Foster care for children with disabilities: comparative analysis of selected Council of Europe national practices



Consultation Group on the Children of Ukraine
www.coe.int/cgu

Building a Europe
for and with children

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Foster care for children with disabilities: comparative analysis of selected Council of Europe national practices

Czechia, Finland, Lithuania
& Northern Ireland,
United Kingdom

Based on Expert Bilateral Consultations,
February & March 2026

Author:
Elayn M Sammon,
Independent Expert

Council of Europe

The opinions expressed in this work are the responsibility of the author(s) and do not necessarily reflect the official policy of the Council of Europe.

The reproduction of extracts (up to 500 words) is authorised, except for commercial purposes, as long as the integrity of the text is preserved, the excerpt is not used out of context, does not provide incomplete information or does not otherwise mislead the reader as to the nature, scope or content of the text. The source text must always be acknowledged as follows: "© Council of Europe, year of the publication". All other requests concerning the reproduction/translation of all or part of the document should be addressed to the Publications and Visual Identity Division, Council of Europe (F-67075 Strasbourg Cedex) or publishing@coe.int.

All other correspondence concerning this document should be addressed to the Directorate General of Democracy and Human Dignity, Children's Rights Division. E-mail: children@coe.int

Cover image:
Artwork by Christian Guémy alias C215

Cover design and layout: Publications and Visual Identity Division (DPIV), Council of Europe

This publication has not been copy-edited by the DPIV Editorial Unit to correct typographical and grammatical errors.

© Council of Europe, September 2026

Acknowledgements

I would like to thank, most warmly, the government representatives of Czechia, Finland, Lithuania and Northern Ireland, United Kingdom, who generously shared their time, expertise, and insights during the consultations for this study. Their contributions were essential to understanding the complex challenges and promising practices surrounding foster care for the protection and integration of the children of Ukraine with disabilities across Council of Europe member states.

Finally, I wish to acknowledge with deep appreciation the Government of Ukraine's steadfast commitment to developing rights-based childcare practices for all children and its dedication to this process. This commitment underpins the shared ambition to ensure that every child, including children with disabilities, can grow up in a safe, nurturing and inclusive family environment.

Contents

	2
1. INTRODUCTION	**7**
1.1. Purpose	7
1.2. What Is Foster Care?	7
1.3. The Global and Regional Context	8
1.4. Structure of This Report	9
2. CZECHIA	**11**
2.1. National Legislative Framework	11
2.2. Overview of the Foster Care System	11
2.3. Foster Families for Children with Disabilities and Special Care Needs	15
3. FINLAND	**17**
3.1. National Legislative Framework	17
3.2. Overview of the Foster Care System	17
3.3. Foster Families for Children with Disabilities and Special Care Needs	19
4. LITHUANIA	**21**
4.1. National Legislative Framework	21
4.2. Overview of the Foster Care System	21
4.3. Foster Families for Children with Disabilities and Special Care Needs	23
5. NORTHERN IRELAND, UNITED KINGDOM	**25**
5.1. National Legislative Framework	25
5.2. Overview of the Foster Care System	25
5.3. Foster Families for Children with Disabilities and Special Care Needs	27
6. COMPARATIVE ANALYSIS	**29**
6.1. Legislative Frameworks	29
6.2. Forms of Care and Professionalisation	29
6.3. Assessment and Matching	29
6.4. Training	30
6.5. Support for Foster Families	30
6.6. Financial Support	30
6.7. Children with Disabilities	31
6.8. Workforce, Caseloads, and Coordination Infrastructure	31
6.9. Aftercare and Transition to Adulthood	32
6.10. Processes and procedures	32
7. SUMMARY COMPARATIVE TABLE	**35**
7.1. Key Considerations for Governments Planning to Strengthen Foster Care for Children with Disabilities	37
7.2. Supplementary Technical-Operational Considerations	38

Acronym	Full Term
AI	Artificial Intelligence
BAAF	British Association for Adoption and Fostering
CIC	Child in Care
CPD	Continuing Professional Development
CRPD	Convention on the Rights of Persons with Disabilities
EU	European Union
GEMS	Going the Extra Mile
HSCT	Health and Social Care Trust
HUS	Helsinki University Hospital Group
ICare	International Classification of Alternative Care of Children
MDFT	Multidimensional Family Therapy
NHS	National Health Service
PIP	Personal Independence Payment
PRIDE	Parent Resources for Information, Development, and Education
SCRPAS	State Child Rights Protection and Adoption Service
SIP	Standards of Social-Legal Protection of Children (Czech national child protection practice standards)
SLPCA	Social and Legal Protection of Children Act
THL	Finnish Institute for Health and Welfare
TBRI	Trust-Based Relational Intervention
UN	United Nations
UNICEF	United Nations Children's Fund

Note on Sources: This report is based primarily on materials shared during bilateral expert consultations involving representatives of Czechia, Finland, Lithuania, and Northern Ireland, United Kingdom, in February and March 2026, responses to structured consultation questions, and supplementary reference documents. The consultations were originally developed to inform Ukraine's ongoing reform of the child care and support system; this publication presents the comparative findings for broader use. Additional context has been drawn from publicly available national legislative and policy sources, THL (Finnish Institute for Health and Welfare) documentation, and UNICEF's 2025 White Paper 'Development of Foster Care in Europe and Central Asia'. Quantitative data reflect the most recent figures available as presented by each national delegation.

Note on use of AI: Artificial intelligence tools, including ChatGPT, Claude, and Grammarly, were used to support formatting, structural refinement, and correction of spelling and grammar; all substantive content, analysis, and conclusions remain the responsibility of the author.

1. Introduction

1.1. Purpose

This report synthesises findings from bilateral expert consultations conducted in February and March 2026 between representatives of Czechia, Finland, Lithuania, and Northern Ireland, United Kingdom, on the development of foster care systems with particular attention to foster care for children with disabilities and children with complex care needs (Box 1). The consultations were originally developed to inform Ukraine's ongoing reform of the child care and support system; this publication presents the comparative findings for broader use by Council of Europe member states and other interested parties.

Box 1. What are Complex Care Needs?

All children who require foster care have complex needs in the broadest sense: every child who has been separated from their birth family has experienced loss, and all will carry the effects of that separation in ways that are unique to them. Trauma-informed principles should therefore be a baseline standard of foster care, not an optional add-on, and both children and foster carers should have timely, sustained access to mental health and psychosocial support responsive to each child's specific needs and circumstances.

For the purposes of foster care system design, however, "complex care needs" refers more specifically to children whose significant trauma, whether resulting from violence (including sexual violence), conflict-related displacement, bereavement, or the cumulative effects of neglect and family breakdown, manifests in emotional and behavioural challenges that require a higher level of structured support. This group also includes children with complex or multiple health conditions, including disabilities, whose care needs extend beyond what standard foster arrangements can readily accommodate and who require specific care arrangements and adapted support within foster families. These are children for whom standard foster care arrangements, without enhanced training, specialist input, and additional resources, are unlikely to be sufficient. It is this group that the system design considerations in this report primarily address.

1.2. What Is Foster Care?

Foster care is a form of family-based alternative care in which a child who cannot, temporarily or permanently live with their birth family, is placed in the home of an approved foster family under the supervision and responsibility of competent public authorities (Box 2). Unlike residential care, foster care places the child in a family environment, providing individual attention, stable attachment relationships, and a sense of belonging to the community. Foster care may be short-term (emergency or transitional), long-term, or specialised, and it is widely recognised as significantly more beneficial for children's development, wellbeing, and lifelong outcomes than residential care.[1]

1. UNICEF, April 2024, White Paper. Development of foster care in the Europe and Central Asia Region. UNICEF: Geneva

Box 2. Alternative Care, Kinship Care and Foster Care
Source: International Classification of Alternative Care of Children (ICare), endorsed at the 57th session of the UN Statistical Commission in March 2026 *Alternative care* refers to the care of a child by person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. Alternative care can be formal or informal and may be provided on a short- or long-term basis. *Kinship care* is alternative care provided by a person/s related or known to the child (other than the parents), whether formal or informal in nature, within her/his/their own household or the household of the child. *Foster care* is a type of family-based alternative care of a child, ordered by a competent authority, provided by a caregiver/s who has/ve been selected, qualified, matched, approved and supervised for providing such care.

1.3. The Global and Regional Context

The global evidence base is unambiguous: children thrive better in families.[2] This principle is embedded in the UN Convention on the Rights of the Child (1989) and the UN Guidelines for the Alternative Care of Children (2010), and the March 2026 International Classification of Alternative Care of Children (ICare) which call on states to prioritise family-based care over institutional placement and to build systems that actively support kinship care and foster care as primary responses when birth family care is not possible.

Across Europe and Central Asia, the transition from large residential institutions to family- and community-based care has been a major policy trajectory over the past three decades. Countries of Central and Eastern Europe have, to varying degrees, reformed their legacy child welfare systems, many of which were characterised by large, Soviet-era children's homes, towards more individualised, rights-based, family-centred approaches. This transformation has been driven by EU accession requirements, human rights obligations, recommendations from the European Commission and the Council of Europe (Box 3), and the demonstrable harms of residential care documented in the neurological, developmental, and psychological research literature.

Box 3. Council of Europe Recommendations Relevant for Foster Care	
The Council of Europe Recommendation CM/Rec (2011)12 on children's rights and social services friendly to children and families	Calls for child-centred, family-oriented social services that prioritise family support and quality alternative family care, including foster care, when children cannot safely remain with their parents.
The Council of Europe Recommendation CM/Rec(2010)[2] on deinstitutionalisation and community living of children with disabilities	Promotes replacing institutional care with community and family-based alternatives, encouraging the development of foster care and other family settings so children with disabilities grow up in inclusive home environments.
The Council of Europe Recommendation CM/Rec(2025)5 on the protection of the rights and best interests of the child in care proceedings	Establishes a common framework for the assessment and determination of the best interests of the child in care proceedings, covering placement decisions, individual care plans, review mechanisms, and support for alternative care providers. Affirms that placement in alternative care should be a measure of last resort, that family-based and family-like placements should be prioritised, and that foster carers and kinship carers should receive structured support in accordance with the individual needs of the child.

