD	*For everyone* **Main occupation during the last 12 months** 1. employee 2. other status as working person (day worker, illegal worker etc.) 3. employer 4. working on his/her own in non-agricultural activities (self-employed person, family business, freelancer etc.) 5. working on his/her own in agriculture (farmer, peasant) 6. family allowance 7. registered unemployed person 8. non-registered unemployed person (no longer receives an unemployment benefit/support allowance and is looking for a job) 9. pensioner for age limit 10. other type of pensioner 11. pupil, student (Attention! Include children who attend kindergarten) 12. housewife 13. person with incapacity for work 14. other status of inactive person (pre-school child who does not go to kindergarten, dependent)
CPERS	**MAINRESP**	**RELRESP**	**NAT**	**STACIV**	**NIVE**	**OCUP**
01						
02						
03						
...						

Write down the CPERS code recorded in the table under section 1. Household Structure.

A0. Sample mother's CPERS

If the mother is not in the household and has no other child still in the household, then the mother will not appear in the table and will not have a CPERS, in which case, the code remains blank. |__|__|

A1-A5. CPERS of the main caregiver of the children now in public care, prior to their last entry in the system

To be filled in only if A0, the selected mother, is no longer in the household. A0 and A1, meaning the mother and the main caregiver of the selected children (from the List of Children) cannot be absent simultaneously!

If the household contains several persons who used to take care of this mother's various children (from the List of Children), prior to their last entry in public care, write down the CPERS of each of these persons.

A1. |__|__| **A2.** |__|__| **A3.** |__|__| **A4.** |__|__| **A5.** |__|__|

Section 2. DATA ON HOUSEHOLD CHILDREN UNDER 18 YEARS OF AGE

Attention! To be filled in only for household children between 0 and 17 years of age. The table will be filled in with the main caregiver of the children in the household.

Person's code Use the same codes as in those *Household Structure* section	*For children under age 7*	*For children over 6 years of age*								
	Is the child enrolled in kindergarten?	**Is the child enrolled in school?**	*If enrolled in school*					*If not enrolled in school*	**Does the child have special educational needs?**	*If YES for SEN*
			What type of school is he/she attending?	**What school grade is the child in?**	**Does the child attend school every day?**	**Does the child intend to drop out of school?**	**Did the child repeat any school year?**	**Has the child ever been enrolled in school?**		**Does the child have a school guidance certificate?**
	1. Yes 2. No	1. Yes 2. No	1. mainstream school 2. special school		1. Yes 2. No	1. Yes 2. No	1. Yes 2. No	1. Yes 2. No	1. Yes 2. No	1. Yes 2. No
CPERS	**GRD**	**SCHOOL**	**TIPSCH**	**CLASS**	**ABS**	**ABN**	**REPEAT**	**SCHOOL1**	**SEN**	**CTFO**
...										

Attention! To be filled in for all household children between 0 and 17 years of age

Person's code Use the same codes as those in the *Household Structure* section	**Is the child registered with a family physician?** 1. Yes 2. No	**Does the child have any disability assessed by the SEC, CPC, SEOSP or COSP?** 1. Yes 2. No	**Does the child have an impairment or a diagnosis of a severe illness that could be certified as a disability degree?** 1. Yes 2. No	*If he/she has a disability/ severe disease* **Does the child have a disability certificate?** 1. Yes 2. No	*If the child has such certificate* **What year did he/she obtain the first certificate?**	**Disability code**	**In his/her daily basic activities, is the child...?** 1. Autonomous 2. In need of help 3. Totally dependent on others	**Is the child occasionally left home alone or only with his/her siblings (with no adult)?** 1. Yes 2. No	**The most frequently used method to discipline the child** 1 – through discussions, resorting to reason 2 – using deprivation/denial as punishment (he/she is not given sweets, not allowed to watch TV, to play etc.) 3 – the child is yelled at 4 – by threatening him/her with punishment 5 – by beating him/her 6 – by using humiliating and offensive language against the child	**Have you ever considered placing the child in public care?** 1. Yes 2. No
CPERS	**MED**	**DIZAB**	**HAND**	**CTFH**	**ANCTF**	**CODCTF**	**AUT**	**CSING**	**DISCIP**	**PROT**
...										

Note: SEC - Comprehensive Assessment Services within the DGASPC; CPC - Child Protection Commission; SEOSP - School and Vocational Assessment and Guidance Services within the CJRAE; COSP - School and Vocational Guidance Commissions of the ISJ.

Section 3. HOUSEHOLD CONDITIONS and BEHAVIORS

Write down the CPERS of the person answering this section (according to the table in Section 1) |__|__|

The person answering this section is:	1. the mother selected in the sample 2. a person who used to take care of the child/children (from the List of Children) prior to their last entry in the protection system 3. another household person
LOC1. Dwelling type:	1. House, villa 2. Apartment or studio apartment in a block of flats 3. Improvised shelter 4. Other. Specify which.....
LOC2. Ownership of dwelling:	1. Owned by the parents 2. Owned by other relatives 3. Rent paid to the state 4. Rent paid to a private owner 5. Social housing or received for free 6. Improvised shelter
LOC3. What is the surface area of the dwelling? (in sqm)	|__|__|__| sqm
LOC4. How many rooms does your dwelling have, other than kitchen, hallways, bathroom and other auxiliary spaces?	|__|__| rooms
LOC5. In how many rooms do the household members sleep?	|__|__| rooms
LOC6. Is there in your household any special place devoted to children, where they can do their homework or play?	1. Yes 2. No
LOC7. In how many beds do the household children and adults sleep?	|__|__| beds in which only children sleep |__|__| beds in which only adults sleep |__|__| beds in which both adults and children sleep
EPOV1. In the past 6 months, did any household member happen to sleep somewhere else (e.g. on the floor, on a wooden bench, in a stable) because he/she did not have room in bed?	1. Yes, several times 2. Yes, very rarely or on a particular occasion 3. No
LOC8. Is the number of rooms in your dwelling enough for the household needs?	1. Yes 2. No
LOC9. Do you have any problems with your dwelling (e.g. roof leaks, damp walls, rotten/deteriorated windows/floors)?	1. Yes 2. No
LOC10. Are rooms lighted naturally, by the sun?	1. Yes 2. No
LOC11. Do you have a bathroom or a shower?	1. Yes 2. No
LOC12. Is there an inside toilet connected to the sewage system?	1. Yes 2. No
LOC13. Number of couples in the household	|__|__| couples
LOC14. Number of single persons aged 18 and more in the household	|__|__| single persons aged 18+
LOC15. Number of girls aged 12-17 not in a couple	|__|__| girls aged 12-17 not in a couple
LOC16. Number of boys aged 12-17 not in a couple	|__|__| boys aged 12-17 not in a couple

EPOV2. How often were you unable to heat your dwelling last winter?	1 - daily 2 - a few times a week 3 - once a week 4 - a few times a month 5 - not often 6 - never
EPOV3. How often did you not have food to put on the table in the past 6 months?	1 - daily 2 - a few times a week 3 - once a week 4 - a few times a month 5 - not often 6 - never
NUTR1. In the past two weeks, how many meals a day did the children of your household receive? *The question refers only to meals offered in the family*	1. A single meal a day 2. Two meals a day 3. Three meals a day
NUTR2. In the past two weeks, did the children who go to kindergarten/school receive there a meal/snack?	1. Yes 2. No 9. Don't know/No-response
RECH. Do household children attending school have a schoolbag, notebooks, handbooks and school supplies?	1. Yes, all of the children 2. Yes, only some of the children 3. No, none of the children
HAINE. From where are most of the clothes worn by the children of your household?	1. From stores, bought by you 2. From second hand stores 3. From relatives, neighbors or other people in the village 4. From somewhere else, namely:
EPOV4. In the past 6 months, did you happen to resort to friends, neighbors, relatives, the church etc. for help with food, clothes or money?	1. Yes, several times 2. Yes, very rarely or on a particular occasion 3. No
WK1. How many of the household children do not attend school sometimes because they need to go to work, stay home with their younger siblings or help with household chores?	|__|__| children

RELF. In your family, how often…?	Never	Some-times	Most of the time	Always	Don't know/No n-response
a. I can help my children with their homework	1	2	3	4	9
b. I spend a lot of time with the children, doing what they like	1	2	3	4	9
c. I am familiar with the things that can harm children	1	2	3	4	9
d. I lose my temper when I want to discipline the children	1	2	3	4	9
e. I resort to the ocassional physical correction in order to raise and educate the children properly	1	2	3	4	9
f. Children misbehave only to drive me crazy	1	2	3	4	9

C1. In the past year (2014), was at least one of the children of your household ill or in need of medical care? 1. Yes 2. No

If YES

C2. What did you do in such case? *If there were several cases, refer to the most recent one*	Yes	No	Don't know/Non-response
a. I went to a doctor	1	2	9
b. I went straight to the pharmacy	1	2	9
c. I went to a known neighbor who is not a doctor	1	2	9
d. I gave him/her a traditional cure	1	2	9
e. I did nothing	1	2	9

If the answer was I did nothing

C3. What was the main reason why you did nothing?

1. I had no money to take the child to a doctor
2. I had no money to buy drugs for the child
3. I did not have time to take him/her to a doctor, I was busy
4. I did not know where to take him/her
5. I knew how to cure him/her
6. Something else. What exactly?

BENF1. Is there anyone in the household who receives a family allowance, income support (guaranteed minimum income) or heating allowance (aid, logs)?	1. Yes, everyone in the household 2. Yes, only some of the household members 3. No, no one
BENF2. Is there anyone who received other benefits or aids, including emergency aid from the municipality in the past year?	1. Yes 2. No
VEN1. Last month, the total amount of money obtained from salaries, pensions, allowances, sales etc. by all household members (including the respondent), was approximately…	RON ……
CHEL. In a regular month, how much do you spend for food products?	RON……
VEN2. Do you have a garden or a household, relatives or friends in the countryside from where you obtain or receive various food products?	1. Yes 2. No
VEN3. In a year, how much per cent of your household members' food consumption is covered by such food products?	|__|__|__| %
VEN4. Did last month's total monthly net income of the household allow you to cover all running expenses?	1. Yes 2. No

VEN5. What is your opinion of the current incomes of your household?

1. they are not enough even for bare necessities
2. they are enough only for bare necessities
3. they are enough for a decent living, but we cannot afford to buy more expensive stuff
4. we manage to buy more expensive stuff, but with restrictions in other areas
5. we manage to have everything we need without depriving ourselves of anything

Section 4. DATA ON THE MOTHER INCLUDED IN THE SAMPLE

Attention! Enter data on the mother included in the sample. If the mother is not the one answering the questionnaire, enter only the data that can be provided by the main caregiver of the child/children at the time of their entry into the protection system.

Write down the CPERS of the person answering this section (according to the table in Section 1)|__ |__|

The person answering this section is:
1. the mother selected in the sample
2. a person who used to take care of the child/children (from the List Ch Children) prior to their last entry in the protection system
3. another household person

Only for checking purposes!	1. from the Sampling Sheet
Use the same code of the mother (CODMOM) recorded in the Social Assistance Sheet and on page 1 of this questionnaire.	2. from the Additional List
Surname and first name of the selected mother	**CODMOM.** |__|__|__|__|__|__|

Consent to record the selected mother's life story

Only for cases where the selected mother is the one who answers and she is coherent, able and willing to tell her story.	1. Used by the operator and accepted by the selected mother 2. Used by the operator and refused by the selected mother 3. Not used

A. Data on the selected mother's family of origin

M0. Mother's birth date	|__||__| |__||__| |__||__||__||__| Day Month Year
M1. Most of your life until age 18 you grew up:	1. In the natural family, with the parents (one or both) 2. In the extended natural family, together with the grandparents as well 3. Only with one or both grandparents 4. In the family of relatives other than the grandparents 5. In the family of other people 6. In the social protection system
If she grew up mostly in the family (M1=1, 2 or 3) **M2. She grew up …**	1. only with the mother 2. only with the father 3. with both parents
M3. Were the parents legally (officially) married?	1. Yes 2. No
M4. Mother's education level	|_ _|_ _| (number of school grades)
M5. Father's education level	|_ _|_ _| (number of school grades)
M6. How many children did the parents have as a couple?	|_ _|_ _| children
M7. Did the parents have any children from other relations as well?	1. Yes 2. No
M8. How many half-siblings did the selected mother have on her mother's side?	|_ _|_ _| brothers and |_ _|_ _| sisters
M9. Is your mother currently alive?	1. Yes 2. No
If NO **M9a. How old were you when she died?**	|_ _|_ _| years old
If YES **M9b. On what terms are you with your mother?**	0. indifferent 1 very bad 2 3 4 5 very good
M10. Is your father currently alive?	1. Yes 2. No
If NO **M10a. How old were you when he died?**	|_ _|_ _| years

If YES **M10b. On what terms are you with your father?**	0. indifferent	1 very bad	2	3	4	5 very good

M11. How old were you when you left your parents' home? *Write down code 100 if she did not leave her parents' home.*	|_ _|_ _|_ _| years old
M12. In your opinion, your family was…	1. very poor 2. poor 3. average 4. rich

If the selected mother grew mostly in her family (M1=1, 2 or 3)	Yes	No
M13. Did the following behaviors exist in your family?		
a. excessive alcohol consumption	1	2
b. drug consumption	1	2
c. criminal record	1	2
d. prostitution	1	2
e. child neglect	1	2
f. physical abuse	1	2
g. sexual abuse	1	2
h. psychic, emotional abuse	1	2
i. child exploitation	1	2
j. working on the street, begging	1	2
k. problems with the police	1	2

B. Sample mother's education, occupation and childhood experience with the protection system

B1. Have you ever been in public care?	1. Yes	2. No

If YES

B1a. To the best of your knowledge, what was the main reason why you entered the protection system? *Multiple answer choices.*

1. Death of a parent, divorce/separation, single-parent	14. Disability of the child
2. Parents left to go abroad	15. Disability of the parent, including mental health problems
3. Mother abandoned the family/deserted the home	16. Family with 4 children or more
30. Father abandoned the family/deserted the home	17. Antecedents - other siblings in public care
4. Incarcerated parent or parents	18. Antecedents - child previously in public care
5. Deprivation of parental rights	19. Excessive alcohol consumption by one or more of the household adults
6. Poor housing conditions or homeless	20. Found child, street child
7. Households with a monthly income per capita of max. RON 400	21. Child relinquished in health units
8. Neglect	22. Underage mother
9. Physical abuse of the child	23. Other reason, namely (*Write down the answer below*):
10. Emotional abuse	
11. Sexual abuse	.....
12. Exploitation of the child for work purposes, including human trafficking	70. I do not know the reason
13. Sexual exploitation of the child	

B2. Was any of your siblings in the protection system?	1. Yes	2. No
B3. How old were you when you went to school? *Write down code 100 if she did not attend school.*	|__|__|__| years old	
B4. Level of education attained (number of school grades)	|__|__| grades	
B5. How old were you when you graduated school? *Write down code 100 if she did not attend school.*	|__|__|__| years old	
B6. How old were you when you started working? *Write down code 100 if she has never had a job.*	|__|__|__| years old	
B7. Do you currently have a job?	1. Yes	2. No

If YES

B7a. What is your job? *Write down her occupation.*

C. Data on children born alive by the mother included in the sample

SOT1. How old were you when you had your first relationship (sexual debut)?	|__|__| years old
SOT2. How many sexual partners have you had so far?	|__|__| partners
SOT3. How many of these partners were you officialy (legally) married to?	|__|__| marriages
SOT4. With how many partners did you have one or more children?	|__|__| partners
AGEFIRST. How old were you when you had your first child?	|__|__| years old
AVRT. How many abortions have you had so far?	|__|__| abortions
DEADKID. Have you ever given birth to a stillborn?	|__|__|

KALL. How many live births have you had so far? Out of these:	|__|__| children
KDEAD. - how many children died	|__|__| children
KV1. - how many children are alive, out of which:	|__|__| children
KV2. - how many children are alive and have ever been placed in someone else's care (relatives, other persons, public care, or left in the maternity or other medical unit)	|__|__| children
KV3. - how many children are alive and have been permanently taken care of by the selected mother, out of which:	|__|__| children
KV3a. - how many children are under 18 years of age and are in the household	|__|__| children
KV3b. - how many children are 18 and over and left the household	|__|__| children

D. Data on the selected mother's health

D1. Do you have any disability or diagnosis of a severe illness that could be certified as a degree of disability?	1. Yes	2. No	9. Do not know
If YES			
D1a. Do you have a disability certificate?	1. Yes	2. No	
D1b. *If YES.* **What year did you obtain the first disability certificate?**	|__||__||__|__|		
D1c. *If YES.* **Type of disability**	1. physical 3. auditory 5. somatic 7. psychic 9. associated	2. visual 4. deafblindness 6. mental 8. HIV/AIDS 10. rare diseases	
D1d. *If YES.* **Degree of disability**	1. mild 3. marked	2. medium 4. severe	
D1e. Disability code	|__||__||__|__|		
D2. Overall, how would you rate your health condition?	1. very bad 2 3 4 5. Very good 9. Non-response		

Section 5. DATA ON SELECTED MOTHER'S CHILDREN WHO HAVE EVER BEEN PLACED IN SOMEONE ELSE'S CARE

Attention! Further on, we speak of the children of the selected mother who have been separated from their mother for the purpose of being taken care of by someone else (relatives, other people, public care, or were left in the maternity or other medical unit), whether temporarily or permanently (KV2 of Section 4C). For each child in such situation, fill in Section 5 or an Additional Sheet to this section.

Section 5 (or the Additional Sheet) will be filled in together with the selected mother. If the mother is not present, it will be filled in together with the child's main caregiver at the time of his/her last entry into the protection system. If there are several children who had different caregivers (e.g., the grandmother and the aunt), then the section corresponding to each child will be filled in together with his/her main caregiver, if he/she is present in the household.

Write down the CPERS of the person answering this section (according to the table in Section 1)|__|__|

The person answering this section is:	1. the mother selected in the sample 2. a person who used to take care of the child/children (from the List of Children) prior to their last entry in the protection system 3. another household person

Only for checking purposes! *Use the same code of the mother (CODMOM) recorded in the Social Assistance Sheet and on page 1 of this questionnaire.*	1. from the Sampling Sheet 2. from the Additional List **CODMOM.** |__|__|__|__|__|
Surname and first name of the selected mother	

Consent to record the child's life story

Only for cases where the selected mother is the one who answers and she is coherent, able and willing to tell the story.	1. Used by the operator and accepted by the selected mother 2. Used by the operator and refused by the selected mother 3. Not used

A. Data on the child CCOPIL. |__|__|

For each child for which you fill in Section 5 or the Additional Sheet, enter a code starting with 1.

Attention! *For a selected mother, the maximum code for CCOPIL has to be equal to KV2 in Section 4C.*

Child's Surname and first name	
Only for children included in the List of Children. **CODKID.** |__|__|__|__|__|	*Only for children who are currently in the household.* **CPERS.** |__|__|
CS1. Child's birth date	|__|__| |__|__| |__|__|__|__| Day Month Year
CS2. Child's birth place	Town/commune: County:
CS3. Child's gender	1. male 2. female
CS4. Child's nationality	1. Romanian 2. Hungarian 3. Roma 4. German 5. other
CS5. Child's birth rank among the mother's children	
CS6. Surname and first name of the child's father	
CS7. Father's education level (number of school grades)	|__|__| grades
CS8. Child's birth weight	|__|__|,|__|__|__| kg
CS9. Child's Apgar score at birth	|__|__| 100. The child was not born in a maternity or medical unit
CS10. Did the child have any impairment or severe illness?	1. Yes 2. No
CS11. Did the child stay in the hospital after birth for more than 7 days?	1. yes, together with his/her mother 2. yes, but the mother was not hospitalized with the baby 3. no, he/she stayed fewer days 100. The child was not born in a maternity or medical unit

CS12. Was the child left in the maternity/medical unit after birth?	1. Yes 2. No, the child was taken home 100. The child was not born in a maternity or medical unit

B. At the time of the last (most recent) separation

MS1. Date of child's first separation from his/her mother for the purpose of being taken care of by someone else	|_|_| |_|_| |_|_|_|_| Day Month Year
MS2. Date of child's last separation from his/her mother for the purpose of being taken care of by someone else. *To be filled in even if only one separation occurred, in which case MS2=MS1*	|_|_| |_|_| |_|_|_|_| Day Month Year
MS3. With whom/where was the child placed (when last separated)?	1. child left in the maternity/medical unit 2. grandparents 3. family of relatives other than the grandparents 4. family of other people 5. the social protection system 6. other, namely:
MS4. Place where the child went to	Town/commune: County:
MS5. At the time of the last separation, was the mother involved in a relationship with any man?	1. yes, with the child's father 2. yes, with a different man 3. no
If YES **MS5a. Was the mother legally (officially) married?**	1. Yes 2. No
MS5b. How does the mother rate the stable relationship she had at that time, on a scale from 1 – very bad, to 10 – very good?	1 2 3 4 5 6 7 8 9 10 Very bad Very good
MS6. Did the mother have children with the child's father only or also from other relationships?	1. the mother had children only with the child's father 2. the mother had children from other relationships as well
MS7. Did the mother also take care of children who were not her own? *For instance, children of her partner at that time.*	1. the mother took care only of her own children 2. the mother also took care of children who were not hers
MS8. At that time (at the last or most recent separation), were there in the family problems such as…? *Multiple answer choices.*	1. excessive alcohol consumption 2. drug consumption 3. criminal record 4. prostitution 5. abuse and violence 6. work on the street, begging (including children) 7. problems with the police 8. infidelity 9. death of the main income provider 10. disability/impairment
MS9. Where did you live?	1. in this dwelling 2. in a dwelling with better conditions than these

	3. in a dwelling with worse conditions than these 4. on the street, did not have a dwelling, wherever possible
MS10. Did the household adults have a job?	1. yes, all of them 2. yes, some of them 3. No
MS11. In your opinion, at that time, your family was…	1. very poor 2. poor 3. average 4. rich

MS12. What do you think was the main reason why you ended up placing the child in someone else's care?

1. Death of a parent, divorce/separation, single-parent	14. Disability of the child
2. Parents left to go abroad	15. Disability of the parent, including mental health problems
3. Mother abandoned the family/deserted the home	16. Family with 4 children or more
30. Father abandoned the family/deserted the home	17. Antecedents - other siblings in public care
4. Incarcerated parent or parents	18. Antecedents - child previously in public care
5. Deprivation of parental rights	19. Excessive alcohol consumption by one or more adults of the household
6. Poor housing conditions or homeless	20. Found child, street child
7. Households with a monthly income per capita of max. RON 400	21. Child relinquished in health units
8. Neglect	22. Underage mother
9. Physical abuse of the child	23. Other reason, namely (*Write down the answer below*):
10. Emotional abuse	
11. Sexual abuse	.....
12. Exploitation of the child for work purposes, including human trafficking	70. I do not know the reason
13. Sexual exploitation of the child	

MS13. Would you say that at that time …	1. you were living a better life than you do now 2. you were living a life as good as you are living now 3. you were living a worse life than you do now
MS14. Prior to separation, has anyone discussed with you before you decided to place the child in someone else's care (to leave him/her in the maternity)? *Multiple answer choices.*	1. yes, someone from Child Protection 2. yes, a social worker from the municipality 3. yes, a representative of an NGO 4. yes, someone else 5. no, no one
MS15. Prior to separation, did you receive any support from anyone to help you keep the child home? *Multiple answer choices.*	1. relatives 2. friends, neighbors 3. the church 4. the municipality 5. other people in the community 6. other people outside the community 7. no, no one

C. After the last (most recent) separation

DS1. After the child was placed in the care of other people, did you ever see him/her again? *Multiple answer choices.*	1. Yes, he/she came to visit 2. Yes, I visited him/her 3. Yes, we met by chance 4. I have not seen him/her but we talked on the phone 5. I have not seen him/her or talked with him/her again

DS2. In the past year…?						1. every week or a few times a month
a. you visited the child	1	2	3	4	5	2. once a month
b. you contacted him/her on the phone	1	2	3	4	5	3. a few times a year
c. you sent him/her parcels	1	2	3	4	5	4. once a year
d. you took him/her on vacation	1	2	3	4	5	5. more rarely or never

DS3. To the best of your knowledge, …?

a. He/she goes to school regularly	1. Yes	2. No	3. I do not know
b. He/she is properly fed	1. Yes	2. No	3. I do not know
c. He/she is properly dressed	1. Yes	2. No	3. I do not know
d. He/she is examined by a doctor periodically	1. Yes	2. No	3. I do not know
e. He/she is healthy	1. Yes	2. No	3. I do not know
f. He/she has proper conditions to rest	1. Yes	2. No	3. I do not know
g. He/she has proper conditions to study	1. Yes	2. No	3. I do not know
h. He/she has proper conditions to play and relax	1. Yes	2. No	3. I do not know
i. He/she has proper conditions to maintain his/her relation with his/her siblings placed in other institutions or with other families	1. Yes 7. not applicable, he/she has no other siblings in the care of others	2. No	3. I do not know

DS4. Since he/she left home, do you happen to know whether he/she's had any problems …?

a. He/she was beaten or abused by carers	1. Yes	2. No	3. I do not know
b. He/she was treated worse than here	1. Yes	2. No	3. I do not know
c. He/she got sick	1. Yes	2. No	3. I do not know
d. He/she was sent to work	1. Yes	2. No	3. I do not know
e. He/she had problems with the law	1. Yes	2. No	3. I do not know

DS5. After the child left home, did anyone discuss with you about his/her situation? *Multiple answer choices.*	1. yes, someone from Child Protection 2. yes, a social worker from the municipality 3. yes, a representative of an NGO 4. yes, someone else. 5. no, no one
DS6. Did you receive any support from anyone to help you take the child back home (to receive him/her back/reintegrate him/her)? *Multiple answer choices.*	1. relatives 2. friends, neighbors 3. the church 4. the municipality 5. other people in the community 6. other people outside the community 7. no, no one

D. At present

PZ1. At present, would you like to take the child back?	1. yes, I would take him/her back any time 2. yes, but I could not take him/her now 3. no, I do not want to take him/her back
If she says she would take him/her any time (PZ1=1) **PZ1a. What prevents you from doing so?**	
If she says that she would not take the child now (PZ1=2) **PZ1b. What would be required for the child to return to the family?** *Multiple answer choices*	1. to build/extend or repair the house 2. to receive a social house (free of charge) 3. to increase the household income 4. the young children to grow older 5. something else, namely:
PZ2. In your opinion, would the child ever want to come back in your family?	1. yes, but only to visit 2. yes, but I do not know for how long 3. yes, he/she will come back for good 4. no, I do not think he/she will ever come back
PZ3. Are you in a stable relationship at present?	1. Yes 2. No
If YES **PZ3a. Are you officially married?**	1. Yes 2. No
PZ3b. How would you rate your relationship?	1 2 3 4 5 6 7 8 9 10 Very bad Very good
PZ3c. Does your husband generally help you with the household chores?	1. Yes 2. No
PZ3d. Did your husband ever hit you?	1. Yes 2. No
PZ4. In your family are there currently problems related to ...? *Multiple answer choices.*	1. excessive alcohol consumption 2. drug consumption 3. criminal record 4. prostitution 5. abuse and violence 6. work on the street, begging (including children) 7. problems with the police 8. infidelity 9. death of the main income provider 10. disability/impairment
PZ5. At the moment, do you believe your family is ...	1. very poor 2. poor 3. average 4. rich
PZ6. How often do you discuss with the social worker from the municipality about the situation of your children?	1. monthly 2. once every 2-3 months 3. once every 5-6 months 4. once a year or more rarely 5. never
PZ7. How useful is to you the information received from the social worker?	1. Very good/useful 2. Good/useful 3. Neither good nor bad 4. Bad/useless 5. Very bad/completely useless

E. Future prospects

PV1. To conclude, how great do you think are your chances of being able to take the child back?	1 Very small 2 Small 3 Average 4 Big 5 Very big
If the chances are very small or small (PV1=1 or 2) **PV1a. Why do you think the chances are small?** *Multiple answer choices*	1. We do not have proper housing conditions 2. We have too many children as it is 3. We have too low incomes 4. The child is ill and we cannot take care of him/her 5. We/I/the father are/am/is too ill 6. The child does not want to come back 7. Others, namely:
If the chances are average or big (PV1>2) **PV1b. How soon do you think this could happen?**	|__|__| months 100. not for another 3 years or more 99. Does not know, cannot estimate

PV2. To what extent do you agree with the following statements?	Totally agree	Partially agree	Partially disagree	Totally disagree	Don't know/No asnwer
a. Sometimes it is better for children to live with other persons	1	2	3	4	9
b. Children who do not live with their parents should be asked where they would like to live	1	2	3	4	9
c. Children who do not live with their parents should be raised in children's homes if there is no one to take care of them	1	2	3	4	9
d. Parents should let children live where they have the best conditions to grow	1	2	3	4	9
e. Children need the love of their parents to develop harmoniously	1	2	3	4	9

PV3. Do you feel that you need information on the laws dealing with the status of children who are in the public care?	1. Yes, to a very large extent 2. Yes, to a large extent 3. Yes, to a low extent 4. Yes, to a very low extent 5. No
If YES **PV3a. From where/whom would you like to find out more about these laws?** *Multiple answer choices.*	1. From the municipality social worker 2. From an educator or teacher 3. From the community health nurse or health mediator 4. From the priest 5. From another trustworthy person in the village 6. From somewhere else. From where? (*Write down the answer below*)

PV4. To the best of your knowledge, in your village, how often does it happen that…?	Never, I've never heard of that	Some-times	Often	Don't know/Non-response
a. Parents place their children in the care of relatives or other people	1	2	3	9
b. Children live with relatives or other people because their parents are gone to work abroad	1	2	3	9
c. Children of poor families are taken to children's homes	1	2	3	9
d. Children are given for adoption to other people	1	2	3	9
e. Parents with children with disabilities place them in children's homes	1	2	3	9

f. Parents no longer visit their children in the orphanage	1	2	3	9
g. Parents leave their children home alone when they go to work	1	2	3	9
h. Step parents behave worse with children who are not their own	1	2	3	9
i. Children run away from home	1	2	3	9
j. Children are sent to beg	1	2	3	9

Assessments of the field operator as a result of direct observation

EVOP1. The hygiene level of the visited household is …?

1. very precarious 2. precarious 3. average 4. good 5. very good

EVOP2. The housing conditions of the visited household are …?

1. very precarious 2. precarious 3. average 4. good 5. very good

Consent to take a picture of the household

Only for cases in which you believe the photos would be useful to illustrate the household's situation.	1. Used by the operator and accepted by the selected mother 2. Used by the operator and refused by the selected mother 3. Not used

A 1.3. Questionnaire for the social workers from rural source communities

NRFAS |__|__|__|__|__|	SOCIAL ASSISTANCE SHEET

Attention! To be filled in at the Public Social Assistance Service (SPAS), at the specialized department within the municipality or together with the municipality staff who has social work duties.

Date when sheet is filled in	|__|__| |__|__| 2015
County	COUNTY CODE
Commune	SIRSUP
How is social assistance organized in the commune?	1. SPAS – Public Social Assistance Service, with |__|__| employees 2. Department, with |__|__| employees 3. Persons with social assistance duties, |__|__| persons 4. Only persons in charge of social benefits
Surname and first name of the person answering the questionnaire	
Position	**Phone no./ e-mail address**
Duties in the municipality 1. Only social assistance 2. Social assistance and other duties 3. Only other duties	**Higher education** 1. Yes, in social assistance or sociology 2. Yes, in psychology 3. Yes, in economic or legal studies 4. Yes, in other specialty 6. No
Total seniority in the field |__|__| years	
Seniority with the municipality |__|__| years	**Signature**

CHILD PROTECTION SERVICES IN THE COMMUNE

Q1. Are there any professional foster carers (AMP) in the commune?	1. Yes, |__|__| AMP, who take care of |__|__| children 2. No
Q2. In the commune, are there any children in family placement with relatives?	1. Yes, |__|__| children placed in |__|__| households 2. No
Q3. In the commune, are there any children in family placement with other people?	1. Yes, |__|__| children placed in |__|__| households 2. No
Q4. Is there any residential center for children in the commune or in the immediately neighboring communes/ town?	1. Yes, in the commune 2. Yes, in immediately neighboring localities 3. No
Q5. Is there any operational day center for children in the commune?	1. Yes, there is an operational day center 2. Yes, there is a day center though it is not functional for various reasons (lack of staff, lack of funds etc.) 3. There is no day center for children
IF there is an operational day center (Q5=1) **Q5a and Q5b. How many employees and**	A. |__|__| employees B. |__|__| child beneficiaries

beneficiaries does this center have?	
Q6. In January and February 2015, was there an increase in the number of applications for family placements for children in the commune?	1. Yes, higher than the one in the same time period of the previous years 2. Yes, similarly to the winter time of previous years 3. No
IF there was an increase (Q6=1 or 2) **Q6a and Q6b. What was the approximate number of applications for family placements for children in the commune in the time period between…?**	A. January and February 2014: |__||__| applications B. January and February 2015: |__||__| applications

Of the following listed services …	**Q7a. Are there any such services in the commune or in the immediate neighborhood?**		**Q7b. Do you know/have you ever met a contact person?**		**Q7c. Have you referred any child or family to any such service in the past month?**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
1. nursery/kindergarten/early education center	1	2	1	2	1	2
2. day center	1	2	1	2	1	2
3. respite center/crisis center	1	2	1	2	1	2
4. family physician/primary healthcare service	1	2	1	2	1	2
5. dental service	1	2	1	2	1	2
6. mental health services	1	2	1	2	1	2
7. service /shelter for victims of violence	1	2	1	2	1	2
8. social canteen	1	2	1	2	1	2
9. social housing	1	2	1	2	1	2
10. home care service	1	2	1	2	1	2
11. employment services	1	2	1	2	1	2
12. adult vocational training services	1	2	1	2	1	2
13. 'Second Chance'	1	2	1	2	1	2
14. 'School after School'	1	2	1	2	1	2
15. parental education service	1	2	1	2	1	2
16. services for teenagers and young people	1	2	1	2	1	2
17. legal/legal assistance services	1	2	1	2	1	2

IF there is 'School after School' in the commune (Q9a14=1) **Q8a. How many children benefit from these services?**	|__||__| child beneficiaries
Q8b. Who pays for School after School classes?	1. the municipality 2. parents 3. an NGO or other not-for-profit organization 4. other, namely:

Q9. Is there in your commune …?	Yes	No
a. a community health nurse	1	2

b. a health mediator	1	2
c. a school mediator	1	2
d. a school counselor	1	2
e. a Consultative Community Structure	1	2
f. support groups offering support to children and families in vulnerable situations	1	2
g. religious groups offering support to children and families in vulnerable situations	1	2
h. NGOs or charity groups	1	2

On a scale from 1="very poor"/"never" to 10="very good"/"always"…

Q12. How would you rate your knowledge about the services and resources available in the commune and in the immediate neighborhood?	1 2 3 4 5 6 7 8 9 10 Very poor Very good
Q13. How would you rate your skills used in helping children and families in the commune to obtain access to needed services and assistance?	1 2 3 4 5 6 7 8 9 10 Very poor Very good
Q14. To what extent do you feel that you can intervene effectively to support children and families in the commune?	1 2 3 4 5 6 7 8 9 10 Never Always
IF he/she feels that generally he/she cannot intervene effectively (Q14<5) **Q14a and Q14b. What prevents you from intervening effectively?**	A. B.

From your experience, at the local level, in order to prevent the child's separation from his/her family…

Q15. … what are the most efficient benefits?	A. B.	**Q16. … what are the most efficient services?**	A. B.

SECTION 1. CHECKING OF THE SAMPLING SHEET

Mother's code (Sampling Sheet)	**Mother's surname and first name** (Sampling Sheet)	**Village** of the commune where the mother lives/lived (Sampling Sheet or corrected/ filled in)	**How well do you know the household,** on a scale from 0 – not at all, to 10 – very well?	**Is the household still present in the commune?** 1. Yes 2. No	*If the household is no longer in the commune* **Please provide details.**	*If the household is in the commune* **Is the mother or main caregiver of the children in public care** (from the List of Children) **present in the household?** 1. Yes 2. No
CODMOM	**MAMA**	**SAT**	**STIEG**	**PREZG**	**PREZGNU**	**PREZM**
…						

The Sampling Sheet refers both to the main sample and to the reserve samples. It means that the received sample is checked in its entirety.

In the database, SAT appears with NUMESAT and SIRINF.

The village in the Sampling Sheet does not necessarily represent the address where the mother can be effectively found. In this table, one can find the *de facto* address of the mother.

For households that are no longer in the commune, household forms only with the first page can be prepared.

In this table, we included 10 cases. Only in 4 communes of the sample, the Sampling Sheet has between 31 and 37 cases.

SECTION 2. PREPARATION OF AN ADDITIONAL LIST

Please mention all cases of mothers with children in public care in your commune not included in the previous list.

Mother's code	**Mother's surname and first name**	**Village** of the commune where the mother lives/lived	**How well do you know the household,** on a scale from 0 – not at all, to 10 – very well?	**Is the household still in the commune?** 1. Yes 2. No	*If the household is no longer in the commune* **Please provide details.**	*If the household is in the commune* **Is the mother or main caregiver of the children in public care** (from the List of Children) **present in the household?** 1. Yes 2. No
CODMOM	**MAMA**	**SAT**	**STIEG**	**PREZG**	**PREZGNU**	**PREZM**
1						
2						
3 …						

SECTION 3. REASON WHY THE CHILD ENTERED THE SYSTEM

SECTION 3 applies to all households in the SAMPLING SHEET (Section 1) & THE ADDITIONAL LIST (Section 2) that are present in the commune (PREZG=1).

Use the same CODMOM of Sections 1 and 2.

Mother's code (Sampling Sheet)	**REASON: What do you think are the main reasons why these mothers ended up placing their children in public care?** *Write down 1 in the corresponding columns* M1. Death of a parent, divorce/separation, single-parent M2. Parents left to go abroad M3. Mother/father abandoned the family/deserted the home M4. Incarcerated parent or parents M5. Deprivation of parental rights M6. Poor housing conditions or homeless M7. Households with a monthly income per capita of max. RON 400 M8. Neglect M9. Physical abuse of the child M10. Emotional abuse M11. Sexual abuse M12. Child exploitation for work purposes, including human trafficking M13. Sexual exploitation of the child M14. Disability of the child M15. Disability of the parent, including mental health problems M16. Family with 4 or more children M17. Antecedents – other siblings in public care M18. Antecedents – child previously in public care M19. Excessive alcohol consumption by one or more adults of the household M20. Found child, street child M21. Child relinquished in health units M22. Underage mother M23. Other reason,namely_____ (*Write down 1 in column M23 and then here the actual answer)*

CODMOM	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**M13**	**M14**	**M15**	**M16**	**M17**	**M18**	**M19**	**M20**	**M21**	**M22**	**M23**

(Section 3 continued)

Mother's code (Additional List)	**REASON: What do you think are the main reasons why these mothers ended up placing their children in public care?** *Write down 1 in the corresponding columns* M1. Death of a parent, divorce/separation, single-parent M2. Parents left to go abroad M3. Mother/father abandoned the family/deserted the home M4. Incarcerated parent or parents M5. Deprivation of parental rights M6. Poor housing conditions or homeless M7. Households with a monthly income per capita of max. RON 400 M8. Neglect M9. Physical abuse of the child M10. Emotional abuse M11. Sexual abuse M12. Child exploitation for work purposes, including human trafficking M13. Sexual exploitation of the child M14. Disability of the child M15. Disability of the parent, including mental health problems M16. Family with 4 or more children M17. Antecedents – other siblings in public care M18. Antecedents – child previously in public care M19. Excessive alcohol consumption by one or more adults of the household M20. Found child, street child M21. Child relinquished in health units M22. Underage mother M23. Other reason,namely_____ (*Write down 1 in column M23 and then here the actual answer)*

CODMOM	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21	M22	M23
1																							
2																							
3																							

SECTION 4. SERVICES RECEIVED BY THE FAMILY IN THE COMMUNITY

SECTION 4 applies to all households in the SAMPLING SHEET (Section 1) & THE ADDITIONAL LIST (Section 2) that are present in the commune (PREZG=1).

Use the same CODMOM of Sections 1 and 2.

Mother's code (Sampling Sheet)	**SERVC. In order to support the return of children in their families, which of the following services did the family receive from SPAS in 2014?** *Write down 1 in the corresponding columns* S1. information and guidance S2. needs assessment S3. counselling S4. accompaniment and support S5. referral to specialized services S6. monitoring S7. other social services							*If S7=1* **Please specify what other social services you are referring to.** **Attention!** *You can use table Q7 for examples of social services.* *Use also the codes from the same table for all the social services mentioned, even if these are not related to SPAS.*				**Has the family received any support from any foundation, NGO, church, charity group or similar?** 1. Yes 2. No
CODMOM	**S1**	**S2**	**S3**	**S4**	**S5**	**S6**	**S7**	**S7a**	**S7b**	**S7c**	**S7d**	**HONG**

The variable named HONG refers to support in the form of money, goods or services from organizations in the commune or other localities.

(Section 4 continued)

Mother's code (Additional List)	**SERVC. In order to support the return of children in their families, which of the following services did the family receive from SPAS in 2014?** *Write down 1 in the corresponding columns* S1. information and guidance S2. needs assessment S3. counselling S4. accompaniment and support S5. referral to specialized services S6. monitoring S7. other social services							*If S7=1* **Please specify what other social services you are referring to.** **Attention!** *You can use table Q7 for examples of social services.* *Use also the codes from the same table for all the social services mentioned, even if these are not related to SPAS.*				**Has the family received any support from any foundation, NGO, church, charity group or similar?** 1. Yes 2. No
CODMOM	**S1**	**S2**	**S3**	**S4**	**S5**	**S6**	**S7**	**S7a**	**S7b**	**S7c**	**S7d**	**HONG**
1												
2												
3												

The variable named HONG refers to support in the form of money, goods or services from organizations in the commune or other localities.

SECTION 5. BENEFITS RECEIVED BY THE FAMILY AND CHANCES OF REINTEGRATION

SECTION 5 applies to all households in the SAMPLING SHEET (Section 1) & THE ADDITIONAL LIST (Section 2) that are present in the commune (PREZG=1).

Use the same CODMOM of Sections 1 and 2.

Mother's code (Sampling Sheet/Additional List)	**BENEFG. What benefits did the family receive from SPAS in 2014?** *Write down 1 in the corresponding columns* B1. Complementary family allowance B2. Single-parent family allowance B3. Monthly placement allowance B4. Aid for persons with extremely serious health conditions granted for medical treatment and surgery abroad B5. Monthly allowance for persons with severe and marked disabilities B6. Monthly allowance for attendants of adults with severe visual impairment B7. Monthly food allowance for HIV/AIDS infected persons B8. Food support for children with HIV/AIDS disability, 2009 B9. Income support for securing the guaranteed minimum income B10. Heating aid (heating allowance, wood logs) B11. Support for covering part of burial expenses B12. Emergency aid B13. Food aid from the European Union B14. Powder milk for babies B15. Other benefits														**Are there any children aged 0-17 currently in the household?** 1. Yes 2. No	*If YES* **From your experience, how would you assess the risk of separation for children of this household?** 1. Very low 2,3,4, 5. Very high	**Given the current situation, how would you assess the chances of the children in public care being reintegrated in this family?** 1. Very low 2,3,4, 5. Very high
CODMOM	**B1**	**B2**	**B3**	**B4**	**B5**	**B6**	**B7**	**B8**	**B9**	**B10**	**B11**	**B12**	**B13**	**B14**	**B15**	**KALT**	**KALTSEP**	**KIDINT**

Annex 2. Five Case Studies in Urban Source Communities

Five cities were considered as case studies: Arad, Bacău, Bârlad, Craiova, and Piatra Neamţ.

Annex 2.1. Interview Guide with Parents

Interview Guide

Parents

INTRODUCTION

Thank you for responding to our invitation to take part in this discussion. As we have told you, this is a study conducted for UNICEF aimed at analysing the wellbeing of children and their families, with a special focus on children in public care and children at risk of being deprived of parental care.

Because everything we discuss here is very important to us, we ask for your permission to make an audio recording of our discussion, in order to make it easier for us to remember the details later on when we draw up the final report and decide on the next best steps.

This is a free discussion based on an interview topic guide; we point out that your answers will not be assessed as good or bad, right or wrong! They are important for us, which is why we invite you to say anything that comes to mind about one topic or another.

To start with, please briefly introduce yourself: name, education, occupations you've had, and a short description of your family.

