Child Welfare Reform in Bulgaria – from Institutional to Family-Based Community Care: Engaging with Families, Children and Colleagues?

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Abstract: The authors present the child welfare policy reform and the process of deinstitutionalization of children's services in Bulgaria. These developments are examined in the context of the country's transition from a post-totalitarian to a liberal democratic state and from collectivistic to individual-centred practices. Therefore, the implementation of social policy promoting and regulating individualised community-based services faces challenges related to attitudes that support group-oriented and institutional-based care. There are three key contextual barriers to the provision of quality services for children with disability: engaging with the individual client, involving parents, and working in multidisciplinary teams. Clinical social work vignettes are presented to illustrate the above challenges.

I. THE INSTITUTIONAL SYSTEM AND ITS IMPACT ON FAMILIES

In 1989 the socialist regime in Bulgaria came to an end, giving space for democratic developments in the country. This transition – although initiated with enthusiasm - has stumbled upon resistances related mostly to attitudes towards the state. In the social welfare field the basis of these is the so-called 'state paternalism' – the belief that the state is responsible and can provide the best care to children and adults. Regarding children's services, state paternalism is not unique to Bulgaria but is an attitude common to all socialist countries as it was fostered by their totalitarian governments. Sugareva [1] explains it by pointing out that legislation in socialist countries "encouraged" childbirth by providing benefits and services to parents and as a result they still maintain the view that the State is obligated to help the parents in the child rearing process (p. 34).

State paternalism attitudes among parents have developed as a parallel process to the expanding state institutional system of child care during the socialist years (1945-1989). Markova [2] writes that during this period the number of so-called 'orphanages' increased from 30 to 285, accommodating approximately 35,000 institutionalized children. The system copied the one that was developed in the Soviet Union, implementing its social policy that viewed the family as a dying institution due to the fact that the woman's role as a caregiver was to be substituted with the one of a worker [3, p. xxii].

Ten years after the fall of the regime, the World Bank funded the first study on child care in the country to find that it is provided only in specialized state institutions for different groups of children: children from 0 to 3 years of age, from 3 to 18, for children with disabilities, and for children in conflict with the law. In many cases, after placing their children in an institution, parents stopped visiting them without terminating their parental rights. As a result only 3% of the 35000 children in institutional care in 2000 had no family [4]. This study [4] challenged the shared belief that institutional care was a home for orphans and revealed the pattern of institutionalizion in Bulgaria: when facing a problem, biological families would often place their child in an orphanage negotiating the stay directly with its director. As there were no services for parents to help them cope with crises, they would prolong their contract with the institution. As most of the institutions were located in remote places, it was not possible for poor families to visit them. Additionally, the institutional staff would discourage the parents from visiting their

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children arguing that these visits disturb them. In the institutions the children were chronically deprived from human interactions, let alone attachment relationships.

Most often children with disabilities would be placed in institutional care immediately after birth following doctors' advice. These children would spend all their lives in institutional care – initially in children's homes and after the age of 18 in institutions for adults.

In summary, the institutionalization fostered a culture of parental reliance on the state, a culture of long-term isolation of children "with problems", and a culture of disengagement with the individual child. The medical model was operating in all types of institutional care without differentiating whether the problem was medical or social.

II. SETTING UP THE CHILD PROTECTION SYSTEM

After the democratic changes in Bulgaria in 1989, foreign NGOs started addressing the problem through advocacy and program development. As a result, several institutions were closed down but the system remained intact. Reducing the number of children in institutional care became one of the requirements for Bulgaria's accession to the EU, which intensified the deinstitutionalization process (DI).

In 2000, the Bulgarian Parliament passed the first Child Protection Act which launched a child care reform [5]. The legislation's main objective was to ensure children's safety in their homes and to promote community-based individualized care. The government set up a child protection system at national and local level, and established a network of community-based services. Social work was identified as the profession responsible for the child care reform's implementation and training was provided to people interested in pursuing this career. Case management and casework with their focus on individualization of care were supposed to replace the group-oriented institutional approach. Therefore, the training emphasized individual needs assessment, treatment planning, and employing variety of interventions. As the legislation was developed to protect the children in their home environment, the family focus was often limited to assessing possible abuse and neglect in children's homes. This focus shaped anti-parent attitudes among the newly-built professional community of social workers. It is no surprise that 17 years later social workers feel unprepared to work with families, resulting in continuing child-parent separation.

Regarding institutional care, the Child Protection Act narrowed the entrance to institutions by stipulating that all referrals of children shall be done on the grounds of a court order or as a temporary measure. Because community services were few and because of the attitudes supporting the pattern of institutionalization, institutions continued providing shelter for the most vulnerable whose number was increasing in a time of political and social change in the country.