2. Cantwell, Nigel, et al., Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children', UK: Centre for Excellence for Looked After Children in Scotland, 2012, https://pure.strath.ac.uk/ws/portalfiles/portal/263862550/Cantwell-etal-Strathclyde-2013-Moving-Forward-Implementing-the-Guidelines-for-the-Alternative-Care_of-Children.pdf ; Garcia Quiroga, M., Hamilton-Giachritsis, C. Attachment Styles in Children Living in Alternative Care: A Systematic Review of the Literature. *Child Youth Care Forum* 45, 625–653 (2016). https://doi.org/10.1007/s10566-015-9342-x ; Goldman, Philip S., et al., 'Institutionalisation and Deinstitutionalisation of Children 2: Policy and practice recommendations for global, national, and local actors', The Lancet Child & Adolescent Health, vol. 4, no. 8, 2020, pp. 606–633, https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30060-2/fulltext

Within this broader transformation, foster care has assumed a central role. Several countries, including Czechia, Finland, Lithuania, and Northern Ireland, UK, have developed regulated and extensively supported foster care systems at different levels of maturity that now accommodate tens of thousands of children, including children with disabilities and children with complex care needs. These systems offer rich lessons for countries still navigating this transition.

1.4. Structure of This Report

Following this introduction, Sections 2 to 5 provide detailed country portfolios for Czechia, Finland, Lithuania, and Northern Ireland, UK, respectively. Each portfolio includes three subsections: national legislative framework, an overview of the foster care system, and specific provisions for foster families caring for children with disabilities and complex care needs. Section 5 provides a comparative analysis of the four countries' approaches. Section 6 presents a summary comparative table.

The report draws on materials shared by each delegation during the bilateral consultations, including presentations, written responses to consultation questions, and supplementary reference documents. It also references publicly available policy documents and legislative frameworks. Where consultation materials were limited, additional context has been drawn from publicly available national sources.

2. Czechia

Czechia's child protection system has undergone substantial transformation since 1989, shifting from a heavy reliance on institutional care towards a family-centred model underpinned by robust legislation, professional foster care, and extensive support structures. The Czech experience is particularly instructive for countries at earlier stages of this transition, given the significant progress achieved in a relatively short period of time.

2.1. National Legislative Framework

The Czech foster care system is governed by a comprehensive legislative architecture spanning child protection, civil law, social services, and healthcare. The principal legislative instruments are as follows:

- The Social and Legal Protection of Children Act (No. 359/1999 Coll., most recently amended by Decree No. 477/2024 Coll.) is the cornerstone statute. It defines the scope of child protection, the roles and responsibilities of municipal and regional authorities, the forms of alternative care, the procedures for assessment and placement, and the standards for monitoring. The 2024 implementing decree introduced significant improvements to the speed and flexibility of the placement arrangement procedure.
- The Civil Code (No. 89/2012 Coll.) regulates the legal status of foster families, including parental responsibility, guardianship, and the rights and duties of foster parents. It establishes that parental responsibility can only be restricted by a court decision and that courts bear exclusive authority to remove a child from their family.
- The Social Services Act (No. 108/2006 Coll.) governs the ecosystem of support services for children and families, including respite care, early intervention, counselling, and the specialised services increasingly available to foster families caring for children with disabilities. This Act, when it came into effect in 2007, is credited with enabling a significant increase in the number of families able to care for children with disabilities at home.
- Additional relevant statutes include the Institutional Care Act (No. 109/2002 Coll.), the Health Services Act (No. 372/2011 Coll.), the Education Act (No. 561/2004 Coll.), and the Act on Special Court Proceedings (No. 292/2013 Coll.).

Amendments introduced in 2025 have further strengthened the legal framework by establishing age limits for the placement of children in all types of institutional care and mandating the closure of institutions caring for the youngest children (baby homes).

2.2. Overview of the Foster Care System

2.2.1. Forms of Alternative Care

Czechia operates a differentiated system of alternative care that encompasses multiple placement types, ranging from short-term to long-term family-based arrangements to, as a last resort, residential care. The main categories are:

- Temporary foster care (up to 12 months): designed to provide immediate safe placement while family reunification or permanent solutions are pursued. Accepts children of all ages, including infants.
- Long-term foster care (informal): typically for relatives or persons with close emotional ties to the child.
- Long-term foster care (formal): state-arranged placement where the foster family receives the full support package described below.
- Guardianship with personal care: a legal status conferring a higher degree of responsibility and legal representation.
- Entrusting a child to the care of another person (close person): a non-formal arrangement for trusted adults.
- Adoption: the most permanent form, transferring full parental rights.
- Residential facility for immediate help (up to 6 months): short-term emergency placement.

- Residential care: children's homes, children's homes with schools, educational facilities, diagnostic facilities, and facilities for people with disabilities, for example, early childhood medical care institutions for children under three are closed in favour of family-based and community-based family-type settings[3].

2.2.2. Scale of the System

With a child population of approximately 2.1 million, Czechia has around 111 583 families (approximately 5%) under some form of social and legal protection. As of the most recent statistical report, approximately 21 854 children are in alternative family-based care, and 6 896 children remain in residential care, a proportion that reflects the sustained policy drive towards deinstitutionalisation. Within the system, foster care encompasses 12 789 children in long-term foster care, 713 in temporary foster care, 3 113 under guardianship with personal care, and 5 230 in the care of another person.

2.2.3. Applicant Assessment and Matching

Any adult may apply to become a foster carer by submitting an application to the municipal social and legal child protection authority. The municipal authority assesses the applicant's economic and social circumstances and criminal record, and forwards the file to the regional authority, which initiates a formal administrative proceeding, including a mandatory personal hearing. Applicant assessment covers:

- the capacity to provide appropriate care;
- the integrity of the household;
- health status;
- reliability and personal prerequisites;
- motivation;
- the ability of existing household children to accept a new child;
- marital or partnership stability;
- housing conditions; and
- other relevant factors.

A mandatory psychological assessment is required of every applicant, conducted by an expert chosen from a national register of authorised assessors (a recent reform replacing the previous system of in-house regional assessment, which had led to delays and concerns about objectivity). This assessment is funded by the regional authority and informs the broader suitability determination.

When a specific child requires placement, the regional authority searches its register of approved applicants, prioritising local matches to maintain proximity to the child's birth family. If no suitable carer is found locally, the search extends nationally. Children's files are simultaneously shared with the Office for International Protection of Children (covering international adoption), though this is not a preferred pathway. Matching focuses on the child's care needs rather than diagnosis, and a multidisciplinary panel issues a formal recommendation before the applicant is introduced to the child. The applicant then has 30 days to initiate the pre-foster care process through the court.

2.2.4. Training

Pre-service training is mandatory for all applicants. Adoption and foster care applicants, together with their partners, must complete at least 48 hours of training; applicants for temporary foster care must complete at least 72 hours. Training is delivered by certified organisations and funded by the regional authority. The applicant's biological children may be included. The training covers child development, attachment, trauma-informed caregiving, and practical aspects of the foster care role. Social and legal protection authorities and CSOs provide additional support to children transitioning into foster care.

2.2.5. Support for Foster Families

Every state-arranged foster family is required to enter into a support contract with the municipal authority or a designated organisation. This contract guarantees: home visits and counselling at least every two months;

3. Council of Europe. (May 2025) European Committee of Social Rights. Finding on Follow-up to the Complaint No. 157/2017 European Roma Rights Centre (ERRC) and Mental Disability Advocacy Centre (MDAC) v. Czech Republic. https://rm.coe.int/finding-on-follow-up-to-errc-and-mdac-v-czech-republic-cc157-2017-e/488029d98b

24 hours of continuing education per year; two weeks of free short-break care annually (Box 4); short-term childcare; psychotherapy or psychological support; and supported contact with the child's biological family. Informal support structures, including foster parent support groups, helplines, and peer networks, complement the formal system.

Monitoring by the social and legal protection authority requires personal contact with the child at least every three months during the first six months of placement, and at least every six months thereafter when a support contract is in place.

Box 4. Short-break care or respite care?

Short-break (or respite) care provides temporary, time-limited placements that give foster carers and birth families a planned rest, without transferring the child's primary care arrangement. Unlike mainstream foster care, it is designed as a support mechanism rather than an alternative home.

The term «short-breaks» has largely replaced «respite care» in professional usage, reflecting a shift in focus from the carer's relief needs to the child's positive experience and developmental benefits. The shift in terminology reflects a deliberate conceptual reframing: where «respite» implies relief from a burden, «short-breaks» centres the experience of the child, recognising that periodic placements with a trained carer can offer positive, enriching experiences in their own right, not merely a pause in the primary carer's responsibilities.

2.2.6. Financial Benefits

Czechia's financial support framework for foster families is substantial and calibrated to the child's needs (Box 5). The model demonstrates how linking foster carer remuneration to the minimum wage, alongside child-centred allowances, can help professionalise and stabilise foster care.

Box 5. Czechia's Foster Care Financial Support Framework

Benefit / Support Measure	Amount (CZK)	Approx. EUR Equivalent	Notes
Children's needs contribution (monthly)	6 290 to 9 920 Czech Koruna (CZK)	€258 to €407	Amount varies depending on the child's age
Enhanced children's needs contribution for children with disabilities (monthly)	Up to 12 575 CZK	Up to €516	Higher rate reflecting additional needs
Foster parent benefit	1 to 2 minimum wages	€912 to €1 824	Based on the national minimum wage
Additional supplement for each child with disability	0.5-0.7 minimum wage	~€638	Paid on top of the foster parent benefit
One-time contribution when taking a child into care	10 800 – 13 500 CZK	€443 to €554	Initial placement support
Vehicle purchase contribution	Up to 100 000 CZK	Up to €4 100	Up to 70% of vehicle cost for carers of three or more children
Maintenance allowance for young adults leaving foster care while studying	17 250 CZK per month	€690 per month	Supports transition to independent living while studying
Minimum wage reference (Feb 2026)	22 400 CZK	~€912	Used as the benchmark for several benefits

Key legislative reforms have progressively strengthened this system: in 2013, formal support contracts and short-term foster care were introduced; in 2022, a distinction was introduced between support for state-arranged and non-arranged care; and in 2025, the arrangement procedure was accelerated, and institutional age limits were introduced.