FAMILY BACKGROUND

What are the main aspects of your household you are satisfied with? *(dig into all the mentioned aspects)*

Are you satisfied with your housing conditions? Why yes/no? Did you apply for social housing? If not, why not? If yes, what happened once you applied?

What are the main challenges your family is facing? What are the causes of these challenges? How could you overcome these difficulties? Who could help you in the attempt to overcome them? What help would you like to receive?

CHILDREN IN THE FAMILY

What are the positive aspects of the presence of the child(ren) in your household?

What do you think works well in your household regarding child care? / What are the aspects you are satisfied with?

What are the main difficulties you face regarding child care? *(dig into all the mentioned aspects)*. Can you think of any other difficulties?

How many children do you have in your household at present? Please introduce each child (age, gender, education, etc.).

How many children do you have who are not present in your household now? Please introduce each child (age, gender, education, etc.). Where are these children now?

For those in public care: Why are these children in the protection system and the others aren't? *(gender, age, health problems, disabilities, stepchildren – children of another father, etc.).*

How many of the household children go to school/kindergarten? How do you manage with the things needed for school – school clothes, school supplies? And with the children's homework? How are the children doing? Do they need help with their homework? Are there any particular challenges you face regarding the children's school attendance? If yes, what are they?

If there are children who don't go to school/kindergarten: Why don't these children go to school/kindergarten? Any other reasons?

Did you ever take any of your children to the emergency room? Please tell about that experience! *(the health problem, etc.)*

How often do you take the children to a doctor? What doctors have you seen lately? Why did you need to see the doctor (what health problems did the children have)? Are there cases where you manage to treat the children at home, without needing to go to a doctor? Please describe such a situation.

How do you manage when children have health problems, as all children have – colds, diarrhoea? And when they have more serious health problems – high fever, spots on their body, injuries, the child complains of serious pain?

Do you have a family physician? How many times have you been to the family physician and for what reasons; how did he/she help you? How many times have you been visited by the nurse or health mediator and what was the matter?

What connection did you have with the municipality social assistance service? How did things work between you and the social assistant? What did he/she help you with (identity documents, birth certificates, welfare payments, children's school enrolment)? And with other civil servants? Where did they come from? How did they help you?

Did you receive support from people in NGOs? What did they help with?

Are there any activities you do together with the children during an ordinary week? What kinds of activities do you usually do with your children?

What kinds of activities do your children take part in? Do they go to after-school activities? Do they go to a social canteen? Other? Do you think these activities are good for the children and for your household? Please explain!

CHILD-FAMILY SEPARATION

For parents with children in public care: Why did you have to place the child in public care?

Please describe what happened then! (who made the proposal for separation, what institutions/individuals did the parent contact, what happened at each stage, etc.)

What do you think could have been done so that you didn't have to be separated from your child? Who should have helped you (institutions, individuals, etc.)?

For parents with children at risk of separation: Did you ever consider sending your child(ren) in the protection system? Why yes/no? Please explain.

What support do you think you would need so that you wouldn't have to place your child in public care? Who should help you (institutions, individuals, etc.)? What should the support consist of?

REINTEGRATION OF CHILDREN IN THE FAMILY – *Parents with children in public care:*

Would you like for your child(ren) currently in the protection system to come back to you? Why?

Do you think it is possible for the child to come back to your household? Please explain.

Did you do something in this regard? What?

Did you visit your child(ren) in placement? Tell me about these visits: how often you go, how long you stay with them, what you do together with the children, etc. *If not*: Why didn't you visit them?

Has the child come to visit you at home since his/her placement? Tell me about these visits: how often they come, how long they stay with you, what you do together with the children, etc. *If not*: Why didn't they visit you?

What difficulties do you encounter in trying to bring the child back to your household? / What obstacles/difficulties do you think will prevent you from bringing the child back to your household?

Do you think there are other important aspects we didn't address? Please specify!

Thank you!

Annex 2.2. Interview Guide with Professionals

Interview Guide

- case managers, DGASPC representatives, DAS representatives within the municipality, placement center representatives, etc. -

INTRODUCTION

Thank you for responding to our invitation to take part in this discussion. As we have told you, this is a study conducted for UNICEF, aimed at analysing the wellbeing of children and their families, with a special focus on children in public care and children at risk of being deprived of parental care.

Because everything we discuss here is very important to us, we ask for your permission to make an audio recording of our discussion, in order to make it easier for us to remember the details later on when we draw up the final report and decide on the next best steps.

This is a free discussion based on an interview topic guide; we point out that your answers will not be assessed as good or bad, right or wrong! They are important for us, which is why we invite you to say anything that comes to mind about one topic or another.

To start with, please briefly introduce yourself: name, position, seniority, and your main duties within the institution.

DESCRIPTION OF THE SOURCE COMMUNITY

From what you have seen, is there an area in your locality where most children in public care come from – a source community? Where is this area located (street, neighborhood, etc.)? Are there any other areas with an increased risk for families placing their children in public care? Please specify (street, neighborhood, etc.).

What are the characteristics of the source community (*SPONTANEOUS ANSWER. Answers such as "poverty" shall be detailed as much as possible*)? What is the difference between this community and other communities with a high risk for children to end up in public care, but where these children's share is still comparatively low (i.e. other communities with a high risk, but which are the source of a lower number of child entries in the protection system)?

CAUSES OF SEPARATION

In the identified source community, what would you say are the main causes leading to child-family separation? (*Answers such as "poverty" need to be detailed as much as possible*) Please detail.

- The family's socioeconomic status
- Housing quality
- Parents' education level
- Number of children
- Presence of children with disabilities or of people in the family
- Sick parents
- Domestic violence
- Physical violence against the child
- Child exploitation
- Lack of food
- Neglect in terms of education, health care
- Sexual abuse, promiscuity

- Alcoholism
- Violence in the community, membership in delinquent groups
- One parent is missing – abroad for work

DESCRIPTION OF STANDARDS AND OPERATIONAL PROCEDURES – prevention

What activities are carried out in the concerned source community to prevent the separation of the child from his/her family? Who is targeted by these activities (the parents/the children/the community, etc.)? Who (institution, NGO, individual, etc.) is responsible for carrying out these activities? How efficient are the activities, in your opinion? Why do you say that? What could be done to increase their efficiency? What other activities/measures could be implemented to prevent the separation *(including measures/activities which had good results in communities with high risk)*?

DESCRIPTION OF STANDARDS AND OPERATIONAL PROCEDURES – taking the child

In the source community, who made the referrals to have the children taken from their families (*parents/relatives, social workers/judges*)? What situations are most common?

What are the stages of the process upon which a child enters the protection system? What is your and your institution's role in this process? Who decides that a child is going to be institutionalized? What criteria underlie this decision? How clear/interpretable are these criteria, in your opinion? Examples! Who (institution/individual) is responsible for each stage? To what degree are the responsibilities of each institution clearly defined, in your opinion?

DESCRIPTION OF STANDARDS AND OPERATIONAL PROCEDURES – child within the system

What are the stages after a child entered public care? What individuals step in during these stages? What is the role of each individual? And in case of children with disabilities? How is the cooperation between these various individuals, in your opinion?

How are things in the case of the Individualized Protection Plan, in your opinion? What aspects work well? And those which could be improved? To what extent are the activities stipulated in the Individualized Protection Plan implemented? What are the main obstacles in their implementation? What improvements do you consider necessary?

DESCRIPTION OF STANDARDS AND OPERATIONAL PROCEDURES – the child/youth leaves the system

In your locality, what are the most frequent ways in which children leave the protection system *(returning to their families, adoption, coming of age, etc.)*? Are there cases of children who should leave the system because they have come of age, but are still in the system? Why are they still in the system? What should be done for them? Who should do it?

What activities are carried out to support the child's exit from the system? What institutions/individuals are responsible for these activities? To what extent are these activities efficient, in your opinion? Explain.

To what extent does the children's reintegration in their biological families succeed as a result of the activities carried out? Please detail! What are the main obstacles?

To what extent is the integration in the community of the young people leaving the system *(upon coming of age)* successful, in your opinion? Please detail! What steps should be taken for a better integration?

What do you think about the labor market insertion of the young people leaving the system? Explain! What could be done to improve it?

DIFFERENCES BETWEEN STANDARDS AND PROCEDURES AT THE NATIONAL LEVEL

In general, how clear and objective are the standards and operational procedures in the field of child protection, in your opinion? Please explain and provide examples! What standards or legislative procedures need improvement? How should these be improved? *(INCLUDE WHAT IS SPECIFIC TO YOUR FIELD)*

As far as you know, are there differences at the national level regarding the standards and procedures applied to child protection? / The same rules apply in all counties or are the rules different? The existence of these differences is something positive or negative, in your opinion? Please detail. *(Could you also identify positive/negative aspects determined by the mentioned differences?)*

Can you provide examples of counties where, in your opinion, things work well in the field of child protection? What are you referring to when you say things work well? Why do you think things work better in these counties? / What is the difference compared to other counties?

What are the main aspects that you recommend improving so that your activity can be carried out optimally?

COMMUNICATION AND COOPERATION BETWEEN INSTITUTIONS

How would you assess the way all institutions involved in child protection interact in your county?

What are the main positive aspects of the interaction? Please detail.

What are the main negative aspects? How could they be diminished? / What suggestions for improvement would you make?

DESCRIPTION OF THE ACTIVITY OF THE INSTITUTION

Unless already mentioned: What is the role of the institution you represent in the child protection process? What activities are carried out?

What are the main positive aspects in the way the institution operates?

What are the main obstacles encountered when carrying out child protection activities?

- human resources,
- financial resources,
- characteristics of the beneficiaries,
- other.

RECOMMENDATIONS

What are your main recommendations for improvement in the field of child protection? Do you have any other recommendations?

Are there any other aspects concerning child protection that you think we didn't address? What are they?

Thank you!

Annex 2.3. Interview Guide with NGO representatives

Interview Guide

- NGO representatives -

INTRODUCTION

Thank you for responding to our invitation to take part in this discussion. As we have told you, this is a study conducted for UNICEF, aimed at analysing the wellbeing of children and their families, with a special focus on children in public care and children at risk of being deprived of parental care.

Because everything we discuss here is very important to us, we ask for your permission to make an audio recording of our discussion, in order to make it easier for us to remember the details later on when we draw up the final report and decide on the next best steps.

This is a free discussion based on an interview topic guide; we point out that your answers will not be assessed as good or bad, right or wrong! They are important for us, which is why we invite you to say anything that comes to mind about one topic or another.

To start with, please briefly introduce yourself: name, position, seniority, and your main dutiese within the NGO.

NGO DESCRIPTION AND MISSION

Please describe the NGO you represent (mission, objectives, experience, size, etc.).

What are the main projects/activities you have carried out in the field of child protection? What were they about? What were the results of the project? What support did these projects provide to the households (parents, children, etc.) having or at risk of having children in public care?

Do you think the projects/services you provide overlap with or are additional to the services provided by the public authorities (DAS, DGASPC, etc.)? What overlaps? / What is additional? Why do you think the public authorities fail to meet these needs and the NGOs have to step in?

DESCRIPTION OF THE SOURCE COMMUNITY

From what you have seen, is there an area in your locality where most children in public care come from? Where is this area located (street, neighborhood, etc.)?

What are the characteristics of such a community? (*SPONTANEOUS ANSWER*) What are the differences between this community and other communities with a high risk for children to end up in public care, but where these children's share is still comparatively low (i.e. other communities with a high risk, but which are the source of a lower number of child entries in the protection system)?

CAUSES OF SEPARATION

From your experience, what are the main causes leading to child-family separation in the identified community? Please detail.

What do you think should be done in that community to reduce the risk of child-family separation? What institutions should be responsible?

In your opinion, what is the role of the non-governmental sector in the endeavour to reduce the separation of children from their biological families? What more should be done? What are the obstacles encountered?

ASSESSMENT OF THE PUBLIC CHILD PROTECTION SYSTEM

How would you assess the public child protection system in your locality? Which aspects work well, in your opinion? Which aspects don't work well in the system? How do you think they could be improved?

What is your opinion of the results/outcomes achieved by the public institutions in your locality in the child protection process?

POTENTIAL FOR COOPERATION BETWEEN THE PUBLIC ADMINISTRATION AND THE NON-GOVERNMENTAL SECTOR IN THE CHILD PROTECTION PROCESS

To what extent was the cooperation between public institutions and various non-governmental organizations or associations attempted in the child protection process so far?

If it was: What was the cooperation about? What activities/projects have been carried out? What were the outcomes?

What are the main obstacles in trying to cooperate with the public institutions in the field of child protection? How could they be overcome?

What would be the advantages of a cooperation between the public institutions and various non-governmental organizations/associations in the field of child protection? And the disadvantages?

RECOMMENDATIONS

What main actions would you suggest should be carried out in order to reduce the risk of separation of the children from their biological families? (at all possible levels: family, involved institutions, etc.)

What main actions or measures would you suggest should be undertaken for a better reintegration of the children from the system into their biological families? And for a better community insertion of the young people leaving the protection system? And for a better labor market insertion of the young people leaving the protection system?

If there are any other important aspects related to child protection, which we didn't address, please detail them.

Thank you!

Annex 3. Survey of the Case Files of Children in Public Care

A 3.1. Methodology

A.3.1. Table 1: DGASPC Specialists that Filled In the Forms Based on the Case Files of Children in Public Care (the Special Protection System), by County (%)

		Forms were completed by DGASPC specialists working as:					
	Valid forms	Case manager/ case responsible officer	Social worker	Inspector	Counselor	Other job titles	**Total**
ALBA	38	0	63	0	37	0	100
ARAD	233	78	6	6	0	10	100
ARGEȘ	20	0	5	95	0	0	100
BACĂU	375	12	20	67	0	2	100
BIHOR	342	0	2	98	0	0	100
BISTRIȚA NĂSĂUD	117	0	2	0	95	3	100
BOTOȘANI	272	0	22	5	57	16	100
BRAȘOV	37	16	0	32	38	14	100
CARAȘ SEVERIN	213	0	0	92	2	6	100
CONSTANȚA	345	0	64	26	6	5	100
COVASNA	266	0	31	50	0	20	100
DÂMBOVIȚA	194	0	16	71	0	13	100
DOLJ	228	4	19	75	0	2	100
GALAȚI	252	0	0	7	93	0	100
GORJ	124	71	17	5	0	7	100
HARGHITA	274	0	62	18	0	19	100
HUNEDOARA	301	53	10	27	5	5	100
MEHEDINȚI	159	1	17	71	7	4	100
NEAMȚ	346	1	49	24	2	25	100
OLT	244	7	5	0	50	38	100
PRAHOVA	343	1	48	3	43	4	100

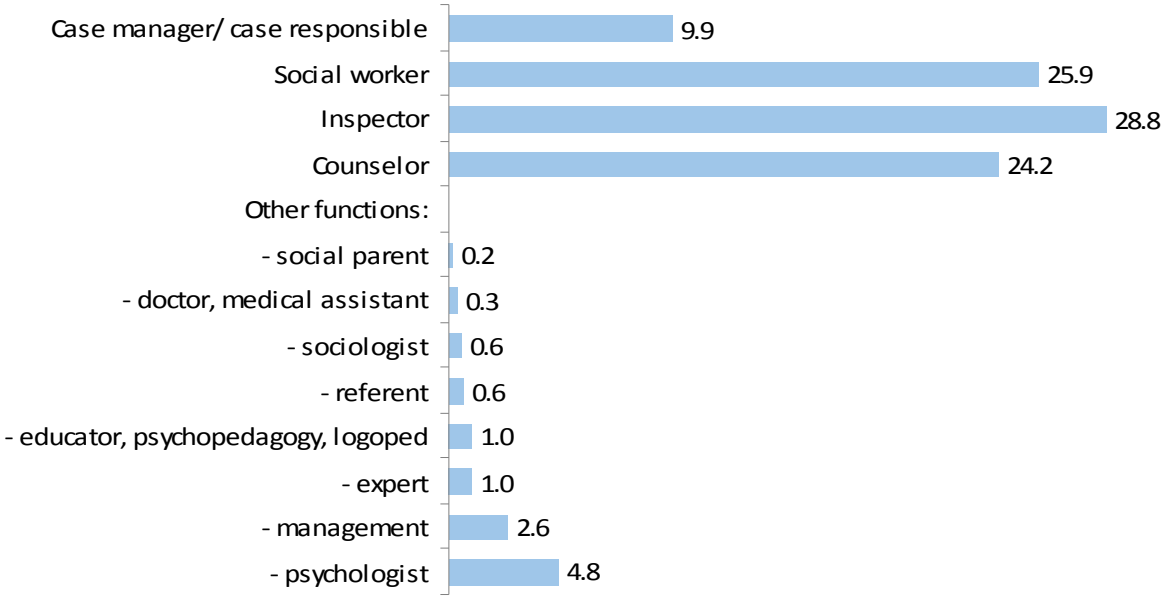
(A.3.1. Table 1 continued)

	Valid forms	Forms were completed by DGASPC specialists working as: Case manager/ case responsible officer	Social worker	Inspector	Counselor	Other job titles	Total
SATU MARE	260	14	0	0	86	0	100
SIBIU	295	0	1	0	95	4	100
SUCEAVA	361	16	48	5	9	21	100
VASLUI	287	5	34	0	54	7	100
VÂLCEA	269	2	15	39	1	43	100
VRANCEA	212	0	88	0	0	12	100
Total - N	6,493	640	1,681	1,873	1,572	727	6,493
- %	100	10	26	29	24	11	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014).

Notes: Only valid forms were considered. Only counties with 20 or more valid forms are shown. Only Total rows refer to all valid forms from all counties. The job title/capacity of the DGASPC specialists that filled in the forms was an open question, so in some counties the specialists who self-declared to be social workers/inspectors/counselors may also be undeclared case managers/case responsible officers.

A.3.1. Figure 1: DGASPC Specialists who Filled In the General Questionnaires (the Child Forms) Based on the Case Files of Children in Public Care (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014).

Notes: Only valid forms were considered. The job title/capacity of the DGASPC specialists who filled in the forms was an open question, so in some counties the specialists who self-declared to be social workers/inspectors/counselors may also be undeclared case managers/case responsible officers. * "Referent" is another Romanian job title term for specialist/counselor/adviser.

A.3.1. Table 1: Valid and invalid adoption forms

	N	%
Valid forms	680	74.5
Invalid forms, excluded:	233	25.5
- with partial non-responses	7	0.8
- with blank general questionnaire (child form)	5	0.5
- with invalid general questionnaire (child form) invalid, with partial non-responses	138	15.1
- covering children who left the system	83	9.0
Total	**913**	**100**

Source: Study of the Case Files of Children in Public Care: Adoption Form (November-December 2014).

A.3.1. Figure 2: DGASPC specialists who Filled In the Adoption Forms, Based on Case Files of Children in Public Care (%)

Source: Study of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted (N=252).

Notes: All forms (valid and invalid) are taken into account. The job title/capacity of the DGASPC specialists who filled in the adoption forms was an open question, so in some counties specialists who self-declared to be social workers/ inspectors/ counselors may also be undeclared case managers/case responsible officers.

A 3.2. Data Sheet on Children in Public Care

QUESTIONNAIRE

On the status of institutionalized children in Romania

|__|__|__|__|__|

(Write down the child's code used in the Sampling Sheet)

The National Authority for the Protection of Child Rights and Adoption, together with UNICEF and the World Bank, is conducting a nationwide study in order to identify existing problems as well as changes required for improving the quality and effectiveness of child protection services in a realistic, efficient and sustainable manner. The study will input:

- *The prioritization and operationalization of objectives of the Strategy for the Protection and Promotion of Children's Rights;*
- *The drafting of strategic directions for the development of DGASPC, with a focus on services for the protection of children deprived of parental care, as part of the National Strategy on Social Inclusion and Poverty Reduction;*
- *The design of operational programs under the 2014-2020 financial programming.*

ID1. DGASPC (County/District) _____

ID2. Person in charge of filling in the questionnaire

Surname ..... **Title** .....

First name ..... **Signature** .....

Instructions

- *The data provided by you are extremely important for the conducting of this nationwide review.*
- ***Please enter the requested information individually, for each child selected in the sample.***
- ***The information is entered only based on documents and data available in the child's file.*** *If information does not exist with regard to any question, please encircle the "Unspecified/Unknown" answer option. Please do not enter information from other sources.*
- *The answers obtained by us will not be communicated to anyone in this form, but will be used through a statistical analysis. Such analysis will observe all confidentiality and ethics rules.*

IDENTIFICATION DATA

QK. CHILD

Please specify or encircle the applicable code.

1a. Surname: **1b. First name:**

2. Date of birth: |__||__| |__||__| |__||__||__||__|
Day Month Year

3. PIN: |__|__|__|__|__|__|__|__|__|__|__|__|__|

4. Birth place: **4a. Town/commune:** **4b. Village:** **4c. County:**

5. Gender: 1. Male 2. Female

6. Ethnicity: 1. Romanian 2. Hungarian 3. Roma 4. Other. 9. Undeclared/Unknown

CHILD'S MOTHER

Please specify or encircle the applicable code.

If upon the child's entry into the system, the mother was Unknown (code 1), SKIP to the next section

QM. Mother was/is known or not:

a. Upon the child's entry into the system |__| *Please use one of the codes below.*

b. At present (the last 3 to 6 months) |__|

1. Unknown
2. Known, alive
3. Known, deceased
4. Known, in one of the situations listed under Art. 60 item a) of Law 272/2004

1a. Surname: **1b. First name:**

2. Date of birth: |__||__| |__||__| |__||__||__||__|
Day Month Year

3. PIN: |__|__|__|__|__|__|__|__|__|__|__|__|__|

6. Ethnicity: 1. Romanian 2. Hungarian 3. Roma 4. Other 9. Undeclared/unknown

7. Mother's civil status (legal status):

a. Upon the child's entry into the system |__| *Please use one of the codes below.*

b. At present (the last 3 to 6 months) |__|

1. Legally married
2. Consensual union
3. Unmarried
4. Divorced, separated, widow
9. Unspecified/Unknown

8. Mother's health:

a. Upon the child's entry into the system |__| *Use one of the codes below.*

b. At present (the last 3 to 6 months) |__|

0. The mother was/is apparently healthy
1. The mother is diagnosed with a current disease (e.g. tuberculosis) disability/impairment
2. Was/is suffering from a psychic disability/impairment, but not from a physical
3. Was/is suffering from a physical disability/impairment, but not from a psychic disability/impairment
4. Was/is suffering from both a psychic disability/impairment and a physical disability/impairment
9. Unspecified/Unknown

9. Mother's education:	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__| *Use one of the codes below.* |__|
	1. No school graduated, illiterate 2. Primary school (grades 1 to 4) 3. Gymnasium (grades 5 to 8) 4. Vocational, apprentice or complementary school	5. First high school stage (grades 9 to 10) 6. High school (grades 9 to 12) 7. Specialized or technical-foreman post-high school education 8. Short term university education/college 9. Master, PhD 90. Unspecified/Unknown
10. Mother's occupation:	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__|__| *Use one of the codes below.* More precisely, what was she doing? ..... |__|__|
	1. Employee 2. Day worker, working illegally or similar 3. Employer with employees 4. Self-employed in non-agricultural activities 5. Self-employed in agriculture	6. Family allowance 7. Unemployed or a person with no occupation 8. Pensioner for age limit 9. Other type of pensioner 10. Pupil, student 11. In prison 12. Housewife, unable to work or other inactive 90. Unspecified/Unknown
11. Consumption of substances and risks:	**a. Upon the child's entry into the system, did the mother:** **a. consume alcohol in excess?** **b. use drugs?** **c. have a criminal record?** **d. prostitution experiences?**	 1. Yes 2. No 9. Unspecified/Unknown 1. Yes 2. No 9. Unspecified/Unknown 1. Yes 2. No 9. Unspecified/Unknown 1. Yes 2. No 9. Unspecified/Unknown
12. Former residence:	**a. Upon the child's entry into the system** a1. The mother was: *Legal residence:* a2. Town/commune: a3. Village: a4. County:	 1. In the country 2. Gone abroad
13. Current residence:	**b. At present (the last 3 to 6 months)** b1. The mother is: *Legal residence:* b2. Town/commune: b3. Village: b4. County:	*Fill in even if current residence is same as former residence* 1. In the country 2. Gone abroad Address & Phone no.:

CHILD'S FATHER

Please specify or encircle the applicable code.

If upon the child's entry into the system, the father was Unknown (code 1), SKIP to the next section

QT. The father was/is known or not:	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__| *Use one of the codes below.* |__| 1. Unknown 2. Known, alive 3. Known, deceased 4. Known, in one of the situations listed under Art. 60 item a) of Law 272/2004
1a. Surname:		**1b. First name:**
2. Date of birth:	|__||__| |__||__| |__||__||__||__| Day Month Year	**3. PIN:** |__|__|__|__|__|__|__|__|__|__|__|__|__|
6. Ethnicity :	1. Romanian 2. Hungarian	3. Roma 4. Other 9. Undeclared/Unknown
7. Father's civil status (legal status):	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__| *Use one of the 1 to 4 codes listed under QM. MOTHER.7* |__| 9. Unspecified/Unknown
8. Father's health:	**a. Upon the child's entry into the system** **b. At present (November 2014)**	|__| *Use one of the 0 to 4 codes listed under QM. MOTHER.8* |__| 9. Unspecified/Unknown
9. Father's education:	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__| *Use one of the 1 to 9 codes listed under QM. MOTHER.9* |__| 90. Unspecified/Unknown
10. Father's occupation:	**a. Upon the child's entry into the system** **b. At present (the last 3 to 6 months)**	|__|__| *Use one of the 1 to 12 codes listed under QM. MOTHER10* More precisely, what was he doing? ..... |__|__| 90. Unspecified/Unknown
11. Consumption of substances and risks:	**a. Upon the child's entry into the system, did the father:** **a. consume alcohol in excess?** **b. use drugs?** **c. have a criminal record?**	1. Yes 2. No 9. Unspecified/Unknown 1. Yes 2. No 9. Unspecified/Unknown 1. Yes 2. No 9. Unspecified/Unknown
12. Former residence:	**a. Upon the child's entry into the system** a1. The father was: *Legal residence:* a2. Town/commune:	1. In the country 2. Gone abroad a3. Village: a4. County:
13. Current residence:	**b. At present (the last 3 to 6 months)** b1.The father is: *Legal residence:*	*Fill in even if current residence is same as former residence* 1. In the country 2. Gone abroad b2. Town/commune: b3. Village: b4. County: Address: Phone no.:

CHILD'S CAREGIVER

Attention! This section is to be filled in only in a situation where, prior to entering the system, the child was taken care of by a person other than his/her mother or father.

Please specify or encircle the applicable code.

QRL. Data about the child's caregiver

0. Capacity:	1. Relative	2. Neighbor 3. Other person
If a relative:	**a. kinship degree** |__| &	**b. Kinship relation,** *Specify here:*
1a. Surname:		**1b. First name:**
2. Date of birth:	|__|__| |__|__| |__|__|__|__| Day Month Year	**3. PIN:** |__|__|__|__|__|__|__|__|__|__|__|__|__|
5. Gender:	1. Male 2. Female	
6. Ethnicity:	1. Romanian 2. Hungarian	3. Roma 4. Other 9. Undeclared/unknown
7. Civil status (legal status):	**a. Upon the child's entry into the system**	**|__|** *Use one of the 1 to 4 codes listed under QM. MOTHER.7*
	b. At present (the last 3 to 6 months)	**|__|** 9. Unspecified/Unknown
8. Health:	**a. Upon the child's entry into the system**	**|__|** *Use one of the 0 to 4 codes listed under QM. MOTHER.8*
	b. At present (the last 3 to 6 months)	**|__|** 9. Unspecified/Unknown
9. Education:	**a. Upon the child's entry into the system**	**|__|** *Use one of the 1 to 9 codes listed under QM. MOTHER.9*
	b. At present (the last 3 to 6 months)	**|__|** 90. Unspecified/Unknown
10. Occupation:	**a. Upon the child's entry into the system**	**|__|__|** *Use one of the 1 to 12 codes listed under QM. MOTHER10*
	b. At present (the last 3 to 6 months)	More precisely, what was he/she doing? ..... **|__|__|** 90. Unspecified/Unknown
11. Consumption of substances and risks:	**a. Upon the child's entry into the system, did the child's caregiver:**	
	a. consume alcohol in excess?	1. Yes 2. No 9. Unspecified/Unknown
	b. use drugs?	1. Yes 2. No 9. Unspecified/Unknown
	c. have a criminal record?	1. Yes 2. No 9. Unspecified/Unknown
12. Former residence:	**a. Upon the child's entry into the system**	
	a1. The child's caregiver was:	1. In the country 2. Gone abroad
	Legal residence:	a2. Locality: a3.Village: a4. County:
13. Current residence:	**b. At present (the last 3 to 6 months)**	*Fill in even if current residence is same as former residence*
	b1. The child's caregiver is:	1. In the country 2. Gone abroad
	Legal residence:	b2. Locality: b3.Village: b4. County:

WHEN FIRST ENTERING PUBLIC CARE

FIRST ENTRY INTO THE SYSTEM

QEE1a. Date of <u>first</u> entry into the protection system: |__||__| |__||__| |__||__||__||__|

Attention! If the first entry was via emergency placement, specify the date when that occurred.

Day Month Year

QKID: Does the child have a document with a PIN (birth certificate, identity card)?

1. Yes, ever since the first entry into the system
2. Yes, documents were obtained while the child was in the system
3. He/she has no civil status documents to this day
9. Unspecified/Unknown

CHILD'S EDUCATION

Attention! This section is to be filled in only for children aged 3 or more upon their first entry into the system.

Please specify or encircle the applicable code.

QEDUC: At the moment of the first entry into the protection system, ...

1. Kindergarten:	**Had the child ever been enrolled in kindergarten?**	1. Yes 2. No
2. School:	**Had the child ever been enrolled in school?**	1. Yes 2. No 7. NA
	NA - Not applicable, the child was below 6 years of age	
	If he/she had ever attended school:	
	a. what type of school was he/she attending?	1. mainstream school 2. special school
	b. what grade was the child in?	|__||__|
	c. had he/she repeated any school year?	1. Yes 2. No 9. Not known
	d. was he/she at risk of dropping out?	1. Yes 2. No 9. Not known
	e. had he/she dropped out school?	1. Yes 2. No 9. Not known
3. SEN	**a. Did the child have special educational needs?**	1. Yes 2. No 9. Not known
	b. Did he/she have a school guidance certificate?	1. Yes 2. No 9. Not known

CHILD'S HEALTH

Please specify or encircle the applicable code.

QSAN: At the moment of his/her first entry into the protection system, …

1. G_birth:	**What was the child's weight at birth?**	|__||__|,|__||__|__| kg
2. A_birth:	**What was the child's Apgar score at birth?**	|__||__|
3. Weight:	**What was the child's weight upon his/her first entry into the system?**	|__||__|,|__||__|__| kg 90. Unspecified/Unknown
4. Height:	**What was the child's height?**	|__||__||__| cm 900. Unspecified/Unknown
5. Vaccines:	**Was the child administered the mandatory vaccines to date?**	1. Yes, all of them 2. Yes, some 3. No, none 9. Not known
6. Nutrition:	**Did the child show signs of malnutrition or undernutrition?**	1. Yes 2. No 9. Not known
7. Hygiene:	**Did the child have lice, scabies or any other disease related to poor hygiene?**	1. Yes 2. No 9. Not known
8. Physician:	**Was the child registered with a family physician?**	1. Yes 2. No 9. Not known
9. Disability	**Did the child have any disability assessed (by SEC, CPC, SEOSP or COSP)?**	1. Yes 2. No 9. Not known
10. Impairment:	**Did the child have an impairment or a diagnosis of a severe illness that could be certified as a disability degree?**	1. Yes 2. No 9. Not known
11. Autonomy:	**In his/her daily basic activities, was the child …?** *Attention! Autonomous means that he/she eats, gets dressed or walks by him/herself.*	1. Autonomous 2. In need of help 3. Totally dependent on others 9. Not known
12. Psychological assessment:	**Did the child receive an assessment of his sensorial and psychic and affective status or a psychological assessment?**	1. Yes 2. No
13. *If YES:*	**What are the conclusions of the standard assessment report available in the case file:** *Please fill in the box with one of the 1 to 3 codes hereby* **a. emotional** |__| **b. cognitive** |__| **c. behavioral** |__| **d. psychophysiological** |__| **e. personality-related** |__| **f. interpersonal skills** |__|	1. Normally developed, according to his/her age 2. Delays, disorders 3. With developmental delay

PARENTS' DWELLING

Please specify or encircle the applicable code.

For situations with codes 4, 5 and 9, SKIP to the next section.

QLOC: At the time of his/her first entry into the protection system, ...

1. Dwelling:	**Dwelling type:**	**|__|** *Use one of the codes below.*
	1. House, villa 2. Apartment in a block of flats 3. Improvised shelter	4. Was living on the street 5. The child was taken from a health unit or institution 9. Unspecified/Unknown
2. Housing security:	**Ownership of the dwelling:**	**|__|** *Use one of the codes below.*
	1. Owned by the parents 2. Owned by other relatives 3. Rent paid to the state	4. Rent paid to a private owner 5. Social housing or received for free 6. Improvised shelter 9. Unspecified/Unknown
3. Dwelling facilities:	**a. number of rooms**	|__|__| rooms
	b. kitchen	1. Yes 2. No 9. Not known
	c. bathroom/shower	1. Yes 2. No 9. Not known
	d. toilet inside	1. Yes 2. No 9. Not known
	e. proper heating	1. Yes 2. No 9. Not known
	f. a special place for the child	1. Yes 2. No 9. Not known
	g. hygiene conditions	1. Appropriate 2. Inappropriate 9. Not known
	h. endowed with durable goods *Durable goods such as: refrigerator, gas cooker, furniture etc.*	1. Appropriate 2. Inappropriate 9. Not known
4. Issues:	**The dwelling had problems such as: roof leaks, damp walls, rotten/damaged windows/floors etc.**	1. Yes 2. No 9. Not known
5. Assessment of environmental risk:	**What are the conclusions related to the environmental risk mentioned in the social inquiry available in the file?**	1. Yes, major risks 2. Yes, medium risks 3. Yes, minor risks 4. No risks, good/very good conditions 9. Unspecified/Such conclusions do not exist
6. Overcrowding:	**In total, how many persons were living in the dwelling/shelter,** out of which:	|__||__| persons, out of which:
	a. children aged 0-17 years	|__||__| children aged 0-17 years (including the child in question)
	b. adults aged 18+	|__||__| adults aged 18+

FAMILY RELATIONS

Please specify or encircle the applicable code.

For situations with codes 2, 3, 4 and 9, SKIP to the next section.

QFAM: At the time of his/her first entry into the protection system, .

1. Family:	**Did the child live with a family?**	**|__|** *Please use one of the codes below.* 1. Yes 2. No, the child was living alone 3. No, the child was living on the street 4. No, the child was taken from a health institution 9. Unspecified/Unknown
2. Family network:	**Did the child live with ...?** *Multiple answer choices. Please encircle all the corresponding codes from 1 to 6.*	1. Parents 2. Siblings 3. Other children 4. Grandmother, grandfather, grandparents 5. Other relatives 6. Other persons 9. Unspecified/Unknown
3. Risks	**Did one or more of the persons with whom the child was living (including his/her mother, father or caregiver) have any problems related to ...?** *Multiple answer choices. Please encircle all the corresponding codes from 1 to 6.*	1. Physical or neuromotor disabilities/impairment 2. Psychic or mental disabilities/impairment 3. Alcohol addiction 4. Drug addiction 5. Psychic disorder 6. Experiences with the police or a criminal record 9. Unspecified/Unknown
4. Relations with the family:	**The child's relations with his/her family were ...?**	1. Good 2. Difficult 9. Unspecified/Unknown
5. Neglect, abuse	**Does the file mention any acts of ...:**	
	a. ... child neglect?	1. Yes 2. No 9. Not known
	b. ... physical abuse?	1. Yes 2. No 9. Not known
	c. ... sexual abuse?	1. Yes 2. No 9. Not known
	d. ... psychic or emotional abuse?	1. Yes 2. No 9. Not known
	e. ... child exploitation?	1. Yes 2. No 9. Not known

RISKY BEHAVIORS

Attention! This section is to be filled in only for children aged 7 or more at their first entry.

Please encircle the corresponding code.

QRISC: At the time of his/her first entry into the protection system, ...

	Did the child have any of the following types of risky behaviors:	Yes	No	Not known
1	- was sexually active	1	2	9
2	- was an underage mother, was pregnant or had children already	1	2	9
3	- consumed alcohol, tobacco or drugs	1	2	9
4	- had experiences of fights or violence with other children or youth	1	2	9
5	- was in a "gang" or in a risk group of friends	1	2	9
6	- had run from or had left home	1	2	9
7	- had previous problems with the police	1	2	9
8	- was working on the street or begging	1	2	9

HOUSEHOLD INCOMES

QVEN: At the time of his/her first entry into the protection system, ...

	The household from which the child came had revenues from the following sources:	Yes	No	Not known
1	- salaries	1	2	9
2	- revenues from day work, illegal work or similar	1	2	9
3	- state social insurance pensions	1	2	9
4	- other pensions (farmer, veteran's, social or survivor's pension)	1	2	9
5	- monthly placement allowance	1	2	9
6	- monthly allowance for persons with severe and marked disability	1	2	9
7	- monthly food allowance for HIV infected persons	1	2	9
8	- family allowance	1	2	9
9	- income support (guaranteed minimum income)	1	2	9
10	- social canteen	1	2	9
11	- emergency aid	1	2	9
12	- food aid from the European Union	1	2	9
13	- heating aid (allowance for heating, logs)	1	2	9
14	- other benefits, aids	1	2	9
15	- money or parcels from relatives living abroad	1	2	9

16. What was the total estimated monthly income of the household (in RON) considering all the income sources mentioned above? **RON** 9. Not known

QDOT: The household from which the child came has/had possession of:		Yes	No	Not known
1	- a car	1	2	9
2	- a garden	1	2	9
3	- farming land, forest, grassland	1	2	9
4	- immovable assets	1	2	9

COMMUNITY

Please specify or encircle the applicable code.

QSPAS: Prior to the child's first entry into the protection system, ...

1. Source locality	**Locality from the jurisdiction of which the child was effectively taken...?**	
	a. Town/commune	b. Village: c. County:
2. SPAS	**In the town/commune from where the child came there is ...?**	1. Only one person with social assistance duties 2. A social assistant 9. Unspecified/Unknown
3 & 3a. Social inquiry	**Who conducted the social inquiry at the time of the first entry ...?** *Multiple answer choices. Please encircle all corresponding codes from 1 to 3.*	1. SPAS representative 2. DGASPC representative 3. Someone else, namely ..... 9. Unspecified/Unknown
4 & 4a. Child's needs	**Are the child's needs clearly identified in the inquiry?**	1. Yes, namely .... 2. No
5 & 5a. Family's needs	**Are the family's needs clearly identified in the inquiry?**	1. Yes, namely .... 2. No
6 & 6a. Services	**Is the offer of services that can meet such needs identified in the inquiry?**	1. Yes, namely .... 2. No
7. Plan	**Is there a service plan in the child's file?**	1. Yes 2. No 9. Not known
8 & 8a. Prevention	**Has the SPAS from the child's locality of origin mentioned any of the activities for preventing family separation listed in the right column:** *Multiple answer choices. Please encircle all corresponding codes from 1 to 5.*	1. Information, counselling and family support services 2. Consultation/collaboration with the family physician, teachers, police, other community representatives or with the Community Consultative Council/Structure 3. Referral to the prevention services in the area (day center, mobile teams, recovery center etc.) 4. Inclusion of the family in an economic support private program for abandonment prevention, if such program exists 5. Other prevention activities, such as: ..... 9. Unspecified/Unknown
9 & 9a. Support	**Is there any mention of any person or group, within the community or outside it, who offered support to the child and his/her family?**	1. Yes, namely: .... 9. Unspecified/Unknown

ENTRIES INTO AND EXITS FROM THE SYSTEM

In this section, we list all the entries - exits and re-entries (returns) of the selected child.

- ***We consider the actual exits form the system, for instance, those through reintegration or integration, upon termination of the protection measure. Short leaves of absence or IVAs are not deemed exits.***
- ***If a child has a single entry into the system, fill in only the last line*** *of the table below entering 1 in the No. column and the entry date. The exit date is already filled in with "Child currently in the system (November 2014)".*
- ***If a child has 2 entries,*** *fill in the first line (No. 1), the entry and exit date, and then enter 2 in the No. column on the last line and the entry date. The exit date on the last line is already filled in with "Child currently in the system (November 2014)".*
- ***If a child has several returns in the system,*** *fill in the first line (No. 1), enter 2 in the No. column on the second line as well as the entry and exit date on that line, and continue down to the last (most recent) entry, for which you enter on the last line the entry number in the No. column and the entry date, as the exit date is already filled in with "Child currently in the system (November 2014)".*

QEE. Child's entries into and exits from the system

Attention! The table needs to cover the child's entire history in the protection system

No.	Entries	Exits
1.	|__||__| |__||__| |__||__||__||__| Day Month Year	|__||__| |__||__| |__||__||__||__| Day Month Year
	|__||__| |__||__| |__||__||__||__|	|__||__| |__||__| |__||__||__||__|
	|__||__| |__||__| |__||__||__||__|	|__||__| |__||__| |__||__||__||__|
	|__||__| |__||__| |__||__||__||__|	|__||__| |__||__| |__||__||__||__|
	|__||__| |__||__| |__||__||__||__|	Child currently in the system (November 2014)

QEE1. <u>The child's first entry - exit</u> into/from the protection system:

a. The entry date:	**Date of <u>first</u> entry into the protection system:** *Only for verification against QEE table*	|__||__| |__||__| |__||__||__||__| Day Month Year
b. Origin:	**The child came from/was:** 1. A family 2. Relinquished in the maternity/pediatric wards 3. Relinquished in public spaces	**|__|** *Use one of the codes below.* 4. Living on the street 5. Relinquished or left with relatives 6. Left in the care of acquaintances or friends
c. Notification	**The case was notified:** 1. At the DGASPC's own initiative 2. By SPAS 3. By other institution	**|__|** *Use one of the codes below.* 4. By an individual 5. As a request of the child's family 6. As a request of the child
d. Entry verdict	**Entry decided based on:** 1. Decision of the DGASPC Director 2. Presidential order	**|__|** *Use one of the codes below.* 3. CPC decision 4. Court ruling

e. Cause of entry	**Cause for child-family separation stated in documents:** 1. Death of parents 2. Disappearance of parents 3. Deprivation of parental rights 4. Poverty	**|__|** *Use one of the codes below.* 5. Abuse, neglect, exploitation or any other form of violence 6. Disability of the child 7. Disability of the parent 8. Other, namely .....
f. PIP goal	**PIP goal** *If the PIP was revised, enter the last (most recent) goal.*	1. Reintegration in the family 2. Adoption 3. Social and professional integration 4. Other, namely .....
g. Exit date	**Date of <u>first</u> exit from the protection system:** *Encircle code 0 if the child is still in the system, or fill in the date, if the child left the system.*	0. Child currently in the system (November 2014) |__|__| |__|__| |__|__|__|__| Day Month Year

*If a child has more than one entry into – exit from the system, please fill in an **Entries-Exits Additional Sheet** in order to cover the child's entire history in the protection system.*

DO NOT FORGET to fill in the Entries-Exits Additional Sheet!

