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The challenge of reforming child protection in Eastern Europe: The cases of Hungary and Romania

Roxana Anghel[a], Maria Herczog[b], and Gabriela Dima[c]

[a]*Anglia Ruskin University, UK*
[b]*Eszterházy Károly College, Hungary*
[c]*Transylvania University, Romania*

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ABSTRACT

This paper discusses the challenges of reforming the child welfare and protection systems in Hungary and Romania –two countries in transition from socialism to capitalism– and the impact on children, young people, families, and professionals. Brief overviews of the social, political, and economic characteristics of the two countries and of the evolution of their child welfare systems set the context of discussion. The focus is on the efforts made to deinstitutionalise children from large institutions, develop local prevention services, and develop alternatives to institutional care. The two countries had different starting points in transforming the child protection system: Romania started only after 1989 under political and economic pressures with little internal initiative, whilst Hungary begun in the mid 1980s, being more advanced than other transition countries in developing alternative services. Whilst statistical data show a decline in the care population and a shift between institutionalisation and foster care, demonstrating progress and change, the slow implementation of the reforms generate wide gaps between the UNCRC-based legislation and national plans and the quality of life and wellbeing of children. Among the factors causing this discrepancy are: insufficient financial investment, lack of professionalization and accountability, and underuse of research and evaluation to clarify the link between services and needs.

El reto de reformar la protección de la infancia en Europa del Este: Los ejemplos de Hungría y Rumanía

Palabras clave:
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Desinstitucionalización
Europa Central y del Este
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RESUMEN

Este artículo aborda los retos de la reforma de los sistemas de bienestar y protección de la infancia en Hungría y Rumanía –dos países en transición del socialismo al capitalismo– y la repercusión en los niños, jóvenes, familias y profesionales. El contexto del debate lo constituye una breve revisión de las características sociales, políticas y económicas de ambos países y de la evolución de sus sistemas de bienestar infantil. El énfasis se pone en los esfuerzos realizados para desinstitucionalizar a los niños de las grandes instituciones y desarrollar servicios locales de prevención y alternativas a la asistencia institucional. Los dos países tenían puntos de partida diferentes a la hora de transformar el sistema de protección de la infancia. Rumanía solo comenzó después de 1989, bajo presiones políticas y económicas, con escasa iniciativa interna, mientras que Hungría comenzó a mediados de los años 80, estando más avanzada en el desarrollo de servicios alternativos que otros países en transición. A pesar de que los datos estadísticos muestran un descenso en la población objeto de asistencia y un cambio de la institucionalización al acogimiento familiar, lo que demuestra avance, la lenta aplicación de las reformas da lugar a grandes desfases entre la legislación inspirada en la UNCR y los planes nacionales y la calidad de vida y bienestar de los niños. Entre los factores que explican esta discrepancia se encuentra la deficiente inversión, la falta de profesionalización y fiabilidad y el escaso uso de la investigación y evaluación para esclarecer el vínculo entre servicios y necesidades.

e-mail: Roxana.anghel@anglia.ac.uk

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This article updates previous work (Anghel & Dima, 2008; Gavrilovici, 2009; Herczog, 2008), which described and analysed the child welfare and protection systems in Hungary and Romania up to the financial crisis of 2008. As elsewhere in Europe, the financial crash has impacted severely on the countries' investment in social welfare and on the overall approach to providing care and prevention services. In the field of child protection, Central and Eastern European (CEE) countries currently deal with a number of common priority areas. For over fifteen years, spurred on by focus of European and United Nations (UN) agendas, CEE countries share the challenges of deinstitutionalising children from large institutions, working on ways to prevent separation from families by providing local services alternative to institutional care. There are an estimated 1.3m children in public care, including 600,000 children in institutions across CEE and the former Soviet Republics (Feuchtwang, 2005, cited in Carter, 2005). Despite ample resources and policies being drawn by member states and outside donors, progress is perceived as slow (Bellamy & Santos-Pais, 2007). The gap between government pledges, actual implementation and positive impact on children's lives has been observed to be significant. In effect, in the past 15 years it has been estimated by Everychild that the number of children entering institutions in the region has been rising in real terms, albeit by 3% (Carter, 2005). In this article we explore the conditions under which these reforms have taken place in CEE by looking at the cases of two neighbouring countries in Eastern Europe: Hungary and Romania. We begin by laying out the political, financial, institutional, and social contexts to understand the challenges each country is facing, the changes achieved, and the context within which families, children and young people live and experience transitions. We will then give an account of the history of the child welfare and protection systems in the two countries, based on current available statistical information about the care population and the services provided, and on the latest research evidence depicting achievements and tensions on the ground.

CEE countries are often grouped together based on their common political experience between 1945 and 1989, although they have diverse historical, economic, linguistic, and cultural backgrounds. For the past twenty years since the fall of communism, these countries have had similar tasks: to develop a multi-party democratic political system, to adopt the principles of a free market economy in order to bring their economies to internationally competitive levels, and to empower the population to make free choices at individual and community levels. Their common goals have been to join the EU, develop economically, reach higher living standards comparable to those in Western countries, increase consumption, modernise the infrastructure, and integrate into the wider political arena and make political and economic alliances. The challenges were also similar: struggling with limited resources or the ability to absorb the resources transferred by external donors, lacking the know-how yet needing to implement change rapidly, whilst being largely disempowered in decision-making by being dependent on donors who pushed reform despite hardship and significant negative social impact. More recently, fast growing gaps between different groups in the society, increasing poverty and social problems, discrimination, prejudice, xenophobia, and political extremism are raising serious concerns in the region.

Hungary and Romania share a border to the east of Hungary. They are located at the central-eastern part of Europe between Ukraine and Austria. Romania is a medium size country with a population of 20.1, while Hungary has almost 10m citizens. Administratively, they are divided into 41 and 19 decentralised counties respectively, and the capital city. Both countries are largely ethnically homogenous with only few minorities such as the Roma (7% in Hungary and 3.08% in Romania) (National Institute of Statistics, 2011, Table 8), whilst in Romania 6.6% of the population is Hungarian. Both countries are parliamentary-representative democratic republics and members of the EU, Romania achieving this status in 2007, three years after Hungary. Currently, both countries are run by coalition governments; Romania by a mixed cabinet of centre-right and centre-left social democrat and liberal politicians, and Hungary by centre-right conservatives and Christian democrats. This mix makes it difficult to categorise the social welfare model of these countries. Analysing the situation prior to the financial crisis based on the size of social welfare expenditure, transition shock, redistributive nature of social transfers, and ethnic heterogeneity, Beblavý (2008) suggested that there is a significant distance between the welfare status of CEE countries and the EU-15 countries. In his analysis Hungary had a 'light conservative' welfare model, while Romania was in an unclear position between 'light liberal' and 'light conservative'. The unclear status of Romania's welfare has been observed also by Fenger (2005) who suggested that it fits a 'developing type'. Hungary has had no major welfare reform as none of the political parties attempted to introduce a comprehensive program in health or social welfare. However, as elsewhere in Europe, the current neo-liberal influence, requiring funding cuts and shrinking of the public sector, is significant to a degree that it could be argued that the government's political ideology is less relevant to the country's welfare policy. Whilst this affects the availability of much needed support to vulnerable groups the two countries are also grappling with corruption, bureaucracy, lack of coordination across ministries, insufficient collaboration between state and the non-governmental organisations representing the civil society, and growing levels of poverty.

