НОУ-ХАУ ЦЕНТЪР ЗА АЛТЕРНАТИВНИ ГРИЖИ ЗА ДЕЦА, НБУ

Support of childcare reforms in an environment of political instability, poverty and limited human resources

(Assessment of the work of Hope and Homes for Children – Bulgaria (HHC) for the period 2014-2016)

Research team: Borislava Metcheva, Valentina Bizheva, Galina Markova, Evgenia Toneva, Lyubomir Dzhalev, Kristina Slavova, Yana Katzarova

Know How Centre for Alternative Care for Children, New Bulgarian University

НБУ ул. Хан Крум № 38 А, t: +359 2 403 20 30

e: info@knowhowcentre.org, w: http://knowhowcentre.nbu.bg

OAK FOUNDATION

Table of contents

1. Introduction.....p. 3

2. In what new context is the project being realised?.....p.5

3. A holistic and complex HHC model for closing HMSCCs.....p. 6

4. Research methodology.....p. 10

5. Scope of the project……...p. 12

6. Results.....p. 18

6.1. Relevance.....p. 18

6.2. Effectiveness.....p. 30

6.3. Benefit….. .....p. 45

6.4. Sustainability.....p. 53

7. Conclusions.....p. 67

8. Recommendations .....p. 72

9. General conclusion……..p. 75

10. Attachments

10.1. Attachment 1.....p. 77

10.2. Attachment 2 .....p.

10.3. Attachment 3.....p.

10.4. Attachment 4……p.

1. Introduction

In comparison to other areas of reform, Bulgaria's national deinstitutionalisation (DI) program is highly complex - political will is reflected in action plans, common values, investments in child protection, cross-sectoral coordination and the extensive involvement of NGOs.

In the context of this reform, the work of Hope and Homes for Children can be separated into four stages:

1. Deinstitutionalisation of children from a home for medical and social care for children (HMSCC) before the DI policy implementation started. (In 2009-2010 Hope and Homes for Children, in partnership with the Bulgarian NGO Equilbrium, closed the first home for children ages 0 to 3 in the town of Teteven and created a model for reforming these types of institutions).

2. Deinstitutionalisation of children from HMSCC after the reform had started, but outside a government EU funded project for DI. (Together with the Bulgarian government, Hope and Homes for Children closed HMSCCs in Shiroka Luka (2011) and Kjustendil (2015) as part of the HHC project 'Strategic deinstitutionalisation and reform of childcare for children aged 0 to 3 in Bulgaria').

3. Deinstitutionalisation of children from 8 pilot HMSCCs as part of the independent HHC project 'Strategic deinstitutionalisation and reform of childcare for children aged 0 to 3 in Bulgaria', supporting the government EU funded DI project "Direction-family".

4. Closure of HMSCCs in the period after the end of the project "Direction-family" as part of the new HHC project "Strategic deinstitutionalisation for **eradication** of childcare for children aged 0 to 3 in Bulgaria"

The Know-How Centre for Alternative Care for Children (KHC) of the New Bulgarian University was invited by HHC to conduct an intermediate assessment, which would study the results of HHC's work undertaken during three of the total five-year new project financed by an external donor. Since this assessment is the fourth done by the KHC, the centre's team

is assessing not only the effect of HHC's work during the separate periods and projects, but also the effect of the changing context on the work of the organisation.

The context in which HHC was working in the assessment period was characterised by changes of governments leading to weak political engagement with the issue of DI. This impacts on other factors: political and professional values, investments in the child protection system, coordination of the work among the relevant sectors and engagement with NGOs.

The main conclusion of the assessment is **that in this context (also) the application of HHC's model remains relevant, effective, sustainable and valuable, because:**

- **It continues to lead to the closure of HMSCCs,**
- **It provides family care for deinstitutionalised children, or children living at risk of institutionalisation,**
- **It achieves and maintains motivation towards DI in the child protection system.**

In combination with the factors listed above, aspects of the wider context – high levels of poverty and shortcomings in the professional capacity of the child protection system, destines HHC to become engaged with more than simply playing the role of a catalyst and performing leadership functions related to the implementation of DI. The same factors have a negative effect on the sustainability of HHC's work, which is limited in time.

2. In what new context is the project being realised?

Deinstitutionalisation (DI) and more exactly the closure of the homes for children aged 0-3 (HMSCCs) is the context in which the organisation undertakes its activities. That is why its successes and difficulties have to be contextualised in terms of the specific socio-demographic profile of the locations in which the organisation works, as well as in terms of in what way each successive government implements the DI policy at a central level over and above local actions. This includes: the existence of will, free-flow and adequacy of funding, relationship between the local authorities and political masters and balancing the interests of the various sectors involved in DI.

We can list several main characteristics of the political context during this period:

- **Repeated changes of government**: Between 2014 and 2016 pre-term elections were held twice, as well as presidential and local elections. This brought about frequent changes to the teams involved with the implementation of the deinstitutionalisation policy. During this period, in the Ministry of Labour and Social Policy which plays a leading role regarding DI there were five changes of ministers. This caused instability and delays while creating conditions in which important political measures that were included in the long-term strategy "Vision for deinstitutionalisation of the children in Bulgaria" were not implemented.
- **Lack of leadership**: The high-level, interdisciplinary working group - which includes deputy ministers from all ministries that are related to this reform - and the permanent expert working group were influenced by the changes in state governance. This turned into a reason to delay updating the action plan for implementation of the vision for deinstitutionalisation by more than two years and it delayed implementation.
- **Every new government in Bulgaria adhered to the DI policy**. However, on the one hand, the lack of leadership in the process of implementing the reform and the stop-start, bureaucratic approach jeopardised the sustainability of the results achieved in DI to date. On the other hand, it impacted negatively on the planning of new measures and investment of adequate resources for continuing the reform.
- **Lack of national DI projects.** This lead to lack of structure of the work for DI reform and there were significant delays in defining approaches to continue the DI reform process and to sustain the partnerships that were developed in the previous period.

- **The child protection system remains under-resourced**: Both human and financial resources are barely adequate to respond to the demands created by the DI programme.
- **All children from homes for children and young people with mental disabilities as well as young people from homes for children deprived of parental care have been placed in community based care**. This is a process that has caused tension in the child protection system and has identified problems at all levels – management of services, work with children and families, work with the community.
- **Strategic investments are being made mainly by NGO:s:** These organisations are investing resources and working intensively to continue the DI process despite the factors that threatened stagnation as well as to minimize the risks to the children and families.
- **Coalition 2025**: The coordinated efforts of coalition members help to sustain the DI process. HHC is an active member of this organisation that prioritizes DI reform.

3. A holistic and complex HHC model for closing HMSCCs

Among the organisations that are replacing institutional care for children aged 0-3 with family care, HCC stands out. The organisation works directly in prevention of abandonment and reintegration of children from institutions. It actively supports the child protection system. It plays a catalytic role in administrative closure of the relevant HMSCCs. This is to say HHC's intervention changes the system in a tangible way – holistically.

HMSCCs are the most difficult residential institutions to close for the following reasons:

- They are managed by the Ministry of Health – an institution which identifies least with the social model that DI follows.
- There was continuing placement of babies in HMSCCs
- There has been a lack of appropriate and timely support for families in the community
- There is a critical lack of municipal housing for low-income families
- The insufficient capacity of the child protection system is self-evident in the lack of adequate services in the community or capacity in the existing servicers to work

with the target group aged 0-3.The Child Protection Department is over-stretched and under-resourced.

- There is a systematic lack of data or restricted access to data regarding assessment of children in support of their placement in services, foster families and adoptive families.

During the assessment period 2014-2016 the number of children in HMSCCs was 975 (source -HHC website).

The holistic and complex HHC model for closing HMSCCs is as follows:

- achieving memorandum of partnership with the central government
- achieving agreements with the local authorities
- analysis of the condition of the relevant HMSCCs
- analysis of the protection system at the appropriate regional level
- analysis in partnership with the local authorities of the need for new social services and/or support for increasing the capacity and quality of work of the existing ones
- analysis together with the local authorities of the material and human resources of the HMSCCs and their redeployment in new or existing community-based services after closing the institution
- creation of an approach for coordination among the stakeholders in DI with the formation and operation of Regional Coordination Mechanisms for DI
- increase in the professional capacity of the various practitioners from the Child Protection Department (CPD), social services and other institutions and organisations according to the ascertained needs.
- assessment of the children and their families and planning of care (the assessment is always done together with the families)
- implementation of the care plan accompanied by use of the model for ACTIVE family support
- active work with the families, CPDs and other institutions and organisations involved in the process of prevention and reintegration
- closure of HMSCCs on the basis of radical reduction of child placements and effective work on prevention of abandonment

A key component of the holistic and complex model for closing HMSCCs is the model of ACTIVE family support. It has been developed by HHC on the basis of their 20 years of practical experience in different countries in the process of managing the transition from institutional to family-based childcare system. It provides a good practice that is flexible and adaptable to different contexts that involve planning suitable interventions and services for vulnerable children and families. The model supports the closure of institutions and the preparation of the protection system to function without being dependent on institutional care by channelling the resources and services in such a way as to prevent children entering the formal care system in the first place.

The model of ACTIVE family support is an intervention model focused on identifying and supporting children at risk of separation from their parents and being institutionalised. It is also used to promote reintegration of children with their biological or extended families.

An important element of HHC's holistic and complex model for closing HMSCCs is the introduction of the coordination mechanism at regional level. This is a special instrument for applying DI policy locally thus providing the opportunity to focus on the problems of the target group (subject to the policy) and to make decisions and achieve changes in the interest of the target group. The regional coordination mechanism creates an environment for interinstitutional interaction at local level, applying principles that are both very simple and effective. These regulate the relationships and responsibilities in the regional partnerships for implementing the national child protection policies, and especially the DI process. With this mechanism the expertise and resources are integrated in order to find the best solution for the cases of children and families at risk, to plan strategies for their implementation in practise and, importantly, to make *concrete* commitments on these cases. This environment of analysing cases and for creating plans for resolving them, is also an environment in which the capacity of the partners to guarantee the rights of children and families is increased.

The regional coordination mechanism as it is developed and systematically applied by HHC is considered by the professional community as a "second model".

Previous assessment show that by applying these two models – ACTIVE family support and the regional Coordination mechanism - HHC has significantly increased the ability of all participants – political players, local authorities, specialists and parents, to provide alternatives to the institutionalisation of disadvantaged children and the indicators shown below position HHC is a key agent of the change required by DI.

These are:

- Number of closed institutions
- Number of supported families
- Increased capacity of families
- Using the coordination mechanism for the creation of partnership that did not exist before HHC's intervention
- Applying the model of ACTIVE family support
- Applying the Regional coordination mechanism model

4. Research methodology

a. Aim of the assessment

As in the previous assessment, the team follows the principles of good governance and the guidelines of the European Commission (EC) that prescribe the need to evaluate the overall impact and effectiveness of HHC's program in Bulgaria. During the processes of data collection and analysis we applied the following evaluation criteria:

- Does the programme gel with national and local policy so as to respond to the identified needs? (Relevance)

- Does it actually achieve its intended end results and does it mobilise sufficient and suitable resources to support them? What are the effects on the target regions and groups and do they correspond to the objectives? (Effectiveness)

- What are the gains and what is the impact on the target groups? (Benefit)

- Can and will the elements of the programme continue to be implemented and to what extent? (Sustainability)

The assessment aims to study the extent to which the holistic model of HHC is implemented during the stated period in 5 out of 15 regions in the country in which HHC is operating within the current project.

When it comes to the impact of HHC's work in DI, the evaluation team has considered the impact on both the hierarchal system in which the process is managed (international, national, regional, community, family, individual) and the "horizontal" component that entails coordinating multidisciplinary and cross-sectoral teams. The team considers the impact of HHC's work on the broad system. And since under "system" the team understands not only the existence or absence of institutions for children, but also the relationships that replace the institutional paradigm, it places a focus on the extent to which the hierarchical relationships typical for the institutional approach are replaced by partnerships among all stakeholders that are engaged with the child and family and to what extent the attitudes that they support are a result of HHC's work.

b. Team

The assessment team is multidisciplinary and consists of researchers with practical experience from direct work with clients and researchers with experience in studying DI. Every member of the team studied one of the chosen locations. A team with experience in conducting in-depth interviews was chosen, in order to achieve a comprehensive analysis of the process with the participants.

c. Regions covered by the research

5 regions were selected, three had a population over 200 000 people (1,2,4). One had a population under 200 000, and the last was over 500 000.

Region 1 – *According to the Regional strategy for development of social services 2016-2020* less than 10 services are functioning on the territory of the region.

Region 2 has a Roma population of about 4%. According to the *Regional strategy for development of social services 2016-2020* there are over 20 social services for children, 50% of which are residential.

Region 3 consists of 7 municipalities, inhabited by more than 129 000 people. There are 30% ethnic communities. On the region's territory there are a centre for social support, a centre for social rehabilitation and reintegration catering for young people with disabilities and family-type accommodation for young people with and without disabilities and a day centre for children with disabilities.

Region 4 has a population of 112 000 people living in 7 municipalities. The mixed ethnic composition of the population is clearly defined. The existing social services for the target group aged 0-3 are a day centre for children with disabilities, a home for medical and social care of children and 27 foster families (21 of them are in the biggest municipality in the region). The foster care is mainly dedicated towards new-born babies and young children.

Region 5 consists of 22 municipalities with a population of about 250 000 people. The largest town, which is also a regional centre, consists of 18 administrative units with mayors of their own, covering parts of the town or parts of the town with other settlements, and 3 administrative units without mayors of their own. Total population of the city is slightly under 1.5 million people. According to the *Regional strategy for development of social services 2016-2020* on the territory of the region in the end of 2015 there were 14 community based

services and 5 community based residential services. In the regional capital there are currently 23 family-type placement centres (half of them for children and young people with disabilities), 4 centres for social support, 4 crisis centres and only one mother-and-baby unit that serves the entire region.

5. Scope of the project

In Region 1 HHC have worked with 26 families and children, supported the reintegration of 5 children, conducted supervision of the child protection department (CPD), convened 2 round-table discussions, run 3 training sessions for members of the regional coordination mechanism, CPD and social service providers in the region. It has closed a HMSCC. It continues the work of the regional coordination mechanism created to support the closure of another HMSCC in the region, closed during the previous project. HHC took part in a working group for the preparation of a concept for opening services for children and families in the second closed HMSCC.