THE CHILD'S PATHWAY THROUGH THE SYSTEM

In this section, we refer only to the period between the child's last (most recent) entry in the system and the present time. More specifically, this section targets the time period referred to in the last line of the QEE table above which, for verification purposes only, we ask you to copy once more below:

No.	Entry	Exit
	|__|__| |__|__| |__|__|__|__| Day Month Year	Child in the system at present (November 2014)

- *For this time period, we record data for all protection measures/services, so that we can obtain a picture of the child's entire pathway through the system.*

QM. History of special protection measures

(established between the date of the child's last entry in the protection system and the present time)

No.	Special protection measure	Date when the protection measure was established
1.	|__| *Use one of the codes below* 1. Placement 2. Placement on an emergency basis 3. Specialized supervision	|__|__| |__|__| |__|__|__|__| Day Month Year
2.	|__| *Use one of the codes above*	|__|__| |__|__| |__|__|__|__|
3.	|__| *Use one of the codes above*	|__|__| |__|__| |__|__|__|__|

- ***For each protection measure**, we further record the history of services (individual or family, professional foster carer (AMP), residential service) and of providers, in order to obtain a picture of the child's entire pathway through the system.*
- *For this purpose, **we divide the time period into stages,** differentiated based on the changing of the measure, service or provider (e.g., transfer from a professional foster carer (AMP) to another or from a center to another) or of any combination thereof. **Please identify and write down the stages in the QMET table**.*
- *If the history of a child requires more than 7 stages, fill in a **System Pathway Additional Sheet.** Also, further on, you can enter data only for the first 3 stages. For all the other stages (4, 5, etc.), use the same System Pathway Additional Sheet.*

QMET. The child's history in the system, organized per stages

(time between the date of the child's last entry in the protection system and the present time)

Stage no.	**Time period**		**What has changed to deem it a distinct stage?**		
	(A1) from …	**(A2) until …**	**(B1) The measure**	**(B2) The service**	**(B3) The provider**
1	|__|__| |__|__| |__|__|__|__| Day Month Year	|__|__| |__|__| |__|__|__|__| Day Month Year	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
2	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
3	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
4	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
5	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
6	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No
7	|__|__| |__|__| |__|__|__|__|	|__|__| |__|__| |__|__|__|__|	1.Yes 2.No	1.Yes 2.No	1.Yes 2.No

- ***For each stage**, fill in tables QMET1, QMET2, QMET3 below using the instructions and codes presented next.*

Instructions and list of codes for filling in tables QMET1, QMET2, QMET3 per stages

Do not fill in this list, only use it when filling in the tables.

(A) Service	*Codes for protection services:*	
	1. Placement with relatives up to the 4th degree	5. Small group homes
	2. Placement with other families/people	6. Placement center
	3. Placement with foster carers (AMP)	7. Emergency reception center
	4. Apartments	8. Maternal center
(B) AMP Service	*If the service consisted of placement with professional foster carers (code 3)*	**Surname and first name of the foster carer:**
(D) Locality:	**Locality where the child was placed:**	
	(D1) Town/commune	**(D2) Village:** **(D3) County:**

(C) Residential service	*If the service consisted of placement in a small group home or in a center (codes 5 or 6)* **(C1) Institution type |__|** *Use one of the 1 to 8 codes listed in the right column* **(C2) Institution code |__|__|__|__|__|** *Use the codes available in the list of institutions in the county. If the institution does not appear in that list, use code "9. Not known".* **(C3). Institution name:**	1. Classical placement centers taken over from MEN (former dormitories of special schools) 2. Modular placement centers taken over from MEN (former dormitories of special schools) 3. Classical placement centers for children with disabilities (other than MEN centers) 4. Classical placement centers for children without disabilities (other than MEN centers) 5. Modular placement centers for children with disabilities (other than MEN centers) 6. Modular placement centers for children without disabilities (other than MEN centers) 7. Small group homes for children with disabilities 8. Small group homes for children without disabilities
(E) Case manager: *If YES*	**(E1) Was there a case manager?** *Case manager(s) appointed by decision of DGASPC.*	1. Yes, several case managers, namely |__||__| 2. Yes, a single case manager 3. No
	(E2) The only (or most recent during this stage) case manager was/is …	1. A DGASPC employee 2. Subcontracted service 3. OPA 4. Other situation, namely:
	(E3) His/her code: |__||__||__||__|	*Use the codes in the list of case managers made available by the county. If the case manager is not on that list, use code "0. Not listed".*
	(E4) His/her Surname and first name:	
(F) Person in charge of the PIP: *If YES*	**(F1) Was there a person in charge of implementing the PIP?** *Case responsible officer appointed by decision of the case manager(s).*	1. Yes, several PIP responsible officers, namely |__||__| 2. Yes, a single person in charge of the PIP 3. No
	(F2) The only (or most recent during this stage) person in charge of implementing the PIP was/is …	1. A DGASPC employee 2. Subcontracted service 3. OPA 4. Other situation, namely:
	(F3) His/her code: |__||__||__||__|	*Use the codes in the list of case managers made available by the county. If the case manager is not on that list, use code "0. Not listed".*
	(F4) His/her Surname and first name:	
(G) PIP goal:	**(G1) What was the PIP goal?** *If the PIP was revised, please mention the last (most recent) goal for each stage.*	1. Reintegration in the family 2. Adoption 3. Social and professional integration 4. Other, namely (*write down*):
	(G2) Was the PIP goal revised during the relevant stage?	1. Yes, once 2. Yes, several times 3. No

If YES	**(G3) Write down the reason for reassessment 1:**
	(G4) Write down the reason for reassessment 2:

1 **QMET1. <u>First stage</u> completed by the child in the system:**

Attention! *Check the QMET table which shows when the stage started and ended.*

To fill in QMET1 table, use the instructions and codes listed above.

Service	**AMP service** *If the service consisted of placement with professional foster carers (code 3)*	**(C) Residential service** *If the service consisted of placement in a small group home or a center (codes 5 or 6)*		
(A)	**(B) AMP's surname and first name**	**(C1)**	**(C2)**	**(C3) Institution name**
|__|		|__|	|__|__|__|__|__|	
	(D) Locality where the child was placed			
	(D1) Town/commune:		**(D2)** Village:	**(D3)** County:
	(E) Case manager			
	(E1) Was there one or more?	**(E2)**	**(E3)**	**(E4) Manager's Surname and first name**
	1. namely |__||__| 2 3	|__|	|__|__|__|__|	
	(F) Person responsible with implementing the PIP			
	(F1) Was there one or more?	**(F2)**	**(F3)**	**(F4) Responsible officer's Surname and first name**
	1. namely |__||__| 2 3	|__|	|__|__|__|__|	
	(G) PIP goal			
	(G1) Last/latest goal	**(G2)**	**(G3) Reason 1**	.....
	|__| or other, namely:	|__|	**(G4) Reason 2**	.....

2 **QMET2. <u>2nd stage</u> completed by the child in the system:**

Attention! *Check the QMET table which shows when the stage started and ended.*

To fill in the QMET2 table, use the instructions and codes listed above.

Service	**AMP service** *If the service consisted of placement with professional foster carers (code 3)*	**(C) Residential service** *If the service consisted of placement in a small group home or a center (codes 5 or 6)*		
(A)	**(B) AMP's surname and first name**	**(C1)**	**(C2)**	**(C3) Institution name**
|__|		|__|	|__|__|__|__|__|	
	(D) Locality where the child was placed			
	(D1) Town/commune:		**(D2)** Village:	**(D3)** County:

(E) Case manager

(E1) Was there one or more?	**(E2)**	**(E3)**	**(E4) Manager's Surname and first name**
1. namely |__||__| 2 3	|__|	|__|__|__||__|	

(F) Person responsible with implementing the PIP

(F1) Was there one or more?	**(F2)**	**(F3)**	**(F4) Responsible officer's Surname and first name**
1. namely |__||__| 2 3	|__|	|__|__|__||__|	

(G) PIP goal

(G1) Last/latest goal	**(G2)**	**(G3) Reason 1**	.....
|__| or other, namely:	|__|	**(G4) Reason 2**	.....

3 **QMET3. <u>3rd stage</u> completed by the child in the system:**

Attention! *Check the QMET table which shows when the stage started and ended.*

To fill in the QMET3 table, use the instructions and codes listed above.

Service	**AMP service** *If the service consisted of placement with professional foster carers (code 3)*	**(C) Residential service** *If the service consisted of placement in a small group home or a center (codes 5 or 6)*		
(A) |__|	**(B) AMP's surname and first name**	**(C1)** |__|	**(C2)** |__|__|__|__|__|	**(C3) Institution name**

(D) Locality where the child was placed

(D1) Town/commune:	**(D2)** Village:	**(D3)** County:

(E) Case manager

(E1) Was there one or more?	**(E2)**	**(E3)**	**(E4) Manager's Surname and first name**
1. namely |__||__| 2 3	|__|	|__|__|__||__|	

(F) Person responsible with implementing the PIP

(F1) Was there one or more?	**(F2)**	**(F3)**	**(F4) Responsible officer's Surname and first name**
1. namely |__||__| 2 3	|__|	|__|__|__||__|	

(G) PIP goal

(G1) Last/latest goal	**(G2)**	**(G3) Reason 1**	.....
|__| or other, namely:	|__|	**(G4) Reason 2**	.....

*If the history of a child includes more than three stages, please fill in a **System Pathway Additional Sheet**, in order to cover the entire time period between the child's last (most recent) entry in the system and the present time.*

DO NOT FORGET to fill in the System Pathway Additional Sheet!

*If a child currently has a PIP adoption goal, fill in an **Adoption Form**.*

DO NOT FORGET to fill in the Adoption Form!

CHILD'S EDUCATION AT PRESENT

Attention! This section is to be filled in only for children currently aged 3 or more.

Please specify or encircle the applicable code.

QEDUCP: At present (the most recent report on the child's status), …

2. Kindergarten or school:	**Is the child enrolled in a kindergarten/school?**	1. Yes 2. No
	If he/she attends school:	
	a. what school does he/she attend?	1. mainstream school 2. special school
	b. what grade is the child in?	|__||__|
	d. is he/she at risk of dropping out of school?	1. Yes 2. No 9. Not known
2a. Dropping out of school	*While he/she was in the protection system:*	
	c. did he/she repeat any school year?	1. Yes 2. No 9. Not known
	e. did he/she drop out of school?	1. Yes 2. No 9. Not known
3. SEN	**a. Does the child have special educational needs?**	1. Yes 2. No 9. Not known
	b. Does he/she have a school guidance certificate?	1. Yes 2. No 9. Not known

CHILD'S HEALTH AT PRESENT

Please specify or encircle the applicable code.

QSANP: At present (the most recent report on the child's status), …

		|__||__|,|__||__|__| kg
3. Weight:	**What is the child's weight?**	90. Unspecified/Unknown
4. Height:	**What is the child's height?**	|__||__||__| cm
		900. Unspecified/Unknown
8. Physician:	**Is the child registered with a family physician?**	1. Yes 2. No 9. Not known

9. Disability:	**Does the child have any disability assessed (regardless of the time of assessment?**	1. Yes 2. No 9. Not known
If YES **9a. Assessment:**	*If the child with a disability has ever been assessed (regardless of the time of assessment):* **a. which of the following institutions conducted the assessment?** *Multiple answer choices. Please encircle all corresponding codes from 1 to 4.*	1. The Comprehensive Assessment Services (SEC) within the DGASPC 2. School and Vocational Assessment and Guidance Services (SEOSP) within the CJRAE 3. Child Protection Commissions (CPC) 4. School and Vocational Guidance Commissions (COSP) of the ISJ
	b. when (year) was the first assessment of the child with disabilities conducted?	|__||__||__|__|
	c. for what purpose was the assessment conducted?	1. Certification as disability degree 2. School and vocational guidance 3. Planning of habilitation and/or rehabilitation services
10. Impairment:	**Does the child have an impairment or a diagnosis of a severe illness that could be certified as a disability degree?**	1. Yes 2. No 9. Not known
If YES **10a. Certificate:**	*If the child has ever had an impairment or a severe disease:* **a. does the child have a disability certificate?** **b. what year did he/she obtain the first certificate?** **c. disability code**	1. Yes 2. No 9. Not known |__||__||__|__| |__||__||__|__|
11. Autonomy:	**In his/her daily basic activities, the child ...?** *Attention! Autonomous means that he/she eats, gets dressed or walks by him/herself.*	1. Is autonomous 2. Needs help 3. Is totally dependent on others 9. Not known
12. Psychological assessment:	**How many psychological assessments (including of the sensorial and psychic and affective status) has the child had between his/her last entry into the system and the present time?**	|__||__| number of assessments
13. *If YES* *(number of assessments >0)*	**Compared to the assessment conducted at the time of his/her first entry into the system, does the most recent assessment show progress or regress in the following areas ...?** **a. emotional** |__| **b. cognitive** |__| **c. behavioral** |__| **d. psychophysiological** |__| **e. personality-related** |__| **f. interpersonal skills** |__|	1. Progress 2. No change 3. Regress 9. Unspecified/Unknown

RISKY BEHAVIORS AT PRESENT

Attention! This section is to be filled in only for children currently aged 7 or more.

QRISCP: While he/she was in the protection system (time between his/her last entry and the present time) ...

	Did the child have any of the following types of risky behaviors:	Yes	No	Not known
1	- was sexually active	1	2	9
2	- was an underage mother, was pregnant or had children already	1	2	9
3	- consumed alcohol, tobacco or drugs	1	2	9
4	- had experiences of fights or violence with other children or youths	1	2	9
5	- was in a "gang" or in a risk group of friends	1	2	9
6	- had run from or had left home	1	2	9
7	- had previous problems with the police	1	2	9
8	- was working on the street or begging	1	2	9

CHILD'S OPINIONS

Attention! This section is to be filled in only for children currently aged 10 or more.

QVOCE: While he/she was in the protection system (time between last entry and the present time) ...

1. Child's voice:	**Is there any document indicating the child's opinion of his/her separation from the family and establishment of the protection measure?**	1. Yes 2. No 9. Not known
2. Satisfaction:	**Is there any mention, statement or satisfaction questionnaire reflecting the child's opinion of the quality of the protection services he/she receives or received in time?**	1. Yes, fairly positive/satisfactory opinions 2. Yes, rather negative/non-satisfactory opinions 3. Yes, the child claims neglect or abuse 9. Unspecified/Unknown
3. Participation:	**Is there any mention or document indicating the child's participation in decision making, his/her consultation on aspects concerning him/her (e.g., preparation of the PIP, the service plan, education, health etc.)**	1. Yes 2. No 9. Not known

PROSPECTS OF LEAVING PUBLIC CARE

CHANCES OF INTEGRATION or REINTEGRATION IN THE FAMILY

REINTEGRATION: Between the child's last entry into the system and the present time ...

1. Housing:	**In the family of origin or for the mother, father or the child's caregiver, the housing status ...?**	1. Has worsened 2. Remained as it was at the time of the child's entry 3. Has improved 9. Unspecified/Unknown

2. Revenues:	**In the family of origin or for the mother, father or the child's caregiver, the status of revenues...?**	1. Has worsened 2. Remained as it was at the time of the child's entry 3. Has improved 9. Unspecified/Unknown
3. DGASPC contact with the family:	**Is there any DGASPC specialist in constant contact with the biological family through letters, invitations, phone calls, meetings, home visits etc. ...?**	1. Yes 2. No 9. Not known
4. Child's connection with the family:	**Has anyone in the family...** *Multiple answer choices. At each item, encircle all corresponding codes.* **a. filed a visit request** 1 2 3 4 5 6 7 8 9 **b. visited the child** 1 2 3 4 5 6 7 8 9 **c. contacted the child by phone** 1 2 3 4 5 6 7 8 9 **d. sent parcels to the child** 1 2 3 4 5 6 7 8 9 **e. taken the child on vacation** 1 2 3 4 5 6 7 8 9	1. Yes, the mother 2. Yes, the father 3. Yes, both parents 4. Yes, another former caregiver 5. Yes, siblings 6. Yes, the 1st and/or 2nd degree family 7. Yes, other relatives up to the 4th degree 8. No, no relative 9. Unspecified/Unknown
5. Visits:	**In total, according to the data in the file, how many visits did the child receive in the past 12 months?**	|__||__||__|
6. Siblings in the system:	**Does the child have any siblings in the protection system? If yes, how many brothers and how many sisters?**	1. Yes, brothers |__||__| 2. Yes, sisters |__||__| 3. Neither brothers nor sisters 9. Unspecified/Unknown
If YES **7. Group:**	**Are one or more of the brothers or sisters placed together with the child?**	1. Yes 2. No 9. Not known
8. The child's relation with his/her siblings:	**Is there any information as to how the child's relationship with his/her siblings placed in other institutions or with other families is maintained?**	1. Yes 2. No
9. Relatives up to the 4th degree:	**Is there a list of relatives up to the 4th degree identified for the child?**	1. Yes 2. No
10. Consent to integration:	**Is there a consent or refusal of relatives up to the 4th degree to integrate the child in the family?**	1. Yes, there is consent 2. Yes, there is refusal 3. It does not exist
11. SPAS:	**Is there any report, analysis or data submitted by the SPAS of the locality or localities where the natural family/parents or relatives up to the 4th degree reside that indicate what activities were carried out with these people in order to foster the child's reintegration?**	1. Yes 2. No *e.g. family monitoring, information and counseling services, parental education, or inclusion in an economic support program etc.*
12. Where could the child be integrated:	**Is there any report, analysis or data to indicate progress in terms of the community service supply (day centers, recovery centers, mobile teams etc.) available in the locality or localities where the natural family/parents or relatives up to the 4th degree reside?**	1. Yes 2. No

13. Chances of reintegration:	**Is there an estimate or assessment provided by the case manager or the person responsible with implementing the PIP in regard to the child's actual chances of integration/reintegration …**		
	a. in the natural family?	1. Yes, there is an assessment	9. No
	b. with relatives up to the 4th degree?	1. Yes, there is an assessment	9. No
14. PIP goal:	**Considering the data in the file, from your experience, are the three PIP goal alternatives (reintegration, adoption, and social and professional integration) appropriate and relevant for the status of this child?** *This is an opinion question, to which you respond if and as you wish. The question refers to the need to revise the rules regarding the PIP goals, in terms of including more choices to allow for more flexibility and enable matching to a wider range of situations. Any opinion in this sense is welcome.*	1. Yes 2. No, because for such cases, a different goal would be much more appropriated, namely: …… …… 9. I do not know/do not answer	

A 3.3. Adoption Form

ADOPTION FORM

|__|__|__|__|__|

(Write down the child's code used in the Sampling Sheet)

Atention! This questionnaire is filled in only for children included in the sample who currently have adoption as their PIP goal.

ID1. DGASPC (County/District) _____

ID2. Person in charge of filling in the questionnaire

Surname ..... **Title** .....

First name ..... **Signature** .....

ADOPTION PIP

QEP. <u>The child's last (most recent) entry</u> in the protection system:

Only for checking against the QEE table in the main Questionnaire.

No.	Entry	Exit
	|__||__| |__||__| |__||__||__||__| Day Month Year	Child currently in the system (November 2014)

QLM: Date of last connection with the biological family or with relatives up to the 4th degree (visits, short leaves of absence in the family)

|__||__| |__||__| |__||__||__||__| Day Month Year	0. Not applicable, there was never a connection

QFR. Group of siblings:	**Does the child have any adoptable siblings**:	1. Yes 2. No
	a. How many?	|__||__|
	b. How many adoptable together?	|__||__|

OPENING THE ADOPTION PROCEDURE (DPA) (DOMESTIC ADOPTION)

QDPA. Data on the DPA

1. File submission:	**Was the child's file handed over to the adoption department/office?**	1. Yes 2. No
If YES	a. Date of submission *Date when the child's PIP adoption file was handed over by the case manager to the adoption department/service will be filled in only for children with an adoption PIP after April 2012.*	|__|__| |__|__| |__|__|__|__| Day Month Year
2. Court:	**Was there a request to open the adoption procedure (DPA) filed with the court?**	1. Yes 2. No
If YES	a. Date when request was filed	|__|__| |__|__| |__|__|__|__|
	b. Date when the court ruled on the request	|__|__| |__|__| |__|__|__|__| 0. Not applicable, case pending
	c. Date when the court ruling was communicated to DGASPC	|__|__| |__|__| |__|__|__|__| 0. Not applicable, case pending
	d. Date when the DPA court ruling became final	|__|__| |__|__| |__|__|__|__| 0. Not applicable, case pending

THEORETICAL MATCHING

QPT. Data on the theoretical matching. *Please fill in the data below for the first theoretical matching (the 'oldest' in a chronological order) with the last adoption PIP.*

1. Number of lists:	**How many times was the theoretical matching initiated for the child?**	**|__|__|** *Number of theoretical matching lists.*
2. Initiation of practical matching:	*If YES, number of lists=1* **In situations where only one theoretical matching list was issued, was practical matching initiated?**	1. Yes 2. No
If YES	**a. Was/is the person/family included in the theoretical matching list in one of the following situations:** |__|	1. Is the child's foster carer 2. Has the child in placement 3. Is a relative of the child 4. Is the child's guardian 5. None of these
	b. Does the person or family have the residence in the district/county in which the child is under protection measure?	1. Yes 2. No

PRACTICAL MATCHING

Attention! This section is to be filled in only in situations where the child's theoretical matching list submitted by ORA or ANPDCA included adopting persons/families.

QPPNO. What are the reasons given by the persons/families on the child's list/lists why the practical matching could not be initiated?

1. Reasons for non-initiation: *Multiple answer choices. For each item encircle the corresponding codes.*	**a. Reasons related to the child**	0. No reasons related to the child were given 1. Child's medical history 2. Type of developmental delay 3. Child's ethnicity 4. Child's age 5. The group of siblings (requirement to adopt the whole group) 6. Other reason, namely:
	b. Reasons related to the mother	0. No reasons related to the mother were given 1. The mother consumed alcohol during pregnancy 2. The mother used hallucinogenic substances during pregnancy 3. The mother was recorded with sexually transmitted diseases 4. The mother is recorded with psychic disorders 5. The mother served/is serving a custodial sentence 6. Other reason, namely:
	c. Reasons related to the father	0. No reasons related to the father were given 1. The father consumes alcohol 2. The father uses hallucinogenic substances 3. The father was recorded with sexually transmitted diseases 4. The father is recorded with psychic disorders 5. The father served/is serving a custodial sentence 6. Other reason, namely:
	d. Reasons related to the adopting person/family	0. No such reasons were given 1. They want to adopt the child they have in placement but the child does not have an internal adoption procedure opened 2. They want to begin practical matching only with children under protection measure in the person's/family's county of residence or in adjacent counties 6. Other reason, namely:

QPPE. Failed practical matching

The table should be filled in for any practical matching that failed

No.	**Date when practical matching started**	**Date when practical matching ended**	**Reason/Reasons** (*write down*)	
			Of the family/person	**Of the child**
1.	|_|_| |_|_| |_|_|_|_| Day Month Year	|_|_| |_|_| |_|_|_|_| Day Month Year	.....	.....
	|_|_| |_|_| |_|_|_|_|	|_|_| |_|_| |_|_|_|_|	.....	.....

	|__||__| |__||__| |__||__||__||__|	|__||__| |__||__| |__||__||__||__|	.....	.....

- ***For each failed practical matching****, fill in the QPE1, QPE2, QPE3 tables below. If there are more than three failed practical matchings, use a new* ***Adoption Form,*** *keeping the same child's code used in the current form.*

1 **QPE1. First failed practical matching**

Attention! *Check the QPPE table which shows when the stage started and ended.*

1. Location:	**Do the persons/families with whom the practical matching failed have their residence in the district/sector in which the child is under protection?**	1. Yes 2. No	
2. Number of visits, meetings:	**In total, how many meetings/visits did the child have with the person/family with whom the practical matching failed?**	|__||__| meetings/visits	
3 & 3a. Short leave of absence:	**Was the child granted a short leave of absence in the family?**	1. Yes, for |__||__| days	2. No

2 **QPE2. Second failed practical matching**

Attention! *Check the QPPE table which shows when the stage started and ended.*

1. Location:	**Do the persons/families with whom the practical matching failed have their residence in the district/sector in which the child is under protection?**	1. Yes 2. No	
2. Number of visits, meetings:	**In total, how many meetings/visits did the child have with the person/family with whom the practical matching failed?**	|__||__| meetings/visits	
3 & 3a. Short leave of absence:	**Was the child granted a short leave of absence in the family?**	1. Yes, for |__||__| days	2. No

3 **QPE3. Third failed practical matching**

Attention! *Check the QPPE table which shows when the stage started and ended.*

1. Location:	**Do the persons/families with whom the practical matching failed have their residence in the district/sector in which the child is under protection?**	1. Yes 2. No	
2. Number of visits, meetings:	**In total, how many meetings/visits did the child have with the person/family with whom the practical matching failed?**	|__||__| meetings/visits	
3 & 3a. Short leave of absence:	**Was the child granted a short leave of absence in the family?**	1. Yes, for |__||__| days	2. No

QPPA. Accepted practical matching

1. Start date:	**Date when the practical matching started**	|__||__| |__||__| |__||__||__||__| Day Month Year
2. Report date:	**Date when the practical matching final report was prepared**	|__||__| |__||__| |__||__||__||__| Day Month Year
3. Location:	**Do the persons/families for which the practical matching was accepted have their residence in the district/sector in which the child is under protection?**	1. Yes 2. No
4. Number of visits, meetings:	**In total, how many meetings/visits did the child have with the persons/families for which the practical matching was accepted?**	|__||__| meetings/visits

5 & 5a. Short leave of absence:	**Was the child granted a short leave of absence in the family?**	1. Yes, for |__||__| days 2. No
6. Opinion:	**Is there any mention or statement reflecting the child's opinions of the person/family for which the practical matching was accepted?**	1.Yes, fairly positive/satisfactory opinions 2. Yes, rather negative/unsatisfactory opinions 97. Not applicable, the child is below 10 years of age 9. The child's opinion was not asked for

ENTRUSTING THE CHILD FOR ADOPTION (IVA)

QIVA. Data on the IVA

1. Court:	**Was there a request for entrusting the child for adoption filed with the court?**	1. Yes 2. No 9. Not applicable[463]
If YES		
2. Data on IVA	**a. Date when the request was filed**	|__||__| |__||__| |__||__||__||__| Day Month Year
	b. Date when the court ruled on the request	|__||__| |__||__| |__||__||__||__|
	c. Date when the court registry certificate was issued	|__||__| |__||__| |__||__||__||__|
	d. Date when the child moved in with the adoptive family	|__||__| |__||__| |__||__||__||__|
	e. Date when the court ruling was communicated to DGASPC	|__||__| |__||__| |__||__||__||__|
	f. Date when the court ruling became final	|__||__| |__||__| |__||__||__||__|

[463] If a child was subject to a placement measure for more than 2 years with the person/family who wants to adopt him/her.

ADOPTION REVOCATION OR APPROVAL

QNEXT:	**What was the IVA court ruling in the adoption trial?**	1. Revocation 2. Approval
QREV. *If REVOCATION*	**a. Date when IVA ruling was revoked**	|_|_| |_|_| |_|_|_|_| Day Month Year
	b. Reason for revocation:	.....
	d. Was the PIP goal changed from internal adoption (DPA) to a different goal?	1. Yes 2. No
	e. If adoption remained the PIP goal, was the theoretical matching procedure reinitiated?	1. Yes 2. No

*If the theoretical matching procedure was reinitiated, please fill in a new **ADOPTION FORM** for this child, using the same child's code on its first page and starting from the **Theoretical matching** section.*

DO NOT FORGET to fill in a new ADOPTION FORM for this child!

QAD. *If APPROVAL*	**a. Date when the request was filed**	|_|_| |_|_| |_|_|_|_| Day Month Year
	b. Date when the court ruled on the request	|_|_| |_|_| |_|_|_|_|
	c. Date when the court ruling was communicated to DGASPC	|_|_| |_|_| |_|_|_|_|
	d. Date when the court ruling became final	|_|_| |_|_| |_|_|_|_|

QPAR. Did the child's parents file a motion for a review of the IVA/Approval court ruling?

1. Petition:	**Did the child's parents file a motion for review?**	1. Yes 2. No
If YES **2. Stage:**	**At what stage of the adoption procedure was the motion for review filed?**	1. IVA - Entrusting for adoption 2. Adoption approval
3 & 3a. Court:	**What is the current status of the motion for review?**	1. Date when it was accepted: |_|_| |_|_| |_|_|_|_| Day Month Year 2. Date when it was rejected: |_|_| |_|_| |_|_|_|_| Day Month Year 3. Pending before the court

Annex 4. Focus Groups

The cities considered for the focus group discussions were: Iaşi, Focşani, Ploieşti, Craiova, Timişoara, Cluj-Napoca, Braşov, and Bucharest.

Population categories included in the focus groups:

1. Children (aged 10+) receiving residential services: placement centers (including family-type services), emergency child reception centers, etc., including children with disabilities (1-2 in each group)

2. Professionals within the child protection system:
   - Representatives of family-type services, placement centers, emergency child reception centers, maternal centers;
   - Representatives of the DGASPC;
   - Representatives of the SPAS within the municipality;
   - Case managers;
   - Representatives of NGOs working in this field.

A 4.1. Guide for Focus Groups with Providers of Child Protection Services

Focus Group

Professionals within the public child protection system

INTRODUCTION

Thank you for responding to our invitation to take part in this discussion. As we have told you, this is a study conducted for UNICEF aimed at analysing the wellbeing of children and their families, with a special focus on children in public care and children at risk of being deprived of parental care.

Because everything we discuss here is very important to us, we ask for your permission to make an audio recording of our discussion, in order to make it easier for us to remember the details later on when we draw up the final report and decide on the next best steps.

This is a free discussion based on an interview topic guide; we point out that your answers will not be assessed as good or bad, right or wrong! They are important for us, which is why we invite you to say anything that comes to mind about one topic or another.

To start with, please briefly introduce yourself: name, position, seniority, and your main duties regarding child protection.

CAUSES FOR THE SEPARATION OF CHILDREN FROM THEIR BIOLOGICAL FAMILIES

From your work experience, what are the main causes leading to the separation of the children from their biological families? *(spontaneous answers)*. Please explain!

(Possible re-launches) To what extent have you encountered in your experience so far the following aspects among the causes of separation:

- Family's social and economic background,
- Quality of the place of residence,

- Parents' education level,
- Number of children,
- Presence of disabled children or of people in the family,
- Sick parents,
- Domestic violence,
- Physical violence against the child,
- Child exploitation,
- Lack of food,
- Educational, healthcare neglect,
- Sexual abuse, promiscuity,
- Alcoholism,
- Violence in the community, membership in delinquent groups ,
- One parent missing – work abroad

Of all the mentioned causes, which ones did you encounter most frequently in your work?

MEASURES AND ACTIVITIES TO REDUCE SEPARATION

What activities are carried out at present to reduce the number of children separated from their biological families? What institutions are involved in this prevention process?

What activities are carried out in the institutions you represent in order to reduce the cases whereby children are sent into the protection system? *(spontaneous mentions)*. *(Possible re-launches):* To what extent the following activities are also undertaken:

- Involvement of the community services? Who are these services' beneficiaries? To what extent is such a measure efficient in preventing children from entering public care, in your opinion? What could be improved?
- Providing material support to the families at risk of sending their child(ren) into the protection system? What does this material support consist of? Who are the beneficiaries? How efficient is this measure, in your opinion? What could be done for improvement?
- Granting social housing? Who receives these services? How efficient is this measure, in your opinion? What could be improved?
- Support towards the employment of the parents? What kinds of activities are carried out as part of this measure? Who are the beneficiaries? How efficient is this measure, in your opinion? What could be done for improvement?
- Activities with the children, such as facilitating schooling, tutoring, participation to after-school activities, individual or group counselling/psychotherapy, training? What kinds of activities are actually undertaken? Who are the beneficiaries of these activities? How efficient are these activities, in your opinion? What suggestions for improvement do you have?
- Activities with the parents, such as counselling, non-violent parental education methods, facilitating medical examinations, medication, treatments, therapies? What kinds of activities are actually undertaken? Who are the beneficiaries of these activities? How efficient are these activities, in your opinion? What suggestions for improvement do you have?

What other kinds of activities would help reduce the risk of separation, in your opinion? In what way do you think they would benefit the families at risk of sending their children into public care? Who should implement them? Who should they target?

We talked about all these measures to prevent separation. What main obstacles to the optimal performance of the activities do the institutions involved encounter? What could you tell me about the resources available to the involved institutions? Are they sufficient? What should be improved?

MAKING THE DECISION TO REMOVE THE CHILDREN FROM THEIR FAMILIES – BY COURT ORDER IN CASE OF CHILD ABUSE AND NEGLECT

Have there been situations where the social worker recommended removing the children from their biological families? What are the characteristics of these situations? What was the basis of the social worker's recommendation to remove the child from his/her family?

What are the criteria considered when taking children away from their families? Who set these standards? To what extent are they clear/objective?

Is there a collective body/authority where cases are discussed, when there is the issue of removing a child from his/her family? Who are the members of this body?

Who makes the final decision to remove the child from his/her biological family (a judge or someone else)? What are the arguments underlying the decisions?

In the decision-making process for removing the child from his/her family, what is the role of the case manager or of the person which assessed the case? Does he/she have any decision-making power?

PROCESS OF TAKING THE CHILDREN INTO THE PROTECTION SYSTEM

Who makes the referrals to take a child from his/her family (a parent, a relative, the municipality 'referent' (adviser), others)? What were the most frequent situations in your locality until now? Which are the professionals, services and institutions involved in making the decision to separate a child from his/her family? What factors underlie the decision?

Please describe how the process works!

From your work experience, is belonging to a certain ethnical group (Romanian or other) a factor which facilitates or delays the care of the child by the protection system? Please explain!

What are the main improvements required in this process of taking the children into public care? Can you think of others, too?

STEPS AND ACTIONS TOWARDS REINTEGRATING CHILDREN INTO THEIR BIOLOGICAL FAMILIES

What steps and actions are undertaken to reunite children from public care with their families?

What can you tell me about the existence of the following measures for the reintegration of the children at present?

- Forms of material support, in case poverty was the reason for separation?
- Activities with the parents: counselling, non-violent parental education methods, facilitating medical examinations, medication, treatments, therapies?
- Granting social housing?
- Facilitating the employment of the parents?
- Activities with the children: facilitating schooling, tutoring, participation in after-school activities, individual or group counselling/psychotherapy, training, etc.?

What professionals, community/universal or specialized services and institutions are involved in the reintegration process? What are the roles of these institutions/professionals?

How efficient are these measures, in your opinion? Please explain. What would be the main suggestions for improvement of the current actions and measures?

What other additional measures or activities do you think would contribute to supporting the children's reintegration in their biological families?

If we talk about the measures and institutions currently involved, what are the main difficulties encountered in carrying out their activity? *(Spontaneous answer)* Do you think the following aspects are obstacles to carrying out their activity:

- The available resources,
- The communication between institutions.

Do you think there are certain categories of children/young people that require special reintegration measures? What are the characteristics of these categories? What kinds of measures should be considered for them?

CHILDREN/YOUNG PEOPLE LEAVING THE SYSTEM

What measures are taken at present to prepare for the youth's exit from the system? What professionals or institutions are involved in this process? What is the role of each institution/professional? To what extent are they efficient, in your opinion? Explain!

Do the children take part in home management, as a readiness measure before they leave the system? What kinds of activities are carried out (cleaning, cooking, shopping, life management, setting and negotiating the rules within the institution)? To what extent is this efficient, in your opinion? Explain!

Can you think of other measures taken at present to support young people when they leave the system? Please specify. To what extent are they efficient, in your opinion? Explain!

What would be the main additional actions/measures to be taken in order to ensure the young people's successful exit from the system? Who should be responsible (institutions, professionals, etc.) for their implementation? What would be the benefits of these measures?

What other proposals for (additional) training and community orientation activities do you have to ensure the better integration of the youth (in the community, into the labor market, etc.) at the time of his/her exit from public care?

Do you think there are certain categories of young people that require special integration measures? What are the characteristics of these categories? What kinds of measures should be considered for them?

Do you think there are other important themes we haven't covered? Which are they?

Thank you!

A 4.2. Guide for Focus Groups with Children in Public Care

Focus Group

Children in the public protection system

We are conducting a study about children like you, to find out how they live and what they feel. We have invited you here to talk with some of you. Nobody will find out the answers you give. There are no right or wrong answers. All we are interested in is your opinion.

Grown-ups want to understand what place is better for children like you, *i.e.* children whose families have troubles and cannot raise their own children during certain periods of time. Please explain where you think it would be better for you: at the center or in your own family.

INTRODUCTION

To start with, please introduce yourself: name, age, school grade you are in, the things you like to do in your spare time.

How long have you been in this center? Do you remember why you had to come here? To whom did you talk about this?

LIVING CONDITIONS IN THE CENTER

We would like to know how you feel here, in the center. Tell me about this place where you live. What do you like/don't like in the center, in terms of the space, the building (room, bathrooms, playgrounds)?

How satisfied are you with: the food, cleaning, play time, the help received?

How do you help out with the food, cleaning, order?

We would like to know if you feel safe – when you play, when you sleep. Is anybody bothering you? What do you do if somebody doesn't let you sleep or see to your business? Who do you ask for help?

CHILD EMOTIONAL SUPPORT AND RELATIONSHIPS

How do you get along with the other children in the home you live in? How about your schoolmates? Do you have close friends? Who are they (children in the same home, schoolmates, etc.)?

Do you trust the people working in the center? If yes, why do you? If not, why not?

On a scale from 1 to 10, how happy would you say you are?

What should happen to determine you to change your rating to a higher one? What exactly makes you feel happy? What makes you unhappy?

Have you gone through anything that made you feel that people, in general, treat you differently than the rest of the children? What was it?

When you are sad, as all children are sometimes, to whom do you talk about it (director, teacher, social worker, class master, psychologist)? When did you last talk to this person? Did you talk several times with this person? Are these discussions helpful in any way?

EDUCATION, SOCIALIZATION AND LEISURE IN THE CENTER

We would like to understand a few things about your school situation.

What are the main difficulties you encounter in school and learning? Are there any others that come to mind?

Where do you prepare for school? At the after-school program, or at the center? Do you prepare in your room or do you have a common room? Who and what helps you with your homework (silence, books, internet, computer)?

Do you believe you know as much and about the same things as the other children in your school? Why do you say that?

What do you think about the teaching staff in your school? Do you think they treat you differently than the rest of the children? Tell me about such a situation!

And the other pupils/students, do they treat you differently than the rest of the children? Tell me about such a situation!

SOCIALIZATION

How much time do you spend with the children outside the center? What kinds of things do you do together?

When was the last time you went on a hike or on vacation outside the center? Where did you go? How often are such activities carried out?

What other kinds of activities do you participate in outside the center? With whom?

What other things would you like to do outside the center?

CONTACT WITH THE FAMILY. INVOLVEMENT OF THE CHILD IN THE DECISIONS ABOUT SEPARATION FROM AND REINTEGRATION INTO THE FAMILY

Do you maintain contact with your biological family? Who in the family did you interact with? When was the last time you met? When was the last time you went home for a visit?

When you were sent to the center you live in now, did anybody talk to you about what was happening? Who (parents, social workers, judge, etc.)? What did they ask you? To what extent did they take into account what you said?

What nice things did you use to do with your family before coming to the center?

What things happened in your family that you wouldn't like to see happening again if you went back there?

What do you think about the chance of going back to your biological family? Would you like that? Why would you/not? Did you talk to somebody about your wish? What did they tell you?

Please fill in the following sentence: I would like to go back to my family, because …

Before going back to my family, I would like to know that ....

What are the things that matter to you, the children in the centers, that we, grown-ups, should know about? What should we do for you to feel better?

Annex 5. Survey of the Case Managers

CODE |__|__|__|__|__|	**CASE MANAGER SHEET**

Attention! *This questionnaire is filled in only for the case managers selected in the sample, either at the General Directorate for Social Assistance and Child Protection (DGASPC) or at the subcontracted service or accredited body (OPA) headquarters. Case managers selected in the sample cannot be replaced by other DGASPC employees.*

Date when sheet was filled in	|__|__| |__|__| 2015
County	COUNTY CODE
Commune	SIRSUP
Case manager **Surname and first name:**	
Position:	**Phone no./E-mail address:**
Higher education 1. Yes, in social assistance or sociology 2. Yes, in psychology 3. Yes, in economic or legal studies 4. Yes, medical studies 5. Yes, in other specialty 6. No	Seniority in the institution |__|__| years Seniority in child protection services |__|__| years Age |__|__| years old Latest continuous professional training session |__|__| |__|__|__|__| Month Year
The case manager is: 1. A DGASPC employee 2. Subcontracted service 3. OPA 4. Other, namely:	**Signature:**

ACTIVITY IN THE INSTITUTION

Q1. In what service/department do you work? (please specify its full name, as spelled out in the organizational chart of your institution)

_____

Q2. To what extent are you satisfied with…?

	Very dissatisfied	Dissatisfied	Neither dissatisfied nor satisfied	Satisfied	Very satisfied
1. Your profession	1	2	3	4	5
2. Your position	1	2	3	4	5
3. Your work place	1	2	3	4	5
4. Your professional activity	1	2	3	4	5
5. Your yearly income	1	2	3	4	5
6. The opportunities for continuous training	1	2	3	4	5
7. The equipment you have available (computers, printers etc.)	1	2	3	4	5
8. The work instruments you use	1	2	3	4	5
9. Access to a car to travel in the field	1	2	3	4	5

10.The monthly caseload	1	2	3	4	5

QMC. Data on the institutional set-up

MC1. **Set-up** How are case managers organized in your institution? **|__|** *Use one of the codes below.*

1. Based on a specific territory (geographic area)
2. Based on specific services
3. Based on children
9. Other. Which?_____

QDA. **Please mention the criteria and storage location of the files of your active cases of children in public care**. *Encircle the corresponding codes*

Location	**Criterion**
1. At the DGASPC headquarters 2. At the headquarters of the institution/protection measure provider	1. Alphabetical order of the children's names 2. Order of the children's PIN 3. Alphabetical order of the case managers 4. Other criterion. Which? .....

QBD1. **Does your institution use a database for children in public care?** 1. Yes 2. No

QBD2. *If yes*, is it the CMTIS? .....

QBD3. *If not*, what year did you start using your database? Year .....

QC1. **Have you personally participated in filling in the questionnaire regarding the *Status of institutionalized children in Romania,* based on children's files?** 1. Yes 2. No

QC2. *If yes*, how long did it take on average to identify the child's file? .....

QC3. *If yes*, how long did it take on average to fill in the questionnaire? .....

Q3. Have you used the following types of social protection services in 2014?

	Yes	No	If yes, how many of them are active (are open, require specialists' intervention)?
1. Prevention of child-family separation	1	2	
2. Psychological and legal counseling	1	2	
3. Residential-type protection (placement centers, maternal centers, or centers for children with special needs)	1	2	
4. Foster carers	1	2	
5. Placement with relatives up to the 4th degree	1	2	
6. Placement with other families/people	1	2	
7. Adoption	1	2	
8. Placement on an emergency basis	1	2	
9. Social integration of young people who come of age (18) and leave the protection system	1	2	
10. Protection of abused and/or homeless children	1	2	
11. School and vocational support and guidance for children with disabilities	1	2	
12. Reintegration in the natural family of children protected in placement centers or in substitute families	1	2	
13. Other types of services. Which?	1	2	

Q3a. Please specify the total number of social protection cases managed by you in 2014 for each category of children (even if they were taken over from previous years).

	A. Children with severe disabilities			B. Children with special educational needs		C. Children from vulnerable areas			D. Groups of siblings
	Under 3 years of age	3-13 years of age	14-18 years of age	3-13 years of age	14-18 years of age	Under 3 years of age	3-13 years of age	14-18 years of age	
1. Prevention of child-family separation									
2. Psychological and legal counseling									
3. Residential-type protection (placement centers, maternal centers, or centers for children with special needs)									
4. Foster carers									
5. Placement with relatives up to the 4th degree									
6. Placement with other families/people									
7. Adoption									
8. Placement on an emergency basis									
9. Social integration of young people who come of age (18) and leave the protection system									
10. Protection of abused and/or homeless children									
11. School and vocational support and guidance for children with disabilities									
12. Reintegration in the natural family of children protected in placement centers or in substitute families									
13. Other types of services. Which?									

Q3B. Please describe clearly how you would proceed in the following hypothetical case: a request from hospital/ maternity ward X regarding child Andrei, 3 days old, relinquished at birth. Andrei was born at full term, he weighs 3.5 kg, has received an Apgar score 9 at birth, and is of Romanian ethnicity. Andrei's father is unknown.

Suggested questions:

1. How many children like Andrei/cases like Andrei's do you have?

2. What is their PIP? If their PIPs differ, why is that?

3. According to the law, what should be done for a child in this situation? If it is not possible to implement all the applicable legal provisions, what are the major causes?

4. What do you think should be done for a child like Andrei?

5. What are the child's chances of being reintegrated into his natural family or of being adopted?

6. Which of the case management stages seemed most difficult to you and what were the difficulties you encountered?

Q3C. Please describe clearly how you would proceed in the following hypothetical case: you are notified about a 10-year-old little girl, Lavinia, currently in public care (in a residential placement, small group home) who, according to the medical report, suffers from behavioral disorders. Lavinia comes from a deprived family and has another five siblings, two of whom are also covered by a protection measure.

Suggested questions:

1. How many children like Lavinia/cases like Lavinia's do you have?

2. What is their PIP? If their PIPs differ, why is that?

3. According to the law, what should be done for a child in this situation? If it is not possible to implement all the applicable legal provisions, what are the major causes?