Economically, Romania and Hungary had uneven starting points at the beginning of the transition to free market economy and democracy. By 1989 Romania had no foreign debt but very poor infrastructure and resources having emerged from an oppressive and exploitative regime, which strained the country economically and psychologically. Hungary, the "happiest barrack", had very high foreign debt and critical financial and economic situations because the increasing consumption and the costs of a "premature welfare state" (Kornai, 1992) were not backed by enough economic achievements, despite the presence for decades of a limited private and semi-private sector. Currently, both countries have fragile economies and have experienced similar paths of development. In Romania there was slow growth in the 1990s, followed by a period of sustained growth between 2000 and 2008, facilitated by external investment and by financial support from the IMF, the World Bank, and structural funds from the EU. During this time Romania's poverty levels dropped dramatically from 36% to 5.7% (World Bank, 2013). Hungary experienced fast development from 1993 until 2000. However, after 2008 the slowdown and the structural problems have been tackled ineffectively causing child poverty disproportionate to the poverty of the entire population. The 2008 financial crash has destabilised both countries, which required large emergency fund packages from the IMF and the EU.

Romania's inflation rate is the highest in Europe (Eurostat, 2013). In Hungary the overwhelming political victory of the current government drives drastic political and economic changes with the aim to decrease the debt to less than 3% 'at any price' (Hirek, 2013). This contributes to low investment in public services such as health, education, and social welfare and protection. For example, in 2012 Romania invested just under 6% in health care which is the lowest among the EU-27 (Eurostat, 2013), whilst Hungary's investment was also low at 7.3% (Central Intelligence Agency). Expenditure on education in Romania (4.2%) is half that of Denmark (8.7%), whilst Hungary is approaching the EU average at 5.4%. This, and low educational quality, affects the achievement in the two countries compared to most European nations, which has implications for employment. Persons with lower education are more likely to be economically inactive and at risk of poverty (Eurostat, 2013). Employment rates in Romania (58.5%) and Hungary (55.8%) are among the lowest in Europe, the most affected being women with

children and young people 15-24. Among the latter, only 23.8% in Romania and 18.3% in Hungary find work compared with, for example, 46.4% in UK (Eurostat, 2013). Eurostat (2013) reports that by 2010 Romania had the second highest level of risk of poverty and social exclusion in Europe (41%). The country's social transfers do not succeed in safeguarding minimum living standards for a fifth of the population. Hungary's poverty level is also high at 30%. In the two countries, children (0-17 years) are the most affected (Eurostat, 2013), nearly half (48.7%) of the Romanian and 38.7% of Hungarian children being at risk of social exclusion and segregation.

Hungary

The Evolution of the Child Protection System

Brief historical overview

In Hungary, the first child protection legislation was approved by Parliament in 1901. This was a comprehensive law, acknowledging for the first time the responsibility of the State for the care of children in need. At the time, almost all children under 15 (apart from the severely disabled and young offenders) were placed in foster care (95%) and this remained the case until the end of the WWII. The post-war ideology however, emphasised more professional, controlled provisions, leading to a gradual decrease in foster care. This was based on the belief that institutions could serve better the developmental needs of children. Professionals working in teams aligned ideologicaly with the new politics were regarded as more suitable than the often uneducated *petit bourgois* families who were fostering without monitoring and seen to transfer undesirable values to children. Institutions were instead regarded as transparent, professional, and providing an environment in which children could learn the socialist model of community living. Important changing factors were also: the widely publicised experience of Attila József, the most popular Hungarian poet, who suffered severely in foster care, and a novel by Zsigmond Móricz (later turned into film) describing the life of an orphan girl humiliated, exploited and abused by her foster parents (Móricz, 1940/2006). Under these conditions the proportion of foster care provision decreased to 20%.

In institutions, children lived in large-scale settings and were separated according to gender and age, which also separated siblings. For example, the largest 'child-town', a gated settlement set up in 1957 after the 1956 revolution resulted in many children being abandoned by dissident parents, accommodated 1,500 children 3 to 18 years old (Herczog, 1994). The settlement was provided with kindergarten, school, sports facilites, paediatric hospital, laundry, and central kitchen. Until the mid 1980's this was the model public care institution. The children living in these establishments, now adults, appraise the living conditions provided by this type of institution as better than those in the average family where children did not have access to these resources.

By mid 1980's it became clear however, that the institutions could not provide the care and personal relationships children needed. This marked the beginning of the first child protection reform, which aimed to reverse institutionalisation. In 1986 social work education was re-established, and a new programme of social pedagogy challenged the dominance of the previous autocratic pedagogic model. The Ministry of Social Affairs and Labour introduced national pilot programs providing experimental training for foster parents. The aim was to employ professional foster parents, as it did not appear realistic to rely on voluntary provision. Due to low wages and a push for an increase in the employment of women, most families required two incomes. This called for developing a foster care system that provided not only financial resources but also employment status for access to health care and pension. Other alternatives to classic institutionalisation were offered by SOS Children's Villages who opened the first village in 1986 providing a new care model and better living conditions. Since then, the organisation developed three villages in Hungary and gradually improved the care provision by employing foster families outside the villages and working closely with the local communities.

However, this reform encountered a number of cultural and structural barriers. The closure of the first three infant homes in 1988 in Pest county took place in the context of strong resistence from the residential care lobby, particularly the infant homes (Herczog, 2003). The political and economic transitions after 1989 have further slowed down the process of reform, as other major changes were given priority. Whilst Hungary ratified the UN Convention for the Rights of the Child (UNCRC) in 1991, later embeding it in the national legal framework, the weakest element of the child protection system remains the lack of: comprehensive, holistic, rights-based vision; co-operation between health, education and social and justice sectors; grasp of the importance of high quality prevention and early intervention; and adequate provisions to children and families involving them at all stages.

Developments after 1989: achivements and barriers

Ninety six years after the first child protection legislation, the UNCRC-based 1997 Law on Child Protection & Custody reorganised the system, emphasising the local preventive services, focusing on support and not punishment, prioritising early intervention, and promoting out-of-home care facilities (primarily kinship and foster care) only as a last resort. New local child welfare services coordinate the health, social, educational, and law enforcement services and all professionals working with children are now expected to report to the local child welfare services any suspicion of risk, abuse, and neglect.

The reform prioritises family preservation and foster care over separation and institutionalisation. Two forms of foster care are available: 'traditional', which entitles foster parents to allowances based on the number of children they care for (maximum four including own children), and 'professional' foster carers who can care for seven children and are employed and have access to welfare provisions based on their age, qualification and former work experience. All foster carers receive compulsory training (PRIDE) based on a national curriculum which requires 60 hours of training for the traditional, and an additional 300 hours in-house training for the professional foster carer. PRIDE is a standardized, competency-based training focused on selection, assessment and preparation of foster families towards achieving child safety, well-being, and permanency (CWLA, n. d.). To date, the programme has trained 5,000 foster parents and 240 PRIDE trainers. A new emphasis on supervision by social pedagogues or social workers replaces the previous monitoring approach.

