A BETTER FUTURE IS POSSIBLE

Promoting family life for children with disabilities in residential care

Manual for professionals

International Social Service
Service Social International
Servicio Social Internacional

A BETTER FUTURE IS POSSIBLE

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The International Social Service (ISS) is an international NGO founded in 1924 in Geneva. Thanks to its network present in more than 120 countries, ISS is a global actor promoting child protection and welfare. Supporting individuals having difficulties of a social and legal nature as a consequence of international migration or displacement constitute ISS network's historical engagement.

ISS also has a recognised expertise on issues relating to the protection of children deprived of their families, and is a key actor in promoting children rights and international standards.

For more information: www.iss-ssi.org

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Manual for professionals caring for children with disabilities in residential care

Contents

Disclaimer: For the purpose of this Manual any person, male or female, under 18 years of age, is considered a child, as established in Article 1 of the Convention on the Rights of the Child.

Part A

Introduction

ABBREVIATIONS

United Nations	**UN**
UN Convention on the Rights of the Child (1989)	**CRC**
UN Convention on the Rights of Persons with Disabilities (2006)	**CRPD**
UN Guidelines for the Alternative Care of Children (2009)	**Guidelines**
Hague Convention on Protection of Children and Cooperation in respect of Intercountry Adoption (1993)	**HC-93**
Accredited Adoption Body	**AAB**
Residential Care Institutions	**RCI**
Prospective Adoptive Parents	**PAPs**
Accredited Adoption Bodies	**AAB**

1. PREAMBLE

Although global statistics do not exist on this subject, available information shows that throughout the world several thousands of children with disabilities and deprived of their family are placed in residential care facilities without any other proposition of protection measures. The UN Committee on the Rights of the Child has regularly expressed concerns regarding the systematic recourse to residential care for children with disabilities, underlining the fact that this population is particularly at risk to all forms of abuse. Furthermore the 1989 Convention on the Rights of the Child (preamble, articles 20 and 21) and the Convention on the Rights of Persons with Disabilities (preamble, article 23) as well as multiple other international standards fully recognise the right of the child to grow up within a family environment.

Achieving this right for children with disabilities deprived of their family remains a worldwide challenge. Despite the efforts and resources engaged in finding families ready to care for a child with disabilities, no country has managed to fully respond to these needs. This situation is even more pronounced in developing countries and those in transition, where the resources and expertise needed to develop family type protection measures for these children are often lacking. Furthermore, sometimes beliefs and taboos relating to the notion of disability create further obstacles. In certain contexts, few measures are taken to reintegrate the child into his/her family or community or, if this is not possible, to find him/her a family through foster care, national adoption or, as a subsidiary option, intercountry adoption.

As a result numerous children with disabilities grow up in residential care institutions without being offered the possibility of being cared for by a family (foster or adoptive) for reasons that are often independent of their actual capacity to benefit from this measure. International Social Service (ISS) and the French adoption body Médecins du Monde (MdM - Doctors of the World), a medical NGO with the status of Accredited Adoption Body (AAB), have observed this through their mandates in numerous countries of the world.

On the basis of their additional experience (as observers of the rights of children deprived of their family and as professionals in the field), and in close collaboration with a group of recognised international experts[1], ISS and MdM have chosen to work in favour of family settings for children with disabilities, rather than residential care. This Manual is the principal tool of their action. It is a working tool proposing recommendations aimed at guiding professionals in their practice. More than a method in the strictest sense, the Manual is designed as an ideal to strive towards, which needs to be adapted according to the specific reality and the resources available in each context. It should also be a source of reflection and inspiration for all the people involved in the care of children with disabilities without parental care in order to support them in the development of their professional skills.

In concrete terms, the document proposes an approach that allows a systematic evaluation of the situation of each child with disabilities entering a residential care institution – regardless his/her health status – and to develop for him/her an individualised life plan responding to his/her needs and by applying the principle of subsidiarity.

A model for the child's dossier bringing together all the important information relating to the child in order to develop his/her life plan is proposed throughout the manual. The manual also proposes, in the appendix, a series of grids with questions to describe and assess the context of protection of children with disabilities deprived of their family within a given country. This part is designed to bring together, in the same document, all the information necessary to put into place a policy or project promoting the care of children with disabilities within a family environment.

With the intention of being distributed on a large scale this Manual is designed for use by a wide range of persons or organisations within varying contexts. It can, for example, support the work of a State undertaking to implement a national policy or support the action of an NGO or an International Consultant within the framework of a project (national or regional). It can equally serve an AAB wishing to specialise in the adoption of children with disabilities. Each potential user should find the support they need.

ISS team
September 2016

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[1] For the composition of the group, please see Authors on the back of the cover.

2. DEFINITIONS OF TERMS AND BASIC ASSUMPTIONS

The development of the project and its working tool – the present Manual – has generated much debate within the project team. Who are the children to be targeted? Is it really beneficial and/or feasible for all children with disabilities to be placed in a foster/adoptive family? Is it ethical to declare children adoptable when the chances of finding prospective adoptive parents are limited, even extremely limited? Is the project idealistic in view of the prevailing situation in numerous developing countries or those in transition? Will it not contribute indirectly to putting pressure on the countries of origin to increase the number of intercountry adoptions? Etc.

There are numerous issues surrounding this theme and the responses are rarely unique and clear-cut. We have nevertheless chosen to take a position because, it seems to us, that a clear positioning as reflected in this Manual, will better serve the objective of the project by proposing concrete ways to promote family care for children with disabilities. The recommendations that we formulate are a result of the experience and expertise of our two organisations together with those of the experts who have participated in the publication of this work. These recommendations are equally the fruit of long reflexions and discussions within the ISS team. We are however fully aware that other points of view exist and are also valuable.

The conception of the project led us to make choices, notably the ***terms used to refer to the children*** targeted by the project. Do we refer to children with disabilities, children suffering from a disability, children with a disability, living with a disability etc.? Each term conveys an image and a meaning that can sometimes be stigmatising. Finally, our choice is the term « children with disabilities », because this terminology is used in principal international texts relating to the subject, notably in the Convention on the Rights of Persons with Disabilities. The Committee on the Rights of the Child also uses the term in the General Comment n° 9 on the Rights of Children with Disabilities. On occasions, we have also used the term « child living with a disability » that seems appropriate for its descriptive character and avoids stigma. It also reminds us that these people are children first with all the rights, wishes and needs of a child and these are not reduced because of their disability.

As we see it the term « ***children with disabilities*** », or « children living with a disability » is not only a medical concept, but should be included in a broader conception, encompassing a social dimension. Disability not only defines a motor, mental, intellectual or sensorial condition but also how it is perceived and supported by the society and the obstacles that this will bring about for the person concerned. Thus, a person living with the same condition can be considered as with disabilities in one country when s/he would not be in another, according to the context and life environment. The Convention relative to the rights of persons with disabilities brings out this social dimension of disability. According to its first article, persons with disabilities « *include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others* »[2].

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[2] http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

The World Health Organisation (WHO) goes further and describes disability as "an umbrella term for impairments, activity limitations and participation restrictions. Disability is the interaction between individuals with a health condition (e.g. cerebral palsy, Down's syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports)"[3]. This definition expands somewhat the notion of disability, the difficulty encountered can relate to the individual or their environment. It seems, to us, appropriate for the project because this contextual dimension of disability plays a very important role in the situation of many children with disabilities living in residential care institutions without any other life plan.

We also sought to clarify the concept of **permanency planning,** as we understand it in the manual. In compliance with the main international standards in this field[4], it implies that family settings are preferred and sought as a priority at national level. Specifically, these considerations involve maintaining or reintegrating the child in his/her family of origin or community as the first plan to be considered. If this project is impossible or contrary to the interest of the child, a permanent protection measure must be envisaged, mainly national adoption (or Kafala in Muslim countries), but also long term foster care if it meets the best interests of the child. As a subsidiary option, after consideration of national solutions, the child's plan may also be intercountry adoption.

Sometimes, none of these options are feasible or responding to the best interests of the child. More innovative forms of family life may also be considered, such as cluster foster care or child-headed households. In this manual, we chose to focus on the more traditional forms of family setting, of which the full implementation would allow to meet the needs and interests of the vast majority of children with disabilities deprived of family care, such as: the reintegration of the child in his/her family (nuclear or extended), foster care, national adoption or intercountry adoption. If it is true that in many countries these solutions are still poorly developed, especially for children with disabilities, they must still be fully considered during the case management process.

However, the Manual recognises and also takes into account the fact that for some children a family setting can be difficult to achieve. Permanency planning must still be developed for the child, even if it is through adapted residential care such as small group homes. In any case those children must be nurtured and prepared for their adult life in the most appropriate way possible. This can take different forms such as facilitation of contacts with the child's family and strengthening links, integration into a school, rehabilitation programmes, etc.

The Manual promotes a systematic and thorough assessment of the situation of each child in residential care, regardless of their health status, in order to understand their needs and develop an appropriate case plan. Through this approach, children with disabilities benefit from the same consideration and are treated the same as other children while always taking into account their own specificity. This is reflected in the

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[3] http://www.who.int/mediacentre/factsheets/fs352/en/index.html

[4] More specifically: United Nations 1989 Convention on the Rights of the Child; Guidelines for the Alternative Care of children, formally adopted by the General Assembly of the United Nations in 2009; 1993 Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption.

Manual through recommendations that can be applied to all children as well as specific recommendations for children with disabilities. Of course, the aim of this is not to stigmatise or discriminate against children with disabilities but to recognise their particular needs and to provide an appropriate response in order to ensure their rights and to give them the same opportunities as other children of growing up within a family.

3. GLOSSARY

We have decided to use "informal" definitions that would be most easily accessible for the widest possible number of stakeholders - professionals and non-professionals.

- **Adoptability:** determination, by a multi-disciplinary team (when possible) from the country of origin, of the legal, medical and psychosocial capacity of the child to benefit from an adoption.

- **Adoption:** a measure of child protection that entrusts a child, in a permanent and official manner, to a person or couple other than his/her birth father or mother. This measure creates a new line of parentage, similar to a biological parent-child relationship. It severs the biological parentage if the adoption is full, but it is conserved if the adoption is simple. The adoption is national if the child is entrusted to a family who is resident in the country of origin of the child, or intercountry if the family adopting the child is usually resident abroad. In all cases, the adoption is based on the best interests of the child in offering him/her a permanent family environment conducive to his/her development whilst respecting the child's fundamental rights.

- **Alternative Care:** a range of suitable protection options for children deprived of parental care or who are at risk of being so. Each child in need of alternative care has specific requirements with respect to, for example, short or long-term care or keeping siblings together. The care option chosen has to be tailored to the individual needs of the child. The suitability of the placement should be regularly reviewed to assess the continued necessity of providing alternative care, and the viability of potential reunification with the family.[5]

- **Authorised Adoption body (or accredited) AAB:** an intermediary appointed by the Adoption Central Authority to carry out certain stages of the adoption process, essentially the preparation and the support of prospective adoptive parents in the country of origin.

- **Best interests of the child:** consists of putting the child at the heart of all decisions concerning him/her and ensuring that the child's interests and fundamental needs are always respected, beginning with the development of the child's life plan.

- **Caregiver:** residential care staff responsible for the daily care of the child and supporting the child in his/her development.

- **Central Authority (of adoption):** body designated by a State party to the HC-93 (see below) to implement and supervise the entire adoption procedure. As such, according to the Guide to Good Practice n°1 for the implementation and operation of HC-93, the Central Authority must exercise the obligatory functions required under Articles 7, 8 and 33, as well as those required under Articles 9 and 14 to 21, unless it delegates to another organization, public or private.

- **Competent authority:** body designated by the State, responsible for acting in a specific field (i.e.: child protection, protection of persons with disabilities, etc.).

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[5] Definition from the Guidelines for the Alternative Care of Children, 2010 Launch paper, p. 5. Available at: http://www.iss-ssi.org/images/advocacy/UN-Guidelines-Anglais.pdf

- **Consultation/Participation of the child:** the participation of the child is one of the fundamental principles of the Convention on the Rights of the Child which requires firstly that the child is heard and also that his/her viewpoint is then taken into consideration, in accordance with his/her age and maturity, for all decisions concerning him/herself. The child should be informed of all measures taken in these matters and of the consequences for his/her future life. Furthermore the child should be able to express him/herself in an environment favourable for free expression and exempt from all pressure.

- **(Hague) Convention on Protection of Children and Cooperation in respect of Intercountry Adoption, 1993 - HC-93:** the main Convention regulating the procedures for intercountry adoption and setting out the basic principles in this field.

- **(United Nations) Convention on the Rights of the Child, 1989 - CRC:** main international Convention protecting the specific rights of the child.

- **(United Nations) Convention on the Rights of Persons with Disabilities, 2006 - CRPD:** main international Convention protecting the specific rights of persons with disabilities. In 2014, this Convention was ratified by 154 countries.

- **Family setting:** a generic term that we use to facilitate the reading of this Manual and that includes all the options where the child can live in a family: reintegration of the child in his/her own family, kinship, adoption measures (national and intercountry), Kafala and long term placement in a foster family.

- **Foster care:** a care arrangement ordered or administered by a competent authority, whether on an emergency, short term or long-term basis, whereby a child is placed in a family home where the carers have been selected, prepared and authorised to provide such care, are supervised, and may receive financial or other support or compensation for doing so.[6]

- **(United Nations) Guidelines for the alternative care of children- Guidelines:** formally approved by the General Assembly of the United Nations (GAUN) 20 November 2009, these directives complete the implementation of the Convention on the Rights of the Child. They are principally aimed at ensuring that children do not unnecessarily become the object of an alternative care measure and, when this is necessary, that the placement meets the appropriate conditions required to guarantee the rights of children and their best interests.

- **Intermediary body:** the organism responsible for diffusing information and for the preparation and monitoring of families within a national or intercountry adoption framework or for a foster family project.

- **Kafala:** a measure of legal care of a minor (the « Makfoul ») by a person or entity (the « Kafil ») without breaking the link with the family of origin or creating a parent-child link with the « Kafil ». Kafala is revocable at any time and without justification. It involves an obligation for the « Kafil » to accept responsibility for the maintenance, education and protection of the minor as if s/he was their own child.

- **Matching:** choice of the family best able to respond to the needs of the child to be adopted or cared for.

- **Permanency plan/ planning:** a permanent protection proposed for the child that responds to his/her needs and best interest and that aims at allowing the child to grow up within a family whenever possible. In accordance with international principles, priority must be given to maintain or reintegrate the child in his/her family of origin or his/her community, followed by national adoption or Kafala and, as a subsidiary option, intercountry adoption. Foster care, in accordance with the national context, can be used as a long-term protection measure. In some cases, permanency can also be provided through innovative ways, such as placement in small group homes, cluster foster care or child headed households.

- **Placement in Residential Care:** a measure of protection that is, in principal, provisional and considered as a transition to a permanent family solution (e.g. the reintegration of the child in the family of origin, adoption or long term foster care). In cases where the search for a family is not successful, despite the efforts undertaken, residential care could become permanent and therefore must be developed to be as much suitable as possible for the needs of the child. (§21 Guidelines).

- **Reference Person:** staff member responsible for the follow-up of one particular child throughout his/her stay within the residential care institution. The child's reference person could be a caregiver, an educator, a social worker, a teacher, a nurse or any other professional in direct contact with the child. Beside the monitoring and perfect knowledge about the child situation, the reference person also ensures the respect of the rights of the child and make sure his/her voice and opinion are heard during any decision making-process.

- **Residential care Institution - RCI / Residential care facility:** any non-family-based group setting specially designed or designated to care for children without parental care where staff or volunteers ensure care. In this manual it includes short and long-term arrangements, private or public facilities from a small to a large capacity.

- **Subsidiarity:** according to this principle intercountry adoption can only be envisaged if the child cannot remain in his/her biological family and if no other appropriate protection measure is available for the child within his/her own country.

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[6] Definition from "Identifying basic characteristics of formal alternative care settings for children a discussion paper – march 2013"

Main steps to promote the right of children with disabilities in residential care to grow up in a family setting adapted to their needs:

SECTION 1 - Part B

Chapter 1

CHILD'S ARRIVAL IN RESIDENTIAL CARE

- A detailed entry report (cf. 1.1)
- Evaluation of the immediate medical needs and general description of the child (cf. 1.2)
- The first actions to carry out (cf. 1.3)

Objective: **GET A 1ST IMPRESSION OF THE CHILD**

Chapter 2

IMPROVING THE KNOWLEDGE ABOUT THE CHILD'S NEEDS

- Regular observations of the child (cf. 2.1)
- Adapted care for children with disabilities (cf. 2.2)
- Regular team meetings (cf. 2.2)

Objective: **DEVELOPING AN ADAPTED AND INDIVIDUAL SHORT TERM CARE PLAN (cf. 2.3)**

Chapter 3

REGULAR AND SYSTEMATIC EVALUATION OF THE CHILD

- Evaluation of the child on 3 levels (legal, medical, psychosocial) (cf. 3.1, 3.2, 3.3)
- Situation of the child regularly reviewed by the multidisciplinary team (Use and regular updates of the child's file)
- Consultation of the child during the decision-making process (cf. 43, 60-61, 63)

Objective: **PROMOTING SUITABLE PERMANENCY PLANNING (cf. 3.4)**

Chapter 4

PREPARATION OF THE CHILD FOR A FAMILY LIFE

- Simple and cost effective child preparation activities (cf. 4.1, 4.2, 4.3)
- Use of the child's Lifebook as a preparation tool (cf. 69)

Objective: **PROMOTING THE TRANSITION TO HIS/HER NEW ENVIRONMENT**

SECTION 2 - Part C

AUTHORITIES PROMOTE AND DEVELOP ACCES TO FAMILY LIFE FOR CHILDREN WITH DISABILITIES

- ISS offers technical assistance to develop family setting options.

For the professionals in direct contact with children with disabilities

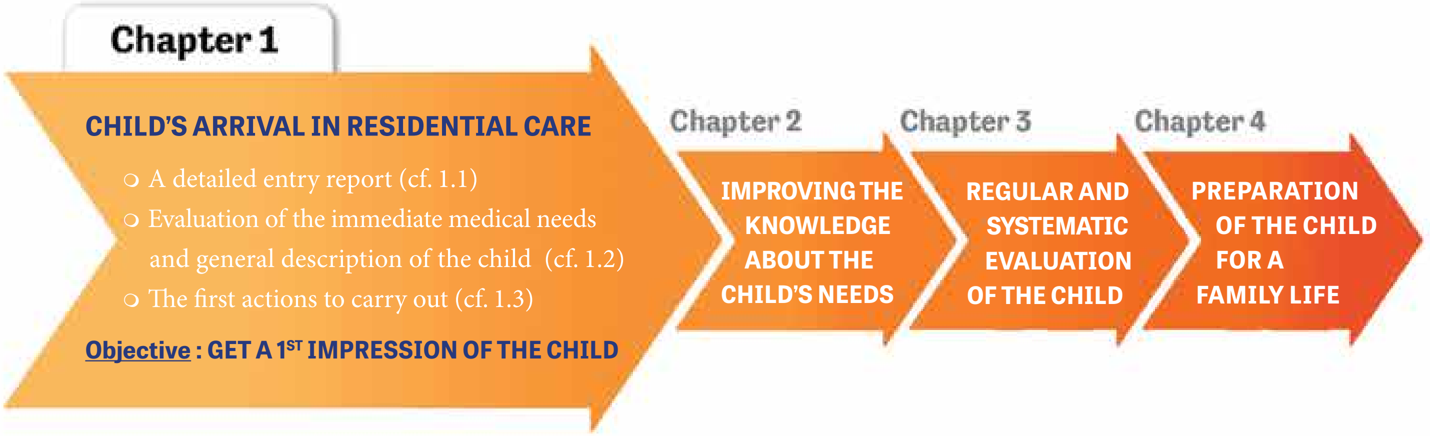
Part B

Method of intervention

Residential care placement remains a measure widely used for children without parental care, despite the concerns of the international community and their reiteration of the principle that all children should grow up in a family environment, or at least within their community. Based on this reality, this manual, targets children with disabilities placed in residential care institutions (RCI) and is intended for the concerned professionals.

It is important however to underline, that, as specified in paragraphs 20 and 21 of the UN Guidelines for the Alternative Care for Children (Guidelines below), the use of residential care should always be considered as a temporary measure, a transition towards the reintegration of the child into his/her family or, when this is not possible, towards the child's placement within another family. RCI must ensure the most individualised care possible for the child and a good quality of life free from abuse (Guidelines, § 84-88). The daily care of all children and in particular of children with disabilities within the RCI plays a key role in his/her development and well-being both for the present and his/her future. The efforts related to improve care in such facilities should necessarily run along with other efforts such as preventing family separation, reintegrating the child into his/her family and searching for permanent family solutions.

RECEPTION OF CHILDREN WITH DISABILITIES IN RESIDENTIAL CARE

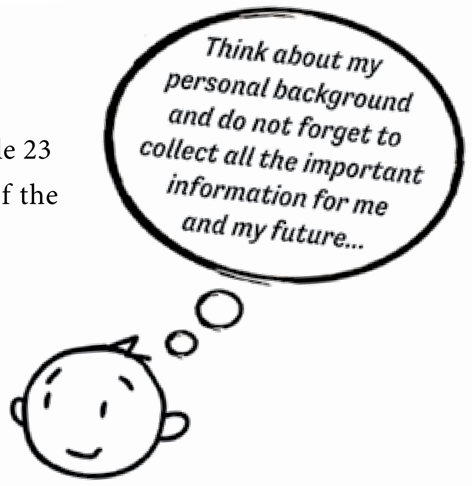


CHILD'S ARRIVAL IN RESIDENTIAL CARE

- A detailed entry report (cf. 1.1)
- Evaluation of the immediate medical needs and general description of the child (cf. 1.2)
- The first actions to carry out (cf. 1.3)

Objective : GET A 1ST IMPRESSION OF THE CHILD

General principles



- This section relies more specifically on article 25 of the CRC, article 23 of the CRPD, paragraphs 51, 81, 109-111, 113-117 and 123-127 of the Guidelines.

- The RCI should work and collaborate with the competent authority in order to take short-term protection measures, investigate the situation of the child and the family, and then develop a suitable permanency plan for each child.

- The child protection authorities should be responsible for the evaluation of and the decisions concerning the child. They should be supported by the professionals caring for the child and the social services supporting the family (depending on the situation in the country).

- The child's file should be initiated at the child's arrival. It is the basis to develop a summary of the situation of the child by gathering all the relevant information including observation reports, regular evaluations, and care plans. All the data collected will support the care plan and define a suitable permanency planning.

A template of the file is proposed throughout chapters 1, 2 and 3
in grid format and compiled in the annex.

1.1 The entry report

- An entry report should be completed and kept in the register of the RCI and in the child's file that must be created. It is important for the child to keep a written record of this moment. An example of the entry report below page 21 shows the information to record.

The circumstances relating to the arrival of the child and his/her background should be identified and analysed (Guidelines, § 110-111) in order to investigate his/her situation and that of the family, for the purpose of permanency planning.

1. If the child has been left at a hospital or maternity home by the parents and placed in residential care by the hospital or maternity home:

- The hospital staff should provide all the information at their disposal relating to the child's parents (including their identity and their address if possible) together with the reasons for the abandonment (young mother without support, visible disability at birth, spontaneous or considered abandonment plan, etc.).
- The possibility of searching for the birth parents or, if known, of working with them towards the reintegration of the child should be discussed rapidly with social services, the protection authorities and the RCI staff.
- No direct payment should be made to the birth family, nor should any form of remuneration be made for the abandonment of the child.