4. What do you think should be done for a child like Lavinia?

5. What are the child's chances of being reintegrated into her natural family or of being adopted?

6. Which of the case management stages seemed most difficult to you and what were the difficulties you encountered?

Q3D. Please describe clearly how you would proceed in the following hypothetical case: you are notified via the Child's Hotline about the situation of Veronica, an 8-year-old girl with severe disabilities, currently placed with a foster carer. The foster carer's neighbors have called to report cases of abuse and violence against this child. Veronica has been with this foster carer for one year.

Suggested questions:

1. How many children like Veronica/cases like Veronica's do you have?

2. What is their PIP? If their PIPs differ, why is that?

3. According to the law, what should be done for a child in this situation? If it is not possible to implement all the applicable legal provisions, what are the major causes?

4. What do you think should be done for a child like Veronica?

5. What are the child's chances of being reintegrated into her natural family or of being adopted?

6. Which of the case management stages seemed most difficult to you and what were the difficulties you encountered?

CASE MANAGEMENT

Q4. Normally, what is the actual duration (in working days) for proper completion of the following activities…?

Type of activities carried out	**Actual duration** (in working days)
1. Case identification, initial assessment and takeover	
2. Detailed/comprehensive assessment of the child's status	
3. Planning of services and interventions (PIP, recovery plan, rehabilitation and/or social reintegration plan, service plan)	
4. Provision of services and interventions for the child, family/legal representative and other persons important to the child	
5. Monitoring and regular reassessment of progress, of specialized decisions and interventions	
6. Case closure	

Q4a. From your experience at the local level, which of the types of activities mentioned above (Q4) seems the most difficult to implement?

Q4b. Please explain the reasons here:

Q5. Normally, how long after your intervention do you record case-related information in meeting/visit reports pertaining to your active cases?

1. on the same day	4. more than a week later
2. one day later	5. I record it upon request
3. during the same week	6. I do not manage to record it

If not recorded during the same week.

Q6. What do you think are the main reasons why you do not manage to record the case information in due time, according to the minimum working standards?

1.	99. I don't know/Non-response
2.	99. I don't know/Non-response

Q7. For which of the following categories of social protection services do you think it is the most difficult to complete the… ?

Q 7.1. Initial identification & assessment
Q 7.2. Detailed assessment report
Q 7.3. PIP & service plan
Q 7.4. Service & intervention provision
Q 7.5. Monitoring & regular reassessment report
Q 7.6. Case closure

Categories of services	**Q 7.1**	**Q 7.2**	**Q 7.3**	**Q 7.4**	**Q 7.5**	**Q 7.6**
1. Prevention of child-family separation	1	1	1	1	1	1
2. Psychological and legal counselling	2	2	2	2	2	2
3. Residential services (placement centers, CTF etc.)	3	3	3	3	3	3

Categories of services	Q 7.1	Q 7.2	Q 7.3	Q 7.4	Q 7.5	Q 7.6
4. Foster carers	4	4	4	4	4	4
5. Placement with relatives up to the 4th degree	5	5	5	5	5	5
6. Placement with other families/people	6	6	6	6	6	6
7. Adoption	7	7	7	7	7	7
8. Emergency placement	8	8	8	8	8	8
9. Social integration of young people who come of age (18) and leave the protection system	9	9	9	9	9	9
10. Protection of abused and/or homeless children	10	10	10	10	10	10
11. School and vocational support and guidance for children with disabilities	11	11	11	11	11	11
12. Reintegration in the natural family of children protected in placement centers or in substitute families	12	12	12	12	12	12

For Q 7.1 **Q8. What is the reason why you believe that the preparation of an initial assessment report is more difficult when you provide the service you selected in table Q7?**

For Q 7.2 **Q9. What is the reason why you believe that the preparation of a detailed assessment report for a case is more difficult when you provide the service you selected in table Q7?**

For Q 7.3 **Q10. What is the reason why you believe that the preparation of a PIP for a case is more difficult when you provide the service you selected in table Q7?**

For Q 7.4 **Q11. What is the reason why you believe that the provision of services and interventions is more difficult when you provide the service you selected in table Q7?**

INDIVIDUALIZED PROTECTION PLAN (PIP) GOALS/OUTCOMES

Q12. Considering your experience to date in the social protection area, what are the most frequent PIP implementation outcomes?
(mention them in the decreasing order of their frequency, from the most frequent down to the most rare)

1.
2.
3.
4.

Q13. How easy or difficult is it to obtain the following PIP implementation outcomes?

	Very easy	Fairly easy	So and so	Rather difficult	Very difficult
1. Prevention of child-family separation	1	2	3	4	5
2. Psychological and legal counseling	1	2	3	4	5
3. Residential services (placement centers, CTF etc.)	1	2	3	4	5
4. Foster carers	1	2	3	4	5
5. Placement with relatives up to the 4th degree	1	2	3	4	5
6. Placement with other families/people	1	2	3	4	5
7. Adoption	1	2	3	4	5
8. Emergency placement	1	2	3	4	5
9. Social integration of young people who come of age (18) and leave the protection system	1	2	3	4	5
10. Protection of abused and/or homeless children	1	2	3	4	5
11. School and vocational support and guidance for children with disabilities	1	2	3	4	5
12. Reintegration in the natural family of children protected in placement centers or in substitute families	1	2	3	4	5

Q14. With respect to the outcomes you selected as being "rather difficult" (=4) or "very difficult" (=5) to obtain, what do you think are the main reasons for this being so?

1. _____

2. _____

3. _____

Q15. Do you believe that the difficulty of implementing a PIP may depend on…?	Yes	No
1. The category of beneficiaries to which a child belongs	1	2
2. The type of service which the child receives	1	2
3. The existing caseload	1	2
4. Complexity/multidisciplinary nature of interventions/services	1	2
5. Other factor. Which?	1	2

Q16. For which of the following categories of beneficiaries do you believe that the PIP goal is more difficult to achieve?

|__| *Use one of the following codes*

1. children with disabilities (0-3 years of age)
2. children with disabilities (3-13 years of age)
3. adolescents with disabilities (14-18 years of age)
4. children with special educational needs (3-13 years of age)
5. children with special educational needs (14-18 years of age)
6. children from vulnerable groups (0-3 years of age)
7. children from vulnerable groups (3-13 years of age)
8. adolescents from vulnerable groups (14-18 years of age)
9. groups of siblings

Depending on the choice you made at Q16

Q17. What is the reason why you believe that the PIP goal is more difficult to achieve when a child belongs to the above-mentioned category?

_____

_____

Q18. What was the average time length required for achieving the PIP goals proposed for the cases you completed in 2014?

	Max. 3 months	3 to 6 months	6 to 12 months	1 to 2 years	2 to 3 years	Over 3 years
1. Prevention of child-family separation	1	2	3	4	5	6
2. Psychological and legal counseling	1	2	3	4	5	6
3. Residential services (centers, CTF etc.)	1	2	3	4	5	6
4. Foster carers	1	2	3	4	5	6
5. Placement with relatives up to the 4th degree	1	2	3	4	5	6
6. Placement with other families/people	1	2	3	4	5	6
7. Adoption	1	2	3	4	5	6
8. Emergency placement	1	2	3	4	5	6
9. Social integration of young people who come of age (18) and leave the protection system	1	2	3	4	5	6
10. Protection of abused and/or homeless children	1	2	3	4	5	6
11. School and vocational support and guidance for children with disabilities	1	2	3	4	5	6
12. Reintegration in the natural family of children protected in placement centers or in substitute families	1	2	3	4	5	6

Q19. How many cases did you close in 2014 by achieving the PIP goals?	Number of cases
1. Reintegration	
2. Adoption	
3. Socio-professional integration	

RELATION WITH OTHER MEMBERS OF THE WORKING TEAM

Q20. Please tell us to what extent you agree with the following statements:

	Totally disagree	Disagree	Agree	Totally agree
1. I have a sufficient number of specialists on my team	1	2	3	4
2. The main mission of DGASPC is to be a provider of social services	1	2	3	4
3. NGOs should be the main social service providers in the county	1	2	3	4
4. At present, there are no clear standards for the provision of child protection social services	1	2	3	4

Q21. What are the aspects with which you are most satisfied in your relation with the other specialists involved in solving the cases you manage?

Q22. How often do you organize meetings with members of the team involved in the case solving for the purpose of their resolution?

|__| *Use one of the following codes*

1. Daily
2. Weekly (at least once a week)
3. Monthly (at least once a month)
4. Quarterly (once every three months)
5. Half-yearly (twice a year)
6. Yearly (once a year)

Q23. How many members does your working team have? _____ members

Q24. Which of the persons on your team are in charge of the PIP?	Yes	No
1. the case manager	1	2
2. the service head	1	2
3. another member of the multidisciplinary team. Who?	1	2

If the respondent is in charge of preparing the plan.

Q25. In implementing a PIP, have you ever happened to need consulting from specialists whom you were unable to find in your county? 1. Yes 2. No

If yes.

Q26. What did you do in such case?

1.

2.

Q27. How often do you reassess the PIP when you manage a case?

1. Whenever necessary 2. Quarterly 3. Half-yearly 4. Yearly or less

Q28. Have you ever happened to fail to reassess the PIP in due time for all the managed cases? 1. Yes 2. No

Q29. Do you believe that an amendment to the legislation would be necessary for an improvement of your daily activities? 1. Yes 2. No

If yes.

Q30. What amendments do you think are necessary?

INTER-INSTITUTIONAL RELATIONS/ SYSTEM EFFICIENCY

Q31. To what extent are you satisfied with your collaboration with the following institutions?

	Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
1. Courts	1	2	3	4
2. Law enforcement bodies	1	2	3	4
3. School inspectorate (ISJ)	1	2	3	4
4. County capital municipality	1	2	3	4
5. Other municipalities in the county	1	2	3	4
6. NGOs dealing with children	1	2	3	4

	Very dissatisfied	Dissatisfied	Satisfied	Very satisfied
7. Public Health Directorate (DSP)	1	2	3	4
8. Child Protection Commission (CPC)	1	2	3	4
9. Comprehensive Assessment Commission	1	2	3	4
10. School and Vocational Guidance Commission under School Inspectorates (CJRAE)	1	2	3	4
11. Community Consultative Structures (community support groups) (SCC)	1	2	3	4
12. Public Social Assistance Services (SPAS)	1	2	3	4

Q32. To what extent do you believe that, in general, the current child protection system is efficient in protecting children from families at risk of…?

	Very inefficient				Very efficient
1. Excessive alcohol consumption	1	2	3	4	5
2. Drug consumption	1	2	3	4	5
3. Criminal record	1	2	3	4	5
4. Prostitution	1	2	3	4	5
5. Child neglect	1	2	3	4	5
6. Physical abuse	1	2	3	4	5
7. Sexual abuse	1	2	3	4	5
8. Psychic or emotional abuse	1	2	3	4	5
9. Child exploitation	1	2	3	4	5
10. Work on the street, begging	1	2	3	4	5
11. Problems with the police	1	2	3	4	5

Q33. If you find it very inefficient, please explain here the main factors with negative impact on the quality of the services provided by your institution (legislation, small number of specialists, employees' salaries etc.).

If applicable, explain separately for each type of risk.

Q34. To what extent do you believe that, in general, the current child protection system is efficient in working with client families that have children in the following situations…?

	Very inefficient				Very efficient
1. Death of a parent, divorce/separation, single-parent	1	2	3	4	5
2. Parents gone abroad	1	2	3	4	5
3. Mother abandoned the family/deserted the home	1	2	3	4	5
4. Imprisoned parent or parents	1	2	3	4	5
5. Deprivation of parental rights	1	2	3	4	5
6. Poor housing conditions or homeless	1	2	3	4	5
7. Hhds with monthly income/capita of max. RON 400	1	2	3	4	5
8. Child neglect	1	2	3	4	5
9. Physical abuse of the child	1	2	3	4	5
10. Emotional abuse of the child	1	2	3	4	5
11. Sexual abuse	1	2	3	4	5
12. Child exploitation for work, human trafficking	1	2	3	4	5

13. Sexual exploitation of the child	1	2	3	4	5
14. Disability of the child	1	2	3	4	5
15. Disability of the parent, incl. mental health problems	1	2	3	4	5
16. Family with 4 or more children	1	2	3	4	5
17. Antecedents – other siblings in public care	1	2	3	4	5
18. Antecedents – child previously in public care	1	2	3	4	5
19. Alcohol abuse by one or more of the household adults	1	2	3	4	5
20. Relinquished child in public spaces, street child	1	2	3	4	5
21. Child relinquished in health units	1	2	3	4	5
22. Teenage mother	1	2	3	4	5
23. Other reason, namely	1	2	3	4	5

Q35. If you find it very inefficient, please explain here the main factors with negative impact on the quality of the services provided by your institution (legislation, small number of specialists, employees' salaries etc.).

If applicable, explain separately for each type of risk.

Q36. From among the following types of services/service providers ...	**a. Is there any service provider in your county?**		**b. If yes, do you know/have you met any contact person?**		**c. If yes, have you referred anyone in the past three months?**	
	Yes	No	Yes	No	Yes	No
1. nursery/kindergarten/early education center	1	2	1	2	1	2
2. day center	1	2	1	2	1	2
3. respite center/crisis center	1	2	1	2	1	2
4. family physician/primary healthcare	1	2	1	2	1	2
5. dental service	1	2	1	2	1	2
6. mental health services	1	2	1	2	1	2
7. service/shelter for victims of violence	1	2	1	2	1	2
8. social canteen	1	2	1	2	1	2
9. social housing	1	2	1	2	1	2
10. home care service	1	2	1	2	1	2
11. employment services	1	2	1	2	1	2
12. adult vocational training services	1	2	1	2	1	2
13. "Second Chance"	1	2	1	2	1	2
14. "School after School"	1	2	1	2	1	2
15. parental education service	1	2	1	2	1	2
16. services for adolescents and youths	1	2	1	2	1	2
17. legal/legal assistance services	1	2	1	2	1	2

On a scale from 1="very poor"/"never" to 10="very good"/"always"…

Q37. How would you rate your knowledge about the services and resources existing in the commune and immediate neighborhood?

1	2	3	4	5	6	7	8	9	10
Very poor									Very good

Q38. How would you rate your skills used in helping children and families in the commune to obtain access to needed services and assistance?

1	2	3	4	5	6	7	8	9	10
Very poor									Very good

Q39. To what extent do you feel that you can intervene effectively to support children and families in the commune?

1	2	3	4	5	6	7	8	9	10
Very poor									Very good

IF he/she generally feels that he/she cannot intervene effectively (Q39<5)

Q39a.

Q39b.

Thank you!

Annex 6. Statistical Information

Annex 6 Table 1: Sample of Children in the Special Protection System (extracted from the CMTIS), by County and Type of Questionnaire (Number)

	Valid forms	Non-responses	Cases out of scope		Files not available	Sampling errors	Total	% Valid forms
			Services not included in the analysis	Children who had left the system				
ALBA	38	0	7	16	0	1	62	61.3
ARAD	233	8	10	11	0	0	262	88.9
ARGEȘ	20	0	4	36	1	0	61	32.8
BACĂU	375	4	9	37	2	0	427	87.8
BIHOR	342	4	3	62	19	0	430	79.5
BISTRIȚA NĂSĂUD	117	0	5	28	0	0	150	78.0
BOTOȘANI	272	16	4	27	4	0	323	84.2
BRĂILA	2	31	0	2	25	0	60	3.3
BRAȘOV	37	1	0	41	19	0	98	37.8
BUZĂU	7	31	0	20	2	0	60	11.7
CĂLĂRAȘI	6	39	0	13	2	0	60	10.0
CARAȘ SEVERIN	213	2	3	30	3	0	251	84.9
CLUJ	4	32	0	22	2	0	60	6.7
CONSTANȚA	345	7	1	11	13	0	377	91.5
COVASNA	266	5	27	8	0	0	306	86.9
DÂMBOVIȚA	194	0	8	15	4	0	221	87.8
DOLJ	228	1	19	17	1	0	266	85.7
GALAȚI	252	4	33	53	1	0	343	73.5
GIURGIU	6	51	0	3	0	0	60	10.0
GORJ	124	13	14	8	0	0	159	78.0
HARGHITA	274	10	20	30	5	0	339	80.8
HUNEDOARA	301	5	6	13	1	0	326	92.3
IALOMIȚA	0	22	0	38	0	0	60	0.0
IAȘI	0	49	0	12	0	0	61	0.0
ILFOV	4	19	0	34	3	0	60	6.7
MARAMUREȘ	2	45	0	14	0	0	61	3.3
MEHEDINȚI	159	0	0	1	0	0	160	99.4
MUREȘ	1	24	0	35	0	0	60	1.7
NEAMȚ	346	2	7	96	9	25	485	71.3
OLT	244	3	6	18	0	0	271	90.0
PRAHOVA	343	4	2	119	1	1	470	73.0
SĂLAJ	0	23	0	36	1	0	60	0.0
SATU MARE	260	13	4	10	0	0	287	90.6
SIBIU	295	2	29	17	1	0	344	85.8
SUCEAVA	361	1	14	14	2	0	392	92.1
TELEORMAN	1	7	0	51	1	0	60	1.7
TIMIȘ	1	24	0	12	23	0	60	1.7

	Valid forms	Non-responses	Cases out of scope		Files not available	Sampling errors	Total	% Valid forms
			Services not included in the analysis	Children who had left the system				
TULCEA	5	40	1	13	2	0	61	8.2
VASLUI	287	25	1	16	1	0	330	87.0
VÂLCEA	269	3	3	16	0	0	291	92.4
VRANCEA	212	1	6	7	0	0	226	93.8
BUCHAREST								
SECTOR 1	8	135	0	35	0	0	178	4.5
SECTOR 2	12	53	0	40	0	0	105	11.4
SECTOR 3	3	19	1	11	26	0	60	5.0
SECTOR 4	4	84	0	15	3	1	107	3.7
SECTOR 5	16	34	1	7	2	0	60	26.7
SECTOR 6	4	94	0	2	0	0	100	4.0
Total	6.493	990	248	1.172	179	28	9.110	71.3

Source: Survey of the Case Files of Children in Public Care (November-December 2014).

Note: Services not included in the analysis refer to guardianship, emergency reception centers, maternal centers, shelters, day centers, and others.

Annex 6 Table 2: Distribution of Children in Special Protection, by Ethnicity, Gender, Age, and Residency (% of Total)

	Romanian	Hungarian	Roma	Other	Undeclared	Total
Total, of which: N	**28,263**	**2,124**	**5,409**	**174**	**16,374**	**52,344**
%	**54.0**	**4.1**	**10.3**	**0.3**	**31.3**	**100**
Gender:						
Boys	27.7	2.0	5.6	0.2	17.1	52.7
Girls	26.2	2.1	4.7	0.1	14.2	47.3
Child's age at the time of study:						
<1 year	0.8	0.1	0.1	0.0	0.6	1.5
1-2 years	2.4	0.2	0.5	0.0	1.8	4.9
3-6 years	5.8	0.4	1.4	0.0	4.1	11.8
7-10 years	10.8	0.5	2.5	0.0	7.1	20.8
11-14 years	16.3	1.2	3.7	0.1	8.9	30.1
15-17 years	11.1	0.9	1.3	0.1	5.8	19.3
18-26 years*	6.8	0.8	0.9	0.1	3.1	11.6
Area of residence:						
Urban	27.2	2.6	7.0	0.2	19.6	56.5
Rural	26.6	1.4	3.3	0.1	11.2	42.6
Romania, without additional information	0.3	0.1	0.1	0.0	0.4	0.8
Abroad	0.0	0.0	0.0	0.0	0.1	0.1

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: *Including youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 3: Distribution of Children in Special Protection, by Disability, Gender, Age, Ethnicity, and Residency (% of Total)

	Children without disabilities	Children with disabilities	No info in case files	Total
Total, of which: N	**32,468**	**14,973**	**4,903**	**52,344**
%	**62.0**	**28.6**	**9.4**	**100**
Gender:				
Boys	31.0	16.7	5.0	52.7
Girls	31.1	11.9	4.4	47.3
Child's age at the time of study:				
<1 year	1.3	0.1	0.1	1.5
1-2 years	3.6	0.9	0.4	4.9
3-6 years	8.1	2.8	0.9	11.8
7-10 years	13.4	5.1	2.3	20.8
11-14 years	18.4	8.8	2.9	30.1
15-17 years	11.8	5.9	1.6	19.3
18-26 years*	5.4	5.0	1.2	11.6
Ethnicity:				
Romanian	35.3	14.6	4.0	54.0
Hungarian	2.5	1.0	0.6	4.1
Roma	6.1	3.3	1.0	10.3
Other	0.1	0.2	0.0	0.3
Undeclared	17.9	9.5	3.8	31.3
Area of residence:				
Urban	33.5	17.6	5.4	56.5
Rural	28.0	10.8	3.7	42.6
Romania, without additional information	0.5	0.2	0.2	0.8
Abroad	0.0	0.0	0.0	0.1

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: *Including youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 4: State of Health of Mothers and Fathers of Children in Public Care (%)

	Mothers' state of health		**Fathers' state of health ...**	
	When the child entered the system	At present (Nov.-Dec. 2014)	When the child entered the system	At present (Nov.-Dec. 2014)
Apparently healthy	49.2	37.0	43.7	32.9
A chronic disease such as tuberculosis	3.1	2.3	3.1	2.4
Mental health problems but no physical disability/impairment	10.0	9.1	3.7	3.8
A physical disability/impairment but no mental health problems	1.2	1.3	1.6	2.0
Both mental health problems and a physical disability/impairment	1.5	1.3	0.7	0.7
No info in case files	35.1	49.1	47.3	58.2
	100	100	100	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=29,037 mothers and 14,739 fathers).

Note: Unknown parents and deceased parents are not considered.

Annex 6 Table 5: Employment of Mothers and Fathers of Children in Public Care (% valid data)

	Mothers' employment		Fathers' employment	
	When the child entered the system	At present (Nov.-Dec. 2014)	When the child entered the system	At present (Nov.-Dec. 2014)
Employee or employer	4.14	6.43	11.97	11.33
Day worker, casual, informal or black labor	10.33	14.25	33.02	35.14
Self-employed in non-agricultural activities	1.47	1.98	1.78	1.83
Self-employed in agriculture*	3.16	4.12	4.42	4.96
Unemployed or jobless	23.13	20.01	21.54	18.97
Begging, vagrancy, prostitution, petty theft	2.39	0.15	0.19	0.00
Pensioner	2.59	3.83	4.55	7.56
Pupil, student	3.46	1.00	0.27	0.00
Houseperson, other dependants**	40.43	37.99	7.32	5.54
In prison	2.49	1.59	8.64	5.28
In a health or social institution	0.53	0.54	0.15	0.27
Work abroad***	5.83	8.08	5.62	8.60
In prison, abroad	0.04	0.04	0.54	0.52
	100	100	100	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=16,478 mothers and 7,427 fathers).

Notes: Only parents who are alive and known are considered. Employment data are missing for 43 percent of mothers and 50 percent of fathers. *Including being unpaid worker within the household. **Including people unable to work. ***Including a few cases of prostitution abroad.

Annex 6 Table 6: Marital Status of Mothers and Fathers of Children in Public Care (%)

	Mothers' marital status ...		Fathers' marital status ...	
	When the child entered the system	At present (Nov.-Dec. 2014)	When the child entered the system	At present (Nov.-Dec. 2014)
Legally married	22	22	36	26
Consensual union	29	22	27	15
Never married	32	17	10	5
Divorced, separated, widowed	9	12	17	20
Undeclared	8	27	11	34
	100	100	100	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=29,037 mothers and 14,739 fathers).

Note: Unknown parents and deceased parents are not considered.

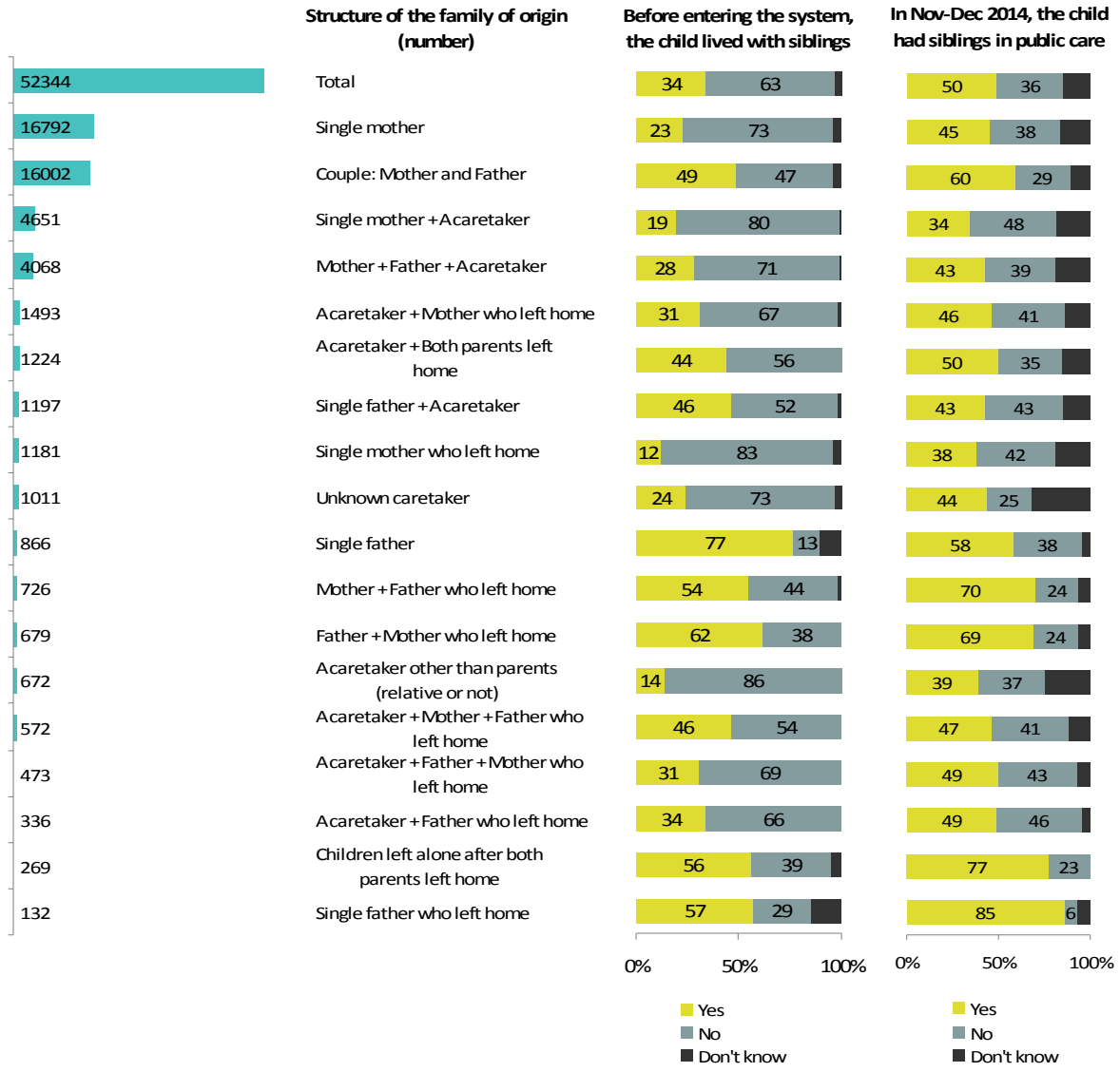
Annex 6 Table 7: Mothers and Fathers of Children in Public Care Versus the General Population Aged 20-64 with Regard to the Level of Education Achieved (% valid data)

	Mothers' level of education ...		General female population *	**Fathers' level of education ...**		General male population *
	When the child entered the system	At present		When the child entered the system	At present	
No school, illiterate	23	23	1	10.0	10.4	1.2
Primary (grades 1 to 4)	18	17	5	15.7	15.8	3.9
Gymnasium (grades 5 to 8)	36	35	26	36.0	36.6	20.4
Vocational, apprentice, and first high school stage (grades 9 to 10)	14	15	12	24.7	24.2	23.6
High school (grades 9 to 12)	8	8	31	11.0	10.6	30.7
Specialized or technical-foreman, post-high school education	1	1	4	1.3	1.3	3.2
University	0	1	21	1.2	1.0	17.1
	100	100	100	100	100	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=14,700 mothers and 6,136 fathers). Only living parents aged 20-64 are considered. Data on education are missing for 47 percent of mothers and 50 percent of fathers.

Note: *Structure of the resident population in Romania, by gender, age groups and level of education, 2011 Census, vol1_t40.xls, http://www.recensamantromania.ro/noutati/volumul/

Annex 6 Figure 1: Structure of the Family of Origin by the Existence of Siblings at Home Before the Child Entered the System, and by the Existence of Siblings in Special Protection at the Time of Study (number and %)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Annex 6 Table 8: Distribution of Children in Special Protection, by Disability, Gender, Age, Ethnicity, Residency, and Structure of the Family of Origin (% of Total)

		Family - single father	Family - single mother	Nuclear family	Extended family (especially grandparents)	No family	Total
Total	**N**	**1,824**	**18,842**	**14,545**	**12,784**	**4,349**	**52,344**
	%	**3**	**36**	**28**	**24**	**8**	**100**
Gender:							
Boys		4	36	29	23	8	100
Girls		3	36	27	26	8	100
Child's age at the time of study:							
<1 year		1	67	25	4	4	100
1-2 years		1	56	27	10	6	100
3-6 years		3	38	29	22	8	100
7-10 years		3	39	26	23	9	100
11-14 years		4	37	28	23	8	100
15-17 years		4	28	27	33	9	100
18-26 years*		5	27	32	28	8	100
Ethnicity:							
Romanian		4	31	29	26	9	100
Hungarian		4	36	21	32	7	100
Roma		1	47	24	20	8	100
Other		0	39	32	16	13	100
Undeclared		2	41	27	22	8	100
Area of residence:							
Urban		3	45	25	18	9	100
Rural		4	24	32	33	8	100
Somewhere in Romania or abroad		0	38	24	33	6	100
Child's disability:							
Without disabilities		4	32	26	30	8	100
With disabilities		3	42	33	12	9	100
Not known		2	39	21	29	9	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: *Including youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 9: Entry Routes Related to Family and Kinship Network (%)

		Maternity ward --> Family with stable dwelling --> Special Protection System (SPS)	Maternity ward --> Family --> Relatives --> SPS	Maternity ward --> Family --> Non-Relatives --> SPS	Maternity ward --> Family --> Children left home alone --> SPS	Other routes	Total
Total	**N**	**26,639**	**5,457**	**1,049**	**701**	**18,499**	**52,344**
	%	**51**	**10**	**2**	**1**	**35**	**100**
Child's age at the most recent entry into the system:							
0-12 months		24	2	1	0	72	100
1-2 years old		55	9	3	2	32	100
3-6 years old		67	14	3	3	13	100
7-10 years old		71	18	2	1	8	100
11-14 years old		67	21	4	1	7	100
15-17 years old		62	29	2	2	5	100
Child's age at the time of study (Nov.-Dec. 2014):							
0-12 months		19	1	1	0	79	100
1-2 years old		33	3	2	1	61	100
3-6 years old		46	8	3	2	42	100
7-10 years old		48	12	3	2	36	100
11-14 years old		51	10	1	1	36	100
15-17 years old		59	14	3	1	23	100
18-26 years old		58	11	2	1	29	100
Gender:							
Boys		50	10	2	1	36	100
Girls		51	11	2	1	34	100
Ethnicity:							
Romanian		58	11	2	1	28	100
Hungarian		56	10	1	1	32	100
Roma		34	9	1	1	55	100
Other		37	3	5	0	55	100
Undeclared		44	10	2	2	42	100
Area of residence:							
Urban		36	8	2	1	54	100
Rural		71	14	3	2	11	100
Somewhere in Romania or abroad		46	5	2	3	44	100
Child's disability:							
Without disabilities		54	12	2	1	29	100
With disabilities		46	5	1	1	47	100
Not known		42	15	2	1	39	100
Mother ...							
Unknown		0	0	6	0	94	100
Deceased before the child entered the system		63	18	3	9	7	100
Deceased while the child was in the system		50	3	2	0	45	100
Alive, but no information is available		46	8	0	1	44	100
Alive, but she is deprived of parental rights		46	8	7	1	39	100
Alive and information is available		51	10	2	1	36	100
Father ...							

		Maternity ward --> Family with stable dwelling --> Special Protection System (SPS)	Maternity ward --> Family --> Relatives --> SPS	Maternity ward --> Family --> Non-Relatives --> SPS	Maternity ward --> Family --> Children left home alone --> SPS	Other routes	Total
Total	**N**	**26,639**	**5,457**	**1,049**	**701**	**18,499**	**52,344**
	%	**51**	**10**	**2**	**1**	**35**	**100**
Unknown		35	7	2	1	54	100
Deceased before the child entered the system system		64	23	4	4	5	100
Deceased while the child was in the system		68	5	1	0	25	100
Alive, but no information is available		60	13	2	2	23	100
Alive, but she is deprived of parental rights		53	17	2	7	22	100
Alive and information is available		63	12	2	1	22	100
Mother's age when the child entered the system:*							
Unknown		54	16	2	4	24	100
12-17 years		35	5	1	0	58	100
18-24 years		40	10	1	1	48	100
25-39 years		55	11	2	1	31	100
40+ years		66	8	4	1	21	100
Mother's age in Nov 2014:*							
Unknown		54	16	2	4	24	100
14-24 years		43	12	2	1	43	100
25-39 years		50	12	2	1	35	100
40-49 years		55	8	2	2	34	100
50-68 years		55	4	4	1	37	100
Father's age in ov 2014:*							
Unknown		56	22	3	2	17	100
17-24 years		35	17	0	0	49	100
25-39 years		57	19	2	1	22	100
40-49 years		68	10	1	1	20	100
50-80 years		64	7	2	2	24	100
Family structure when the child entered the system:							
Single mother **		36	0	0	0	64	100
Couple: Mother and Father		67	0	0	0	33	100
Single mother + A caretaker ***		54	34	8	0	3	100
Mother + Father + A caretaker ****		55	36	5	0	3	100
Unknown caretaker		16	0	0	16	69	100
Other types of families		49	24	5	6	16	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: *Only parents who are alive and known are considered. **Data about the father are not available. ***Mother lived in the same dwelling with other person(s) (usually, the grandmother) who took care of the child. ****Generally multigenerational households in which the grandparents or other relatives took care of the child, although the parents were present. The route Maternity ward --> Family: Single mother institutionalized --> SPS is included in the category "other routes" due to the small number of cases. The age category 18-26 years includes youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 10: Entry Routes Related to Family and Kinship Network (%)

	Maternity ward --> Family with stable dwelling --> Special Protection System (SPS)	Maternity ward --> Family --> Children left home alone --> SPS	Maternity ward --> Family: Single mother institutionalized --> SPS	Maternity ward --> Family --> Relatives --> SPS	Maternity ward --> Family --> Non-Relatives --> SPS	ALL routes related to family and kinship network
National average	**26,639**	**701**	**65**	**5,457**	**1,049**	**33,910**
%	**51**	**1**	**0**	**10**	**2**	**65**
ARAD	33.7	0.6	0.0	22.3	2.2	59
BACĂU	52.5	3.4	0.0	9.0	2.1	67
BIHOR	40.4	1.6	0.2	4.1	0.0	46
BISTRIȚA-NĂSĂUD	48.3	0.0	0.0	15.7	0.0	64
BOTOȘANI	54.4	1.4	0.8	9.6	2.5	69
CARAȘ-SEVERIN	48.1	1.0	0.0	11.6	3.6	64
CONSTANȚA	50.8	0.7	0.1	8.4	1.5	61
COVASNA	48.2	1.2	0.3	10.6	0.3	61
DÂMBOVIȚA	52.8	1.1	0.0	6.6	2.7	63
DOLJ	37.7	1.4	0.1	12.2	4.2	56
GALAȚI	68.3	0.9	0.0	7.6	2.8	80
GORJ	63.6	1.1	0.0	15.7	4.9	85
HARGHITA	39.8	0.8	0.4	4.7	1.7	47
HUNEDOARA	52.9	1.8	0.0	22.1	1.9	79
MEHEDINȚI	41.3	0.7	0.0	19.7	2.2	64
NEAMȚ	53.2	1.3	0.0	2.2	0.8	57
OLT	58.6	1.2	0.0	8.6	1.8	70
PRAHOVA	56.0	2.2	0.0	10.5	2.0	71
SATU-MARE	51.8	0.7	0.0	5.7	1.8	60
SIBIU	45.4	3.7	0.0	1.7	1.9	53
SUCEAVA	61.8	1.8	0.4	13.1	3.5	81
VASLUI	43.9	0.0	0.0	15.1	1.4	60
VÂLCEA	52.6	0.0	0.0	6.4	1.1	60
VRANCEA	65.9	1.1	0.3	8.4	2.1	78

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=50,668).

Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Table 11: Entry Routes Related to Relinquishment in Health Facilities (%)

		Relinquished after birth in a maternity ward --> SPS	Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS	Other routes	Total
Total	**N**	**12,501**	**3,714**	**36,129**	**52,344**
	%	**24**	**7**	**69**	**100**
Child's age as of the most recent entry into the system:					
0-12 months		69	0	31	100
1-2 years old		0	27	73	100
3-6 years old		0	8	92	100
7-10 years old		0	3	97	100
11-14 years old		0	2	98	100
15-17 years old		0	1	99	100
Child's age at the time of study:					
0-12 months		77	0	23	100
1-2 years old		56	2	42	100
3-6 years old		29	7	64	100
7-10 years old		27	5	68	100
11-14 years old		25	7	68	100
15-17 years old		11	8	81	100
18-26 years old		13	11	76	100
Gender:					
Boys		24	7	68	100
Girls		23	7	70	100
Ethnicity:					
Romanian		19	6	76	100
Hungarian		15	9	76	100
Roma		41	10	50	100
Other		18	32	50	100
Undeclared		29	8	63	100
Area of residence:					
Urban		38	10	52	100
Rural		5	3	92	100
Somewhere in Romania or abroad		27	6	67	100
Child's disability:					
Without disabilities		21	4	74	100
With disabilities		30	13	58	100
Not known		23	9	68	100
Child's weight at birth:					
Very low (below 1,500 grams)		60	12	28	100
Low (less than 2,500 grams)		58	7	36	100
Normal - high (over 2,500 grams)		53	5	42	100
No info in case files		15	8	77	100
Mother ...					
Unknown		49	28	23	100
Deceased before the child entered the system		3	2	95	100
Deceased while the child was in the system		33	7	60	100
Alive, but no information is available		27	7	66	100
Alive, but she is deprived of parental rights		26	12	62	100
Alive and information is available		25	7	68	100
Father ...					
Unknown		41	9	50	100
Deceased before the child entered the system		1	2	97	100

		Relinquished after birth in a maternity ward --> SPS	Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS	Other routes	Total
Total	**N**	**12,501**	**3,714**	**36,129**	**52,344**
	%	**24**	**7**	**69**	**100**
Deceased while the child was in the system		11	10	79	100
Alive, but no information is available		11	3	86	100
Alive, but she is deprived of parental rights		13	6	82	100
Alive and information is available		12	6	82	100
Mother's age when the child entered the system:*					
Unknown		12	9	79	100
12-17 years		52	4	44	100
18-24 years		35	9	56	100
25-39 years		20	6	74	100
40+ years		10	6	84	100
Mother's age at the time of study:*					
Unknown		12	9	79	100
14-24 years		34	5	61	100
25-39 years		25	6	69	100
40-49 years		20	9	71	100
50-68 years		23	9	67	100
Father's age at the time of study:*					
Unknown		7	5	88	100
17-24 years		28	20	51	100
25-39 years		12	5	83	100
40-49 years		11	5	84	100
50-80 years		12	7	81	100
Family structure when the child entered the system:					
Single mother **		49	10	41	100
Couple: Mother and Father		18	9	73	100
Single mother + A caretaker ***		1	1	98	100
Mother + Father + A caretaker ****		0	1	99	100
Unknown caretaker		35	26	39	100
Other types of families		10	4	87	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: *Only parents who are alive and known are considered. **Data about the father are not available. ***Mother lived in the same dwelling with other person(s) (usually, the grandmother) who took care of the child. ****Generally multigenerational households in which the grandparents or other relatives took care of the child, although the parents were present. Only 22 percent of all children in public care have any data about their birth weight in their files. Most of those are children who arrived in the system after being relinquished in health facilities. The age category 18-26 years includes youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 12: Entry Routes Related to Relinquishment in Health Facilities (%)

	Relinquished after birth in a maternity ward --> SPS	Maternity ward --> Family --> Children left by parents in a pediatric unit/ other institution --> SPS	ALL routes related to relinquishment in heath facilities
National average	**12,501**	**3,714**	**16,215**
%	**24**	**7**	**31**
ARAD	26.2	9.7	36
BACĂU	16.5	12.4	29
BIHOR	34.8	12.3	47
BISTRIȚA-NĂSĂUD	25.7	3.3	29
BOTOȘANI	22.8	6.3	29
CARAȘ-SEVERIN	30.5	1.4	32
CONSTANȚA	18.2	13.7	32
COVASNA	27.7	8.5	36
DÂMBOVIȚA	21.2	9.7	31
DOLJ	33.1	5.0	38
GALAȚI	13.0	6.4	19
GORJ	6.6	4.6	11
HARGHITA	34.9	11.0	46
HUNEDOARA	15.9	3.1	19
MEHEDINȚI	27.0	6.5	34
NEAMȚ	25.0	14.8	40
OLT	24.7	2.5	27
PRAHOVA	21.7	3.0	25
SATU-MARE	25.6	6.0	32
SIBIU	32.9	10.0	43
SUCEAVA	11.9	2.6	15
VASLUI	29.4	7.7	37
VÂLCEA	35.8	3.1	39
VRANCEA	15.2	2.9	18

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=50,668).

Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Table 13: Average Length of Stay in Health Facilities of the Children in Public Care After Being Relinquished in a Maternity Ward, by County and Entry Year (Number of Days)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
AR						172	71	34			89	79	129
BC						326	74	53	29	82	92	190	142
BH				91	127	2	220	85	201	211	132	117	84
BN	198						186		236	82	45	44	72
BT						235	11	1	186	190	86	132	127
CS					44		236		282	105	89	27	37
CT				293		240	321				91	164	100
CV									109			142	117
DB										81	233	15	216
DJ								28		206	90	45	49
GL			79							45	111	102	202
GJ								29					
HR	83	296		109			96	116	112	221		116	152
HD									260	72	45	20	119
MH			86			82				53		39	36
NT			180			1		59	101	113	188	125	159
OT						159			77	50		176	128
PH								96	124	263	163	129	111
SM				120		198			216	46	49	52	129
SB								123	122	137	96	29	158
SV	53									32	37	50	78
VS									134	150		168	252
VL								181	143	106	120	51	34
VN				128		76		89				6	117

(continuation)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
AR	191	90	57	124	169	36	264		72	171	65	251	52
BC	58	126	26	188		268	112	12	32	109	230	79	59
BH	121	148	124	188	127	78	76		293		97	173	88
BN	52		28	117	192			321	92	83	66	137	
BT	84	154	134		130	159			28	15	242	115	130
CS	39	75	9	13	21	79	120	37	9	19	21	16	14
CT	49	129	82	185	280	205		146	313	251	111	148	139
CV	134	151	78	120	155	142	92	95		109	68	79	102
DB	93	135	77	41	161		227	11			64	35	20
DJ	53	89	60	103	71	274	43	47	22	93	69	66	69
GL	86	89	178	88	81		116	154	184	49	42	40	51
GJ	22										29	26	20
HR	130	62	143	55	35	202	94		44	104	69	52	57
HD	87	118	65	106	35	150	110		212	55	42	112	25
MH	29	172	49	143	138	40	14			47	37	38	18
NT	115	246	141	172	219	325	189	218	178	101	96	95	106
OT	47	56	104	34	28	135	41	39	69	40	39	54	35
PH	62		107	73	46	18	92	25			171	32	
SM	181	88	77	125	40	34	66	27	25	143	31	105	97
SB	35	35	73	34	20	99	53	63		134	129	97	173
SV	122	153	25	10			161	28	6	6	81	38	51
VS	129	34	60	92	107	79	62	50	25	40	89	23	22
VL	48	106	26	23	12	14	16	51	24	54	51	44	139
VN		20			36	14	22		139	45	112	37	59

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=11,950).

Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Table 14: Main Determinants of the Average Length of Stay in Health Facilities of the Children in Public Care After Being Relinquished in a Maternity Ward, during 1989-2014

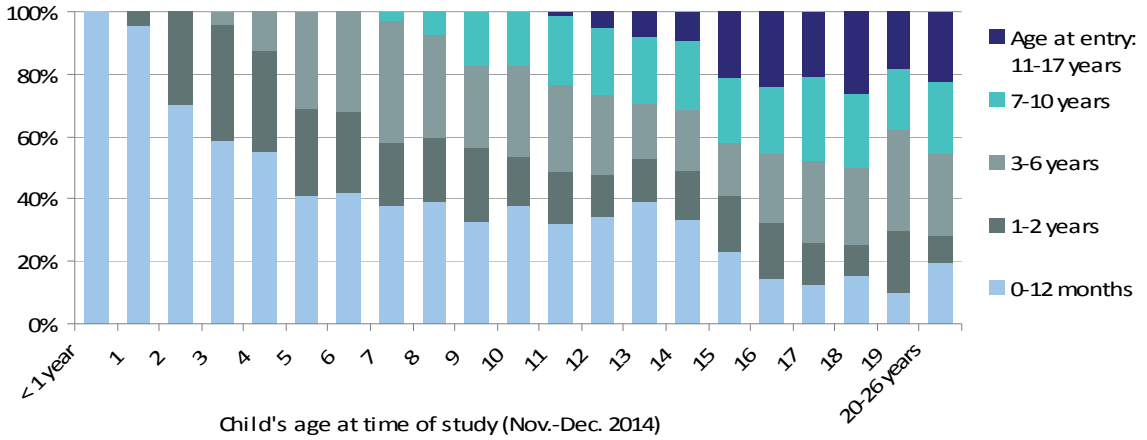
	Unstandardized coefficients		Standardized coefficients			Collinearity statistics	
Predictors	B	Std. Error	Beta	t	Sig.	Tolerance	VIF
(Constant)	5073.137	355.975		14.251	.000		
Child							
Weight at birth (1=very low <1.500 grams)	39.893	3.876	.125	10.293	.000	.900	1.111
Ethnicity (1=Roma)	2.614	2.735	.012	.955	.339	.787	1.270
Health state (1=disability)	6.041	1.962	.039	3.079	.002	.818	1.222
Mother							
Deceased in maternity (1=yes)	70.879	10.320	.080	6.868	.000	.960	1.041
Ran away from maternity (1=yes)	36.597	7.163	.060	5.109	.000	.970	1.031
Entry Year (the most recent admission into the system)							
Between 1989 and 2014	-2.468	.177	-.183	-13.944	.000	.768	1.302
Institutional factors							
(County - dichotomous variables)							
AR	-45.393	8.015	-.091	-5.664	.000	.511	1.959
BC	-51.951	7.020	-.140	-7.401	.000	.369	2.709
BH	-45.241	6.666	-.162	-6.787	.000	.232	4.315
BN	-27.711	8.790	-.048	-3.153	.002	.570	1.756
BT	2.484	8.002	.005	.310	.756	.512	1.954
CS	-96.931	6.560	-.316	-14.777	.000	.287	3.479
CV	-20.680	7.787	-.044	-2.656	.008	.474	2.108
DB	-43.127	7.211	-.107	-5.981	.000	.409	2.447
DJ	-83.922	6.293	-.324	-13.336	.000	.224	4.473
GJ	-81.283	11.638	-.091	-6.984	.000	.773	1.293
GL	-11.746	8.065	-.023	-1.456	.145	.533	1.875
HD	-36.122	6.862	-.102	-5.264	.000	.349	2.867
HR	-60.047	6.641	-.188	-9.042	.000	.304	3.284
MH	-33.405	7.607	-.074	-4.391	.000	.465	2.151
NT	.092	7.042	.000	.013	.990	.388	2.574
OT	-67.435	6.367	-.239	-10.592	.000	.259	3.866
PH	-61.284	6.867	-.175	-8.924	.000	.341	2.929
SB	-37.399	6.969	-.101	-5.367	.000	.372	2.690
SM	-74.927	7.607	-.165	-9.850	.000	.467	2.139
SV	-65.347	7.187	-.163	-9.093	.000	.411	2.434
VL	-76.815	6.807	-.220	-11.285	.000	.347	2.880
VN	-67.968	7.484	-.154	-9.082	.000	.461	2.170
VS	-70.852	6.457	-.241	-10.973	.000	.273	3.666

Dependent variable: Average length of stay in health facilities of the children in public care after being relinquished in a maternity ward, during 1989-2014 (number of days)

Source: Estimations by the World Bank based on the Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=6,057).

Notes: Linear regression model, Enter method, R2=0.21, Durbin-Watson 1.29. Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1); Constanța (CT) is the reference country.

Annex 6 Figure 2: Distribution of Children in Public Care by Age When Entering the Special Protection System and Age at the Time of the Study (November-December 2014)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: The age category 20-26 years includes youths aged over 26 who were still in the system at the time when the research was conducted.

Annex 6 Table 15: Distribution of Children Aged 6-17 with Special Educational Needs (SEN) at the Time When the Child Entered the Special Protection System (%)

SEN - according to case file	SEN - existence of a school guidance certificate	Age at Entry			Total
		3-6 years old	7-10 years old	11-17 years old	
Yes	Yes	0	3	1	5
	No	1	2	1	3
	Not known	0	0	1	1
	Total	1	5	3	9
No	No	10	39	22	70
	Total	10	39	22	70
No info	No	1	2	1	4
	Not known	5	8	3	16
	Total	6	10	4	21

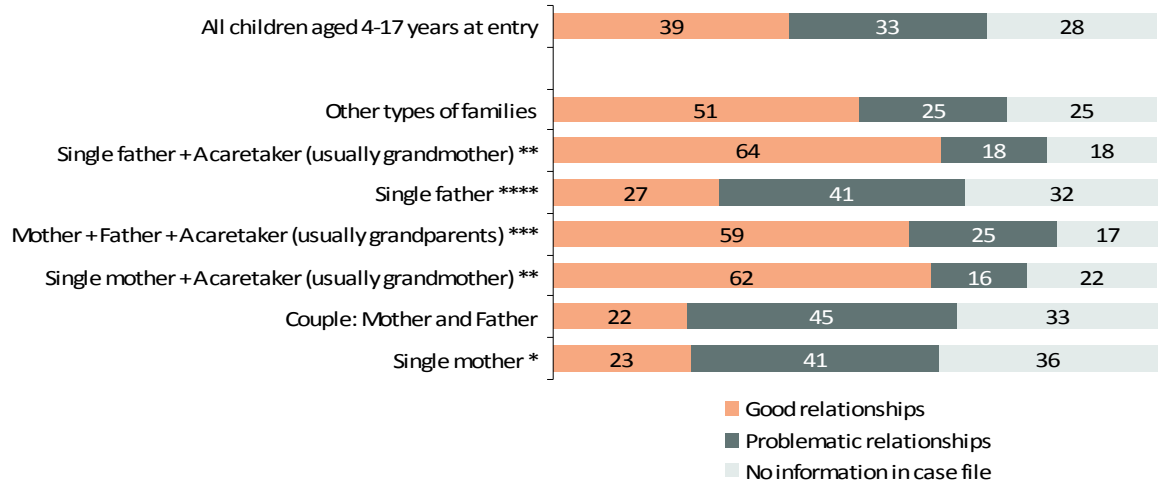
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=15,742).

Annex 6 Table 16: Education Level of Children with Special Educational Needs (SEN) Versus All Children Aged 6-17 When the Child Entered the Special Protection System (%)

Indicators		Age at Entry: 6 years	7-10 years	11-14 years	15-17 years	Total
Total	N	2,673	8,483	3,961	625	15,742
	%	100	100	100	100	100
TOTAL						
Children 3-6 years who have ever attended kindergarten	- yes	52	52	55	66	53
	- no	40	24	18	16	25
	Missing data	8	24	27	18	22
Children 6-17 years at entry who have ever attended school	Out of school: Never in school	57	17	6	13	21
	Out of school: school dropout	1	4	9	9	5
	In school and no risk of dropout	17	46	52	54	43
	In school with risk of dropout	3	13	15	8	12
	In school, no other information	5	16	15	11	14
	Missing data	17	5	2	5	6
Children 6-17 years at entry who went to a school	- mainstream	23	69	83	71	65
	- special	0	4	3	4	3
	Missing data	76	27	14	25	32
Children 6-17 years at entry who have ever repeated a grade	- yes	0	5	8	7	5
	- no	22	57	62	51	52
	Missing data	78	38	30	42	43
CHILDREN WITH SEN						
Children 3-6 years who have ever attended kindergarten	- yes	17	43	38	36	38
	- no	77	37	30	23	38
	Missing data	5	21	32	41	24
Children 6-17 years at entry who have ever attended school	Out of school: Never in school	50	21	16	18	22
	Out of school: school dropout	0	9	14	2	8
	In school and no risk of dropout	7	34	31	39	31
	In school with risk of dropout	9	19	21	10	18
	In school, no other information	21	15	14	22	16
	Missing data	14	3	4	8	5
Children 6-17 years at entry who went to a school	- mainstream	30	44	38	40	41
	- special	7	27	30	22	25
	Missing data	63	29	32	38	34
Children 6-17 years at entry who have ever repeated a grade	- yes	0	11	12	12	10
	- no	16	48	39	15	40
	Missing data	84	41	49	73	50

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

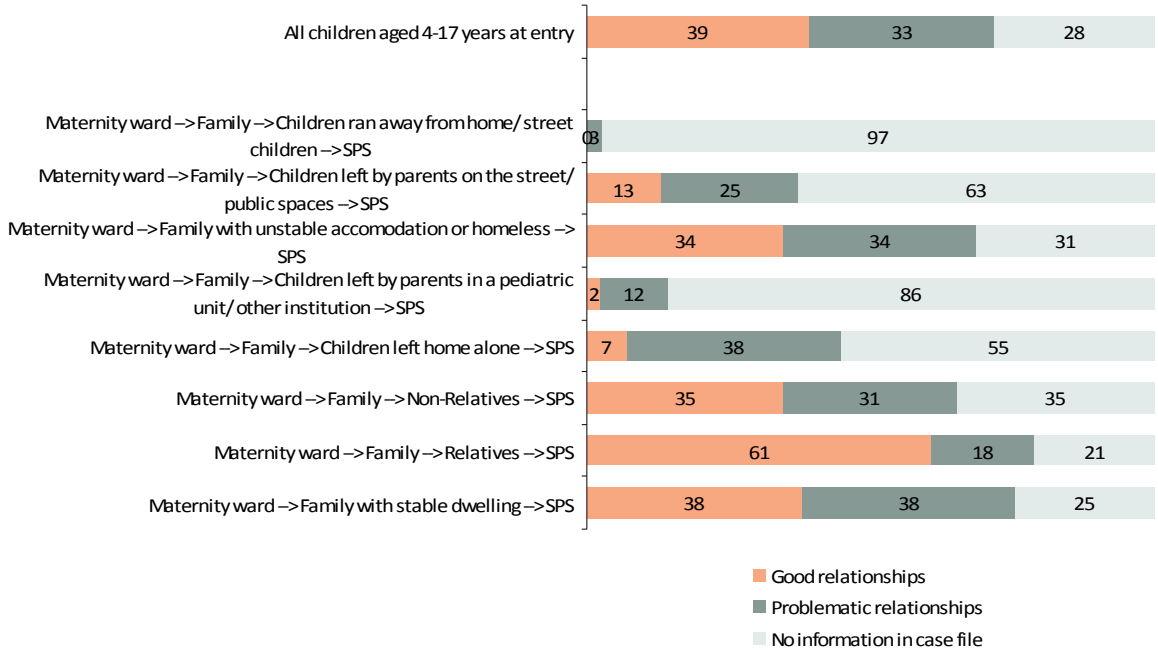
Annex 6 Figure 3: Relationship of Children Aged 4-17 at Entry with Their Parents or Caretakers Before Entering the Special Protection System, by Structure of the Family of Origin (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=21,779).

Notes: *Data about the father are not available. **Mother/father lived in the same dwelling with other person(s) (usually, the grandmother) who took care of the child. ***Generally multigenerational households in which the grandparents or other relatives took care of the child, although the parents were present. ****Mother was not at home (deceased, left, no info.

Annex 6 Figure 4: Relationship with Parents or Caretaker of Children Aged 4-17 at Entry, by the Route Followed Before Entering the Special Protection System (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=21,779).

Annex 6 Table 17: Share of Children in Special Protection with Evidence of Exploitation Before Entering the System as Registered in the Case Files (%)

	Yes	No	No info	Total
National average	**1,682**	**20,979**	**16,024**	**38,685**
%	**4**	**54**	**41**	**100**
ARAD	3	38	59	100
BACĂU	5	54	41	100
BIHOR	6	61	33	100
BISTRIȚA-NĂSĂUD	5	71	24	100
BOTOȘANI	6	51	43	100
CARAȘ-SEVERIN	2	63	35	100
CONSTANȚA	2	35	63	100
COVASNA	0	73	27	100
DÂMBOVIȚA	3	49	48	100
DOLJ	5	46	49	100
GALAȚI	2	61	38	100
GORJ	3	61	36	100
HARGHITA	4	48	48	100
HUNEDOARA	3	63	33	100
MEHEDINȚI	4	55	42	100
NEAMȚ	7	33	60	100
OLT	1	68	31	100
PRAHOVA	7	56	37	100
SATU-MARE	7	49	44	100
SIBIU	6	48	46	100
SUCEAVA	5	41	53	100
VASLUI	6	57	37	100
VÂLCEA	7	55	38	100
VRANCEA	7	66	27	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=38,685).

Notes: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1). Children relinquished straight after birth in a maternity ward are not considered.

Annex 6 Table 18: Incidence of Child Neglect, Abuse, or Exploitation Among Children with Parents Gone Abroad (for Work) When the Child Entered the Special Protection System (%)

At entry into protection system ...	Evidence of:				Children relinquished in maternity ward	Total	
	Neglect	Abuse	Exploitation	Any form of violence		- %	- N
One or both parents left to go abroad	52	10	*	58	3	100	2,412
Parent/parents at home	42	12	3	46	26	100	45,261
All children in public care	42	12	3	46	25	100	48,761

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: Children with unknown parents and true orphans are not included. *Cells with a low number of cases.

Annex 6 Table 19: Incidence of Imprisoned Parents Among Households with Promiscuous and/or Criminal Behavior Before the Child Entered the Special Protection System (%)

Adults with a criminal record, with problems with police, and/or practicing prostitution		Imprisoned parents			Total
		Yes	No	No info	
Mother and father (+others)		66	30	4	100
Only the mother (+others)		44	56	0	100
Only the father (+others)		65	35	0	100
Other adult household member		0	98	2	100
No adult household member		0	98	2	100
All children in public care	- %	6	92	2	100
	- N	2,739	44,931	1,037	48,707

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: Children with unknown parents and true orphans are not included.

Annex 6 Table 20: Incidence of Child Neglect, Abuse, or Exploitation by the Existence of Promiscuous and/or Criminal Behavior in the Household Before the Child Entered the Special Protection System (%)

Adults with promiscuous and/or criminal behavior:	Evidence of:				Children relinquished in maternity ward	Total	
	Neglect	Abuse	Exploitation	Any form of violence		- %	- N
Mother and father	53	16	19	60	7	100	302
Only the mother	43	18	7	48	22	100	2,162
Only the father	53	22	5	62	9	100	2,694
Other adult household member	82	50	18	86	3	100	1,200
None	40	10	2	44	27	100	42,675
All children in public care	42	12	3	46	25	100	49,033

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: Children with unknown parents and true orphans are not included.

Annex 6 Table 21: Proportion of Children Affected by Parental Promiscuous and/or Criminal Behavior Before They Entered the Special Protection System, by County (%)

	Imprisoned parents	Parental promiscuous and/or criminal behavior	Other adult person(s) in the household with promiscuous and/or criminal behavior
National average	**6**	**11**	**3**
ARAD	6	11	2
BACĂU	6	10	4
BIHOR	5	13	2
BISTRIȚA-NĂSĂUD	3	8	2
BOTOȘANI	6	13	3
CARAȘ-SEVERIN	1	4	1
CONSTANȚA	2	5	1
COVASNA	5	7	0
DÂMBOVIȚA	4	8	1
DOLJ	7	11	2
GALAȚI	8	15	2
GORJ	8	12	0
HARGHITA	6	9	2
HUNEDOARA	8	13	3
MEHEDINȚI	4	9	2
NEAMȚ	3	10	4
OLT	12	16	0
PRAHOVA	6	11	1
SATU-MARE	4	11	3
SIBIU	7	11	2
SUCEAVA	6	12	7
VASLUI	4	8	3
VÂLCEA	7	13	4
VRANCEA	3	10	6
BUCHAREST (all 6 sectors)	18	24	0

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=47,806).

Notes: Only the 24 counties with solid data in the CMTIS plus Bucharest (the sum of the six sectors) are considered (see Annex 6 Table 1). Children with unknown parents and true orphans are not included.

Annex 6 Table 22: Incidence of Parental Disability and/or Mental Health Problems When the Child Entered the Special Protection System (%)

	Children in public care from families of origin with adult person(s) with ...			Evidence of child neglect, abuse, and/or exploitation before the child entered the system	Child neglect, abuse, and/or exploitation is registered in case file as the main cause of separation
	Mental health problems	Physical disability*	Any parental health problem	Any parental health problem	Any parental health problem
Parents, of which:	12.1	7.5	17.6	16.6	14.2
- mother and father	0.8	0.8	1.9	2.1	1.6
- only the mother (+others)	9.9	4.7	12.9	11.0	9.1
- only the father (+others)	1.4	2.0	2.8	3.4	3.5
Other adult household member	2.7	3.1	4.9	6.5	6.5
No adult household member	70.6	75.0	63.5	60.9	60.8
No info	14.6	14.4	14.1	16.1	18.6
Total - %	100	100	100	100	100
- N	48,760	48,760	48,760	25,394	15,918

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: Children with unknown parents and true orphans are not included. *Includes chronic illnesses such as tuberculosis.

Annex 6 Table 23: Incidence of Parental Disability and/or Mental Health Problems When the Child Entered the Special Protection (%)

	Mother	Father
(Apparently) Healthy	49.9	43.8
Chronic illnesses such as tuberculosis	3.0	3.4
Mental health problems but not physical disability/impairment	9.3	3.5
Physical disability/impairment but not mental health problems	1.1	1.7
Mental health problems and physical disability/impairment	1.4	0.7
Not known	35.3	46.9
Total - %	100	100
- N	48,760	27,018

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: Children with unknown parents and true orphans are not included.

Annex 6 Table 24: Children with Special Needs Before Entering the Special Protection System, by County (%)

	Children 0-17 years old with disabilities	Children 0-17 years old with developmental delays	Children 6-17 years old with special educational needs	Children 7-17 years old with behavioral problems	Children 0-17 years old with any special need
National average	**11**	**17**	**9**	**10**	**23**
ARAD	9	14	13	14	20
BACĂU	13	23	8	10	29
BIHOR	13	32	7	14	35
BISTRIȚA-NĂSĂUD	13	9	0	0	17
BOTOȘANI	8	28	3	12	30
CARAȘ-SEVERIN	6	8	11	5	12
CONSTANȚA	19	19	6	10	33
COVASNA	10	13	2	0	18
DÂMBOVIȚA	6	8	2	3	11
DOLJ	11	24	7	31	28
GALAȚI	6	12	9	10	17
GORJ	18	13	5	8	23
HARGHITA	8	15	22	9	22
HUNEDOARA	8	10	9	4	15
MEHEDINȚI	10	20	13	12	22
NEAMȚ	27	29	29	7	39
OLT	18	9	10	5	22
PRAHOVA	9	11	13	9	21
SATU-MARE	6	9	7	14	13
SIBIU	11	28	4	19	35
SUCEAVA	10	17	14	16	25
VASLUI	5	19	4	10	21
VÂLCEA	13	18	6	18	25
VRANCEA	9	12	8	12	20

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=50,668).

Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Table 25: Income Sources of Households in which Children in Public Care Lived Before Entering the Special Protection System, by Type of Entry Route (%)

		Families with stable dwelling	Families living at relatives or others	Routes linked to relinquishment in health units	Homeless, unstable accommodation, & street routes	Route not known	All children in public care
Total	**- N**	**26,639**	**7,205**	**16,280**	**1,750**	**470**	**52,344**
	- %	**100**	**100**	**100**	**100**	**100**	**100**
Wages	Yes	14	24	5	12	4	12
	No	58	42	50	47	41	53
	DK	28	35	45	41	54	35
Casual	Yes	41	27	26	31	41	34
Work	No	29	28	24	28	12	27
	DK	30	45	50	42	46	39
Pensions	Yes	14	24	2	4	1	11
(social	No	53	34	45	47	38	48
insurance)	DK	33	42	52	49	61	41
Other pensions	Yes	10	13	4	6	3	8
(Invalidity, social	No	56	41	45	43	36	50
sickness etc.)	DK	35	46	52	52	60	42
Remittances	Yes	17	17	20	22	25	18
from abroad	No	2	3	0	2	0	2
	DK	64	52	59	66	54	61
Social benefits, of which:		44	33	30	28	22	38
Placement allowance		4	4	2	1	0	3
Allowance for people with disabilities		8	5	7	4	11	7
Allowance for people living with AIDS		0	1	0	1	0	0
Family allowance (ASF)		13	8	4	9	4	9
Guaranteed Minimum Income (GMI)		21	12	14	13	10	17
Social canteen		2	0	1	3	0	2
Emergency help provided by mayoralties		1	0	0	0	1	1
Food staples		1	1	0	1	0	1
Heating subsidy		3	2	1	1	1	2
Other (non-contributive) benefits		10	6	5	7	5	8

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: For details on entry routes, see Chapter 3.1.3. DK - Don't know.

Annex 6 Table 26: In-kind Income Sources of Households in which Children in Public Care Lived Before Entering the Special Protection System, by Type of Entry Route (%)

		Families with stable dwelling	Families living at relatives or others	Routes linked to relinquishment in health units	Homeless, unstable accommodation, & street routes	Route not known	All children in public care
Total	**- N**	**26,639**	**7,205**	**16,280**	**1,750**	**470**	**52,344**
	- %	**100**	**100**	**100**	**100**	**100**	**100**
Urban	(Vegetable) Garden	7	8	3	3	3	5
	Agricultural land, forest	4	4	3	2	0	3
	Other properties	16	16	8	4	12	11
	Automobile	1	2	0	0	0	1
Rural	(Vegetable) Garden	21	25	5	11	16	20
	Agricultural land, forest	16	19	5	13	16	16
	Other properties	23	31	9	6	20	23
	Automobile	1	2	0	4	3	1
Total	(Vegetable) Garden	15	17	4	5	9	11
	Agricultural land, forest	11	12	3	4	8	8
	Other properties	20	24	8	4	15	16
	Automobile	1	2	0	1	2	1

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: For details on entry routes, see Chapter 3.1.3.

Annex 6 Table 27: Income Sources of Households in which Children in Public Care Lived Before Entering the Special Protection System, by Monthly Per Capita Income (%)

		Missing data on household income	Homeless, unstable accomm., & street routes	Very poor (<140 lei per capita, GMI threshold)	Poor (141-240 lei per capita, Family Allowance threshold)	Relative poverty (241-400 lei per capita, national threshold)	Non-poor (401+ lei per capita)	All children in public care
Total	**- N**	**42,807**	**1,591**	**6,012**	**963**	**567**	**405**	**52,345**
	- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Wages	Yes	10	11	15	44	54	54	12
	No	52	46	63	42	36	33	53
	DK	38	43	21	13	10	14	35
Casual work	Yes	35	32	32	37	30	11	34
	No	25	25	40	31	51	51	27
	DK	41	44	28	32	19	39	39
Pensions (social insurance)	Yes	10	2	15	30	31	52	11
	No	46	45	62	46	41	24	48
	DK	44	53	23	23	27	23	41
Other pensions (Invalidity, social sickness etc.)	Yes	7	4	13	21	22	21	8
	No	48	42	63	47	48	53	50
	DK	45	54	24	32	30	25	42
Remittances from abroad	Yes	1	2	1	9	4	1	2
	No	40	43	56	45	49	34	42
	DK	58	55	43	47	47	65	56
Social benefits, of which:		33	25	69	53	48	39	38
Placement allowance		2	1	5	8	19	17	3
Allowance for people with disabilities		7	2	11	19	17	17	7
Allowance for people living with AIDS		0	1	1	0	0	0	0
Family allowance (ASF)		7	8	22	20	3	5	9
Guaranteed Minimum Income (GMI)		15	11	37	6	7	4	17
Social canteen		1	2	2	1	0	2	2
Emergency help provided by mayoralties		1	0	1	0	0	0	1
Food staples		1	1	2	1	2	1	1
Heating subsidy		2	2	2	4	5	0	2
Other (non-contributive) benefits		6	6	18	14	4	2	8

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: Incomes are inflated to reflect their value as of December 2014 in order to ensure comparability. DK - Don't know.

Annex 6 Table 28: In-kind Income Sources of Households in which Children in Public Care Lived Before Entering the Special Protection System, by Monthly Per Capita Income (%)

		Missing data on household income	Homeless, unstable accomm., & street routes	Very poor (<140 lei per capita, GMI threshold)	Poor (141-240 lei per capita, Family Allowance threshold)	Relative poverty (241-400 lei per capita, national threshold)	Non-poor (401+ lei per capita)	All children in public care
Total	**- N**	**42,807**	**1,591**	**6,012**	**963**	**567**	**405**	**52,345**
	- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Urban	(Vegetable) Garden	5	3	7	15	5	0	5
	Agricultural land, forest	3	0	6	7	5	0	3
	Other properties	11	4	16	21	14	27	11
	Automobile	1	0	1	5	1	6	1
Rural	(Vegetable) Garden	19	4	20	38	26	49	20
	Agricultural land, forest	14	7	17	36	31	40	16
	Other properties	22	7	25	26	44	41	23
	Automobile	1	3	2	3	4	15	1
Total	(Vegetable) Garden	11	3	14	25	17	25	11
	Agricultural land, forest	8	2	12	20	20	20	8
	Other properties	15	4	21	23	31	34	16
	Automobile	1	1	1	4	3	10	1

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: Incomes are inflated to reflect their value as of December 2014 in order to ensure comparability.

Annex 6 Table 29: The List of Cities (Urban Areas) by the Number of Mothers with Children in the Special Protection System, in November 2014

Number of mothers with children in public care in descending order (from most to least)	Name of the city	Population (Census 2011)	% mothers of all mothers with children in public care from URBAN AREAS
1	București	1,883,425	8.0
2	Constanța	283,872	3.5
3	Piatra Neamț	85,055	2.8
4	Craiova	269,506	2.7
5	Galați	249,432	2.4
6	Arad	159,074	2.4
7	Drobeta Turnu-Severin	92,617	2.2
8	Bârlad	55,837	2.1
9	Bacău	144,307	2.1
10	Roman	50,713	2.0
11	Brașov	253,200	1.8
12	Iași	290,422	1.8
13	Brăila	180,302	1.7

14	Râmnicu Vâlcea	98,776	1.6
15	Baia Mare	123,738	1.5
16	Cluj-Napoca	324,576	1.5
17	Pitești	155,383	1.5
18	Reșița	73,282	1.5
19	Satu Mare	102,411	1.3
20	Medgidia	39,780	1.2

Source: CMTIS

Note: Only the counties that systematically entered data into the CMTIS on the mothers whose addresses were registered are considered. The following counties have a low number of mothers with registered addresses: Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu.

Annex 6 Table 30: Average Level of Local Development as Measured by the 2011 Local Human Development Index, by Commune Size and by the Number of Mothers with Children in Special Protection in the Commune (Rural Areas)

Number of mothers with children in public care	Commune size (number of inhabitants) - RURAL AREAS				
	0/1.999	2.000/2.999	3.000/3.999	4.000/4.999	5.000+
0	34	37	39	39	48
1-10	34	36	37	39	42
11+	32	35	36	38	40

Source: CMTIS

Note: Only the counties that systematically entered data into the CMTIS on the mothers whose addresses were registered are considered. The following counties have a low number of mothers with registered addresses: Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu.

Annex 6 Table 31: Average Percentage of People Living in Marginalized Communities out of Commune Total Population, by Commune Size and the Number of Mothers with Children in Special Protection in the Commune (%)

Number of mothers with children in public care	Commune size (number of inhabitants) - RURAL AREAS				
	0-1,999	2,000-2,999	3,000-3,999	4,000-4,999	5,000+
0	2	3	2	0	0
1-10	6	7	6	6	4
11+	27	21	23	16	9

Source: CMTIS

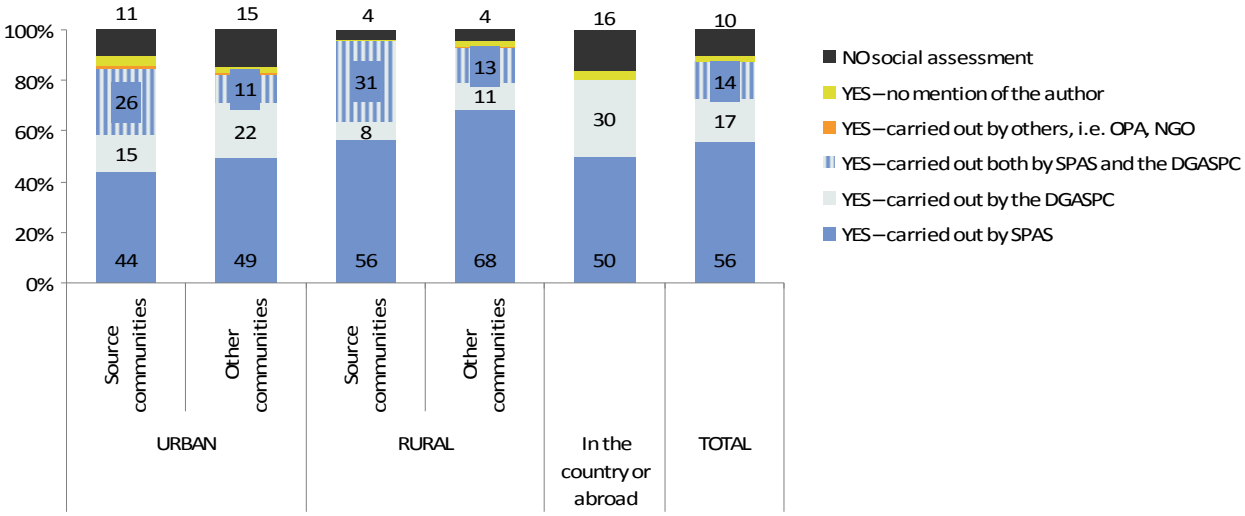
Note: Only the counties that systematically entered data into the CMTIS on the mothers whose addresses were registered are considered. The following counties have a low number of mothers with registered addresses: Bistrița-Năsăud, Botoșani, Harghita, Ialomița, Mureș, Olt, Sălaj, Teleorman, Călărași, and Giurgiu.

Annex 6 Table 32: Percentage of Children in Special Protection from Rural and Urban Source Communities (%)

	Children from source communities	Children from other communities	Total
National average	**7,382**	**43,616**	**50,998**
%	**14**	**86**	**100**
ARAD	0	100	100
BACĂU	10	90	100
BIHOR	0	100	100
BISTRIȚA-NĂSĂUD	0	100	100
BOTOȘANI	0	100	100
CARAȘ-SEVERIN	1	99	100
CONSTANȚA	24	76	100
COVASNA	70	30	100
DÂMBOVIȚA	0	100	100
DOLJ	1	99	100
GALAȚI	5	95	100
GORJ	1	99	100
HARGHITA	0	100	100
HUNEDOARA	0	100	100
MEHEDINȚI	17	83	100
NEAMȚ	0	100	100
OLT	0	100	100
PRAHOVA	0	100	100
SATU-MARE	0	100	100
SIBIU	34	66	100
SUCEAVA	17	83	100
VASLUI	83	17	100
VÂLCEA	59	41	100
VRANCEA	9	91	100
BRAȘOV	52	48	100

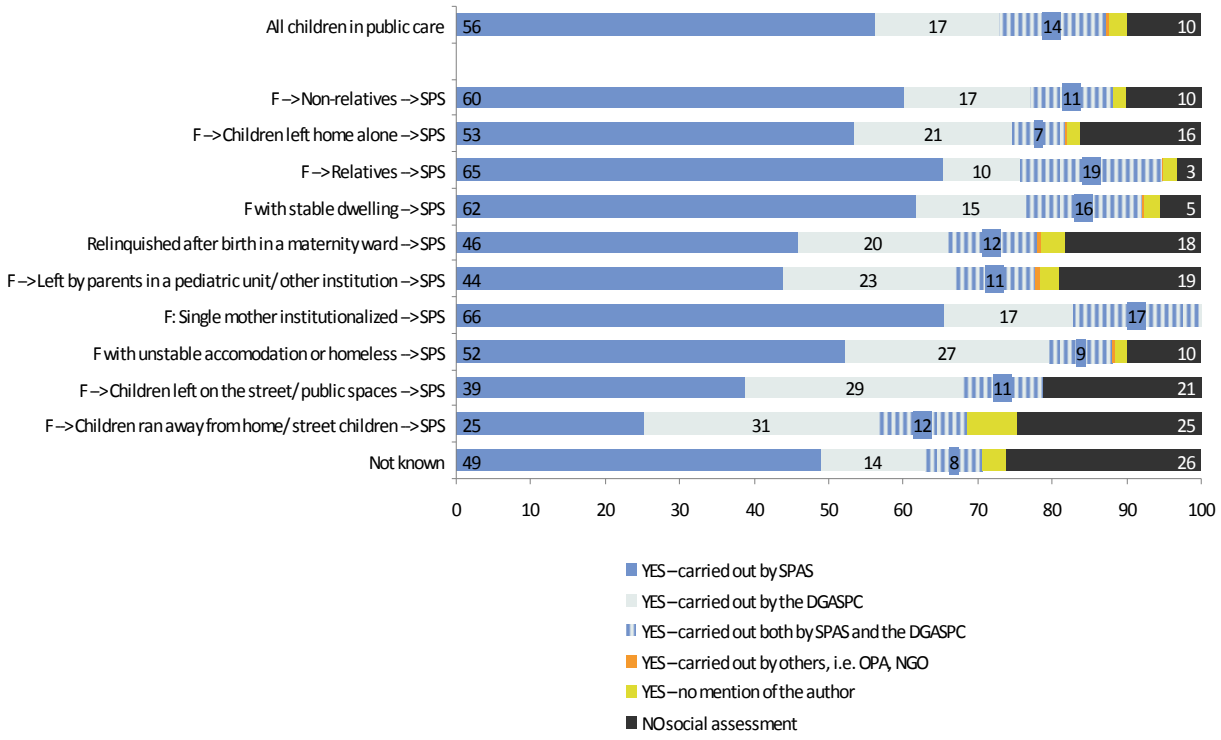
Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.
Note: Only the 24 counties with solid data in the CMTIS (see Annex 6 Table 1) plus Brașov county are considered.

Annex 6 Figure 5: Distribution of Children in Special Protection, by the Existence of a Social Assessment in the Case File, by Area of Residence, by Type of the Community of Origin, and by the Entity that Carried Out the Assessment(s) (%)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Annex 6 Figure 6: Distribution of Children in Special Protection, by the Existence of a Social Assessment in the Case File, by the Entity that Carried Out the Assessment(s), and by Type of



Entry Route (%)

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344).

Note: For details on entry routes, see Chapter 3.1.3. F = Family.

Annex 6 Table 33: Quality of Social Assessments from the Case Files by the Type of Information Provided, by the Entity that Carried Out the Assessment(s), by Area of Residence, by Type of the Community of Origin, by Type of Entry Route, and by the Year when the Child Entered Special Protection (% of Children with Social Assessments in their Case Files)

	Only child's and/or family's needs	Only services provided and/or current offer	Needs and services	Neither needs nor services	All children with social assessments in their case files
Total - N	**8,423**	**10,548**	**14,518**	**13,645**	**47,134**
- %	**18**	**22**	**31**	**29**	**100**
Social assessment: Institutions					
– carried out by SPAS	17	24	29	31	100
– carried out by the DGASPC	23	12	29	35	100
– carried out both by SPAS and the DGASPC	14	25	42	18	100
– carried out by others, i.e. OPA, NGO	31	19	13	37	100
– no mention of the author	23	42	29	6	100
Social assessment: Representatives					
– SPAS staff with social assistance duties	16	27	29	29	100
– (professional) social worker	18	21	32	29	100
– no mention of the author	26	22	24	28	100
Area of residence					
Urban	19	19	30	31	100
Rural	16	26	32	26	100
Somewhere in the country or abroad	31	20	24	26	100
Community of origin					
Source communities	19	20	32	29	100
Other communities	10	38	21	30	100
Entry route in the Special Protection System (SPS)					
F with stable dwelling --> SPS	16	25	34	25	100
F --> Children left home alone --> SPS	29	8	32	31	100
F with unstable accommodation or homeless --> SPS	34	17	41	8	100
F: Single mother institutionalized --> SPS	5	12	52	31	100
F --> Relatives --> SPS	16	26	29	29	100
F --> Non-relatives --> SPS	21	30	14	35	100
Relinquished after birth in a maternity ward --> SPS	20	17	27	36	100
F --> Left in pediatric units/ other institutions --> SPS	21	16	27	37	100
F --> Children left in public spaces/street --> SPS	13	38	30	19	100
F --> Children ran away from home/ street children --> SPS	9	15	33	43	100
Not known	30	14	18	38	100
Year when the child entered the system (selection)					
...					
1997	31	11	15	44	100
1998	29	13	12	46	100
1999	19	18	17	46	100
...					
2009	16	29	38	17	100
2010	13	22	39	26	100
2011	14	25	36	25	100
2012	16	26	35	23	100
2013	15	21	41	23	100
2014	16	25	38	22	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted. F = Family.

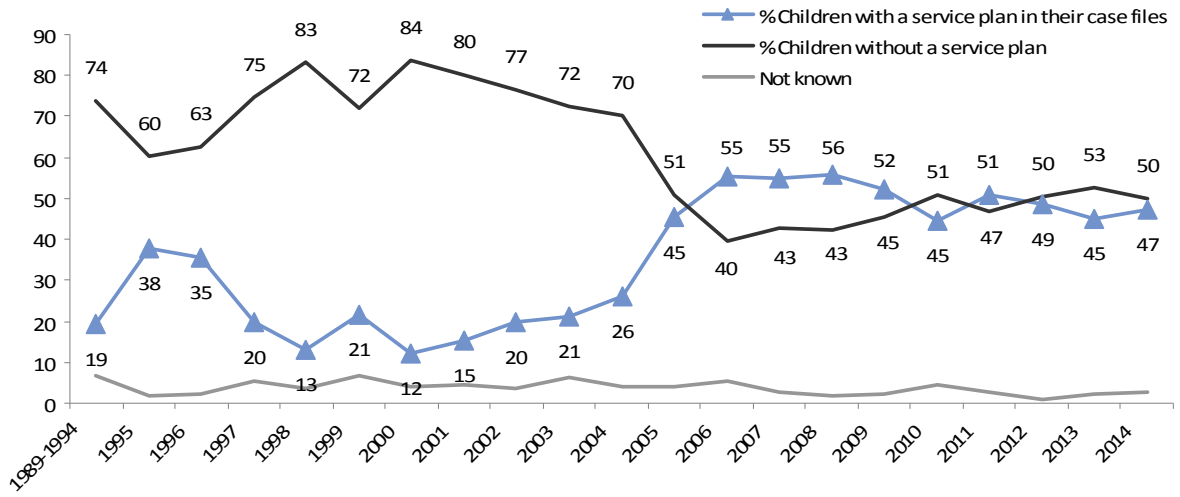
Annex 6 Table 34: The Needs of the Child and/or Family and the Services Provided in the Community Before the Child Entered Social Protection, by the Quality of the Social Assessments in the Case Files (% of Children with Social Assessments in their Case Files)

	Only child's and/or family's needs	Only services provided and/or current offer	Needs and services	Neither needs nor services	All children with social assessments in their case files
Total - N	**8,423**	**10,548**	**14,518**	**13,645**	**47,134**
- %	**100**	**100**	**100**	**100**	**100**
Needs					
Social assessment identifies only the child's needs	58	0	44	0	24
Social assessment identifies only the family's needs	8	0	6	0	3
Identifies both the child's and family's needs	34	0	51	0	22
Offer of services within community					
Current offer within community and its vicinity	0	12	51	0	18
Preventive service plan, according to the law	0	86	68	0	40
Services provided in the community before the child entered public care					
Information, counseling, and moral support services to the family	0	34	54	0	24
Consultation/collaboration with other specialists and community representatives (including the Community Consultative Structure)	0	20	30	0	14
Referral to local preventive services (daycare centers, maternal centers, mobile teams etc.)	0	5	9	0	4
Inclusion of the family in a private financial support program (if there is one) to prevent child relinquishment	0	2	4	0	2
Other services (see Figure 46)	0	4	21	0	7
Number of these prevention services received by the child and family within the community before entering the system					
None	100	55	27	100	67
One service/activity	0	28	39	0	18
Two services/activities	0	15	25	0	11
Three services/activities	0	2	8	0	3
Four services/activities	0	0	1	0	0
Five services/activities	0	0	0	0	0

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: With regard to needs and services, the questionnaire used open-ended questions except for the one related to the existence of a preventive service plan.

Annex 6 Figure 7: Distribution of Children in Special Protection by the Existence of a Preventive Service Plan in the Case File and by the Year When the Child Entered Special Protection (% of Children with Social Assessments in their Case Files)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=47,134 children with social assessments in their case files).

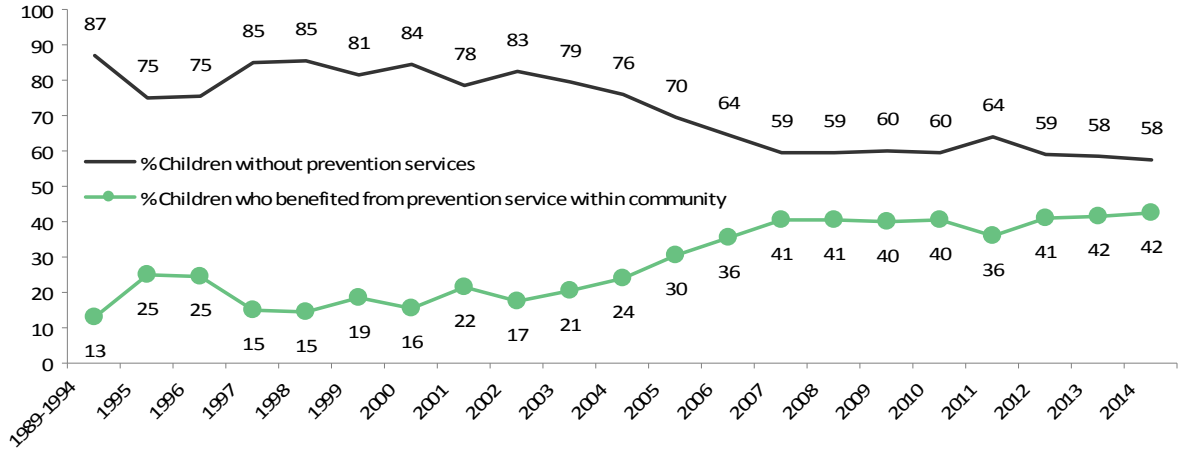
Annex 6 Table 35: Existence of a Preventive Service Plan When the Child Entered Special Protection, by County (% of Children with Social Assessments in their Case Files)

	% Children with a preventive service plan	% Children without a preventive service plan	Not known	Total
Total - N	**18,545**	**25,635**	**1,554**	**45,734**
- %	**41**	**56**	**3**	**100**
ARAD	21	76	4	100
BACĂU	36	60	5	100
BIHOR	48	46	6	100
BISTRIȚA-NĂSĂUD	37	59	4	100
BOTOȘANI	44	53	3	100
CARAȘ-SEVERIN	37	61	2	100
CONSTANȚA	44	55	1	100
COVASNA	59	30	10	100
DÂMBOVIȚA	19	79	2	100
DOLJ	34	61	5	100
GALAȚI	37	61	1	100
GORJ	50	44	6	100
HARGHITA	61	38	2	100
HUNEDOARA	36	62	2	100
MEHEDINȚI	25	75	0	100
NEAMȚ	72	19	9	100
OLT	59	39	2	100
PRAHOVA	27	70	3	100
SATU-MARE	37	59	4	100
SIBIU	35	57	8	100
SUCEAVA	20	79	2	100
VASLUI	61	38	1	100
VÂLCEA	36	62	2	100
VRANCEA	40	59	1	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Figure 8: Prevention Services Provided within Community Before the Child Entered Public Care, by the Year when the Child Entered Special Protection (% of Children with Social Assessments in their Case Files)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=47,134 children with social assessments in their case files).