Closure of large institutions is another priority. A decision was made to reduce residential acommodation to maximum 40 residents or to develop group homes for maximum 12 children, although the justification for these numbers is not clear. This transformation has been supported financially by the central government, which the municipalities were invited to tender for. This has generated 400 group homes, and most of the old homes were reported to have closed down.

However, on the ground, the progressive provisions enshrined in legislation and policy have not been evenly implemented, municipalities often failing to set up the required services. The disinsentives are embeded within the financial system and the approach to transformation. Traditional funding streams (from central and county budgets to public care) encouraged referal to public care and discouraged the development of support services for local families in need. In extreme, this has resulted in preventable child deaths. The deinstitutonalisation process has been ineffectively implemeted due to lack of investment in preparation, training of staff, and genuine transformation of residential accommodation. As

a result, closure of the large institutions sometimes meant dividing the space into six to 10 'group homes' without reforming the management and children's everyday life. Another undermining strategy was to use the EU structural funds committed to deinstitutionalisation on refurbishment of institutions instead of closure (Flynn, 2011). The untrained staff maintained old methods of child rearing focused on physical health and independence and overlooking the children's need for emotional attachment. Punitive attitudes towards foster carers, assumed to be unsuitable and to opt for this role primarily for financial reasons (45% reside in areas of deprivation, unemployment and low educational outcomes), contributed to the resistance to deinstitutionalisation (Babusik, 2009; Herczog, 2007). In these families children continue to be at risk of social exclusion and lack access to quality education and other necessary services. Poverty undermines also kinship care, which is now unsupported, as it was observed that parents, particularly of Roma origin, would often arrange long-term childcare with relatives for the financial benefits associated with this type of out-of-home care.

Currently, the foster families prefer young children (increasingly infants as well) without complex needs, whilst children with disabilities, older children of Roma origin, or those presenting behavioural problems, and teenagers remain in or are referred back to institutions. Apart from cultural barriers linked to the Hungarian society's attitude to disability, this is due to lack of therapeutic, emergency, and specialised foster care support, as well as lack of differentiated pay and successful professionalisation of foster carers (only 323 are salaried compared to over 5,000 'traditional' carers) (Central Statistical Office, 2012a, table 5.13). The professionalisation of foster carers might suffer further as from 2014 new legislation will aim to replace the well established and adapted PRIDE training programme with a new much longer EU-funded curriculum to be designed without expert input by a Teachers' College.

The bias towards 'easy children' is also observed in group homes, as the staff are not trained to work with complex groups and challenging behaviours and do not receive back up support. Lack of training has made unsuccessful the few attempts to specialise the group homes, for instance on drug and alcohol abuse.. The lack of specialist knowledge is endemic throughout the system, some communities lacking entirely psychological, psychiatric or councelling support with recovery from abuse, trauma, suicide attempts, mental health difficulties, or learning disabilities. This affects not only the children in care or in the community who might need this type of services, but also the child offenders (over 4,000) (Chief Prosecutor' Office, 2012) of whom a growing number are accommodated in regular residential homes until 18, and where staff are not trained in reabilitation or any other methods (Herczog, 2008). Overall, the quality of care and of the children's living conditions is unscrutinised. This leaves undetected and unadressed not only developmental needs but also diverse forms of abuse, including sexual abuse. When such incidents are reported, as was the case with a series of severe incidents in one children's home in Budapest, the institutional culture of not listening to the voice of the child, inaction, and non-accountability resulted in lack of proper intervention and of consequences of any kind. (OBH, 2011).

The difficulties in the child protection system are better understood against the wider context of the current struggle in Hungarian society. The 2008 economic crisis has impoverished not only families and children but also municipalities and local services. The funding cuts led to almost unmanageable situations in health, education and social services, endangering also the tax-paying middle class. High unemployment, family debt in foreign currency, low income, decreasing allowances, high prices and the political climate of blaming and shaming instead of focusing on solutions has led to social crisis and growing depression, hopelessness, anger and a climate of hate. This has made poverty one of the main reasons for referral into care (one third of referrals). Recently, new services have been put in place to increase parental capacity and to encourage tolerance and inclusion. These include: adapting the UK model 'Sure Start' to provide parents with learning opportunities through play groups or self-help; introducing mandatory kindergarten enrolment to prepare children for school and to supplement family care; and launching awareness campaigns to educate the public about disability and the Roma community. The objectives of these services are however potentially undermined by a generalised lack of professional training.

Within this context, the crisis has given way to an increasigly closed and autocratic approach to change. Decisions on public policies are now taken without public and professional consultations, information, or involvement of NGOs. This has resulted in delay and even reversal of some of the measures pledged in the strategies submitted to the EU such as poverty reduction, Roma inclusion, deinstitutionalisation, especially of disabled children, and decentralisation. A recent restructuring of public administration, nationalisation and centralisation of almost all services (e.g., schools, hospitals, psychiatric services and children's homes) places the decision-making power over financial and professional matters exclusively with the Ministry of Social Affairs and Labour dismissing the involvement of local actors and generating a culture of lack of transparency and disrespect for ground level expertise.

Key indicators

In 2012, a quarter of Hungary's population were under 18, a number which has declined since 2000. Among them, over 18,000 children under the age of 18 live in out-of-home care and almost 4,000 over 18 in after-care (Central Statistical Office, 2013). Hungary is a CEE country where, since 1989, the number of children in institutional care has steadily decreased (UNICEF, 1993), but in the last 3 years the tendency has been changing. While absolute numbers have not increased, compared to the decreasing child population, the proportion has. Whilst the pattern of relying heavily on institutional care has been difficult to challenge, the child protection system has made gradual, albeit slow, progress so that between 2003 and 2004 the ratio of children in institutional and foster care equalised. By 2011, over 60% of children lived with foster parents (Central Statistical Office, 2012a, 12th chart).

Overall however, the population of children in out-of-home care is insufficiently understood due to political and professional disinterest in regularly gathering, monitoring and evaluating the changing situations at individual, settlement, regional and national levels. This makes it difficult to ascertain accurately the outcomes of care and the policy and practice changes required. The data gathered is regarded as unreliable, suspected to reflect mostly the subjective opinions of the local service providers, decision makers and authorities, due to lack of proper training on decision making and categorisation, and calculations based on too general terms and definitions.

Nevertheless, the current figures indicate that the majority (86%) of children in out-of-home care are in 'temporary' care, 7.5% in 'permanent' care, and 7% in 'transitional' care (Central Statistical Office, 2012b, p. 4). By law, out-of-home care should be temporary, whilst the family is supported to recover through intensive casework. Yet, according to case reviews, reunification is rarely achieved, 86% of children remaining in placement for five years or more. This is because social workers are mostly unaware of new casework techniques and methods and are also unable to refer families and children to specialised services as those do not exist. Very high caseloads (often over 100 families per social worker) also prevent adequate care of those in need. The clear resistance of both the public and politicians to support families facing parenting and other problems is blocking the implementation of both the legislation and the long term child anti-poverty strategy.