In Region 2 HHC has supported 47 families and children (including 13 cases of reintegration). One supervision of the CPD has been carried out and 4 training sessions for the members of regional coordination mechanism, CPD and services providers in the region. Additionally, HHC provided specialised training for the team at the family-type home using the IMPACT method (a model for reacting to challenging behaviour) were conducted in support of the professionals working with families and children. The coordination mechanism has existed since 2016 on the basis of a memorandum for partnership with the regional administration.

In Region 3 HHC closed a HMSCC, worked on prevention with 27 families and children and on reintegration with 3 children. They conducted a supervision of the CPD in the region, conducted 2 round-table discussions in the region, 3 training sessions for members of the coordination mechanism, CPD and service providers in the region. HHC supported the opening of a day centre for children with disabilities by providing equipment, funding building repairs and purchasing a vehicle.

In Region 4 HHC worked on a total of 55 cases of children, 40 of which were prevention, and 15 of which were reintegration of children from the HMSCC. Of the prevention 17 were of children aged 0 to 3 that were supported in foster families. The remaining 23 cases were prevention of abandonment with direct support for the biological families. There were 15

successful reintegration cases during the period. HHC decreased the number of children in the HMSCC from 21 in 2015 to 5 in 2018. 15 children left the home and were successfully reintegrated, there were three adoptions and, unfortunately, two children died. All the reintegration and prevention cases were effective. There were one or two cases of children with especially severe disabilities for whom no alternative service was found and they were accommodated in the HMSCC.

In Region 5, according to data from HHC, the scope of the organisation's work was:

Work on prevention for the period 2014 until now - 224 families and children

Work on reintegration for the period 2014 until now – 7 children

Conducted 4 trainings in the two regions for members of the coordination mechanism

Conducted 4 trainings on the topics "ACTIVE family support" and "DI and alternative care" for the CPD and service providers

Conducted 3 round-table discussions

a. Participants in the assessment:

- Professionals at national level – HHC management team and experts
- Professionals at regional level – representatives of regional and municipal administrations, regional health inspectorates, general hospitals, regional police directorates, local coordinators of Ministry of Health and HHC personnel in all regions in which the assessment was undertaken.
- Professionals from the social and healthcare system - regional directorates of social assistance, CPDs, social service providers, HMSCCs
- Biological and foster parents and relatives
- Children

Participants in the study – summarised information:

CPD = child protection department

RDSA = regional directorate of social assistance

CpxSS = complex for social support

CtreSS = centre for social support

FTPC = family-type placement centre

MBU = mother-and-baby unit

NGO = non-governmental organisation

MA = municipal authority

Region/ participants	**Region 2**	**Region 5**	**Region 4**	**Region 3**	**Region 1**
Parents/ families	3 families (mothers, children, members of extended family)	18 families (parents, children, members of extended family)	8 families (parents, foster parent)	4 families (parents, children, members of extended family)	7 families (biological and foster parents, children and members of extended family, including representatives of a foster family, a family with prevention of abandonment and a family with a reintegrated child)
Professionals	1 Head of CPD 7 social workers from CPD 2 foster care social workers 3 managers of social services (CtreSS,	4 Head of CPD 4 social workers from CPD 1 director from CplxSS (MBU to NGO 1 manager of CtreSS	2 people from municipality 1 Deputy Director of HMSCC, head doctor 5 experts (Director of directorate “Social work” ;	1 Head of CPD 1 chief expert regional administration 1 Director of РЗИ 1 expert - MA 1 chief expert RDSA 1 psychologist -	1 representative of regional administration 2 experts from CPD 1 expert from RDSA 4 expert from CpxSS 1 HHC coordinator

	CtreSS, FTH)) 2 social workers from services 1 employee with managerial role in municipal administration 1 HHC coordinator	1 HHC coordinator	3 Heads of CPD; Chief expert RDSP 1 director of NGO	CtrSS 2 Heads of CPD	
Total number of participants in the region	**20 people**	**29 people**	**17 people**	**12 people**	**15/16 people**

Participants in the study are employees of HHC working in different positions, specialists in governmental departments and NGO organisations.

All meetings with families and children were held in the family homes and in the presence of a coordinator from HHC, which is an additional source of data: regarding the living environment, the relationship between the children and parents, communication within the family and with the HHC representative.

b. Assessment design

The study combined quantitative and qualitative methods by following the methodology of the previous assessment (to enable comparisons to be made). The combination of both types of data allows the discovery of general tendencies (through the quantitative data) and their explanation through the qualitative analysis. This design has been used for assessing the effectiveness of the HHC model with regard to the resources invested and the interventions in the families.

c. Tools

The quantitative research uses: analysis of reports and documentation, semi-structured interviews and focus groups and direct observation. The questions included in the semi-structured interview are shown in Appendix 3.

Assessment survey in Appendix 4

The three sets of tools are shown in appendices.

d. Work ethics

Ethical research methods were used during the collection and documentation of the data. All participants were informed of the aims and objectives of the assessment, the approach to be used, the method for collecting, documenting and using the information and the duration of the meetings. The anonymity of the participants was guaranteed, as well as the right to refuse to participate or leave the meeting at any moment they decide. Despite the fact that some participants were happy to disclose their identity, total anonymity was observed in the final report.

e. Analysis of the data

Data taken from both individuals and groups were analysed on the basis of 4 criteria - relevance, effectiveness, benefit and sustainability, as well as with regard to the question of the way in which the context changes the work of HHC. The analysis of the data was also conducted on the basis of international standards of social work practice: guaranteeing of rights, access to services, right of choice, multidisciplinary teamwork, work in the community, empowerment, practice based on a combination ok knowledge, skills and attitudes that are sensitive to local culture.

The quantitative data was analysed statistically.

f. Assessment limitations

The limitations of the assessment relate to the fact that access to participants was provided by HHC employees and former coordinators from the organisation.

6. Results

6.1. Compliance of HHC's work to the policy and its application to the relevant context *(Relevance)*

Conclusion: The HHC model is relevant in relation to DI policy and is a meaningful response to barriers to the implementation of DI in the different contexts. HHC achieves this with active implementation of the policy, provision of knowledge, skills and overcoming of resistance that maintains the institutional approach. Additionally, HHC provides role models in the personae of its regional coordinators who directly implement the various components of the model.

6.1.1. HHC applies the "Vision for deinstitutionalisation of the children in Bulgaria" (2010) and the updated plan for implementation of the national strategy "Vision for deinstitutionalisation of the children in Bulgaria" (October 2016) by closing HMSCCs and by overcoming the resistance to the reform.

6.1.2. HHC applies an evidence-based approach, so that it is relevant to every context by overcoming the barriers to DI: limited material and human resources, lack of leadership in overcoming the resistance towards DI supported by:

- Overturning a bureaucratic approach BY providing flexible, individualised support;
- Overcoming the stigma towards the users of the new services BY creating relationships of attachment with a coordinator;
- Combating lack of partnership among stakeholders BY fostering teamwork and networks.

6.1.1. Relevance to the policy

HHC applies the "Vision for deinstitutionalisation of the children in Bulgaria" and the updated plan for implementation of the national strategy "Vision for deinstitutionalisation of

the children in Bulgaria" (October 2016), with a focus on closure of HMSCCs.
HHC is an international organisation whose work is relevant to the global agenda for closing institutions for children.

In Bulgaria HHC's greatest contribution in regard to the relevance of its work to the DI policy is the fact that even when the state governance doesn't hold its role as a leader in implementing its own policy, HHC does so by systematically implementing documents and laws related to it. As well as the systematic referral to accepted documents, HHC's profile as an international organisation implementing DI on a global scale has an additional effect on the consistency with which HHC supports the implementation of the policy.

During the period that is being reviewed, there were still 17 HMSCC existing in the country, and of the total of 647 children in them 467 were in the HHC's target group– aged 0-3 years. The results of HHC's work is that in this period it has closed 1 HMSCC in Region 3, 1 HMSCC in Region 1 and another HMSCC in Region 5, and has placed around 131 children in a family environment.

In order to achievement this result the profile of the organisation is important.

HHC was described an *"international organisation that has big achievements in the sphere of deinstitutionalisation. Before us they have been in Romania. In many other counties, but they come directly from Romania. And since that in X we had a home for medical and social care for children from 0 to 3, and their target group is exactly that, they signed an agreement at regional level to participate in the process of closing the institution, by providing us support in the work on cases of prevention and reintegration of children from 0 to 3 years."* (CPD representative)

To achieve this result of eroding resistance to DI on all levels, it is important that HHC understands that DI and resistance come together and operates accordingly.
Resistance towards closure of institutions continues. Despite the existence policy on DI for five years (2012-2015) that was financially supported by the three big national projects "Direction: Family" (closing 8 baby institutions), "Accept me" (developing foster care) and "Childhood for all" (closing all institutions for disabled children in the country), in some regions of the country (at a local level) resistance to the closure of HMSCCs is strong. In such

places the intervention from HHC turns out to be critical as a catalyst for kick-starting the process and implementation of the national policy.

The resistance is manifest during the closure of every institution.

> *"There was a great deal of resistance form the staff in the home. They did everything possible… they refused to cooperate with having the children moved. As part of the project "Childhood for all" it was intended to have them accompany children (during transportation) so that their adaptation would be easier but they refused categorically. They (the staff) didn't cooperate in any way. On the contrary, they looked in all possible ways for children to be accommodated (in the institution)… they made it difficult for us in all possible ways…"* (CPD representative)

Or

> *"Their main device was to categorize children with different clinical diagnoses (heart problems, slowing of neuro-psychological development, problems with hip joints) with the aim of slowing down their removal by showing that these were children requiring special care"* (representative of regional directorate of social assistance)

> *"They want to hang on to the children so as to keep their jobs. It was war. There was terrible resistance. One used emotional blackmail saying we'd sabotage her pension because she would not work until retirement and get full benefits. They scratched our car during the meeting… the director of the home was a very old woman and she had spent her whole life in this institution. The coordinator and HHC were a serious support, I'm not sure that we would have held in at the home if we were alone. The feeling that you have someone behind your back all the time is irreplaceable. And the thing that is missed a lot even now, when we don't need financial resources. At the meeting with the director, when she was hostile and constantly attacking, I'm not sure that we could have fought with her alone, if she (the HHC coordinator) wasn't there. She is a serious resource, a serious fighter. Otherwise you feel alone…"* (Foster mother).

The HHC coordinator, social workers and families speak of harsh and rude treatment, scratching of cars, withdrawing from agreements or obstructing the contact between children and the foster families, in order to jeopardize their desire to take a child. They were threatened, insulted and told the children were a challenge and they would not be able to manage.

There was also resistance against blocking the flow of children to the institution.

> *"The coordinator stood up against the pressure to accommodate the child by actively supporting the family. She helped with a baby pushchair, bed, diapers and food and with some other support from the CPD and centre for social support. That is how we stopped the placements (in the institution). And in this way we managed to decrease the number of children in the HMSCC. Only by blocking the flow. Otherwise a very small part of the children were adopted, few were reintegrated. We accommodated one to two children a year." (*CPD representative)
>
> The resistance at DI management level was manifest in the form of neglecting the care for the emotional attachments of the children.
>
> *"It was a struggle … some people didn't overcome their ego. We witnessed horrific things. For me this about Location X was one of the most difficult moments in my whole career. The children we scattered like dogs, like suitcases… You lose faith when you see before you a system, a mechanism that cannot be overcome"* (Representative of regional directorate of social assistance).

In these cases the activities of the HHC coordinator were aimed at trying to maintain a focus on the children, to explain the consequences of these actions and to search for like-minded people for their values. In Location X, however, all attempts for intervention on an institutional level failed to protect both the children and the professionals form the trauma of being participants in the *"scattering"* of the children to different corners of Bulgaria.

6.1.2. Relevance to the context and barriers to DI

HHC achieved relevance to the needs by undertaking an assessment of needs in the given context, based on which it planned its activities in it. 80% of the people interviewed believe

that HHC meets their needs of: 1/material and human resources to fill in the gaps in the system and overcome the bureaucratic management in every context, 2/ partnership.

6.1.2.1.Provides material and human resources

HHC helps the system with resources that "are absent in the government policy", but without which DI cannot take place. These include financial support, timely and individual approach and high trust in the intermediation between the families and the state.

HHC's resources help for:

- **the closure of homes,**

"A barrier for the faster closure of homes during the last two years was the children with severe disabilities that we had to accommodate in specialised family-type placement centres. We had serious problems with transporting them. They helped us with these children (HHC). Financially again, by hiring an ambulance, because only with a specialised ambulance they can be transported, with medical equipment and staff and it was very risky. The fact that they (HHC) took on this responsibility was priceless, because initially the project "Childhood for all" has planned funds for transport, but in Location X they were very late with the family-type placement centre and the project had already finished, and there was no way to transport the children" (CPD representative).

- **closing the pathway to HMSCCs**,

The network of alternative care services, which have to achieve successful prevention of abandonment of children doesn't work well. In region 5 - for example - there is one mother-and-baby unit with a capacity of 10 people (*as per* the d*irector of the MBU*), and foster care in the country is imbalanced and doesn't respond adequately to the needs of the local municipalities (*from an interview with manager of CtreSS)*.

HHC is often the only organisation that provides the support needed for preventing the abandonment of a child. Social welfare is provided slowly and the procedures are complicated. The lack of capacity in the various systems is a barrier for them to seek or mobilise the existent resources. The one-off welfare payments after the birth of a child are received after a period of at least a month and this type of delay can be critical for the decision of a family to abandon or care for the new baby. Often after using government resources statutory social workers are subject to deliberate inspection and penalised.

Mobility, crisis reaction and giving direct work with the family priority over administrative tasks are three general characteristics of the work of HHC's coordinators that have the

following resources:

- A company car with a big boot, loaded with the necessary humanitarian packages and with the capability of transporting large loads (for example wood for heating), fuel for the car and a company mobile phone.
- Good logistic skills
- Telephone contact with the families to keep track of their situation and needs with regard to the healthy development of the child, where the regular contact serves not only the pragmatic aim of adequate assessment of needs, but is also perceived by the family as engagement, individual approach, care, emotional support.

The result:

> *"Their support was absolutely timely, accurate and as it is said life-saving for the family and their potential to care for its child"* (CPD representative).