2.2.7. Workforce: Size, Qualifications, and Structure

Foster care in Czechia is coordinated and supported by various responsible bodies, with responsibility shared between the state and the non-governmental sector. Three principal workforce tiers deliver the system.

Municipal-level workforce

At the level of municipalities with extended powers – which bear primary responsibility for the provision of social and legal protection of children – specialisation in foster care is mandatory in accordance with quality standards for social and legal protection of children (alongside guardianship for children and youth and specialisation in child abuse and neglect). The specific number of foster care specialists at individual offices depends on the quality standards, where staffing levels are determined by the total number of children in the given territory.

In 2024, a total of 2 755 staff members were employed at the municipal level, of whom 586 persons were assigned to foster care duties (recruitment, participation in placement, supervision) and 177 persons were responsible for managing foster care agreements.

Overall responsibilities at the municipal level include: identifying children requiring foster care and assessing their needs; maintaining records; forwarding documentation to the regional office or Office for International Protection of Children; participating in placements; monitoring children's interests and rights post-placement; accepting applications for inclusion in the registry of applicants; conducting social investigations; and forwarding applications to the regional office. Some municipal authorities also provide direct support to foster families under the mandatory support agreements, though in most cases this function is carried out by authorised CSOs.

Qualifications are governed by the Social Services Act, which requires a university degree or higher vocational education in social work, social pedagogy, social and humanitarian work, social and legal work, theology, pedagogy, or psychology (provided the individual meets professional competence conditions). All staff are required to complete initial and regular continuing education.

Regional authority workforce

Regional authorities are responsible for the foster care placement process, including: maintaining records of children and applicants; coordinating and arranging professional assessments of prospective foster parents; preparing prospective foster parents for foster care or adoption; running matching panels; and coordinating the child's introduction to prospective caregivers. A total of 52 staff members (out of 109 in total) are currently assigned to the foster care agenda across the 14 regional offices in Czechia. The same qualification requirements as at the municipal level apply.

Authorised organisations and individuals

Legal entities or individuals meeting the legal requirements (including a clean criminal record and professional qualifications) may be authorised to perform certain activities related to social and legal protection of children. These activities include: providing professional counselling to applicants regarding foster care or adoption; preparing applicants for placement of a child in a family; assessing the psychological suitability of applicants; and providing ongoing professional support, monitoring, and assistance under foster care agreements. There are currently 238 organisations in Czechia authorised to carry out such activities. Professional qualifications for authorised personnel include credentials as social workers, social service workers, healthcare professionals, educators, marriage and family counsellors, and other relevant fields, or, alternatively, two years of experience and 200 hours of accredited training courses. Volunteers may also be involved in accordance with the Volunteer Service Act.

All authorised persons adhere to quality standards when providing social and legal protection for children and are subject to oversight by regional authorities.

2.2.8. Caseloads and Supervision

The number of foster care agreements in place, that is, families supported by municipal authorities or authorised individuals, is 10 900. The maximum number of families per social and legal child protection worker, as stipulated by the quality standard, is 40.

A further 6 800 children are registered for foster care placement. They fall under the jurisdiction of foster care specialists at child welfare authorities and staff at regional offices responsible for child registration.

Supervision of staff at child welfare agencies and of authorised individuals providing child welfare services is mandated as a quality standard. Format and frequency of supervision are determined in accordance with individual training and professional development plans.

2.2.9. Workforce for Specialist and Disability-Inclusive Placements

Specialisations within the professional provision of foster care are not mandated by law. However, all staff members of child welfare agencies and authorised individuals are required by law to pursue continuing professional development based on individual training plans aligned with their professional focus. In practice, this framework enables the development of specialist competencies in disability-inclusive care, though the system does not currently mandate the designation of dedicated disability specialists, psychologists, or therapeutic advisors embedded within foster care teams.

2.3. Foster Families for Children with Disabilities and Special Care Needs

2.3.1. Scale

Of the approximately 33 000 children with disabilities in Czechia, around 850 are in foster care, and 500 are in institutional care (and the remainder are living with their birth families). Data trends show a dramatic positive shift: in 2010, 1 000 children with disabilities were in institutional care and 451 in foster care; by 2024, the institutional figure had decreased to 450, while the foster care figure had risen to 950. This inversion reflects the sustained effect of legislative reforms, expanded support services, and public awareness campaigns.

2.3.2. Support and Services

Prevention and early support for families of children with disabilities includes: prenatal and neonatal screening; early education and psychosocial support for parents; connections to self-help groups and information services; and awareness campaigns. The Social Services Act has been instrumental in enabling biological families to manage complex care needs at home through a care allowance graded across four disability levels (4 900 to 27 000 CZK per month).

For children with disabilities in foster care, the system provides: the enhanced needs contribution; additional short-break care; in-home support services; counselling; specialist multidisciplinary input; and educational support measures. The foster care matching process explicitly describes children with disabilities through the lens of care needs rather than diagnostic labels, a significant conceptual shift that affects how carers are prepared and supported.

2.3.3. Critical Developmental Moments and Challenges

The Czech materials identify specific developmental transition points that require heightened support for children with disabilities in foster care: school entry at age seven (requiring appropriate educational pathways and transport); adolescence from age 12 (managing physical growth, assistive technology, and emotional regulation); and the transition to adulthood at 18 (planning housing, employment, and follow-up care). Remaining systemic challenges include the geographic availability of specialised services and the adequacy of support for families caring for children with multiple or severe disabilities.

2.3.4. Campaigns and Recruitment

Czechia has developed innovative national and regional campaigns to recruit foster carers, including for children with disabilities. The national 'Be In Foster' campaign[4] includes an interactive database of training and assessment providers. The National Foster Care Day ('Cupcake Day') and the TV documentary series 'The Full

4. www.budinpestoun.cz

Nest' have been important tools for raising awareness of foster care in the public consciousness. For children for whom standard matching has failed, individual campaigns are conducted: a child's story is developed (without identifying information), a video featuring the child's carers is produced, and prospective carers are actively engaged through digital channels. This approach has a reported success rate of approximately 65%, of which about 50% involve children with disabilities.

3. Finland

Finland's foster care system is widely regarded as one of the most comprehensive and child-centred in Europe, embedded within a universal welfare state framework and governed by strong legislative standards. Finland's approach offers particularly useful insights regarding the professionalisation of foster care, the rights-based assessment of family capacity, and the provision of needs-based support for children with complex care requirements.

3.1. National Legislative Framework

Finland's foster care system is grounded in two principal legislative instruments: the Child Welfare Act (*Lastensuojelulaki*) and the Family Care Act (*Perhehoitolaki 263/2015*). Together, these statutes define the conditions under which children are placed in foster care, the rights of children and foster families, the responsibilities of public authorities, and the standards governing the quality of care.

The Child Welfare Act establishes that child-centred decision-making, maintenance of family relationships, and the best interests of the child are paramount in all child welfare actions. It mandates multi-professional cooperation in assessment and planning, confers a legal right on children to participate in decisions affecting them, and places ultimate responsibility for placement decisions with the Wellbeing Services Counties (*hyvinvointialueet*), regional bodies established under Finland's major 2023 welfare reform.

The 2023 Wellbeing Services reform transferred responsibility for organising health, social, and rescue services from 293 municipalities to 21 newly established Wellbeing Services Counties. The City of Helsinki continues to manage services independently, and the HUS Group[5] retains responsibility for specialised healthcare in the Uusimaa region. This centralisation has created a more unified and equitable system, with national funding and oversight through the Ministry of Social Affairs and Health, while preserving regional flexibility in service delivery.

The Family Care Act governs the contractual framework for foster care, setting national minimum standards for financial compensation, placement limits, training requirements, respite entitlements, and the conditions of the commission agreement (*toimeksiantosopimus*) that governs the relationship between foster families and the placing authority. Additional relevant legislation includes the Act on Disability Services and the national quality recommendation (*Lastensuojelun laatusuositus*) jointly issued by the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities.

3.2. Overview of the Foster Care System

3.2.1. Types of Foster Care

Finland organises foster care through two primary models. Ordinary foster care involves a family that provides nurturing care and an everyday home environment for a placed child, working in close collaboration with social workers, birth families, and other professionals. Professional foster care involves at least one carer who holds relevant professional qualifications and provides more intensive, therapeutically informed care for children with complex needs. Finland does not maintain a legally distinct category of 'specialised' foster family, but in practice, many families develop recognised expertise in particular areas, including disability, trauma, or complex developmental conditions.

5. HUS stands for Helsingin ja Uudenmaan sairaanhoitopiiri; the Hospital District of Helsinki and Uusimaa (or HUS Helsinki University Hospital). It is the largest hospital and specialised healthcare organisation in Finland, serving the Uusimaa region which includes Helsinki. Because of the scale and complexity of the Helsinki metropolitan area, HUS was carved out as a separate entity rather than folded into the general wellbeing services county structure like the rest of the country.

Short-term (short-break) foster care (one to 14 days per month) is used to support children with disabilities and their birth families, preventing carer fatigue and enabling families to maintain care at home over the long term. This flexible model is an important component of the Finnish approach to disability-inclusive care.

3.2.2. Employment Status and Contractual Framework

Foster care in Finland is not classified as employment. Foster parents do not hold employment contracts; instead, they sign a commission agreement with the relevant wellbeing services county. This agreement outlines duties, confidentiality obligations, cooperation expectations, and compensation arrangements. As a result, foster parents receive care allowances and expense reimbursements rather than wages, and they do not accrue standard employment entitlements such as annual leave or sick pay. However, the commission agreement explicitly provides for respite days, and the county is legally responsible for arranging substitute care when foster parents require time off or are unable to care for the child.

3.2.3. Financial Compensation

Box 6 summarises the minimum national financial compensation framework for foster care in Finland as of January 2026, outlining the key payments provided to foster carers to cover caregiving responsibilities, the child's living expenses, and initial placement costs. The indicative minimum combined monthly support per child is €1 467.45 (care fee + expense allowance), excluding any higher payments for complex care needs.