The children in permanent care are mostly older, disabled, Roma or very troubled and could not be adopted or fostered, whilst transitional care is for children who are awaiting a placement decision following referal. Often, the latter experience extended periods of care (over the legislated 30 days) due to lack of information, assessment and proper care planning. When children are put on the child protection register due to being regarded as 'at risk' they are also at risk of being placed in out-of-home care. In 2012, almost half (47%) of the children referred were put on the register due to parental behaviour (Central Statistical Office, 2012a). 'At risk' is a wide category (Figure 1) that encompases a diversity of conditions from severe abuse, to living with a lone parent or divorced or remarried parents, with unemployed or depressed parents, or without adequate food, clothing and heating. These conditions are considered 'neglect' and rather than support, they generally attract advice to parents to find jobs and to change their attitude, parenting practice, and bad habits. Most often, if uncooperative, parents risk losing custody of their children. The UN CRC Committee has expressed concerns about the ease with which children are placed in out-of-home care, often for financial reasons and often for long periods of time, and has urged the government to ensure that the period of care is reduced and family reunification takes place as soon as possible (UNCRC Concluding Observations, 2006)

Currently, half (52%) of the children in institutional care are aged 12 and over (Central Statistical Office, 2012b, table 5.9). This proportion is likely to change as Parliament has approved legislation which in 2014 will launch gatekeeping regulations to prevent children under 12 from living in institutional care (with the exception of siblings and disabled children). However, similarly to numerous previous provisions, this measure is taken without exploring the needs of the children currently in care, the best gatekeeping strategies, or the best methods towards family strengthening and reintegration.

Research evidence

Hungarian research on child protection is limited despite the funding opportunities provided through the 2004 EU membership and the abundance of gaps in knowledge and opportunities to evaluate the legal and practical changes all across the system. Research is also not a tool when preparing new legislation.

Some knowledge is however built through international research that includes Hungary, such as the EU Daphne Project led by University of Nottingham (Browne, Chou, & Whitfield, 2012), which tapped into the knowledge of staff from 100 maternity hospitals and 100 prevention programs across 10 mostly Eastern European countries. The study investigated the reasons for abandonment of very young children in Eastern Europe. The findings highlight that Hungary is among the countries (e.g., Lithuania, Romania, and Slovak Republic) where the legislation does not mention or define abandonment. There is no precise statistical data on infants left in the maternity wards or incubators (placed since 1996 in front of hospitals to prevent infanticide) and no knowledge at national level on gender, ethnicity, disability or other circumstances. There is also no follow up on the abandoned babies most of whom are adopted. In 2012, 165 new-borns were adopted abroad and 20 in Hungary.

The data collection in the study revealed that 30 out of 10,000 children under 3 are institutionalized and remain in care, on average, for 15 months. It is estimated that there are 100 newborns abandoned every year. Despite universal provision for health visitation many pregnant women in crisis are not reached, the hospital staff are not trained in recognizing crisis situations and risk of abandonment, and there is no clear protocol on how to proceed besides informing the local child protection agency once the mother has left the child behind or declares that she wants to give up the child for adoption.

In contrast to developed countries, where children are referred to care mostly due to abuse, in Hungary, similar to other transition countries, the low economic status of the parents is the main reason for referral or abandonment. Children are mostly abandoned or neglected (42%), whilst almost a third (30%) enters care due to the parents' imprisonment or health problems (on the increase since 2006). Only in 22.5% of cases is abuse mentioned, whilst children with both parents deceased make up only 1% of the care population. The previous study in 2005 also found that one fifth of children return to their families including extended family, half are placed in foster care or are adopted nationally, and less than 20% are transferred to institutions for older children. Infant homes accommodate children up to 6 years old but in some instances, due to shortages and also to maintain the necessary numbers in care to prevent closure, disabled children are accommodated for longer. The situation of siblings (three quarters of the children in care) is difficult as they tend to be placed in institutional care, not always in the same setting, and often without opportunities for contact based on the belief that if they are unattached they are easier to be adopted.

Roma children, a prevalent but hidden care population (collecting data on ethnicity is regarded as discriminatory, unless it is offered

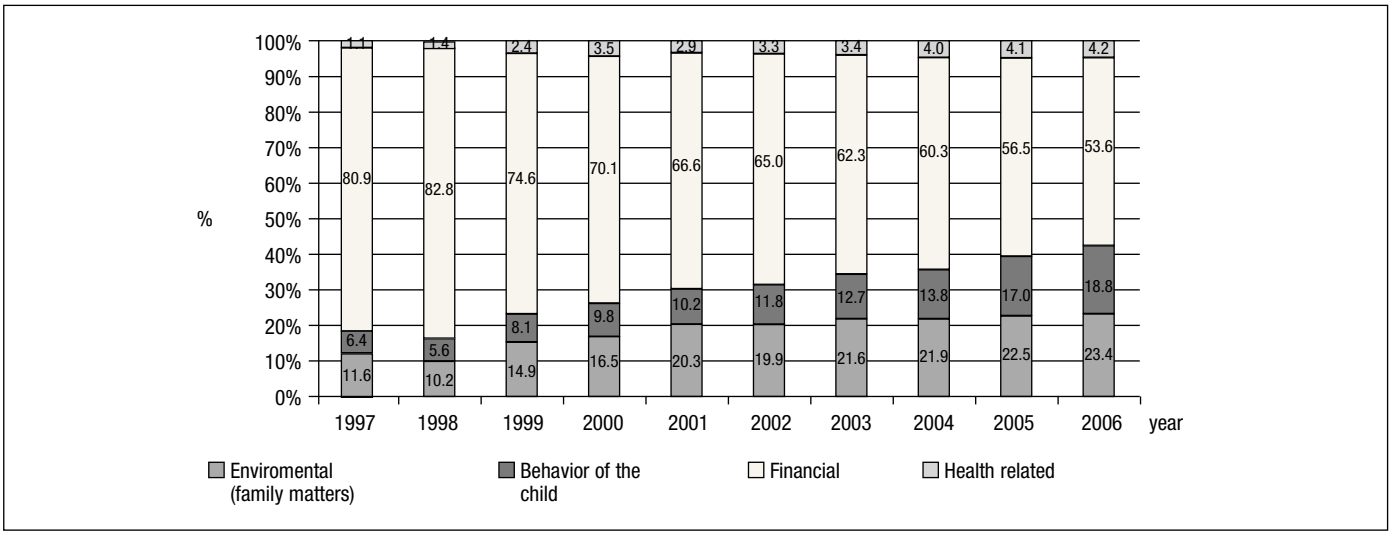

Figure 1. Reasons for children being registered as 'at risk' 1997-2006
Source: Papházi and Szikulai (2008, 1, chart).

voluntarily), have been the focus of another European study by the European Roma Rights Center (ERRC, 2007). The study, conducted by Hungarian researchers through focus groups and interviews, was focused on exploring the over-representation of Roma children in institutions; the tendency to categorize them as mentally disabled; and issues of identity and adoption. The study has taken place in every of the seven regions of Hungary and has involved 68 professionals including government officials, 13 Roma and non-Roma parents of children in care, and 12 Roma and non-Roma children aged 14 to 21 living in different forms of out-of-home care. The discussions focused on the development of identity when living away from family, and the children's experiences of inclusion, exclusion, belonging and personal relationships with family, peers and carers.