- **Providing a family for all children from HMSCCs**

The HHC model is critical in such a context because it responds to the necessity of crisis support for the family/ child. HHC activate their own network of connections with foster families in regions of the country in which they have worked, and provide financial resources for transporting the child, which the government doesn't do.

> "*We do not have foster families (for disabled children) in some of the municipalities. Part of the staff from a closed institution became foster parents. In the end, only they (HHC) have helped us in this process (closure of HMSCC), until now no other organisation has joined in, everything else we have done alone. Unfortunately we didn't have contact before and they joined in the last stages, but their help was priceless, because if it wasn't for them we would probably not have managed with transporting the children".*

- **Increases the capacity of the system**

The participants identified the following elements in the work of HHC that achieve the aim:
1/ practical trainings, 2/ human factors – relationships of attachment with the coordinators and the team's dynamism, 3/ teamwork with representatives of the system, in the context of which the model is adopted by the system.
The trainings are "always very good" (CPD representative) and beneficial:

"The trainings included things that we can implement in practice… Topics like alternative care, deinstitutionalisation, disabilities…" (CPD representative)

Not all participants are able to point to such specific topics. The training has a more lasting effect when it is provided to newly-employed specialists that before the training have developed working experience of the model through contact with HHC. The combination of training and relevant practice is important.

The same effect is seen in the teamwork with HHC coordinators who form relationships of attachment with the clients.

6.1.2.2.HHC compensates for the lack of leadership by systematically overcoming resistance to DI that is supported by:

- *A highly bureaucratic approach BY providing flexible, individualised support*
- *Stigmatization of those using the new social services BY creating relationships of attachment with the coordinator.*
- *Lack of partnership between the stakeholders BY promoting teamwork and networks;*

<u>The coordinators demonstrate leadership in working with the families by replacing the bureaucratic approach with flexible and individualised support.</u>

In all regions, participants in the study acknowledged these elements of the model applied by the coordinators. They recognised their engagement with the personal story of the family members, their role in actively resolving crises after the birth of a child or returning the child in cases of reintegration, the fast reactions when new needs of the family arise, readiness to provide emotional support and mentoring regarding the child's development, mobilisation of the resources of social services for the purpose of prevention/ reintegration.

<u>The coordinators overcome the stigma towards the families by forming relationships of attachment with the families.</u>

The most valuable quality of the HHC model is the human factor. The regional coordinators play a key role in implementing the model. The families that were interviewed during the study often do not know the name of the organisation and aren't familiar in detail with the activities of HHC, because the relationship with the organisation is person-based. The

relationships with the coordinators that are described above are new relationships based on understanding and empathy, which overcome the attitudes towards institutionalisation both of the parents and the system.

"I suffered a lot, my husband and I both cried all day long, because I know what an expense a child is, and it has to have a future… My husband would say, if there is an option to leave it for 3 months and we would do everything to get things right and would then take it back after 3 months… I was very sad that we would have to leave the baby… and she (HHC coordinator) *came to the hospital that same day…she explained to me that they are such a foundation that helps mothers that can't manage in the beginning… and she helped me with clothes for the baby,, brought diapers to my husband, formula milk, things for washing… she had brought absolutely everything and she had even bought wood and it was warm when we returned from the hospital (12 February)… She gave me a lot of faith in the fact that she will help and I didn't hesitate any more…"* (Mother of 9 month old baby)

The teamwork with representatives of the system - "working together" with them - creates conditions for sustainability of the implementation of the model after HHC withdraws. It's especially important that they changed deep-rooted attitudes based on seeking to keep one's job and negativity towards parents. Overcoming this resistance leads to the creation of new principles in the system (as presented in separate section).

There are several factors that contribute to this aspect of HHC's activities.

The actual profile of HHC's work has primary significance. In the memorandums of agreement with the State Agency for Child Protection the program and approach of HHC are described as "*additional, upgrading and supportive activities".* The fact that HHC isn't a provider of social services but simply supports the local professional communities and institutions to implement their responsibilities effectively creates conditions – both material and emotional, for teamwork. HHC isn't seen as a competitor, but as a genuine source of support.

The second factor is **referencing practice to statements of government policy.** With this HHC overcomes the culture of imitation (entrenched routine) that prevails in the country: the existence of two parallel worlds that have no connection between them: the one of documents and the one of practice – accepting documents "on paper" and their neglect in practice.

The third factor is **including all stakeholders without exceptions,** by (even) partnering with HMSCCs from which are referred the children and their families to HHC.

"We were referred to the HHC coordinator by the baby home… we had left the child there, because it needed constants medical care… When it was seen that they had started closing the homes and the children were going to foster families, the doctor told us that she (the baby daughter) *had potential and no longer required non-stop medical care… in the baby home. After asking us about our decision, they told us that HHC will help us with whatever they can, for adaptation, and then they connected us to the coordinator…"* (Mother of disabled child aged 2.5 years)

The fourth factor **is managing DI at local level and achieving horizontal partnerships through the coordination mechanism** which meets only when a real need has been identified. It's convened by the regional governor or through the proposal of some of the participants. The coordination mechanism is a tool for effective communication aimed at reaching a joint decision whenever in cannot be achieved by the traditional models. The participants in the study perceive it in different ways. Some experience it as an additional burden with associated documentation. However, a representative from HHC confirms conclusions from previous studies that the coordination mechanism is the most successful tool for DI.

The relevance of the coordination mechanism is limited in a context in which the resistance at national and local level combine in such a way as to make the strategic objectives of DI look almost unachievable.

One of the largest HMSCCs in the country with a capacity of 150 children was situated Region 2. Here, almost all participants (professionals) shared the categorical **opinion that the closure of this HMSCC would be particularly difficult, even impossible.** This argument they support with the statement that there are no suitable forms of alternative care for children with severe disabilities neither in the region, nor elsewhere in the country.

> *"For the children with severe disabilities they have to open small-group homes with constant medical care. Foster care is not suitable for them"* (CPD representative)
>
> *"I don't see who would do it as a foster parent. It is impossible to speak of such a thing*" (Municipal foster care team)

"Not only that there will be no point, but the children will be put at risk. This can't be taken seriously" (CtreSS representative)

When questioned whether HHC can influence this situation somehow, the professionals almost without hesitation answer negatively.

"Rather – no. For the children without disabilities they could maybe help, if they were given a chance (Note – HHC have virtually no chance, because the administration of the HMSCC doesn't work with them), *but for those with disabilities – they can't"* (CPD representative)

It appears that the belief that this HMSCC accommodates children with the most severe disabilities possible in the country is universal among the relevant professionals. The institution is constantly "fed" with new cases, most of them children that are transferred from other regions. With the closure of HMSCCs in the surrounding regions these cases are actually increasing.

"At the moment we are accommodating a child from the neonatal ward in X (a town located about 300 km from the town where the HMSCC is located), *The parents live in Y* (a town located about 200 km from X and more than 500 from the town in which the HMSCC is located)".

Gatekeeping (blocking the flow of children), which appears to be a crucial step in direction of closing the institution, is impossible for another reason– **the institutions don't recognise the closure of the HMSCC as their responsibility.** In the *Regional strategy for social service development 2016-2020* caring for the children certainly appears as a number one priority, but "*maintaining the activity of the HMSCC* is noted as a specific objective, and improving the quality of services provided in the specialised institution is listed as an indicator of good performance. This corresponds to what is said in the *Municipal strategy* which specifies an activity - continuing the operations of the HMSCC and caring for high risk newborns with a capacity of 150 places. In this way the local policy differentiates from the policy for deinstitutionalisation adopted by HHC, but - more paradoxically - is also in complete contradiction with the national policy for deinstitutionalisation of childcare.

In response to these issues, HHC has made several unsuccessful attempts to bring about positive change. Most noteworthy was an approach to the municipal authority asking for creation of a partnership memorandum for the closure of the HMSCC. This attempt was

greeted with fierce resistance by the municipality claiming its objectives were very different from those of HHC (which certainly appears to be true on the basis of the documented local strategy improvement of services).

> *"They* (HHC) *have their own position. They work on certain projects, but their priorities do not always coincide with the priorities of the municipalities. They say – "we will close HMSCC", but we respond to them – 'That is the job of other institutions' The HMSCC does not belong to the municipality, it is not our job to close it."* (Representative of municipality)

The local strategic documents also contained a series of noteworthy statements – 1.Poverty and disability were reasons for placing children in institutions 2.These placements could be limited by developing community-based services to support families at risk 3.It is more cost-effective to invest in prevention than to pay for remedial action once risks have materialized. These statements correlate fully with the priorities of HHC but, seemingly, the relationship between them and the organisation's work, on one hand, and the actual closure of the HMSCC, on the other, isn't clear for the local institutions. (Perhaps this is the reason why these statements remain fragmented phrases that are nowhere reflected among the measures that are planned in the documents.)

> *"The fact that we have no signed memorandum doesn't mean that we can't work together. Their* (HHC's) *main objective is to help mothers with diapers, with milk, with this kind of essential things for living. This is a niche."* (Representative of municipality)

The reason for the unusual attempt to sign a memorandum with the municipal administration is the fact that, at regional level, the coordination mechanism doesn't work, even though it formally exists on the basis of a memorandum signed with the regional administration. **The coordination mechanism isn't recognised neither as an appropriate forum for decision-making on individual cases and reconciliation of positions, nor as a place for meetings, briefings and discussions.** It has met only once during its two years of existence. Among the reasons for this is that there is no understanding among local institutions (or the other stakeholders as well) concerning the advantages offered by such a structure and none of the partners is motivated to sustain its work. In addition, the administrators believe that the coordination mechanism duplicates other forms of governance at regional level, e.g. regional

consultative council on social issues, local team for monitoring and assessment of the services, municipal commission for the child, and others.

Local practitioners say that communication among them is already active enough and it would hardly be necessary for the mechanism to streamline the communication process. This is confirmed by the HHC coordinator who says that relations between social service providers, HMSCC personnel and the CPD when working on cases are very good. The manager from one of the services provided a contradictory statement regarding the coordination mechanism

"It is a pity that it is not happening. And there is great need for such a thing. There should be a forum where we discuss problems that exceed the range of our daily activities. Also to make joint decisions" (Manager of a family-type accommodation)

However, the very idea of making "joint decisions" is problematic in this region. The feeling of most of the participants in the study that have managerial roles is that decisions are usually political and definitive. Of course, they are not always adequate at a local level (even for the local administrations), but, despite this, there are almost no possibilities for a meaningful local reaction. In this sense, the representative of the municipal administration openly states (and his opinion is widely shared), that entering into strategic partnerships with NGOs is pointless if the aim is to exert an influence on national planning.

This situation is directly linked to common attitude towards the process of deinstitutionalisation. At local level, the relevant professionals hardly recognise the principles and aim of the DI process, its course and the vision for the future. They are instead preoccupied with following daily routines (and if there were no institutions in the locality, it is even harder to understand). For them it is no at all obvious how these daily activities are linked to the global aims of the DI process. The people who have occupied or currently fulfil administrative roles share rather bad experience.

However, in a context in which DI is not a priority, HHC continues to be in compliance with the DI policy. Even though closing the HMSCC is not possible, the organisation creates conditions for implementing DI through its work on prevention and reintegration, by changing attitudes and increasing the capacity of the system.

It isn't easy, there has to be a sharp stick poking the institutions. But that is maybe the main role of HHC. Somehow to make them feel some kind of responsibility." (Representative of the regional directorate of social assistance)

Question:

This challenging environment drives HHC to become a leader in DI not only a catalyst. Is it possible that this HHC's need to compensate the government failure can impact negatively on state commitments under the project?

Is it possible for HHC to reconsider its partnership with the government on the basis of the effectiveness of its interventions on the basis of their relevance to the Vision for DI? If HHC becomes not only an agent but also a leader in DI, does it have more leverage to make demands from the government and local authorities?

6.2. Effectiveness

Conclusion: The HHC model has been effective even in a politically unstable context in which successive governments have not prioritised DI. It is effective in: 1/closing homes, 2/ providing (more secure) family care for children, via 3/ effective deployment of the resources invested by the organisation. Analysis using both qualitative and quantitative methods shows that the achievements are an actual result of HHC's work.

This part of the report contains summaries and analysis of the quantitative data, assessing the effectiveness of the work with families and the resources invested in this area.

6.2.1. Regarding closure of HMSCCs

The closure of HMSCCs is important as signifying effectiveness as well as it having symbolic significance for the aim of DI. HHC successfully closed 3 HMSCCs and the number of children in another HMSCC was decreased from 21 to 5.

6.2.2. As regards the provision of families for the children, the study showed that for nearly all children that were subjects of HHC actions, a home environment was provided.

With exception in Silistra where few children continue to be accommodated in the HMSCC until alternative care is found for them.

In two of the regions, those interviewed claimed *that "all of the cases that the HHC coordinators work on finish successfully".* For cases of prevention, coordinators and social workers from the CPD emphasize the fact that on the basis of the intervention of HHC the children are no longer accommodated in HMSCCs but live in a family environment. Children are no longer placed in HMSCCs and, instead, they continue to live with their families or with foster parents and they are monitored in the long-term. The study didn't find any examples of children that have been removed from family care. Participants claim that the number of adoptions has increased and better quality foster families have been found – a result of increasing the capacity of these parts of the system.

Data from two regions shows that the nature of the partnership with the CPD can limit the effectiveness of HHC's work. In the first instance, CPDs give HHC access to cases having already decided that there is a good chance that HHC intervention would be effective. (Prevention of abandonment can be achieved.). Second, effectiveness can be disputed in those cases in which HHC intervention was limited to a single action and HHC coordinators did not remain in lasting relationships with the families that they have helped (for time periods of more than 6 months).

Below a summary of the quantitative data analysis is provided, which points out the changes that were achieved for the families through the intervention and reintegration programs. (The full research is shown in Appendix 1)

Effectiveness of program "Prevention"

The aim of the research is to study the effectiveness of the help for families in risk to meet their basic needs in order to prevent these families from abandoning children in institutions. For assessing the effectiveness data is used that was collected during three short time periods during the execution of the program: (1) before the intervention (initial assessment); (2) immediately after the intervention (when ending the support) and (3) six months after finishing the work with the children and their families.

Participants in the study are the families of 108 children. They live in 15 towns and villages distributed across the country. Of the 108 children, 58 (57.7% of the total) are boys and there are 50 girls (46.3%). The age of the children varies from zero (new-born) to 36 months, with an average age of M=9.42 months.