Box 6. Finland Foster Care Financial Compensation (Minimum National Rates, January 2026)

Support Measure	Amount (EUR)	Frequency	Purpose / Coverage	Key Policy Notes
Care fee (hoitopalkkio)	At least €966.35 per child	Monthly	Compensation for the foster carer's caregiving work	Amount is graded by the child's level of need and may be higher for particularly demanding care; accrues pension rights and is taxable income
Expense allowance (kulukorvaus)	At least €501.10 per child	Monthly	Covers the child's everyday living costs including food, housing, hobbies, healthcare, and personal needs	Paid to ensure the foster family is not financially burdened by the child's expenses
Start-up compensation	Up to €3 558.60 per child	One-time payment	Supports initial placement costs such as furniture, assistive devices, clothing, and home adaptations	Paid when the child first enters foster care
Care fee determination	Variable above minimum	Monthly	Final level agreed between county authority and foster carer	Based on the individual needs of the child

3.2.4. Placement Structure and Capacity

Placement decisions are holistic, taking into account the child's cultural identity, trauma history, educational needs, social ties, and health. Sibling groups are prioritised for joint placement wherever possible. Under the Family Care Act, a standard foster home may accommodate up to four persons (including the family's biological preschool children); homes with two qualified carers may accommodate up to six; professional foster homes may accommodate up to seven. Children with different care needs and conditions may be placed together if an assessment confirms that this is in each child's best interests and that the family has the necessary capacity and support.

Assessment of Foster Family Capacity Assessment of prospective foster families is a multi-stage, multi-professional process coordinated by the wellbeing services county. It involves the child's designated social worker, psychologists, educational specialists, disability services professionals, and mental health professionals as relevant. All applicants must complete background checks (criminal record, finances, health), undergo a home study, personal interviews, and mandatory Parent Resources for Information, Development, and Education (PRIDE) pre-service training (see below). Assessment tools include structured home visits, interviews, and the

PRIDE competency evaluation framework. For children with disabilities or complex needs, additional specialist assessment is undertaken to verify the family's practical capacity, knowledge base, and access to appropriate support services.

Supervisory responsibility for foster family care lies with the Wellbeing Services Counties. The National Licensing and Supervision Agency (*Valvira*) provides guidance and oversight of how counties discharge this responsibility.

3.2.5. Training

All prospective foster parents in Finland are required to complete the PRIDE pre-service training before signing a commission agreement. PRIDE is Finland's nationally recognised standard, combining group sessions (typically nine to 10 sessions) with individual home consultations, and covering: child development and trauma; the impact of abuse, neglect, and separation; cooperation with birth families; working with social services; attachment and relational care; and parenting strategies for children with behavioural and emotional needs. The training is not merely educational but also functions as a formal screening tool: PRIDE instructors assess applicants' strengths, capacities, and limitations, and their evaluations inform the suitability determination. An applicant who fails to demonstrate suitability during PRIDE training will not be approved as a foster carer.

Additional specialist training is available in therapeutic work, trauma-informed care, and behavioural support. Training formats vary across Wellbeing Services Counties. Post-approval training is a continuing expectation.

3.2.6. Aftercare

Young people aged 18 to 23 are entitled to aftercare (*jälkihuolto*) following the end of a foster care placement. Finland strongly supports continuity of relationships, and the majority of young people receiving aftercare continue to live with their former foster families during this period. Aftercare includes housing support, financial assistance, counselling, and support for education and employment. Individual care plans are regularly reviewed and adapted to the young person's evolving needs and level of independence.

3.2.7. Workforce Context

Substitute care in Finland is delivered through a mixed model in which Wellbeing Services Counties retain statutory responsibility for decision-making, while a significant proportion of foster care and residential services are delivered through contracted providers, including private and third-sector organisations.

Statutory decision-making authority in child welfare is reserved exclusively for licensed social workers employed in public service roles. These professionals are required by law to hold a Master's degree in social work, ensuring a high and standardised level of professional, legal, and ethical competence across the system.

Social instructors, typically holding a Bachelor's degree in social services, support implementation through direct work with children and families, but do not exercise public authority

The Finnish Child Welfare Act establishes a statutory caseload limit of no more than 30 child clients per responsible social worker, ensuring that workers have sufficient capacity to maintain regular contact, undertake assessments, and safeguard the child's best interests.

Employers (Wellbeing Services Counties) are legally obliged to ensure that social workers receive professional support, coaching, and supervision. This includes structured reflective practice ('social work coaching'), aimed at strengthening ethical decision-making, professional resilience, and the integration of theory and practice.

Oversight is further reinforced through national supervision mechanisms, with the Finnish Supervisory Agency (*LVV*) responsible for monitoring service providers and ensuring compliance with legal and quality standards.

3.3. Foster Families for Children with Disabilities and Special Care Needs

3.3.1. Legislative and Regulatory Framework

While Finland does not create a distinct legal category of specialised foster family, the Family Care Act, the Disability Services Act, and the national quality framework together create a comprehensive architecture of disability-inclusive foster care. The commission agreement and the child's individual care plan document all disability-related obligations and supports, ensuring transparency and accountability.

Finland operates a structurally embedded multidisciplinary model, whereby healthcare and therapeutic professionals (including physicians, psychologists, occupational therapists, and psychotherapists) are integrated into care planning and service delivery based on the child's individual care plan.

The Social Welfare Act places a legal obligation on social workers to ensure multidisciplinary coordination, including mandatory involvement of healthcare professionals where required for the child's best interests.

Specialist involvement may occur at any stage of the placement process, including at the initial care planning stage, with an emphasis on continuity of care and non-interruption of existing health or rehabilitation services.

3.3.2. Requirements and Living Conditions

Foster homes must be safe and accessible. Wellbeing services counties may fund home modifications (ramps, accessible bathrooms, lifts), safety systems, assistive devices, specialised equipment, and adapted transport based on the child's assessed needs. These adaptations are funded for the duration of the child's care.

3.3.3. Medical, Rehabilitation, and Therapeutic Costs

All costs for medical treatment, rehabilitation, and therapies (speech therapy, physiotherapy, occupational therapy) are covered by the county. Children may also receive disability benefits from Kela (the national social insurance institution), which supplements county-funded services. Individual therapy, specialist equipment, and holiday costs are reimbursable as special expenses.

3.3.4. Coordination and Case Management

The child's designated social worker coordinates all intersectoral support, working with healthcare professionals, therapists, educators, and psychologists. Multidisciplinary collaboration is a core principle of the Finnish system. The individual care plan specifies all services, responsibilities, and review timelines. Social workers must meet Finnish professional qualification requirements in social work.

3.3.5. Long-Term Housing and Lifelong Support

If independent living is not possible, the wellbeing services arrange supported housing, group homes, small residential units, or disability services with part-time or full-time support. In disability services, there is no separate 'aftercare' phase. Support continues seamlessly into adulthood according to the individual's functional needs, including housing support, daily living assistance, education and employment support, and rehabilitation. This seamless continuity is a distinctive feature of the Finnish approach.

4. Lithuania

Lithuania's foster care system is characterised by a well-structured regulatory framework, a strong role for municipal-level foster care centres, and a distinctive professional foster care model designed specifically for children with complex needs. Lithuania's experience offers particularly instructive lessons regarding the professionalisation of foster care, the role of specialised support organisations, and inclusive education policy.

4.1. National Legislative Framework

Foster care in Lithuania is governed by a multi-layered legislative framework, centred on the Civil Code of the Republic of Lithuania, which defines the legal rights and duties of guardians, and the Law on Social Services, which establishes the operational framework for foster care centres. The State Child Rights Protection and Adoption Service, operating under the Ministry of Social Security and Labour, holds national oversight responsibility for foster care.

The Civil Code establishes that all persons exercising guardianship or care of a child must have full legal capacity, no restrictions on parental authority (current or historical), no relevant criminal convictions, and no mental or behavioural disorders. The principle that children from the same family should not be separated except in exceptional circumstances is codified in the Civil Code, which permits separation only where cohabitation would be contrary to the child's best interests.

Professional foster carers operate under the Law on Social Services, which defines the minimum salary, entitlements, and working conditions for both on-duty (*koruojančiasis globėjas*) and permanent (*nuolatinis globėjas*) caregivers. Since 2018, the foster care centre model has been established in all municipalities, providing a mandatory, uniform infrastructure for supporting and supervising all forms of foster care.

The operational requirements for foster care service provision, including staffing ratios and service standards, are further regulated through secondary legislation, notably the Description of Requirements for the Provision of Accredited Social Services (2021), which establishes minimum staffing structures and caseload expectations for foster care centres.

4.2. Overview of the Foster Care System

4.2.1. Forms of Foster Care

Lithuania's system encompasses four distinct forms of foster care, distinguished by legal status, carer compensation, and capacity:

- Regular foster care: The carer acts as legal representative; no salary is paid (caregivers receive allowances for the child's needs); maximum three children (or six, including the carer's own children).
- Professional foster care, caregiver on duty: A paid, professional role; carer is not a legal representative; the foster care centre holds legal representation; maximum three children (or six including own); minimum wage guaranteed throughout the duration of the agreement, even when no child is currently placed.
- Professional foster care, permanent caregiver: A paid, professional role specifically designed for children with complex characteristics; maximum one specialised child (or four including own); not a legal representative.
- Family-based foster care household: A form in which a legal entity (the foster family) cares for four or more children (up to eight total, including their own) within a family environment.
- Community-based children's care home: A residential social service operating on a small-group, family-type model for up to eight children; distinct from foster care as it is a legal entity with staff, not a family.

Two temporal forms exist across all categories: temporary care (up to 12 months, extendable to 18 months) and permanent care.

4.2.2. The Permanent Caregiver Model

Lithuania's permanent caregiver model is particularly relevant to systems seeking to develop disability-inclusive foster care. This model is designed exclusively for children with complex needs who have experienced failed placements, who have severe or permanent developmental or mental disorders, who exhibit significant functional difficulties (maladaptive behaviour, social withdrawal, suicidal tendencies), who are older than 10 years, or who come with sibling groups. The permanent caregiver must meet enhanced requirements, including one year of prior foster care experience and completion of both basic and specialised training modules. Competency is reassessed every two years.

4.2.3. Assessment and Matching

The foster care centre is responsible for identifying suitable guardians for specific children. Upon receiving a referral, the centre selects candidates from its database of trained carers and convenes a special committee (three to nine members) including representatives of the municipal administration, the State Child Rights Protection Authority, and the foster care centre. At least one member must be a foster carer training specialist. The committee determines which candidate best serves the child's interests, with capacity, experience, and the child's specific needs as the primary criteria for matching. The committee is constituted for one-year terms.