Annex 6 Table 36: Prevention Services Provided within the Community Before the Child Entered Special Protection, by County (% of Children with Social Assessments in their Case Files)

	% Children without prevention services	% Children who benefited from prevention services within the community	Total
Total - N	**30,747**	**14,987**	**45,734**
- %	**67**	**33**	**100**
ARAD	83	17	100
BACĂU	65	35	100
BIHOR	70	30	100
BISTRIȚA-NĂSĂUD	72	28	100
BOTOȘANI	63	37	100
CARAȘ-SEVERIN	82	18	100
CONSTANȚA	64	36	100
COVASNA	69	31	100
DÂMBOVIȚA	62	38	100
DOLJ	65	35	100
GALAȚI	75	25	100
GORJ	91	9	100
HARGHITA	60	40	100
HUNEDOARA	82	18	100
MEHEDINȚI	92	8	100
NEAMȚ	28	72	100
OLT	50	50	100
PRAHOVA	76	24	100
SATU-MARE	66	34	100
SIBIU	58	42	100
SUCEAVA	80	20	100
VASLUI	52	48	100
VÂLCEA	63	37	100
VRANCEA	46	54	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.
Note: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1).

Annex 6 Box 1: The Social Worker's Role and Responsibilities in the Protection and Promotion of Children's Rights

Any family may go, at a certain point, through difficult times because of losing a job, small income, ageing or illness. Social workers have to support the family, providing it with all available facilities and services, using all the community's resources, in order to help keeping the children within their families. In principle, the best place for a child is together with his/her parents, although, sometimes, the parents may face difficulties. In cases like this, it is very important to support the family in raising the children, so as to avoid separation and its impact on the children's development.

Social workers should not only be aware of all the resources and services available in their community, but also take proactive action, notifying the local authorities (mayor and to local council) of the various needs of the community (nurseries, kindergartens, day care, school transportation, medical practice or even utilities, such as electricity or running water etc.) and requesting them to take the necessary measures.

If the family faces more serious problems, such as drug or alcohol consumption, domestic violence or behaviour disorder, the social workers within SPAS shall have to identify such situations and intervene as soon as possible in order to prevent such problems from aggravating. Through the service plan, they shall aim at keeping the child together with his/her parents, granting all necessary services, including counselling and therapy.

Only when it is clear that the support provided does not have the expected results and that the child's development is endangered within the family, additional measures shall have to be taken into account. In such cases, SPAS shall notify DGASPC immediately.

Not even in this case shall separation of the child from his/her parents be automatically recommended. DGASPC shall make its own assessments and shall be able to recommend the provision of specialized services. However, if it is necessary that the child be placed outside the family, the social workers shall continue to cooperate with DGASPC during such placement, in order to help maintain the relations between the child and the parents or other persons with whom the child enjoyed family life, in so far as this is not contrary to his/her higher interest. Also, the social workers shall offer support to the parents, in order to help them reintegrate the child within the family.

Many children feel that they are responsible for what happened and they are worried about how their parents manage the situation. Maintaining the relationship with the parents may reduce the feeling of guilt and responsibility of the child and help them form a more realistic idea of the reasons for which they were "put in a foster home". This connection may also contribute to building a bridge between the past and the future, which is important in order to ensure continuity and development of the child, as well as between the child and his/her parents. Even if they are unable to provide for his/her care on a permanent basis, they may develop their capacities. In his/her turn, the child may better understand the situation and will not feel "abandoned".

Source: ANPDC (2006:67-68)

Annex 6 Table 37: Who Notified the DGASPC of the Case When the Child Entered Special Protection, by Various Indicators (% of Entries)

	Referral from other institutions	Request from family	Referral from SPAS	Other people	DGASPCs' own initiative	Request from the child	No info in case file	**Total entries**
Total - N	16,059	14,988	12,960	3,646	2,787	84	3,422	**53,946**
- %	100	100	100	100	100	100	100	**100**
Age at the first entry into the system:*								
0-12 months	62	19	18	11	33	0	27	**32**
1-2 years old	15	19	15	17	18	0	14	**16**
3-6 years old	10	26	30	34	21	0	16	**22**
7-10 years old	5	22	21	22	15	23	11	**15**
11-14 years old	3	9	10	8	4	61	7	**7**
15-17 years old	0	2	1	2	0	11	1	**1**
Children with special needs:								
Total, of which:	34	18	28	21	32	32	27	**27**
Children (0-17 years) with disabilities	12	10	10	8	13	0	12	**11**
Children (0-17 years) with developmental delays	20	11	20	15	22	0	14	**17**
Children (6-17 years) with SEN	1	4	3	3	2	0	4	**3**
Children (7-17 years) with behavioral problems	3	1	3	4	3	32	2	**3**
Infants (0-12 months) born premature and/or underweight	12	2	2	2	4	0	6	**5**
Causes of separation:**								
Violence against children, of which:	22	44	64	66	47	90	44	**44**
- neglect	19	42	62	63	44	61	40	**41**
- abuse	6	7	20	17	15	71	10	**11**
- exploitation	3	1	5	5	6	27	3	**3**
Child relinquishment	71	7	9	5	32	0	28	**29**
Unfortunate events***	1	5	3	3	2	0	1	**3**
Avoidable entries, of which:	6	44	24	26	19	11	27	**24**
- Child disability	2	8	5	3	5	0	5	**5**
- Social causes: individual risk factors	2	22	13	16	8	11	14	**12**
- Social causes: poverty, inadequate housing	2	14	6	8	6	0	8	**7**
Individual risk factors:								
Parent(s) gone abroad	2	7	5	9	2	12	3	**5**
Dysfunctional families	11	21	17	24	14	30	12	**16**
Teenage mothers when the child entered the system	6	4	2	1	5	0	4	**4**
Parental alcohol and/or drug abuse	10	15	34	29	27	68	19	**20**
Promiscuous and/or criminal behavior								
- parental	9	10	10	12	8	2	11	**10**
- other adults	2	1	4	2	2	0	1	**2**
Disability or mental health problems								

	Referral from other institutions	Request from family	Referral from SPAS	Other people	DGASPCs' own initiative	Request from the child	No info in case file	**Total entries**
Total - N	16,059	14,988	12,960	3,646	2,787	84	3,422	**53,946**
- %	100	100	100	100	100	100	100	**100**
- parental	20	13	15	15	17	14	15	**16**
- other adults	2	7	6	5	4	0	4	**5**
Structural risk factors:								
Poverty and inadequate housing	35	37	38	35	39	49	28	**36**
Benefited from ... within community, before entering the system:								
- prevention services	22	29	39	28	30	48	22	**29**
- support	6	11	16	20	8	15	11	**11**
Entry routes into the system:****								
Not known	0	0	0	0	0	7	13	**1**
Relinquished in a MW --> SPS	59	6	7	3	25	0	22	**24**
MW --> F with stable dwelling --> SPS	18	69	72	60	48	93	38	**51**
MW --> F --> Children left home alone --> SPS	1	0	3	1	2	0	1	**1**
MW --> F with unstable accommodation or homeless --> SPS	1	3	1	3	4	0	3	**2**
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	1	0	0	**0**
MW --> F --> Relatives --> SPS	2	18	11	14	4	0	12	**10**
MW --> F --> Non-relatives --> SPS	1	1	2	15	1	0	1	**2**
MW --> F --> Left in pediatric units/ other institutions --> SPS	16	1	3	3	10	0	8	**7**
MW --> F --> Children left in public spaces/street --> SPS	1	0	1	1	4	0	1	**1**
MW --> F --> Children ran away from home/ street children --> SPS	1	0	0	1	1	0	1	**1**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=53,946 entries of the 52,344 children in public care).

Notes: *The sums per column are lower than 100 percent because only the children's first entries into the system are considered (3 percent of children in special protection enter the systen two to four times). **See Infograph Chart 4 and Chapter 3.2.7. ***Unfortunate life events refer to the death or institutionalization of the parent/parents. ****SPS - Social Protection System; MW --> F - Maternity ward --> Family. Highlighted cells indicate statistically significant higher values.

Annex 6 Table 38: Who Decided to Place the Child into Special Protection When He/She Entered Public Care, by Various Indicators (% of Entries)

	Placement decided by the DGASPC director	Placement decided by the Child Protection Commission (CPC)	Court ruling	Presidential ordinance	No info in case file	**Total entries**
Total - N	21,513	22,370	5,744	998	3,320	**53,946**
- %	100	100	100	100	100	**100**
Age at the first entry into the system:*						
0-12 months	38	34	9	13	27	**32**
1-2 years old	16	18	11	21	15	**16**
3-6 years old	21	22	27	25	17	**22**
7-10 years old	14	13	29	26	10	**15**
11-14 years old	6	5	19	12	6	**7**
15-17 years old	1	1	3	1	1	**1**
Children with special needs:						
Total, of which:	31	25	15	38	27	**27**
Children (0-17 years) with disabilities	9	13	7	8	11	**11**
Children (0-17 years) with developmental delays	20	16	10	31	14	**17**
Children (6-17 years) with SEN	2	3	3	2	3	**3**
Children (7-17 years) with behavioral problems	4	1	3	9	2	**3**
Infants (0-12 months) born premature and/or underweight	7	5	1	1	7	**5**
Causes of separation:**						
Violence against children, of which:	48	35	56	89	45	**44**
- neglect	45	33	53	87	42	**41**
- abuse	16	7	9	33	12	**11**
- exploitation	5	1	3	15	3	**3**
Child relinquishment	36	30	6	7	31	**29**
Unfortunate events***	2	2	8	0	1	**3**
Avoidable entries, of which:	14	33	30	4	24	**24**
- Child disability	3	7	3	1	4	**5**
- Social causes: individual factors	7	16	18	2	12	**12**
- Social causes: poverty, inadequate housing	4	10	9	1	8	**7**
Individual risk factors:						
Parent(s) gone abroad	4	2	14	3	4	**5**
Dysfunctional families	15	16	24	8	13	**16**
Teenage mothers when the child entered the system	4	4	2	2	4	**4**
Parental alcohol and/or drug abuse	24	15	18	52	19	**20**
Promiscuous and/or criminal behavior						
- parental	11	8	13	8	11	**10**
- other adult household member(s)	3	1	2	5	1	**2**
Disability or mental health problems						
- parental	17	17	12	20	15	**16**
- other adult household member(s)	4	5	6	7	4	**5**
Structural risk factors:						
Poverty and inadequate housing	38	36	32	47	28	**36**
Benefited from ... within community, before entering the system:						
- prevention services	31	27	32	42	22	**29**
- support	12	10	13	17	12	**11**

	Placement decided by the DGASPC director	Placement decided by the Child Protection Commission (CPC)	Court ruling	Presidential ordinance	No info in case file	**Total entries**
Total - N	21,513	22,370	5,744	998	3,320	**53,946**
- %	100	100	100	100	100	**100**
Entry routes into the system:****						
Not known	0	0	0	0	13	**1**
Relinquished in a MW --> SPS	30	24	4	5	24	**24**
MW --> F with stable dwelling --> SPS	49	53	56	85	37	**51**
MW --> F --> Children left home alone --> SPS	2	1	1	1	2	**1**
MW --> F with unstable accommodation or homeless --> SPS	3	1	1	3	3	**2**
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	0	**0**
MW --> F --> Relatives --> SPS	5	10	32	3	11	**10**
MW --> F --> Non-relatives --> SPS	2	2	3	0	1	**2**
MW --> F --> Left in pediatric units/ other institutions --> SPS	7	8	3	3	9	**7**
MW --> F --> Children left in public spaces/street --> SPS	1	0	1	0	0	**1**
MW --> F --> Children ran away from home/ street children --> SPS	1	0	0	0	1	**1**
Social assessment in the case file, Institution:						
No social assessment	10	11	3	3	18	**10**
– yes, carried out by SPAS	49	59	70	64	50	**56**
– yes, carried out by the DGASPC	22	14	9	12	17	**17**
– yes, carried out both by SPAS and the DGASPC	15	14	15	18	11	**14**
– yes, carried out by others, i.e. OPA, NGO	0	0	1	1	1	**0**
– yes, but no mention of the author	3	2	2	3	3	**2**
Quality of the social assessment, which identifies:						
Only child's and/or family's needs	17	16	12	19	18	**16**
Only services provided and/or current offer	15	23	34	20	14	**20**
Needs and services	33	23	25	43	22	**27**
Neither needs nor services	25	27	26	15	28	**26**
Who notified the DGASPC of the case:						
Referral from other institutions	42	27	11	19	3	**30**
Request from family	16	39	47	5	0	**28**
Referral from SPAS	27	23	25	49	3	**24**
Notified by other people	8	4	12	14	0	**7**
DGASPCs' own initiative	6	5	4	12	0	**5**
Request from the child	0	0	0	1	0	**0**
No info in case file	0	1	1	1	93	**6**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=53,946 entries of the 52,344 children in public care).

Notes: *The sums per column are lower than 100 percent because only the children's first entries into the system are considered (3 percent of children in special protection enter the systen two to four times). **See Infograph Chart 4 and Chapter 3.2.7. ***Unfortunate life events refer to the death or institutionalization of the parent/parents. ****SPS - Social Protection System; MW --> F - Maternity ward --> Family. Highlighted cells indicate statistically significant higher values.

Annex 6 Table 39: Residential Services Included in the Study, by Type and by County, as of November 30, 2014 (Number)

		CTF - Small group homes		CP - Placement centers					
	AP	CTF-disab	CTF-non-disab	CP-MEN-classical	CP-MEN-mod	CP-classical - disab	CP-classical - non-disab	CP-mod-disab	CP-mod-non-disab
ALBA	5	9	25						1
ARAD		5	37		1			2	1
ARGEȘ	17	4		1	1	1	2	2	1
BACĂU	19	17	26	1		1	2		1
BIHOR		22	38	1			4	1	
BISTRIȚA-NĂSĂUD			5				1	1	2
BOTOȘANI	21	1	8			1	4		1
BRĂILA	18	8	4						
BRAȘOV		2	19	3	1	1	1	1	4
BUZĂU	8	2	6	4			1	1	2
Bucharest SECTOR 1	4	9	3				5		
Bucharest SECTOR 2	16	1	1	3		1	1		
Bucharest SECTOR 3	25							1	1
Bucharest SECTOR 4	16								1
Bucharest SECTOR 5	9		1			1	1		
Bucharest SECTOR 6	5		1	2			1		
CĂLĂRAȘI		2	11					2	1
CARAȘ-SEVERIN	21	2	2				3	1	
CLUJ	8	6	15	1			3	3	1
CONSTANȚA		7	18		2			3	3
COVASNA	4	2	10	1			1	1	1
DÂMBOVIȚA	3	2	6			1			
DOLJ	16	2	1					3	1
GALAȚI	10	3	1	1		3	1		3
GIURGIU	2	9	11						
GORJ	10	2	3	1				1	1
HARGHITA	17	1	24	3		2	1		
HUNEDOARA	3	2	12					2	5
IALOMIȚA		4	4			1	2	1	
IAȘI	13		18	2	1			4	5
ILFOV		5		3		2			3
MARAMUREȘ		12	24						1
MEHEDINȚI	6		1					2	
MUREȘ	9	10	52					2	
NEAMȚ	12		8	4				3	5
OLT	29	8	6	1					
PRAHOVA			9	3	1	1	5		
SĂLAJ		6	4		1		1		2
SATU MARE		8	10						3
SIBIU		5	7			3	4		
SUCEAVA	17	12	11				1	1	1
TELEORMAN	26	1						1	
TIMIȘ		3	22			2		1	3

		CTF - Small group homes		CP - Placement centers					
	AP	CTF-disab	CTF-non-disab	CP-MEN-classical	CP-MEN-mod	CP-classical - disab	CP-classical - non-disab	CP-mod-disab	CP-mod-non-disab
TULCEA	8	5	4			1	1		1
VÂLCEA	8	2	2	1		4	1		
VASLUI	6	6	2					1	
VRANCEA	17	3	4	1		1			
Total	408	210	476	37	8	27	47	41	55

Source: ANPDCA

Notes: AP = apartments; disab - for children with disabilities; non-disab - for children without disabilities; CP MEN = placement centers taken over from MEN (Ministry of National Education); mod = modulated.

Annex 6 Table 40: Number of DGASPC Employees, Number of Children in Public Care, and Ratio of Children per Employee, by Type of Service and by County, as of December 31, 2014

(A) DGASPC Foster carers

	Children placed with foster carers by the DGASPC	Professional foster carers (AMPs) employed by the DGASPC	Ratio of children to AMPs
TOTAL	**18,726**	**12,079**	**1.6**
Alba	161	100	1.6
Arad	158	83	1.9
Argeş	391	268	1.5
Bacău	621	388	1.6
Bihor	687	375	1.8
Bistriţa-Năsăud	251	144	1.7
Botoşani	402	193	2.1
Brăila	243	130	1.9
Braşov	264	140	1.9
Buzău	357	207	1.7
Bucharest Sector 1	138	125	1.1
Bucharest Sector 2	91	91	1.0
Bucharest Sector 3	106	98	1.1
Bucharest Sector 4	115	109	1.1
Bucharest Sector 5	119	101	1.2
Bucharest Sector 6	75	64	1.2
Călăraşi	361	299	1.2
Caraş-Severin	555	504	1.1
Cluj	198	136	1.5
Constanţa	422	248	1.7
Covasna	290	148	2.0
Dâmboviţa	595	330	1.8
Dolj	298	168	1.8
Galaţi	678	370	1.8
Giurgiu	168	143	1.2
Gorj	178	119	1.5
Harghita	415	203	2.0
Hunedoara	291	143	2.0
Ialomiţa	100	85	1.2
Iaşi	1,284	817	1.6
Ilfov	119	78	1.5
Maramureş	390	314	1.2
Mehedinţi	251	164	1.5
Mureş	456	248	1.8

	Children placed with foster carers by the DGASPC	Professional foster carers (AMPs) employed by the DGASPC	Ratio of children to AMPs
TOTAL	**18,726**	**12,079**	**1.6**
Neamţ	548	430	1.3
Olt	480	282	1.7
Prahova	419	257	1.6
Sălaj	137	90	1.5
Satu-Mare	451	235	1.9
Sibiu	318	167	1.9
Suceava	635	422	1.5
Teleorman	347	196	1.8
Timiş	1,088	601	1.8
Tulcea	285	176	1.6
Vâlcea	530	344	1.5
Vaslui	1,663	1,456	1.1
Vrancea	597	290	2.1

Source: ANPDCA, www.copii.ro

(B) Residential Services

	Children in public residential services	DGASPC employees in residential services	Ratio of children to employees in DGASPC residential services	Children in public residential services as % of total children in residential services
TOTAL	**17,453**	**12,336**	**1.4**	**81**
Alba	490	111	4.4	88
Arad	461	207	2.2	77
Argeş	422	427	1.0	99
Bacău	410	364	1.1	59
Bihor	448	265	1.7	56
Bistriţa-Năsăud	268	146	1.8	90
Botoşani	462	303	1.5	76
Brăila	248	234	1.1	77
Braşov	588	500	1.2	85
Buzău	696	426	1.6	96
Bucharest Sector 1	329	285	1.2	70
Bucharest Sector 2	341	227	1.5	85
Bucharest Sector 3	183	70	2.6	93
Bucharest Sector 4	222	268	0.8	99
Bucharest Sector 5	127	173	0.7	83
Bucharest Sector 6	136	128	1.1	69
Călăraşi	299	250	1.2	100
Caraş-Severin	219	152	1.4	85
Cluj	339	337	1.0	84
Constanţa	592	468	1.3	83
Covasna	324	144	2.3	96
Dâmboviţa	246	170	1.4	90
Dolj	365	305	1.2	100
Galaţi	361	360	1.0	95
Giurgiu	181	157	1.2	77
Gorj	292	288	1.0	96
Harghita	606	342	1.8	86
Hunedoara	177	157	1.1	41
Ialomiţa	204	136	1.5	97
Iaşi	1,303	756	1.7	92

	Children in public residential services	DGASPC employees in residential services	Ratio of children to employees in DGASPC residential services	Children in public residential services as % of total children in residential services
TOTAL	**17,453**	**12,336**	**1.4**	**81**
Ilfov	129	183	0.7	61
Maramureş	342	301	1.1	86
Mehedinţi	170	157	1.1	96
Mureş	459	392	1.2	68
Neamţ	731	259	2.8	89
Olt	305	394	0.8	97
Prahova	529	447	1.2	60
Sălaj	374	227	1.7	87
Satu-Mare	254	46	5.6	71
Sibiu	351	294	1.2	61
Suceava	517	244	2.1	80
Teleorman	304	190	1.6	100
Timiş	389	287	1.4	54
Tulcea	344	209	1.6	100
Vâlcea	348	364	1.0	91
Vaslui	252	25	10.1	92
Vrancea	316	166	1.9	100

Source: ANPDCA, www.copii.ro

(C) Daycare services and DGASPC core structure

	Employees in the DGASPC core structure	Employees in public daycare services	Total children in special protection (all public services)*	Total DGASPC staff	Ratio of children to DGASPC employees
TOTAL	**4,412**	**3,409**	**54,019**	**32,236**	**1.7**
Alba	87	42	971	340	2.9
Arad	123	60	1,090	473	2.3
Argeş	130	125	1,052	950	1.1
Bacău	97	94	1,500	943	1.6
Bihor	106	41	1,675	786	2.1
Bistriţa-Năsăud	54	19	810	363	2.2
Botoşani	62	33	1,323	590	2.2
Brăila	29	28	717	421	1.7
Braşov	111	34	1,337	785	1.7
Buzău	92	27	1,485	752	2.0
Bucharest Sector 1	75	230	595	715	0.8
Bucharest Sector 2	213	55	571	586	1.0
Bucharest Sector 3	102	152	428	422	1.0
Bucharest Sector 4	128	106	478	611	0.8
Bucharest Sector 5	82	159	568	515	1.1
Bucharest Sector 6	201	367	343	760	0.5
Călăraşi	75	57	986	681	1.4
Caraş-Severin	85	8	1,044	749	1.4
Cluj	91	106	830	670	1.2
Constanţa	118	0	2,111	834	2.5
Covasna	68	66	906	426	2.1
Dâmboviţa	98	37	1,221	635	1.9
Dolj	64	272	1,080	809	1.3
Galaţi	141	14	1,451	885	1.6

	Employees in the DGASPC core structure	Employees in public daycare services	Total children in special protection (all public services)*	Total DGASPC staff	Ratio of children to DGASPC employees
TOTAL	**4,412**	**3,409**	**54,019**	**32,236**	**1.7**
Giurgiu	48	38	512	386	1.3
Gorj	80	63	777	550	1.4
Harghita	87	12	1,200	643	1.9
Hunedoara	74	19	1,073	393	2.7
Ialomiţa	63	39	644	323	2.0
Iaşi	122	77	3,647	1,772	2.1
Ilfov	52	0	559	313	1.8
Maramureş	79	5	1,226	699	1.8
Mehedinţi	81	97	688	498	1.4
Mureş	107	0	1,597	747	2.1
Neamţ	101	33	1,797	823	2.2
Olt	87	100	1,110	863	1.3
Prahova	95	0	1,500	799	1.9
Sălaj	62	0	803	379	2.1
Satu-Mare	67	162	1,023	509	2.0
Sibiu	95	6	872	562	1.6
Suceava	168	237	1,629	1,071	1.5
Teleorman	81	34	832	501	1.7
Timiş	147	37	2,054	1,072	1.9
Tulcea	39	16	776	440	1.8
Vâlcea	93	24	1,303	825	1.6
Vaslui	94	248	2,711	1,823	1.5
Vrancea	60	34	1,114	550	2.0

Source: ANPDCA, www.copii.ro

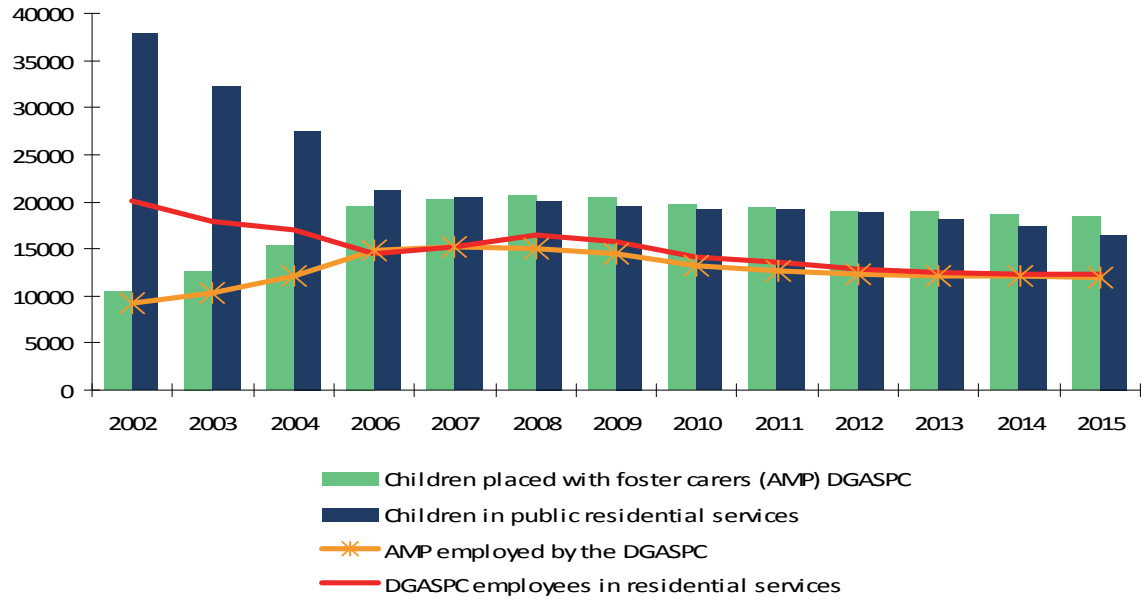
Note: *Includes children placed with relatives and with other people or families.

Annex 6 Table 41: Number of DGASPC Employees in Public Family-Based Care and in Residential Services, Number of Children, and the Ratio of Children per Employee in These Services, 2002-2015

	Children placed with foster carers by the DGASPC	AMPs employed by the DGASPC	Ratio of children to AMPs	Children in public residential services	DGASPC employees in residential services	Ratio of children to employees in DGASPC residential services
2002	10,461	9,170	1.1	37,781	20,069	1.9
2003	12,657	10,311	1.2	32,171	17,869	1.8
2004	15,308	12,083	1.3	27,579	16,943	1.6
2006	19,571	14,800	1.3	21,198	14,484	1.5
2007	20,194	15,225	1.3	20,532	15,262	1.3
2008	20,642	15,023	1.4	20,033	16,535	1.2
2009	20,498	14,432	1.4	19,525	15,785	1.2
2010	19,811	13,287	1.5	19,126	14,085	1.4
2011	19,376	12,667	1.5	19,215	13,644	1.4
2012	19,046	12,383	1.5	18,793	12,854	1.5
2013	18,947	12,201	1.6	18,148	12,513	1.5
2014	18,726	12,079	1.6	17,453	12,336	1.4
2015	18,545	12,005	1.5	16,396	12,292	1.3

Source: ANPDCA, www.copii.ro

Annex 6 Figure 9: Number of DGASPC Employees in Public Family-Based Care and in Residential Services and the Number of Children in These Services, 2002-2015



Source: ANPDCA, www.copii.ro

Annex 6 Table 42: Initial Placements of Children on Their Most Recent Admission into the System, by Type of Service (A-D) and by Various Indicators (% of Category)

(A) Family-type Services

	Placement with other people or families	Placement with relatives up to the 4th degree	Placement with foster carers (AMPs)	**Total family-type services (A)**
Total - N	**2,031**	**12,091**	**12,992**	**27,115**
- %	**4**	**23**	**25**	**52**
Child's age at the most recent entry into the system:				
0-12 months	3	8	42	**53**
1-2 years old	5	21	30	**56**
3-6 years old	4	32	15	**50**
7-10 years old	4	33	9	**46**
11-14 years old	5	44	4	**53**
15-17 years old	7	46	1	**54**
Gender:				
Boys	3	22	25	**50**
Girls	4	24	24	**53**
Ethnicity:				
Romanian	4	25	22	**52**
Hungarian	2	30	19	**51**
Roma	3	19	24	**46**
Other	12	0	8	**20**
Undeclared	4	20	30	**54**
Area of residence:				
Urban	4	17	30	**50**
Rural	4	31	18	**53**
Somewhere in Romania or abroad	0	46	27	**73**
Type of community:				
Source communities	2	32	35	**69**
Other communities	4	22	23	**49**
Who took care of the child before entering the system:				
Unknown caretaker	3	5	33	**41**
A caretaker other than the parents who left home	8	60	9	**76**
Parent(s) at home	2	6	32	**40**
Mother and/or father + a caretaker (usually grandmother/ grandparents)	8	69	7	**84**
Child's relationship with parents/family before entering the system:				
Good	5	58	3	**66**
Difficult	3	18	7	**28**
No info in case file	2	28	13	**44**
Not applicable, child under 6 years old	4	17	32	**54**
Children with special needs:				
Children (0-17 years) with disabilities	3	12	11	**25**
Children (0-17 years) with developmental delays	3	7	18	**28**
Children (6-17 years) with SEN	2	15	6	**23**
Children (7-17 years) with behavioral problems	4	14	6	**25**
Infants (0-12 months) born premature and/or underweight	3	1	47	**51**
Causes of separation:*				
Violence against children, of which:	4	25	19	**48**
- neglect	4	25	19	**48**

	Placement with other people or families	Placement with relatives up to the 4th degree	Placement with foster carers (AMPs)	**Total family-type services** **(A)**
Total - N	**2,031**	**12,091**	**12,992**	**27,115**
- %	**4**	**23**	**25**	**52**
- abuse	1	12	19	**32**
- exploitation	3	8	17	**27**
Child relinquishment	3	1	43	**48**
Unfortunate events**	5	49	16	**70**
Avoidable entries, of which:	5	43	14	**62**
- Child disability	4	19	11	**34**
- Social causes: individual factors	6	54	13	**72**
- Social causes: poverty, inadequate housing	5	40	17	**62**
Individual risk factors:				
Parent(s) gone abroad	5	47	10	**63**
Dysfunctional families	4	38	15	**58**
Teenage mothers when the child entered the system	5	27	33	**65**
Parental alcohol and/or drug abuse	3	15	22	**40**
Promiscuous and/or criminal behavior	3	22	24	**49**
Disability or mental health problems				
- parental	3	18	29	**50**
- other adult household member(s)	7	27	23	**58**
Structural risk factors:				
Poverty and inadequate housing	3	19	27	**50**
Benefited from ... within community, before entering the system:				
- prevention services	4	27	24	**55**
- support	8	25	19	**52**
Entry routes into the system:* **				
Not known	0	10	25	**35**
Relinquished in a MW --> SPS	3	1	46	**51**
MW --> F with stable dwelling --> SPS	3	28	18	**49**
MW --> F --> Children left home alone --> SPS	2	13	26	**41**
MW --> F with unstable accommodation or homeless --> SPS	3	14	19	**35**
MW --> F: Single mother institutionalized --> SPS	0	0	56	**56**
MW --> F --> Relatives --> SPS	3	73	6	**82**
MW --> F --> Non-relatives --> SPS	44	6	17	**67**
MW --> F --> Left in pediatric units/ other institutions --> SPS	3	3	32	**38**
MW --> F --> Children left in public spaces/street --> SPS	7	10	24	**42**
MW --> F --> Children ran away from home/ street children --> SPS	0	8	14	**23**
Social assessment in the case file, Institution:				
No social assessment	4	8	27	**39**
– yes, carried out by SPAS	4	26	24	**54**
– yes, carried out by the DGASPC	3	16	27	**46**
– yes, carried out both by SPAS and the DGASPC	4	34	23	**61**
– yes, carried out by others, i.e. OPA, NGO	1	6	38	**46**
– yes, but no mention of the author	2	14	20	**37**
Quality of the social assessment, which identifies:				
Only child's and/or family's needs	4	19	23	**45**
Only services provided and/or current offer	4	39	24	**68**
Needs and services	4	21	25	**49**
Neither needs nor services	4	21	26	**51**
Who notified the DGASPC of the case:				

	Placement with other people or families	Placement with relatives up to the 4th degree	Placement with foster carers (AMPs)	**Total family-type services (A)**
Total - N	**2,031**	**12,091**	**12,992**	**27,115**
- %	**4**	**23**	**25**	**52**
No info in case file	4	19	28	**51**
DGASPCs' own initiative	3	11	33	**46**
Referral from SPAS	3	24	20	**46**
Referral from other institutions	3	4	40	**47**
Notified by other people	15	22	17	**54**
Request from family	3	47	13	**63**
Request from the child	0	11	3	**15**
Who decided to place the child in public care:				
No info in case file	3	22	28	**53**
Decision of the DGASPC director	2	4	35	**41**
Presidential ordinance	1	3	42	**45**
Decision of the Child Protection Commission (CPC)	5	32	18	**56**
Court ruling	7	63	9	**79**
Number of the child's entries into the system:				
One entry	4	23	25	**52**
Multiple entries (2 to 4)	2	13	22	**37**
Siblings in public care at the time of study:				
Yes	3	17	26	**47**
No	4	30	23	**56**
A list of identified relatives up to the fourth degree is in the case file	4	18	28	**49**
Protection measure given when the child entered the system:				
No info in case file	1	29	27	**57**
Placement	5	38	17	**61**
Emergency placement	2	4	34	**41**
Specialized supervision	0	16	17	**33**
Others****	0	69	31	**100**
ONLY CHILDREN WHO ENTERED THE SYSTEM IN 2013-2014				
Total, of which:	**9**	**22**	**34**	**65**
Child's age at the most recent entry into the system:				
0-12 months	12	6	67	**85**
1-2 years old	11	18	44	**73**
3-6 years old	4	25	16	**45**
7-10 years old	8	36	8	**51**
11-14 years old	6	38	6	**50**
15-17 years old	5	48	2	**55**
Children with special needs:				
Children (0-17 years) with disabilities	6	13	15	**34**
Children (0-17 years) with developmental delays	10	10	18	**36**
Children (6-17 years) with SEN	4	19	5	**28**
Children (7-17 years) with behavioral problems	6	14	4	**23**
Infants (0-12 months) born premature and/or underweight	11	1	64	**76**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, of whom 6,476 children entered the system in 2013-2014).

Notes: *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others. Highlighted cells indicate statistically significant higher values.

(B) Small-scale Residential Services (Apartments and Small Group Homes)

	AP	CTF-disab	CTF-non-disab	Total CTF *****	Total small-scale residential services ***** (B)
Total - N	**572**	**809**	**2,753**	**3,630**	**4,202**
- %	**1**	**2**	**5**	**7**	**8**
Child's age at the most recent entry into the system:					
0-12 months	0	1	2	3	**4**
1-2 years old	1	1	5	7	**8**
3-6 years old	1	2	8	10	**11**
7-10 years old	2	1	8	9	**11**
11-14 years old	2	2	7	9	**11**
15-17 years old	3	2	15	17	**20**
Gender:					
Boys	2	2	5	7	**8**
Girls	1	1	5	7	**8**
Ethnicity:					
Romanian	2	2	5	7	**9**
Hungarian	0	2	10	12	**13**
Roma	1	2	5	7	**8**
Other	0	0	15	15	**15**
Undeclared	0	1	4	6	**6**
Area of residence:					
Urban	1	2	5	7	**8**
Rural	1	1	6	7	**8**
Somewhere in Romania or abroad	0	0	0	0	**0**
Type of community:					
Source communities	0	2	3	5	**5**
Other communities	1	2	6	7	**8**
Who took care of the child before entering the system:					
Unknown caretaker	0	2	7	9	**9**
A caretaker other than the parents who left home	1	0	4	4	**4**
Parent(s) at home	1	2	7	9	**10**
Mother and/or father + a caretaker (usually grandmother/ grandparents)	0	0	1	1	**2**
Child's relationship with parents/family before entering the system:					
Good	2	1	6	7	**9**
Difficult	3	2	10	12	**15**
No info in case file	1	3	8	10	**11**
Not applicable, child under 6 years old	1	2	4	6	**7**
Children with special needs:					
Children (0-17 years) with disabilities	1	10	2	12	**13**
Children (0-17 years) with developmental delays	2	5	5	11	**13**
Children (6-17 years) with SEN	1	8	2	10	**12**
Children (7-17 years) with behavioral problems	3	2	9	12	**15**
Infants (0-12 months) born premature and/or underweight	1	4	1	5	**5**
Causes of separation:*					
Violence against children, of which:	2	1	7	8	**10**
- neglect	2	1	7	8	**10**
- abuse	2	1	10	11	**13**
- exploitation	1	2	7	9	**10**
Child relinquishment	0	2	3	5	**5**
Unfortunate events**	1	1	4	4	**5**
Avoidable entries, of which:	0	2	6	8	**8**

	AP	CTF-disab	CTF-non-disab	Total CTF *****	Total small-scale residential services ***** (B)
Total - N	**572**	**809**	**2,753**	**3,630**	**4,202**
- %	**1**	**2**	**5**	**7**	**8**
- Child disability	1	7	5	12	**13**
- Social causes: individual factors	0	0	6	6	**6**
- Social causes: poverty, inadequate housing	0	1	7	8	**8**
Individual risk factors:					
Parent(s) gone abroad	0	1	6	7	**7**
Dysfunctional families	1	1	5	6	**8**
Teenage mothers when the child entered the system	0	1	0	2	**2**
Parental alcohol and/or drug abuse	3	2	9	11	**13**
Promiscuous and/or criminal behavior	1	2	5	7	**8**
Disability or mental health problems					
- parental	2	1	5	6	**8**
- other adult household member(s)	1	1	5	6	**7**
Structural risk factors:					
Poverty and inadequate housing	2	1	7	8	**9**
Benefited from ... within community, before entering the system:					
- prevention services	1	1	6	7	**8**
- support	2	1	6	7	**9**
Entry routes into the system:* **					
Not known	2	6	5	13	**16**
Relinquished in a MW --> SPS	0	2	2	4	**4**
MW --> F with stable dwelling --> SPS	2	2	7	9	**10**
MW --> F --> Children left home alone --> SPS	0	0	13	13	**13**
MW --> F with unstable accommodation or homeless --> SPS	2	1	3	4	**6**
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	**0**
MW --> F --> Relatives --> SPS	1	0	2	3	**3**
MW --> F --> Non-relatives --> SPS	1	1	1	1	**2**
MW --> F --> Left in pediatric units/ other institutions --> SPS	0	4	7	11	**11**
MW --> F --> Children left in public spaces/street --> SPS	0	0	9	9	**9**
MW --> F --> Children ran away from home/ street children --> SPS	4	0	3	3	**6**
Social assessment in the case file, Institution:					
No social assessment	1	1	3	5	**6**
– yes, carried out by SPAS	1	2	6	8	**10**
– yes, carried out by the DGASPC	1	1	4	5	**6**
– yes, carried out both by SPAS and the DGASPC	0	1	5	6	**6**
– yes, carried out by others, i.e. OPA, NGO	0	0	17	17	**17**
– yes, but no mention of the author	0	2	4	7	**7**
Quality of the social assessment, which identifies:					
Only child's and/or family's needs	1	2	5	8	**9**
Only services provided and/or current offer	1	1	5	6	**6**
Needs and services	2	1	7	8	**11**
Neither needs nor services	1	2	5	6	**7**
Who notified the DGASPC of the case:					
No info in case file	0	1	4	5	**6**
DGASPCs' own initiative	1	1	5	6	**7**
Referral from SPAS	2	2	8	10	**11**
Referral from other institutions	1	2	4	6	**7**
Notified by other people	2	0	4	4	**6**

	AP	CTF-disab	CTF-non-disab	Total CTF *****	Total small-scale residential services ***** (B)
Total - N	**572**	**809**	**2,753**	**3,630**	**4,202**
- %	**1**	**2**	**5**	**7**	**8**
Request from family	1	1	5	7	**8**
Request from the child	11	0	16	16	**27**
Who decided to place the child in public care:					
No info in case file	1	1	4	5	**6**
Decision of the DGASPC director	1	1	5	6	**7**
Presidential ordinance	3	0	4	4	**7**
Decision of the Child Protection Commission (CPC)	1	2	7	9	**10**
Court ruling	1	1	4	4	**6**
Number of the child's entries into the system:					
One entry	1	2	5	7	**8**
Multiple entries (2 to 4)	2	3	6	10	**12**
Siblings in public care at the time of study:					
Yes	1	1	8	9	**10**
No	1	2	3	5	**7**
A list of identified relatives up to the fourth degree is in the case file	2	1	5	7	**9**
Protection measure given when the child entered the system:					
No info in case file	1	1	2	4	**5**
Placement	1	2	6	8	**9**
Emergency placement	1	1	4	6	**7**
Specialized supervision	0	0	0	0	**0**
Others****	0	0	0	0	**0**
ONLY CHILDREN WHO ENTERED THE SYSTEM IN 2013-2014					
Total, of which:	**1**	**1**	**6**	**7**	**8**
Child's age at the most recent entry into the system:					
0-12 months	0	2	0	2	**2**
1-2 years old	3	1	6	7	**9**
3-6 years old	1	1	10	10	**12**
7-10 years old	2	0	11	11	**13**
11-14 years old	1	1	9	10	**11**
15-17 years old	0	0	17	17	**17**
Children with special needs:					
Children (0-17 years) with disabilities	1	8	0	8	**9**
Children (0-17 years) with developmental delays	5	3	8	10	**15**
Children (6-17 years) with SEN	0	0	0	0	**0**
Children (7-17 years) with behavioral problems	0	0	12	12	**12**
Infants (0-12 months) born premature and/or underweight	0	6	0	6	**6**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, of whom 6,476 children entered the system in 2013-2014).

Notes: AP = Apartments; CTF = Small group homes; disab = for children with disabilities; non-disab = for children without disabilities. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others. *****The total column also includes 68 children placed in CTFs without knowing the specific type of service (CTF-disab or CTF-non-disab); these children are not shown in a separate column given the small number of cases. Highlighted cells indicate statistically significant higher values.