Most of the families being assessed include both parents - 80 families in all (74.407% of the total). The remaining 28 (25.93%) are single parent families which include only the mother.

The age of the mothers varies from 14 to 48 years, and their average age is M=28.83 years. Only three of them are under 15 and the number aged above 40 is also relatively small.

As regards their labour status, 45 of the monitored cases are on maternity leave (41.67% of all cases), and 58 mothers are unemployed (53.7%). Among the rest there are several individual cases of imprisoned, under working age or receiving a disability pension. Only two of the mothers have proper jobs and receiving income from employment. On this basis, 98.15% of the mothers are outside the labour market and not receiving income from employment.

Fathers are aged between 17 and 63 with an average age of M=34.61 years. Most of the fathers are aged between 20 and 40 years, 5 of them are aged under 20 years, and 12 are over 40 years. In 34 of these families the father is absent and doesn't provide care for the child, in the other 10 the father of the child is unknown.

52 of the fathers (54.17% of those that we have data for) are unemployed – a share that is almost equal to the share of unemployed mothers. Of the remaining: 8 people were in places of confinement, one was abroad and two received disability pensions. Those with proper work, 14 in total, had low-qualified work in construction, agriculture and public hygiene. Therefore, 82.5% of the fathers included in the subsample are outside the labour market and don't receive income from employment.

As regards cohabitation of the parents, 83 families (65.87% of the total) live without marriage, and in another 20 (15.87%) the parents live separated.

The majority of the children (69.04%) have at least one sibling, and about half of them (48.4%) have two or more. In general, the siblings are being raised in the biological family (85.23% of the first in line brothers/ sisters and 80.65% of second in line). Cases of siblings raised in the extended family are rare (4.55% and 3.23% respectively), in a foster family (2.27% and 1.61%), in a specialised institution (3.42% and 11.29%) or in a residential service (1.14% and 1.61%). It is noteworthy, that it is mainly the second siblings that have been placed in specialised institutions and this may indicate the existence of a trend for the parents to be more inclined to leave their second child in an institution.

The toolkit is a specialised instrument developed in compliance with the design of the study – "A generic form for children raised in a family environment". The form contains the following six groups of indicators for assessment of the children:

1. Living conditions – 9 indicators

2. Family and social relationships – 7 indicators

3. Behaviour – 12 indicators

4. Physical and mental health – 8 indicators

5. Education – 7 indicators

6. Employment and household – 5 indicators

Every group, in accordance with its specific characteristics, contains a different number of indicators – between 5 (group 6. Employment and household) and 12 (group 3.Behaviour).

With each group of indicators a certain specific area of the wellbeing of the family and the child living in the family environment is assessed. There are indicators of risk (risk factors) that can provoke the abandonment of the child in an institution, as well as the related protective factors and the interrelation is expressed in an antonymic sense, such as "Lack of or insufficiently strong emotional connection between the mother and child" (risk factor from group 2. Family and social relationships) and the protective factor that mirrors it - "Strong relationship between the mother and child" (a protective factor from the same group). The separate indicators refer to specific aspects of the potential of the family to provide optimal living conditions for their child by meeting its needs.

Every monitored child has received three assessments for every risk factor (during each of the time periods of the monitoring), as well as three corresponding assessments for each protective factor. The assessments on each separate indicator are dichotomous (presence/ absence).

As well as assessments on every group of factors, for each collection of indicators (areas of wellbeing) each child has also received three summarising dichotomous assessments of whether his/her needs are met - "yes/no" (for each of the time periods of the monitoring).

In the child's assessment form there is also special attention paid to the measurement of the change in the families' wellbeing. The data that show whether such a change has really happened is collected for each area of wellbeing during each of the three time periods of the monitoring. The number of indicators in each group for measuring change is also different. The change assessment is made in relation to the extent to which the needs of the child have been met with the following 5-grade assessment scale: 1-not at all; 2-weakly; 3-moderately (intermediately); 4-almost; 5-entirely.

Apart from the indicators described above, the generic form for assessment of children contains also a wide demographic block, with which detailed information of the monitored children and their families is collected. In the next part of the report their summarised demographic profile is presented.

The results of the data analysis from all structural parts of the specialised instrument "generic form for children raised in a family environment" that is designed for the assessment of 6 groups of indicators of the wellbeing of the children and their families are used as effectiveness measures. These structural components are:

1. Risk factors – they reflect those aspects of the child's situation that could provoke the parents to make the decision to abandon the child in a specialised institution.

2. Protective factors – they reflect those aspects of the child's situation that act in the opposite direction and favour the child being raised in the family.

3. Summarised (dichotomous) assessment of the children's needs being met – it synthesises the influence of the risk and protective factors in a single, overall assessment.

4. Measuring change – a broad assessment of the extent to which the child's needs are met. Are things getting better?

The assessments are made on each area of wellbeing in all of the three time periods of the program's implementation.

The results are as follows:

During the first period of the assessment the level of risk factors is statistically more significant than during the second period, while during the third period, in general, it remains at the level of the second period. Therefore, it can be concluded that the intervention of the

social workers has been effective in reducing risk factors. This is confirmed by the analysis of the protective factors. From relatively low levels during the first assessment period in all areas of wellbeing, there is a statistically significant increase in the second period and the situation is almost unchanged in the third period.

It is important to note that there is a balance between the factors before the intervention that is reflected on in the initial assessments of HHC. The level of risk factors in all areas of wellbeing is around or below the average for the respective group of indicators. Milder risk is seen in areas of Family and social relationships, Education and especially Behaviour. More significant are the risks in the areas of living conditions and Employment and household. The level of the protective factors is also aroud or below the average. One interesting exception is the area of Behaviour, in which the level of protective factors is extremely high in contrast to the relevant risk groups. Other areas with a relatively higher level of these factors are Physical and mental health and Family and social relationships. Areas with lower levels of protective factors are Education and Employment and household.

In the first four areas of wellbeing, (1. Living conditions, 2. Family and social relationships, 3. Behavior and 4. Physical and mental health), the levels of protective factors are actually higher than those of the risk factors. And vice versa – for the last two (5. Education and 6. Employment and household) they are lower. It can be said that in general the two groups of counteracting factors are not balanced and that protective factors prevail, which can be seen as a condition which, to a certain extent, favors the work of social workers in the implementation of the program's activities.

The results of the analysis of the summarised (dichotomous) assessment of meeting the needs of the children also testify to the successful implementation of the prevention activities - in all areas of wellbeing, there is a significant increase in the number of children whose needs are met.

The data from measuring the change - groups of indicators designed to directly assess the effectiveness of social workers' work - reflect the same pattern of change as the protective factors - a relatively low level in the initial measurement period (prior to the intervention, initial assessment), a significant increase in the second period (immediately after the intervention, upon completion of the support) and maintaining the level 6 months after the end of the intervention.

It can, therefore, be concluded that, in all areas of the wellbeing of the children and their families, across all groups of indicators, significant improvements in family conditions are seen, which can be explained by the effective work of the social workers implementing the program for the prevention of abandonment of children in specialized institutions.

Effectiveness of program "Reintegration"

The HHC program assists families at risk to meet their basic needs in order to reintegrate their children previously placed in specialized institutions.

The survey covers a relatively small number of children - a total of 18, whose families live in 15 towns and villages throughout the country. Of these, 10 (55.56% of all) are boys and 8 (44.44%) are girls. The age of the children varies from 1 to 36 months, with an average age of M = 13.06 months (SD = 10.15). The age range of reintegrated children almost coincides with that of children included in the study of prevention but their average age is higher by about 4 months.

The majority of the families assessed include the two parents - 16 families (88.89% of the total). The other 2 are single mothers (one of them includes a grandmother as well).

The age of the mothers varies from 16 to 42 years, and their mean age M = 30 years is slightly higher than that of the mothers included in the study for prevention.

The majority of mothers are aged 20-30 years. Only 1 of them (5.56% of the total) is under the age of 20. The number of those above the age of 40 is relatively small. The structure of this subsample in regard to the labour status is relatively simple. The majority of them (17 mothers, 94.44% of all) are unemployed and only one (5.56%) has income from work as a school janitor.

As regards the fathers, most of the families (88.89 %) include both parents, therefore the volume of the father's subsample is smaller, but is comparable to that of the mothers. As regards the age the fathers, they are between 16 and 71 years old, with an average age of M = 36.73 years (SD = 12.73), also higher, by about 2 years, than that of the fathers in the prevention study. By this indicator the father's subsample is slightly more differentiated than that of the mothers, with no distinctive frequencies.

Although fewer in umbers, the persons included in this subsample are employed in a larger variety of jobs. It should be noted that 10 of the fathers (62.50% of those for which there is

data) are unemployed - a proportion which is much lower than the number of unemployed mothers, but - on the other hand - is about 10% higher than the share of unemployed fathers in the prevention study. Among the remaining fathers, one person is in jail, another has temporary employment, and for two there is no data. Those with real jobs, 4 men in total, are in manual work in construction or as general workers. Therefore, 66.67% of the fathers included in the subsample are outside the labour market and do not receive employment income.

As regard the form of cohabitation between the parents, the families are grouped into two major categories. In the majority of cases, the two parents live together but are not married – 14 families (87.50% of all).In 2 families (12.50%) the parents are separated and for two families there is no data on the form of cohabitation between the two parents.

The majority of the children (83.33%) have at least one sibling, and over half (61.11%) - two or more. In general the siblings are raised in the biological family (86.67% of the first brothers / sisters and 54.54% of the second). There a few cases of raising the siblings in the extended family (6.67% and 9.10% respectively), in a foster family (6.67% and 9.10%), in a specialized institution (0.00% and 27.27%). As in the prevention cases, the relatively high proportion of second siblings raised outside of the biological family is noteworthy and this may be an indication of a tendency for the parents to be willing to abandon their second child.

In order to assess the effectiveness of the work of the social workers, the data is collected in three short time periods: (1) before the intervention (initial assessment) while the child is still in the institution or immediately after it was taken back into the family ; (2) immediately after the intervention (upon completion of the support); the work with each child and its family has a different duration depending on the needs of the family and (3) six months after completing work with the children and families. This procedure of gathering evidence coincides fully with the procedure used in the activities on prevention of the abandonment of children in specialized institutions.

2. Toolkit. Structure of the data

The data is collected and presented using a specialized tool developed in accordance with the design of the study, "Generic form for children raised in a family environment", also used to collect the data in the study of the effectiveness of prevention. The form contains the following six groups of indicators for assessing the children:

1. Living conditions – 9 indicators

2. Family and social relationships – 7 indicators

3. Behaviour – 12 indicators

4. Physical and mental health – 8 indicators

5. Education – 7 indicators

6. Employment and household – 5 indicators

Every group, in accordance with its specific characteristics, contains a different number of indicators – between 5 (group 6. Employment and household) and 12 (group 3.Behaviour).

With each group of indicators a certain specific area of the wellbeing of the family and the child living in in the family environment is assessed. There are indicators of risk (risk factors) that can provoke the abandonment of the child in an institution, as well as the related protective factors and the interrelation is expressed in an antonymic sense, such as "Lack of or insufficiently strong emotional connection between the mother and child" (risk factor from group 2. Family and social relationships) and the protective factor that mirrors it - "Strong relationship between the mother and child" (a protective factor from the same group). The separate indicators refer to specific aspects of the potential of the family to provide optimal living conditions for their child by meeting its needs.

Every monitored child has received three assessments for every risk factor (during each of the time periods of the monitoring), as well as three corresponding assessments for each protective factor. The assessments on each separate indicator are dichotomous (presence/ absence).

As well as assessments on every group of factors, for each collection of indicators (areas of wellbeing) each child has also received three summarising dichotomous assessments of whether his/her needs have been met - "yes/no" (for each of the time periods of the monitoring).

In the child's assessment form there is also special attention paid to the measurement of the change in the families' wellbeing. The data that show whether such a change has really happened is collected for each area of wellbeing during each of the three time periods of the monitoring. The number of indicators in each group for measuring change is also different.

The change assessment is made in relation to the extent to which the needs of the child have been met with the following 5-grade assessment scale: 1-not at all; 2-weakly; 3-moderately (intermediately); 4-almost; 5-entirely.

Apart from the indicators described above, the generic form for assessment of children contains also a wide demographic block, with which detailed information of the monitored children and their families is collected. In the next part of the report their summarised demographic profile is presented.

The results of the data analysis from all structural parts of the specialised instrument "generic form for children raised in a family environment" that is designed for the assessment of 6 groups of indicators of the wellbeing of the children and their families are used as effectiveness measures. These structural components are:

1. Risk factors – they reflect those aspects of the child's situation that could provoke the parents to make the decision to abandon the child in a specialised institution.

2. Protective factors – they reflect those aspects of the child's situation that act in the opposite direction and favour the child being raised in the family.

3. Summarised (dichotomous) assessment of the children's needs being met – it synthesises the influence of the risk and protective factors in a single, overall assessment.

4. Measuring change – a broad assessment of the extent to which the child's needs are met. Are things getting better?

The assessments are made on each area of wellbeing in all of the three time periods of the program's implementation.

The criteria for evaluating the effectiveness of reintegration work are identical to those used in the analysis of the prevention program. As regards risk factors, effective work by social workers lowers their level in the second period assessment (immediately after the intervention, on completion of the support) as compared to the first (prior to the intervention, initial assessment). Conversely, for protective factors, effective work has led to an increase in their level during the second period compared to the first period. The same criterion should be applied to the summarized dichotomous assessment as well as to the measurement of the change.

The next equally significant criterion is the durability and sustainability of the results of the intervention over a longer period of time, ie preservation of the level of the results achieved or their reduction (in the case of risk factors), and, conversely, an increase (for the protective measures) .

Between the results of the reintegration analysis and those of prevention, there is extremely high typological similarity.

With regard to the risk factors, there is an almost identical trajectory of performance levels across all areas of wellbeing. During the first evaluation period, their level was statistically significantly higher than in the second period, while in the third period it remained at the level of the second period with weak, statistically insignificant movements (decrease or increase). Consequently, it can be concluded that the intervention of the social workers in the process of reintegration was effective in the reduction of risk factors.

The influence of social work on protective factors is also positive. From relatively low levels during the first evaluation period, in all areas of wellbeing, they increased their level significantly over the second period to keep it almost unchanged in the third. Therefore, with regard to protective factors it can be concluded that the intervention of the social workers was effective.