III. SOCIAL POLICY FOR INDIVIDUALIZATION OF CHILD CARE – CLOSING DOWN INSTITUTIONS FOR CHILDREN

The more radical development of the child care system began with the 'Vision for deinstitutionalization', a policy document announced by the Bulgarian Government in 2010. It presents the agreement of all stakeholders on the reform's goal - namely, that institutional care would have to be replaced with community-based services and families would have to be supported to provide the care their children need through integrated health, education, and social services.

The policy implementation of the 'Vision' started in 2010 when there were 7587 children placed in 137 institutions [6]. National and EU funding supported the implementation of the deinstitutionalization (DI) through different projects, the first of which was 'Childhood for All' aimed at closing down all institutions for children with disability and replacing them with community group homes. In 2016 the number of institutionalized children was reduced to1495 children living in 48 homes [6].

IV. IMPLEMENTATION OF THE DI POLICY: ENGAGING WITH THE CHILD

The 'Childhood for All' project was launched in 2010 and was implemented by the State Agency for Child Protection in partnership with the Social Assistance Agency and the Ministry of Health. Its aim was the deinstitutionalization of 1797 children with disabilities living in 23 institutions for children with intellectual disabilities ('Homes for Mentally Retarded Children'), 1 institution for children with physical disabilities ('Home for Children with Physical Disabilities') and 31 Homes for Medico-Social Care [6]. The project included an assessment of each child and his/her family, the construction of small buildings for social services in the community, staff trainings, moving children from the institutions to the new services, and the eventual closure of the institutions.

Prioritizing the wellbeing of children with disability was passionately discussed by the stakeholders, some of whom argued that institutions for children without parental care or those for infants should be closed first instead. Still, disabled children were given priority which was the first important political message against the stigma towards this group and for promoting the social and holistic rather than the medical approach in the disability field. The implementation of the policy however was and still is a turbulent process that has affected all participants: the children and their families, the service providers and the communities. All DI procedures starting from the needs assessment and ending with the children's transportation to the new homes have required complex professional responses for containing the crisis that the loss has provoked: the children were losing their environment, the institutional staff were losing their jobs, the communities were losing their institutions that provided income and resources, the communities who were meeting the children were losing their sense of safety, and the families were losing their belief that the state could provide parental care. The 'Childhood for All' project however provided only a 4-day training to prepare professionals in the new services to work with the institutionalized and disabled children. It was a network of NGOs who invested funds and capacity to compensate for this insufficient support [6].

The most difficult task was to support the adaptation of a group of 112 children and young people with intellectual disability in the new community services. All of them were labeled as displaying "challenging" behavior that was harmful to them and to their environment. The Know How Centre for Alternative Care for Children which was set up to study and consult the DI process , invited experts in the field of mental health to consult the deinstitutionalization of this group. These were 15 professionals – psychiatrists, psychologists and a social worker, all of whom had had experience with working with children from institutions.

The group suggested that the old institutional group-oriented approach that was still operating in the new services had to be substituted by an individual approach. More specifically, their recommendations considered : 1/ introducing a casework approach by providing the child with an attachment relationship throughout the process of deinstitutionalization, 2/ understanding the individual meaning of the "challenging behavior" of every child and young person; 3/ regular team meetings to discuss the on-going assessment, development and implementation of the treatment plan, 4/ provision of group and individual supervision in the implementation of the treatment.

In addition, it was recommended that multidisciplinary teamwork had to address both the children's complex needs, and the traditional isolation of residential care. The group insisted that the anonymous institutional way of communicating to the children had to be substituted by discovering a specific individualized approach to each one of them after understanding the meaning of their communication. This change had to start with the staff using the children's names. The team also suggested that the staff develops strategies for containing the "challenging behavior" after a detailed analysis of the environment and the triggers provoking it. First, the staff was supposed to change the environment and their responses to the children's behavior, after which to evaluate and diagnose possible somatic or psychiatric disorders and provide treatment for those. It was obligatory that the staff was supervised by and consulted with clinical psychologists and psychiatrists (data obtained from an unpublished paper – Mental health experts' group vision on DI of children with challenging behavior, 2012).