2. If the child has been found in a public or dangerous place by an individual or the police and s/he has been placed in residential care by social services or the police:

- The persons concerned should pass on all the information they have on the place and circumstances under which the child was discovered and on the progress of the family tracing and the prospects that they open up for the child. Even small details should be transcribed because it may be that these are the only information the child will have about his/her history.

3. If the child was placed in RCI by his/her family:

- An interview should be organised with the family, a supervisory worker of the RCI and, if possible, a social worker in order to determine the reasons for this placement, whether this seems to be temporary or permanent, and the demand of the parents regarding the placement.
- The bond between the parents and the child should be assessed, preferably by a social worker or a psychologist if it is possible: maintaining contact should be encouraged and facilitated with the purpose of a family reintegration if that is possible and in the interests of the child (as mentioned in paragraphs 51 and 81 of the UN Guidelines). If applicable, all efforts should be made to support the (extended) family, to attempt to find a family solution for the child and avoid the relinquishment of the child in the RCI (see section C1 for more details).
- The motivation of parents to care for their child should be assessed. However hasty judgements about their motivations should be avoided because they could be traumatised by the situation and incapable of a rational judgement at this stage.

4. If the child has been abused or neglected by the family and placed in residential care by social services, the police or the local competent authorities, on the basis of a formal court order or administrative decision:

- The persons concerned should pass on all the information they have on the circumstances of the removal of the child from his/her family, indicating if a protection decision has been taken, if the removal seems definitive or not, etc. The possibilities of further family mediation should be considered rapidly with a view to the care of the child being undertaken by the birth or extended family. If it is in the interests of the child, his/her reintegration into the birth family should be facilitated.

5. If the child has lost his/her father, mother or both parents and is placed in residential care by a member of the family, social services or the local authorities:

- The circumstances of the disappearance of the parents should be passed on to the RCI and permanency planning should be considered rapidly and as a priority with the extended family and the community.

- After their admission, the child's personal belongings should be listed and mentioned in the child's file. It is essential to keep all the child's belongings including those which seem to have no « value », in order to be able to hand them to the child or to persons who will care for the child in the future They could be the only links with his/her origins.

- A life book should be initiated quickly by the reference person of the child in order to write down all the relevant information concerning the child. The child should have the possibility to fill it in him/herself or in collaboration with his/her caregiver, if s/he is old enough to do it. The life book is the child's property and thus s/he can bring it with him/her when s/he leaves the facility.

ENTRY REPORT: INFORMATION TO OBTAIN ON THE ARRIVAL OF THE CHILD IN THE RESIDENTIAL CARE FACILITY

This document must be filled in with the person who brings the child in order to gather as much information as possible about the child. It is important for the child to keep a record of this moment by collecting the following information that may be his/her only link with his/her origins.

Name of the facility in charge of the child ....

Date and time of arrival ....

I. BASIC INFORMATION ABOUT THE CHILD

For the RCI, these items are basic information about the child. They enable to identify and record the child and ease the communication with him as well as his/her care. **For the child's future,** this information is the basis of his/her origins and personal history.	Date and time of arrival in the facility	
	Name(s) and forename(s) of the child	
	Sex	
	Date of birth	
	Place of birth	Hospital ☐ At home ☐ Other ☐
	Religion if known	
	Mother tongue	
	Location of the child before arrival? Please detail the name(s) of the facility(ies) and/or hospital(s):	☐ With his/her birth parents: from......................... to......................... ☐ With relatives: from......................... to......................... ☐ In another centre: from......................... to......................... ☐ In hospital: from......................... to.........................
	Physical description and, if possible, a photography of the child (in attached file)	

II. INFORMATION ABOUT THE PERSON WHO BRINGS THE CHILD

For the RCI, this information is precious should it be necessary to reconnect with the person who brings the child in order to have further details on the origins of the child and the circumstances of his/her placement. **For the child's future,** this information is essential, should s/he not know anything else about his/her origins. S/he may know thus how s/he has arrived into the centre.	Name(s), forename(s), gender	
	Age	
	Address	
	Phone number	
	Relationship between the child and the person (father, mother, relatives, police, child protection services, local authorities, social welfare department, etc.)	
	Professional position of the person in case s/he belongs to an official authority	
	In an attached file: Copy of the identity card of the person and Photography of the person	

III. REASON FOR THE PLACEMENT IN RESIDENTIAL CARE

For the RCI, this information enables to start social work and to support the child in this always traumatic stage. **For the child's future,** this information gives him/her details on the circumstances of his/her placement and enables to better understand the decision of his/her birth parents.	☐ Orphan: ☐ Abandoned in a public place, without known parentage: provide details relating to circumstances of abandonment (place where the child was found, the person who found the child, etc.) .... ☐ Withdrawal of parental authority by a judicial decision ☐ Brought directly by the family of origin
	If the child is brought directly by the family of origin, what is the demand of the parents, if known (temporary placement or long term placement, etc.)?
	If the child was brought by his/her family or if parental authority was withdrawn, what were the reasons and circumstances of the placement (poverty, illness, abuse, etc.)?

IV. INFORMATION ON THE FAMILY OF ORIGIN

For the RCI, this information is essential to start the social work and the investigation within the family and to determine rapidly the legal status of the child. It provides details on the siblings in order to attempt reunification if they are also under protection measures. **For the child's future,** these items give him/her essential information to lead research on his/her origins should s/he wish to do so later.	Name and age of the mother if known	
	Name and age of the father if known	
	Address, phone number(s) of the mother and/or the father	
	Ethnic origin of the parents if known	
	Civil status, number of years together, bond between the parents	
	Number of brothers/sisters and siblings, position if appropriate	
	Are the child's brothers and sisters:	
	- remaining with the parents/family?	Yes ☐ No ☐
	- placed in the same facility?	Yes ☐ No ☐
	- placed in another centre?	Yes ☐ Name of the centre: .... No ☐
	- placed in a foster family?	Yes ☐ No ☐
	- other?	

V. MEDICAL HISTORY OF THE CHILD

For the RCI, this is important to ensure the medical follow-up of the child and adapted care. The person who brings the child can have crucial information about his/her health, it is therefore essential to ask him/her these questions. **For the child's future,** this information enables to know more about his/her own development, medical history and its eventual impacts on the long run.	Health status of the child at birth (if known):	
	Weight and height at birth	.... kg .... cm
	Head circumference at birth	.... cm
	Was the pregnancy monitored?	Yes ☐ No ☐
	Was the delivery normal?	Yes ☐ No ☐ Premature birth ☐ Do not know ☐
	Place of delivery:	
	Details known on the delivery:	
	Medical history known, diseases occurred in the past, specific treatments, etc.:	
	Evaluation of the immediate needs of the child (nutritional status, dehydration, etc.):	

List of the personal effects at the child's arrival (clothes, letter(s), jewellery, toy(s) etc.)
(It is important to keep the personal effects of the child since it is often the only link with his/her past)

....
....
....
....
....
....
....

Signature of the person who brings the child

Signature of the staff in charge of
of the admission of the child

1.2 Evaluation of the immediate medical needs and general description of the child

❖ A full medical examination should be carried out in the first days following the arrival of the child, if possible by a paediatrician or a medical doctor and/or nurse (see section 3.2.). Basic serology (HIV, HepB, Syphilis) and basic vaccinations should be given if the immunisation status is unknown and noted on his/her health card if one exists (or one should be created if necessary). This admission consultation is essential to get an overview of the global situation of the child, to help assess the immediate medical needs and plan adapted care within the RCI:

- If the child is healthy, the caregivers can promote the integration of the child: presentation of the staff, other children, the environment, the timing, if necessary the regulations, etc.;
- If the child has a disability which is evident at this stage, the medical doctor or nurse should provide specific advice adapted to the needs of the child;
- If the health status of the child is not satisfactory, the medical personnel present should provide first aid or, if necessary, refer the child to a hospital.

MEDICAL CONSULTATION TO BE CARRIED OUT IN THE FIRST DAYS FOLLOWING THE ARRIVAL OF THE CHILD

This form enables to know the health status of the child and to start adapted medical care and follow-up.

This data gives a 1st indication on the development of the child.	Weight: .... Length: .... Head circumference: ....
Malnutrition can lead to developmental delays.	Malnutrition: Yes ☐ No ☐
Is the child ill, tired, in good condition, etc.?	What is the global health status of the child?
These items enable to plan the caring of the child and eventual necessary adjustments.	Does the child have any visible and/or known disability(ies) upon his/her arrival? Yes ☐ No ☐ If yes: • What are they and what treatment/therapies are envisaged and how frequently?.. .... • What impacts do they have on the life of the child (daily life, autonomy etc.)? ....

This information enables to plan adapted treatment of the child.	Were any chronic diseases or serious health problems detected on his/her arrival? Specify the treatment plan and timetable:
These items enable to specify the global health status of the child and the eventual impacts on his/her current and future life.	Has the child had any diseases in the past? Ordinary children's diseases (whooping cough, measles, chicken-pox, rubella, mumps)? Yes ☐ No ☐ Do not know ☐ Please indicate the age of the child in respect to each disease as well as any complications: Disease .... date .... at .... months/years; complications : .... Disease .... date .... at .... months/years; complications : .... Disease .... date .... at .... months/years; complications : ....
These items enable to specify the global health status of the child and the eventual impacts on his/her current and future life.	The results of clinical examinations, with details of the dates: • Skin (done the ....) .... • Cardiopulmonary (done the ....) .... • Abdominal-pelvic (done the ....) .... • Neurological (done the ....) .... • Musculoskeletal system (done the ....) .... • Other (done the ....) ....
	The results of the following biological tests, with details of the dates: • Blood counts (done the ....) .... • Iron levels (done the ....) .... • Screening for sickle cell disease (done the ....) .... • Serology (HIV, Syphilis, Hepatitis B and C if possible) (done the ....) .... • Miscellaneous (done the ....) ....

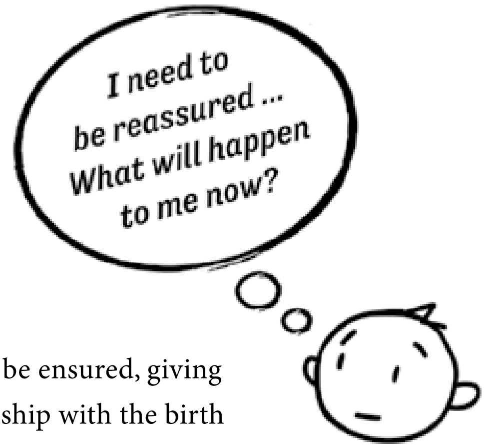
GENERAL DESCRIPTION OF THE CHILD

Does the child seem to be confused, depressed, aggressive, etc.?	Personality of the child (character, behaviour with other children/adults, sleeping pattern, specific problems, etc.). Provide as much detail as possible: ....
Motor	- The child sits by him/herself Yes ☐ Not yet ☐ - The child crawls/moves forward Yes ☐ Not yet ☐ - The child stands with support Yes ☐ Not yet ☐ - The child walks on his/her own Yes ☐ Not yet ☐
Language	- The child starts to prattle Yes ☐ Not yet ☐ - The child says single words Yes ☐ Not yet ☐ - The child says sentences Yes ☐ Not yet ☐
Social interaction	- The child looks for physical contact with adults: Always ☐ Often ☐ Sometimes ☐ Never ☐ - The child communicates and plays easily with other children: Yes often ☐ Yes rarely ☐ Never ☐
Emotions	The child shows emotions (anger, fear, joy, sadness, surprise): Easily ☐ With difficulty ☐ Never ☐
General level of activity	Passive ☐ Active ☐
If the child is at school:	- Which class is s/he currently in? - Can s/he draw a picture? Easily ☐ With difficulty ☐ Is not able to ☐ - Does s/he know the letters of the alphabet: Yes ☐ With difficulty ☐ Does not ☐ - Can the child read? Easily ☐ With difficulty ☐ Is not able to ☐

SUGGESTIONS FOR AN ADAPTED CARE PLAN

Get a first idea of the immediate needs of the child for Short-term care.	....

1.3 The first actions to carry out



- On his/her arrival: it is important for the child to feel secure; and that a professional takes the time to listen to the child, to reassure him/her, to explain why the child is there. As soon as possible, a reference person should be assigned to the child to provide him/her with appropriate consideration and individualised support (Guidelines, § 126).

- Insofar as possible, a personalised psycho-social support should be ensured, giving particular attention to the condition of the child, his/her relationship with the birth family, the child's abilities and limits of attachment, his/her expectations and demands, his/her potential traumas, etc.

- The caregivers and the reference person of the child should ensure his/her smooth transition within the RCI and provide him/her with special attention and support appropriate to the child's age and state of health. The child should be introduced to his/her new companions and particular attention should be paid at the beginning to ensure an effective integration into the group.

- For all children coming into care, a system for early diagnosis of disability should be implemented through regular observations and assessments (see sections 2.1 and 3 for details). This system should help to quickly identify children with disabilities or with psychomotor development delays in order to orientate the child towards a rapid and adapted care.

For the care of children with disabilities, complementary actions adapted to the disability should be undertaken, in particular:

- Specific attention should be given in order to ensure that the child is well accepted by the other children and that his/her disabilities are not the subject of derision or exclusion. In this perspective, a group session can, for example, be organised with the other children to introduce and welcome the child.

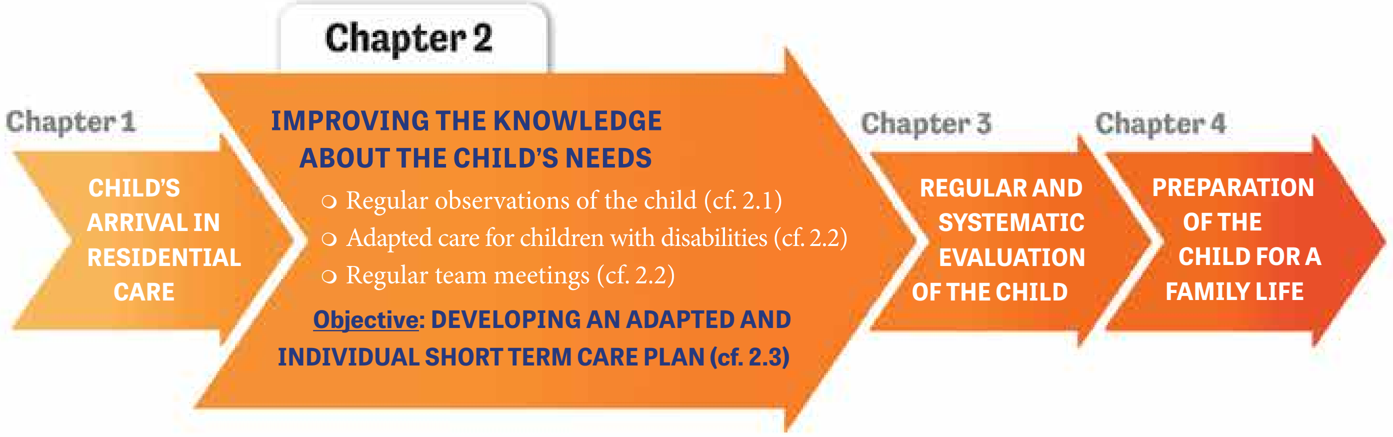
- Basic medical examinations should be the responsibility of the RCI.

- If the pathology or disability of the child requires an urgent intervention, the operation should be the responsibility of the State.

- Training should be put in place for the multi-disciplinary team (caregivers, educators, managers) relating to the identification and early detection of the main forms of disability. This should be completed by raising awareness, helping them to know and understand the specificities of the various disabilities encountered and to adapt their behaviour to the needs of each child with disabilities (Guidelines, § 115-117).

IMPROVING THE KNOWLEDGE ABOUT THE CHILD'S NEEDS

How to offer an environment that allows a child living with disabilities to develop at his/ her own pace and to experience new competences and self-esteem? How to support professionals in their work with this child? These are some of the questions that the team working with the child should keep in mind to ensure nurturing and individual care..



2.1 Regular observations of the child

- Regular observations enable to understand the child's needs and progress, to detect any development disorders and to adapt the care plan.

- The observation should, as much as possible, be carried out by the reference person of the child and starts once the child seems familiar with his/her new environment.

- The more the multidisciplinary team working with the child will have a precise understanding of the child's needs, the more adapted and individual the care will be. This will enable to support the child's competencies and development.

« Observation is a core activity within the caregivers, nurses, educators, psychologists, paediatricians and managing staff, and enable to build a thriving and shared representation of every child in care. At all levels, each staff member cares about concrete details of the child's life and focuses on finding suggestions to help the child to develop and to progress at his own pace with pride and courage »[7].

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[7] Dr Isabelle DELIGNE paediatrician, excerpt from the article "Observation according to Pikler: A revolution for children placed in institutional care", ISS Monthly Review, August 2014.

- **These observations could also be useful for:**
    - Comparing and getting a baseline to detect an eventual discomfort or pain in the child. (For more details see chapter 2.3).
    - Supporting the child's on-going assessment (see chapter 3 « Regular and systematic assessment of children").

- A template of an observation grid called « Observation Matrix » is proposed pages 32 to 35.

OBSERVATION MATRIX, a tool to observe the child

Name and forename(s) of the child:

Place of residence:

Date of the observation:

Person in charge:

1. SOCIAL INTERACTION

- How does the child experience the relationship? Check boxes:

Degree Type of people	Initiates contact easily	Withdrawal/ Inhibition	Other	How?
With his/her caregivers				
With other adults within the facility				
With other children				
With casual visitors				

- Does the child show interest in social environments (parties, moments of sharing, outing)?
- Does the child easily participate to proposed activities?

2. COMMUNICATION circle the one(s) that apply

- Does the child communicate: Verbally | Not verbally | Both
- How? Vocabulary | Sounds | Glances | Mimes | Movements | Others
- How does the child show that s/he did not understand?
- Does s/he sometimes express him/herself with cries?

Always | Most of the time | Often | Sometimes | Rarely | Never

3. EXPRESSING THE NEEDS circle the one(s) that apply

- Is the child able to express a need, a desire, for example: to eat, to drink, to be changed, discomfort, pain, etc?

Always | Often | Occasionally | Rarely | Never

If yes, which need(s)

- How does s/he express that s/he is still hungry or thirsty?
- How does s/he show/express his/her discomfort:

Does s/he show identifiable motor and/or verbal reactions (e.g. when s/he is in an uncomfortable position, if his/her environment is disturbing, etc.)? If yes, which ones?

- Does s/he express physical complaints (nausea, itching, pain, etc.)?
- What kind of strategies does s/he use to relieve physical pain?
- Can s/he make a choice: YES | NO

4. EMOTIONS

- Does s/he express the emotions mentioned below? Check boxes:

Degree Emotions	Yes	A little	No	How?
Joy				
Sadness				
Fear				
Disgust				
Surprise				
Anger				

- The child's smile:

When does the child smile?

How does s/he smile? Is it natural, spontaneous, fixed, tight?

- Does the child cry?

When does the child cry? How does s/he cry? Tears, cries, moans

- Is his/her face frozen, without significant expression?

5. INTELLECTUAL DEVELOPMENT

- Is the child interested in his material environment (toys, objects, etc.)? Does s/he seek to manipulate them?
- Is the child able to be attentive, and to concentrate?
- Does s/he demonstrate the concepts of danger?
- About his/her **space orientation:**

Locates him/herself in his/her room: Very good | Moderate | Not yet

Locates him/herself within the facility: Very good | Moderate | Not yet

Locates him/herself in known places: Very good | Moderate | Not yet

- About his/her **time orientation**?

Identifies the difference between morning and evening	Very good	Moderate	Not yet
Locates him/herself in relation to the daily routine activities	Very good	Moderate	Not yet
Locates him/herself in the week	Very good	Moderate	Not yet
Locates him/herself in relation to the celebrations	Very good	Moderate	Not yet

- What is the child's **autonomy level**?

1. **Autonomy**: does not depend on help;
2. **Monitoring**: requires verbal support;
3. **Support**: requires physical support;
4. **Complete dependency**: requires total support.

Bath/shower:	1	2	3	4
Dressing:	1	2	3	4
Meal:	1	2	3	4
Elimination				
Urines:	1	2	3	4
Stools:	1	2	3	4

6. BEHAVIOUR

- What are his/her main personality traits?
- Does s/he have unusual behaviours
(e.g. itching, rocking, repetitive movement, etc.)?: YES NO

If yes, which one(s)?

- Does he have « obsessive » activities (manipulates a specific toy)
and important for him/her? YES NO

If yes, which one(s)?

- Does s/he have one or many ritual(s)?
(e.g. needs to execute a specific task, always in the same order) YES NO

If yes, which one(s) AND in what circumstance(s)

- What is the child's behaviour during baths, meals, body treatments
(ways of participating, refusing, playing)?
- Others

7. MOVEMENTS OF THE CHILD circle the one(s) that apply

- Most of the time the child's movements are: Controlled Uncontrolled
- Does s/he have a sense of balance? YES NO
- What kind of movements can the child do:

Pivot, turn, lift his/her pelvis, get on his/her side, sit, kneel, stand.

- What is his/her main way of moving: Rolls, crawls, on all fours, walks while holding something, walks alone.
- Is the child: Right handed Left handed

8. WHAT IS THE STATE OF TENSION OF THE CHILD'S MUSCLES (= tone)

Normal / Abnormal / Low tone / High tone / Strong tensions / Spasms

- Is the tone annoying the child in his/her daily life?
  - For him/herself: YES NO
  - For the caregiver: YES NO

(If yes, describe the manifestations and circumstances for the child and for the professional)

9. COMFORT POSITION circle the one(s) that apply

- What is the child's usual position: leaning, forward, sideways, backwards, curled up, etc.?
- What is his favourite comfort position? (E.g. lying, on the back, in a foetal position on the side, sitting. etc.)
  - during a free activity:
  - at nap time:
  - in the bath:
  - during meals:
  - when carried by an adult:

10. SLEEP

- On average, how many hours does the child sleep By night .... h By day .... h
- Sleep quality: Quiet Continuous Discontinuous Deep Agitated

11. CARE

Does the child easily accept care?	If the person is known by the child	Unknown person
Nurse(s)	Yes / No	Yes / No
Doctors	Yes / No	Yes / No
Paramedics / Therapists	Yes / No	Yes / No

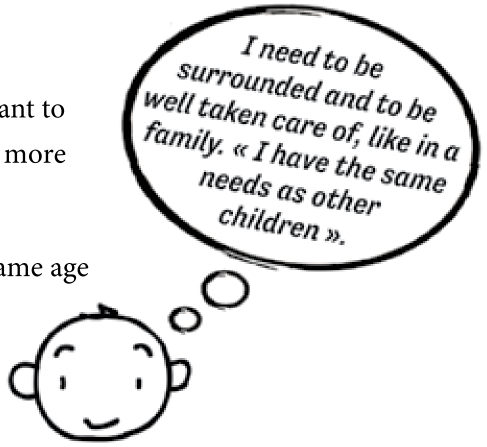
Does the child need (and expresses the need)
to be accompanied by a caregiver during care? YES NO

2.2 Recommendations for an adapted care

Several of the recommendations below are inspired by article 4§1 of CRPD, paragraphs 71, 100, 123 to 130 of the Guidelines and by the Emmi Pikler[8] method. Their aim is to propose ways to support professionals in RCIs in their delicate work.

THE CHILD AT THE CENTRE OF THE PROCESS

Care within a small group



- As children need the most personalised care possible, it is important to form small groups of children. The work of the caregiver will be more efficient and directed towards the needs of the child.
- The child can better benefit from interactions with peers of the same age in a small group

***Recommendation:** the staff to child ratio should be defined regarding the age and profile of the children in care, for a group of children with disabilities the minimum required should be 1 staff to every 3-5 children during daytime*[9].