(C) Placement Centers

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP (C)**
Total - N	**3,836**	**611**	**48**	**1,376**	**2,932**	**1,715**	**1,903**	**12,421**
- %	**7**	**1**	**0**	**3**	**6**	**3**	**4**	**24**
Child's age at the most recent entry into the system:								
0-12 months	14	0	0	3	8	6	3	**34**
1-2 years old	8	0	0	3	5	3	3	**23**
3-6 years old	3	1	0	2	4	2	5	**17**
7-10 years old	2	3	0	3	4	2	5	**18**
11-14 years old	1	2	0	2	3	2	3	**14**
15-17 years old	2	4	1	0	3	0	0	**10**
Gender:								
Boys	8	1	0	3	6	3	4	**26**
Girls	6	1	0	2	5	3	3	**22**
Ethnicity:								
Romanian	6	1	0	2	5	3	4	**22**
Hungarian	11	1	0	2	4	1	5	**24**
Roma	11	0	0	4	7	4	4	**31**
Other	15	0	0	5	0	15	7	**41**
Undeclared	8	1	0	3	6	4	3	**25**
Area of residence:								
Urban	9	1	0	3	7	4	4	**28**
Rural	5	1	0	3	4	2	3	**18**
Somewhere in Romania or abroad	7	2	0	1	2	3	3	**18**
Type of community:								
Source communities	3	0	0	5	2	1	3	**13**
Other communities	8	1	0	2	6	4	4	**25**
Who took care of the child before entering the system:								
Unknown caretaker	14	1	0	3	9	4	4	**35**
A caretaker other than the parents who left home	2	1	0	0	2	1	2	**7**
Parent(s) at home	9	1	0	4	7	4	5	**31**
Mother and/or father + a caretaker (usually grandmother/ grandparents)	1	1	0	0	1	0	1	**4**
Child's relationship with parents/family before entering the system:								
Good	1	3	0	1	2	2	4	**13**
Difficult	3	2	0	2	6	2	5	**20**
No info in case file	2	3	0	3	5	2	4	**19**
Not applicable, child under 6 years old	10	1	0	3	6	4	3	**27**
Children with special needs:								
Children (0-17 years) with disabilities	9	3	0	11	4	16	3	**47**
Children (0-17 years) with developmental delays	8	2	0	5	6	8	3	**34**
Children (6-17 years) with SEN	6	12	1	10	1	7	1	**40**
Children (7-17 years) with behavioral problems	1	4	1	1	6	0	4	**17**
Infants (0-12 months) born premature and/or underweight	11	0	0	4	6	10	3	**35**
Causes of separation:*								
Violence against children, of which:	4	1	0	2	5	2	4	**17**
- neglect	4	1	0	1	5	2	4	**17**

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP (C)**
Total - N	**3,836**	**611**	**48**	**1,376**	**2,932**	**1,715**	**1,903**	**12,421**
- %	**7**	**1**	**0**	**3**	**6**	**3**	**4**	**24**
- abuse	3	2	0	2	5	1	4	**18**
- exploitation	6	2	0	1	4	2	6	**21**
Child relinquishment	15	0	0	4	8	6	3	**37**
Unfortunate events**	3	1	0	0	4	2	3	**13**
Avoidable entries, of which:	4	2	0	3	4	3	4	**21**
- Child disability	8	8	1	9	5	10	3	**44**
- Social causes: individual factors	3	1	0	1	4	0	4	**12**
- Social causes: poverty, inadequate housing	5	1	0	2	5	1	5	**19**
Individual risk factors:								
Parent(s) gone abroad	1	1	0	1	4	2	1	**9**
Dysfunctional families	6	1	0	1	5	2	3	**19**
Teenage mothers when the child entered the system	10	0	0	1	4	4	2	**21**
Parental alcohol and/or drug abuse	4	2	0	2	6	2	5	**20**
Promiscuous and/or criminal behavior	6	2	0	1	6	3	3	**21**
Disability or mental health problems								
- parental	9	1	0	3	7	4	3	**26**
- other adult household member(s)	4	1	0	2	5	4	4	**20**
Structural risk factors:								
Poverty and inadequate housing	7	1	0	3	5	2	5	**23**
Benefited from ... within community, before entering the system:								
- prevention services	4	1	0	2	4	3	4	**19**
- support	2	0	0	2	5	1	6	**17**
Entry routes into the system:* **								
Not known	4	6	0	9	4	2	7	**32**
Relinquished in a MW --> SPS	15	0	0	3	9	6	3	**37**
MW --> F with stable dwelling --> SPS	4	2	0	2	5	2	4	**20**
MW --> F --> Children left home alone --> SPS	6	2	0	1	11	2	6	**27**
MW --> F with unstable accommodation or homeless --> SPS	8	4	0	0	6	1	3	**22**
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	13	0	0	**13**
MW --> F --> Relatives --> SPS	1	0	0	0	1	1	1	**5**
MW --> F --> Non-relatives --> SPS	4	0	0	0	2	0	2	**8**
MW --> F --> Left in pediatric units/ other institutions --> SPS	12	1	0	8	6	5	4	**36**
MW --> F --> Children left in public spaces/street --> SPS	18	0	0	2	3	2	0	**24**
MW --> F --> Children ran away from home/ street children --> SPS	7	0	0	1	16	0	2	**26**
Social assessment in the case file, Institution:								
No social assessment	17	1	0	4	8	4	7	**41**
– yes, carried out by SPAS	7	2	0	2	5	2	3	**21**
– yes, carried out by the DGASPC	7	0	0	4	7	6	4	**28**
– yes, carried out both by SPAS and the DGASPC	3	1	0	2	5	3	3	**16**
– yes, carried out by others, i.e. OPA, NGO	7	0	0	1	19	0	0	**27**
– yes, but no mention of the author	6	1	0	5	11	4	4	**31**

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP (C)**
Total - N	**3,836**	**611**	**48**	**1,376**	**2,932**	**1,715**	**1,903**	**12,421**
- %	**7**	**1**	**0**	**3**	**6**	**3**	**4**	**24**
Quality of the social assessment, which identifies:								
Only child's and/or family's needs	10	2	0	2	8	4	3	**29**
Only services provided and/or current offer	3	1	0	2	3	2	4	**14**
Needs and services	5	1	0	3	5	4	4	**21**
Neither needs nor services	8	1	0	3	6	3	2	**24**
Who notified the DGASPC of the case:								
No info in case file	6	1	0	5	7	4	5	**29**
DGASPCs' own initiative	7	2	0	3	6	5	6	**28**
Referral from SPAS	5	2	0	1	6	2	5	**21**
Referral from other institutions	12	1	0	4	8	5	3	**33**
Notified by other people	4	0	0	1	4	1	2	**13**
Request from family	5	1	0	2	3	2	3	**17**
Request from the child	0	7	3	0	0	0	0	**10**
Who decided to place the child in public care:								
No info in case file	8	0	0	5	7	4	5	**28**
Decision of the DGASPC director	6	1	0	3	4	3	4	**21**
Presidential ordinance	0	3	0	2	3	4	1	**13**
Decision of the Child Protection Commission (CPC)	10	1	0	3	8	4	4	**31**
Court ruling	1	0	0	0	3	1	2	**7**
Number of the child's entries into the system:								
One entry	7	1	0	3	6	3	3	**23**
Multiple entries (2 to 4)	6	3	0	2	7	5	10	**34**
Siblings in public care at the time of study:								
Yes	6	1	0	2	5	2	5	**22**
No	8	1	0	3	6	4	2	**24**
A list of identified relatives up to the fourth degree is in the case file	8	1	0	2	5	4	4	**24**
Protection measure given when the child entered the system:								
No info in case file	14	0	0	4	12	1	0	**32**
Placement	8	1	0	3	6	3	4	**26**
Emergency placement	6	1	0	2	5	3	4	**21**
Specialized supervision	21	0	0	0	0	0	13	**34**
Others****	0	0	0	0	0	0	0	**0**
ONLY CHILDREN WHO ENTERED THE SYSTEM IN 2013-2014								
Total, of which:	**0**	**2**	**0**	**1**	**2**	**2**	**3**	**11**
Child's age at the most recent entry into the system:								
0-12 months	0	1	0	2	0	4	0	**7**
1-2 years old	0	0	0	1	0	2	3	**6**
3-6 years old	0	1	0	1	4	1	5	**12**
7-10 years old	0	3	0	1	5	1	6	**15**
11-14 years old	1	4	0	1	3	1	4	**15**
15-17 years old	0	8	2	0	6	0	0	**16**
Children with special needs:								

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP (C)**
Total - N	**3,836**	**611**	**48**	**1,376**	**2,932**	**1,715**	**1,903**	**12,421**
- %	**7**	**1**	**0**	**3**	**6**	**3**	**4**	**24**
Children (0-17 years) with disabilities	0	9	1	11	1	17	1	**40**
Children (0-17 years) with developmental delays	0	5	1	5	5	7	3	**26**
Children (6-17 years) with SEN	0	26	1	8	2	6	3	**46**
Children (7-17 years) with behavioral problems	0	8	1	1	12	0	4	**27**
Infants (0-12 months) born premature and/or underweight	0	0	0	5	0	11	0	**16**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, of whom 6,476 children entered the system in 2013-2014).

Notes: CP = Placement centers; CP MEN = placement centers taken over from MEN (Ministry of National Education); mod = modulated; disab = for children with disabilities; non-disab = for children without disabilities. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others. ***** The type of CP is not known as these cases relate to old institutions that have already been closed down when children who entered the system many years ago were placed. Highlighted cells indicate statistically significant higher values.

(D) Other Protection Services and the General Total

	CPRU	CM	Total residential services ***** (D) = (B+C+CPRU+CM)	Other services	Not known	**General Total (A+D)**
Total - N	**7,037**	**675**	**24,335**	**348**	**547**	**52,344**
- %	**13**	**1**	**46**	**1**	**1**	**100**
Child's age at the most recent entry into the system:						
0-12 months	7	2	46	0	1	**100**
1-2 years old	10	2	43	0	1	**100**
3-6 years old	20	1	48	0	1	**100**
7-10 years old	21	1	50	2	2	**100**
11-14 years old	19	0	45	2	1	**100**
15-17 years old	8	2	40	2	5	**100**
Gender:						
Boys	13	1	48	1	1	**100**
Girls	14	1	45	1	1	**100**
Ethnicity:						
Romanian	14	1	46	1	1	**100**
Hungarian	10	1	47	2	0	**100**
Roma	13	1	52	1	0	**100**
Other	20	3	80	0	0	**100**
Undeclared	13	1	45	0	1	**100**
Area of residence:						
Urban	11	1	48	0	1	**100**
Rural	17	1	44	1	1	**100**
Somewhere in Romania or abroad	9	0	27	0	0	**100**
Type of community:						
Source communities	11	0	30	0	1	**100**
Other communities	14	1	49	1	1	**100**
Who took care of the child before entering the system:						
Unknown caretaker	13	1	59	0	0	**100**
A caretaker other than the parents who left	8	0	20	1	3	**100**

	CPRU	CM	Total residential services ***** (D) = (B+C+CPRU+CM)	Other services	Not known	General Total (A+D)
Total - N	**7,037**	**675**	**24,335**	**348**	**547**	**52,344**
- %	**13**	**1**	**46**	**1**	**1**	**100**
home						
Parent(s) at home	16	2	59	1	0	**100**
Mother and/or father + a caretaker (usually grandmother/ grandparents)	6	0	13	0	3	**100**
Child's relationship with parents/family before entering the system:						
Good	9	1	31	1	3	**100**
Difficult	32	1	68	3	0	**100**
No info in case file	22	0	53	1	2	**100**
Not applicable, child under 6 years old	11	2	45	0	1	**100**
Children with special needs:						
Children (0-17 years) with disabilities	12	1	73	1	1	**100**
Children (0-17 years) with developmental delays	21	1	69	2	1	**100**
Children (6-17 years) with SEN	19	1	72	3	2	**100**
Children (7-17 years) with behavioral problems	34	1	67	8	0	**100**
Infants (0-12 months) born premature and/or underweight	6	3	49	0	0	**100**
Causes of separation:*						
Violence against children, of which:	21	1	49	1	2	**100**
- neglect	20	1	49	1	2	**100**
- abuse	33	2	65	2	0	**100**
- exploitation	33	1	65	7	1	**100**
Child relinquishment	8	2	52	0	0	**100**
Unfortunate events**	10	0	30	0	1	**100**
Avoidable entries, of which:	7	1	38	0	1	**100**
- Child disability	6	1	66	0	0	**100**
- Social causes: individual factors	7	2	27	0	1	**100**
- Social causes: poverty, inadequate housing	8	1	37	0	1	**100**
Individual risk factors:						
Parent(s) gone abroad	17	1	34	1	1	**100**
Dysfunctional families	13	1	41	1	1	**100**
Teenage mothers when the child entered the system	7	5	35	0	0	**100**
Parental alcohol and/or drug abuse	24	1	58	2	1	**100**
Promiscuous and/or criminal behavior	18	1	48	2	1	**100**
Disability or mental health problems						
- parental	12	2	49	0	1	**100**
- other adult household member(s)	12	1	41	1	1	**100**
Structural risk factors:						
Poverty and inadequate housing	14	2	48	1	1	**100**
Benefited from ... within community, before entering the system:						
- prevention services	15	1	43	1	0	**100**
- support	17	1	44	2	2	**100**
Entry routes into the system:* **						
Not known	17	0	65	0	0	**100**
Relinquished in a MW --> SPS	7	2	49	0	0	**100**
MW --> F with stable dwelling --> SPS	17	1	49	1	1	**100**
MW --> F --> Children left home alone --> SPS	20	0	59	0	0	**100**
MW --> F with unstable accommodation or	26	8	63	2	0	**100**

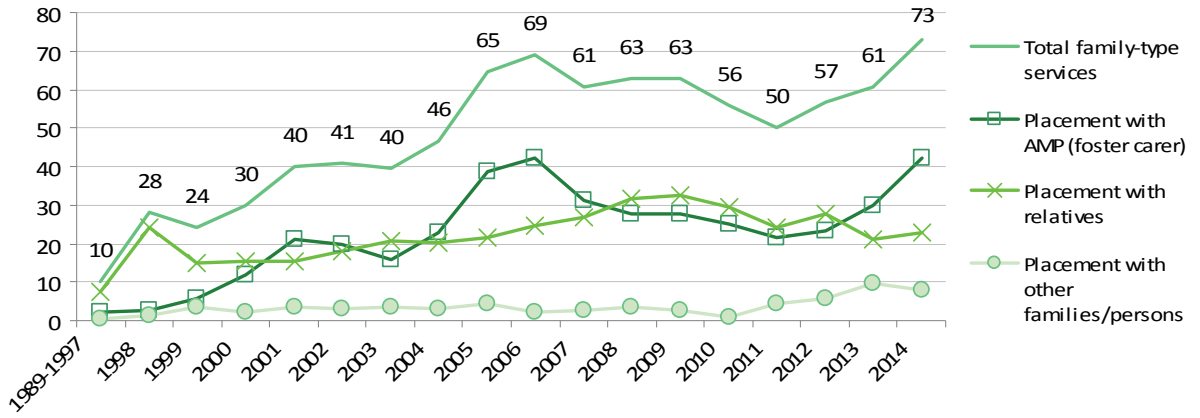
	CPRU	CM	Total residential services ***** (D) = (B+C+CPRU+CM)	Other services	Not known	General Total (A+D)
Total - N	**7,037**	**675**	**24,335**	**348**	**547**	**52,344**
- %	**13**	**1**	**46**	**1**	**1**	**100**
homeless --> SPS						
MW --> F: Single mother institutionalized --> SPS	9	22	44	0	0	**100**
MW --> F --> Relatives --> SPS	6	0	14	1	3	**100**
MW --> F --> Non-relatives --> SPS	17	0	27	2	3	**100**
MW --> F --> Left in pediatric units/ other institutions --> SPS	13	1	61	0	0	**100**
MW --> F --> Children left in public spaces/street --> SPS	20	0	54	3	1	**100**
MW --> F --> Children ran away from home/ street children --> SPS	43	0	75	2	0	**100**
Social assessment in the case file, Institution:						
No social assessment	11	2	59	0	2	**100**
– yes, carried out by SPAS	12	1	44	1	1	**100**
– yes, carried out by the DGASPC	17	2	53	1	0	**100**
– yes, carried out both by SPAS and the DGASPC	16	0	38	1	0	**100**
– yes, carried out by others, i.e. OPA, NGO	10	0	54	0	0	**100**
– yes, but no mention of the author	22	2	62	1	0	**100**
Quality of the social assessment, which identifies:						
Only child's and/or family's needs	15	1	55	0	0	**100**
Only services provided and/or current offer	9	1	31	1	1	**100**
Needs and services	17	1	49	1	0	**100**
Neither needs nor services	13	1	46	0	2	**100**
Who notified the DGASPC of the case:						
No info in case file	12	2	48	0	0	**100**
DGASPCs' own initiative	15	4	53	0	1	**100**
Referral from SPAS	19	1	52	1	1	**100**
Referral from other institutions	12	1	52	1	0	**100**
Notified by other people	25	1	44	1	1	**100**
Request from family	8	2	34	0	2	**100**
Request from the child	46	0	83	2	0	**100**
Who decided to place the child in public care:						
No info in case file	11	2	47	0	0	**100**
Decision of the DGASPC director	27	2	58	1	0	**100**
Presidential ordinance	32	1	54	0	1	**100**
Decision of the Child Protection Commission (CPC)	2	1	43	0	1	**100**
Court ruling	4	0	18	0	3	**100**
Number of the child's entries into the system:						
One entry	13	1	46	1	1	**100**
Multiple entries (2 to 4)	16	1	63	0	0	**100**
Siblings in public care at the time of study:						
Yes	18	1	51	1	1	**100**
No	9	1	42	0	1	**100**
A list of identified relatives up to the fourth degree is in the case file	15	2	49	1	1	**100**
Protection measure given when the child entered the system:						
No info in case file	3	2	41	0	1	**100**

	CPRU	CM	Total residential services ***** (D) = (B+C+CPRU+CM)	Other services	Not known	**General Total (A+D)**
Total - N	**7,037**	**675**	**24,335**	**348**	**547**	**52,344**
- %	**13**	**1**	**46**	**1**	**1**	**100**
Placement	2	1	37	0	2	**100**
Emergency placement	28	2	58	1	0	**100**
Specialized supervision	10	0	44	23	0	**100**
Others****	0	0	0	0	0	**100**
ONLY CHILDREN WHO ENTERED THE SYSTEM IN 2013-2014						
Total, of which:	**13**	**2**	**34**	**1**	**0**	**100**
Child's age at the most recent entry into the system:						
0-12 months	2	3	14	0	1	**100**
1-2 years old	7	2	25	2	0	**100**
3-6 years old	30	0	55	0	0	**100**
7-10 years old	18	2	48	1	0	**100**
11-14 years old	21	0	48	2	0	**100**
15-17 years old	12	0	45	0	0	**100**
Children with special needs:						
Children (0-17 years) with disabilities	15	0	65	1	0	**100**
Children (0-17 years) with developmental delays	20	0	61	2	0	**100**
Children (6-17 years) with SEN	22	0	68	3	0	**100**
Children (7-17 years) with behavioral problems	33	1	74	2	0	**100**
Infants (0-12 months) born premature and/or underweight	0	1	24	0	0	**100**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, of whom 6,476 children entered the system in 2013-2014).

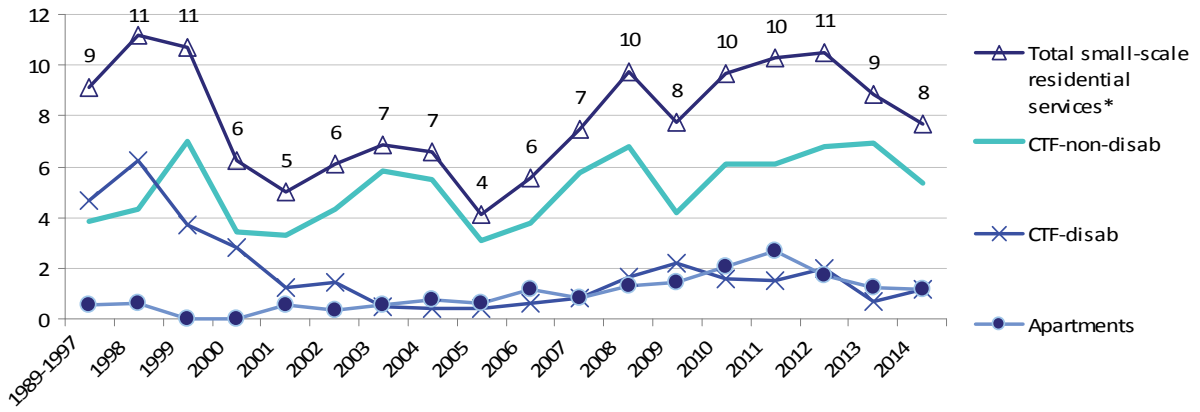
Notes: CPRU = emergency reception centers; CM = maternal centers. Other services comprise day shelters, night shelters, daycare services, rehabilitation services, counseling services, and services for the development of independent life skills. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others. *****Total residential services is the sum of (B) small-scale services (apartments and CTF), (C) placement centers, CPRU and CM. Highlighted cells indicate statistically significant higher values.

Annex 6 Figure 10: Proportion of Children Placed in Family-type Services in the First Stage after their Most Recent Admission into Special Protection, by Type of Service and Admission Year (% of All Children in Special Protection)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, for 1 percent of children the service is not known).

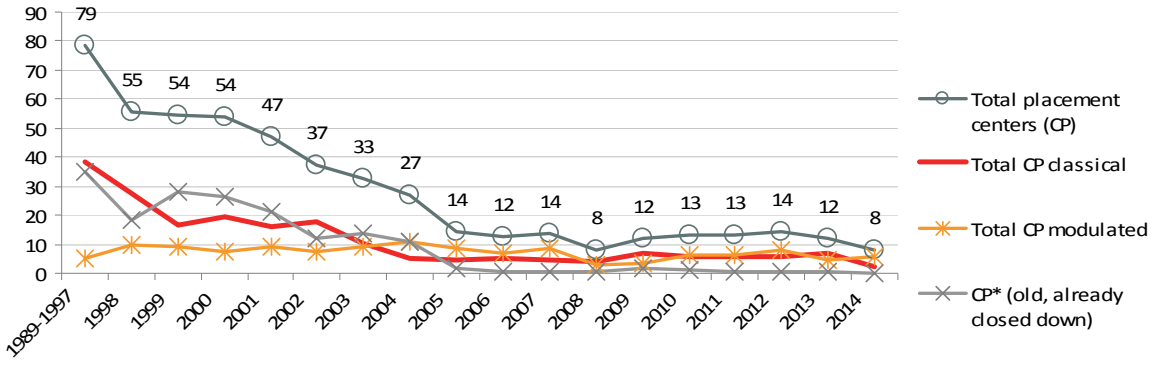
Annex 6 Figure 11: Proportion of Children Placed in Small-scale Residential Services in the First Stage after their Most Recent Admission into Special Protection, by Type of Service and Admission Year (% of All Children in Special Protection)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, for 1 percent of whom the service is not known).

Notes: CTF = Small group homes; disab = for children with disabilities; non-disab = for children without disabilities. *The total column also includes 68 children placed in CTFs with no information on the specific type of service (CTF-disab or CTF-non-disab). These children are not shown in a separate line given the small number of cases involved.

Annex 6 Figure 12: Proportion of Children Placed in Placement Centers in the First Stage after their Most Recent Admission in Special Protection, by Type of Service and Admission Year (% of All Children in Special Protection)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, for 1 percent of whom the service is not known).

Notes: Total CP classical/modulated consists of classical centers for children with disabilities, those for children without disabilities, and the former dormitories of special schools taken over from MEN. *The type of CP is not known as these cases relate to old institutions that have already been closed down where children who entered the system many years ago were placed.

Annex 6 Table 43: Children who Entered the System during 2010-2014 and Were Placed in Placement Centers in the First Stage after Admission, by Various Indicators (% of Category)

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP**
Total - N	**100**	**337**	**27**	**243**	**394**	**464**	**592**	**2,157**
- %	**1**	**2**	**0**	**1**	**2**	**3**	**3**	**12**
Child's age at the most recent entry into the system:								
0-12 months	0	0	0	2	0	7	0	**9**
1-2 years old	0	0	0	1	1	3	3	**8**
3-6 years old	0	2	0	1	3	1	6	**14**
7-10 years old	1	4	0	2	4	1	5	**16**
11-14 years old	1	3	0	2	4	1	3	**15**
15-17 years old	2	4	1	0	4	0	0	**11**
Gender:								
Boys	1	1	0	2	2	2	4	**12**
Girls	0	3	0	1	2	3	3	**12**
Ethnicity:								
Romanian	0	2	0	1	2	2	4	**12**
Hungarian	0	1	0	1	3	1	4	**9**
Roma	1	0	0	1	1	4	6	**14**
Other	10	0	0	0	0	11	11	**32**
Undeclared	1	2	0	2	3	4	2	**14**
Area of residence:								
Urban	0	2	0	1	2	4	4	**13**
Rural	1	2	0	2	3	1	3	**12**
Somewhere in Romania or abroad	0	0	0	0	0	0	4	**4**
Type of community:								
Source communities	0	0	0	1	1	0	1	**3**
Other communities	1	2	0	1	2	3	4	**14**

	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP**
Total - N	**100**	**337**	**27**	**243**	**394**	**464**	**592**	**2,157**
- %	**1**	**2**	**0**	**1**	**2**	**3**	**3**	**12**
Who took care of the child before entering the system:								
Unknown caretaker	2	0	0	1	7	6	2	**17**
A caretaker other than the parents who left home	0	1	0	1	2	1	2	**7**
Parent(s) at home	1	3	0	2	2	4	5	**16**
Mother and/or father + a caretaker (usually grandmother/ grandparents)	1	1	0	0	2	0	1	**5**
Child's relationship with parents/family before entering the system:								
Good	0	4	0	1	2	1	5	**13**
Difficult	3	2	1	2	6	0	5	**18**
No info in case file	0	4	0	2	5	1	2	**15**
Not applicable, child under 6 years old	0	1	0	1	1	4	3	**10**
Children with special needs:								
Children (0-17 years) with disabilities	1	7	1	11	0	17	1	**38**
Children (0-17 years) with developmental delays	1	4	1	5	3	8	3	**25**
Children (6-17 years) with SEN	4	16	2	11	1	5	2	**41**
Children (7-17 years) with behavioral problems	0	4	1	1	9	0	5	**20**
Infants (0-12 months) born premature and/or underweight	0	0	0	5	0	11	0	**16**
Causes of separation:*								
Violence against children, of which:	1	2	0	1	3	1	4	**13**
- neglect	1	2	0	1	3	1	5	**13**
- abuse	1	4	0	1	3	0	3	**12**
- exploitation	1	4	0	1	5	2	8	**20**
Child relinquishment	0	0	0	2	0	8	1	**11**
Unfortunate events**	0	0	0	0	1	4	1	**6**
Avoidable entries, of which:	0	4	0	2	2	1	4	**13**
- Child disability	1	17	2	9	3	7	1	**40**
- Social causes: individual factors	0	0	0	0	2	0	3	**6**
- Social causes: poverty, inadequate housing	0	2	0	0	2	0	8	**12**
Individual risk factors:								
Parent(s) gone abroad	0	1	0	1	3	1	2	**9**
Dysfunctional families	1	1	0	1	2	2	4	**10**
Teenage mothers when the child entered the system	1	0	0	0	0	5	0	**6**
Parental alcohol and/or drug abuse	1	4	0	1	4	1	4	**14**
Promiscuous and/or criminal behavior	1	3	0	1	3	3	4	**15**
Disability or mental health problems								
- parental	0	2	0	2	2	5	4	**14**
- other adult household member(s)	0	2	0	2	6	1	1	**12**
Structural risk factors:								
Poverty and inadequate housing	1	2	0	1	1	1	6	**13**
Benefited from ... within community, before entering the system:								
- prevention services	1	1	0	2	2	2	4	**14**
- support	1	1	0	1	4	1	5	**13**
Entry routes into the system:* **								
Not known	0	0	0	0	0	0	0	**0**
Relinquished in a MW --> SPS	0	0	0	2	0	7	0	**10**

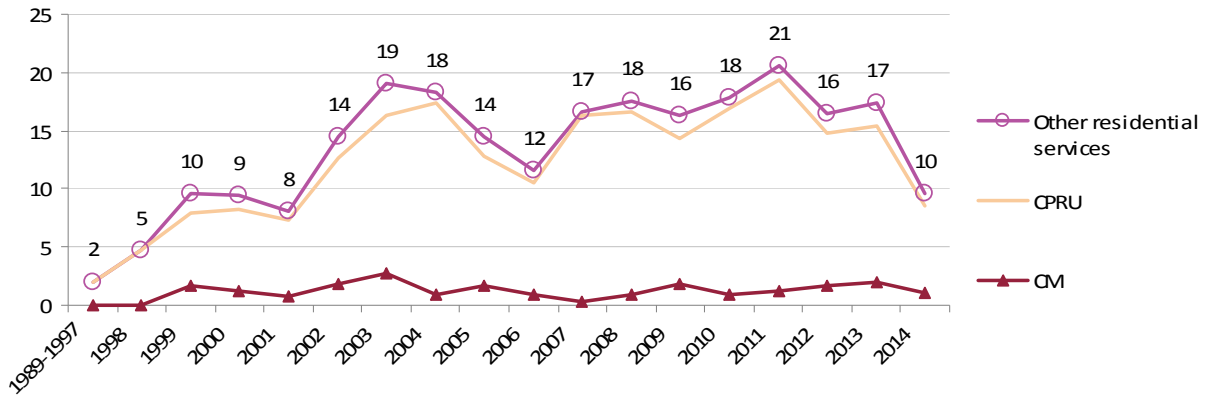
	CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP**
Total - N	**100**	**337**	**27**	**243**	**394**	**464**	**592**	**2,157**
- %	**1**	**2**	**0**	**1**	**2**	**3**	**3**	**12**
MW --> F with stable dwelling --> SPS	1	3	0	2	3	2	5	**16**
MW --> F --> Children left home alone --> SPS	2	0	0	0	13	4	5	**24**
MW --> F with unstable accommodation or homeless --> SPS	0	9	0	1	1	0	8	**18**
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	17	0	0	**17**
MW --> F --> Relatives --> SPS	0	1	0	0	1	1	1	**4**
MW --> F --> Non-relatives --> SPS	0	0	0	0	1	0	2	**2**
MW --> F --> Left in pediatric units/ other institutions --> SPS	0	2	0	1	1	8	3	**15**
MW --> F --> Children left in public spaces/street --> SPS	3	0	0	0	0	4	0	**8**
MW --> F --> Children ran away from home/ street children --> SPS	4	0	0	0	0	0	11	**14**
Social assessment in the case file, Institution:								
No social assessment	0	0	0	1	3	6	3	**14**
– yes, carried out by SPAS	1	3	0	2	2	2	3	**13**
– yes, carried out by the DGASPC	1	1	0	2	3	5	4	**14**
– yes, carried out both by SPAS and the DGASPC	0	1	0	1	1	3	4	**10**
– yes, carried out by others, i.e. OPA, NGO	0	0	0	0	0	0	0	**0**
– yes, but no mention of the author	0	0	0	2	6	4	5	**17**
Quality of the social assessment, which identifies:								
Only child's and/or family's needs	0	4	0	1	3	3	3	**15**
Only services provided and/or current offer	0	1	0	1	2	2	7	**13**
Needs and services	1	1	0	2	3	2	3	**13**
Neither needs nor services	0	3	0	1	1	3	1	**10**
Who notified the DGASPC of the case:								
No info in case file	0	1	0	4	6	0	2	**13**
DGASPCs' own initiative	2	4	0	1	2	3	2	**14**
Referral from SPAS	1	2	0	1	4	1	6	**16**
Referral from other institutions	0	2	0	2	1	7	1	**13**
Notified by other people	0	0	0	1	2	1	3	**6**
Request from family	1	2	0	2	1	1	3	**11**
Request from the child	0	13	7	0	0	0	0	**20**
Who decided to place the child in public care:								
No info in case file	0	1	0	4	6	0	2	**13**
Decision of the DGASPC director	1	2	0	1	2	3	3	**12**
Presidential ordinance	0	6	0	1	0	3	3	**13**
Decision of the Child Protection Commission (CPC)	1	3	0	2	2	4	4	**16**
Court ruling	0	0	0	0	3	1	3	**8**
Number of the child's entries into the system:								
One entry	1	2	0	1	2	3	3	**12**
Multiple entries (2 to 4)	0	4	1	1	7	4	10	**27**
Siblings in public care at the time of study:								
Yes	1	2	0	1	3	2	5	**14**
No	1	2	0	2	1	4	1	**11**
A list of identified relatives up to the	1	2	0	1	2	3	4	**13**

		CP *****	CP-MEN-classical	CP-MEN-mod	CP-classical-disab	CP-classical-non-disab	CP-mod-disab	CP-mod-non-disab	**Total CP**
Total	**- N**	**100**	**337**	**27**	**243**	**394**	**464**	**592**	**2,157**
	- %	**1**	**2**	**0**	**1**	**2**	**3**	**3**	**12**
fourth degree is in the case file									
Protection measure given when the child entered the system:									
No info in case file		0	0	0	0	5	0	0	**5**
Placement		0	2	0	2	2	2	4	**12**
Emergency placement		1	2	0	1	2	3	3	**13**
Specialized supervision		0	0	0	0	0	0	0	**0**
Others****		0	0	0	0	0	0	0	**0**

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N= 17,341 children who entered special protection during 2010-2014).

Notes: CP = Placement centers; CP MEN = Former dormitories of special schools taken over from MEN; mod = modulated; disab = for children with disabilities; non-disab = for children without disabilities. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others. *****The type of CP is not known as these cases relate to old institutions that have already been closed down where children who entered the system many years ago were placed. Highlighted cells indicate statistically significant higher values.

Annex 6 Figure 13: Proportion of Children Placed in Other Residential Services in the First Stage after their Most Recent Admission in Special Protection, by Type of Service and Admission Year (% of All Children in Special Protection)



Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N=52,344 children in public care, for 1 percent of whom the service is not known).

Notes: CPRU = emergency reception centers; CM = maternal centers. Other residential services comprise day shelters and night shelters.

Annex 6 Table 44: The First PIP Goal Received by Children Entering Special Protection Starting 2005, by Various Indicators (% of Category)

	Family reintegration	Adoption	Socio-professional integration	Other PIP goals	Without a PIP	Not known	**Total**
Total - N	**27,220**	**2,550**	**1,503**	**637**	**1,161**	**769**	**33,841**
- %	**80**	**8**	**4**	**2**	**3**	**2**	**100**
Child's age at the most recent entry into the system:							
0-12 months	73	19	1	2	3	2	100
1-2 years old	82	8	2	1	3	2	100
3-6 years old	88	3	2	2	3	2	100
7-10 years old	83	2	6	2	4	2	100
11-14 years old	76	0	13	3	4	3	100
15-17 years old	62	0	32	0	4	2	100
Gender:							
Boys	81	7	4	1	4	2	100
Girls	80	8	4	2	3	2	100
Ethnicity:							
Romanian	81	6	5	2	3	2	100
Hungarian	86	3	8	1	2	0	100
Roma	83	5	2	3	5	1	100
Other	89	4	7	0	0	0	100
Undeclared	77	11	3	2	3	3	100
Area of residence:							
Urban	77	11	3	2	4	2	100
Rural	84	3	6	1	3	2	100
Somewhere in Romania or abroad	70	18	0	0	4	8	100
Type of community:							
Source communities	85	7	3	1	2	2	100
Other communities	80	8	5	2	4	2	100
Who took care of the child before entering the system:							
Unknown caretaker	69	10	6	1	7	7	100
A caretaker other than the parents who left home	80	4	7	2	6	2	100
Parent(s) at home	79	10	4	2	3	2	100
Mother and/or father + a caretaker (usually grandmother/ grandparents)	87	2	6	2	2	1	100
The child lived with siblings before entering the system:							
No	79	10	4	2	3	2	100
Yes	84	3	5	2	4	2	100
Children with special needs:	79	7	6	2	4	2	100
Children (0-17 years) with disabilities	80	4	7	3	5	1	100
Children (0-17 years) with developmental delays	80	7	6	2	3	1	100
Children (6-17 years) with SEN	68	1	17	1	11	2	100
Children (7-17 years) with behavioral problems	81	0	12	2	3	1	100
Infants (0-12 months) born premature and/or underweight	71	18	1	3	5	2	100
Causes of separation:*							
Violence against children, of which:	83	4	5	2	3	2	100
- neglect	83	4	4	2	3	2	100
- abuse	79	3	6	3	4	4	100
- exploitation	81	3	7	2	4	2	100

	Family reintegration	Adoption	Socio-professional integration	Other PIP goals	Without a PIP	Not known	**Total**
Total - N	**27,220**	**2,550**	**1,503**	**637**	**1,161**	**769**	**33,841**
- %	**80**	**8**	**4**	**2**	**3**	**2**	**100**
Child relinquishment	70	21	1	2	4	2	100
Unfortunate events**	68	4	14	0	13	1	100
Avoidable entries, of which:	85	3	6	1	2	3	100
- Child disability	79	2	8	1	8	1	100
- Social causes: individual factors	88	3	4	1	1	3	100
- Social causes: poverty, inadequate housing	85	4	7	1	0	3	100
Individual risk factors:							
Parent(s) gone abroad	87	2	3	4	3	1	100
Dysfunctional families	83	5	4	1	5	2	100
Teenage mothers when the child entered the system	77	13	0	1	8	1	100
Parental alcohol and/or drug abuse	81	4	5	3	4	3	100
Promiscuous and/or criminal behavior	84	5	4	2	2	3	100
Disability or mental health problems							
- parental	81	10	3	2	2	2	100
- other adult household member(s)	78	8	6	2	3	3	100
Structural risk factors:							
Poverty and inadequate housing	82	7	5	2	3	2	100
Benefited from ... within community, before entering the system:							
- prevention services	83	6	5	2	3	1	100
- support	80	5	5	3	6	1	100
Entry routes into the system:* **							
Not known	44	8	0	3	6	39	100
Relinquished in a MW --> SPS	69	23	1	2	3	2	100
MW --> F with stable dwelling --> SPS	84	4	6	2	3	2	100
MW --> F --> Children left home alone --> SPS	75	0	9	2	9	5	100
MW --> F with unstable accommodation or homeless --> SPS	82	5	4	1	3	4	100
MW --> F: Single mother institutionalized --> SPS	70	17	0	0	13	0	100
MW --> F --> Relatives --> SPS	86	2	4	2	3	2	100
MW --> F --> Non-relatives --> SPS	78	7	6	4	4	2	100
MW --> F --> Left in pediatric units/ other institutions --> SPS	75	14	3	1	5	2	100
MW --> F --> Children left in public spaces/street --> SPS	81	7	8	1	3	0	100
MW --> F --> Children ran away from home/ street children --> SPS	70	11	17	0	0	1	100
The case file contains a preventive service plan drawn up before the child entered the system							
Yes	85	5	4	1	2	2	100
No	76	10	5	2	4	3	100
Social assessment in the case file, Institution:							
No social assessment	64	17	2	3	5	8	100
– yes, carried out by SPAS	81	7	5	2	3	2	100
– yes, carried out by the DGASPC	80	9	3	1	4	2	100
– yes, carried out both by SPAS and the DGASPC	85	6	4	2	2	1	100
– yes, carried out by others, i.e. OPA, NGO	90	3	0	2	0	5	100

– yes, but no mention of the author	80	10	2	2	2	5	100
Quality of the social assessment, which identifies:							
Only child's and/or family's needs	79	6	4	3	5	3	100
Only services provided and/or current offer	86	6	4	1	1	2	100
Needs and services	83	5	4	2	4	2	100
Neither needs nor services	75	12	6	2	4	2	100
Number of the child's entries into the system:							
One entry	81	8	4	2	3	2	100
Multiple entries (2 to 4)	68	1	8	5	5	13	100
Siblings in public care at the time of study:							
Yes	82	7	3	2	4	2	100
No	81	7	5	2	3	2	100
A list of identified relatives up to the fourth degree is in the case file	82	9	3	2	3	1	100
Protection measure given when the child entered the system:							
No info in case file	68	12	8	1	1	10	100
Placement	82	6	6	2	2	2	100
Emergency placement	79	9	3	2	5	2	100
Specialized supervision	100	0	0	0	0	0	100
Others****	0	0	0	0	100	0	100
The first service in which was placed the child on his/her most recent admission into the system:							
Placement with relatives	87	1	6	1	2	3	100
Placement with other families/persons	78	12	5	3	1	2	100
Placement with AMP (foster carer)	73	20	1	1	3	2	100
Apartment	86	0	10	3	0	0	100
CTF - disab	91	0	6	0	3	0	100
CTF - non-disab	82	0	11	1	3	2	100
CP MEN classical	81	0	7	0	12	0	100
CP classical - disab	69	3	16	1	8	2	100
CP classical - non-disab	87	2	5	2	2	3	100
CP modulated - disab	84	8	2	4	2	0	100
CP modulated - non-disab	94	1	4	0	1	1	100
CPRU	80	2	4	3	7	4	100
CM	75	2	1	7	8	7	100

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted (N= 33,841 children who entered special protection during 2005-2014).

Notes: PIP = Individualized Protection Plan; CTF = Small group homes; CP = Placement centers; CP MEN = Former dormitories of special schools taken over from MEN; disab = for children with disabilities; non-disab = for children without disabilities; CPRU = emergency reception centeres; CM = maternal centers. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****Guardianship and others.

Annex 6 Table 45: The Sample of Children in Public Care and Their Situation as of the End of 2014 (%)

	Young 18-26 years old (born before Nov. 4, 1996) arrived in the system at the age of:				Adolescents 15-17 years old arrived in the system at the age of:				All children in public care aged 10-14 years old	All children in public care, as of Nov.-Dec. 2014
	<1 year	1-2 years	3-10 years	11+ years	<1 year	1-2 years	3-10 years	11+ years		
Left the system, of which:	39.8	41.5	50.3	49.2	4.8	4.3	6.8	5.8	5.1	13.1
Family reintegration	1.0	2.5	2.7	3.4	0.7	1.9	2.2	3.5	1.6	3.6
Adoption	0.0	0.0	0.2	0.0	0.3	0.0	0.0	0.0	1.3	1.4
Left the system upon coming of age	25.2	26.3	38.6	38.4	0.0	0.0	0.0	0.0	0.0	4.9
Transferred to institutions for adults	10.2	4.2	2.4	0.6	0.7	0.0	0.0	0.0	0.0	0.5
In prison, others	3.4	8.5	6.3	6.8	3.1	2.3	4.6	2.3	2.2	2.7
Still in the system										
Valid data sheets	46.6	44.1	38.6	36.5	77.4	84.0	76.1	82.0	80.9	72.5
Not included in the study										
Deceased children	0.0	2.5	0.2	0.6	0.0	0.4	0.0	0.0	0.1	0.2
Out of scope services	0.5	1.7	0.5	2.8	0.3	0.4	2.2	2.9	1.0	2.8
Non-responses	13.1	10.2	10.5	10.8	17.5	10.9	14.9	9.3	12.9	11.4
Total	100	100	100	100	100	100	100	100	100	100

Source: Survey of the Case Files of Children in Public Care: Sampling Lists (November-December 2014). Data are not weighted (N=8,954 children with available data sheets out of the total of 9,110 children selected from the CMTIS).

Note: The 18-26 age category includes young people aged over 26 who were still in the system.

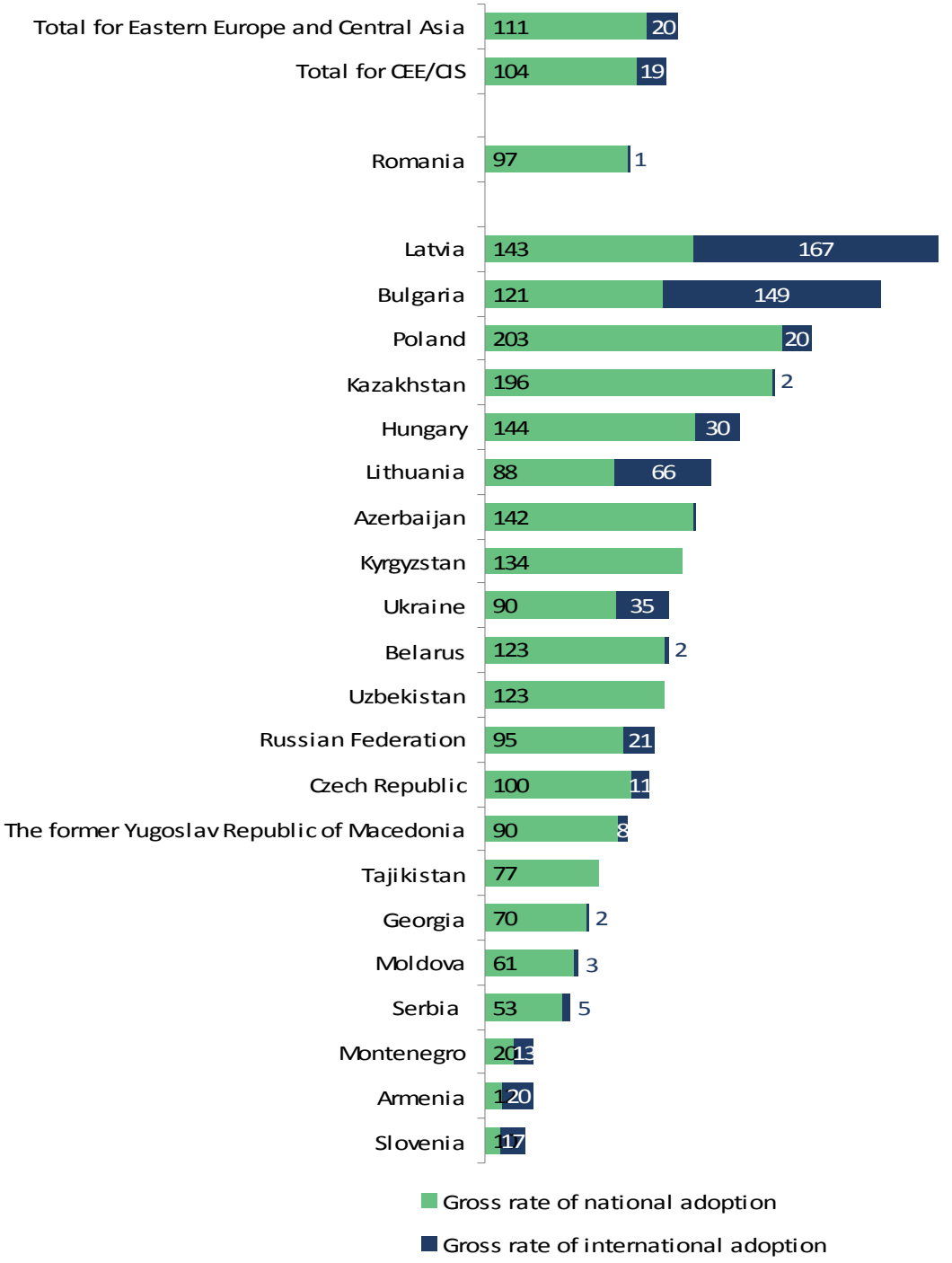
Annex 6 Table 46: "The System's Children" by Age Cohort and Health Status as of End of 2014 (Estimated Number of Children)

Age cohort as of November 2014	Arrived in the system at the age of 0-12 months old			Arrived in the system at the age of 1-2 years old			Total
	Without disability	With disability	Health status not known	Without disability	With disability	Health status not known	
<1 year old	696	48	46	0	0	0	790
1-2 years old	1,556	389	172	312	102	24	2,555
3-6 years old	1,873	899	196	1,276	414	178	4,836
7-10 years old	2,205	1,294	540	1,348	566	243	6,196
11-14 years old	2,874	1,963	642	1,309	773	261	7,822
15-17 years old	725	828	148	907	589	159	3,356
18-26 years old *	223	685	61	157	414	98	1,638
Total	10,152	6,106	1,805	5,309	2,858	963	27,193

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Note: The 18-26 age category includes young people aged over 26 who were still in the system.