In April 2012 LUMOS foundation that supports the DI process in Bulgaria and globally funded a program for containing challenging behavior in children and young people living in 3 institutions. A team of clinical psychologists developed the program within the 'Childhood for All' project and applied it following the needs assessment of its residents. This stage of the project was characterized by a time gap between the needs assessment and the leaving of individual children and young people to the new services. First, the psychologists trained the staff in how to conduct and document detailed observations on the children's behavior. The observation focused on the child's visual, vocal and body communication, the child's way of using the environment, the language and his/her relating to objects and people. Second, the team organized the data collected and redefined the challenging behavior as a message the child used to communicate his/her needs and suffering. Finally, interventions were developed within a systematic treatment plan [7]. A clinical psychologist presented the following account at a conference:

> "*Ivan's eyes attracted my attention – animated and clever. I learned that he had lived with his family for some time before*

they placed him in an institution. He can speak but his understanding of the words is literal. He is friendly towards the staff and the children. One day when he could not find his trousers Ivan started biting his hands, hitting his body. He fell on the floor and started kicking around. He took off his clothes and remained naked. I said to him "nice beds, nice blankets, nice sheets make our room nice." Gradually he calmed down. I understood that his violent behavior got activated when he could not demonstrate his developing autonomy. The team supervision suggested that it was necessary to take care of the objects that Ivan liked (trousers, shoes, sheets, blankets) and it was important to ensure that he was able to spend time undisturbed and alone, outside the group. It was also important to cease telling him orders like "stay here", "do not", "you must ". Ivan benefitted from the changes. He started talking more, he was better understood by the rest of the staff. He started taking care of other children. He knows what they like, what their favorite blankets are and he likes to cover them gently with those." [7]

However, this style of care remains inconsistent because it is underfunded by DI projects and because it faces resistance. The services are understaffed and the team meetings and the supervision (when available) are often considered too time consuming The social workers responsible for integrating de-institutionalized children and young people feel disempowered to engage professionals from different fields in the service provision which is a barrier to multidisciplinary teamwork and the provision of holistic child-centered care. Reflection required for effective teamwork, as the vignette presented above suggests can be achieved within a long-term process of supporting the professionals. Only when additional NGO funding is provided, can the practice of individualization of care be implemented.

V. IMPLEMENTATION OF THE DI POLICY: ENGAGING WITH THE PARENT

Reestablishing or strengthening the relationships between parents and children is the key principle guiding the DI implemented through programs for reintegrating institutionalized children in their biological families and for preventing placements of children in residential care by their families. The 'Childhood for All' project planned that the children from institutions are either reintegrated in their biological families, or placed in community services geographically close to their parents. Parents' readiness for these interventions was evaluated and more than 50% of them were positive towards reestablishing relationships with their children [8]. This evaluation was not followed by consistent and long-term interventions aiming at reestablishing attachment relationships in families. On the contrary, the principle of placing the child close to the family was violated.

The Know How Centre studied the process of DI between October 2012 – November 2013 and between September 2016 – June 2017 [9, 10]. Both studies found that parents of disabled children were not sufficiently involved in the DI process. The professionals who participated in the first study believed that rebuilding relationships between the parents and their institutionalized children was impossible. These parents were considered 'irresponsible' and 'not worth the effort". The second study has not documented statements expressing this level of stigma but the professionals participants in the study shared the view that they did not have either the skills, or the time to involve parents [10]. The following vignette from a supervisory report illustrates the problem.

Steven has lived in an institution for 14 years. His mother placed him there immediately after his birth because a doctor diagnosed him with disability. When the DI started he went through the individual needs assessment planned within the framework of the Childhood for all project. The history of his institutionalization showed that his mother had visited him several times and the project team concluded that the relationship between Steven and his mother could be reestablished. A social worker responsible for the case of Steven contacted her to inform her about the reintegration program, about Steven's needs, the benefits and the services the family was supposed to receive. Steven's mother decided to take the child back home and quit her job. The project protocol included that the mother goes

through a training on disability and supports Steven to receive community services. The mother who had 10 years of experience in providing care for elderly people with disability in Italy considered the training useless and stopped attending it. Additionally, she stopped taking Steven to services because there was no transportation available and it was hard for her to walk Steven because the boy felt anxious to move around the foreign city environment. She could not afford to take taxies because the promised benefits were delayed. The social worker who monitored the case evaluated the re-integration as premature and Steven was placed in a group home in another city.

Cases like the above are rare because few parents are ready to reunite with their children who have lived in institutional care for years. They need time and support which the system is not capable to provide.

Excluding parents from DI produced the expected results. In its evaluation of the DI impact by 2015 UNICEF found that the number of children in institutions had dropped dramatically, but the number of children placed in formal (out-of-home care) has remained the same [6].

The above studies showed that the DI's mission - to delegate the children's care back to their own parents and thus reversing the process that started during the socialist years has not happened yet. Even though DI is eliminating the big institutions for children, without engaging with the child and with the family the parenting remains delegated to the state[13].