The continuity of care

- The child, whatever his/her health status, needs stable reference points. It is important that the persons looking after him/her are always the same and are few in number. A limited number of adults should therefore be involved with the same small group of children.
- Infants are capable, from birth, of recognising people close to them. It is essential to also ensure this permanence for them.

***Recommendation:** ideally four caregivers care for the children of the same group, ensuring successively the morning, afternoon, night or weekend services.*

The reference person

- Each child should have a reference person, specifically responsible for his/her follow-up, to ensure his/her rights are respected and his/her voice and opinion are heard.

***Recommendation:** ideally the reference person should be responsible for the follow-up of a small number of children (3 or 4).*

The creation of an intimate and personal relationship

- The child needs, from a young age, to be considered unique when the adult is caring for him/her. S/he needs a special and individual recognition. The time given to care (meals, changing, washing, putting to bed, etc.) provides privileged bonding moments. These individualised times allow the creation of an intimate and personal relationship between the child and the adult and assists in mutually getting to know, listening to and appreciating one another. It helps to build an emotional relationship that assures the child that s/he can count on the attention and the availability of an adult who looks after him/her, who has a personal interest and is ready to respond to his/her demands and emotions.

***Recommendation:** each child should have time consecrated to him/her during baths, meals, game sessions and regular carrying. For example, for the younger children, feeding bottles should be given in the arms of the educator who gives all his/her attention during this very important stage of life.*

The life book

- In order to keep a trace of the child's story and experience, it is essential that important information about his/her personal history be recorded. This should include the main stages of the child's development, progress, strengths and highlights in the life of the child, as mentioned in paragraph 100 of the Guidelines.
- The life book should begin at the child's arrival in the facility.
- The reference person who follows the child keeps the information contained in the life book up to date together with the child if s/he is old enough.
- The life book contains cherished and irreplaceable letters / photographs etc. and is the child's property. As such it is recommended that copies be made of these precious records, in case the child destroys any of the photos in anger, or if the book gets damaged (both common occurrences).

THE MULTI-DISCIPLINARY APPROACH

Basic training -continuous training- Supervision - for the RCI' staff

- With the arrival of a new caregiver, a basic practical and theoretical training should be provided on the concepts of hygiene, of psychology and the development of the child, good caregiving practices, etc. An educational programme should be established at the arrival of each caregiver as promoted in paragraph 71 of the Guidelines.
- The RCI staff should benefit from an ongoing training, provided by specialists in early childhood, in order to optimise practices, learn new techniques, review and increase their knowledge on child development.
- Teamwork is essential in order to ensure and maintain consistency and continuity of the activities and of the different people who are responsible for the same group of children, in order to share knowledge of each child, to find help and support in addressing the problems encountered and progressing in their professional competence.
- The team of caregivers who take care of the children with disabilities should be reinforced as much as possible. They need to be able to work in pairs in order to enhance the safety of the children and also have the time to organise sessions of group and individual games for the children.
- A discussion group and/or regular debriefing sessions for professionals caring for children with disabilities should be set up to help them talk freely about practical difficulties and emotional experiences during daily care.

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[8] Website of the Association Pikler Loczi: http://www.pikler.fr/

[9] Example of standard of staff to child ratio: Guidelines and Standards residential care for vulnerable children and youth in Lesotho, UNICEF 2006 http://ovcsupport.net/wp-content/uploads/Documents/Guidelines_and_standards_residential_care_for_vulnerable_children_and_youth_1.pdf, p. 34-35.

- The RCI should be the object of an independent, external assessment both for the level of care of the children and the quality of their infrastructure (in compliance with paragraphs 128 to 130 of the UN Guidelines on the subject).

2.3 Developing an individual and short-term care plan

To develop an individual and short-term care plan, it is necessary to focus on the child's needs and his/her own expectations.

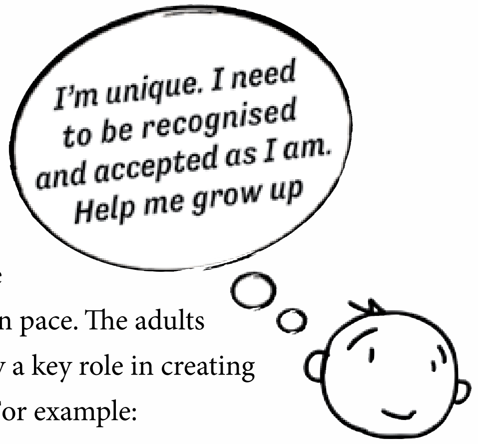
The development of an individual care plan is based on the following steps:

1. Set goals for the personal growth and development of the child
2. Activities / Steps to achieve the goals
3. Calendar / deadlines for achieving the objectives
4. Which member(s) of the team are involved in the activities?

The importance of teamwork

*Here are some **areas of focus** that can be developed in the individual care plan of the child:*

Supporting the child's development



- The child needs encouragement; the adults will support the child by showing interest in his/her activities, by sharing the pleasure to discover the world and his/her own abilities.
- The child also needs a stimulating space, furnished with appropriate equipment, to help him/her discover the environment at his/her own pace. The adults should endeavour to promote the curiosity of the child and will play a key role in creating this stimulating space adapted to the child's abilities and potential. For example:
    - **Sensorial stimulation**: through songs, stories, music, speaking to the child (importance of exposure to language), toys that are age appropriate, etc.
    - **Motor stimulation**: the child should be accompanied in his/her movements and be encouraged in his/her progress to the main motor acquisitions such as the sitting position or walking. The adult should encourage discovery time for the child whilst always protecting him/her from the dangers. With this in mind, the children should only be left in bed at naptime and during the night.
    - **Affection**: the child needs to be carried regularly. Affection is also shown by giving regular attention to the child, through eye contact and in the language of the child minder to the child.

- Appropriate daily care in line with instructions from specialised physiotherapists and focused on the child's needs have a positive impact on the development of children with disabilities. In parallel, specific sessions of rehabilitation and/or stimulation, with qualified personnel, should be developed and benefit to every child.
- The premises shall be adapted as much as possible to support children with disabilities and allow for rehabilitation sessions with the proper equipment.

Language and communication with the child

- It is important for the adult to use the child's name when speaking to him/her in order to enable the child to exist as an individual and to gain confidence in him/herself.
- The caregiver « should take care to inform and warn the baby of what s/he does with him/her. The caregiver should endeavour to be understood by and to understand the child through speaking and putting into words what the adult is doing, what s/he notices about the actions being carried out and in addition communicates through gestures »[10].

The integration of children with disabilities into RCI

- The child should be integrated into the community life of the centre (meals, games, outings, school, etc.) and as much as possible into the outside community.
- To raise awareness of disability issues of other children and counter the negative stereotypes which surround it, activities should be undertaken where children with disabilities take the lead for example in discussions and debates.

The consideration of the pain and the relation with the child

- Children with disabilities do not always or fully have means of expressing discomfort or pain. It is particularly difficult for professionals to determine manifestations of pain, as sometimes this pain is only noticeable by a change of behaviour. The «Observation matrix » will be helpful here and should be considered as a « reference during calm situations » of behaviour, body language and usually adopted positions. This reference can be used as a point of comparison when there is a suspicion of pain. The professionals who know the child can work together on the observation matrix in order to enhance the multidisciplinary view on the child and help him if needed.
  With reference to the « observation matrix » and the whole team's good knowledge of the child, it may be possible to detect unusual verbal or non-verbal manifestations of the child which could be linked to discomfort or pain.
- A detailed and precise knowledge of the child should enable to identify the areas through which the adult can easily come into contact with the child as well as the sensitive areas and the very sensitive areas. This type of information and knowledge about the child can easily be shared with all members of the multidisciplinary team using a map as shown below.

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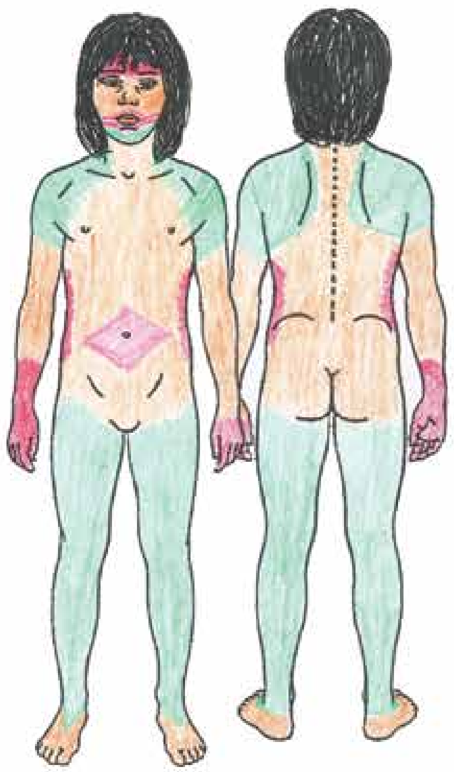
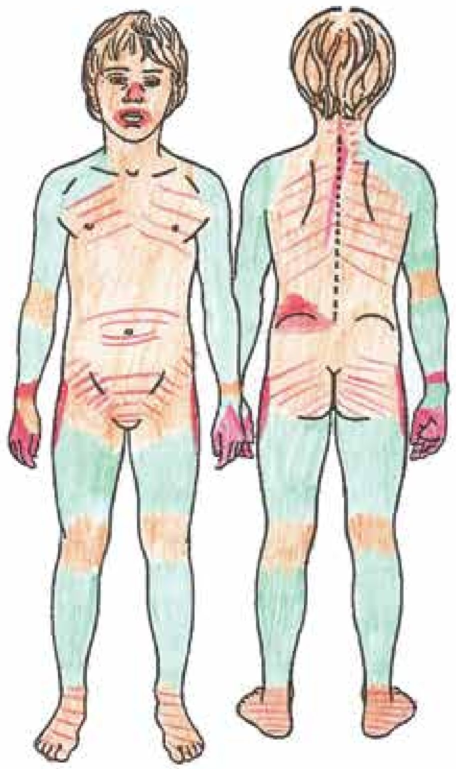
[10] From Pickler's pedagogy http://www.pikler.fr



Thea, is a 6-year-old girl, she is visually impaired.

She has perceptual disorder including hypersensitivity of the hands (mainly her fingertips), head and back. She often bites her left wrist very strongly. She shows teeth grinding and **rocks back and forth with** her upper body. Sometimes she may shout for a long time.



Jonathan, 10 years old, has multiple disabilities.

He shows uncontrolled movements of his head and arms; hypersensitivity to his body's extremities and face (mainly around his mouth).

A deformity of his back makes his upper body support very difficult.

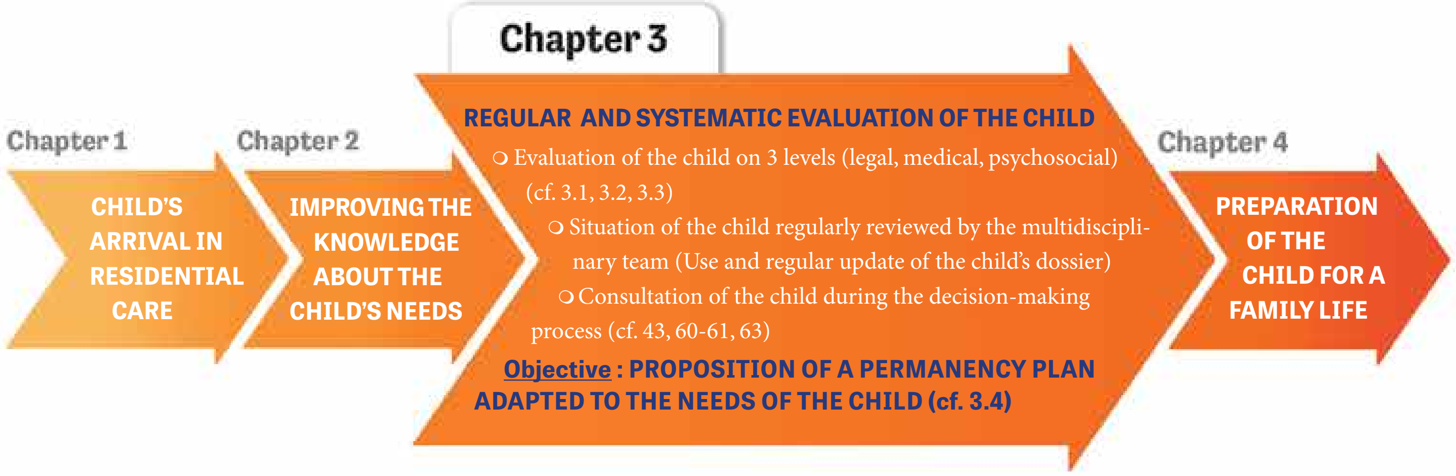
(Blank templates are available in the appendix)

IN GREEN= **Easily accesible area:** body areas where caregivers can enter in contact with the child, without significative manifestation of discomfort.

IN ORANGE= **Sensitive area:** Warning, the child may have particular reactions when contacting these areas which requires an adaptation from his/her caregivers.

IN RED= **Very sensitive or painful area**: here the child needs to be touched with great care.

REGULAR AND SYSTEMATIC ASSESSMENT OF CHILDREN


Chapter 1

CHILD'S ARRIVAL IN RESIDENTIAL CARE

Chapter 2

IMPROVING THE KNOWLEDGE ABOUT THE CHILD'S NEEDS

Chapter 3

REGULAR AND SYSTEMATIC EVALUATION OF THE CHILD

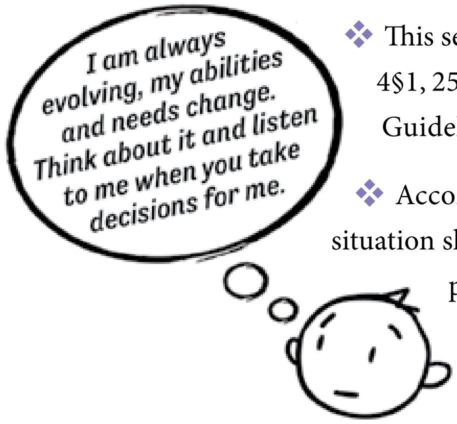
- ❍ Evaluation of the child on 3 levels (legal, medical, psychosocial) (cf. 3.1, 3.2, 3.3)
- ❍ Situation of the child regularly reviewed by the multidisciplinary team (Use and regular update of the child's dossier)
- ❍ Consultation of the child during the decision-making process (cf. 43, 60-61, 63)

Objective : PROPOSITION OF A PERMANENCY PLAN ADAPTED TO THE NEEDS OF THE CHILD (cf. 3.4)

Chapter 4

PREPARATION OF THE CHILD FOR A FAMILY LIFE

General principles



❖ This section relies more specifically on articles 12, 24 and 25 of the CRC, on articles 4§1, 25 and 26 of the CRPD, and on paragraphs 57 to 68, 71, 103, 115 to 117 of the Guidelines.

❖ According to these standards, a regular and systematic assessment of the child's situation should be carried out according to his/her age and disability to assess his/her psychological, social and physical development. This regular comprehensive assessment will support the permanency planning for the child.

❖ This assessment should be carried out by various means:

- *On-going assessment* of the child through the generous care given by the caregivers and the observations and reports made during the usual daily care of the children (see Observation Matrix 2.1).
- *A timely assessment* of the child addressed in this chapter (Legal, medical and psychological) should be realized at least every 6 months[11].

❖ The child should be consulted at all stages, according to his/her maturity level.

For children with disabilities in particular

❖ All hospitalisation or surgical intervention should be noted in the dossier of the child, with a copy of the hospital report or of the surgical operation.

❖ A special attention to children with disabilities must be given concerning the development of the child in relation to his/her disability. The conditions to put in place to ensure proper care should be rapidly defined (see 2.3) and regularly re-evaluated. The social perception of the disability of the child, as well as existing resources and obstacles within the society on this matter, should be considered.

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[11] The Guidelines recommends regular and thorough review– preferably at least every three months – of the appropriateness of the child's care and treatment, § 67. We consider this period as a goal to achieve. However, we have extended to six months to make a recommendation that better reflects the resources available to most countries.

Why take into account the views of the child in decisions that affect him/her?

- ✔ In accordance with article 12 of the CRC, the child has the right to participate in decisions affecting him/her and to be informed of the plan(s) elaborated for him/her as well as the consequences on his/her future life. This right does not give the child the authority to make a final decision but it gives him/her the right to give his/her opinion and to clearly understand how it is taken into consideration and integrated into the decision-making process.
- ✔ As part of a permanency plan, each option and its consequences must be presented and explained to the child so that s/he can give his/her opinion.
- ✔ The opinion of the child must be "duly taken into consideration given due weight in accordance with his/her age and maturity": children are generally consulted after a minimum age which varies depending on the country[12] and/or the maturity of the child[13]. Although the establishment of a minimum age is beneficial, it is recommended to leave some flexibility in the law to include the consent of younger children according to their evolving capacities.

<u>Sources</u> : SS/IRC Monthly review of 01/2009 and 07/2009.

3.1 Evaluation of the legal status of the child:

General principles

❖ **The evaluation of the legal status of the child should:**

- be started in a systematic manner at the arrival of the child in residential care with the help of the person who brings the child;
- define clearly who will assume responsibility and/or parental authority of the child;
- contribute to rapidly establishing a suitable family permanency plan for the child;
- be carried out and covered by the competent state services (the search for the birth family, family mediation if possible, obtaining consent from the families wishing to place their children for adoption, etc.).

It should be questioned whether it is in the interest of the child to be proposed for adoption without any other permanency plan if the actual chances of finding adoptive parents are <u>very</u> low.

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[12] For example: The minimum age is 7 years old in India and Norway, 10 years old in Russia and 12 years old in Kazakhstan, Cape Verde and Brazil.

[13] In Greece for example.

- **The legal status (guardianship, withdrawal of custody, placement, etc.) of the child should:**
  - be validated by a competent authority;
  - be carried out in the interest of the child;
  - appear in the dossier of the child;
  - be established before the definition of a permanency plan for the child;
  - be established in a sufficient but reasonable time fixed by the competent authorities.

- **If the child is permanently and officially deprived of his/her family:**
  - his legal status must comply with the legal criteria in the country always taking into account the child's best interests;
  - a permanent family plan should be actively sought according to the principle of subsidiarity. The care of the child by his/her extended family or within the community as well as national adoption, are options that must be considered for the child before intercountry adoption. In some circumstances, long-term placement in a foster family must be equally considered in priority. More innovative forms of protection may also be considered if it is appropriate, such as the placement in small group homes, cluster foster care or child headed households.

- **If the legal adoptability of the child is envisaged:**
  - his/her legal status must comply with the legal criteria of adoptability in the country, always taking into account the child's best interests;
  - in all cases, intercountry adoption should remain a subsidiary measure and takes place when a local permanency plan cannot be envisaged;
  - his/her psychological and emotional adoptability should also be evaluated. It is important to ensure that the child is able to create new ties, notably parent-child relationships, which are different from an existing or a possible attachment (see part 3.3).

- The child should be consulted at all stages, according to his/her capacities, and give his/her consent to what is decided for him/her, depending on his/her age.

EVALUATION OF HIS/HER LEGAL STATUS

This evaluation will help to define a permanency plan according to the individual situation of the child. Thanks to this information the child will know (once s/he will reach the age of majority) what has been done for him/her.

This element is the basis to help professionals to understand the situation of the child and undertake the necessary next steps.	Status of the child: ☐ Orphan ☐ Abandoned without known parentage ☐ Abandoned with known parentage (placed by his/her parents in view of adoption) ☐ Relinquished by his/her family of origin ☐ Left temporarily by his/her family of origin ☐ Withdrawal of parental authority by a judicial decision
For the RCI, enables to have a written track on what has been done to find the birth family of the child.	Details of the social inquiry (to fill in when it is undertaken) ● Conducted by: …………………………………… …………………………………… ● Date of the beginning of the enquiry: …………………… ● Length of the inquiry: …………………………… ● Stages and actions taken: …………………………… …………………………………… …………………………………… ……………………………………
These elements help the professionals to know if family reintegration is possible and to design the child's permanency plan. For the child's future, these elements will enable him/her to know the efforts made to reintegrate him/her in his family of origin.	Was some form of social work undertaken in order to try and reintegrate the child into his/her family of origin or the extended family? Yes ☐ No ☐ If yes, what action was taken? …………………………… …………………………………… …………………………………… …………………………………… …………………………………… …………………………………… …………………………………… …………………………………… ……………………………………
Dated conclusion by the competent services (a copy of the report should be enclosed):	
…………………………………… …………………………………… …………………………………… …………………………………… ……………………………………	

In the case of an abandoned child without known parentage

The following elements should be taken into account in order to determine the child's legal status:

- A clear and detailed process, which takes into account local realities, should be put in place and scrupulously followed.
- A police enquiry should be carried out in order to try to find some trace of the birth family.
- An adequate but reasonable time limit should be left in order to carry out this enquiry.
- If the professionals in charge of the enquiry believe that they need more time than the limit established by law in order to finish their work, an extension should be possible.

In the case of a child placed in residential care by his/her parents of origin with a view to adoption

The following elements should be taken into account in order to determine the child's legal status:

- In the case of a decision of adoption for the child, the consent of the parents must be obtained in a free and informed manner. On this occasion, the social workers should inform the parents of the consequences of their action according to whether this relates to a simple or full adoption and national or intercountry adoption.
- The parents' consent should only be given after the birth of the child and within the legal time-span prescribed, preferably not before s/he is aged 2 to 3 months.

In the case of a child relinquished by his/her parents

The following elements should be taken into account in order to determine the child's legal status:

- A specific service, if possible interdisciplinary, should be dedicated to enquiries (if parents are known but have disappeared) and, if applicable, to give social assistance and support for families. This work should be undertaken by social welfare professionals (educators, social workers, psychologists, etc.).
- If it is in the interests of the child, it is essential to maintain links with the family. Attempts towards family reintegration, including with the extended family, should be undertaken (see item 1.1 for further details).
- If the relinquishment is linked solely to the disability of the child, adequate assistance should be offered in order to avoid this (see item 1.1 for further details.
- If the child is left without news or contact from his/her parents, and family mediation attempts have failed, the authorities should determine a reasonable time limit before the legal status of the relinquished child is permanently established.
- If an adoption plan is envisaged as the most appropriate solution for the child, the formal consent of the parents should always be obtained whenever possible.

In the case of a child placed through a judicial decision because of the danger s/he faces within the family (ill-treatment, abuse, neglect, rejection, etc.), or whose parents are deprived of their parental authority

The following elements should be taken into account in order to determine the child's status:

- A social work enquiry and further attempts at family mediation with the extended family should be conducted, if this is feasible, safe for the child and in the child's interests, in order to maintain the child, as much as possible, in a family system that s/he knows according to paragraph 14 of the Guidelines. However, when the parents are failing, it is not always in the interest of the child to be cared for by the extended family.
- This evaluation should be carried out within a reasonable time frame, in accordance with the child's situation.

> ***It should be noted that the child could only be declared legally adoptable if:***
>
> ***◆ this is in his/her interests and corresponds to the child's suitability for adoption***
>
> ***◆ family reintegration is not applicable or has failed***
>
> ***◆ the biological parents (if known) or any other persons entitled to do it and the child (if he is old enough and the law allows him/ her to do it), have given their consent to adoption***

3.2 Medical assessment of the child

General Principles

- The medical evaluation of all children should be carried out by a medical doctor, if possible a paediatrician. If the child lives with a disability or particular illness s/he should, if possible, also be examined by a specialist.