The study estimated (based on visible characteristics, surname or location of parents) that 40% of children in care are of Roma origin and 18% are half-Roma. As this minority makes only 7% of the overall population and 13% of the overall child population, this data highlights a gross over-representation of Roma children in care. However, as by and large the Roma children tend to experience deep poverty, isolation, and discrimination in school it is not clear whether more Roma children should be in care, or whether those in care are in fact further oppressed by being deprived of family care. The system does not provide this population with family preservation services or other community development programs, whilst the length of stay in care is an extensive forcing child to live in institutions or with non-Roma families whilst still facing discrimination in school. For many (63%) of those interviewed by ERRC the involvement with the care system has resulted in being categorized as having a mental disability or special learning needs. Roma children, like disabled children, are rarely adopted (Herczog & Nemenyi, 2007).

Finally, investigations undertaken by the Hungarian Ombudsman on the quality of care in institutions and foster care and in basic and specialized services have concluded that none of these meet the minimum quality requirements in the UNCRC-based legislation, on the contrary, some violate children's rights (Lux, 2013).

In summary, between mid-1980's and 2005, the Hungarian child protection system has experienced an extensive period of gradual development, followed by a period of stagnation, partly due to the 2008 financial crisis. Funding cuts delay the implementation of the 2007 long term anti child poverty program "Let it be better for children" (47/2007. V. 31. OGY határozat), whilst children and young people in out-of-home care cannot benefit from improved care plans and practice. The crisis affecting the society overall and especially the services for vulnerable families generates punitive attitudes and an atmosphere of intolerance, whilst access to support is reduced. The quality of care is further affected by lack of research and evaluation, and by lack of public debate, professional and NGO involvement in decision making and development of practice.

Romania

The Evolution of the Child Protection System

The Romanian children living in warehouse size institutions have been the most publicised and controversial example of the inhuman conditions in which abandoned children lived across Eastern Europe at the end of communism. It prompted immediate reaction from the western world from where various inputs came at different times to rescue, improve, change, update, modernise and later empower. Without external intervention, a system that had stagnated for almost 30 years probably could not have changed easily taking into account Everychild's observation that in some countries the overthrow of communism is considered enough reform (Carter, 2005). Unfortunately the impetus for rapid change was not matched by sufficient know-how on either side. However, since those deeply disturbing images, Romania has made notable progress (Feuchtwang, in Carter, 2005) reforming the childcare system twice and gradually increasing the awareness and the involvement of local researchers and champions in the improvement of the system. For most part, the main challenge in this process has been the impact, at the level of practice and everyday living of the speed and the approach to change imposed by the external and internal actors at decision-making levels.

Brief historical overview

Similar to other countries in Europe, Romania began to create a system for protecting destitute children through the church and later the aristocracy who run shelters for the poor, disabled and abandoned as early as the sixteen century. Social work and the first protection laws and infrastructure were then developed at the beginning of the 20th century (Gavrilovici, 2009). The current legacy of institutionalisation however, originates from the Soviet ideology, which regarded parents as largely inadequate to raise children in the correct doctrine and which promoted state social care as alternative (Carter, 2005).

Whilst this was a general approach across the communist bloc, in Romania the 1966 pro-natalist policy, banning contraception and abortion for women under 45 and taxing childless couples, has made institutionalisation the worst and most prevalent form of childcare (only 14% of children in care were placed with the extended family in 1989) (Zamfir, 1996). In parallel, the social work profession was banned in the belief that the regime was providing enough protection through the universalist social policy to not necessitate additional professional support, and that the state was best capable to take care of abandoned children. Thus, families were easily deemed incompetent in their parenting role and easily lost their parental legal capacity as contact with children was not encouraged or supported. By 1989, this policy combined with poverty (Hogue et al., 2004) and the social implications of illegitimate children, had increased the number of large children's homes to 250 and of children living in institutions to an estimated 100,000 (Micklewright & Stewart, 2000).

Children were segregated by age and gender (Tolstobrach, 2000) into three types of establishments: infant homes, pre-school, and school-age children's homes and prepared mostly for the army, secret police, agriculture and industry (East & Pontin, 1997). Their social integration however was severely impaired by social isolation and by the institutional-custodial model of care, which was focused mostly on hygene and education and not on the children's social and emotional needs (Stephenson et al., 1993). Children with physical or mental health needs were placed in 'centres for the dystrophic', an overused umbrella diagnostic (CHCCSG, 1992), or homes for mental or physically handicapped children where, according to local observers, they were treated 'like animals' (Rus, Parris, Cross, Purvis, & Draghici, 2011; Zamfir, 1996). The conditions in children's homes generally were severe with frequent abuses particularly from older residents but also from the largely untrained staff (Zamfir & Ionita, 1997). The children's histories and contact with their living families, including siblings also in care were not preserved, over time making them 'social orphans' (only 4% had no biological families in 2000) (Gavrilovici, 2009).

Developments after 1989

Despite being among the first countries to ratify the UNCRC in 1990, due to inadequate infrastructure and unqualified staff, the living conditions in children's homes remained unchanged until the first child protection reform initiated by a new conservative government in 1997. The impetus for change was the application for accession to the European Union, which was conditional *inter alia* on improving the situation of children in care. The change that ensued

was mostly systemic and legislative and the rapid, unprepared change generated much disruption affecting children and staff alike. The reform was based on the first modern legislation which replaced the 1970 communist law, and which introduced the concept of human rights, and decentralised the system giving decision-making powers to local authorities (OMAS, 1999). A new Department for Child Protection took administrative responsibility from three separate Ministries (Health, Education, and Labour), and began the closure or transformation of children's homes into temporary 'placement centres' and family-type homes, the developmemnt of a foster care system especialy for the younger children in residential units, and the reunification of children with their families. After twenty seven years of stagnation the change was seismic. The infrastructure, professional status, legal context of practice, and language of care began to change (Anghel, 2010).

This reform has been criticised by the new generations of university-trained social workers for going 'too far, too quickly' (Dickens & Serghi, 2000, p. 259) without adequate knowledge, resources, vision and guidance. The decentralisation was imposed without attention to the financial implications for local authories creating the risk of 'total collapse' of the child protection system (Dickens & Groza, 2004) some of which could not sustain the costs of food and medicine in local children's homes. Closing down the institutions was seen as a 'quick fix', with children ending up in worse forms of care such as being moved to unfamiliar but similar centres or being sent back to families which exploited them forcing some to run away and end up back in care. Family support services were poorly targeted and not integrated within the national deinstitutionalisation plans (Fulford, 2009). At exit from care, young people did not have access to any support system so that many were allowed to extend their stay in care which as consequence increased the opression of younger children.