VI. IMPLEMENTATION OF THE DI POLICY: ENGAGING A MULTIDISCIPLINARY TEAM

Institutionalization of children can be considered a symptom of a problem of the larger society [11,12]. In his study of suicide, Durkheim [11] found that in societies in transition the number of suicides is higher in comparison with countries less influenced by crises. He introduced the term "anomie" to refer to a state of society in which there is a breakdown of social standards that regulate individuals' behavior. Anomie reflects the time when common values in society are rejected but new ones are not yet developed – a process that erodes the societal cohesion and produces alienation.

After 25 years of democracy and capitalism Bulgaria is struggling to negotiate the old socialist values with the new liberal ones and Bulgarian society is often referred to as anomic. This process affects the child welfare field and the disengagement with the clients can be seen as a characteristic of the system. Additionally, working in multidisciplinary teams is in conflict with the medical model because it requires horizontal rather than hierarchical communication. Therefore its introduction in the field of child care services faces resistance. The child protection system and the values it integrates were imported from the West and are not yet integrated either within the system itself, or in the educational or the health sectors.

Multidisciplinary teamwork is the tool for ensuring both individualization of care and implementation of a holistic approach in the provision of services for children with disability. There are four major factors specific to the system of service provision for children and families that prevent teamwork. First, the child protection system is rather new and the social work community responsible for its development has not announced its standards for monitoring the cases it refers to other sectors. Therefore professionals working in the educational and the medical sectors feel reluctant to collaborate with this system. Second, the field of disability is developing alongside the process of deinstitutionalization and there are no shared standards for all caring professionals working with children with disability. Third, the stigma associated with vulnerable groups often results in teachers and medical staff referring children with disability and their families to the social services thus delegating their own responsibilities to this sector. The following vignette summarizes a case of supervision provided by a Know How Centre team.

A child protection worker cannot decide whether to close a case of a boy. The child, a 10-year-old boy, is referred by the school for skipping classes. The child has learning difficulties but the social workers' risk assessment concludes that the boy's mother who has schizophrenia neglects his needs due to a psychotic episode. The mother is referred to a psychiatrist, she recovers and the social worker supports the family for a year by providing benefits, consulting the mother, and monitoring the boy's academic performance. The family

copes better, there is no risk for the child but the social worker feels uncertain about whether to close the case. The supervisor asks about the psychiatrists' assessment which puzzles the social worker who is not aware that it is the psychiatrist who is responsible for his patient's evaluation and treatment and for collaborating with the social services in relation to the risk assessment. Social worker shares that it is the psychiatrist who has asked him about the mother's condition.

There are different ways of maintaining the medical model and resist the multidisciplinary work in any of the sectors participating in the provision of child care services, as the vignette shows. The lack of social work educational and practice standards prevents teamwork even within the child welfare system.

However when stigma towards institutionalized children and their families is addressed through trainings and supervision, social workers are able to engage with their clients and as a result to form multidisciplinary teams and use them for the benefit of their clients. The closure of the first institution for children with disabilities in the village of Mogilino provided the needed comprehensive care for all its residents even before the formal DI process was launched [6].

Nevertheless, social work university education for social workers does not address the issue of stigma. Of 8 universities providing social work training only one MASW program requires a long-term internship which addresses students' attitudes within individual supervision.

Scientific evidence as an additional tool for dismantling beliefs and attitudes in the field of service provision is similarly lacking. A main barrier to collecting evidence and using it in the field of disability rights is the top-down approach of service planning and funding [10] .There are emerging multidisciplinary research communities that succeed to overcome this tendency by studying the field and lobbying for evidence-based practices in service development. In the area of DI, the collaboration between the New Bulgarian University, Know How Centre and the Child Psychiatric Clinic "St. Nicholas" is an example of how this can be achieved in practice.

VII. CONCLUSION

Respect for human rights and children's rights is integrated in all Bulgarian political documents, while the relevant national legislative framework is harmonized with the EU one. The child welfare reform has started to translate these constitutional rights into practice, attempting to ensure that the child protection system and the process of deinstitutionalization guarantees that children and families in Bulgaria are provided with holistic care and a therapeutic process that they can understand and relate to. This process creates opportunities for professionals to gradually replace the medical with the social model in the field of disability rights. To achieve this, it is essential that all trainings for professionals provided by national or foreign teams address the existing attitudes that prevent engagement with the clients, parents and colleagues. Professionalization of social workers is a key factor in the process given that the latter are authorized to refer children and families to various services, to monitor the process and thus – to set the stage for a meaningful collaboration between clients and professionals.

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