- The frequency must be adapted to the age and health status of the child, for example during his/her first year, the child should be assessed every three months rather than every 6 months.

- The caregivers should contribute to the medical evaluation by sharing results of basic examinations that they have carried out on the child (weight curve, height and head circumference) and with their observations during daily care:

    - The facility should be equipped to assure basic examinations of the children. They should have at least baby weighing scales and standard scales, a height measuring tape, a water point (so that the educator can wash their hands between each examination or each change) and an observation notebook.

    - The caregivers should be trained to the observation as well as basic controls of the child: how to weigh the child and how to measure both height and the head circumference. For babies under six months, the weight, height and head circumference should be recorded on a monthly basis, weekly or even daily in the case of a declared pathology (for example gastro-enteritis). This information should be noted in the monitoring records of the centre, and then inserted in the dossier of the child.

- The medical evaluation of the child should help to design and review the most adapted permanency plan. It must also specify the implications and prospects linked to his/her disability and the concrete and practical issues for the child and his/her family.

- This evaluation should also help to define the possible therapies and/or anticipated medical interventions, their timing and whether they can take place in the country or should be carried out abroad. The cost relating to the medical care of the child should be assumed by the State. When possible necessary efforts should be undertaken, with the help of specialised associations, so that all children have equal opportunities to be treated.

- Before considering international adoption for a child, the medical evaluation must certify that the disability or illness of the child does not prevent his journey to another country.

MEDICAL ASSESSMENT

This evaluation enables to compile important information about the child's health during his/her stay within the Residential Care Institution. It also helps to refine a care and permanency plan tailored to the health status of the child.

REGULAR MONITORING OF ANTHROPOMETRIC DATA AND GENERAL OBSERVATIONS

(This regular recording is a simple and effective tool to screen eventual developmental delays of the child)

Data Date + Age	Length	Weight	Head circumference	Malnutrition (yes-no)	General observations on the child's development and/or important elements to note and monitor

VACCINATIONS

Vaccines		Date of injection	Date of booster	Date of recall	Date of recall	Date of recall
Tuberculosis	Yes ☐ No ☐					
Diphtheria	Yes ☐ No ☐					
Tetanus	Yes ☐ No ☐					
Mumps	Yes ☐ No ☐					
Whooping cough	Yes ☐ No ☐					
Rubella	Yes ☐ No ☐					
Poliomyelitis	Yes ☐ No ☐					
Hepatitis B	Yes ☐ No ☐					
Other immunisations (for ex. measles, etc.)	Yes ☐ No ☐					

MEDICAL CONDITION

For the RCI, these elements enable to monitor the health status of the child during his/her stay. **For the child's future**, they are very important to know for his/her future life.	Did any illnesses occur during the child's stay in the facility? Yes ☐ No ☐ If yes, provide details relating to the illness(es) and indicate the child's age when it/they appeared, and any complications: Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications ....
For the child's future and his/her (future) family, previous medical history is essential to know in order to ensure an adapted follow-up.	Details of any hospitalisation of the child during his/her stay in the facility (date, circumstances, name of the hospital and treatment given) ....
For the RCI, this information is essential to ensure adapted care, design a life plan and, if needed, find an adequate family for the child.	Has the screening of a disability/specific medical condition taken place since the child has been in care? Yes ☐ No ☐ If yes, provide details of which disability and indicate the age of the child when screening took place: ....
For the child's future and his/her family, these elements enable to know the care s/he benefits from during the placement and to ensure the follow-up of this caring.	What treatments/therapies are foreseen and how often should they take place?.................... ....
	Does a specialist follow the child? Yes ☐ No ☐ If yes, what kind of specialist: ....
This opinion helps design the most adapted permanency plan to the child's needs and helps prospective adopting parents to make a decision regarding the child.	Opinion of the specialist (or the doctor responsible) on the evolution of the child's illness/disability, the impact on his/her daily life and assessment of future potential to live in an independent fashion (attach the report): ....

Conclusion and medical report on the appropriate permanency plan envisaged or to be considered for the child (detail the prospects and risks, the implications for his/her future family).
....

Elements to take into account in the medical evaluation of all children

- Ideally, the basic examination should gather together all the information collected in the model of a medical report from the Guide to good practice No 1 of the 1993 Hague Intercountry Adoption Convention[14] as well as the child's file model proposed below.
- When the conditions in the country do not permit the collection of all this information, it is advisable to proceed in stages and to begin by an examination gathering together the minimum elements contained in the Model for the Child's File below and to proceed with additional examinations if necessary.
- In all cases, it must be acknowledged that the medical status of the child cannot be considered as a guarantee that will exclude all other medical difficulties, regardless of the examinations already carried out.

> ***In the case of intercountry adoption the conditions of transfer and arrival of the child in the receiving country should be assessed and necessary measures should be taken (sanitary facilities, medical appointments, etc.)***

Supplementary elements to take into account in the evaluation of the child with disabilities

- On the basis of the basic medical evaluation valid for all children, further examinations should be carried out in order to refine the diagnosis and clarify the implications and prospects of the disability of the child. Additional costs linked to these examinations should be assumed by the competent services.
- In the case of an intercountry adoption, if the resources in the country of origin do not permit these supplementary investigations, they can be carried out in cooperation with the child's receiving country, at a distance and on the basis of the child's medical records, by a partner specialist of the Central Authority or the AAB.
- The costs can be supported by the AAB, which may then report them to the prospective adoptive parents if this is their wish.

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[14] Available on the site of The Hague Conference on Private International Law: www.hcch.net

3.3 Psychosocial evaluation of the child

General principles

- The psychosocial evaluation should be centred on the most appropriate permanency plan for the child. It should establish:
    - the child's resources, potential and challenges, both in their personality and personal experience;
    - the needs of the child in terms of a parent-child relationship, integration and family relations with a view to establishing an appropriate permanency plan;
    - the status of the child's relations and interactions with the birth family;
    - the child's relationship and interactions with his/her current living arrangements;
    - the capacity of the child to build an attachment with his/her future living environment. This delicate task should be carried out by specialists, as a residential care placement is a situation of suffering for the child making the diagnosis difficult;
    - his/her capacity to develop from his/her past.
- The psychosocial evaluation should be developed, preferably, by a multidisciplinary team. If this is not possible in practice, it should at least be realised by a team composed of staff members in daily contact with the child. The caregivers should indeed record and transmit to the team in charge of the assessment, their observations (e.g. the daily life of the child, the difficulties that s/he encounters, unusual behaviour, incidents which occur etc. see 2.1 "observation matrix"). The information from caregivers will facilitate the assessment of the child's situation and development as well as suggestions of care. It is always valuable to compare assessment reports with the report established at the child's arrival in the facility.
- The psychosocial evaluation should include (as much as possible):
    - interviews with the staff in daily contact with the child and with his/her (extended) family, if it is appropriate and if they are known, and with the surrounding community;
    - a consultation with the child, if s/he is old enough to give his/her opinion and his/her vision of permanency planning, should be taken into account and analysed in accordance with article 12 of the CRC, article 4 of the CRPD and paragraph 7 of the UN Guidelines. It should be mentioned that this process is long-term work that should be carried out by a professional who knows the child's background and evolution. It is important however to not dangle the possibility of a family life in front of the child too long before this takes place (see Practical Elements of this section for more details);
    - a recommendation on the appropriate permanency plan(s) for the child, if his/her legal status allows for this.
- The report of the psychosocial enquiry should not contain definitive judgements (such as lost case, child at risk etc.) that overshadow all possibility for the development of the child. The report should be based on diverse views, sometimes contradictory, analysed with particular care to ensure consistency. This step, based on the combination of different views, aims to prevent final judgements and to help remain open to more realistic and nuanced assumptions.
- The costs related to the psychosocial assessment should be assumed by the competent services.

Regarding the process of attachment for the child (identifiable from the age of 3 years): the more the child tends towards a secure attachment model the more easily s/he can build links with his/her new family and adapt easily to a new environment. However, it is important to note that the concept of attachment does not have a predictable value. Thus if a child demonstrates characteristics of an insecure attachment model this does not mean that s/he will never have the ability to form a secure attachment. Indeed, actions can be mobilised for this child and help their relationship with his/her future environment, especially if s/he benefits, within his/her present living environment (residential care or short term foster care), from a high quality of attention and appropriate care.

PSYCHOSOCIAL EVALUATION

This evaluation helps to accurately identify the child's needs, his/her potential, resources and difficulties. These elements are essential to ensure an adapted care and define the most appropriate option for the child. They will also be useful to find a family, if needed, who could respond to his/her needs.

• EMOTIONAL BACKGROUND OF THE CHILD AND POTENTIAL SPECIAL CIRCUMSTANCES:

These elements enable to understand the links between the child and his/her birth family and to know if family reintegration is possible, secure and in his/her interest.	Nature and frequency of contacts with the birth family: ....
	Evaluation of social and emotional relationships between the child and each member of his/her family (father-mother, siblings, grand-parents) ....
This data is essential to determine the most adapted permanency plan adapted to the child's needs.	Evaluation of the possibility for the child to form new family links if family reintegration is not possible: ....
If the child is old enough to be consulted, it is important to record what the child thinks about the project planned for him/her.	Report of consultations with the child: ....

• **CHILD'S DEVELOPMENT** (Description of the child's psychomotor development, resources, evolution, with the help of the various professionals involved with the child: medical personnel, the child's reference person, caregivers known to the child, psychologists, physiotherapists, social workers, etc.).

For the professionals involved with the child, these elements are essential to help them to better understand the child and his/her needs and propose a form of adapted care.

For the child's future, these elements are very important because they will enable him/her later to know the major steps of his/her own development, behaviour, and evolution during his/her placement etc. These elements are part of the child's history.

For the prospective adopting parents to whom the child is proposed, this information will help them to better know him/her, understand his/her needs, take a decision and confirm the proposition. Once the child will be with them, this information will enable them to adapt their care.

Additional elements to take into account in the evaluation of a child with disabilities

❖ On the basis of the evaluation of the child in general, the psychosocial evaluation of the child with disabilities should also focus on:

- the history of the disability in the life of the child;
- the degree of autonomy and socialisation of the child (in his/her movements, taking meals, activities of daily living);
- the expression of basic needs, pain and emotions (anger, sadness, joy, etc.);
- the perception the child has of his/her disability;
- the social perception, resources and obstacles related to the disability of the child in his/her social environment.

The relevant elements of the child's file gathered during observations and regular assessments (stages of important development, progress, difficulties, key moments, etc.) should be transcribed into the child's life book.

Practical Elements

Benchmark on the stages of the child's development

These indicators are established according to the usual development of a healthy child living in a positive family environment. This grid can nevertheless be useful for the regular evaluation of the child, especially for the early detection of certain disabilities/developmental delays. These benchmarks can also be used for the psychosocial assessment.

Up to 4 months:

- holds head straight
- makes sounds
- catches the eye (eye contact)
- smiles when someone smiles at him/her

From 4 to 6 months:

- sits up with help
- gurgles
- laughs out loud
- follows an object with his/her eyes
- holds an object in the hand
- orientation of a sound (turns towards the noise)
- the cuddly toy becomes a true transitional object that is to say something reassuring which accompanies the child along his/her journey
- turns over alone

From 6 to 9 months:

- sits up
- says some syllables
- passes an object from one hand to another
- appears worried in front of a stranger
- beginning of a diversified diet

- acquires notion of the permanence of an object (e.g. acquired through the game peek-a-boo)
- points a finger at a distant object
- moves alone: crawls on stomach, on hands and knees

From 9 to 15 months:

- stands on 2 legs, begins to walk
- gibberish, imitates (no, bye, etc.)
- understands simple orders
- points a finger at the object s/he wants
- uses toys in his/her games
- helps when s/he is dressed
- nursery rhymes and hand games
- claps

From 18 to 24 months:

- walks well and eats alone
- starts to run, to jump on 2 feet, walks backwards
- says 7 to 10 words, identifies some parts of his/her body
- obeys orders
- turns the pages of a book
- appearance of « NO »
- says « ME » or indicates his/her self with a gesture

About 2 years:

- learns to run, to jump
- begins to hold a pencil and to copy forms
- begins to create phrases and to use « I-me-you »
- beginning of daytime sphincter control
- can play with other children and alone

About 3 years:

- climbs and descends stairs alone
- jumps on one foot
- speaks well , ask lots of question (why?)
- shares his/her toys
- draws circles and crosses
- dresses him/herself

At 4 years :

- is autonomous and his/her birth size has doubled
- knows how to tell a story
- can dress him/herself with a little help
- can ride a bike
- draws varied forms
- seeks to play with other children
- toilet trained in the daytime

3.4 Developing a permanency plan for children with disabilities living in residential care institutions

This section is based in particular on articles 12, 20, 21, 24 and 25 of the CRC, articles 23, 25 and 26 of the CRPD and paragraphs 7, 14, 57-67 of the Guidelines.

- Developing a permanency plan involves a three level assessment: legal, psychosocial and medical (see 3.1 to 3.3 for further details). The results of this assessment should be included in the child's file.
- The child's file should contain the necessary information to support the identification of the most suitable permanency plan. It should be as complete a picture as possible of the child's needs and background (through reports and/or regular observations and assessments).
- Should adoption or foster care be the option suggested for the child, a comprehensive file describing in depth the child's needs and situation plays a key role during the matching process to find the most suitable family.
- During the matching phase, a comprehensive file will also help future adoptive families to position themselves with regards to their capacity to make the child feel welcome.

How to take into account the views of the child in developping a permanency plan

General Principles

- The consultation of the child should be carried out by trained and competent professionals (specialized educators, social workers, etc.).
- The child must be informed that s/he has the right to refuse an interview or to answer questions in which s/he does not feel comfortable. In exceptional circumstances and at his/her request, the child can be accompanied by his/her key care provider that s/he trusts.
- The child must be informed in advance of the course, the length and the follow-up of the interview. The professional must take the time to explain to the child the reason of the interview and how the information gathered will then be used.
- The length of the interview should be adapted to the rhythm of the child, his/her age and maturity. If applicable, it is often better to make several short interviews to minimize the stress of the child.
- The child can choose the place of the interview ensuring that it is quiet, confidential and without external disruption.
- Professionals shall establish a relationship based on trust and listening with the child so that s/he can express himself/herself as freely as possible. For example, the professional can use drawings, role-playing, building games or other activities to establish a climate of trust and free the speech of the child.
- The professional must be neutral and non-judgmental towards what the child is saying, even if his/her speech seems to be inconsistent or groundless.
- The professional must determine the real views of the child, which can sometimes be fully or partly manipulated by others.
- During the interview, the professional shall value the child's self-esteem and give him confidence, especially if s/he suffered from traumas and is reluctant to talk to adults. The professional can reformulate and/or summarize the words of the child in order to help him/her to understand that his/her opinion is seriously taken into account and understood.
- The child must be able to speak freely and to ask any questions.
- The professional shall use a simple and appropriate language considering the age of the child. It is better to ask open questions that invite the child to a non-directive and elaborated answer rather than yes or no.

***Sources**: ISS/IRC Monthly Review of 05/2010; UNHCR Guidelines on determining the best interest of the child www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4566b16b2&query=best%20interest%20of%20the%20child; Field handbook for the implementation of UNHCR BID Guidelines http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=4e4a57d02.*

PROPOSAL AND REASONS FOR THE CHOICE OF THE PERMANENCY PLAN ENVISAGED FOR THE CHILD

This document helps to understand the whole process that has led to define the permanency plan for the chid. This information is important for the child and his/her new family if applicable.

For the child's future, this information is important and will help him/ her to know that his/her life plan has been decided by authorised and competent entities.	Permanency plan proposal: ………………
	Entity(ies) that established the proposal: ………………
For the child's future, this information enables to understand why this decision has been taken (report of the assessments and professional opinion). **For the competent authorities,** this enables to keep track of the process that has led to the decision.	Reasons for deciding this specific permanency plan (legal, social, psychological, medical): ………………
These elements provided by the staff members who know the child well, will help **the professionals** find the most appropriate family for the child.	If a foster family or adoptive family needs to be found for the child: Guidance on the typical family who could respond to the needs of the child and facilitate his/her integration with them and the surrounding society (composition of the family, character, age etc.) ………………
For the child's future and for the adoptive family, these elements will help them to understand why adoption has been chosen and how the decision has been taken.	If adoption is the option envisaged for the child: ● date when the child was declared adoptable: ……………… ● entity(ies) that established the adoptability: ……………… ● elements that led to declare the child adoptable: ……………… ● circumstances and reasons of the consent for the adoption by biological parents (if applicable): ……………… ● steps undertaken to find a family at a national level: ………………
For the child's future and for the adoptive family, these elements will help them to understand why adoption has been chosen and how the decision has been taken. **For the competent authorities of the receiving country,** this information will be useful to undertake the necessary steps for the visa of the child.	If international adoptability is envisaged: ● date when this solution was decided: ……………… ● entity(ies) that has/have decided: ……………… ● reasons for this decision: ……………… ● steps undertaken to find a family at an international level: ………………
Opinions and comments from the various professionals in direct contact with the child on a suitable permanency plan(s) for the child:	

Stamp of the competent body (Signed) Date………………

The Director (Signed and Stamped) Rapporteur (Signed)

How to receive the (non)-consent of the child in developping a permanency plan

- ✔ The (non)-consent of the child allows to refine the psychological assessment as well as the permanency planning while taking into account the opinion of the child.
- ✔ From the beginning of the interview, it should be clear to the child that his/her opinion is important and fully part of the decision-making process, but that no guarantee can be given that the final decision would correspond to all his/her wishes. Indeed, the child has to understand that this decision is undertaken on the basis of several opinions including his/her own, the psychologist's and the social worker's.
- ✔ Before the consent (or non-consent) to the permanency plan is received, the relevant professionals must present all the possible options to the child and their consequences on his/her future life. They have to explain to him/her what will happen if s/he accepts or refuses the decisions that has been prepared for him/her.
- ✔ In case of an adoption, the child should give his/her formal consent if s/he is old enough to do so. The consent must be given personally and verified by a court or a government body[15]. This ensures that an independent and ideally professional assessment of the child's consent has been made.

***Sources**: ISS/IRC Monthly Review of 04/2010 and 06-07/2010*

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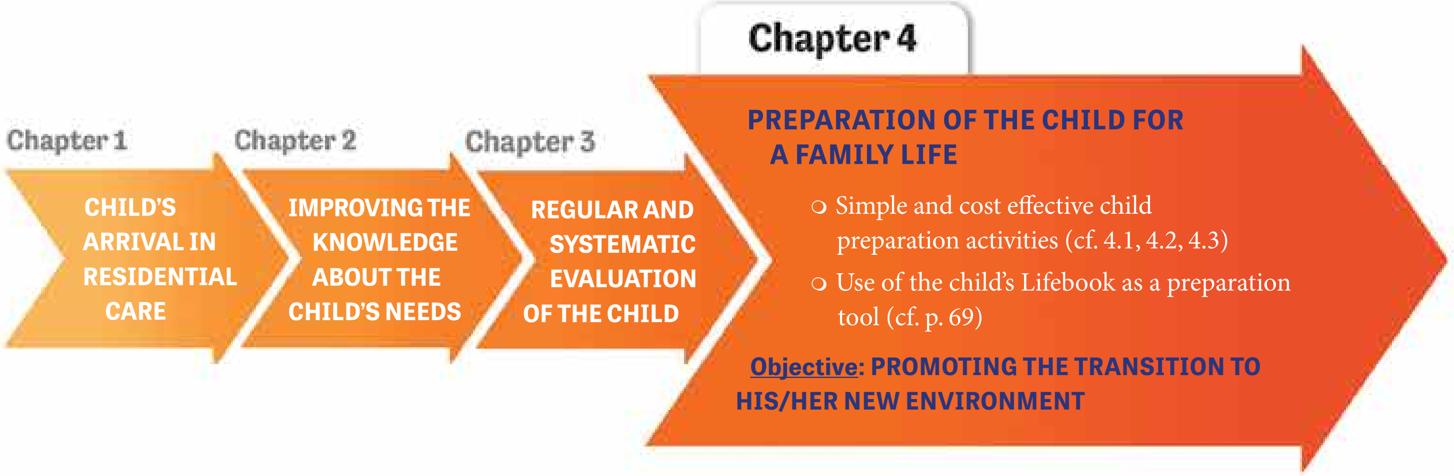
[15] For example, the case in Latvia, source: Art. 169.2 of the civil law and arts. 3, 5 and 10 of the adoption procedure.

THE PREPARATION OF THE CHILD WITH DISABILITIES FOR A FAMILY LIFE



Chapter 1

CHILD'S ARRIVAL IN RESIDENTIAL CARE

Chapter 2

IMPROVING THE KNOWLEDGE ABOUT THE CHILD'S NEEDS

Chapter 3

REGULAR AND SYSTEMATIC EVALUATION OF THE CHILD

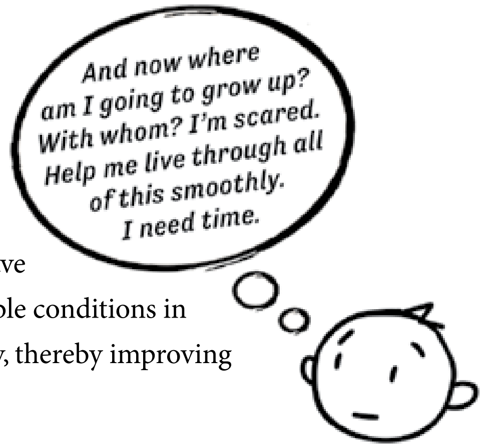
Chapter 4

PREPARATION OF THE CHILD FOR A FAMILY LIFE

- Simple and cost effective child preparation activities (cf. 4.1, 4.2, 4.3)
- Use of the child's Lifebook as a preparation tool (cf. p. 69)

Objective: PROMOTING THE TRANSITION TO HIS/HER NEW ENVIRONMENT

General principles



❖ The preparation of all children, with or without disabilities, for their new family setting, is very important whatever their age. Integration into a new family always represents a rupture for the child, implicating sacrifices and losses. Thus the better the child is prepared the more the transition towards his/her new environment will be facilitated. Besides numerous positive effects that this can have on the child, good preparation also contributes to creating favourable conditions in weaving an attachment between the child and his/her future family, thereby improving the chances of success of the care decision.

❖ The preparation of the child should consist of several stages:

1. a basic preliminary support;
2. preparation of the child for his/her new life plan and the family who are going to care for him/her;
3. preparation of the child for the departure.

❖ The preparation of the child for his/her new family life should be made according to his/her age and disability. This should help the child to:

- imagine what is going to happen;
- begin to create links with the future family;
- prepare him/herself for meeting the future family;
- live through a smooth transition between two places of life and two groups of people who are responsible for his/her care (RCI – future family);
- overcome his/her fears, questions, anxieties concerning integration into the new family and the acceptance of his/her disability;
- enter a new parent-child relationship in the case of an adoption.

The preparation of the child to his permanency plan, seen by professionals from an RCI for children with disabilities 7 years and older, in the Baku region of Azerbaijan:

Benefits for the child:

- ✔ the child is informed about what will happen next and about his/her future life setting so that s/he won't be lost during the transition;
- ✔ it enables the child to adapt from a collective life to an individual family life;
- ✔ it helps the child build his/her identity;
- ✔ the preparation prevents psychological trauma to the child;
- ✔ it enables the child to get to know his/her new family and to create bonds.

Benefits for professionals:

- ✔ the preparation helps to improve the professional' practice;
- ✔ it gives self-confidence to professionals who see that the transition goes well, which helps to encourage them and makes them feel valued;
- ✔ professionals develop their creativity by searching for adapted activities of preparation;
- ✔ it enables the professionals to be more involved in the future of the child;
- ✔ the staff work on preparing the children who will remain in the RCI, to the departure of their peer;
- ✔ it enables the staff to meet with families, which is rewarding.