Fragmentation, lack of a database and tracking system (Gavrilovici, 2009), superficial and rushed decisions made under external pressure that failed to take account of the local culture and specific circumstances, and lack of accountability and focus resulted in overall institutional inefficiency that required perpetual patching up of negative side effects (Tomescu-Dubrow, 2005). Analysing the change in institutions within an organisational management framework (Bridges, 2009), Anghel (2010, 2011) also observed that at practice and everyday living levels it was not acknowledged that both residential staff and young people were going through transition. The narratives of the practitioners showed that they needed clear updated information, a vision of the reason and nature of the change, appreciation of their effort and support with their anxiety, and better opportunities for learning. Similarly, the young people needed quality interaction with the staff, a stregths assessment, a plan for exit from care, and diverse learning opportunities. Instead, the rapid and accelerated 'blind' change was creating conflict across actors and sectors (public and NGO), paralysis among practitioners, and a feeling of abandonment among children and young people (Anghel, 2011; Anghel & Becket, 2007).

Most of the shortcomings of the first reform were addressed in the 2004 legislative pack, which includes The Child Act and a large set of quality standards addressing various forms, methods and stages of care (e.g., residential and foster care, prevention, pathway plans). This reform aimed to harmonise the system and, for the first time, it stated the rights of all children. A few years later, changes were observed in the children's routes through care, the types of services available, the quality of care in institutions, and the overall population of children in care (Rus et al., 2011). Admission into residential care is now more difficult (forbidden for children under two, unless they are severely disabled), whilst the provision of care is organised around a set of individualised pathway plans for all care decisions (e.g., prevention of separation or placement in temporary care). The family is the preferred environment for child care. However, when this is not available, alternative care services such as family-type services, small scale residential, and day care services replace institutions (Rus et al., 2011). The state's duty of care post residential living, which in the 1990s was almost entirely abandoned, is now acknowledged and extended. Although not expressed as such, the state appears to adopt the role of corporate parent enhancing the young person's life chances through extended care (up to two years on request), provisions for developing independent living skills, and generous financial resources and employment opportunities at exit from care. Reviewing the reform documents Anghel (2010) observed that these changes appeared to indicate an emerging shift in the vision of children and young people in care from 'problem' to 'resource', a distinction made by Walther, Hejl, and Jensen (2002). Children were seen as both: dependent, irresponsible and ungrateful, but also capable, more mature than their peers, whilst needing substantial support to become more resourceful. The practice, which operates largely on deserving-undeserving criteria, reflects this dichotomy. Formally, the care leavers are rarely prioritised for access to local resources as required by the legislation, and encounter barriers such as lack of information about their rights, and the practitioners' discriminatory attitudes. Informally, the practitioners develop selective relationships with some young people who they provide with learning opportunities and access to community resources (Anghel & Dima, 2008; Dima, 2012).

Key Indicators

In 2010 there were 3.9 million children in Romania, of whom 1.6% were children separated from their families. By 2013, up to 40,000 (63%) lived in family-type care (foster care, family placement, adoption) and almost 23,000 lived in public and private residential care, a reversed prevalence through deinstitutionalisation and the development of alternative services (Table 1). By 2006, there were 1,140 public and 405 private placement centres. The public residential centres were further divided into: 467 social flats; 361 family type houses; 132 modular institutions; and 180 warehouse type institutions. However, whilst up to 2006 this trend was steadily increasing (Figure 2), a recent audit of local authorities found that only 8 of 45 directors of county Directorates for Social Assistance and Child Protection reported plans to close down institutions (HHC & ARK, 2012), indicating a significant slow down in deinstitutionalisation.

Admission into care is mostly caused by neglect (68% of cases) largely associated with poverty. However, a large number also come from failed foster care (20%, HHC & ARK, 2012), or unsuccessful family reintegrations (in 2006, 134 returns, 67% from rural areas) (Cojocaru & Cojocaru, 2008). The failed foster care could be caused by relationship breakdown, or by the foster carer giving up the job due to lack of support and adequate pay (during 2012, 1000 foster carers resigned) (Preda et al., 2013).

Table 1
Number of children in care and distribution of services at 31.03.2013

Type of service	Number of children	Percentage
Family type services	38,741	62.8%
Professional foster care (employed by public and private agencies)	19,185	31.1%
Extended family (kinship care)	15,650	25.4%
Other families/persons	3,906	6.3%
Residential services	22,899	37.2%
Public	18,825	30.6%
Private	4,074	6.6%

Source: Ministry for Labour, Family, Social Protection and the Elderly. http://www.copii.ro/alte_categorii.html