We need to make reference to the same complex factor that could have impacted on prevention cases. It is equally likely to have an independent impact on the effectiveness of the efforts of social workers to reintegrate the children into their biological families. We are referring to the situation in the families before the intervention, reflected in the initial assessments, with the risk and the protective factors and the balance between them being particularly interesting.

Similar to the prevention analysis, the level of risk factors in all areas of wellbeing is around or below the average for the respective group of indicators.

Risks in the areas of Physical and mental health, Family and social relationships, Education, and especially Behaviour are clearly seen to be milder. Risks relating to Living conditions and Employment and household are more significant. The level of protective factors is also around and below average. An interesting exception (as was seen in the prevention analysis) is the area of B behaviour in which the level of protective factors is extremely high, in contrast to the relevant risk factors. Other areas with a relatively high level of these factors are

Physical and mental health and Family and social relationships. Education and Employment and household have relatively low levels of protective factors.

In two of the areas of wellbeing, (3. Behaviour and 4. Physical and mental health) the levels of protective factors are higher than those of the risk factors. In the other four areas, they are lower (1. Living conditions, 2. Family and social relations, 5. Education and 6. Employment and household). It can be said that the two groups of counteracting factors are generally not balanced and that the risk factors prevail, which can be seen as a condition impeding the work of social workers in the early stages of implementing the reintegration program.

The results of the analysis of the summarized (dichotomous) assessments of how the needs of the children are met also testify to the successful implementation of the reintegration tasks - in all areas of wellbeing, there is an increase in the proportion of children whose needs are met.

The change measurement data - groups of indicators designed for direct assessment of the performance of the social workers - show the same pattern of change as the protective factors - relatively low level in the initial measurement period (prior to intervention, initial assessment), significant increase during the second period (immediately after the intervention at the end of the support) and maintaining of the level 6 months after the end of the intervention.

It can, therefore, be concluded that in all areas of wellbeing of the children and their families, across all groups of indicators, there are significant improvements in the family conditions, which can be explained by the effective work of the social workers implementing the program for reintegration of children in their biological families.

The conclusion on the sustainability of the results is important. Six months after the intervention the results are preserved.

6.2.3. Effectiveness of the HHC's financial investment

A separate study of the value of the active family support was conducted for the purposes of the assessment, in order to answer the questions:

1. What is the average monthly value of the support provided by HHC and of donations collected and distributed by HHC, by a service provider and from social welfare? How does this amount relate to a child's monthly child allowance in an institution?

2. How are the funds distributed according to what areas of life and what specific costs for each of the three types of families (prevention cases, reintegration case and foster families)?

3. What is the ratio between the resources invested by HHC and the resources provided by the government in the form of welfare and services?

4. In reintegration cases is there any relationship between the proportion of the funds spent on supporting the family in preparation for reintegration and the proportion after the child returns to the family?

The analysis shows that the most significant resources are dedicated to improving the child's living conditions (including environmental safety, heating in the winter months, essential childcare items from 0 to 3 years, etc.). The share of funds provided for the health of the child and - in some cases - also of the parent is significant. The resources allocated under the heading of "Labour" are working hours of the coordinator, transport and intermediation for finding employment.

The average monthly value of the support provided by HHC and the donations collected and distributed by HHC (i.e. the active support) is as follows:

- Prevention 67 leva

- Reintegration 115 leva

- Foster families 90 leva

Support is provided most intensely during family crisis. The total aid varies widely depending on the specific needs of the family. On average, the value of the support for cases is as follows:

- Prevention 532 leva

- Reintegration 1041 leva

- Foster families 141 leva

The monthly support from a service provider is as follows:

Family-type placement centre - 692 leva

Centre for social support - 238.75 leva.

Mother and baby unit - 562.33 leva

This means that HHC adds to the support provided by the existing system by means of a strategic form of support that is timely (crisis), targeted, specific to family needs, which means HHC successfully identifies and responds to gaps in the system in the absence of adequate community services and in the absence of a mechanism for flexible financial support and crisis response.

2. With different combinations of sources of funding for family support, the total monthly amount of maintenance in a family environment would, in rare cases, exceed the amount of 1000 leva per month that was planned for child support in HMSCC.

3. For each of the three types of families (prevention cases, reintegration cases and foster families), the material support is focused on improving living conditions, with specific spending being focused on home safety, heating, providing baby equipment, feeding the baby, providing comfort for the baby and the parents with reference to the healthy development of the child.

4. In contrast to the pilot phase of the project, a weakness in fundraising activities and raising of material donations was reported in the period being assessed. In the pilot phase, donations made up almost 50% of the material support provided to families, and in the period under review, the percentage is only 10%.

5. In the cases of reintegration, approximately one third of the funds are allocated to support the family in preparation for reintegration, and approximately two thirds are distributed after the child's return to the family.

Conclusions

The HHC model is effective for closing institutions and providing an improved family environment for children living in risk of institutionalization or those children being deinstitutionalized.

Performance factors identified by childcare professionals: (1) the speed at which things happen and (2) the flexibility of the forms of support, (3) simple procedures for requesting and reporting support, (4) responsiveness (the feeling that the organization can be relied on at any moment), and less often, but also mentioned (5) the positive attitude towards the clients, and (6) the creativity in identifying solutions for cases.

For the families the qualitative data shows that it is the timely support, persistence of care and understanding that are important.

As regards the funds invested, the costs for each family are relevant and based on a precise assessment of the needs of that family. They bring about financial stability and sustainable income through improved access to social benefits and improved domestic budgeting skills. Spending is effective because it 1) overcomes fragmentation and waste of funds by providing resources that are missing in the system, 2) stimulates mutual support processes in the community, 3) involve different actors (family, interdisciplinary teams, local authorities) in the evaluation and decision-making on allocating funds that overcomes fragmentation and wasting funds through poor targeting.

The qualitative data shows that effectiveness is challenged by the system when the organization's values and goals are not shared by the local administration. In these cases, the withdrawal of the organization restores the hierarchical model, which is a risk for the removal of children from families and for ensuring speed and flexibility of family support.

"...HHC has to continue to work because there is no other resource, apart from HHC, to help socially disadvantaged families in this way"

Questions:

Is it possible that the chosen focus of partnership with local authorities is not sufficient in the new situation of disengagement at central level? Is it possible to achieve greater efficiency by including more interventions at national level?

Is it possible for the training and teamwork with social workers to include the topic of "networking", "advocacy" and "lobbying" so that the system can accumulate knowledge and experience that can be applied after HHC's withdrawal?

Is it possible for HHC to leave more trained personnel in places after its withdrawal, to support the horizontal model through team meetings and regional coordination mechanisms?

6.3. Benefit

Conclusion: The HHC model: 1 / provides family care for children at risk, 2 / restores stability to families, 3 / helps specialists and develops the child protection system, 4 / makes use of the child protection policy.

6.3.1. The HHC model provides a family for children in risk

HHC achieves the desired end result - ensuring family life for children in risk.

> *"When they came to our area there were 21 children in the home. They helped us most with prevention. We essentially stopped the placements thanks to them. What is different from before is that when we get a signal of a newborn at risk of abandonment, we immediately contact the coordinator. She did everything possible to help the parents and the child*."(CPD representative)

To achieve this, HHC offers financial and psychological-consultative interventions, mediation between the minority group and the majority group. The parents with whom the organization works often speak Bulgarian poorly, their literacy rate is low and they are not competent to deal with bureaucracy. Without assistance, they could not manage in a hospital or other type of institution. According to a CPD representative, the coordinator achieves prevention of abandonment in 60-70% of cases through financial support, family mediation, connection and contact with the doctors, provision of funds for certain medicines and escorting family members to specialized hospitals in the country.

> *"If that was not for this help, none of the children could be reintegrated. Many of these children would have found themselves in the HMSCC.* "(CPD representative)

For the prevention of abandonment and reintegration of children with disabilities that can be raised in a family environment, HHC provides comprehensive assistance that includes intermediation to institutions, language translation, and symbolic authority to representatives of health institutions whose attitude is often rejecting and disparaging towards the minority communities. The organization covers travel expenses, communication with hospitals and medical specialists. The flexibility of the intervention ensures that cases proceed faster than via institutional channels - HMSCC - hospitals.

6.3.1. The HHC model rebuilds families

The families supported by HHC appreciate the work of the organization extremely high. They say that the moment they met with the HHC coordinator, they were already tired and desperate from the long and fruitless conversations with institutions that they had approached for help. They needed something definite and the coordinator finally *"had ears to listen"*. The story below reveals the work of the HHC model and its effect.

> *Hristo was born with a malformation and his life was at risk. The condition of the child demands emergency surgery for restoring organs. The parents are in shock. They could neither think nor act. From the hospital, they directed the family to the CPD and HHC. According to Hristo's mother, the support they received immediately was one-time support from HHC. This gave her the strength to travel alone to the capital and to live through 6 operations of the child. HHC continues to support the family with travel expenses. Now the child is playful and sociable. After the project expires, the mother relies on the HHC coordinator.*
>
> *"If I did not have the support of HHC, it is not clear where the treatment of the child would have got to ... I know that I can call her whenever I want, for any help and support, never mind that she no longer works in HHC... she is a person who will again do everything possible to help me ... "*

The HHC model successfully rebuilt several groups of families who, without the help of the organization, would not have coped with chronic or unexpected crises.

HHC support for families living in extreme poverty

According to HHC's philosophy, in 21st century, no EU member state can allow poverty be a reason for separating a child from its biological, social and cultural background. It is among the few organizations working with families living in extreme poverty by supporting them in their community. These are most often marginalized neighbourhoods and small towns or villages where there are no social services. They succeed in responding to the basic needs of the family (shelter, food, medicines), to individualise support, and to connect with institutions and services that can provide long-term support after HHC withdraws.

The organisation provides essential support for biological families living in deep poverty. Through the intervention initial support is given and stabilization of the living conditions is achieved, the children being with the parents.

Such is the case of M., a poor woman of Roma origin, with 8 children who, after her sixth child, was abandoned by the father. HHC helped the mother to get her children back and to raise the smallest one in improved material conditions. HHC carried out a partial repair of the hut where the mother was living, installed windows, a septic tank, and provided a small stove. The co-ordinator supported the mother and helped in the lawsuit against the father for child support. The children were enrolled in school and nursery. During the observation the woman was stable, maintained domestic hygiene and had improved the environment for feeding the children. However, some of the school-age children did not attend school and the mother's social benefits were suspended. There was no electricity and living conditions were extremely poor. The failure of the children to attend school was explained by a number of factors – living in a remote location, lack of shoes and clothing for the children, lack of teaching aids, and a sense of harassment and failure of the school to appreciate the efforts made by the family. Apart from the help from HHC, the mother has not received support from any other institution.

The limitations on the benefit of HHC's work are related to the chronic poverty that has been passed from one generation to the next. The strategic document for managing poverty in Bulgaria outlines a comprehensive approach, but, for the moment it, is only a declaration of intent since the two-year plans for putting into practice the concrete measures have not been developed[1].

> *"With regard to childcare in the extended family - there are families where poverty has existed for generations. If it is a single family that has been impoverished, there is always a circle that becomes active in a natural way. But there are those who are in constant helplessness for generations, and this is becoming a factor for violence ... Even in such cases HHC do not baulk at the challenge and would try to help ...* "(CPD representative)

The context in which "cross-sectorial services that include healthcare, education and social activities are underdeveloped (mostly in the form of single pilot projects which, due to lack of financial sustainability, do not multiply), making it difficult to provide comprehensive support for vulnerable groups"[2] can compromise the benefit, effectiveness and sustainability of the

[1] National Strategy for Poverty Reduction and Enhancing Social Inclusion 2020 - https://www.mlsp.government.bg/ckfinder/userfiles/files/Nacionalna%20strategia.pdf

[2] Quote from National Strategy for Poverty Reduction and Enhancing Social Inclusion

support provided by HHC and the results achieved for families living in extreme poverty.

The support provided for such families by HHC as an NGO with flexible structure and mobility is often the only help provided.

> *"We only approach them in the case of families living in extreme poverty; those who are most in need."* (Representative of CtreSS)

HHC support for ethnic minority families

HHC helps ethnic minority families living in severe poverty and social exclusion. These are cases of families from the Roma community who represent a large part of CPD clientele. Often simply belonging to an ethnic minority is, in itself, seen as a criterion for falling into a risk group.

> *"For the Roma in our area early marriages and early births are quite common. They live several generations in one room and they won't have a working refrigerator. They have no idea what a normal home looks like. Our clients live in misery – primitively - but they do not consider it abnormal. They do not use hairdryers or sanitary towels. They do not 'see' that there is a problem with childcare. Roma families are very dependent on the system: they cannot get away from it. We work with several generations, the grandparents are our clients, their children and their granddaughters are our cases again. Communication with them is difficult, the guidelines are not understood. It is very complicated."* (CPD representative)

This description is confirmed on the basis of visits made during this study to underage mothers that HHC supports. In one of the homes, more than 15 people lived in two rooms together with a newborn baby, and the mother does not understand the meaning of the questions that she is asked.

HHC's intervention in such cases has the potential to change the "climate" in the homes of families, and when the effect of change is visible in the closed community, it also changes.

> *HHC returned twins - a boy and a girl - to a mother with 6 children after the CPD had given them to a foster family after their birth because of very poor living conditions. The children were in the foster family until the age of 2. With the help of the CPD and HHC, the parents were stabilized. The mother-in-law helped to buy a house, the repair of which was supported by HHC, which the mother still relies on. After returning to*

the biological family, the boy started to get ill. HHC financed his treatment in a hospital and his mother's stay there. After the end of the project, the family continued to develop their parenting capacity. A neighbour repaired the family bathroom on a voluntary basis. With friends and neighbours they are doing each other favours, exchanging products. Currently both parents work: they collect herbs and receive a daily wage of 3.50 leva / hour. At the shop they buy things on credit up to a limit of 270 leva. This is the monthly value that the children are entitled to as social benefit. The mother of the twins seems completely satisfied with the fact that all six of her children are with her.

HHC support for foster families

In the budget of the national foster care project, the costs arising immediately after placing the first child are not covered and foster parents receive their first salaries only after a month and a half has elapsed. This is the time when they have their biggest expenses for meeting the needs of the child. At this point, working with HHC is particularly beneficial.