Benefits for families:

- ✔ families can better cope with the child's difficulties;
- ✔ the transition is made easier for them too;
- ✔ families learn to know the child and prepare for his/her arrival;
- ✔ they can better adapt to the child's needs;
- ✔ extended families are ready to welcome and care for the child;
- ✔ the preparation contributes to avoid the secret related to the adoption;
- ✔ the child becomes real and no more dreamt.

4.1 Preliminary basic support

What does this support consist of for all children cared for in RCI?

- ✓ Invite the child to tell his personal history, to relate this (if s/he is old enough) during games, walks, stories, reading, etc. This story should allow the child to construct or reconstruct his/her personal history, to question his/her past, his/her family history, the circumstances of his/her placement, etc. It is important to give the child the opportunity to put into words and stories, what s/he knows about his/herself, regardless of the truth of his/her remarks. The adult should not seek information or revelations within the child's account. In the beginning it is not the « truth » that counts but the truth for « him/her». It is only after consultation that the professionals will decide what should be reconstructed with him/her;
- ✓ To give to the child explanations appropriate to his/her age and situation concerning the decisions (administrative, legal etc.) that have been/are being taken regarding his future.

What does this support consist of for the child who needs a new family setting?

- ✓ In accordance with his/her plan, initiate work with the child on the concept of family, parents, birth parents, adoptive or foster parents, about loss and hope and if applicable work through the loss of a return to the birth family;
- ✓ To help the child express the emotions aroused at the prospect of a new life in a new family and to overcome his/her fears, questions and anxieties.

What additional work should be done with children with disabilities?

- ✓ Address his/her disability with the child, fears, perceptions, and expectations on this subject and, when appropriate, help with awareness of his/her body image (perception of his/her body in relation to his/her peers);
- ✓ Help the child to overcome his/her fears, questions, anxieties, etc. regarding the acceptance of his/her disability within the future living environment (family, friends, etc.);
- ✓ Help the child to develop a better self-esteem.

When does this occur?

- ✓ This preliminary work should be carried out as soon as possible and form part of the basic psychosocial support of each child in residential care;
- ✓ Only introduce the idea of a family life plan once the child's legal and psychosocial status is determined and make sure not to talk about adoption to the child if he/she has not been declared adoptable.

Who is responsible?

- ✓ The constancy of the person who accompanies the child should be ensured. This could, for example, be the key carer or a social worker that the child knows.

What procedures should be used?

- ✓ In private, in a calm and familiar place for the child where s/he is at ease in order to share his/her feelings, emotions and questions;
- ✓ In several phases, following the rhythm of the child;
- ✓ Adapted to the child's age: the baby up to one year, early childhood from 1 to 3 years, the child from 4 to 10 years and the adolescent.

THE BABY (UP TO ONE YEAR)

- Preparation of the infant is mainly carried out by a good practice of mothering throughout his/her stay in the RCI, the development of a protective environment and consistency in the care of the child. A key caregiver should be designated for each baby in order to ensure a basic emotional security. It should be noted that within a period of 24 hours, there should be at least three educational staff, if possible always the same, to ensure the continuity of care.
- Basic emotional security is fundamental for the child and is based on quality, continuity of care, the investment made by the caregiver and love for his/her profession (different from affectionate gestures such as kisses, hugs, gentle words). This overall attention to the needs of the baby should however respect the subsequent abilities for attachment to a family. The caregiver must act like a mother with each child but not become the mother.
- Particular attention should be paid to children with disabilities: their specific needs, their discomfort, their daily problems and their prospects should be assessed, understood and anticipated.

Practical Elements[16]

The simple and child centred actions of the RCI's staff can have enormous emotional value for the child. For example:

- carrying in a gentle and cocooning manner;
- changing diapers and clothes whilst exchanging words and vocalising;
- a calm bath concentrating on the baby;
- a calm meal/bottle given on the knees of the carer while taking account of the pace of the child;
- specific attentions;
- establishing sensory activities, movements and stimulation, etc;
- Talking to them is equally very important for feelings of safety for the young child. Even when s/he is very young, the personnel surrounding the child should talk about his/her past and the future: what will happen during the day and the following day or in the future if this is already known.

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[16] The tools presented in this section can also be used in other stages of the preparation of the child.

THE CHILD IN EARLY CHILDHOOD (FROM 1 TO 3 YEARS)

- The child with disabilities can begin to understand his/her differences and to ask questions about his/her disability. These questions should not be forbidden and the supporting personnel should reassure and respect the child.

THE CHILD OF OVER 4 YEARS

- The first stage, for these children, will most probably consist of working on the child's esteem that has often been damaged by their life history.
- Through the preparation, the professional should be able to detect resistance, fears and/or the specific problems of the child and work with him/her in order to overcome these difficulties and alleviate worries.

THE CHILD OVER 7 YEARS

- The child should be consulted on all decisions concerning him/her; furthermore, the child should give his/her agreement to their own life plan according to age and maturity (see "In Practice" parts 3.0 and 3.4 on the consent of the child).
- The older child has a history, memories of his/her past, birth family and his/her life in an RCI. It is therefore important to ease the transition for the child.

The importance of the life book

The explanations given to the child about his/her family life plan can be developed thanks to the child's life book, which should be designed to illustrate his/her life and help the child to develop his/her sense of identity and continuity (Backhaus 1984).

If the child already has a life book, the educator and the child can browse through together, asking the child questions and allowing him/her time for comments especially for those pages that are still empty. If the child does not have a life book, the professional can create one with the child, based on the child's relationships, acquisitions, and abilities and on the comments of his/her representative.

4.2 Preparing the child to the family who is going to care for him/her

- This preparation is composed of two phases: the announcement to the child that s/he is going to be adopted or fostered by a family and the preparation for the meeting with this new family.

4.2.1 THE ANNOUNCEMENT of the adoption or placement in a foster family

What is involved in this announcement for a child with disabilities?

✓ It is announcing to the child that a family is ready to take care of him/her and to provide the child with the information available (location, family composition, type of home, etc.) More than an announcement it is in fact an introduction to new relationships;

✓ It is presenting this news as a positive thing for the child and showing general enthusiasm whilst paying attention to the reactions of the child and listening to how the child imagines this.

When does this occur?

✓ The child should know that s/he is going to be in a long-term placement or adopted when a family has confirmed the proposition relating to the child and after the initial work on this project has been carried out (see 4.1 above for more details).

Who is responsible?

✓ The reference person of the child, the director of the facility or a social worker. Continuity with the person who has ensured the basic preparation is recommended.

What procedures should be used?

✓ In private, in a calm and familiar environment, during a time dedicated to the child without external disruption;

✓ Whatever the age or abilities of the child, one should always explain what is going to happen to him/her in the future, the different stages and the implications of the plan for his/her future life. The conversation should however be adapted to the age of the child, his/her capacities and should be repeated and reformulated several times;

✓ The information provided to the child should be constructive and positive but not too embellished and idealised in order to avoid unnecessary and unrealistic expectations.

What could be done when the decision is contrary to the wishes of the child?

In the event that the child's opinion is not followed, the relevant professionals must always take the time to inform him/her of the decision taken for him/her and explain to him/her the reasons why his/her opinion was not followed. If the decision is imposed, taking the child by surprise, without any possibility for him/her to react and without any explanation, s/he could feel anger and oppose resistance against his/her life plan.

In some cases, the child may have expressed his/her opinion against a family reintegration, foster care placement or adoption because s/he might have painful memories about the separation with his/her biological family. S/he can also feel angry towards abandonment or be afraid to live with people he/she doesn't know. To a certain extent, the intervention of mediation services or social services can be necessary to detect with the child the real needs hiding behinds his/her emotions. In all cases, adequate preparation of the child to his/her life plan is essential for him/her to succeed in projecting him/herself into a new future without fear.

Sources : ISS/IRC Monthly review of 06-07/2010; UNHCR Guidelines on determining the best interest of the child
http://www.unhcr.org/4566b16b2.html?_ga=1.236391169.1240440268.1394447181

4.2.2 Preparation of the child with disabilities for THE MEETING with his/her new family

What is involved in this preparation of the child with disabilities for the meeting with the family?

- The meeting between the child and the foster or adoptive parents is a very important moment in the life of the child and of his/her new family that will leave its mark on the family history. As such, this moment needs special attention. The more the child is well prepared beforehand the better the first meeting is anticipated and experienced;
- The child should be informed that his/her family is going to come and see him/her (and collect the child if that is the case) and explain how this time will evolve;
- Also the child should be helped to imagine the family and his/her future life with them by giving elements of the reality of his/her future living environment (see practical elements part 4.1 " the importance of the life book" for more details);
- The child should be reassured as much as possible. S/he should feel able to ask any questions s/he has in mind (e.g. through a drawing or a life book). It is normal for the child to be anxious, the adult should therefore try to identify these signs of anxiety, acknowledge his/her emotions and if necessary, talk to him about this;
- The other children should also be implicated in the process and be aware of the forthcoming departure of the child in order to ensure a positive attitude with regards to the life plan of their friend (see item 3 of this section for more details);
- The child with disabilities should be reassured that the future parents already know and love him/her very much. It is important that the child understands that the new family have made a fully informed decision when they chose to care for the child "in full knowledge of the facts" and therefore will be aware of his/her difficulties;
- It is equally important to reassure the child that s/he will continue to be cared for and helped.

When does this occur?

- The child should be aware that s/he is going to meet his/her new family several days or weeks before the meeting, depending on the child's age and when the family accepts the matching proposal.

Who is responsible?

- The reference person of the child, the caregiver in whom s/he has confidence and/or, when possible, a social worker responsible for the child's project. Continuity with the person who has provided the previous stages of preparation is recommended;
- If applicable, the representative of the AAB as a third person outside the RCI, in order to assure the link between the child and the parents.

What procedures should be followed?

- In a calm and familiar environment where the child is at ease in order to share his/her feelings, emotions and questions;
- In several phases. A specific time should be dedicated to the child once to twice per week for example, in addition to all the times when the question can be approached in a spontaneous way;
- Adapted to the age of the childt.

THE BABY (UP TO ONE YEAR)

- Despite the fact that the baby does not have the ability to fully understand what is going to happen, it remains important to speak to the infant in order to explain that a family is coming to collect him/her, where they live, who are the members of that family, what they are like, etc.

Practical Elements

The professional can use the early abilities of the child in order to prepare him/her for adoption or long-term placement in a foster family and can ask the prospective adoptive or foster parents to send the infant an item of clothing or a cloth that has their odour to give to the child in order to help the baby gradually become used to them. The professional could also ask the parents to send photos of themselves and their environment in order to help in talking about them to the child.

THE CHILD IN EARLY CHILDHOOD (FROM 1 TO 3 YEARS)

- Despite the fact that language and reasoning capacities are still limited within pre-school age children; strategies can be implemented to help them understand their future family life plan[17]. Their capacity to express their emotions and to understand what they are experiencing is, of course, still limited. Therefore adequate preparation is essential and the personnel in charge should be trained in preparing these children without the children having to be actively involved.
- The professional should speak in simple words to the child about the new family, using toys for example, based on the perceptions and wishes that the child has previously expressed during his/her general preparation and solicit his/her reactions.

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[17] Toddler Adoption: The Weaver's Craft, Mary Hopkins- Best, Perspectives Pr; First Edition, 1997, 271 pp.

THE CHILD OVER 4 YEARS

- The professional should follow the same recommendations as for the child in early childhood, while adapting the language he/she uses. The professional can also take the exchange further.
- The preparation should allow the child to communicate about his/her project and express his/her emotions, ask questions about what is going to happen, express an opinion, etc. The child is the protagonist of his/her own life plan.
- The professional should also know how to reassure the child and discuss with him/her the question of his/her disability, the fears and anxieties that s/he has about this, including the practical aspects of future life.
- More so than other children, the child with disabilities should be reassured and know that the future family will accept and love him/her as s/he is. It is important however not to give the impression that the future parents are going to heal the child's disability, the child may have misconceptions about this.

Practical Elements

Interviews with the child: Beginning to discover the future

The professional can ask the child to give voice to his/her images of the family s/he would like to live with and to articulate their expectations in relation to his/her permanency plan around three themes: the objects, the places and the persons. The professional can also ask the child what s/he would like the future family to know about him/herself. This discussion provides an indication to the professionals about what is important for the child and how s/he perceives her/himself.

Drawings The person responsible can ask the child to draw his/her future family as s/he imagines them, for example, or in fact draw any other theme relative to his/her project: The child should always be accompanied during the drawing sessions and during this time discussions should be held about what is represented in the image. It is during these privileged moments that the child will engage most about his feelings, his worries and his needs.

Establishing links In order to help the child to imagine the future family, the professional can describe the family and their environment. In order to facilitate the exercise, the professional can ask the parents, for example, for photographs of their family, their living environment and the child's bedroom. These photos could then be stuck in the life book of the child with his/her participation. Alternatively the child can be photographed in various scenes from his/her life whilst explaining that these photos are for the parents who are waiting for him/her and discussing the subject of adoption or of the foster family each time.

Example of something the family could send to the child:

- a small backpack
- an item of clothing
- a photo album of the family, their living arrangements, their leisure activities, etc.
- small presents
- letters, films presenting the family, the house, the child's room, etc.
- audio recordings of their voices

Example of something the child could send to the family:

- drawings
- letters (depending on the age)
- small presents (pebbles, etc.)

The meeting

- Just before the meeting the supporting personnel from the RCI and the intermediary body (if applicable) should have a short interview with the family. They should transmit the expectations and descriptions the child has expressed in relation to them, in order for the family to better understand the child and avoid committing any blunders.
- The meeting should take place in a calm and familiar environment for the child, which respects the intimacy of the meeting, and at a time that respects the rhythm of the child. To ensure the child is as receptive as possible it is best to avoid nap time, bedtime or mealtimes for example.
- The child should be washed, changed and dressed for the meeting. Older children could choose their clothes themselves.
- The child should be accompanied by a known representative, which makes him/her feel safe, in order to ease the first meeting and explain to the child who the adults are and make the introductions.
- The professional should be able to withdraw progressively to enable the child and his/her family to be able to express themselves and to have a certain amount of privacy.
- After the meeting the event should be noted and described by the parent in the life book of the child that has been passed on by the RCI staff.

4.3 Preparing the child for his/her departure and the transition towards his/her new environment

What is involved in the preparation of the child with disabilities for his/her departure?

- ✓ The child should be led to understand that s/he is going to leave the facility and live in a new environment to ensure that the transition is as smooth as possible.

When does this occur?

- ✓ The personnel of the RCI should talk to the child about his/her departure several days before it occurs, so that it is not put before the child as a "fait accompli".

Who is responsible?

- ✓ The reference person of the child, caregivers, managing staff and, if possible, a social worker;
- ✓ If the child is supported by a therapist or another professional, these sessions could also be an opportunity to help the child to discuss his/her life plan. It is therefore important that all the professionals are in agreement and give the same commentary to the child about his/her foster family placement or an upcoming adoption;
- ✓ The prospective adoptive parents play an equally important role in the transition.

What procedures should be followed?

- ✓ In a calm environment;
- ✓ Before the departure, there should be a period of social interaction helping the child to learn to know and recognise his/her parents, whilst staying within the usual environment of the child. This period will ensure a smooth transition between the two living places and two groups of people who are responsible for the child;
- ✓ Ensure that the child can keep equipment related to his/her disability: wheelchair, orthotics, spectacles, various devices etc. ;
- ✓ Adapted to the child's age.

THE BABY (UP TO ONE YEAR)

- For the very young, the senses are an essential element: they are very sensitive to odours, to the scent of the family, to rhythms and the infant is going to be aware of the change of environment. If this change is too abrupt, this can upset, for example, his/her appetite, sleep cycle and behaviour. A progressive and well-planned transition promotes a better adaptation of the child, who will feel safer with his/her parents. The probationary period is therefore very important for these children.

Practical Elements

The professional can use the early abilities of the infant to facilitate the transition and to reassure him/her:

- ⇨ An item of clothing that has the odour of one of his/her caregivers could be given when the child is leaving. The new family can then put this item in the child's cradle.
- ⇨ If the child comes from a residential care institution, the parents could exchange new bedding or an item of clothing for the actual bedding in the infant's cradle. This bedding can reassure the child during the first nights.
- ⇨ Alternatively, after the first meeting, the parents could send or leave something belonging to them, an item of clothing for example, so that the infant can get used to their odour.

THE CHILD IN EARLY CHILDHOOD (FROM 1 TO 3 YEARS)

- Children from 1 to 3 years are too young to understand why they are leaving their environment but old enough to understand that something is different. Therefore it is important to have a transition programme for these children as well.
- Children from 1 to 3 years often fear strangers and the unknown, therefore it is important to avoid changes that are too abrupt by, for example, leaving the child suddenly with his/her new parents. Even holding the child should be progressive despite the often-pressing desire of the parents. A well-prepared and gradual transition favours a better adaptation of the child who will feel more secure with his/her parents. The period of social interaction is therefore very important for these children.

Practical Elements

- The personnel responsible for the preparation of the child in early childhood (1 to 3 years) should not hesitate to speak to the child about his/her integration into his/her new family. With this aim they could use play moments with the child and scenes from his/her daily life to address this issue. For example, at bed time, the professional can explain to the child that soon, it will not be the carer who puts him/her to bed but daddy or mummy. The professional can also use children's books in order to tell the child stories related, directly or indirectly, to adoption or foster care and use the reactions that they provoke in the child in order to focus on the child's own permanency plan.
- The child should be able to leave the facility with his/her cuddly toy/ security blanket (transition object) or a familiar article that s/he often holds or something that the child sleeps with (this could be a toy, a teddy or soft animal, one of his/her clothes, a piece of material, etc.). This object can reassure the child during the first days after arrival.
- Two or three weeks before the departure, the professional can prepare a calendar with the child on which s/he checks off each day that remains until s/he moves to his family.

THE CHILD OVER 4 YEARS

- The child of more than 4 years is old enough to understand his/her situation. Therefore it is important to explain what is going to happen and to respond to the child's questions.
- If hospitalisation or a surgical operation is anticipated, it is important to describe this to the child and explain the reasons, to ensure that s/he is prepared and that the child does not equate the adoptive parents or foster parents with the persons who have hospitalised him/her. In this context, it is important to enhance and be positive about the prospect of the evolution of the disability and of his/her care.

Practical Elements

- The child over 4 years can gradually build up a « box of treasures » that s/he could then take to the new family.
- The professional can take the child out of the facility from time to time and take him/her on the journey that s/he will follow with the adoptive or foster family. After these outings, time should be taken to talk and exchange with the child;
- In the case of intercountry adoption, the professional can teach the child some words in his/her new language, as well as the main customs of the new country that could surprise or shock him/her (hugging, the cot or crib for children, etc.).
- A calendar or schedule could be very useful and adapted for children of over 4 years.

Role-play

The professional can ask the child to take on the character of his/her best friend and then ask about his/her life in the centre, about their disability, their new life and the future parents, etc. This method will help the child verbalise his/her feelings more easily through the dialogue of the best friend. For example[18] :

- **Educator:** John, we are going to play a game.
- **John:** What game?
- **Educator:** A game where you pretend to be your best friend
- **John:** My best friend?
- **Educator:** Tell me what is your best friend called, we are going to see how well s/he knows you...
- **John:** My best friend is called Hugo.
- **Educator:** Hello Hugo! How are you? I would like us to talk a bit about your best friend, you know, John! Is he in the centre with you?
- **John:** Yes we are in the same bedroom.
- **Educator:** Oh really? That's good, well then can you tell me something interesting about John?
- **John:** What do you want to know about John?
- **Educator:** What does he look like?
- **John:** He is a small boy; he doesn't walk like other children...
- **Educator:** Oh ok...why doesn't John walk like other children?
- **John:** Because he is ill!
- **Educator:** Did he tell you that he is going to leave the centre soon?
- **John:** Yes he told me...
- **Educator:** And did he tell you where he is going because I don't know about this
- Etc.

Books for children about adoption or foster care: The professional can read a story with the child, let him/her interrupt the reading, ask the child questions and analyse the illustrations together for example.

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[18] Inspired by John W. MCINTURF, « Preparing Special-Need Children for Adoption Through Use of a Life Book », in Child Welfare, Vol. LXV, No 4, July-August 1986.

The moment of DEPARTURE of the child

- The child should have the time to say goodbye to his/her friends and to the persons who have cared for him or her. A little celebration to mark the occasion of the child's departure could be organised for example.
- The supporting personnel should take time to discuss with the parents which words the child uses to express his/her needs, what behaviour s/he adopts when faced with different situations, what are his/her routines and tastes (food, bedtime, games, etc.). This will help the parents better understand their child and assure as smooth a transition as possible.

How to approach the departure of a child with other children for whom permanent family placement may not be possible?

- Adoption or long-term foster family placement should not be a taboo subject and the children who remain should not feel underestimated or rejected. The difficulty of the exercise is to find the right balance in order to show enthusiasm for the proposed life plan for the child who is going to be cared for in a family without upsetting the other children or creating false hopes for them. This question is particularly important for the children with disabilities whose self-esteem could be fragile.
- The other children in care should also be prepared for the various departures of their friends and be quickly made aware when a child is leaving.
- The RCI staff should ensure that there is no feeling of rejection by the children who remain there.

Practical Elements

The personnel can lead regular talks and discussions with the children in care allowing each one to express themselves freely. This can help identify the children who may suffer and not understand why their friend has found a family when they must remain in residential care, so enabling the personnel to work with the child on this aspect thanks to various tools: books for young people, comics, drawings, etc.

Recommendations for the authorities

Partie C

Promote family life for children with disabilities

At State level, a clear procedure should be established to manage the protection of children, indicating the factors to be taken into account and the different stages and steps to comply with in order to find a family for the child.

An individualised family permanency plan should be developed for each child, whether with or without disabilities. Whenever possible and preferable the child should be able to reintegrate with his/her family or community (principle stated in paragraph 3 of the UN Guidelines). However, when this is not possible, an alternative permanent family placement should be sought, first at national level and, following the principle of subsidiarity, at an international level.

For children with disabilities it is often difficult to find a family solution in their country of origin. Despite this, it remains important to avoid the systematic placement of these children in intercountry adoption without first investigating a national solution.

For this reason it is important to take measures to promote and encourage the reintegration of the child in his/her family, national adoption, but also a system of foster care which can be thought of as a life-long arrangement. Other forms of protection measures such as small group homes or cluster foster care can be developed to create a family setting on a long-term basis.

« It is clear that children's psychological need for permanency and individual attachments can be met without the formality of adoption ».[19]

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[19] Cantwell, Nigel (2014). The Best Interests of the Child in Intercountry Adoption, Innocenti Insight, Florence: UNICEF Office of Research.

1. The reintegration of the child into his/her family of origin

As this Manual is focused on the search for alternative solutions for children with disabilities who are already in residential care, no part is specifically dedicated to the prevention of family separation. However, the recommendations below, concerning the reintegration of the child into his/her family and the proposals for support mechanisms to help the families, can be applied equally to policies for prevention of separation[20].

General Principles

- This section is based in particular on the preamble and article 20 of the CRC, article 23 of the CRPD and paragraphs 14, 15, 32-52, 76-79 of the Guidelines.
- Poverty and the difficult living conditions of the family of origin should never be the sole reason for placing a child in residential care, as specified in paragraph 15 of the UN Guidelines. When this is the case, the competent authorities should put in place a support mechanism to help families provide for their child again.