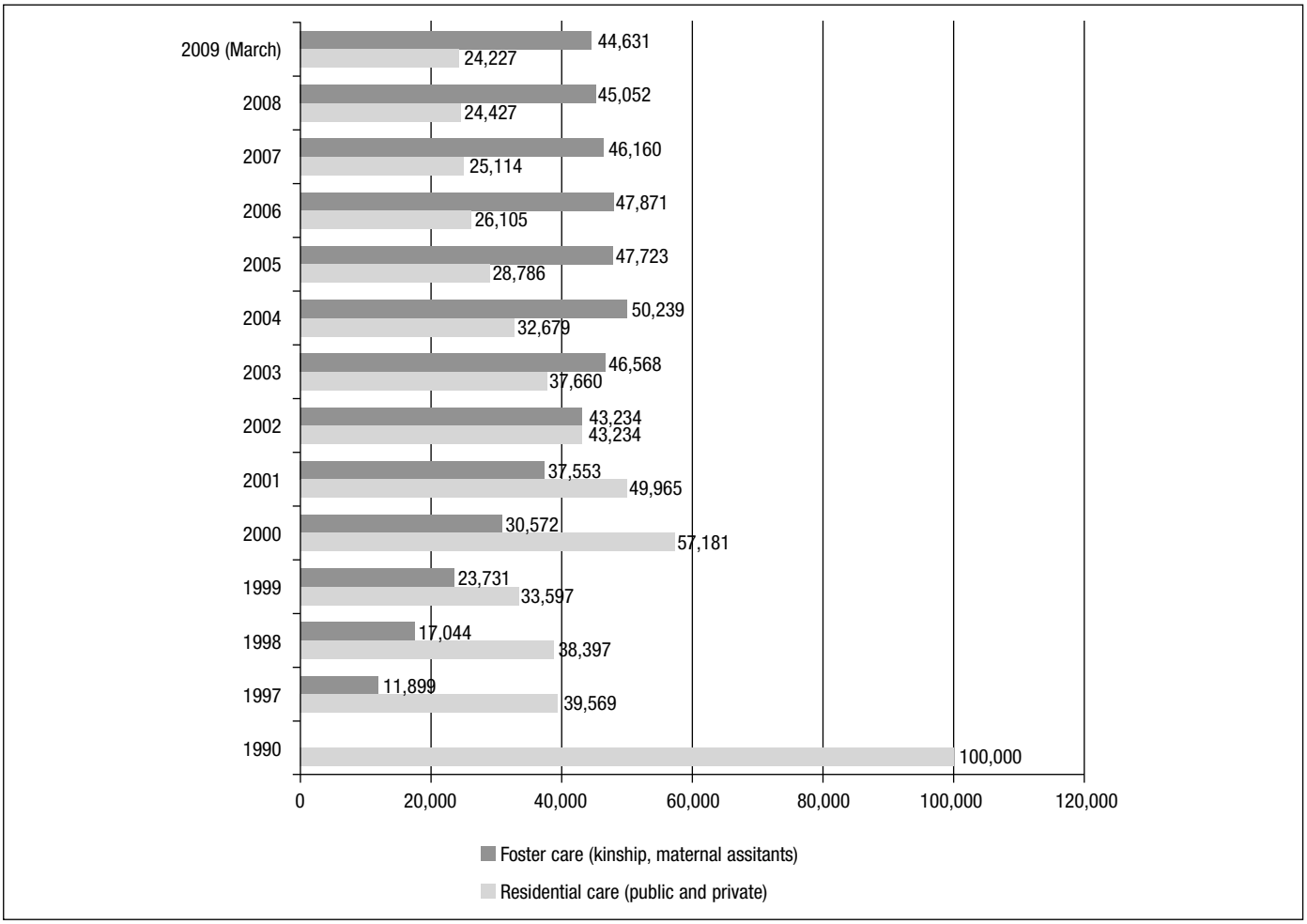

Figure 2. The evolution of the child care reform through deinstitutionalisation and promotion of foster care.
Source: Ministry for Labour, Family, Social Protection and the Elderly. http://www.copii.ro/alte_categorii.html

In public and private residential care most young people are aged 10 to 17 followed by a large number of young people aged over 18 (Figure 3). The statistics also show that, despite the ban on admissions of young children, 684 children under two still live in institutions, bringing into question the system's capacity to protect children's rights.

Among the groups vulnerable to institutionalisation are the disabled children (over 60% according to Open Doors, 2013) and children from the Roma community. Although no official data is available, there is a perception that Roma children are over-represented in care (Buzducea, 2013). In 2011, the European Centre for the Rights of Roma (ERRC, 2011) found that the staff estimated between 20% and 80% Roma children in residential care. Similar to Hungary, the study found that the lack of data on the ethnic background of children in care was due mostly to the staff's misunderstanding of anti-discriminatory practice.

In Romania the legal age of discharge varies from 18 to 26 and depends on whether the young person requests two more years of support according to the law, or whether they continue education. During 2001-2005, 45.000 children and young people left residential care, mostly by being reunited with their natural family (53%), or by reaching the legal age of discharge (27%) (Panduru et al., 2006). This trend remained constant until 2012 (HHC & ARK, 2012). According to the National Authority, by 2006, young people were leaving care at a rate of aproximately 2000 per year. After 2006, this group appears to cease to be a priority so that there is no follow up data publically available.

Children also exit care through adoption. In the 1990s Romania intensified the international adoptions which were loosely regulated. Whilst this phenomenon was seen by local professionals as 'rescuing the orphans' (Dickens & Groza, 2004), it was regarded as an abuse of human rights (children were sometimes sent to high-risk unregulated and un-monitored environments) by the country *raporteur* for the EU accession who imposed a moratorium in 2001. Since then, the policy encouraged national adoption but this has remained at a steady but low level of approximately 1000 children annually as adoptive parents prefer children without care experience (Buzducea & Lazar, 2011).

Overall, despite a focus on prevention, the lack of detailed monitoring as to numbers, causes and follow up support makes it difficult to ascertain the actual level of need (Buzducea, 2013). A solution is suggested by HHC & ARK (2012) who call for the externalisation of services arguing that it is unethical for the General Directorates to both: provide services and monitor, control, and inspect their effectiveness.

Current challenges and research review

Rus et al. (2011) suggest that the 2004 legislation brought Romania closer to the practices of more advanced countries. However, seven years later, implementation has been observed to be patchy (Buzducea, 2013). The financial crisis of 2008 combined with reduced funding from the EU and investment from international developmental agencies post-accession (Lazar & Grigoras, 2013)

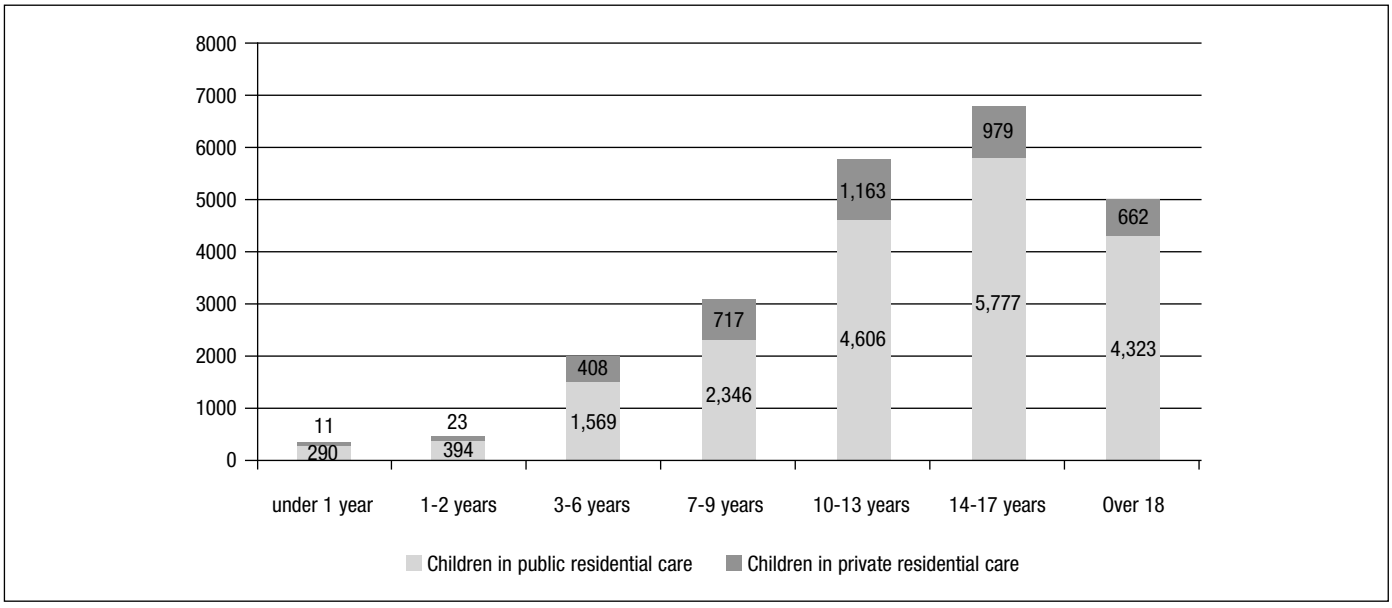

Figure 3. Children in public and private residential care in March 2011 (Buzducea, 2013, p. 96).
Source: Ministry for Labour, Family, Social Protection and the Elderly

have slowed down progress and have created new barriers to change. Recent literature (Stanculescu & Marin, 2012) shows that the main challenges of the system of social care and child protection are: developing prevention methodologies and services; focusing on the rural; professionalising the workforce; and developing adequate practice for deinstitutionalising disabled children.