4.2.4. Training

Any adult meeting the Civil Code requirements may apply to become a foster carer. For professional foster care, applicants must additionally hold at least a secondary education and have completed both a basic module (ten sessions) and a specialised module (eight sessions) of the State Child Rights Protection Authority's preparation programme. Upon completion, preparation specialists conduct individual consultations and produce an assessment report on the applicant's readiness. Only those receiving a positive evaluation may become professional foster carers. For regular foster care, no formal professional requirements beyond those in the Civil Code apply.

All professional foster carers are required to participate in at least 16 hours of continuing training per year and to receive supervision at least quarterly (minimum of eight academic hours per year). Training content is determined by the Foster Care Centre based on assessed needs. As described in Box 7, topics currently include TBRI (Trust-Based Relational Intervention) and MDFT (Multidimensional Family Therapy).

Foster care specialists themselves are also required to undertake a minimum of 16 academic hours of annual professional development, reinforcing a system-wide emphasis on continuous capacity building and resilience.

Box 7. What are TBRI and MDTF?	
TBRI – Trust-Based Relational Intervention	A therapeutic model that trains caregivers to provide effective support and treatment for at-risk children. TBRI is a trauma-informed care approach, designed specifically for children who have experienced early harm, neglect, or adversity. It focuses on empowering caregivers, connecting with children through relationship-building, and correcting behavioural patterns rooted in trauma rather than punishing them. It is widely used in foster and adoptive care contexts.
MDFT – Multidimensional Family Therapy	An evidence-based therapeutic intervention that works simultaneously with the young person, their family, and the wider systems around them (school, social services, peers). Originally developed for adolescents with substance use and behavioural problems, it is used in foster care settings to address complex needs and strengthen family relationships, including in reunification and placement stability work.

4.2.5. Foster Care Centres

Since 2018, foster care centres have operated in every municipality in Lithuania, covering all foster care cases. The centre appoints a foster care coordinator to each case, who, within 30 days of placement, conducts a comprehensive assessment of the child's health, developmental, educational, and social needs; prepares a Support Plan; and provides or arranges individual consultations at least fortnightly (or one to two times weekly for cases requiring intensive support). The coordinator maintains regular contact through all communication

channels, organises psychological counselling, liaises with educational and health services, and updates assessment documentation in response to significant changes.

As of the end of 2025, foster care centres collectively comprised approximately 407 established positions (389 filled), including foster care coordinators, psychologists, certified assessment specialists, and managerial staff, reflecting a relatively well-developed multidisciplinary support infrastructure.

Foster care coordinators typically manage 25–30 cases, with reduced caseloads (10–15 cases) when working exclusively with emergency or permanent caregivers, as defined by national service standards.

The care coordinator must hold a degree in social work, social pedagogy, psychology, or education, or hold certification from the State Child Rights Protection Authority. This professional infrastructure ensures that all foster care in Lithuania, regardless of whether the child has special needs, is accompanied by structured, qualified case management.

Coordination functions are supported by a multidisciplinary team structure, including psychologists and certified assessment specialists, although access to more specialised therapeutic services is often arranged externally rather than embedded within the centre.

There are no dedicated specialist roles within foster care centres exclusively assigned to children with disabilities or complex care needs. Instead, centres mobilise external specialists, including psychologists, therapists, and other service providers, based on individual case needs.

4.2.6. Working Conditions for Professional Carers

Professional foster carers receive a salary paid through the foster care centre from municipal funds. Specific provisions include: short-break service (up to two nights every two months for personal needs); work ability restoration service (up to 30 calendar days per year when a child is transferred); and crisis short-break service (up to two weeks, extendable, when a child experiences acute adaptation difficulties). During crisis short-breaks, the child is transferred to another carer. Regular foster carers have no comparable working condition provisions.

4.2.7. Age of Majority and Aftercare

Formal foster care under the Civil Code ends at the age of majority (18 years). For professional foster carers (caregivers on duty and permanent caregivers), the salary continues to be paid if the young person remains under their supervision and is enrolled in full-time education, up to the age of 24. A separate Transition Service (*Perėjimo paslauga*), introduced through the Social Services Catalogue in 2021, provides support to care leavers aged 16 to 24, encompassing communication, psychological assistance, daily living skills, social skills, and employment preparation, through an individually appointed coordinator and an Independent Living Plan.

4.3. Foster Families for Children with Disabilities and Special Care Needs

4.3.1. Inclusive Approach

All four forms of Lithuanian foster care may accommodate children with disabilities and complex care needs. There are no automatic limitations on the number of children placed solely on the basis of disability status; placement decisions are governed by an individual assessment of carer capacity. Children with different conditions may be placed together within the same family, provided an assessment confirms that the carer can meet all the children's needs. No restrictions are placed on the presence of the carer's biological children.

4.3.2. Coordination and Support

Foster families caring for children with complex disabilities are entitled to: financial support (guardianship allowance and targeted supplements based on disability level); case coordination by the Foster Care Centre, including psychological counselling and a short-break service; access to healthcare, rehabilitation, and social services; day social care services; integral home services combining nursing and social care; special technical assistance devices; and educational support including inclusive arrangements and individualised programmes.

Support is coordinated at the municipal level through the foster care centre coordinator, who liaises with health, education, and social protection. Municipalities may provide targeted financial assistance to adapt living conditions or provide in-kind support (items, resources from municipal budget funds). There is no uniform national standard for housing support, and practices vary across municipalities.

The involvement of specialised services is triggered following assessment of the child's needs and may include both publicly funded and privately purchased services, depending on availability and urgency.

4.3.3. Financial Parity

All disability-related benefits for a child in foster care are identical to those available to a child with a disability in a biological family, a principle of financial parity that avoids creating disincentives related to placement status. Foster carers may utilise a combination of foster care allowances, targeted supplements, and municipal support payments to finance specialised services required for children with disabilities or complex needs, creating flexibility at the point of care but also introducing variability in access depending on local resources.

4.3.4. Inclusive Education

Lithuania has made inclusive education a legal priority, mandatory for all schools since September 2024. Children with special needs are assessed by Pedagogical Psychological Services or Municipal Education Support Services, which recommend educational pathways including mainstream school with individualised support, special classes within mainstream schools, special schools, or home-based education. Foster families receive educational support through the foster care centre's coordination function.

5. Northern Ireland, United Kingdom

Northern Ireland operates a devolved health and social care system through five Health and Social Care (HSCT) Trusts, within the broader UK legislative framework. Northern Ireland's foster care system is characterised by a strong commitment to children's rights, a professional social work infrastructure, a sophisticated approach to short-breaks for children with disabilities, and a post-18 extension scheme (GEMS6) that provides a model for leaving care support.

5.1. National Legislative Framework

The principal legislative framework governing foster care in Northern Ireland derives from the Children (Northern Ireland) Order 1995, which is broadly equivalent to the Children Act 1989 in England and Wales and establishes the legal basis for looked-after children, foster placement regulations, and HSCT responsibilities. The Order requires that the welfare of the child is paramount in all decisions, that children's wishes and feelings are taken into account, and that family reunification is prioritised wherever safe to do so.

Foster placement in Northern Ireland is additionally governed by the Foster Placement Regulations and the Foster Agencies Regulations, which set standards for recruitment, assessment, approval, matching, supervision, and review of foster carers. As of early 2026, the Fostering Services Minimum Standards (11 draft standards covering child-centred assessment and support, training and development, foster home environment, participation and relationships, and leadership and quality) are under consultation and awaiting final approval. These will, once implemented, provide a more explicit national quality benchmark.

The assessment framework for foster carers uses BAAF (British Association for Adoption and Fostering) tools,[7] which establish a competence-based evaluation model requiring evidence of suitability through structured interviews, background checks (Access NI enhanced criminal record checks), medical assessments, home studies, and personal references. Completed assessments are presented to a formal Fostering Panel comprising professionals and independent members.

5.2. Overview of the Foster Care System

5.2.1. Types of Foster Care

Northern Ireland's foster care system encompasses a range of placement types, each specified on the foster carer's registration certificate:

- Short-term foster care: for children awaiting permanent placement decisions.
- Long-term foster care: for children who will not return to their birth families and for whom adoption is not planned.
- Emergency fostering: immediate placement in crisis situations, often at short notice.
- Kinship care: placement with relatives or persons with an existing relationship to the child.
- Short-breaks (disability): periodic relief placements for children with disabilities, supporting their birth or primary families.

6. https://adoptionandfostercare.hscni.net/wp-content/uploads/2023/01/GEM-Scheme1.pdf
7. https://corambaaf.org.uk/

- Specialist fostering: fee-paid placements for children with particularly complex needs, including those with significant developmental trauma.
- GEMS (Going the Extra Mile): a post-18 arrangement that allows young people to remain with carers up to age 21.
- Bail placements: for children in contact with the justice system.

5.2.2. Who Can Foster

Northern Ireland imposes no requirements regarding marital status, and fostering is open to individuals and couples of all backgrounds. The minimum age is 21; there is no upper age limit. Prospective carers must have a right to reside in the UK, a suitable home with appropriate bedroom arrangements, and a willingness to undergo all required checks and training. Prior experience with disability is desirable but not a prerequisite for short-break fostering.

5.2.3. Statutory Limits and Household Capacity

Under the Children (NI) Order 1995, a foster carer must not simultaneously care for more than three children, with exceptions for sibling groups and panel-approved exemptions. A child with a disability counts towards this statutory limit, though the significant care needs of such a child may, in practice, reduce the number of additional placements that are appropriate. Children with different types of needs may be placed together, subject to individual matching and risk assessment.

5.2.4. Assessment Process

All assessments are carried out by qualified social workers from the HSCT. The assessment encompasses social work visits, interviews, background checks, pre-approval training, and a home study. Completed assessments are presented at a formal Fostering Panel. Post-approval, the supervising social worker conducts an annual review, escalating to a full panel review every four years. Unannounced visits are required, as is a joint visit to the placement with the community social worker.

5.2.5. Training

All applicants must complete a mandatory pre-approval training programme known as 'Skills to Foster', delivered over three sessions (one face-to-face, two online). This training introduces key aspects of foster care and helps applicants assess their readiness. Those applying to become short-break carers for children with disabilities must also complete disability awareness training (approximately 2 hours). While pre-approval training is mandatory, it is the broader assessment rather than training outcomes alone that determines suitability.