> ***The reintegration of the child into his/her family often costs much less than residential care***[21]***.***

- The disability of the child and its perception within society should not be at the origin of abandonment. Widespread campaigns should be carried out in order to raise awareness of the population on the issue of disabilities.
- Whenever possible, and when it is in the best interest of the child, the prospect of reintegration of the child with his/her parents or extended family should be considered and assessed as a priority.
- A social assessment of the family (e.g. interviews, home visits, etc.) should be conducted in order to determine if the child will be secure in his/her family environment and if the family can provide appropriate care. Therefore a social assistance service should be put in place, which includes a sufficient number of trained personnel to cover the task of the assessment, contact and social work with the family of the child placed in care.
- Once a decision is made the return of the child should be carefully planned and the child and family should be prepared for this.
- If necessary a system of family support should be implemented to allow the family to assume the therapeutic, medical and educational care of their child. Indeed it is important that the child benefit from the same opportunities for the treatment or rehabilitation of his/her illness/disability within the family as within an RCI.
- Services dedicated to children with disabilities (e.g. specialised schools, professions related to disability, etc.) should be decentralised as much as possible in order to prevent the child from being in residential care solely in order to benefit from appropriate care.
- If the child is old enough s/he should be involved in decisions taken and have the opportunity to be heard.
- If the family is identified and/or found again the social worker can:
    - Make contact with the family and study with them, through interviews with the parents, the possibility of the return of the child. If possible the interviews should take place together and then separately;
    - Encourage contacts whenever possible, between the family and the child (e.g. visits from the family, telephone calls, letters and /or photos etc.) if this is in the child's best interests;
    - Carry out mediation with the family, when appropriate, especially in situations where children born out of wedlock are a major cause of abandonment and where disability is highly stigmatised and also considered as a cause of abandonment. In such situations, mediation between the family of origin and the mother (or future mother) could be very useful to allow her to be accepted in the social fabric and supported by members of her family. This work with families can greatly increase the chances of a family reunification if the child is already placed and it is an effective method of prevention of child abandonment for young girls at risk;
    - Make the parents and family aware of the importance for the child to grow up with his/her parents and of the negative impact of residential care on the child's development;
    - Assess the needs of the family for the care of the child, in terms of equipment adapted to the child's disability and of resources for example, and anticipate the support needed to help the family;
    - Prepare the child and his/her family for reintegration. For example, this process could be conducted through progressive visits by the child to the family.

> ***If mediation is unsuccessful and the child is clearly abandoned by his/her family the competent services should duly inform the family that the child can be fostered or adopted by a substitute family and advise them, when required, about the consequences of simple and full adoption on their parental rights.***

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[20] The principles applicable to this subject together with valuable recommendations can also be found in the Guidelines relative to the protection of children in alternative care (http://iss-ssi.org/2009/assets/files/guidelines/ANG/Guidelines%20for%20the%20Alternative%20Care%20of%20Children%20.pdf), also in the Report Enabling Reform – Why supporting children with disabilities must be at the heart of successful child care reform, Better Care Network and EveryChild, March 2012, 49 pp.

[21] In Romania for example during the 1990's, care of a child in residential care cost 7 times more to the State than a family support plan and family reintegration. Source: Save the Children Romania, Reintegration of institutionalized children in their natural families, 1997

Practical Elements

In order to support the family and enable them to care for their child, specific help can be put into place:

- Specific work on the subject of disabilities can be conducted within the community in order to promote the acceptance and inclusion of children with disabilities, for example through discussion groups, awareness campaigns and movies.
- The family can be integrated into programmes of income generating activities and microcredit by national or international NGOs specialised in this field, in order to develop autonomy and financial stability and so be able to keep or regain their child placed in an RCI.
- A free crèche and day care system for children of pre-school age can be offered to enable the mother to work, especially when she lives alone and has to support her family.
- Respite care should be established to help families who may be overwhelmed with looking after a child living with disabilities or a specific medical condition and help them to cope with the care of their child. This temporary support can be given in the form of occasional day care or short stays in an establishment. In addition to facilitating the reintegration of the child into his/her family, this system can also help avoid the need beforehand of alternative care.
- Children with disabilities should be able to benefit from free sessions of care tailored to their disability or from rehabilitation equipment when their family cannot finance these services.
- Professional support and/or a psycho-social follow-up of the family should be proposed once the child is reintegrating in order to anticipate any new risks with the placement and to help and encourage the family to cope with the difficulties and stress linked to the care of a child with disabilities.
- The creation of support groups for parents of children with disabilities allows parents to feel less isolated and to share their experiences[22].

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[22] In Azerbaijan for example, groups of parents of children with disabilities are set up and meet regularly in order to promote the rights of these children through advocacy activities. In Romania parent groups have developed new services for the children (see: De-institutionalisation of Children's services in Romania, Unicef, 2004).

Reintegration in the extended family

- When a child cannot be reintegrated into his/her family of origin and therefore brought up by his/her own parents, members of the extended family may be willing and able to care for the child. Care by the extended family enables the child to grow up in an environment s/he knows, to maintain close ties with his/her family and to more easily overcome the trauma of separation. Professionals should therefore examine this option very carefully particularly when the child has been removed from parental care due to abuse. In this context it is not always in the best interest of the child to be cared for by the extended family.

- If reintegration into the extended family is possible and decided, the family should benefit from the same services as those cited above.

2. Foster family placement

General Principles

- This section is based in particular on the preamble and article 20 of the CRC, article 23 of the CRPD and paragraphs 118 to 122 of the Guidelines.
- The placement within a foster family, whom the child has no family link with, is generally considered as temporary. For children who are temporarily separated from their family this option is preferable to residential care because they benefit from a personalised care and a protective and beneficial living environment for their development whilst waiting until they can be reintegrated into their family of origin. For children who cannot be reintegrated into their families of origin, foster care should lead to permanence through adoption or a long- term solution as permanent fostering.
- In certain specific situations placement in a foster family may be the most appropriate solution for the child, in particular when the family of origin maintain regular and positive contact with the child without being able to reintegrate him/her or when an adoptive family cannot be found for the child. Permanent fostering must be a commitment to care for the child to adulthood; in many cases this becomes a life-long relationship. Sometimes a temporary placement becomes permanent – through a formal process (not by default). In these circumstances, the foster carers would be re-assessed for permanence, and the child's situation within the family would also be assessed to ensure that staying permanently with this family is in his/her best interests.
- Foster care should never be sought as a means to circumvent an adoption process, the latter being permanent in nature and clearly distinct. Nevertheless, it may be that a family wishes to adopt a child they are caring for. In this case, given the differences between the two projects, the conversion process should include an appropriate assessment of the motivations and abilities of the family and preparation and support for both the foster family and the child with a view to adoption. This should also be discussed with the child if s/he is old enough and the relationship with his/her family of origin should be reassessed (see Section B, chapter 3.4, p. 60-61).
- As with all care options, child placement in a foster family should be considered in the best interest of the child. Such a placement does not constitute a response to the needs of all children who are temporarily or permanently separated from their parents.

Promote fostering and recruit foster families

- During the process of recruitment of foster families an awareness of the specific needs of children with disabilities should be conducted together with a discussion on the possibility of caring for one of these children.

Selection of families

- As for all other children, families willing to care for a child with disabilities should be selected and assessed according to a precise procedure, in an objective manner, on the basis of clear, established criteria which takes into account the specificities of this type of care.
- Guarantees and basic checks on the prospective foster families (e.g. no criminal record, good reputation in the community, care conditions in accordance with national standards, commitment, income, etc.) should be scrupulously respected.
- While it is true that all families cannot be foster families and that all the selected families cannot care for all children, it is also true that people who have never cared for a child with disabilities could nevertheless be a very good foster family. It is important to be able to detect an engagement on the part of the candidates for this plan. The motivations behind their plan should be assessed and their ability for caring should be studied (e.g. suitable environment, access to specialised care for the management of the disability or specific medical condition, efforts towards integration in the outside community). The resources and limitations of the foster family must be part of the criteria evaluated in order to better identify the profile of the child they could care for.
- The matching process of a child and a prospective foster family should be adapted to the needs of the child.

Preparing and training the foster family

- 3 levels of training and information should be considered for the preparation of the foster family for children with disabilities:

<u>PHASE 1 - At an initial stage for all future foster carers</u>:

Practical Elements[23]

Example of topics that can be addressed during generic preparation and information about the issues of looking after someone else's child:

- the impact on the new family's life-style;
- the impact on and involvement of the foster family's own children (current and future impact);
- the need for strong family and community supports;
- the financial implications;
- the fight for services, benefits, appropriate education;
- post-placement agency support.

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[23] Jennifer Cousins, Finding Families for Disabled Child, APFEL conference, November 2014, Geneva.

PHASE 2 - Adapted preparation for selected families who will foster children with disabilities:

Once foster families for children with disabilities are selected an adapted training on disabilities should be provided in order to address the main issues related to the care of a child with disabilities. Professionals specialising in the field of disabilities could be invited to participate during the meetings (for example and according to the existing specialities in the country: physiotherapists, paediatricians, psychomotor therapists, psychologists, etc.). It can also be useful to invite families who have already cared for a child with disabilities to participate in order to talk about their experiences.

Practical Elements[24]

Example of topics that can be addressed during specific training:

- child protection / the disabled child's increased vulnerability to abuse;
- managing intimate care;
- health, safety and hygiene / first aid / fire safety / the suitability of the home environment / moving and handling procedures;
- administering and storing medication;
- understanding and managing the impact of disability on behaviour and mental health;
- self-esteem and resilience;
- the impact of a specific disability on child development;
- communication methods / the use of play;
- the sensibilities of the birth family;
- the inter-relationship between disability and other 'diversities' such as race, culture, language and religion;
- preparing for adulthood / possible need for care as adult;

PHASE 3 - Specific and individualised preparation once the child is matched with a foster family:

Once a child is assigned to a foster family, a specific and individualised preparation should be implemented, as promoted in paragraph 120 of the UN Guidelines. Families caring for a child with disabilities should be put in contact with one or more health professionals related to the medical condition or disability of the child. A progressive connection between the family and the child is advised (see part 4.1 for further details) and both parties should be listened to if they have specific questions.

Following the child

- The foster family should be considered as a partner in the child protection system and should be included as far as possible in the decision-making process about the child, as mentioned in paragraph 121 of the UN Guidelines.
- Once the child is in foster care, a regular and continuous follow-up and support should be implemented by social workers that know the foster family and the child to ensure the child is cared for in an adequate way. Nevertheless social work visits can be seen by the child as a reminder of non-permanence. It has to be handled with great sensitivity.
- In case of contacts with the child's family of origin it is important that supervision is ensured.
- It may be useful to bring together host families regularly to enable them to share their personal experiences, both the difficulties and the happy times, in compliance with paragraph 122 of the UN Guidelines.
- Organising continued training or reflexion workshops for families could be a beneficial option.

Costs

- Promotion and selection measures together with preparation and monitoring of foster families should be managed by the State, supported if necessary by technical and financial partners (national or international NGOs).
- All medical and care costs should be the responsibility of the State once the child is placed in a foster family (e.g. free health care, clothing and food expenses, equipment and apparatus for the child, schooling, etc.).
- In addition to costs linked to the care of the child, foster families can have a remuneration that can be a way to value and recognise them as professionals.

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[24] Jennifer Cousins, Finding Families for Disabled Child, APFEL conference, November 2014, Geneva.

Practical Elements

Avenues for promoting foster family systems at a national level

- It is important to spread the message to a wider public and to recruit foster families within the larger population:

  - ➩ Through awareness campaigns in local and national media (e.g. radio, television, newspapers, Internet, etc.) the general public should be advised that children separated from their own families need foster families regardless of their state of health.

  - ➩ Through poster awareness campaigns (public notice boards on highways on buses, in shops, etc.). In this context it is important that the slogan and/or message be strong[25].

  - ➩ Through the creation of a regularly updated Internet site, informing the public about the process, pointing out relevant contacts, providing testimonies from children and foster families, presenting the rights and duties of foster families, etc.

  - ➩ Through the organisation of information sessions for interested families concerning the foster family system, the allowances available, the support system, the rights and duties of families, respecting the links with the family of origin, etc.

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[25] In India for example, a poster campaign on buses calls on the public directly to ask themselves: « Would you like to open your home to a child deprived of his/her family? ».

- Partnerships can be sought with the media since they are often ready to offer advertising space for this type of campaign, particularly if it concerns children. The same is true for the creation of a film information clip: an appeal to the generosity of communication specialists (e.g. directing, editing) could be envisaged as such agreements can offer them visibility.

- These campaigns should reach a wider target. It is important therefore to avoid imposing straight away criteria that are too restrictive and to positively welcome people of various profiles. If appropriate it can be useful to specify that it is not necessary to be married or own property, for example, in order to be a foster family. Selection will be carried out at a second stage.

- This type of campaign can produce rapid results as the media have a strong influence on public opinion. The services in charge of placement within foster families should therefore be ready to receive requests from interested persons, respond to questions and rapidly launch the process of selection.

To promote foster care for children with disabilities/special needs:

Awareness campaigns can be used where families might be sought who are comfortable, familiar with the idea of disability:

- ➩ staff in special schools, hospitals or Residential care Institutions
- ➩ short breaks (respite) schemes
- ➩ churches
- ➩ specialist support groups
- ➩ specialised press for the caring professions / or disability press
- ➩ disabled people themselves: they know what's involved

3. The process of identifying an adoptive family for children with disabilities

General Principles

- This section relies specifically on the preamble and article 21 of the CRC, article 23 of the CRPD and the HC-93.
- If adoption is the life plan envisaged for the child, this should be carried out as a matter of priority at national level. Intercountry adoption should only occur as a subsidiary option, if no family can be found within the country. This principle is valid for all children, including children with disabilities.
- Initiatives should be taken to promote and value domestic adoption for children with disabilities and raise awareness of this issue at State level and within the RCI. These initiatives should be tailored to the cultural background of the country, as well as respect acknowledged principles, protected by international conventions. It is for example essential that in every circumstance, the matching between the child and his/her adoptive family is made by a professional.
- Example of initiatives that can be taken to promote national adoption for CWD:
    - Organisation of information campaigns in the various media (e.g. newspapers, television, radio, Internet and social networks, etc.) to raise awareness and inform the population that children, including children with disabilities, are waiting for a family;
    - Organisation of poster campaigns, conferences, televised debates, painting and/or photographic exhibitions and diffusion of documentary films for example, in order to fight against the prejudices and taboos about disability (of the child) and to value these children in the eyes of the general public. These events should be part of a national action plan carried out annually and with the participation of the authorities involved in the care of children with disabilities, so that all questions relative to health, education and social protection can be addressed;
    - Organisation of general information sessions on adoption and raising the awareness of prospective adoptive parents to the needs of children with disabilities and to the possibilities of adopting these children. In particular families who have already adopted a child with disabilities could be invited to these sessions to share their experience and generate interest from the prospective adoptive parents. However when a prospective adoptive family orientate their adoption plan towards a child with disabilities or with a specific medical condition, this should be discussed with professionals. The limits of the Prospective Adoptive Parents (PAPs) relating to the child's profile they wish to adopt should be assessed and precise information given to them in order to avoid any failure of the adoption;
    - Setting up a national information point (and if possible in each regional child protection service) to inform the PAPs about the specifications of adoption procedures in general and to raise their awareness about the needs of children with disabilities in need of a family, the implications, realities and the support put in place for the families;
    - Creation of programmes specifically dedicated to the search, at national and/or regional level, for adoptive families for children with disabilities;
    - Creation of an exchange platform, a place of dialogue for adoptive parents in order to work on parenting;
    - Encouragement and support in the establishment of associations of parents (including adoptive parents) of children with disabilities, who could be the spokespeople for children and share the experiences of parents and adoptive parents;
    - Implementation of state financial aid for the healthcare costs of the adopted child with disabilities, according to the medical and/or paramedical benefits available in the country (e.g. physical rehabilitation, physiotherapy, psychotherapy, psychomotricity, occupational therapy, etc.). Such aid could then be extended to other areas such as education for example.
- If adoption is the appropriate solution for the child, a standard procedure adapted to specific needs of children with disabilities and of their future adoptive families, is proposed below. This procedure includes national and intercountry adoption.
- If intercountry adoption is the envisaged life plan, the **receiving country** should furthermore, take the following measures:
    - Authorities responsible for the decision of suitability should orientate the prospective adoptive parents who wish to adopt a child with disabilities towards the partner AABs;
    - At the time of their meetings the AAB should inform and raise the awareness of prospective adoptive parents with regards to the realities, needs and challenges of adopting children with disabilities;
    - The AAB should strive to better know the plan of PAPs and their limits;
    - The dossier of PAPs for the adoption of a child with disabilities should carry a distinctive sign (different colour, special note, etc.) and/or be listed in a specific database of the AAB or of the Central Authority of the receiving country, in order to be easily identified. The socio-psychological report of PAPs should reflect the profile of the child that they could care for based on their adoptive capacities;
    - The Central Authority of the receiving country should be responsible for the monitoring of those AABs, specialised or competent in the adoption of children with disabilities, who could conduct this type of adoption.
- Costs associated with adoption should respect the following principles:
    - The different types of costs associated with adoption must be clear, publicly established and defined by the responsible authority. The administrative costs must be determined by an official decision;
    - Each sum requested from the PAPs must be itemised and its allocation specified;
    - All payments should be made with a receipt acknowledgement or by bank transfer;
    - Medical examinations and all complementary services (e.g. physiotherapy sessions, psychomotricity or other speciality available in the country of origin) requested by the PAPs or by the adoption body serving as the intermediary (AAB) should be assumed by them;

- The preparation of the child for his/her reception into the new family should be undertaken by the PAPs (via the AAB) and the RCI;
- Departments or intermediary services authorised to ask for honorariums or fees must be officially listed;
- A range of costs for the honorariums of private intermediaries must be available and updated regularly;
- Fees charged for the costs of Child Protection services should respect the guarantees set out at point 5.4 of Guide No.1 for the implementation and operation of the 1993 Hague Intercountry Adoption Convention[26];
- If donations linked to the adoption are authorised, they should respect the guarantees set out in point 5.5 of Guide No.1 for the implementation and operation of the 1993 Hague Intercountry Adoption Convention.

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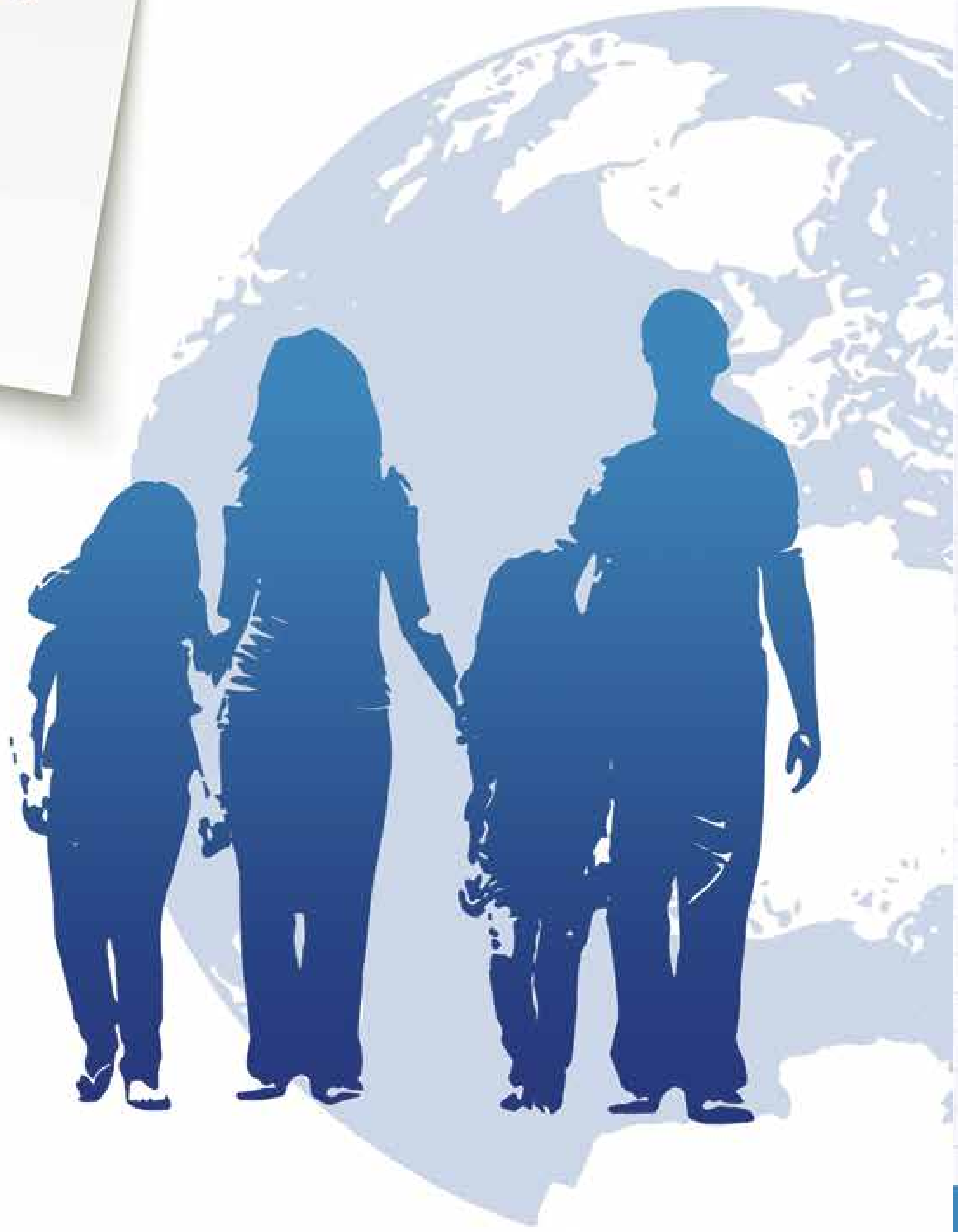
[26] This Guide is available on the website of The Hague Conference on Private International Law: www.hcch.net

Specifics related to National Adoption	Procedure for all adoption	Specifics related to Intercountry Adoption
	The Central Authority or competent body (CA) should raise awareness and develop training for the staff in RCI on the potential adoptability of children with disabilities. Guidelines should be drawn up in respect of matching procedures for children with disabilities.	
The CA dedicates a service to receive, orientate and advise PAPs and/or accredits a national AAB (Accredited Adoption Body) specialised in the question of disability.		The CA or competent body should choose, and limit according to their needs, the receiving countries and the AABs with which they wish to conduct adoptions of children with disabilities
	When a RCI identifies an adoptable child with disabilities (through the legal, medical and psychosocial framework) it should send the child's complete dossier to the CA to enable this authority to establish a comprehensive list of children with disabilities who are awaiting adoption in the country. This list should be updated regularly.	
	The dossier of adoptable children with disabilities should carry a distinctive sign (e.g. different colour, special note, etc.) and/or be listed in a specific database of the CA of the country of origin in order to be easily identified and facilitate their management.	
	Special efforts should be made to find a family willing to ensure the care of the child and, when the matching is carried out, the completion of the adoption procedure should be facilitated and even accelerated, whilst respecting the conditions of establishing relationships.	
	A family should be sought at national level based on the child's file and through the intermediary of an (approved) body or the CA. This search should be made within a fixed and reasonable time. If the adoptable child needs a rapid intervention, the CA should be informed as soon as possible in order to handle the case as a priority and find a family who could respond to the needs of the child.	
A reasonable time for reflexion should be allowed to the prospective adoptive family and their decision should be transmitted to the CA so that the procedure can take its course. The remainder of the process should be identical to other adoption procedures.		
		If a family has not been found for the child at national level by the country: the CA or competent body should transmit the dossier of the child to Central Authorities in partner receiving countries and/or to partner AABs so that they can look for a suitable adoptive family who is ready to adopt the child.
		On the basis of the full child's file, the CA of the country of origin proposes the dossier of the child to one body at a time during a given time, to avoid any risks linked to competition between AAB, the multiplicity of medical exams and bribery.
		Contrary to the matching of children without disabilities, the country of origin trust in one AAB to find a family adapted to the needs of the child. The AAB proceeds then, to the matching on the basis of the full child's file and the knowledge of its prospective families. In the best interests of the child, these stages should be realised in a minimum time limit, fixed beforehand in order to facilitate an early assumption of the care of the child.
	The remainder of the process should be identical to other adoption procedures.	