"They supported foster care as well because we only give the money after one month has passed. By buying food and diapers for the first month, HHC provided great support for our prevention program." (CPD representative)

The above cases illustrate the chosen method used in the HHC model - working during crises and solving crises, in circumstances in which there are no other resources available.

This focus is recognized by the CPDs who turn to HHC "as a rule" for families with "acute need" and "financial problems". These are cases where social workers recognize a crisis that could potentially lead to child neglect, abandonment or removal from the family, separation of parents, or even violence due to deteriorating relationships between the adults in the family or other reasons.

This focus ensures support is provided quickly and in an appropriately flexible manner. This represents genuine risk prevention, as opposed to the tendency of state services to always look for options for formal care and protection measures.

*"Why do they talk about prevention ... the state tells me we are not going to take the child into a home, but then we will not help you look after it ... good that there are organizations like V's" (*a working single mother of four children speaking about a

HHC coordinator)

The crises can be of a different nature, including mental illness.

> *"I went through two periods of depressions in a psychiatric hospital. One time I drank Bluestone* (copper sulphate) *and called the HHC Coordinator to tell her to take care of my children. I was placed in a hospital. ... How could I have left my kids like this? I do not think I would have survived with the children without this help "*(Mother of four children)

Responding to the crisis situation for the family in an adequate way, as well as staying with the family for long enough after the crisis is over, is key to preventing abandonment.

From the point of view of the families, the benefit is obvious, and from the point of view of the system prevention means fewer children placed in formal care and supported in their natural environment – responding to something that the updated Action Plan regards as a weakness in the current system.

6.3.1. HHC helps professionals and the child protection system

For different groups of professionals the benefits are different and this proves the flexibility of the assistance provided to them.

For example, a social worker working in foster care said:

> *"We (*the protection system and HHC*) complement each other. The difference is that it is important for us to have a trustful relationship and a long-term relationship with the clients. For HHC coordinator this is not so important, they just join in at a given moment."*

Other social workers turn to the organization when all their support-providing opportunities are exhausted. Asked what they could not do without HHC, the answer is often:

> *"Material support. We would not abandon our cases, but without it, it would have been very difficult for us. We have similar cases with older children and we find it extremely difficult with them."* (Head of CtreSS)

Participants in the study also refer to the fact that because HHC is outside the formal institutional framework, it is easier to build trust with families:

"HHC even helps with simply observing and learning about clients. Our parents behave in one way in front of us because we can take their child. While in front of A they are much more natural. In some cases she had more accurate observations on the family than us. She became friends with them and had single cases, while we have 300 and above. We cannot go on like this every day. She accompanied them to hospitals." (CPD representative)

Some CPD social workers are ambivalent about using material resources provided by HHC. They believe that the funds will increase their accountability and also increase client expectations for additional financial and material support. The latter would, in their view, create "speculation" and create customer dependence on them.

> *"The clients will start to expect material support from us thinking that this is a mandatory part of the casework and will start to demand it. Overuse will have a negative effect."* (CPD representative).

Over and above their lack of skills and misunderstanding the role of the system, such interviews reveal the helplessness of people working in the system. They are critical of it because it makes them serve administrative procedures instead of the actual clients, but they feel helpless to change it.

> *"The system, if it could do anything, would have done it by now. Since 2003 this system only wants us to perform miracles, but only increases pressure on employees and paperwork, and no emphasis is placed on direct social work."* (CPD representative)

In this way, they feel compelled to work against their own professional views, and instead of working to alleviate poverty and the resulting dependence on resources, they find themselves in the role of creating a barrier between families and the resources they need.

With such a degree of conflict between two styles of work – that of the formal system and that of HHC, we need to acknowledge the existence of different perspectives and ethics when assessing benefit.

At the same time, participants at different levels - from clients to national bodies - are discussing how to achieve system change that integrates the capabilities of HHC for fast, flexible support, clear procedures and long-term relationships of trust. Since this is

"impossible", the withdrawal of the organization restores the hierarchical model. Therefore, it is agreed that "HHC must continue to work" because there is no other such resource.

And this means restoring the institutional model of work with these families.

6.3.4. HHC helps in the implementation of the child protection policy

The participants in the study at this level know the work of the organization and trust it. At the same time, there is an expectation of more systematic work at the political level. For example, the organization is expected to maintain communication at ministry level and to inform them about the DI process in places.

Questions

Is it possible to increase the effectiveness of HHC by increasing intervention on a national level? Do those operating at this level recognize the work of HHC?

Is it possible for social worker training to include skills for building trust with clients? Somewhere it is possible, somewhere - not. It is likely important to assess the training needs in this area.

Is it possible HHC to use the networks it creates for a more systematic change of attitudes?

6.4 Sustainability

Conclusion: HHC achieves sustainable results in: 1 / implementation of DI by closing HMSCC, 2 / providing family care to children at risk, 3 / changing attitudes that support institutional care. 4 / there are risks to sustainability.

6.4.1 HHC achieves closure of homes even under the conditions of government change, lack of leadership for DI at national and local levels.

The achievement of sustainability is integrated into the HHC model through systematic work at all levels: management - at local and national levels, system development, working with families and providing families for children.

In the context of political change, HHC fills the vacuum of local leadership, making DI sustainable. HHC achieves sustainability by not succumbing to the effect of changes in state governance. For the team, DI policy is not a party political issue:

> *"We do not comply to the political changes, DI is accepted by all political parties and governments. We remind all participants in the process of this."* (HHC representative)

The closure of an institution, apart from being an indicator of success, from the perspective of the children, is an indication that DI is an irreversible process.

The study found that, even in periods of political instability, in which political subjects (whose efforts for DI are supported by HHC) are changing frequently, the organization manages to close down institutions for babies. During the evaluation period, HHC closed 3 HMSCCs. They did not complete closing two that continue to work for different reasons. In the first one there is a small number of children with severe disabilities for whom the organization is looking for a family environment before its closure.

> *"In the HMSCC there are 5 children for whom we have not found families. The children will remain in the institution until we find families. This is our philosophy. We are against moving these children from this institution to another, just for the sake of closing it, and to put these children under extra stress by doing such a thing."* (HHC representative)

The second institution is not closed because of lack of political will (the case is described in detail in 6.1)

6.4.2 Providing family care for children at risk

The results show 100% sustainability in providing a family environment to children from institutions and children at risk of abandonment by referring to the situation 6 months after the end of the interventions.

Evidence of this is presented in Chapter 6.2. Efficiency, by a quantitative analysis of the effectiveness of the Active Family Support program. The study came to the conclusion that the changes were sustainable. The study shows that children's risk factors from the family environment are sustainably reduced and protective factors that ensure safety within the families are increased. These factors are “living conditions”, “family and social relationships”, “behaviour”, “physical and mental health”, “education”, “employment and household”.

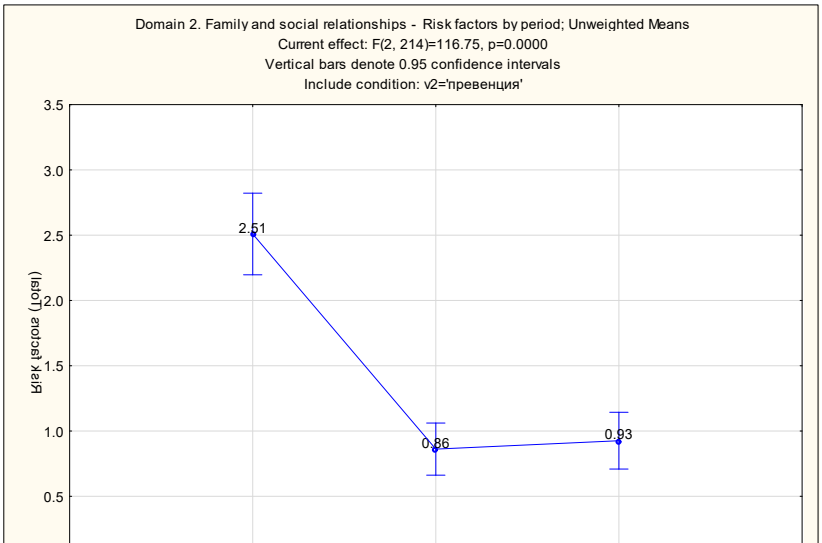
The trend that the analysis identifies is that there is a significant increase in the results of the work, compared to the initial assessment of the factors, and this result remains at the higher level 6 months after the end of the intervention. Therefore, it can be concluded that in all areas of well-being of children and their families, for all groups of indicators, there have been significant improvements in the prevailing conditions, which can be explained by the effective work of the social workers implementing the program for prevention of abandonment in specialised institutions. Maintaining the results for 6 months after the end of an intervention speaks for the sustainability of the changes.

Relationships in families are a critical factor that is directly related to the optimal development of the young children.

The factors in this area of well-being are 1. Insufficiently strong emotional ties between the child, parents and other children in the family, 2. Lack of parental control and support (and from other adults in the extended family as well) 3. Difficulties for the child to make friends with peers, etc.

The results of the analysis are illustrated by a graph in which each of the points shows the overall average level of the risk factors before, after the intervention and 6 months after it was stopped. It shows that in the level of the risk factors in this area there is a significant change during the course of the implementation of the program.

Figure 1. Family and social relationships - risk factors

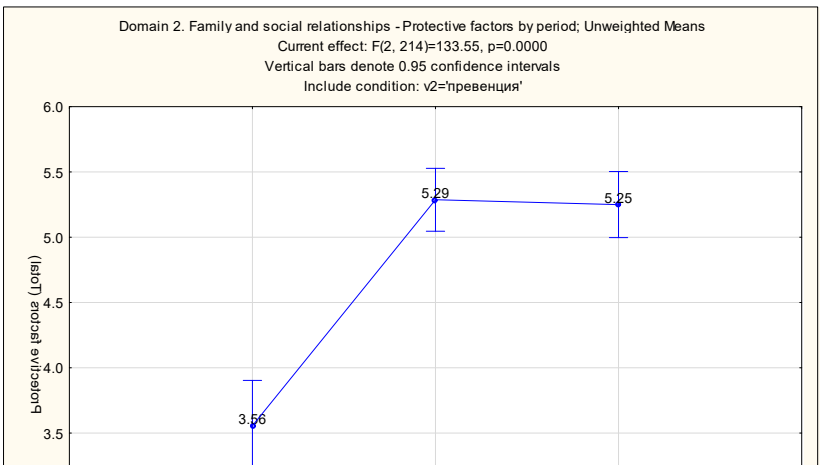


This is confirmed by the test statistic F (2, 214) = 116.75, p = 0.00. While the overall average level of risk factors is 2.51 during the initial observation period (prior to intervention), in the second period (immediately after the intervention) their level is already 0.86, with a slight increase in the third period (six months after the end of the support).

The general level of the protective factors in this area, as opposed to those associated with the risk of child abandonment, significantly increased their level during the program implementation (F (2, 214) = 133.55, p = 0.00).

The initial average level of this group of factors (M = 3.56) is higher than that of the relevant risk factors, which is evidence that in the field of family and social relationships the opposite aspects of these relationships are not in equilibrium and rather they favour the preventive action of social workers. Obviously, they built on this strong foundation and have developed the trend, because at the end of the intervention protective factors increased their level (M = 5.29) and kept it almost unchanged for six months after completing the work with the children and families (M = 5.25).

Figure 2. Family and social relationships - protective factors



Such a clear tendency to improve the quality of social and emotional relationships of children is also observed on the basis of aggregated assessments for meeting the needs of children. While the need for emotional ties and support for 38.89% of children was satisfied before the intervention had started, the share of these children increased to 99.21% after the completion of the intervention and remained the same after the end of the 6-month period.

The report focuses on these results for sustainability, since changes in relationships are most difficult to achieve, and in the case of young children they are of the utmost importance for their optimal development. Therefore, the sustainability of what is achieved in this direction implies sustainability in the long-term development of the child.

(The whole analysis is in Appendix 2)

6.4.3. Changing attitudes that support institutional care.

The data show that a change in the attitudes that support institutional care is starting to happen. These data are summarised in the chapter on sustainability, as attitudes are the most difficult to change, but once changed, they are a guarantee of a sustainable process.

Deinstitutionalization is related to overcoming the attitudes that support institutional care, and therefore the following analysis summarizes the data obtained through the questions: Has the existing attitude towards state paternalism (greater trust in state care compared to family) changed? Is mistrust towards the parents of children “in risk” decreasing? Is the bureaucratic and disengaged style of support changing? Are the attitudes against collaboration and multidisciplinary teamwork being overcome?

The analysis finds that the work of HHC is changing: 1 / attitudes towards the reform, 2 / attitudes towards parents, 3 / attitudes towards the style of support, 4 / attitudes towards the multidisciplinary teamwork.

- The attitude towards the reform is steadily changing, despite the resistance to it, and the missing services that prevent the closure of institutions.

  "The reform and change are very good and meaningful. Deinstitutionalization has led to more meaningful childcare. "(CPD representative)

- Attitudes towards parents who abandon their children are being revised. Moreover, critical awareness regarding the role of the state in the separation of children from families has increased. Both parents and social workers claim that HHC do not prevent the abandonment of children per se, but rather the removal of children from their home, the intervention of the system. Social workers even state that abandonment intentions are rarely recorded and only in cases of minors who learn that they are pregnant.

  "The parents are a young family, both of them have disabilities. They did not give any sign at all that they wanted to abandon the child, on the contrary - they wanted it a lot. We believed that there was a risk for the child, but the risk was the fact that the child could be taken from them." (Representative of CtreSS)

• Attitudes towards the biological parents are also changing

*"It is a sin to give money to residential services and foster families. It is better for the state to give this money to the families. Families at risk receive assistance from the CPD from 12 to 18 months. Then the help stops. The foster families receive support each month during the entire period of childcare. This is not fair to families "(*Focus group comprising municipal experts and representative of district / regional directorates of social assistance)

- There is a change of attitudes towards parents of different ethnic groups, especially in communities with significant Roma and Turkish minorities, where the risks of separation of families are poverty, poor health condition of the children, complicated family history or health problems of family members. The successful reintegration of children has caused the relevant professionals to consider alternative methods for the prevention of abandonment the focus on increasing the capacity of families "if there is anyone to finance these families, like covering monthly fees for the nursery", and to think about families in a different way in general:

"Most parents that we work with want their children. They take care of them in a sensible way. "(CPD representative)

Reforming attitudes is complicated due to the lack of professionalism. A representative from a regional directorate of social assistance provides the following summary:

"For some old-school social workers it is not very easy to change their way of thinking. Get the child out, put him in the HMSCC because it's safer there, but don't return the child to the family. Then she does not care what is happening to this child. As far as she's concerned, it will be bathed and fed and there is no risk as in the biological family. For a very large number of social workers, work with the child ends at this point. Especially if it is placed in another municipality and is now the responsibility of another colleague. This is a strategy that is overused ..... In fact, there is a huge discrepancy in the beliefs of professionals working in the system - where the child is actually better off or what is better for the child."