Post-approval training is both mandatory (covering paediatric first aid, safeguarding, manual handling, infection control, and information governance) and elective, with a range of specialist courses available to develop skills for working with children with disabilities, behavioural difficulties, and complex needs. Supervising social workers assess and review training needs annually.

5.2.6. Support Structures

All approved foster carers are supported by a named supervising social worker who provides regular support visits, guidance, identifies training needs, and prepares annual review reports. Foster carers receive a standard allowance ('model scheme') covering the costs of care. Fee payments (skills payments) are available for particularly complex or specialist placements and are agreed contractually when applicable. Post-approval, all foster carers receive free membership of The Fostering Network, which provides independent legal advice, training resources, and insurance cover related to fostering.

5.2.7. GEMS — Going the Extra Mile

The GEMS scheme, introduced in 2006, enables young people in foster or kinship care to continue living with their carers after the age of 18, up to a maximum age of 21. Financial support continues at a level equivalent to that of a 16-year-old, supporting the transition to adulthood. This scheme provides continuity of relationship and stability during a critical developmental period and is supported by the statutory 14+ leaving care service.

5.2.8. Workforce, Caseloads, and Specialist Roles

The foster care workforce in Northern Ireland is part of a devolved health and social care system administered through five HSC Trusts. Because the number of children in care and local service structures vary significantly between Trusts, workforce size, caseloads, and team configurations differ accordingly. Comprehensive data on the Northern Ireland social care workforce is published by the Department of Health, with detailed national data for England, Scotland, and Wales similarly available through their respective statistical services.

A defining structural feature of the Northern Ireland (and wider UK) system is the mandatory separation of the child's social worker from the foster carer's supervising social worker. Every placement involves two distinct social work roles:

- The child's social worker, employed by the local authority responsible for the child's care, holds overall responsibility for the child's care journey — including placement planning, contact with the birth family, educational decisions, and transition from care.
- The fostering social worker (or supervising social worker), provided either by the local authority with which the carer is registered or by an independent fostering agency, is responsible for ensuring the foster carer has the training, support, and resources needed to meet the child's needs, including advocating for respite where needed to prevent carer burnout.

These two roles may be provided by the same authority or by different organisations, depending on where the child is placed relative to the carer's registration. Independent Fostering Agencies play a significant role in the wider UK system; the specific rules governing their use differ between the devolved administrations.

Caseload sizes are not set by a single national standard but are influenced by targets within individual Trusts, social worker capacity and availability (a factor given ongoing recruitment challenges across the UK), and the volume of children in the system at any given time. Supervision of social workers is governed by professional registration requirements: in Northern Ireland, this falls under the Northern Ireland Social Care Council (NISCC), which sets standards for registration, training, and professional conduct. Equivalent bodies operate in each of the UK's devolved administrations.

The Northern Ireland system does not mandate dedicated disability specialist roles within foster care teams. Whether a fostering team includes embedded multi-agency or disability specialists depends on how individual Trusts have configured their services: some have integrated specialist SEND (Special Educational Needs and Disabilities) professionals within their fostering structures; others rely on external referral pathways. In practice, foster carers and their supervising social workers are expected to access specialist disability, therapeutic, and SEND services as part of the child's care plan. The expectation is that specialist resources are identified and built into the care plan from the outset, though children's needs evolve and additional support may need to be sought at different points in the placement.

5.3. Foster Families for Children with Disabilities and Special Care Needs

5.3.1. Short-breaks for Children with Disabilities

A distinctive and well-developed feature of Northern Ireland's system is the short-breaks programme for children with disabilities, in which assessed carers provide periodic overnight or day care for a child (typically one or more nights per month) to support the child's birth or primary family. Short-break carers are specifically approved for this role, required to complete disability awareness training, and expected to commit to a minimum availability. The HSCT manages availability and matching for short-break placements.

Children in short-break placements are visited by a social worker from the children with disabilities service every six months. CIC (Child in Care) reviews are convened every six months, bringing together all professionals involved in the child's care to agree and review the care plan.

5.3.2. Living Conditions and Home Adaptations

Foster carers are expected to provide a safe, accessible home environment. Where a child with a physical disability requires adaptations, the Trust may reimburse part of the cost, subject to prior approval. Mileage and travel expense payments are available for placement-related travel.

5.3.3. Financial Support and Disability Benefits

A child with a disability in full-time foster care receives the standard fostering allowance as well as any applicable disability benefits (Personal Independence Payment – PIP). The fostering allowance is designed to cover all costs of care. Additional discretionary payments may be approved for exceptional expenditure, provided there is evidence of need. Extra financial support and specialist fees may be provided when a child has additional or complex needs.

5.3.4. Healthcare and Coordination

Medical treatment is provided through the NHS/HSCT statutory healthcare system; foster carers do not bear medical costs. Multisectoral coordination is achieved through the CIC review process, which brings together health, education, and social services professionals on a structured six-monthly cycle.

5.3.5. Transition Planning

Preparation for leaving care begins at approximately age 16, with a transition plan developed in collaboration with the young person, their carer, and social services. For young people with disabilities, the transition to adult disability services is planned individually, with the nature and level of support determined by assessed adult need.

6. Comparative Analysis

6.1. Legislative Frameworks

The Council of Europe Recommendation CM/Rec (2025)5 on the protection of rights and best interests of the child in care proceedings is the overarching normative frame against which alternative systems can be analysed. Specifically:

- Article 76 (range of care services must be available, with understanding that a child should grow up in a family environment) maps directly onto the report's core comparative finding about tiered foster care systems
- Article 85–86 (support for foster and kinship carers, including training and special assistance for children with complex needs) directly supports the report's recommendations on training and support structures
- Article 82 (individual care plans should ensure support for transition to adulthood) supports the aftercare recommendations

All four comparator countries operate within well-developed legislative frameworks that provide clear, enforceable standards for foster care. Czechia and Lithuania have comprehensive dedicated statutes supplemented by implementing decrees and quality frameworks. Finland relies on its Child Welfare Act and Family Care Act, as well as national quality recommendations. Northern Ireland operates within the framework of the Children (NI) Order, supplemented by placement regulations and (pending) minimum standards.

6.2. Forms of Care and Professionalisation

All four countries distinguish between different tiers of foster care, ranging from informal kinship arrangements to highly professionalised, remunerated placements for children with complex needs. Lithuania's four-category model (regular, caregiver on duty, permanent caregiver, family household). Finland's commission agreement model and Czechia's distinction between state-arranged and non-arranged cases both offer mechanisms for differentiating support based on the degree of professional commitment and the complexity of the child's needs.

6.3. Assessment and Matching

All four countries use structured, multi-professional assessment processes that evaluate personal suitability, household capacity, motivation, and the specific ability to meet a particular child's needs. Notably, all four countries explicitly assess disability-specific competencies and the capacity to cooperate with specialist services.

The Czech approach of describing children through the lens of care needs rather than diagnosis during the matching process is particularly instructive. It reframes the assessment question from 'can this family manage this diagnosis' to 'can this family meet these specific care requirements'. This conceptual shift has practical implications for how matching panels operate and how foster parents are prepared.

The Lithuanian committee model, with defined representation from multiple authorities and mandatory inclusion of a training specialist, offers a governance model that is both replicable and accountable.

A key distinction across systems lies in the degree of formalisation and professionalisation of assessment processes. For example, Lithuania and Finland operate highly structured, multi-actor assessment and matching systems; the degree of formalisation varies considerably across other national contexts.

6.4. Training

International experience suggests that:

- training should be mandatory and its completion a precondition for approval; training content should routinely include disability-specific modules;
- a tiered training system should align with the tiers of care; and
- training should double as an assessment mechanism, not merely an educational exercise.

Pre-service training is mandatory in all four countries, though its format, duration, and content vary. Finland's PRIDE programme (9 to ten group sessions plus home consultations) is the most comprehensively documented, with a distinctive dual function as both educational preparation and screening tool. Lithuania's system of basic (10 sessions) plus specialised (eight sessions) modules for professional carers reflects the stepped training model appropriate for a tiered care system. Northern Ireland's 'Skills to Foster' programme is shorter and supplemented by ongoing post-approval training.

All countries provide specialised training for carers of children with disabilities. Finland integrates disability content into PRIDE as standard; Lithuania provides TBRI and MDFT training for professional carers; Northern Ireland requires disability awareness training for short-breaks carers. The Czechia couples training with mandatory continuing education of 24 hours per year, supported by access to training databases.

Finland stands out for the formalisation of professional qualifications within the statutory workforce, requiring Master's-level education for social workers exercising legal authority. In contrast, Lithuania emphasises structured training for foster carers and coordinators, but does not impose equivalent statutory qualification thresholds across all roles.

6.5. Support for Foster Families

The quality and consistency of ongoing support for foster families are key differentiators between mature and developing systems. All four countries provide:

- a named responsible professional (social worker or coordinator) for each placed child;
- structured home visiting schedules;
- access to psychological support;
- short-break care arrangements; and
- continuing training.

Lithuania's foster care centre model is particularly worth noting. Mandatory, municipality-level organisations with qualified coordinators providing intensive, fortnightly (or more frequent) support to professional foster families. Finland's use of commission agreements to contractualise support obligations creates legal certainty for both carers and authorities. Czechia's requirement for a formal support contract that includes guaranteed short-breaks, counselling, and education provides a replicable model for strengthening support structures.

A critical divergence across countries concerns the structure of professional support available to foster families. Finland operates a system of embedded multidisciplinary support through public services, where healthcare and therapeutic professionals are integrated into care planning as a matter of legal obligation. Lithuania, by contrast, operates a coordination-based model, in which foster care centres arrange access to external specialists as needed rather than embedding such expertise within teams.

This distinction has significant implications for system responsiveness: embedded models (Finland) provide greater continuity and predictability of specialist support, whereas externally coordinated models (Lithuania) offer flexibility but may introduce variability in access depending on local resources.

6.6. Financial Support

All four countries provide financial support to foster families that is at least partially calibrated to the complexity of the child's needs. The Finnish approach (fee + expense reimbursement + start-up compensation + disability supplements + Kela benefits) represents the most comprehensive and transparent financial architecture. The Czech benefits table, with clear differentiation between children's needs contributions, carer benefits, vehicle allowances, and maintenance support for care leavers, provides a model for a well-structured benefit system.