Description and understanding of the context of intervention



Part D

Appendixes

This second annex aims at describing and anticipating the context of alternative care for children with disabilities deprived of their family in a specific country to facilitate both its understanding and evaluation. This section takes the form of questionnaires designed in order to put together, within the same document, all the information needed to implement a policy or project favouring family based care of children with disabilities. Collaboration between the different stakeholders is necessary (political, administrative, field workers) in order to respond to the range of questions.

Each user can however utilise the questionnaires according to his needs, function and position. A State organisation however, will probably only need to use certain questionnaires in order to complete the information already at their disposal through the help of other competent actors. On the other hand an external participant will probably need the whole of the document in order to establish a complete profile of the situation and evaluate the context and the feasibility of his intervention. The lists of questions could help orientate enquiries and meetings with the key actors involved in the care of children deprived of a family in general and in particular in the care of children with disabilities.

This appendix combines two levels of information:

- information relevant to the national context, which can be collected from Ministries, Departments and other competent administrative services;
- information relevant to the field that can be gathered from professionals working in RCIs responsible for children and care establishments.

1. NATIONAL CONTEXT AND THE PLACE GIVEN TO CHILDREN WITH DISABILITIES

1.1 General profile of the country

Population

1. Number of inhabitants
2. Population under 18 years
3. Birth rate (‰/hab.)
4. Fertility rate (number of children born per woman)
5. Life expectancy

Economic Situation

6. GDP per capita
7. Average salary and cost of living (US$, € or local currency)
8. Proportion of the population living below the international poverty threshold (fixed at US$1.25 per day)

Socio-political and cultural situation

9. Administrative system/organisation in place (Federal system, centralised, decentralised, regional divisions, etc.)
10. Religion(s) practiced and their impact on society
11. Literacy rate of adults
12. School rate (Overall total + girls)
13. Official languages and other spoken languages

Health and social situation of children

14. Child mortality rate (0 to 5 years)
15. Total number of orphans
16. Number of orphans as a result of HIV/AIDS
17. Level of adolescent mothers
18. Birth registration rate
19. Percentage of the overall population living with a disability
20. Percentage of children with disabilities
21. Level of vaccination DTP, polio, measles
22. Incidence of major diseases (malaria, tuberculosis, HIV/AIDS)
23. Level of underweight children under 5 years

1.2 Child Protection System

Child Protection System in general

1. What legislation is in force in respect of child protection (laws, decree, guidelines, etc.)?
2. At a national, regional and local level, which Ministry, and more precisely which Department or Service, is responsible for child protection?
3. What level of State budget is allocated to child protection?
4. What university degree courses or professional training is offered in the country in relation to child protection?
5. What mechanisms and actual programmes exist to help families in difficulties to prevent family separation?
6. Are all forms of family strengthening services and centres available nationwide?
7. What role does the local community and the extended family play in supporting families in difficulty?
8. Is abandonment punished by law? If yes, what is the penalty incurred?
9. In case of the abandonment of a child:
    - a. Is an enquiry undertaken to find the birth parents? If yes through which service?
    - b. What is the maximum length of such an enquiry and what is the possible follow-up?

Alternative Care for children deprived of their family

10. What legislation is in force in respect of alternative care (law, decree, guidelines, etc.)?
11. Do measures exist for the reintegration of the child into his/her family of origin when s/he has been placed outside the family environment?
12. What are the available temporary protection measures (residential care, kinship care, foster care, respite care, cluster foster care, small group homes, etc.)?
13. What are the available permanent protection measures (foster care, national adoption, intercountry adoption, etc.)?
14. Are all forms of alternative care available nationwide?
15. How is the appropriate protection measure selected for each child? Is there a procedure in place to follow?
16. Is the child's situation regularly re-evaluated?
17. If foster family placement exists in the country:
    - a. Is it used as a temporary or long-term option?
    - b. Is it available throughout the country

c. How is it organised? Is this based on a public or private initiative?
d. How are foster families recruited and evaluated?
e. Are foster families registered and accompanied?
f. Do foster families receive financial subsidies?

18. Is disability part of the causes of abandonment and placement? If yes, to what extent?

The adoption system

General considerations

19. How is adoption perceived within the society?
20. What legislation is in force in respect of adoption (law, decree, guidelines, etc.)?
21. What type of adoption exists in the country (simple, full, open, etc.)?
    a. Formal national adoption, if yes specify (simple, full, open, etc.)
    b. Informal national adoption
    c. Intercountry adoption, if yes specify (simple, full, open, etc.).

National Adoption:

22. Who are the appropriate adoption authorities both nationally and locally? What is their composition? How are they regulated?
23. Which Courts are responsible for family matters and national adoption issues? How are these legal institutions distributed throughout the country? Does a social worker form part of the court team?
24. How long is the search for national prospective adoptive parents before considering intercountry adoption? What steps are taken to promote national adoption to the general public?

For children adopted at a national level:

25. What are the criteria for the adoptability of a child?
    a. Is anonymous childbirth authorised? If yes, how does the child become adoptable?
    b. With the consent of the parents:
        i. At what point is the consent authorised (time for reflexion after birth, etc.)?
        ii. Does the consent have to be given by both parents?
        iii. Does a time limit exist to withdraw the consent? If yes, what is it?
        vi. How are the consents and the adoptability formalised?
    c. Without the consent of the parents (if parents are unknown or parental authority was withdrawn):
        i. What is the procedure for the declaration of adoptability, who initiates it and who carries this out?

26. Is there a specific procedure for the adoption of children with special needs? If yes, how is this process different?
27. What is the profile of children placed in:
    a. Formal national adoption
    b. Informal national adoption
28. How is the child prepared for adoption and who is responsible for this? Is this process compulsory?

For national prospective adoptive parents:

29. What is the profile of families who formally adopt a child at a national level?
30. What procedure is followed for a national adoption?
    a. What is the procedure to evaluate the capacity and aptitude of national families to adopt a child?
    b. What are the conditions and documents required from prospective adoptive parents, (guarantees, health checks, references, etc.)?
    c. What is involved in the evaluation and the preparation of prospective adoptive parents? Who is esponsible? What steps are compulsory?
    d. How is the matching carried out and who is responsible for this?
    e. How does the first meeting with the child take place? How are the parents supported and monimonitored?
    f. Is there an obligatory probationary period? How long is this?
    g. Is the adoption decision a legal or administrative process?
    h. Is there an obligatory post adoptive follow-up? How is this organised?
31. What is the average cost of a national adoption? Is there any financial support to favour national adoption?

Intercountry adoption:

32. Who are the local competent authorities for intercountry adoption?
33. Has the country ratified the 1993 Hague Convention on Intercountry Adoption? If yes, when did this enter into force?

For children adopted at an international level:

34. Are the criteria for adoptability the same for an intercountry adoption as those for a national adoption? If not, what are the differences?
35. Is there a specific procedure for the adoption of children with special needs? If yes, how is this process different?
36. What is the profile of children placed in intercountry adoption?

37. How is the child prepared for adoption and who is responsible for this? Is this process compulsory?

For foreign prospective adoptive parents:

38. Which are the main receiving countries for children placed for intercountry adoption?

39. What procedure is followed for an intercountry adoption?
    - a. What conditions and documents are required from prospective adoptive parents (guarantees, health checks, references, etc.)?
    - b. How is the matching carried out and who is responsible for this?
    - c. Is the preparation of the prospective adoptive parents obligatory?
    - d. Is there an obligatory probationary period? How long is this? Does this take place in the country of origin or can this take place in the receiving country?
    - e. Shall the adoption decision be decided in the country of origin? If yes, is it legal or administrative?
    - f. Is there an obligatory post adoption follow-up? How is this organised?

40. What is the average cost of an intercountry adoption?

The actors in national and intercountry adoption

41. Which are the Central authority and Competent Authorities?

42. Accredited Adoption Bodies (AAB):
    - a. Is their intervention permitted through the law and/or in practice? Is it obligatory?
    - b. What is the accreditation procedure for AAB's? What are the criteria?
    - c. Are they supervised? If so, how?
    - d. How many national AABs are there and foreign AABs (for intercountry adoptions)?

43. Other private intermediaries:
    - a. Is the intervention of other private intermediaries authorised by law and/or in practice?
    - b. What is the role of these potential participants?
    - c. Is their intervention subject to State authorisation?
    - d. Are they supervised?

1.3 Protection and care of children with disabilities

1. What legislation is in force relating to the care of children with disabilities (law, decrees, guidelines, etc.)?

2. At a national, regional and local level, which Ministry and more precisely which Department or Service, is responsible for the protection of these children?

3. What is the State budget allocated to the protection/care of children with disabilities?

4. Are university degree courses or professional training available in the country in respect of disability issues? If yes, provide details?

5. Is any aid offered to families with a child with disabilities? If yes what type of help is available and who is this offered by (financial aid, equipment, help in developing a living environment, access to specialised care, respite care, etc.)?

6. Are there any day care centres and/or permanent residence centres devised for the care of children with disabilities?
    - a. Are they public or private?
    - b. Does the infrastructure and resources allow them to provide care adapted to the specificity of children living with disabilities?
    - c. Do they meet the needs of the country?

7. How are children with disabilities integrated into the school system?
    - a. Are they integrated into schools taking all children?
    - b. Are there schools that have created special classes for children with disabilities? If yes, are they public or private?
    - c. Are there any specialised schools for the education of children with physical or mental disabilities? If yes, are they public or private?

8. Are children with disabilities overrepresented in the global child protection system?

9. Are there any permanent residential centres devised for the care of children with disabilities?
    - a. Si oui, sont-elles publiques ou privées ?
    - b. Does the infrastructure and resources allow them to provide care adapted to the specificity of children living with disabilities?
    - c. Do they meet the needs of the country?
    - d. Are children with disabilities mainly cared for with other children or in specific RCIs? In the latter case, what are the differences between both types of RCIs?

10. Do children with disabilities deprived of their family benefit from the same protection measures as other children?
    - a. Is a specific procedure established for these children?
    - b. Are attempts at family reintegration (including within the extended family) also conducted for these children (with appropriate support measures for the families)?

   - **c.** Are other family life plans devised for these children (permanent placement in a foster family, national adoption and intercountry adoption)? Who is responsible for making this decision for the child?
   - **d.** What proportion of children with disabilities, placed in residential care, could benefit from such a project if families were ready to care for them?

11. Are there specific programmes to assist with the adoption of children with disabilities who are, declared adoptable? If yes, provide details.

1.4 Perception of children with disabilities

1. Which specificity is considered as a disability in your country?
2. How are children with disabilities perceived within society (try to give some examples that illustrate your comments)?
3. Are there any traditional beliefs and/or religious practices attached to disabilities? If yes, what are these?
4. Is there a proactive policy in favour of integrating children with disabilities into society? If not, are they isolated?
5. How does their integration or isolation manifest in reality?
6. Which children are considered as children with disabilities (describe their specificities)?
7. Is disability considered as a cause of abandonment in your country? If yes, what is the profile of the children concerned (describe their specificities)?
8. In your country, is disability considered as a barrier to find a foster family for a child? If yes, what is the profile of the children concerned (describe their specificities)?
9. In your country, is disability considered as a barrier to find an adoptive family at a national level or abroad? If yes, what is the profile of the children concerned (describe their specificities)?

1.5 The health care system

1. How is the allocation of public care structures organised in the country (at national, regional and local level)?
   - **a.** What are their areas of intervention?
   - **b.** What services do they provide?
2. Does the whole territory have access to care? How is the access to care organised in the potential remote and isolated areas of the country?
3. Do specialist health care facilities exist in the area of mental health, child psychiatry, psychology? If yes:
   - **a.** Are these public or private structures?
   - **b.** Where are they located?
   - **c.** What care is provided?
   - **d.** What is the number of patients cared for per year? What proportion of the actual requests/needs does this number represent?
4. Do specialist health care facilities exist in the field of rehabilitation? If yes:
   - **a.** Are these structures public or private?
   - **b.** Where are they located?
   - **c.** What care is provided?
   - **d.** What is the number of patients cared for each year? What proportion of requests/needs does this number represent?
5. Do specialist health care facilities exist for children with disabilities? If yes:
   - **a.** Are these structures public or private?
   - **b.** Where are they located?
   - **c.** What care is provided?
   - **d.** What is the number of patients cared for each year? What proportion of the requests/needs does this number represent?
6. Health care providers
   - **a.** Is the need for medical personnel covered over the whole country? Which regions are less well equipped with personnel?
   - **b.** Are the following specialities represented across the country: paediatrics, cardiology, gynaecology, obstetrics, radiology, orthopaedics, ENT, biologists?
7. Training
   - **a.** How many medical universities are there in the country and where are they located?
   - **b.** How many nursing schools are there in the country? Where are they located?
   - **c.** How many training schools are there specialising in psychology? Where are they located?
   - **d.** How many training schools are there in the country specialising in paramedical methods: physiotherapy, occupational therapy, psychomotricity, etc.? Where are they located?
8. How is the health care financed?
   - **a.** What portion is provided by the State?
   - **b.** What is the portion assumed by the patient?
     - **i.** What is the average price, for the patient, of a consultation?
     - **ii.** What is the average price, for the patient, of a day's hospitalisation (in general and by service, if known, for the large hospitals)?
   - **c.** Do other sponsors finance the care? If yes, who (local donors, financing from one or more foreign countries, one or more NGOs or associations, etc.)?

9. Does traditional medicine exist? If yes:

- **a.** What are the principal fields of intervention?
- **b.** Does it have a role in the treatment of disability or of mental or psychological health? If yes, in what way?
- **c.** At what stage of treatment of the pathology does this take place? Is it used at a first consultation or is it more usually a last resort?
- **d.** Is this spread throughout the country? Is it more present in certain regions, in rural environments or within certain ethnic or cultural groups?
- **e.** What interactions do they have with the official care system? Who are their sponsors?

2. RESIDENTIAL CARE

2.1 Reasons of placement in residential care

This grid should be completed in several respects: nationally and at the RCI level; for children received into care in general and for children with disabilities received into care.

Circumstances under which the child enters in residential care	**Frequency**			**Statistics (if available)**
	Rare	Often	Very regularly	
Child left at birth in hospital (young isolated mother, malformation of the child visible at birth, etc.) ▸ *Child is placed in the RCI by the hospital or maternity home*				
Child found in a public place (under a bridge, in a clinic, on a busy roadway, near a public building, near a hospital, etc.) or a dangerous place (a well, a rubbish dump, a building site, etc.) by an individual, a neighbour or by the police ▸ *Child is placed in the RCI by the police or by social services whilst police investigate to try and find the parents*				
Child abandoned or placed in alternative care due to lack of family resources, for health reasons (illness, a parent involved in an accident, etc.) or for any other reason the family is unable to care for the child ▸ *Child is placed by a relative (father mother, grandparents, aunt, etc.), social services or village authorities*				
Child placed to allow him/her to benefit from care or from training ▸ *Child is placed by a parent*				
Child abandoned, neglected, ill-treated or abused by the parents ▸ *Child is placed by social services, the police or village authorities*				
Child withdrawn from parental authority (abuse, violence, ill-treatment) ▸ *Child is placed by protection authorities*				
Child who has lost the father, the mother or both parents ▸ *Child is placed by a member of the family, social services or village authorities*				

2.2 Evaluation of residential care institutions

GENERAL FRAMEWORK

1. Which Ministry, and more precisely which Department or Service, is responsible for the supervision of these RCIs? What kind of follow-up is practised?
2. How many day-care and RCI are there in the country?
3. What proportion are public, semi-public and private RCIs managed by NGOs or run by religious communities?
4. How are these RCIs distributed geographically? How many are in the capital city, in other large towns and in the provinces?
5. Is registration or accreditation of these RCIs mandatory?
   If not, how many are registered and how many have yet to be registered?
6. Do these RCIs (or some of them) only care for children in need of alternative care or also for children from other backgrounds (delinquent children, street children, teenage mothers, etc.)?
7. Do specialist facilities exist to care only for children with disabilities or are they placed in the same RCIs as other children?
8. Are all RCIs authorised to propose children for national or intercountry adoption, including specialised structures caring for children with disabilities? Are they all authorised for this purpose?
   Is this authorisation for a specific period of time? If yes, how is it renewed and through which body?

GRID FOR FACILITIES CARING FOR CHILDREN WITH DISABILITIES:

Institutional Framework

Administration

9. Does the RCI have internal rules, statutes, guidelines and/or a development project (please attach if available)?
10. Does the RCI have an accreditation from the competent Authority?

Personnel

11. Does each position have a work description?
12. What are the qualifications of the different participants in the establishment (director, managers, and supervising staff)?
13. How is the work schedule organised for the caregivers?
14. Are there medical specialists and personnel (nurses, doctors) present in the RCI? How often do they provide treatment? Are they an integral part of the personnel or do they come from outside the care facility?

15. Are social workers and/or psychologists present in the RCI? How often do they provide treatment? Are they an integral part of the personnel or do they come from outside the care facility?
16. Does the RCI have links with professionals specialised in the care of children with disabilities (psychologist, physiotherapist, occupational therapist, etc.)? If yes, how is this organised? Which organisations do they work for?
17. Is there an external independent person responsible for evaluating the conditions of care of the children (minimum standards) and safety standards?
18. Does the RCI use volunteers (students, expatriates, professionals, etc.)?

Infrastructure and conditions of care

19. What is the general condition of the building?
20. Is there access to drinking water and electricity in the dormitories and the bathrooms?
21. How are the toilets washbasins/showers distributed?
22. Do the children sleep in beds and cribs or on the ground? How many children are there in each dormitory? Can the children personalise their space?
23. Does each child benefit from a private space (shelves, storage box, etc.)?
24. Are there mosquito nets on each bed (when this relates to a country in a malarial area)?
25. What hygiene measures are in force?
26. Is there an infirmary equipped with basic medications, scales for weighing the children, etc.?
27. Is there an isolation room for children suffering from a contagious disease? How far away is the nearest health centre and hospital?
28. Is the environment adapted for the care of children with disabilities (access ramps, adapted sanitary installations, equipment for physiotherapy sessions etc.)?

Conditions for the care of children

29. What is the reception capacity of the RCI in theory and in reality?
30. What is the age group of the children in care? The gender distribution?
31. On average, how many children arrive/leave the facility per month?
32. How does the reception of the child proceed on his/her arrival?
    a. Psycho-social plan: what support is immediately carried out with the person(s) bringing the child and the birth family? Is a representative appointed for each child? How is the child received under the psychological plan? Is a life book started for the child?
    b. Health plan: What examinations and consultations take place at the time of the child's arrival? Are the children systematically vaccinated? Is a medical file held for each child?

33. What is the death rate of children in care? What are the principle causes of death?

34. What is the average length of the stay of children in the facility?

35. How many children does each caregiver care for?

36. How many children are there to a room/a bed?

37. How are the children distributed within the structure (separated by room in accordance to their age, their sex, the date of arrival, etc.)?

38. How are siblings cared for? Do they share the same room? Do they spend some of their time together?

39. How is the day organised for the children?

40. How are the meals organised? For example, are the young children given their feeding bottle directly in their beds? Are the meals for the older children given in a structured environment?

41. How is playtime organised? How often does this occur? Are these structured by a caregiver or another qualified person?

42. What types of sensory and emotional stimulations are available (regularly carried, cuddles, songs, music, talking to the child)?

43. How many televisions are there in the facility? Where are they situated? Is their use regulated?

44. Is the facility open to the public? Is there a school that is open to the children within the community? Do the children from the RCI attend an external school? Are any socio-cultural activities organised organised with children from outside?

Conditions for the care of children with disabilities

45. How many children with disabilities are in care in the facility?

46. What are the main reasons of placement for these children?

47. What is the average length of stay in the RCI for children with disabilities?

48. Is a specific care plan established which is adapted to the needs of the individual child? If yes, what does this involve (presence of social workers and professionals who know sign language, reading Braille, physiotherapy sessions, speech therapy, etc.)?

49. If the RCI cares for all children:
    a. How are children with disabilities integrated? Are they integrated into groups of children without disabilities or are they cared for in separate groups?
    b. Do the children with disabilities participate in the same activities as other children (for example cultural visits, games, etc.)? If not, why not?
    c. Do the children with disabilities benefit from specific care? If so, what does this involve?

50. Do the personnel caring for these children have specific training? Do they have continuing training relative to disabilities?

Development of the child's life plan

51. What is the place of the birth family in the life of the children (open visits, visits under supervision, etc.) ?

52. How is the care plan of the child determined and assessed?
    a. Who will establish this (consultation between a multi-disciplinary team, social services, court, representative of the child, managing staff, etc.)?
    b. What criteria are used to develop the plan?

53. Is a specific procedure implemented for children with disabilities who are deprived of their family? If yes, what does this involve?

54. What type of family life plan is devised for these children (national or intercountry adoption, permanent placement with a foster family)?
    a. What portion of children with disabilities in care could benefit from such a project?
    b. With regards to the remaining children what are the obstacles to their adoption or placement within a foster family?
    c. Are the children fully informed and involved in the preparation for their departure and future life?

Funding

55. What is the budget of the RCI?

56. What is the origin of these funds (private or public) and, if they are numerous, how are they allocated? Does the RCI derive a part of its funds from adoption?

57. Are donations generally given in kind or in cash?

58. What is the average cost of the care of a child per month and by age range (lodging, infrastructure, personnel, food, health, education, etc.)?

2.3 Profile of children in residential care institutions

At a country level

1. How many children are placed in RCIs throughout the country?
2. How many children in RCIs are legally adoptable?
3. How many children in RCIs are children with disabilities?
4. How many children with disabilities in RCIs are legally adoptable?