The poor quality of the workforce has been seen as a barrier to enabling children's protection and participation rights throughout the reform process (Roth 1999, p. 36). Much of the problem is associated with recruitment on political grounds, a background of high unemployment, which staffs the child and social protection system with workers (carers, as well as manangers of county Directorates) with no social care or social work qualification (Preda et al., 2013). Lazar & Grigoras (2013) found that over 60% of workers in prevention programmes, particularly in rural regions, lacked higher degrees, and only 8% of social workers employed by public care Directorates were qualified. At the same time a reduction in workforce overloads case managers with 3 or 4 cases per week, whilst each active social worker would oversee 4000 members of the population (compared with UK for instance 1/600). Critics make a link between lack of qualification and child abuse and inadequate intervention in residential care and in prevention services, whilst the frequent change of managers hinders the implementation of policy and good practice (Bratianu & Rosca, 2005). The government's 2011-2013 reform strategy targets specifically the professionalization of the workforce. To this end it has introduced the expectation for employers to ensure that the staff undertake continuous professional development training for minimum 120 days, half of which are focused on independent living skills (including on enhancing the ability of young people to make decisions) and case management (Campean, Constantin, & Mihalache, 2010).

Funding cuts at county level have had a number of negative effects on effectiveness on the ground (HHC & ARK, 2012). Cuts in travel allowance to outreach workers affect their mobility, particularly in rural areas, preventing them from undertaking adequate monitoring and prevention activities, thus increasing the risk of child abuse and neglect. A 25% salary cut made the job untenable for a large number of professionals who left the system (there are 10% vacancies in each worker category) (HHC & ARK, 2012), whilst cuts in training costs (currently at 0.02% of the total system expenditure) prevent the professionalization of those remaining. Finally, lack of funding slows down the development of the family-type infrastructure, and the deinstitutionalization process.

Resources are lost also through the gaps created by the administration of a duplicate infrastructure. At county level, service provision is monitored by Directorates, which are responsible to County Councils. Locally, the services are provided by the Public Service for Social Assistance, and, in parallel, by the employees of County Councils with social work responsibilities. This structure fragments the power and responsibility for social care, creating resource overlap and waste (Magheru, 2010). A similar situation has been observed at the central level of decision making and administration where too many poorly coordinated autonomous National Authorities are splitting roles and responsibilities (Lazar & Grigoras, 2013). Currently, the system is coordinated at national level by the General Directorate for Child Protection, a subdivision of the Ministry of Labour, Family and Social Protection. This move, however, has been seen to diminish the importance of child protection, in contradiction to the 2009 recommendation of the UNCRC Committee (Lazar & Grigoras, 2013). Overall, commentators have observed a preoccupation with costs and the neoliberal approach to protection, and a decline in the focus on children's rights and quality of care (Buzducea, 2013).

Currently, the children identified as at risk of social and economic exclusion in their communities have been labelled 'invisible' by local commentators (Stanculescu & Marin, 2012) to indicate the government's lack of preoccupation with the social protection of this group. Among them a significant group is 'children left behind' by parents seeking employment abroad. It is estimated by UNICEF (2008, in Buzducea, 2013, p. 102) that from among the 350,000 children with at least one parent abroad (7% of the child population), a third have been left behind by both parents, making this another form of abandonment. This phenomenon has been acknowledged by EU as an unintended effect of external labour migration, a fundamental EU policy (europa.eu). In Romania, this situation affects mostly counties in the north, east and some in the southeast regions. The effects on children are highly damaging including having to take on parental roles for their siblings, lacking structure and guidance affecting their school performance, being more vulnerable to peer pressure and at risk of substance abuse and anti-social behaviour, losing the bond with parents, and developing depression (Soros Foundation, 2009), which in extremes has resulted in suicide.

Analysing the system holistically to consider legislation, actors, resources, monitoring and examples of good practice, Magheru (2010) concludes that the social protection for children is inequitable. Given its starting point, Romania has achieved impressive progress in the past twenty years creating an exemplary legislation and policy framework which fully integrates the UNCRC. However, the financial crash has generated considerable slowdown and even abandonment of the focus on quality of care, child rights and investment in supporting children through very difficult life situations. The system seems less scrutinised, and those in it less empowered and less supported. Overall, the main problem appears to have been the unprepared and rapid reaction to pressing demands from external social and political actors who focused passionately on changing the living conditions of children without however, giving sufficient consideration to the cultural context and the complex process required to achive this successfully. Currently, through increased networking and engagement with local problems local researchers and champions use local knowledge, creativity, stamina and passion to keep the process focused on what is relevant and a priority for Romania. Urgent areas of intervention are: professional training, taking accountability seriously, and developing a methodology of change based on research and evaluation.

Conclusions

While CEE countries are culturally very different, the examples of Romania and Hungary illustrates that they share similarities with regards to the evolution, approach and challenges encountered during the reform of the child protection system. Among them, the following appear most prominent.

Both countries have exemplary child protection legislation and policy based closely on the UN Convention for the Rights of the Child and on new principles of practice such as person centred approach, child and family participation, and community involvement. However, whilst the reform has advanced on paper implementation is a challenge and the gap between changes on paper and the actual quality of life of children, young people, and families remains significant (Anghel, 2011).

Although Hungary had begun deinstitutionalisation and reform before the fall of communism, after 1989, the approach to change in both countries appeared at times to focus on changing the image rather than the nature of care. Examples in both countries include the deinstitutionalisation 'solution' of creating modular group-homes on the premises of old institutions thus generating improved statistics about closure of institutions with no change in actual everyday living conditions.

The quality of the workforce has degraded due to lack of adequate practice methods, lack of investment in updated training, emphasis on liability, lack of monitoring and accountability, and high workload due to large job cuts. This affects the quality of referal, prevention work, and care.

Despite express recommendations from the UNCRC Committee, these countries are unable to avoid admission into care and children being separated from their families as the main solution to poverty.

These challenges could be understood in the context of many factors. The long tradition of Soviet understanding of the purpose of care (collective education preferred), appropriate care practice (regimented and punitive) and attitudes to vulnerability (blaming the individual, encouraging parents to distrust their parental ability) meant that, since the 1997 reform both countries have taken a radically different approach to care. Prevention, supporting the family and being guided by the child's best interest are still new concepts, which are a struggle to accommodate in the local psyche. The social work profession is also relatively new having been reinstated, after a long break, in the early 1990s and is yet to acquire power to engage politically and generate change in practice on the ground. Although the change has been accelerated, when raported to the benefits children need in their lives it has been nonetheless slow. Overall, the active presence of external actors conditioning political and economic access to support on large scale changes has made it difficult for these countries to develop a vision of the change and capacity for initiative and action. The result is that the approach to child protection appears incoherent and without commitment to the interests of the child. As Fulford (2009) suggests, countries in transition need to learn the lessons of their transition. In the case of the reform of the child protection system in transition countries, the lessons could refer to the importance of: political commitment, inter-sectoral co-ordination, long-term planning, sustainability, particularly through understanding the needs of the staff and investing in their professional capacity, and continuous evaluation of outcomes, barriers and enablers of the process.

Conflicts of interest

The authors of this article declare no conflicts of interest.

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