A key principle in all four countries is that children with disabilities in foster care receive disability-related benefits equivalent to those available to children in biological families. This parity principle is important for any system to adopt explicitly, as it removes a financial disincentive to placing children with disabilities in family-based care compared to institutional settings.

Lithuania's model allows foster carers to directly mobilise financial resources (allowances and municipal supplements) to purchase specialised services, creating flexibility at the level of the household. Finland, in contrast, locates responsibility for service provision within the public system, reducing reliance on individual carers to organise or finance specialised interventions.

6.7. Children with Disabilities

Across all four countries, children with disabilities are explicitly accommodated within the general foster care system, with enhanced support structures rather than a separate system. None of the four countries operates a completely separate 'disability foster care' track. Rather, standard foster care is made more robust and better-resourced to accommodate disabilities. This integrated approach aligns with the CRPD and reflects the broader value position that children with disabilities should be part of mainstream family and community life. It also reflects the normative direction set by the Council of Europe Recommendation CM/Rec(2010)2 on deinstitutionalisation and community living of children with disabilities, which calls on member States to replace institutional care with community and family-based alternatives and to ensure that children with disabilities grow up in inclusive home environments: the approaches documented in Czechia, Finland, Lithuania, and Northern Ireland represent national implementations of that standard, not merely domestic policy choices.

Key mechanisms that enable this include:

- enhanced financial compensation;
- home adaptation funding;
- access to disability-specific rehabilitation and healthcare;
- specialist training for carers; stronger case management; and
- public awareness campaigns that specifically address the needs of children with disabilities.

Lithuania's permanent caregiver category, explicitly designed for children with severe disabilities, provides the closest model to a 'specialised' category, but it remains within the overall foster care legal framework.

The comparative evidence suggests a graduated approach for systems at earlier stages of development:

1. invest in training and financial support to create the conditions for disability-inclusive foster care within the existing system;

2. develop professional foster care tiers analogous to Lithuania's permanent caregiver model;

3. build the case-management and intersectoral-coordination infrastructure that all four comparator countries have demonstrated is essential.

6.8. Workforce, Caseloads, and Coordination Infrastructure

The data presented in this report's country chapters enables a direct comparison of the workforce architecture underpinning foster care systems in Czechia and Northern Ireland, and of the structural coordination infrastructure in Lithuania.

In Czechia, foster care is supported by a three-tier professional workforce. At the municipal level, 2 755 staff are employed in child welfare, of whom 586 are assigned to foster care duties (recruitment, placement participation, and supervision) and 177 manage active foster care agreements. The maximum caseload per child protection worker is set at 40 families by the national quality standard — a ratio that provides a concrete benchmark for reform. Regional authorities deploy a further 52 staff specifically on foster care across 14 regional offices. A third tier of 238 authorised organisations (CSOs and certified individuals) provides direct support, counselling, and psychological assessment to foster families under mandatory support contracts. At present, 10 900 active foster care agreements are in place, and a further 6 800 children are registered for placement. Disability-specialist roles are not separately mandated in law; instead, the system relies on continuing professional development aligned to individual training plans to build specialist competencies within generalist teams.

Lithuania's model represents the most clearly specified coordination infrastructure of the four countries. Since 2018, mandatory foster care centres operate in every municipality, each appointing a qualified coordinator to every case. The coordinator is required to conduct a comprehensive assessment within 30 days of placement, prepare a Support Plan, and maintain contact with the family at least fortnightly — or one to two times weekly for cases requiring intensive support. Coordinators must hold a degree in social work, social pedagogy, psychology, or education. This infrastructure ensures that all cases, including those involving children with complex disabilities, are accompanied by structured, qualified case management as a legal entitlement rather than a discretionary provision.

Northern Ireland's system is defined by a structural separation between two distinct social work roles: the child's social worker (responsible for the child's overall care journey) and the fostering social worker (responsible for supporting and supervising the foster carer). This mandatory split — which applies across the five HSC Trusts — ensures that neither the child's interests nor the carer's support needs are subordinated to the other. Caseloads are not set by a single national standard but are governed by Trust-level targets and professional registration requirements administered by the Northern Ireland Social Care Council (NISCC). Dedicated disability specialist roles within fostering teams are not mandated; specialist SEND expertise is integrated differently across Trusts, with some embedding multi-agency disability specialists in their fostering structures and others relying on external referral pathways through the child's care plan.

Taken together, these models point to three workforce-related conclusions of wider relevance for foster care system development:

1. A defined maximum caseload ratio – such as Czechia's standard of 40 families per worker – is an essential precondition for quality case management; without it, support obligations become unenforceable in practice.

2. The Lithuanian model of mandatory, qualified coordinators in every municipality provides a replicable structural model for establishing community-level foster care infrastructure.

3. The Northern Ireland principle of separating responsibility for the child's care journey from responsibility for the carer's support is a structural safeguard that protects both children and carers.

6.9. Aftercare and Transition to Adulthood

All four countries extend support beyond the age of 18, recognising that young people leaving foster care are particularly vulnerable. Finland's aftercare system (to age 23) and Lithuania's Transition Service (to age 24 for care leavers in education) represent the most developed models. Northern Ireland's GEMS scheme (to age 21) and the Czech maintenance allowance (for students) provide additional models.

While all systems recognise the importance of transition support, Finland demonstrates the strongest integration of ongoing social and health services beyond placement, whereas Lithuania relies more on general social support frameworks rather than a distinct extended foster care model.

Across the four countries, the international evidence strongly suggests that: care leavers should be entitled to continued support until at least age 21; young people with disabilities should receive ongoing support through adult disability services without a gap; and carers should have incentives to maintain relationships with young adults post-18.

6.10. Processes and procedures

Here, we present a structured articulation of the core processes and procedures underpinning a functional foster care system, derived from several country examples and identify key commonalities. It is designed to complement the comparative analysis (below) by translating system components into a step-by-step operational pathway, clarifying how decisions are made, by whom, and in what sequence. The matrix below sets out:

- the procedural stages of foster care delivery;
- the specific steps required at each stage;
- the responsible actors;
- the expected outputs and documentation.

Together, these elements define the operational logic. This section focuses explicitly on how the system functions in practice, providing a procedural model that can inform the development of standard operating procedures, service standards, and implementation guidance. This matrix demonstrates that a foster care

system is not only a set of services, but a sequence of interlinked procedures. The effectiveness of the system depends not only on the availability of services, but on the clarity, consistency, and enforceability of the processes governing how children move through it. Across all stages of the foster care pathway, a consistent set of procedural requirements underpins the effective functioning of the system. These include clearly defined roles and responsibilities for each actor at every stage, ensuring that accountability and decision-making authority are unambiguous. The process is further guided by time-bound service standards, with specified timelines for key actions such as intake, assessment, and periodic review, promoting timeliness and consistency in service delivery.

Robust documentation and record-keeping are integral throughout, enabling continuity of care, transparency, and effective monitoring. All actions and decisions are anchored in a child-centred approach, with the best interests of the child serving as the primary consideration in every stage of the process. Given the multi-sectoral nature of foster care, structured intersectoral coordination mechanisms are essential, ensuring that services across social protection, health, education, and other relevant sectors are effectively aligned.

Finally, the system incorporates deliberate adaptations to respond to the specific needs of children with disabilities and those with complex care needs, ensuring that procedures, services, and support arrangements are appropriately tailored to their circumstances.

Core Foster Care Processes and Procedures				
Stage	**Purpose**	**Key Procedural Steps**	**Responsible Actors**	**Outputs / Documentation**
1. Referral & Intake	Identify and register children requiring alternative care	– Receive referral from authorised source – Conduct initial screening (within 24h) – Assess urgency and risk – Decide on emergency placement (if required) – Register case – Assign responsible case worker	Services for Children; police; health; education; CSWs	Case record; risk classification; intake decision; assignment of case responsibility
2. Assessment & Best Interests Determination	Determine necessity and type of placement based on child's needs	– Conduct comprehensive assessment (child + family) – Assess protection risks, disability, psychosocial needs – Convene multidisciplinary review (for complex cases) – Undertake Best Interests Determination (BID) – Develop Individual Care Plan – Issue formal placement decision	Services for Children (lead); CSWs; multidisciplinary actors	Assessment report; BID record; Individual Care Plan; placement decision
3. Carer Recruitment, Assessment & Approval	Ensure availability of suitable, trained foster carers	–	Services for Children; CSWs; training providers	Approved carer profile; assessment report; defined capacity; registration record

4. Matching & Placement	Ensure appropriate and stable placement aligned with child's needs	- Match child with suitable carer - Share relevant information with carer - Prepare child (where feasible) – Approve placement decision – Sign placement agreement – Initiate placement – Provide initial support and monitoring	Services for Children; CSWs; multidisciplinary actors	Placement agreement; updated care plan; placement record; initial monitoring plan
5. Case Management, Monitoring & Support	Ensure quality of care, placement stability, and child wellbeing	– Assign case coordinator – Conduct regular home visits (minimum standard) – Implement and update care plan – Coordinate services (health, education, disability support) – Provide supervision and support to carers – Facilitate multidisciplinary coordination – Maintain case documentation	CSWs (lead); Services for Children; multidisciplinary actors	Case notes; monitoring reports; updated care plans; service coordination records
6. Review, Transition & Aftercare	Ensure ongoing appropriateness of placement and long-term outcomes	– Conduct periodic case reviews (e.g. every six months) – Reassess child's needs and placement stability – Decide on permanency pathway – Develop transition plan (from age 14+) – Provide aftercare support (education, housing, mentoring) – Ensure continuity of services, including disability support	Services for Children; CSWs; multidisciplinary actors	Review reports; transition plan; aftercare plan; final case outcomes

The comparison table below sets out the core procedural elements of a functional foster care system, drawing on the country analyses above. It illustrates that many of the core structural elements required for an effective procedural framework, including defined institutional roles, multidisciplinary coordination mechanisms, and established care modalities. However, these elements are not yet translated into a fully articulated procedural system. In particular:

- Processes are present but not standardised;
- Roles are defined but not operationalised;
- Steps are implied but not sequenced;
- Standards are identified but not formalised.