At the level of a particular RCI

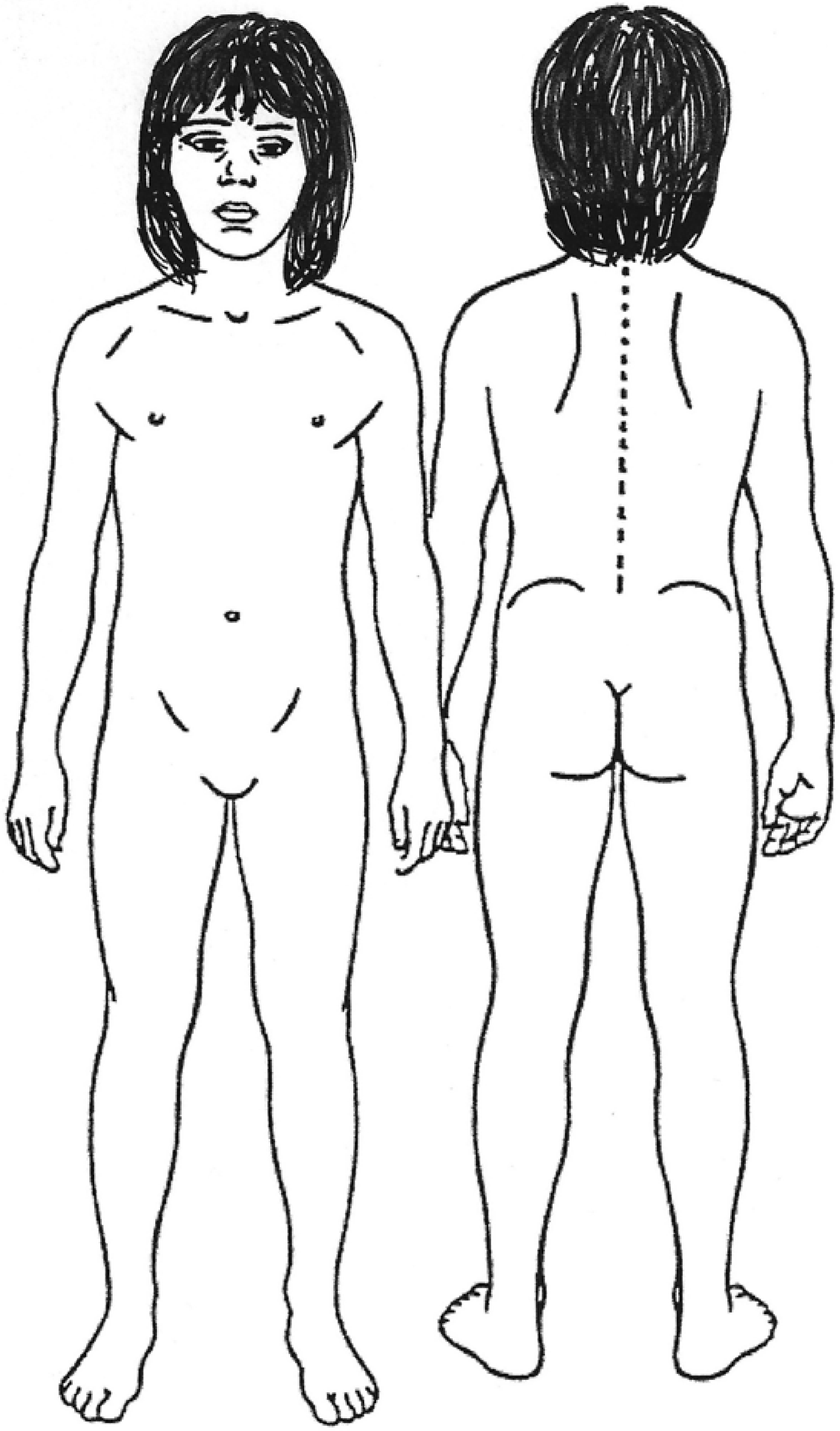
5. How many children are cared for? How many of them are without family?
6. How many of the children have the possibility to return to their birth family? How many of the children in care have the possibility to integrate into their extended family or community?
7. How many children are waiting for alternative family care?
8. How many children are relinquished by their birth family but have some news and/or visits from the birth or extended family?
9. How many children are relinquished by their birth family and have no news or visits?
10. How many children are placed as a result of a judicial decision (due to risk in their family environment)?
11. How many children live with a disability or a medical condition? Amongst them, how many can return to their family or are waiting for alternative family care?
12. How many children are placed because of traditional reasons or religious practices (children perceived as witches, albinos, etc.)? Amongst them how many can return to their family or are waiting for family type protection measures?
13. How many girls and how many boys are in care?
14. What is the division of children by age range (≤ 6 months, 6-12 months, 1-3 years, 3-5 years, + 5 years etc.)?
15. How many groups of siblings are in care? How many children have siblings who are not in care and are still with the birth family?
16. What is the main region of origin of the children (if known)?
17. Is there a particular ethnic group that is over represented in children in care?
18. How many children arrive suffering from moderate to severe malnutrition? Is this systematically confirmed and officially recorded in the child's file?
19. What proportion of children are reintegrated into their family on a permanent basis? What are the other reasons for children leaving the facility?

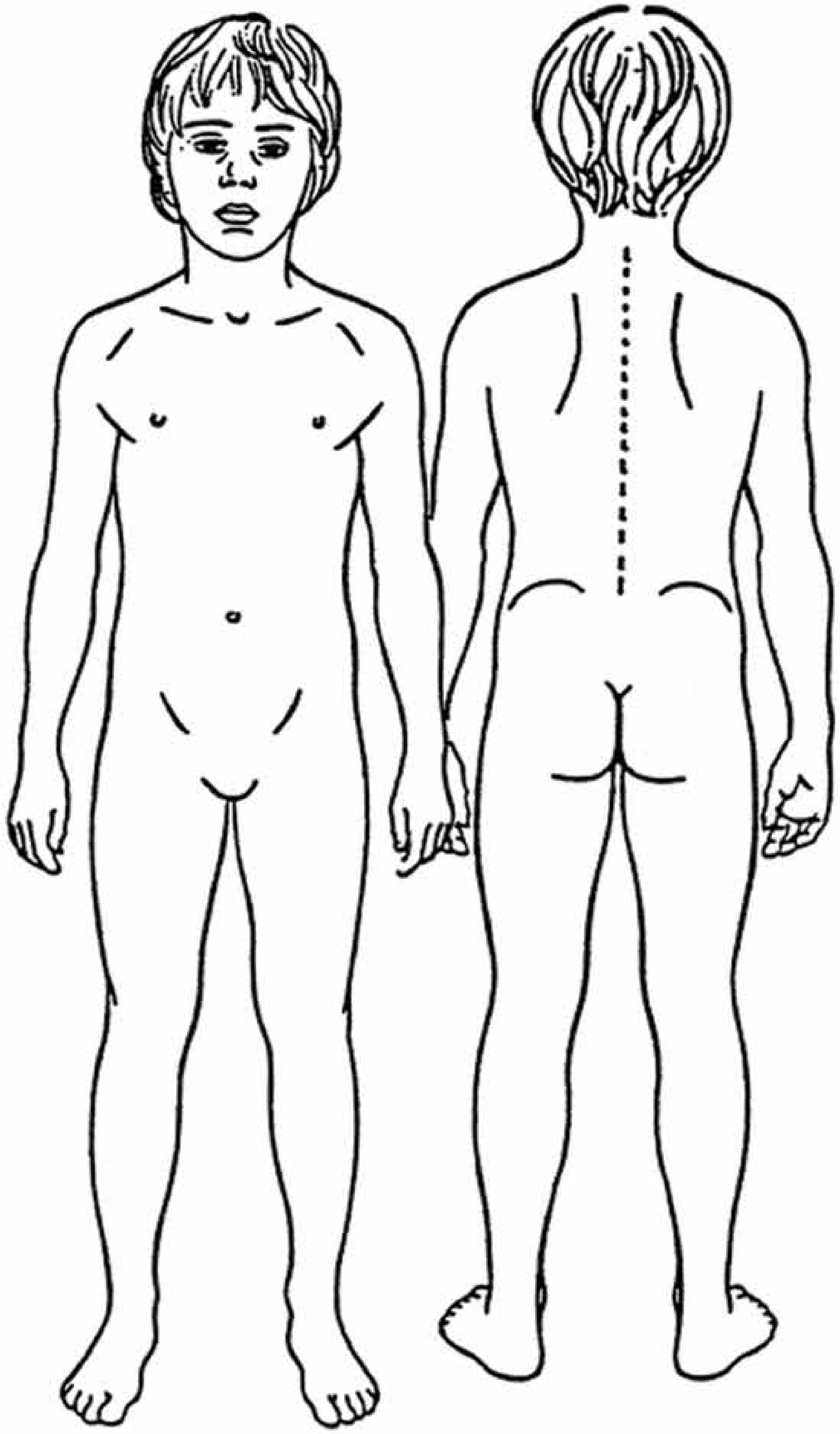
2.4 Statistics relating to children waiting for a family

This grid can be completed at a national level and at the level of a particular RCI:

	2012	2013	2014	2015	2016
Total number of children waiting for permanent family care					
Number of children with disabilities waiting for permanent family care					
Number of adoptable children					
Number of adoptable children with disabilities					
The proportion of adoptable children among the children placed in residential care					
The proportion of adoptable children among the children with disabilities placed in residential care					
Total number of children placed with foster families					
Number of children with disabilities placed with foster families					
The average age of children placed with foster families					
Number of formal national adoptions per year					
Number of informal national adoptions per year					
The proportion of children with disabilities adopted at national level					
Average age of children adopted at a national level					
Number of intercountry adoptions per year (and main receiving countries)					
The proportion of children with disabilities adopted at an international level					
Average age of children adopted at an international level					
The number of children adoptable for more than six months without a matching					
The number of children with disabilities adoptable for more than six months without a matching					

Mapping to identify sensitive areas of the child (see. p. 39-40)





Comprehensive template of the child's file (see section B)

RECEPTION OF CHILDREN WITH DISABILITIES IN RESIDENTIAL CARE

ENTRY REPORT: INFORMATION TO OBTAIN ON THE ARRIVAL OF THE CHILD IN THE RESIDENTIAL CARE FACILITY

This document must be filled in with the person who brings the child in order to gather as much information as possible about the child. It is important for the child to keep a record of this moment by collecting the following information that may be his/her only link with his/her origins.

Name of the facility in charge of the child ....

Date and time of arrival ....

I. BASIC INFORMATION ABOUT THE CHILD

For the RCI, these items are basic information about the child. They enable to identify and record the child and ease the communication with him as well as his/her care. **For the child's future,** this information is the basis of his/her origins and personal history.	Date and time of arrival in the facility	
	Name(s) and forename(s) of the child	
	Sex	
	Date of birth	
	Place of birth	Hospital ☐ At home ☐ Other ☐
	Religion if known	
	Mother tongue	
	Location of the child before arrival? Please detail the name(s) of the facility(ies) and/or hospital(s):	☐ With his/her birth parents: from......................... to......................... ☐ With relatives: from......................... to......................... ☐ In another centre: from......................... to......................... ☐ In hospital: from......................... to.........................
	Physical description and, if possible, a photography of the child (in attached file)	

II. INFORMATION ABOUT THE PERSON WHO BRINGS THE CHILD

For the RCI, this information is precious should it be necessary to reconnect with the person who brings the child in order to have further details on the origins of the child and the circumstances of his/her placement. **For the child's future,** this information is essential, should s/he not know anything else about his/her origins. S/he may know thus how s/he has arrived into the centre.	Name(s), forename(s), gender	
	Age	
	Address	
	Phone number	
	Relationship between the child and the person (father, mother, relatives, police, child protection services, local authorities, social welfare department, etc.)	
	Professional position of the person in case s/he belongs to an official authority	
	In an attached file: Copy of the identity card of the person and Photography of the person	

III. REASON FOR THE PLACEMENT IN RESIDENTIAL CARE

For the RCI, this information enables to start social work and to support the child in this always traumatic stage. **For the child's future,** this information gives him/her details on the circumstances of his/her placement and enables to better understand the decision of his/her birth parents.	☐ Orphan: ☐ Abandoned in a public place, without known parentage: provide details relating to circumstances of abandonment (place where the child was found, the person who found the child, etc.) .... ☐ Withdrawal of parental authority by a judicial decision ☐ Brought directly by the family of origin
	If the child is brought directly by the family of origin, what is the demand of the parents, if known (temporary placement or long term placement, etc.)?
	If the child was brought by his/her family or if parental authority was withdrawn, what were the reasons and circumstances of the placement (poverty, illness, abuse, etc.)?

IV. INFORMATION ON THE FAMILY OF ORIGIN

For the RCI, this information is essential to start the social work and the investigation within the family and to determine rapidly the legal status of the child. It provides details on the siblings in order to attempt reunification if they are also under protection measures. **For the child's future,** these items give him/her essential information to lead research on his/her origins should s/he wish to do so later.	Name and age of the mother if known	
	Name and age of the father if known	
	Address, phone number(s) of the mother and/or the father	
	Ethnic origin of the parents if known	
	Civil status, number of years together, bond between the parents	
	Number of brothers/sisters and siblings, position if appropriate	
	Are the child's brothers and sisters:	
	- remaining with the parents/family?	Yes ☐ No ☐
	- placed in the same facility?	Yes ☐ No ☐
	- placed in another centre?	Yes ☐ Name of the centre: .... No ☐
	- placed in a foster family?	Yes ☐ No ☐
	- other?	

V. MEDICAL HISTORY OF THE CHILD

For the RCI, this is important to ensure the medical follow-up of the child and adapted care. The person who brings the child can have crucial information about his/her health, it is therefore essential to ask him/her these questions. **For the child's future,** this information enables to know more about his/her own development, medical history and its eventual impacts on the long run.	Health status of the child at birth (if known):	
	Weight and height at birth	.... kg .... cm
	Head circumference at birth	.... cm
	Was the pregnancy monitored?	Yes ☐ No ☐
	Was the delivery normal?	Yes ☐ No ☐ Premature birth ☐ Do not know ☐
	Place of delivery:	
	Details known on the delivery:	
	Medical history known, diseases occurred in the past, specific treatments, etc.:	
	Evaluation of the immediate needs of the child (nutritional status, dehydration, etc.):	

List of the personal effects at the child's arrival (clothes, letter(s), jewellery, toy(s) etc.)
(It is important to keep the personal effects of the child since it is often the only link with his/her past)

....

....

....

....

....

....

....

Signature of the person who brings the child

Signature of the staff in charge of
of the admission of the child

MEDICAL CONSULTATION TO BE CARRIED OUT IN THE FIRST DAYS FOLLOWING THE ARRIVAL OF THE CHILD

This form enables to know the health status of the child and to start adapted medical care and follow-up.

This data gives a 1st indication on the development of the child.	Weight: .... Length: .... Head circumference: ....
Malnutrition can lead to developmental delays.	Malnutrition: Yes ☐ No ☐
Is the child ill, tired, in good condition, etc.?	What is the global health status of the child?
These items enable to plan the caring of the child and eventual necessary adjustments.	Does the child have any visible and/or known disability(ies) upon his/her arrival? Yes ☐ No ☐ If yes: • What are they and what treatment/therapies are envisaged and how frequently?.......................... .... • What impacts do they have on the life of the child (daily life, autonomy etc.)? ....
This information enables to plan adapted treatment of the child.	Were any chronic diseases or serious health problems detected on his/her arrival? Specify the treatment plan and timetable:
These items enable to specify the global health status of the child and the eventual impacts on his/her current and future life.	Has the child had any diseases in the past? Ordinary children's diseases (whooping cough, measles, chicken-pox, rubella, mumps)? Yes ☐ No ☐ Do not know ☐ Please indicate the age of the child in respect to each disease as well as any complications: Disease .... date .... at .... months/years; complications : .... Disease .... date .... at .... months/years; complications : .... Disease .... date .... at .... months/years; complications : ....

These items enable to specify the global health status of the child and the eventual impacts on his/her current and future life.	The results of clinical examinations, with details of the dates: • Skin (done the ....) .... • Cardiopulmonary (done the ....) .... • Abdominal-pelvic (done the ....) .... • Neurological (done the ....) .... • Musculoskeletal system (done the ....) .... • Other (done the ....) ....
	The results of the following biological tests, with details of the dates: • Blood counts (done the ....) .... • Iron levels (done the ....) .... • Screening for sickle cell disease (done the ....) .... • Serology (HIV, Syphilis, Hepatitis B and C if possible) (done the ....) .... • Miscellaneous (done the ....) ....

GENERAL DESCRIPTION OF THE CHILD

Does the child seem to be confused, depressed, aggressive, etc.?	Personality of the child (character, behaviour with other children/adults, sleeping pattern, specific problems, etc.). Provide as much detail as possible: ....
Motor	- The child sits by him/herself Yes ☐ Not yet ☐ - The child crawls/moves forward Yes ☐ Not yet ☐ - The child stands with support Yes ☐ Not yet ☐ - The child walks on his/her own Yes ☐ Not yet ☐
Language	- The child starts to prattle Yes ☐ Not yet ☐ - The child says single words Yes ☐ Not yet ☐ - The child says sentences Yes ☐ Not yet ☐
Social interaction	- The child looks for physical contact with adults: Always ☐ Often ☐ Sometimes ☐ Never ☐ - The child communicates and plays easily with other children: Yes often ☐ Yes rarely ☐ Never ☐
Emotions	The child shows emotions (anger, fear, joy, sadness, surprise): Easily ☐ With difficulty ☐ Never ☐
General level of activity	Passive ☐ Active ☐
If the child is at school:	- Which class is s/he currently in? - Can s/he draw a picture? Easily ☐ With difficulty ☐ Is not able to ☐ - Does s/he know the letters of the alphabet: Yes ☐ With difficulty ☐ Does not ☐ - Can the child read? Easily ☐ With difficulty ☐ Is not able to ☐

SUGGESTIONS FOR AN ADAPTED CARE PLAN

Get a first idea of the immediate needs of the child for Short-term care.	....

REGULAR AND SYSTEMATIC ASSESSMENT OF CHILDREN

EVALUATION OF HIS/HER LEGAL STATUS

This evaluation will help to define a permanency plan according to the individual situation of the child. Thanks to this information the child will know (once s/he will reach the age of majority) what has been done for him/her.

This element is the basis to help professionals to understand the situation of the child and undertake the necessary next steps.	Status of the child: ☐ Orphan ☐ Abandoned without known parentage ☐ Abandoned with known parentage (placed by his/her parents in view of adoption) ☐ Relinquished by his/her family of origin ☐ Left temporarily by his/her family of origin ☐ Withdrawal of parental authority by a judicial decision
For the RCI, enables to have a written track on what has been done to find the birth family of the child.	Details of the social inquiry (to fill in when it is undertaken) ● Conducted by: .... ● Date of the beginning of the enquiry: .... ● Length of the inquiry: .... ● Stages and actions taken: ....
These elements help **the professionals** to know if family reintegration is possible and to design the child's permanency plan. **For the child's future,** these elements will enable him/her to know the efforts made to reintegrate him/her in his family of origin.	Was some form of social work undertaken in order to try and reintegrate the child into his/her family of origin or the extended family? Yes ☐ No ☐ If yes, what action was taken? ....

Dated conclusion by the competent services (a copy of the report should be enclosed):

....

....

....

....

MEDICAL ASSESMENT

This evaluation enables to compile important information about the child's health during his/her stay within the Residential Care Institution. It also helps to refine a care and permanency plan tailored to the health status of the child.

REGULAR MONITORING OF ANTHROPOMETRIC DATA AND GENERAL OBSERVATIONS

(This regular recording is a simple and effective tool to screen eventual developmental delays of the child)

Data Date + Age	Length	Weight	Head circumference	Malnutrition (yes-no)	General observations on the child's development and/or important elements to note and monitor

VACCINATIONS

Vaccines		Date of injection	Date of booster	Date of recall	Date of recall	Date of recall
Tuberculosis	Yes ☐ No ☐					
Diphtheria	Yes ☐ No ☐					
Tetanus	Yes ☐ No ☐					
Mumps	Yes ☐ No ☐					
Whooping cough	Yes ☐ No ☐					
Rubella	Yes ☐ No ☐					
Poliomyelitis	Yes ☐ No ☐					
Hepatitis B	Yes ☐ No ☐					
Other immunisations (for ex. measles, etc.)	Yes ☐ No ☐					

MEDICAL CONDITION

For the RCI, these elements enable to monitor the health status of the child during his/her stay. **For the child's future**, they are very important to know for his/her future life.	Did any illnesses occur during the child's stay in the facility? Yes ☐ No ☐ If yes, provide details relating to the illness(es) and indicate the child's age when it/they appeared, and any complications: Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications .... Disease .... date .... at .... months/years; complications ....
For the child's future and his/her (future) family, previous medical history is essential to know in order to ensure an adapted follow-up.	Details of any hospitalisation of the child during his/her stay in the facility (date, circumstances, name of the hospital and treatment given) ....
For the RCI, this information is essential to ensure adapted care, design a life plan and, if needed, find an adequate family for the child.	Has the screening of a disability/specific medical condition taken place since the child has been in care? Yes ☐ No ☐ If yes, provide details of which disability and indicate the age of the child when screening took place: ....
For the child's future and his/her family, these elements enable to know the care s/he benefits from during the placement and to ensure the follow-up of this caring.	What treatments/therapies are foreseen and how often should they take place? .... Does a specialist follow the child? Yes ☐ No ☐ If yes, what kind of specialist: ....
This opinion helps design the most adapted permanency plan to the child's needs and helps prospective adopting parents to make a decision regarding the child.	Opinion of the specialist (or the doctor responsible) on the evolution of the child's illness/disability, the impact on his/her daily life and assessment of future potential to live in an independent fashion (attach the report): ....

Conclusion and medical report on the appropriate permanency plan envisaged or to be considered for the child (detail the prospects and risks, the implications for his/her future family).

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PSYCHOSOCIAL EVALUATION

This evaluation helps to accurately identify the child's needs, his/her potential, resources and difficulties. These elements are essential to ensure an adapted care and define the most appropriate option for the child. They will also be useful to find a family, if needed, who could respond to his/her needs.

• EMOTIONAL BACKGROUND OF THE CHILD AND POTENTIAL SPECIAL CIRCUMSTANCES:

These elements enable to understand the links between the child and his/her birth family and to know if family reintegration is possible, secure and in his/her interest.	Nature and frequency of contacts with the birth family: ....
	Evaluation of social and emotional relationships between the child and each member of his/her family (father-mother, siblings, grand-parents) ....
This data is essential to determine the most adapted permanency plan for the child's needs.	Evaluation of the possibility for the child to form new family links if family reintegration is not possible: ....
If the child is old enough to be consulted, it is important to record what the child thinks about the project planned for him/her.	Report of consultations with the child: ....

PROPOSAL AND REASONS FOR THE CHOICE OF THE PERMANENCY PLAN ENVISAGED FOR THE CHILD

This document helps to understand the whole process that has led to define the permanency plan for the chid. This information is important for the child and his/her new family if applicable.

For the child's future, this information is important and will help him/ her to know that his/her life plan has been decided by authorised and competent entities.	Permanency plan proposal: ....
	Entity(ies) that established the proposal: ....
For the child's future, this information enables to understand why this decision has been taken (report of the assessments and professional opinion). **For the competent authorities,** this enables to keep track of the process that has led to the decision.	Reasons for deciding this specific permanency plan (legal, social, psychological, medical): ....
These elements provided by the staff members who know the child well, will help **the professionals** find the most appropriate family for the child.	If a foster family or adoptive family needs to be found for the child: Guidance on the typical family who could respond to the needs of the child and facilitate his/her integration with them and the surrounding society (composition of the family, character, age etc.) ....
For the child's future and for the adoptive family, these elements will help them to understand why adoption has been chosen and how the decision has been taken.	If adoption is the option envisaged for the child: ● date when the child was declared adoptable: .... ● entity(ies) that established the adoptability: .... ● elements that led to declare the child adoptable: .... ● circumstances and reasons of the consent for the adoption by biological parents (if applicable): .... ● steps undertaken to find a family at a national level: ....

For the child's future and for the adoptive family, these elements will help them to understand why adoption has been chosen and how the decision has been taken.

For the competent authorities of the receiving country, this information will be useful to undertake the necessary steps for the visa of the child.

If international adoptability is envisaged:

- date when this solution was decided: ……………………………………
- entity(ies) that has/have decided: ……………………………………
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- reasons for this decision: ……………………………………
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- steps undertaken to find a family at an international level:
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Opinions and comments from the various professionals in direct contact with the child on a suitable permanency plan(s) for the child:

Stamp of the competent body (Signed)	Date……………………
The Director (Signed and Stamped)	Rapporteur (Signed)

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NOTES

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