There is no common understanding of *"what is best for the child - removing the child from a family at risk, or reintegration with taking a risk"* (HHC coordinator). This leads to inconsistencies in objectives, practices and policies. Some of the specialists prefer the immediate removal of the child from his home for the purpose of risk prevention and placement in a small-group home or foster family. Some respondents report deliberately increasing the duration of the placement to prevent the child from returning to his / her biological family or "persuading" parents to give the child for adoption.

"There was a moment when I was asked for the signature to give her up indefinitely. Some girls came in with papers and I told them I would not sign and decided I should take her with me. Every month they sent me letters and papers to sign. They even offered me money, saying that she would have a better life there, and I decided at one point not to let them have her anymore" (Mother of a reintegrated child aged 4).

Under such motives, children are placed in family-type accommodation instead of with foster parents.

In this environment, which lacks a common mission and approach, HHC's activities consistently bring a clear mission, apply it consistently in practice and, through the co-ordinator, creates a supportive environment for social workers in which they become more inclined to take a higher risk.

"The feeling that you are not alone is very reassuring; there is someone to discuss with, to hear a different opinion, to see a different point of view" (Representative of regional directorate of social assistance)

There are contexts in which HHC needs to change parenting attitudes towards institutionalization. In Region 1, leaving children in the institutions is a practice passed down for generations. In most cases, it is not seen as abandonment, but rather as giving the child to an institution until it *"grows up a little"* and the contact between parents and children is preserved.

"... They simply use the state support for food and accommodation. There are families whose children are all looked after in the institution, the parents were raised in the institution, and parents' parents were raised in the institution" (CPD representative)

Closing the institution in these places confuses the families and leaves them facing the decision as to whether to take their child, give it for adoption or foster care and eventually break their contact with them. The need to make this decision is new and unexpected for them. HHC's activities support decision-making and provide alternatives to those families who are mostly unwilling to interrupt their contact with their children. With their work on reintegration, HHC make the return of children to their biological families to a great extent possible and at the same time change the attitudes of the parents.

- Attitudes towards the style of support

The HHC coordinators become role models for the new style of support. However, this is a gradual process that often causes friction with other professionals in the system (psychologists, social services and social workers from the CPD) who adhere to the traditional work culture.

In the view of a HHC coordinator, both parents and professionals recognize HHC as a resource for material support (covering unpaid household bills, rents of families living in municipal dwellings, repair costs, food and clothing). We should note the flexibility of material support and the way it is allocated - the specificity of this support - with which HHC compensates for the inflexibility of the unified state social benefits. Beyond that, the professionals do not see the work of HHC as different from their own, and they think they share the same approaches, attitudes and principles in communicating with families.

"They accused me of being rude, almost an intruder in the system who has come from outside and does not understand the real problems of the system, as well as the clientele they are working with. When we tried to show them results - they started to become edgy on the topic of professionalism ... When you are slightly outside the system, the people within begin to reject you because you have freedom of action and above all because of the freedom to think differently. And they seem to resist even more with regard to change, to the new, to other alternatives for the family. They cannot accept that the difference is in thinking, attitude, professionalism, and not in the free diapers." (HHC coordinator).

The data however shows that, at the same time, the state system develops the ability to be self-critical. The interviewees recognize the effectiveness of HHC.

"This is direct social work without any the aggravation with deadlines and procedures that would prevent us from helping the family. Things happen quickly and efficiently: HHC respond quickly and we do not have to prepare documents to make a request to them." (CPD representative)

The interviewees like the freedom of the support because it enables HHC to handle the resource in such a way as "*to give a concrete, accurate and quick answer to the emerging needs in each case."* (CPD representative)

The participants take into account the empowering effect of "doing things together" with the families, which HHC practices (1), they take into account the role of empathy, the specific roles the system assigns to them in the process of support (2), they identify themselves with professionalism and identical values and practices (3).

1. *"This is support that helps families to help themselves. You help someone get up on their feet instead of continuing to drag on the ground. This is a kind of non-interest credit of trust."* (CPD representative)

2. *"There is no particular difference between our approach to work and that of the HHC, but for people we are the bad guys. We are the ones who will take their children. People do not understand that we are also looking for ways to help. People perceive HHC, on the other hand, as those who give them something visible and tangible. Our capabilities are limited: our support is strictly targeted,*

and our work is mostly consultative, but sometimes, when people are actually in a state of desperation no matter how much we talk to them, they do not hear anything." (CPD representative)

3. *"There is no difference in the way we and HHC work, and there should not be. We are all social workers."* (CPD representative)

The system also recognizes the relationship between clients and HHC coordinators as a tool for change:

"Transport is not only a help from a financial point of view, but also pure physical assistance: the coordinator is a person who accompanies the family and supports them all the time." (Municipal foster care team)

The importance of the regularity of visits that help parents to structure their day and care for their children is also recognised.

- Attitudes towards multidisciplinary teamwork

These attitudes are changing slowly. In terms of multidisciplinary cross-sectorial work, the participants are more sceptical. However, the CPDs take into account the role of HHC in this area as well.

"It is undoubtedly HHC who establish a network of representatives from institutions and set up multidisciplinary teams to work on the cases of families with a child at risk of abandonment." (CPD representative)

The model has the capacity to change attitudes in the healthcare system. In the course of the project work, from January 2014 until April 2016, family doctors "slowly began to recognize children at risk" and signal the CPD as appropriate.

The participants talk about HHC's achievements in involving hospitals, municipalities, local organizations, but do not define them as networking. One explanation is that they do not participate in HHC's networking activities and do not recognize it in their experience. They may perceive this network as related to the exercise of power that they do not have or do not know they have. CPDs can initiate "networking" activity but do not sustain it.

"At this point in time, this is not happening. On the contrary, after the end of the project, the departments are working alone. Very often after forming multidisciplinary teams for work, we

end up alone in the course of the implementation of the work plan. There is no network, no teamwork." (CPD representative)

The collaborative activity created by local coordination mechanisms is more effective in some places than in others. For those running HHC, it remains the most effective tool for provoking personal responsibility among those with power at local level. They stress that working with the local government agencies is crucial for the DI process.

In regions where "HHC's way of thinking about partnership as a resource and as access to additional resources" coincides with the policy and vision of the district administration, the implementation of the coordination mechanism is successful in making the work of local experts more flexible and supportive of a more individualized approach. The HHC coordinators are a role model for implementing this idea.

"In many of the cases that we have been working on we have also sought HHC's support. They were the people who could support us and help us. That is how the social worker saw HHC. There were a lot of children who were not removed, stayed in the family, or were successfully reintegrated, only thanks to the support HHC and the coordinators. The whole process and the coordination mechanism ... When the district administration is fully aware and when it is positive in its attitude and the district governor can order the participants in the social services and child protection to take their responsibilities, things happen. That is why I see HHC as a catalyst, bringing together all who work on a case and creating links and a basis for teamwork and coordinated joint action" (CPD representative).

Moreover, the implementation of the regional coordination mechanism has the capacity to change the style of policy management at local level.

"HHC is a significant partner in creating an innovative and effective approach. Their way of thinking and seeing partnership as a resource and as access to additional resources coincides with the policy and vision of the district administration. This was a program that made changes not only on the implementation level, but also aimed to make changes at the higher levels of government" (District Administration).

There are barriers to the use of the regional coordination mechanism:

- There is comparison to the non-functioning state coordination mechanism responsible for children who are victims of violence.

*"It (*the coordination mechanism) *will never work this way, just as the one for cases of*

violence does not work. It is very difficult for us to get it together, even though we know both the regional governments and the schools. For example, we have convened a meeting because of sexual violence against a child, the prosecution did not come, and it is the key institution in the case. These mechanisms are difficult to create and difficult to run, because the responsibilities are blurred - we do not know who the particular prosecutor who has not come is, we do not know if our letter to request a meeting has actually been read by anyone at all ..." (CPD representative)

- People that cannot make decisions take part. Then it is not operational and does not lead to results.

"The mechanisms fail when they are attended by a representative of an institution not authorized to decide, for example a representative of the municipality who does not have the authority to decide on the case for municipal housing. Then he only comes to get informed and not to cooperate ... Such cases make the coordination mechanism for us more of a loss of precious time that we don't have, rather than doing real work on the case ..." (Group from CPD)

- After the end of the government DI projects, the teams created under the projects and involved in the process were dismissed which stopped stakeholder involvement in DI on the horizontal level. There are no more considerations on the level of "Case work", which automatically excludes mechanisms to improve coordination and communication between institutions on specific cases. Stakeholders revert to hierarchical governance and the implementation of a horizontal regional coordination mechanism is not understood.
- The frequent change of people in politics and institutions, as well as the lack of professional standards in the field of child rights, make the efforts ineffective and unsustainable. There are no registers available for everyone, of people to be convened at meetings of the regional coordination mechanism.
- The centralized funding limits the flexibility of local structures to the needs of the target groups at the local level.

Several factors change the state system's attitudes to practice. Most importantly, HHC sets such a goal: *Our big goal is for the system to adopt our style of work.* (HHC), which it pursues consistently. The second factor is that by acting as a "catalyst", HHC assumes that there exists a working system whose work has to be made easier. By not taking the full credit,

HHC promote partnership and this is empowering for others. Third, HHC has a clear profile and simple procedures, which are clearly expressed: HHC has priority - DI for children from 0-3. Fourth, HHC consistently applies the Active Family Support model and all participants, without naming its elements, speak of it - working with crises, fast, flexible and lasting. Fifth, HHC maintains teamwork, a reflexive approach. Sixth, it applies the above principles of work in parallel to the system and to the families it works with. That is why both the families and the professionals feel safety, in the context of which they can learn from their experience - basic conditions for development of the system.

"Relationships with the team and the managers are human, there is no fear of criticism, the difficulties and problems in the work are discussed, even the mishaps... we make decisions in dialogue ... I can get support and understanding from a colleague if I call him on the phone in a moment of difficulty ..." (Coordinator, HHC).

This style is popular and sustainability can be sought in identifying with it. Professionals recognize in this style their own version of helping, "real social work", that they would like to apply if they had the resources.

Recognizing the limitations of the system, its representatives wish to maintain cooperation with HHC. This is also a challenge for the sustainability of the effort.

6.4.4 The participants talk about the risks to the sustainability of the results achieved by HHC regarding the integration of the HHC model by the child protection system.

The instability of the protection system is the first factor. The system in which HHC works is not stable. Staff turnover, political appointments of people in managerial positions, combined with an administrative-authoritarian style of work and a lack of standards in the system, predetermine chaos: each new manager has the power to change the style of practice. The only stable factor is the written documentation and the state employees can control chaos and lack of standards by adhering to them. Therefore, the only tool to address risks and fears is to invest in accurate documentation.
In a culture of fear, HHC provides the security that social workers require to focus on the needs of the child.

"It's so much calmer, safer, they do not want to take any risk. Even those who know or

understand that it is not right are afraid, because if you make a mistake the consequences for the social worker are very serious "(HHC coordinator)

Lack of understanding of the model is a second factor. Managers state that there are no regulatory impediments to integrate the HHC model. It is not certain what this belief is based on. Do they understand that the model provides clear rules and procedures? In their minds, the feeling of "freedom and flexibility" is related to the idea of a lack of rules.

> *"Every state system needs regulation and is built on procedures and rules. This makes it an institution. However, at the moment when a service is institutionalized in this way, it loses its freedom, flexibility and individuality of approach ... that is why at this stage we cannot find how to turn HHC model into part of the institution and to keep the parts and features that make it different, innovative and, above all, effective. Objectively, the model does not have an initial level of sustainability built into it, it relies on self-organization, self-coordination and spontaneity, freedom. A little like a flash mob - a problem arises, an organization appropriate to the specific case is created and actions are implemented. These things do not become a procedure."* (Representative of the regional administration).

There is, however, an understanding that sustainability depends entirely on the roles which the HHC practitioners perform. There is no understanding that the sustainability of HHC lies with the skills of the people performing these roles, the standards that the organization abides by, the procedures that it follows, and its ethics of working with clients.

The capacity of the system is small and the leadership style of working on cases - through teamwork and assuming long-term responsibility - cannot be integrated by everyone. Therefore some social workers are disheartened.

"I do not know what has to be done to make sure that the child and only the child is in the focus of decisions" (CPD representative).

Lack of resources and mechanisms for their effective management is a third factor. Scarcity of resources is a risk to sustainability. It is difficult to predict how the poverty of the system combined with the poverty of the families can affect the future functioning of the families. The problems of a proportion of the families that HHC works with are chronic - poverty and

isolation, which have been passed down with generations, severe disabilities. In both cases there is a need for long-term contact with teams of professionals, transport, medicines, and surgery.

"What difficulties will come? We have enough foster families. 20 - in the city, 27 in the region. For healthy children there will be no problem. For the disabled children with permanent medical care - we do not have the appropriate family-type accommodation, only in the city, but there was no place. It turned out that the Health Minister had only authorized certain doctors to decide whether a child was to be accommodated in such family-type accommodation or not. It turned out that there was such a doctor only in the city of X in Northeast Bulgaria. The doctor does not come to our hospital or to come here we arrange transport that HHC pays because the hospital's vehicle can only be used in life-threatening situations. This case does not risk life, but does the department dare? Then A. paid an ambulance. Then the department takes responsibility for the translation of such a child. The hospital only gives an ambulance for a fee. Second problem - taking the child to the city. We were waiting for the specialist doctor to come and decide. But if he decides that it is not suitable, what do we do? For the second case – there is a place only in Y, but the doctor is in the town X again. We made a tour. Finally, what happened – one of the cases remained here, and the other one was taken in the town. HHC paid for transport and if there was no institution what would we do?"

Question:

Is it possible for HHC to make conditions for sustainability before working in a particular area?

Could HHC require guarantees for sustainability of the effects of its work on cases?

Is it possible to achieve a systematic change in the professional capacity of the system through standardized university education and qualifications?