Annex 6 Figure 14: Gross Rates of Adoption 2004-2013 in Eastern Europe and Central Asia, by Country (per 100,000 Children aged 0-3, During 2013)



Source: UNICEF TransMonEE 2015 (Tables 6.4.2 and 6.4.8). Data were not available for Albania, Bosnia and Herzegovina, Croatia, Estonia, Slovakia, and Turkmenistan.

Annex 6 Table 47: Participation in the Adoption Process of the Children in Special Protection by County (%)

	Children who never had adoption as PIP goal	Children with adoption as PIP goal & valid adoption form	Children with adoption as PIP goal & missing adoption form	Children with interrupted or failed adoption*	Total - %	Total - N
ARAD	91	4	1.1	3.6	100	1,948
BACĂU	87	11	0.9	1.3	100	3,389
BIHOR	92	5	2.5	0.3	100	2,884
BISTRIȚA-NĂSĂUD	94	4	0.0	2.2	100	1,067
BOTOȘANI	92	7	0.4	1.0	100	2,269
CARAȘ-SEVERIN	68	31	1.1	0.3	100	2,009
CONSTANȚA	93	2	1.9	2.7	100	1,936
COVASNA	91	9	0.6	0.0	100	2,315
DÂMBOVIȚA	82	15	0.3	2.2	100	1,831
DOLJ	60	34	2.0	4.2	100	2,235
GALAȚI	77	21	0.9	0.5	100	2,369
GORJ	96	4	0.2	0.0	100	1,212
HARGHITA	91	8	0.8	0.7	100	1,859
HUNEDOARA	92	7	0.4	0.5	100	2,635
MEHEDINȚI	77	21	0.7	0.7	100	1,611
NEAMȚ	98	0	0.8	0.4	100	1,579
OLT	90	10	0.6	0.0	100	2,151
PRAHOVA	86	14	0.2	0.0	100	2,274
SATU-MARE	87	3	6.8	3.3	100	2,363
SIBIU	81	16	2.3	0.9	100	1,457
SUCEAVA	89	9	0.7	1.1	100	3,171
VASLUI	92	5	2.0	0.4	100	2,750
VÂLCEA	89	8	2.4	1.5	100	1,431
VRANCEA	85	14	0.6	0.0	100	1,925
All 24 counties	86	11	1.3	1.1	100	50,670
Total	86	11	1.3	1.2	100	52,344

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1). PIP - Individualized Protection Plan. *The current PIP goal is usually family reintegration.

Annex 6 Table 48: Profile of the Children in Special Protection Who Entered the Adoption Process, by Various Indicators (%)

	Children who never had adoption as PIP goal	Children with adoption as PIP goal & valid adoption form	Children with adoption as PIP goal & missing adoption form	Children with interrupted or failed adoption****	Total - %
Total - N	**45,258**	**5,805**	**675**	**607**	**52,344**
- %	**100**	**100**	**100**	**100**	**100**
Child's age at the most recent entry into the system:					
0-12 months	29	70	75	70	35
1-2 years old	18	17	9	11	17
3-6 years old	25	9	9	13	23
7-10 years old	18	4	5	6	16
11-14 years old	9	0	2	0	8
15-17 years old	1	0	0	0	1
Child's age when the adoption process started:					
0-12 months	0	5	0	0	0
1-2 years old	0	16	0	0	0
3-6 years old	0	24	0	0	0
7-10 years old	0	36	0	0	0
11-14 years old	0	17	0	0	0
15-17 years old	0	1	0	0	0
Child's age at the time of study:					
0-12 months	2	1	4	0	2
1-2 years old	4	12	20	3	5
3-6 years old	10	23	23	6	12
7-10 years old	19	33	21	40	21
11-14 years old	30	29	24	30	30
15-17 years old	35	2	8	22	31
Gender:					
Boys	53	53	61	55	53
Girls	47	47	39	45	47
Ethnicity:					
Romanian	55	47	31	41	54
Hungarian	4	1	5	1	4
Roma	10	11	17	12	10
Other	0	0	1	0	0
Undeclared	30	41	46	46	31
Area of residence:					
Urban	53	76	77	80	57
Rural	46	23	17	20	43
Somewhere in Romania or abroad	1	1	6	0	1
Type of community:					
Source communities	85	88	84	92	86
Other communities	15	12	16	8	14
Current structure of child's family:					
Single father	4	1	0	3	3
Single mother	32	62	64	59	36
Nuclear family (mother and father)	29	21	17	19	28
Extended family	27	5	7	6	24
Neither parents nor extended family	8	12	12	13	8
Current education of mother:					
At most primary (4 grades)	18	24	29	29	19
At most gymnasium (8 grades)	30	23	17	23	29

	Children who never had adoption as PIP goal	Children with adoption as PIP goal & valid adoption form	Children with adoption as PIP goal & missing adoption form	Children with interrupted or failed adoption****	Total - %
Total - N	**45,258**	**5,805**	**675**	**607**	**52,344**
- %	**100**	**100**	**100**	**100**	**100**
Not known	43	44	43	37	43
Siblings in public care at the time of study:	50	46	40	54	50
Adoptable siblings at the time of study:	-	38	-	-	-
Children with special needs:					
Children (0-17 years) with disabilities	0	0	0	0	0
- at entry into the system	12	5	7	5	11
- at entry and/or at the time of study	29	29	25	29	29
- severe handicap	12	9	9	8	12
Children (0-17 years) with developmental delays	17	13	21	19	17
Children (6-17 years) with SEN	0	0	0	0	0
- at entry into the system	3	0	0	2	3
- at the time of study	2	0	0	1	1
Children (7-17 years) with behavioral problems	3	0	0	2	3
Infants (0-12 months) born premature and/or underweight	4	12	13	7	5
Causes of separation:*					
Violence against children, of which:	47	27	19	32	44
- neglect	44	26	19	26	41
- abuse	13	5	3	7	12
- exploitation	4	1	0	6	3
Child relinquishment	24	61	73	59	29
Unfortunate events**	3	2	0	0	3
Avoidable entries, of which:	26	10	8	9	24
- Child disability	5	1	3	0	5
- Social causes: individual factors	13	4	3	7	12
- Social causes: poverty, inadequate housing	8	4	2	1	7
Individual risk factors:					
Parent(s) gone abroad	7	2	5	3	7
Dysfunctional families	17	12	13	4	16
Teenage mothers when the child entered the system	4	6	7	6	4
Parental alcohol and/or drug abuse	21	11	8	10	20
Promiscuous and/or criminal behavior	10	7	12	7	10
Disability or mental health problems	16	21	25	23	16
Structural risk factors:					
Poverty and inadequate housing	36	40	29	32	36
Entry routes into the system:* **					
Not known	1	1	2	0	1
Relinquished in a MW --> SPS	19	55	69	55	24
MW --> F with stable dwelling --> SPS	55	28	17	24	51
MW --> F --> Children left home alone --> SPS	1	1	2	0	1
MW --> F with unstable accommodation or homeless --> SPS	2	2	2	2	2
MW --> F: Single mother institutionalized --> SPS	0	0	0	0	0
MW --> F --> Relatives --> SPS	12	3	3	3	10
MW --> F --> Non-relatives --> SPS	2	2	0	2	2

		Children who never had adoption as PIP goal	Children with adoption as PIP goal & valid adoption form	Children with adoption as PIP goal & missing adoption form	Children with interrupted or failed adoption****	Total - %
Total	**- N**	**45,258**	**5,805**	**675**	**607**	**52,344**
	- %	**100**	**100**	**100**	**100**	**100**
MW --> F --> Left in pediatric units/ other institutions --> SPS		7	7	5	11	7
MW --> F --> Children left in public spaces/street --> SPS		1	2	1	0	1
MW --> F --> Children ran away from home/ street children --> SPS		0	1	0	3	1
Number of the child's entries into the system:						
One entry		97	99	100	98	97
Multiple entries (2 to 4)		3	1	0	2	3
Service in which the child was placed at the time of study:						
Placement with relatives		28	2	8	2	25
Placement with other people/families		7	6	11	12	7
Placement with AMP (foster carer)		27	80	71	41	34
Apartment		4	2	1	6	4
CTF – disab		4	1	0	9	4
CTF - non-disab		10	4	3	16	10
CP MEN classical		2	0	0	2	2
CP MEN modulated		1	0	2	0	1
CP classical – disab		3	0	1	1	2
CP classical - non-disab		4	2	1	3	4
CP modulated – disab		3	1	1	2	3
CP modulated - non-disab		6	0	2	4	5

Source: Survey of the Case Files of Children in Public Care (November-December 2014). Data are weighted.

Notes: PIP = Individualized Protection Plan; CTF = Small group homes; CP = Placement centers; CP MEN = Former dormitories of special schools taken over from MEN; disab = for children with disabilities; non-disab = for children without disabilities. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family. ****The current PIP goal is usually family reintegration.

Annex 6 Table 49: The Adoptable Children by Gender, Age at Entry, Disability, and County (%)

	Gender		Child's age at entry				Disability at entry into the system and/or at the time of study		
	Boys	Girls	0 years	1-2 years	3-6 years	7-10 years	Without disabilities	With disabilities	Not known
AR	60	40	81	10	10	0	36	47	17
BC	62	38	50	35	12	2	38	57	6
BH	44	56	63	27	11	0	46	44	10
BN	38	62	100	0	0	0	48	32	20
BT	44	56	83	10	0	7	48	37	14
CS	52	48	76	9	8	7	49	45	6
CT	46	54	100	0	0	0	49	43	8
CV	56	44	75	15	10	0	58	35	7
DB	41	59	73	16	11	0	60	28	13
DJ	53	47	70	16	7	7	61	27	12
GL	44	56	55	27	12	7	63	33	4
GJ	70	30	100	0	0	0	66	25	8
HR	73	27	89	5	5	0	68	24	8
HD	47	53	74	19	7	0	69	8	23
MH	67	33	85	10	3	2	76	24	0
NT	*	*	*	*	*	*	*	*	*
OT	57	43	83	0	14	4	77	18	5
PH	64	36	79	14	3	4	79	11	11
SM	48	52	82	0	18	0	80	20	0
SB	53	47	76	15	5	3	83	5	13
SV	48	52	63	24	11	3	83	4	13
VS	48	52	70	23	7	0	90	7	3
VL	51	49	90	0	0	10	95	0	5
VN	41	59	30	30	36	4	0	0	0
All 24 counties	53	47	70	17	9	4	61	30	9
Romania	53	47	70	17	9	4	62	29	9

Source: Survey of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted.

Notes: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1). *Number of cases is too low.

Annex 6 Table 50: The Distribution of Children Who Entered the Adoption Process by the Stage They Had Reached by November-December 2014 and by County (%)

	STAGE I - Submitting the file to the adoption office	STAGE II - Opening the adoption procedure (DPA)	STAGE III - Theoretical matching (PTA)	STAGE IV - Practical matching (PPA)	STAGE V - Entrusting the child for adoption (IVA)	STAGE VI - Court approval for/ revocation of the adoption	Total - %	Total - N
AR	6	6	75	0	13	0	100	84
BC	13	23	49	0	3	12	100	345
BH	0	3	81	1	9	5	100	149
BN	0	12	24	26	0	38	100	42
BT	0	10	87	0	3	0	100	156
CS	0	10	73	15	2	0	100	624
CT	0	25	18	28	13	18	100	40
CV	8	5	72	0	0	14	100	202
DB	0	10	82	6	3	0	100	280
DJ	0	11	84	1	1	3	100	764
GL	8	8	64	5	3	13	100	478
GJ	0	6	54	23	0	17	100	48
HR	0	2	52	32	3	10	100	147
HD	0	13	65	12	10	0	100	189
MH	0	2	94	1	3	0	100	343
NT	*	*	*	*	*	*	100	6
OT	4	21	61	5	9	0	100	206
PH	4	36	56	2	0	3	100	311
SM	18	35	18	0	0	28	100	60
SB	0	19	61	15	1	5	100	231
SV	8	31	58	4	0	0	100	283
VS	21	31	15	23	10	0	100	145
VL	2	5	70	0	0	24	100	109
VN	2	15	77	0	3	4	100	276
All 24 counties	4	14	68	6	3	5	100	5,518
Romania	3	14	68	6	3	5	100	5,699

Source: Survey of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted (N=5,805 children with valid adoption forms, out of which 1 percent were in the preparation phase at the time of research and for an additional 1 percent the stage was not known).

Notes: Only the 24 counties with solid data in the CMTIS are considered (see Annex 6 Table 1). *Number of cases is too low.

Annex 6 Table 51: Profile of the Children Who Entered the Adoption Process by the Stage They Had Reached by November-December 2014 and by Various Indicators (%)

	Stages						
	I	II - DPA	III - PTA	IV - PPA	V - IVA	VI	Total
Total - N	**195**	**822**	**3,872**	**340**	**163**	**307**	**5,699**
- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Child's age at the most recent entry into the system:							
0-12 months	78	75	67	84	93	72	71
1-2 years old	17	14	19	10	7	4	17
3-6 years old	4	10	9	6	0	14	9
7-10 years old	0	1	5	0	0	10	4
11-14 years old	0	0	0	0	0	0	0
15-17 years old	0	0	0	0	0	0	0
Child's age when the adoption process started:							
0-12 months	7	8	2	11	36	10	5
1-2 years old	14	20	10	46	36	28	15
3-6 years old	46	23	23	23	21	28	24
7-10 years old	16	32	43	16	0	24	36
11-14 years old	10	14	21	3	0	9	17
15-17 years old	0	0	1	0	0	0	1
Number of years between the most recent entry and the start of the adoption process:							
- 0 years	10	9	3	18	41	25	7
- 1 year	10	21	10	22	18	26	13
- 2 years	13	7	7	21	14	4	8
- 3-5 years	23	22	24	23	14	29	23
- 6-10 years	27	28	41	16	7	10	34
- 11-16 years	10	11	15	0	0	6	12
- not known	7	3	1	0	7	0	1
Child's age at the time of study:							
0-12 months	6	3	0	0	2	1	1
1-2 years old	15	22	5	21	57	23	11
3-6 years old	42	22	18	59	28	36	23
7-10 years old	22	35	37	10	14	26	33
11-14 years old	10	18	36	10	0	13	29
15-17 years old	6	0	3	0	0	0	2
Gender:							
Boys	58	47	55	64	40	36	53
Girls	42	53	45	36	60	65	47
Ethnicity:							
Romanian	33	43	46	44	69	55	46
Hungarian	0	1	1	6	0	2	1
Roma	5	4	13	10	3	14	11
Other	63	52	40	40	29	30	42
Undeclared							
Area of residence:	83	68	74	85	90	95	76
Urban	17	30	24	8	7	6	22
Rural	0	2	1	6	3	0	1
Somewhere in Romania or abroad							
Type of community:	84	88	89	77	99	82	88
Source communities	16	12	11	23	1	18	12
Current structure of child's family:							
Single father	0	1	1	0	0	0	1

	Stages						
	I	II - DPA	III - PTA	IV - PPA	V - IVA	VI	Total
Total - N	**195**	**822**	**3,872**	**340**	**163**	**307**	**5,699**
- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Single mother	69	66	59	65	78	62	62
Nuclear family (mother and father)	18	18	22	28	16	8	21
Extended family	7	5	5	1	0	12	5
Neither parents nor extended family	6	9	13	6	6	18	12
Current education of mother:							
At most primary (4 grades)	14	20	25	28	26	22	24
At most gymnasium (8 grades)	34	25	21	32	35	37	24
Not known	45	49	45	37	38	32	44
Children from families with 3+ children	1	29	18	12	16	17	19
Siblings in public care at the time of study:	47	50	49	37	26	29	46
Adoptable siblings at the time of study:							
Yes	27	23	45	28	22	23	38
No	73	69	50	61	78	70	56
Not known	0	8	6	11	1	8	6
Number of adoptable siblings (including the child)							
One	11	12	24	10	14	13	20
Two	10	8	10	3	3	6	9
Three or more	6	2	9	13	4	4	8
Number of adoptable siblings together (as a group):							
None	7	0	4	0	1	2	3
One	6	6	20	6	9	14	16
Two	14	8	9	10	3	0	9
Three or more	0	1	4	3	0	0	3
Last connection with family or relatives up to the 4th degree after entering the system:							
There was a connection with the family	30	19	17	19	3	10	17
There was no connection (never)	60	46	65	57	90	60	62
Not known	10	35	18	24	7	30	21
If it was related to the family:							
- less than a year ago	19	11	2	3	0	1	4
- 1 year ago	6	3	3	3	0	2	3
- 2 year ago	6	3	5	6	3	0	5
- 3-5 years ago	0	3	3	3	0	4	3
- 6-13 years ago	0	0	3	3	0	4	2
Minimum number of years	0	0	0	0	*	0	0
Maximum number of years	2	4	13	6	*	6	13
Average number of years	0.6	0.9	2.9	2.3	*	3.5	2.4
Children with special needs:							
Children (0-17 years) with disabilities							
- at entry into the system	1	5	6	0	0	0	5
- at entry and/or at the time of study	21	30	35	3	0	11	29
- severe handicap	15	9	10	0	0	0	9
Children (0-17 years) with developmental delays	7	14	14	9	1	12	13

	Stages						
	I	II - DPA	III - PTA	IV - PPA	V - IVA	VI	Total
Total - N	**195**	**822**	**3,872**	**340**	**163**	**307**	**5,699**
- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Children (6-17 years) with SEN							
- at entry into the system	0	0	1	0	0	0	0
- at the time of study	0	0	0	0	0	0	0
Children (7-17 years) with behavioral problems	0	0	0	0	0	0	0
Infants (0-12 months) born premature and/or underweight	18	13	12	13	6	9	12
Causes of separation:*							
Violence against children, of which:							
- neglect	11	23	29	12	12	27	26
- abuse	0	4	5	6	0	7	5
- exploitation	0	3	0	0	0	0	1
Child relinquishment	64	57	60	77	85	62	61
Unfortunate events**	0	9	8	0	5	7	7
Avoidable entries, of which:	25	15	8	10	4	12	10
- Child disability	0	2	1	3	0	0	1
- Social causes: individual factors	17	4	4	1	1	10	5
- Social causes: poverty, inadequate housing	7	9	3	6	3	2	4
Individual risk factors:							
Parent(s) gone abroad	0	1	1	0	1	8	2
Dysfunctional families	11	7	11	16	12	30	12
Teenage mothers when the child entered the system	14	3	5	8	14	8	6
Parental alcohol and/or drug abuse	4	10	12	6	3	6	11
Promiscuous and/or criminal behavior	0	8	7	4	4	10	7
Disability or mental health problems	41	19	21	22	16	15	21
Structural risk factors:							
Poverty and inadequate housing	32	49	39	44	40	30	40
Benefited from ... within community, before entering the system:							
- prevention services	28	28	20	46	43	46	25
- support	6	10	8	16	19	8	9
The case file contains a preventive service plan drawn up before the child entered the system	29	28	23	43	33	52	27
Entry routes into the system:***							
Not known	6	1	0	0	0	0	1
Relinquished in a MW --> SPS	60	52	53	71	81	57	55
MW --> F with stable dwelling --> SPS	30	27	29	13	16	29	28
MW --> F --> Children left home alone --> SPS	0	4	0	0	0	0	1
MW --> F with unstable accommodation or homeless --> SPS	0	2	1	6	0	0	2
MW --> F: Single mother institutionalized --> SPS	0	1	0	0	0	0	0
MW --> F --> Relatives --> SPS	0	5	3	0	0	0	2
MW --> F --> Non-relatives -->	0	0	2	3	0	7	2

		Stages						
		I	II - DPA	III - PTA	IV - PPA	V - IVA	VI	Total
Total	**- N**	**195**	**822**	**3,872**	**340**	**163**	**307**	**5,699**
	- %	**100**	**100**	**100**	**100**	**100**	**100**	**100**
SPS								
MW --> F --> Left in pediatric units/ other institutions --> SPS		4	5	8	6	0	7	7
MW --> F --> Children left in public spaces/street --> SPS		0	1	2	0	3	1	2
MW --> F --> Children ran away from home/ street children --> SPS		0	1	0	0	0	0	0
Number of the child's entries into the system:								
One entry		100	98	99	100	101	100	99
Multiple entries (2 to 4)		0	2	1	0	0	0	1
Service in which the child was placed at the time of study:								
Placement with relatives		0	3	1	1	1	18	2
Placement with other people/ families		3	7	5	3	22	17	6
Placement with AMP (foster carer)		88	85	80	96	77	58	80
Apartment		0	0	3	0	0	0	2
CTF – disab		0	1	2	0	0	0	1
CTF - non-disab		9	1	5	0	0	6	4
CP MEN classical		0	0	0	0	0	0	0
CP MEN modulated		0	0	0	0	0	0	0
CP classical - disab		1	0	0	0	0	0	0
CP classical - non-disab		0	3	3	0	0	0	2
CP modulated - disab		0	0	1	0	0	0	1
CP modulated - non-disab		0	0	0	0	0	2	0

Source: Survey of the Case Files of Children in Public Care: Adoption Form (November-December 2014). Data are weighted.

Notes: PIP = Individualized Protection Plan; CTF = Small group homes; CP = Placement centers; CP MEN = Former dormitories of special schools taken over from MEN; disab = for children with disabilities; non-disab = for children without disabilities. *See Infograph Chart 4 and Chapter 3.2.7. **Unfortunate life events refer to the death or institutionalization of the parent/parents. ***SPS = Social Protection System; MW --> F = Maternity ward --> Family.

Annex 6 Table 52: The Relationship between the Number of Children in Public Care and the Number of Children Still Living in the Household (for Sampled Mothers who Could be Identified in the Selected Communes) in Rural Source Communities (% of Total)

Number of children under 18 years who are still separated	Number of children living with their mothers in households					Total	
	0	1	2	3	4+	%	N
1	28	13	10	10	10	71	317
2	8	2	3	1	2	17	74
3	3	1	1	0	1	6	28
4+	4	1	0	0	0	6	26
Total	44	18	13	11	14	100	445

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 53: Is There Any of the Following within a Radius of 200 Meters of the Household? (% of Households in Rural Source Communities)

	% households with the particular problem			% households with the particular problem		
	Village without RMA	Village with RMA	Total	Village without RMA	Village with RMA	Total
	100	100	100			
a. One or more inhabited houses	2	6	4	22	78	100
b. A forest	19	24	22	44	56	100
c. A garbage pit	4	5	4	44	56	100
d. A river, brook, pond	14	24	19	38	62	100
e. Derelict buildings, ruins	8	15	11	34	66	100
Any of the above	28	39	33	42	58	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: RMA = Rural marginalized area.

Annex 6 Table 54: The Quality of Child Nutrition and Incomes as Reported by Households with Children in Rural Source Communities (%)

	Total households	Households with sampled mothers	Households with sampled mothers living with children	Households with sampled mothers with no children at home	Total children	Children of the sampled mothers
Households that in the last six months had no food to put on the table at least ...						
- once every week	12	15	13	18	14	13
- several times per month	23	29	26	34	26	27
Households that in the previous two weeks had provided their children with...						
- only one meal a day	8	10	8	15	8	6
- only two meals a day	40	43	42	45	44	44
Households' own assessment of their incomes:						
- not enough to cover the minimum necessities	57	68	68	68	62	68
- enough only to cover the minimum necessities	32	24	25	23	29	25
- enough for a decent living but not enough for more expensive goods/services	10	7	7	6	8	7
- enough for more expensive goods/services but with restrictions in other areas	1	1		2	1	0
- We manage to have everything we need without any restrictions	0	0	0	1	0	0
Total - %	100	100	100	100	100	100
- N	834	519	331	188	1,316	818

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 55: The Ways in which Clothes for Children are Acquired by Households in Rural Source Communities with At Least One Child in Public Care and At Least One Child at Home (%)

		Households with children at home	Total children	Children of the sampled mothers
New clothes bought from stores		39	30	25
Clothes bought from second-hand stores		31	37	38
Clothes received from relatives, neighbors, other people		27	29	33
Other ways		2	4	4
Total	- %	100	100	100
	- N	585	1,319	811

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 56: Family Support with Homework and Learning Outcomes for Children Enrolled in School in Households in Rural Source Communities with At Least One Child in Public Care and At Least One Child at Home (%)

	How often do you know how to help your child with their homework?			
	Never	Sometimes	Most of the time/ Always	Total
Children 7+ years old who do not attend school every day	24	12	3	15
Children 7+ years old who have repeated at least a year out of all children enrolled in school	22	19	12	19
Children 6-10 years old who do not attend school every day	21	10	6	13
Children 6-10 years old who have repeated at least a year out of all children enrolled in school	15	10	6	11
Children 11-14 years old who do not attend school every day	24	13	0	15
Children 11-14 years old who have repeated at least a year out of all children enrolled in school	22	22	18	21

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: Out of the children aged 7+ who go to school and have parents or caretakers who never help them with homework, 24 percent do not attend school every day and 22 percent have repeated at least a year.

Annex 6 Table 57: Parental Behavior in the Households in Rural Source Communities with At Least One Child in Public Care and At Least One Child at Home (% of Parents/Caretakers)

How often …	Never	Some-times	Most of the time	Always	Total-%	Total-N
Households:						
Know how to help children with their homework	35	40	15	9	100	418
Spend a lot of time with their children doing what the children like	10	45	30	15	100	515
Are aware of things that can harm the children	5	31	40	25	100	510
Lose their temper when disciplining their children	59	34	5	2	100	513
Use physical correction to discipline their children	68	26	4	3	100	518
Believe that their children do not behave specifically to annoy them	64	29	5	3	100	506
Households with sampled mothers living with children:						
Know how to help children with their homework	39	39	16	5	100	185
Spend a lot of time with their children doing what the children like	10	50	29	11	100	234
Are aware of things that can harm the children	5	38	36	21	100	230
Lose their temper when disciplining their children	48	42	9	2	100	233
Use physical correction to discipline their children	62	29	5	3	100	235
Believe that their children do not behave specifically to annoy them	56	35	5	3	100	232

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 58: Self-reported Receipt of Social Benefits or Other Type of Aid by Households in Rural Source Communities with At Least One Child in Public Care, by Type of Income and Type of Benefit, (% of Households)

	Households that received during the previous year:			**Households with children that received during the previous year:**		
Monthly income per capita (lei)	GMI, family allowance, heating aid	Other benefits	Any type of aid	GMI, family allowance, heating aid	Other benefits	Any type of aid
0-100	67	35	73	71	37	76
101-150	72	50	79	76	52	82
151-200	58	50	71	68	54	75
201-540	44	39	50	48	44	53
541-max	45	11	45	47	21	47
Total	59	40	65	64	43	70

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 59: How Often Mothers or Carers in Households with At Least One Child in Public Care and At Least One Child at Home Talk with a SPAS Social Worker by Cause of Separation as Stated by Mothers/Carers (% of Households with Separated Children in Rural Source Communities)

	Monthly	Once every 2-3 months	Once every 5-6 months	Once a year or less	Not at all	Total %	Total N
Unfortunate events:							
1. Death of a parent, divorce/separation, single parent	13	30	8	13	38	100	40
4. Imprisoned parent(s)	15	5	10	25	45	100	20
Child neglect, abuse:							
8. Child neglect	21	7	25	14	32	100	28
21. Child relinquished in health units	9	27	36	18	9	100	11
Individual (parental) risk factors:							
3. Mother abandoned the family/deserted the home	11	20	11	20	37	100	54
30. Father abandoned the family/deserted the home	0	28	22	22	28	100	18
2. Parents left to work abroad	9	30	13	13	35	100	23
19. Alcohol abuse of one or more adults of the household	27	18	0	18	36	100	11
15. Disability of the parent(s), including mental health problems	32	24	24	0	20	100	25
22. Teenage mother	13	39	17	4	26	100	23
Child's special needs:							
14. Disability of the child	18	36	14	20	11	100	44
Structural risk factors:							
7. Households with a monthly income per capita of max. 400 lei	32	16	11	11	32	100	19
6. Poor housing conditions or homeless	16	24	19	20	21	100	85
16. Family with 4 or more children	13	25	31	13	19	100	16

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: The following causes of separation were mentioned by fewer than 10 respondents: deprivation of parental rights, physical abuse of the child, emotional abuse of the child, child relinquished in public spaces or street child, and antecedents (other siblings in public care).

Annex 6 Table 60: The Proportion of Mothers in Households with At Least One Child in Public Care Who Talked with a SPAS Social Worker Once a Year or Less, by Cause of Separation Stated by Mothers/Carers (% of Mothers with Separated Children in Rural Source Communities)

	Mothers with separated children		Mothers with separated children and at least one child at home	
	%	Total N	%	Total N
Unfortunate events:				
1. Death of a parent, divorce/separation, single parent	42	19	56	9
4. Imprisoned parent(s)	25	16	25	12
Child neglect, abuse:				
8. Child neglect	19	37	38	13

	Mothers with separated children		Mothers with separated children and at least one child at home	
	%	Total N	%	Total N
21. Child relinquished in health units	45	11	38	8
Individual (parental) risk factors:				
3. Mother abandoned the family/deserted the home	54	13	50	8
30. Father abandoned the family/deserted the home	31	13	38	8
2. Parents left to work abroad	40	10	50	4
15. Disability of the parent(s), including mental health problems	56	27	60	10
22. Teenage mother	47	15	50	10
Child's special needs:				
14. Disability of the child	55	53	57	30
Structural risk factors:				
Structural risk factors:	42	19	57	14
7. Households with a monthly income per capita of max. 400 lei	37	100	41	61
6. Poor housing conditions or homeless	42	12	36	11

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: The following causes of separation were mentioned by fewer than 10 respondents: deprivation of parental rights, physical abuse of the child, emotional abuse of the child, child relinquished in public spaces or street child, antecedents (other siblings in public care), and alcohol abuse by one or more adults of the household.

Annex 6 Table 61: How Often Mothers/Carers in Households with At Least One Child in Public Care and At Least one Child at Home Talk with a SPAS Social Worker, by the Type of Specialization of the Social Worker (% of Households with Separated Children in Rural Source Communities)

Communes served by at least one SPAS staff with social assistance duties who graduated from higher education with a specialization in …	Monthly	Once every 2-3 months	Once every 5-6 months	Once a year or less	Not at all	Total %	Total N
Social assistance or sociology	13	30	16	21	20	100	153
Psychology	19	22	4	7	48	100	27
Economy or law	12	34	14	11	29	100	76
Other specialization	29	16	17	13	25	100	104
No university degree	15	17	17	15	36	100	118

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 62: How Often Mothers/Carers of Children in Households with At Least One Child in Public Care and At least One Child at Home Talk with a SPAS Social Worker, by Village Characteristics and the Location of the Household within the Village (% of Households with Separated Children in Rural Source Communities)

	Monthly	Once every 2-3 months	Once every 5-6 months	Once a year or less	Not at all	Total %	Total N
Village characteristics:							
Villages with marginalized rural areas	16	26	17	15	26	100	272
Villages without marginalized rural areas	15	21	18	18	29	100	274
Peripheral villages within the commune	9	25	19	15	32	100	280
Central villages within the commune	22	21	16	18	23	100	267
Location of household within the village:							
1. In the center of the village	24	30	16	11	19	100	103
2. Between the center and the outskirts	17	29	16	11	27	100	150
3. At the outskirts or outside of the village	11	19	18	20	32	100	303

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 63: How Often Mothers/Carers of Children in Public Care Talk with a SPAS Social Worker, by the Presence of Sampled Mother (% of Households in Rural Source Communities)

Household comprises:	Monthly	Once every 2-3 months	Once every 5-6 months	Once a year or less	Not at all	Total %	Total N
Mothers with separated minors and other children in the household	17	24	20	18	21	100	309
Mothers with separated minors and no other children in the household	9	29	17	12	32	100	116
Mothers with no separated minors and with other children in the household	21	29	10	14	26	100	58
Other households with children	11	21	14	14	40	100	189

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 64: Mothers of Children in Public Care from Rural Source Communities Who Talked with a SPAS Social Worker At Least Once Every Two to Three Months, by Various Indicators (% of Mothers)

	Mothers with separated children	Mothers with separated children and at least one child at home	Mothers with separated children and with no other children in the household
Type of specialization of the SPAS social worker within the commune:			
University degree in social assistance or sociology	44	40	53
University degree in psychology	47	46	50
University degree in economy or law	46	50	35
University degree in other specialization	48	53	37
No university degree	27	31	14
Village characteristics:			
Villages with marginalized rural areas	37	41	26
Villages without marginalized rural areas	44	41	51
Location of household within the village:			
1. In the center of the village	58	61	52
2. Between center and outskirts	49	52	43
3. At the outskirts or outside of the village	30	30	29
Problems with dwelling such as roof leaks, damp walls, rotten/damaged floors or windows etc.			
Yes	32	31	34
No	49	51	43
Mother's level of education:			
No school, illiterate	34	35	30
Primary (1-4 grades)	35	36	32
Gymnasium (5-8 grades)	51	51	50
Above gymnasium	48	50	45
Mother's age at the time of study:			
15-24 years old	55	59	45
25-34 years old	39	42	27
35-44 years old	38	38	37
45+ years old	42	38	50
Child's age at the last separation of at least one separated child from family:			
0-1 years old	42	42	42
2-5 years old	43	50	30
6-17 years old	51	58	42
The mother has children in the household:			
No	35	26	39
Yes	44	44	
At least one child is separated for less than two years:			
No	39	40	35
Yes	48	46	50

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 65: Children's Age at their Last Separation from their Family, in Rural Source Communities (%)

	0 years old	1-2 years old	3-5 years old	6-9 years old	10-17 years old	Total
Total sample of separated children	46	17	12	17	7	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 66: Share of Children Who Interacted with Their Parents or Carers Since Entering Public Care, by Age at the Time of Their Last Separation, and by Presence of the Mothers in the Surveyed Households (%)

Type of interaction of the separated child with his or her parent/carer	Child's age when last separated from the mother to be taken care of by someone else					
	0	1/2	3/5	6/9	10/max	Total
Children whose mothers still live in the surveyed households:						
The child came to visit the parent/carer	10	17	14	39	48	18
The child was visited by the parent/carer	33	33	43	57	58	39
The child and the parent/carer met by chance	0	1	2	0	0	1
The child was not seen by the parent/carer, but they spoke on the phone	2	2	2	1	0	2
The child had not been seen or spoken to by parent/carer	59	53	45	32	24	51
Children whose mothers are no longer living in the surveyed households:						
The child came to visit the parent/carer	9	16	13	15	19	13
The child was visited by the parent/carer	34	38	33	41	50	38
The child and the parent/carer met by chance	2	2	2	0	0	1
The child was not seen by the parent/carer, but they spoke on the phone	2	5	0	0	0	2
The child had not been seen or spoken to by the parent/carer	61	51	60	56	50	57

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 67: Frequency of Interactions with Separated Children in the Previous Year According to the Statements of Mothers or Carers, in Households in which the Sampled Mothers Still Live (%)

In the last year, the parent/carer …	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
a. Visited the children	10	6	9	5	69	100
b. Contacted them by phone	10	5	6	2	77	100
c. Sent them parcels	6	3	2	1	88	100
d. Took them on holiday	5	3	5	2	85	100
Any of the above	14	6	10	4	66	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 68: Route of the Separated Children from Rural Source Communities After the Last Separation from their Family and Before Entering Public Care (%)

	%
Maternity ward --> Special Protection System	71
Grandparents	20
Relatives other than grandparents	4
Other families/ persons	3
Others	2
Total	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 69: Self-reported Frequency of Contact between Mothers/Carers and Their Separated Children in the Previous Year, by the Route Before Entering Public Care and by the Presence of the Mothers in the Surveyed Households (%)

	Frequency with which separated children were contacted by their mothers/carers in the previous year					
	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
Total households with separated children:						
Maternity ward --> Special Protection System	9	6	10	5	70	100
Other routes *	21	7	10	4	58	100
Children in households where mothers are present:						
Maternity ward --> Special Protection System	11	5	10	5	70	100
Other routes *	32	10	12	3	43	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Note: *See Annex 6 Table 68.

Annex 6 Table 70: Self-reported Frequency of Contact between Mothers/Carers and Their Separated Children in the Previous Year, by Household Income per Capita and by the Presence of the Mothers in the Surveyed Households (%)

	Frequency with which separated children were contacted by their mothers/carers in the previous year					
Monthly household income per capita (lei)	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
Total households with separated children:						
0/100	9	6	13	6	67	100
101/150	9	7	9	7	68	100
151/200	14	14	8	2	62	100
201/540	14	3	9	5	70	100
541/max	28	6	0	4	62	100
Total	12	6	10	5	67	100

Monthly household income per capita (lei)	Frequency with which separated children were contacted by their mothers/carers in the previous year					
	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
Children in households where mothers are present:						
0/100	10	7	13	5	66	100
101/150	7	6	11	6	69	100
151/200	15	6	9	3	67	100
201/540	23	5	10	4	59	100
541/max	34	6	0	0	60	100
Total	14	6	11	4	65	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 71: Self-reported Frequency of Contact between Mothers/Carers and Their Separated Children in the Previous Year, by the Characteristics of the Mothers Still Present in the Surveyed Households (%)

Characteristics of mothers present in the surveyed households	Frequency with which separated children were contacted by their mothers in the previous year					
	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
Household lived in a village:						
- without marginalized areas	22	3	12	4	59	100
- with marginalized areas	7	8	8	4	73	100
Mother was in public care during childhood:						
- yes	18	6	13	5	57	100
- no	14	6	10	4	65	100
Mother's level of education:						
Primary (4 grades) at most	6	5	14	5	70	100
Gymnasium (5-8 grades)	20	7	11	6	55	100
Above gymnasium	22	7	11	2	57	100
Mother has a child of her own in the household:						
- at least one child	12	4	11	6	67	100
- none	16	8	9	3	65	100
Mother with disabilities:						
- yes (or suspect of)	11	8	10	2	69	100
- no	14	6	11	5	65	100
Mother had a stable relation-ship at the time of study:						
- yes, stable relationship	17	6	12	5	60	100
- no	9	5	7	3	75	100
Mother had a relationship at the time of the separation:						
- yes, with the child's father	16	5	13	5	61	100
- yes, other than the father	15	3	7	3	73	100
- no	12	9	7	5	68	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 72: Self-reported Frequency of Contact between Mothers/Carers and Their Separated Children in the Previous Year by the Number of Years Since the Last Separation in those Households in which the Sampled Mothers Still Live (%)

The period (number of years) since the last separation	Frequency with which separated children were contacted by their mothers/carers in the previous year					
	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
0/1 year	21	11	11	7	51	100
2/5 years	24	9	6	4	57	100
6+ years	12	3	14	5	67	100
Total	16	6	11	5	62	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 73: Separated Children Whose Mothers or Carers Have Interacted with Someone Competent to Support Family Reintegration, in Households in which the Sampled Mothers Still Live (%)

	%
1. Yes, with someone from the DGASPC	43
2. Yes, with the SPAS staff with social assistance duties	51
3. Yes, with a NGO representative	0.5
4. Yes, with someone else	4
5. No, with no one	34

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 74: Self-reported Frequency of Contact between Mothers/Carers and Their Separated Children in the Previous Year, by the Type of Specialist with Whom the Mothers or Carers Talked After Separation in Households in which the Sampled Mothers Still Live (%)

Mother or carer talked about the separated child with ...	Frequency with which separated children were contacted by their mothers/carers in the previous year					
	Weekly/ several times per month	Once a month	Several times a year	Once a year	Rarely or not at all	Total
Someone from the DGASPC	28	8	11	14	39	100
The SPAS social worker/ staff with social assistance duties	33	13	8	4	42	100
No one	6	3	10	4	78	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 75: Logistic Regression Models Predicting the Lack of Interactions in the Previous Year with Separated Children from Households in which the Sampled Mothers Still Live

	Odds report			
	Model 1	Model 2	Model 3	Model 4
Child's age at the last separation: "0-1 years old" *versus* "6+ years old"	4.3***	3.2***	3.5***	3.4***
Child's age at the last separation: "2-5 years old" *versus* "6+ years old"	2.4***	2.1**	2.1**	2.3**
Household lived in a village: "with marginalized areas" *versus* "without marginalized areas"		1.5*	1.7**	1.6**
Mother's level of education: "Max. 4 grades" *versus* "More than 4 grades"		1.5	1.6*	1.5
Relationship of the mother at the time of the study: "No stable relationship" *versus* "A stable relationship"		1.7**	2***	1.8**
Relationship of the mother at the time of the separation: "Yes, with a man other than the child's father " *versus* "With the child's father/No"			2.1*	2.1*
Mother talked with a specialist after separation about the child: "Yes" *versus* "No"				2.2***
Pseudo R2	0.058	0.060	0.080	0.101
N	535	373	351	351

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 76: Percentage of Separated Children with Mothers Still Living in the Household Who Would Like to Take Them Back, by Characteristics of the Children and Mothers

		Would you like to take the child back?			
		Yes, I would take him/her back any time	Yes, but I cannot take him/her back now	No, I don't want to take him/her back	Total
Child's age at the last separation (years old)	0-1	14	20	66	100
	2-5	18	32	50	100
	6-17	22	31	47	100
Period since the last separation (number of years)	0-1	21	29	51	100
	2-5	18	28	54	100
	6+	14	22	64	100
Mother had a stable relationship at the time of study	Yes	18	26	56	100
	No	9	16	74	100
Mother had a relationship at the time of the separation	Yes, with the child's father	18	25	58	100
	Yes, with other man	20	16	64	100
	No	7	18	75	100
Mother talked with a specialist after separation about the child	Yes	16	26	57	100
	No	13	16	71	100
Mother's level of education	Max. 4 grades	22	26	52	100
	5-8 grades	13	27	60	100
	More than 8 grades	26	22	51	100

		Would you like to take the child back?			
		Yes, I would take him/her back any time	Yes, but I cannot take him/her back now	No, I don't want to take him/her back	Total
Household monthly income per capita (lei)	0/100	16	27	58	100
	101/150	11	20	68	100
	151/200	14	10	76	100
	201/540	12	30	58	100
	541/max	34	21	45	100

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 77: Reasons Mentioned by the Mothers Still Living in the Household for Their Low Expectations of Reintegrating with Their Children in Public Care (%)

	Total children with low or very low chances of reintegration	Children with mothers who would take them back any time	Children with mothers who cannot take them back now or who don't want to take them back
Inadequate housing conditions	62	49	65
Household incomes too low	49	41	51
Large number of children already living in the household	29	19	30
The separated child has a serious health condition and the family could not take care of hin or her	15	8	16
Mother and/or father and/or other household members are too ill to take care of the child	5	3	5
The child would not want to return	16	27	15
Other reasons	10	5	11
Total N	473	37	418

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

Annex 6 Table 78: Estimates by Mothers/ Carers of the Time Until the Child Will Be Able to Return Home (%)

Estimated time until the child can return home, according to the mothers or carers	Total children with medium, good or very good chances of reintegration	Children with mothers who would take them back any time	Children with mothers who cannot take them back now
One month	5	10	
3 months	2	3	
6 months	2	3	
9 months	2		6
12 months	4	7	
24 months	4		6
48 months	2	3	
Don't know, cannot estimate	73	67	78
Over 3 years	7	7	11
Total	100	100	100
N	56	30	18

Source: Survey of Households with Children in Public Care in Rural Source Communities (July-August 2015). Data are not weighted.

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