Is it possible to train the DI management?

Is it possible to create a balance between the support given by HHC and the responsibility of those working in the state system especially when saving financial support of the state?

Is it possible to rethink the regional coordination mechanism in the direction of supporting coordination mechanisms at local level?

Could the coordination mechanism in Sofia District serve the function of influencing the level

of policies and stimulating cross-sectoral partnership?

Is it possible to improve the communication strategy - on the one hand towards families, community and local CPDs, to better identify cases at risk of abandonment; and, on the other hand, towards managing the DI process at national, regional and local level, to communicate know-how and good practices?

7. Conclusions

7.1. Relevance

The practice of HHC is in line with the national policies and accelerates the implementation of national policies at local level. The HHC model is successful, according to all interviewees. Its adaptability is mainly due to the fact that it is centred on support of every family in the community - taking into account all the factors that prevent and help raise its children.

The assessment of experts, specialists, and supported families determines HHC's activity to be relevant, well measured, accurate, timely and, above all, immediate. It is agreed that this is directly related to:

- Adequate assessment of needs and prioritization of needs, so as to truly support needs that the family cannot meet by itself;
- Individualization of approach and targeting of aid;
- Activation of the family's resources
- Establishment of networks for support in the community and in the institutions and between specialists, leading to increased access of HHC to resources;
- Access to material and financial resources that can be made available quickly, without prior coordination and approval, only at the discretion of the coordinator. Prioritising direct work with families opposed to administrative tasks;
- Access to mobility: independent transport facilitates the fast response in crisis situations, the ability to transport the necessary humanitarian packages and loads, the possibility of frequent meetings with the family, the child, specialists and supporting meetings between them.
- Regular telephone contact that provides a feeling for both families and professionals that they are not alone, emotional support.

All of these activities and working methods support HHC's view that in order to provide support, there is no need for unlimited resources and input, but engagement. This is a new approach and way of thinking about fieldwork.

The "HHC Model" is applicable in any context as it responds to precisely assessed needs related to DI. When there is no political will to shut down an institution, HHC works in part of its algorithm - it creates conditions for DI through working with families.

HHC's interventions are crucial to overcoming resistance to DI at local level. HHC is a key player in advancing the prevention and reintegration practices and increasing the capacity of the system through teamwork with specialists and through trainings.

7.2. Effectiveness

HHC achieves effectiveness by being relevant to the DI policy by closing down HMSCCs and providing families for children at risk. It achieves this by partnering with the local authorities and the child protection system, by delivering resources and by working with families. All of HHC's activities are planned and implemented by a precise assessment of needs, guided by the needs of the children - the main target group.

According to participants, important factors of the model are: the professional assessment of the changing needs of families, the immediate response to the priority needs, and the new type of relationships of partnership and trust, "doing together" with them. The role of the coordinators is crucial in restoring the family during and after its crisis period. Involvement of the community in this process achieves additional effectiveness for the community itself, restoring its potential to provide support.

HHC effectively compensates for gaps in the system due to lack of adequate services in the community and in the absence of a mechanism for flexible financial support and crisis response.

The HHC model integrates into local teams, mainly through collaborative work on cases undertaken with equality and absence of fear. Teamwork increases personal engagement, and predisposes to taking more responsibilities and risks on behalf of the system.

The model achieves efficiency by using informal networks and contacts, ignoring hierarchies in favour of families at risk. HHC has a national network of contacts and links with

institutions. Flexibility in contact with the institutions, in relations of power and ensuring their participation increases efficiency.

The coordination and communication that the HHC coordinators achieve in places is one of the things with greatest effectiveness. The creation of a network of all specialists working on a case, as well as the inclusion of a wide range of experts in order to effectively solve it and increase the resources (material and purely emotional and professional) creates the feeling of wholeness of the state system, of comprehensive care, of better work of the specialists, as well as a sense of them being supported.

7.3. **Sustainability**

The data shows that on a central level HHC implements the DI policy and is partner to be relied on long-term. HHC takes part in the development of policies and "elements" of the model are used in the development of new services. A sustainable model of prevention and reintegration has been established. The actual involvement of the organization in the work in the "next program period" depends on the new distribution of authority. The Ministry of Healthcare, for example, believes that the Agency of Social Protection, which will manage the process, will include HHC in the work on the new tasks. The concept of service mobility is in the updated DI Plan, HHC is a recognized carrier of experience in this field.

The elements of HHC model: material support for families and coordination mechanisms, are built in to the New Action Plan and will be multiplied on a national scale.

At regional level, in areas where DI is a priority, HHC's work is assessed as essential, and some recognize in their work their own understanding of DI. They are aware that HHC applies a model, talk about its various elements, and some of them even have an understanding of the role of relationships as fundamental in achieving the goals of the work.

"With regard to DI they helped a lot because they were convinced of its value. This is one of the main barriers to the process. Not everyone in the system was convinced it had to happen. In this sense, the confidence and dedication of HHC to the idea was an example for everyone else. HHC carries the idea of changing the way of thinking. Their model of work thinking succeeds to penetrate into certain levels, it has entered here in the regional administration,

but in others, such as the local government, it has failed. It is interesting to interpret why this model did not penetrate everywhere. Deinstitutionalization is done with the idea of placing the child as a priority. But not on all levels do they tend to do so, and at times, defending this idea, you take many professional and personal risks "(District Administration).

When local the government does not identify with the DI policy and this is supported at central level, HHC focuses on creating conditions for DI – working with families and creating new attitudes in the system.

On a "system" level, the professionals we interviewed have different capacities to accept, recognize and make use of HHC's resources. Their answers range from full acceptance of HHC - to the assessment of its work as detrimental and creating dependency. Some professionals are not sure whether some families cannot look after their children, but they have no arguments to justify their position. These answers can be explained by the lack of professional standards for providing support, including ethical standards.

The sustainability of HHC's work in the system is associated with the state of the system itself. The people working in it are not optimistic about positive change. Despite this, or perhaps because of it, the professionals are willing to continue working with HHC in the current format. Most see the work of HHC as different from their own only in terms of providing material support, but not as an approach and attitudes. And here the opinions are different. Some CPDs would not want to have the resources that HHC has, because it would rather complicate their work, it would burden them and create higher expectations for them from clients.

It is important to seek the sustainability of HHC's work to the extent that the attitudes towards DI and families begin to change, and they change with the implementation of the HHC Model.

At the "clients" level - families and communities, sustainability is assessed by quantitative data that show that change achieved in the families is maintained 6 months after HHC ending its intervention. Participants evaluate the relationship between families and coordinators as the most sustainable outcome, relationships that are subsequently created by the CPD after the withdrawal of HHC.

Professionals also assess the impact of HHC on isolated communities that restore their ability to support and develop as a result of the work with individual families.

When the clients suffer from chronic poverty and are chronically marginalized, sustainability is more difficult to achieve.

7.4. Benefit

The benefit for the families is confirmed by quantitative and qualitative data. Families report that HHC has provided them with opportunities: to live together, to get help in crises, to have long-term contact with specialists who give them security and support, to develop skills and to seek support from the social structures and services before the next crises for the early prevention of relapsing, improving the family climate and parenting capacity, raising awareness of the opportunities and rights of the parents themselves.

There is a high evaluation for HHC by a regional administration that identifies with the HHC Model.

The specialists recognize the usefulness of HHC in closing homes and increasing the number of supported children and families, highlighting the role of HHC in:

- giving a “push” to resolve the status of children who have spent years in institutions;
- changing the attitudes towards a child-centred approach, and motivating employees to engage in cases and take a measured risk of reintegration,
- inclusion of different specialists in assessing the possibilities for reintegration into the biological family - core or expanded,
- changing the thinking about alternatives to the child and his / her family, for an individualized and more committed approach,
- supporting institutions in their work to increase parental capacity;
- investing in improving the environment and helping families to overcome the obstacles that prevent them from taking back their child;
- building a system for support within the community;
- ensuring mobility and flexibility for meetings between the biological family and the child, or between the social worker and the family.
- synchronizing the efforts between services and CPD in decision-making for children at risk.

8. Recommendations

Recommendations refer to: 1 / DI, 2 / the development of the protection system, 3 / managing DI.

1. The main recommendation that the study makes is for HHC to continue to apply its model as it leads to sustainable results for the families and children looked after at home and to the closure of institutions. The implementation of the model is recognized in all of its elements.

When working with parents it is good for HHC to consider the psychological support for foster mothers who overcome separation with the children with difficulty. Overcoming the sadness after separating with a child would prepare them for new placements.

2. To integrate the Model into the existing system, HHC's task is more complex. It should be considered that in any context the system is different due to the lack of standards in social work, this predetermines that somewhere the model will be easier, in another context - more difficult to adopt. The main obstacle to changing the system is the lack of professional standards. Therefore, the work of HHC on the professionalization of social work by asserting its own standards and requirements for the practitioners is an important process for raising the quality of care as a whole. The lack of professionalism leads to its partial understanding due to a lack of explanatory theoretical or rights-based framework in which the system begins to understand the model - both as a principle of work and as a result. Without understanding and the introduction of a common explanatory framework, adoption by the system will be partial. A particular challenge to the model is that it applies the paradigm of strengths in social work in a system that operates within the paradigm of deficit - the medical model. Furthermore, the model understands the child's emotional needs, family relations, as important for the development of the child, and this also is not understood by the system.

Therefore, if it is intended to increase the capacity of the system, the recommendations to HHC are to maintain the style of partnership they are developing with it. The main expectation for the participants is that HHC will continue to follow its approach - that of a catalyst: to support the CPD, to participate in policies and their creation, to adapt to the context.

> *"HHC gave courage to the institutions to continue in the direction they had chosen. They have always been supportive and understanding, they appreciated our contribution. It is always better not to be alone. They are a*

gentle, adaptable structure that conveys values that are not burdened by considerations like the state apparatus" (Representative of regional directorate of social assistance)

In the situation of political instability and with a childcare system that is not professionalized, the expectation that the system will continue to apply the model is not always realistic, especially when we take into account the existence of strong prejudices. Doing things together, along with trainings that explain the logic of work with families are successful and sustainable approaches.

In trainings and "working together", in supervisions, it is necessary to clarifying the meaning of the model so that professionals can realize how poverty affects relations, how secure relationships with the coordinators influences the development of the child, etc. (In this respect, the trainings can discuss the inconsistences of the qualitative and quantitative data that speak of sustainability of the results with the families).

Working with values is important. Empowerment of families is not understood, and stigma against poor parents is still strong. It is expressed in proposals of the type: instead of HHC *"wasting"* valuable resources for families who have no capacity, they should invest in others for a longer time, thus denying access to resources to the most marginalized families. This shows that the ethical rules for practicing social work are not understood which means that it is good to offer training in working ethics or, alternatively, to recommend to the local government to introduce the topic. (There are ethical rules adopted by the Bulgarian Association of Social Workers)

The trainings can include work on ending the engagement with families and passing them on to the system, as well as supervising this process, with a view to mastering the emotions associated with the separation. Leaving a HHC "substitute" in places in the form of the social workers in the system takes place locally, especially when this person can maintain the style of the HHC model.

It is necessary to rethink the trainings based on the analysis of knowledge and skills necessary to implement the model, as well as publication of standards in this field. A requirement for supervision among colleagues applying the model may be a tool to achieve sustainability in places where it is possible - people are better prepared.

Working at the level of those managing the system is important. The study shows that there

may be a sustainable change in attitudes at this level, and since the system is hierarchical, this can have a good effect on the people working directly with clients.

In terms of work organization, employees in the state system (possibly guided by the style of adhering to documented procedures) want HHC to institutionalize its informal co-operation, because turnover of staff, experts, and managers leads to a change in the style of work and the potential for abandoning verbal commitments made by previous management.
Like the above, they want to discuss and achieve a common understanding of the "interest of the child" and to regulate the responsibilities of the participants in the teamwork on cases. This is especially important for the risk assessments of children.

Regarding the level of DI management, recommendations are made on the basis of the conclusion:

The political vacuum, the lack of DI leadership and the proactive style of HHC's work puts them in the position of a team and a network that can intervene at "policy" level. All participants in the study have such an expectation. As much as this can be the expression of loss of power of the participants, so it may be an expression of an assessment of HHC's work. For work at the level of DI policy, HHC needs to inform all stakeholders about the results of its work, the difficulties that it encounters and the unmet needs of the system and the clients to be reached.

9. General Conclusion

In the conditions of weakening commitment to deinstitutionalization, the HHC model sustainably changes the medical model, thanks to which institutions exist. HHC defies the myth of the omnipotent state by showing how long-term relationships of concern and support to families can replace its anonymous, marginalising style and thus achieve the most important result – giving children the opportunity to grow up in families.

To those in the state child protection system, the work of HHC can seem easy. This is not the case. HHC achieves its results through professionalism achieved by maintaining a clear profile, accurate assessments, working with relationships and high standards in trainings. However, the state system does not understand this because of unpreparedness, fears. The system is in a crisis, the study participants say.

Therefore our main question to HHC is:

Is it possible to apply its Model to work with the "state system" following its own algorithm:

- To define the state of the System (child protection and care) as a crisis, placing both specialists and children at risk of trauma - both for themselves and for others,
- To present the assessment to the state with the strong and problematic areas,
- To bring together a multi-disciplinary (cross-sectorial) coordination mechanism at the state level with clarity about how each of the invited participants will take personal responsibility with regard to the development of the system,
- To package its training module, offer it and require its sustainability,
- To create a set of standards for those using the HHC model and to demand compliance,
- To require compliance with the evidence obtained on the effectiveness on the same principle that is assesses families on - periodically - every 3 and 6 months,
- To require evidence of the children's development.

If this is possible, a question to "policy", argued through this assessment, is:

> Given that there is no decentralization of services, provided that the state wants cost efficiency, provided that the state does not prepare social workers and does not develop the necessary services:
> How can the results that the study shows become sustainable at national level?
> Asking the question this way, in the style of HHC, recognizes the right of the state and its institutions to work in the medical model, BUT on the basis of the results of this assessment, they build upon the strengths, i.e. that in Bulgaria the attitudes and practices are changing in the interest of the child.

HHC has reason to intervene on this because:

- The state wants results and awareness,
- The state does not have the competence of those working in HHC,
- There is an expectation for HHC to seek a systemic course of change in the system, since research shows that HHC model is applicable everywhere,
- It directs actions towards positive development and not towards the deficiencies of the system.