In practical terms, the system functions, but relies heavily on professional discretion rather than codified procedures.

7. Summary Comparative Table

The table below provides a high-level comparison of key system parameters across Czechia, Finland, Lithuania and Northern Ireland. It is designed as a practical reference tool for policy makers and practitioners.

Parameter	Czechia	Finland	Lithuania	N. Ireland
Principal Legislation	SLPCA 359/1999; Civil Code; Social Services Act 108/2006	Child Welfare Act; Family Care Act 263/2015	Civil Code; Law on Social Services; SCRPAS oversight	Children (NI) Order 1995; Fostering Placement Regulations
National Quality Standard	Yes; implementing decree & SIP standards	Yes; national quality recommendation (non-binding)	Yes; legal acts & foster centre model	Draft Fostering Minimum Standards (pending)
Forms of Foster Care	Temporary (≤12m); long-term (arranged); long-term (non-arranged); guardianship; adoption; institutional	Ordinary; professional; short-term (one–14 days/ month)	Regular; caregiver on duty; permanent caregiver; household; community home	Short-term; long-term; kinship; emergency; short-breaks; specialist; GEMS
Professional Foster Care	State-arranged long-term with full support package	Professional family care (trained, qualified carers)	Yes; caregiver on duty & permanent caregiver (salaried)	Fee-paid specialist placements (self-employed)
Mandatory Pre-Service Training	Yes; 48h (foster/ adoption); 72h (temporary)	Yes; PRIDE programme (~nine–10 sessions)	Yes; basic (10 sessions) & specialist (eight sessions) for professional carers	Yes; Skills to Foster (three sessions)
Training as Assessment Tool	Partial; psychological assessment separate	Yes; PRIDE instructors assess suitability	Yes; preparation specialist issues readiness report	Partial; broader assessment determines suitability
Specialist Disability Training	Included in general training; enhanced support for carers of disabled children	Mandatory disability modules in PRIDE; additional specialist training	TBRI; MDFT; ≥16h/ year ongoing CPD	Disability awareness training required for short-break carers
Max Children per Family	Typically four (incl. own); exceptions possible	four standard; six (two qualified carers); seven professional	three regular; three CoD; one (four total) permanent; eight household	three (statutory); exceptions for siblings or panel approval
Financial Compensation	Care fee + needs contribution + one-off custody grant + vehicle allowance; disability supplements	Care fee ≥€966/ month + expense reimbursement ≥€501/month + start-up ≤€3 559	Salary (professional); guardianship allowance; targeted supplements for disability	Fostering allowance (all); fee payments for complex/specialist placements
Disability Financial Parity	Enhanced needs contribution for disabled children; disability supplement for carer	Needs-based & Kela disability benefits equivalent to other family types	Yes; identical disability benefits as in biological family	Yes; PIP + fostering allowance; possibly more than in biological family

Parameter	Czechia	Finland	Lithuania	N. Ireland
Home Adaptation Funding	Not explicitly regulated; varies	Yes; funded by county based on assessed needs	Varies by municipality; targeted financial or in-kind support	Possible Trust reimbursement; prior approval required
Short-break Care	two weeks/year guaranteed in support contract	Legal entitlement; county arranges substitute care	Short-break (two nights/two months); crisis short-break (≤two weeks+); work ability restoration (30 days)	Agreed in contract for fee-paid carers; limited for others
Case Management	Support contract required; home visits ≥ every two months; monitoring ≥ every three–six months	Designated social worker; individual care plan; multidisciplinary coordination	Foster Care Centre mandatory; coordinator visits ≥ fortnightly (intensive); quarterly supervision	Supervising social worker; CIC reviews every six months; visits every 28 days (full-time)
Post-18 Support	Maintenance allowance while studying; may remain in foster care	Aftercare (*jälkihuolto*) to age 23; majority remain with foster family	Salary continuation to age 24 (if in education); Transition Service to age 24	GEMS scheme to age 21; 14+ leaving care service
Monitoring Body	Regional SLPCA authority; national oversight	Wellbeing services county; National Licensing and Supervision Agency	Foster Care Centre & State Child Rights Protection and Adoption Service	HSC Trust; BAAF assessment framework; Fostering Panel
Children with Disabilities in Foster Care	~850 in foster care; ~500 in institutional care (2024); strong upward trend	No separate category; integrated within standard and professional care with enhanced support	All four care forms can accommodate disabled children; permanent caregiver explicitly designed for complex needs	Short-breaks specifically designed for disabled children; general foster care with enhanced support
Workforce & Caseloads	2 755 municipal staff; 586 on foster care duties; 177 managing agreements; max 40 families/worker (quality standard); 238 authorised organisations	Commission agreements with Wellbeing Services Counties; no single national caseload standard; workforce governed by county; Master's degree in social work required for statutory decision-making roles; Statutory maximum of 30 children per social worker; Statutory obligation for supervision, coaching, and professional development	Foster care coordinator per case (mandatory); qualified to degree level; fortnightly minimum contact; municipal-funded; Degree in social work/related field required for coordinators; no uniform national requirement equivalent to Finland; External specialist engagement coordinated by foster care centres; Supervision recommended; CPD required	Mandatory dual-role model: child's SW + fostering SW separate; caseloads set by Trust targets; NISCC professional registration; Degree-based

Parameter	Czechia	Finland	Lithuania	N. Ireland
Coordination Infrastructure	Three-tier: municipal child protection + regional authority + 238 authorised NGOs; 10 900 active agreements; specialist competencies via CPD	Wellbeing services counties; National Licensing and Supervision Agency (*Valvira*); no mandatory municipal foster care centres	Foster care centres in every municipality since 2018; legal mandate; coordinator within 30 days of placement; structured support plan	Five HSC Trusts; CIC review process for multisectoral coordination; no mandatory disability specialist roles in fostering teams

7.1. Key Considerations for Governments Planning to Strengthen Foster Care for Children with Disabilities

The considerations below are consistent with the Council of Europe Recommendation CM/Rec(2025)5 on the protection of the rights and best interests of the child in care proceedings (2025), which affirms that placement in alternative care should be a measure of last resort, that a range of family-based care options should be available, and that care providers, including foster parents, should receive structured support tailored to the individual needs of the child. Drawing on the comparative analysis, the following good practices emerge for consideration:

- **Adopt the International Classification of Alternative Care of Children (ICare), endorsed by the UN Statistical Commission in March 2026**. **Aligning** data collection and reporting systems with the standardised definitions for alternative care, kinship care, and foster care, and applying them consistently across placement types, would enable disaggregated data collection by care form, child characteristics, and disability status. Thus generating the robust, comparable evidence base that effective planning, monitoring, and reform evaluation require. Without this foundation, children with complex care needs and disabilities will remain invisible to the system that is meant to serve them;
- **Consider establishing a tiered foster care framework** with a professional foster care category specifically designed for children with complex needs and disabilities, such as Lithuania's permanent caregiver model, with defined salary, caseload limits, and enhanced training requirements. This recommendation is grounded in the Council of Europe Recommendation CM/Rec(2010)2 on deinstitutionalisation and community living of children with disabilities, which requires member states to replace institutional care with family-based alternatives and to develop foster care as the primary setting in which children with disabilities grow up;
- **Develop and legislate a national quality standard for foster care**, establishing minimum requirements for assessment, training, support, monitoring, and financial compensation, drawing on the Czech and Finnish models. Consider reviewing legislation to ensure that children's right to family-based care is not subordinated to the retention of parental rights where those rights are not being exercised in practice. Where parents retain legal rights but are not providing care, a legal mechanism should be established to enable foster placement without requiring full deprivation of parental rights, balancing family reunification goals with the child's right to grow up in a family environment;
- **Develop a dedicated short-break foster care programme** specifically for children with disabilities, drawing on Northern Ireland's model, in which assessed carers provide periodic overnight or day placements to support birth or primary families. This model is a proven tool for preventing family breakdown and reducing the flow of children with disabilities into full-time institutional care, and its relative simplicity makes it an accessible early-stage reform for developing systems;
- **Make pre-service training mandatory as a precondition for foster carer approval**, and include complex needs and disability-specific content as a standard module. Ensure training functions as a dual assessment and preparation tool, as in the Finnish PRIDE programme;
- **Introduce a formal support contract model** requiring all placed children to have a named case coordinator, structured home visiting schedules, and guaranteed respite, on an example of the Czech and Lithuanian models;[8]
- **Establish municipal-level foster care support centres** (or strengthen existing structures) to provide mandatory, qualified case coordination for all foster families, as Lithuania has done since 2018;

8. See also Articles 78–81 of CM/Rec (2025)5, which require an individual care plan for every child in alternative care, periodically reviewed using a multidisciplinary approach.

- **Create a legal and financial framework for home adaptations**, assistive devices, and specialised transport for foster families caring for children with disabilities;
- **Develop a systematic aftercare framework** that provides continued support to care leavers through at least age 21, with seamless continuation of disability services into adulthood for those unable to live independently;
- **Invest in public awareness campaigns** that raise awareness of foster care for children with complex needs, including disabilities, drawing on Czech campaign models, including individual child campaigns and social media outreach;
- **Ensure structured and accountable multidisciplinary case reviews** are the standard mechanism for intersectoral coordination between health, education, and social protection.

7.2. Supplementary Technical-Operational Considerations

- **Workforce Professionalisation**: Establish statutory qualification requirements for child protection social workers such as Finland's model (Master's-level for decision-making roles), supported by tiered roles (e.g. social instructors) to ensure both legal robustness and operational delivery capacity;
- **Caseload Regulation**: Introduce nationally defined caseload standards (benchmark: 25–30 cases; lower for complex placements), embedded in secondary legislation and linked to service accreditation;
- **Specialist Support Model**: Prioritise the development of an embedded multidisciplinary support model for complex cases (health, mental health, disability), while allowing interim coordinated access models where workforce capacity is limited;
- **Foster Care Coordination Infrastructure**: Scale municipal-level coordination units (similar to Lithuania's foster care centres) with clearly defined staffing structures, roles, and accountability frameworks;
- **Financing of Specialised Support**: Separate core foster care payments from specialised service funding to avoid reliance on carers to procure essential therapeutic services;
- **Supervision and Workforce Wellbeing**: Introduce mandatory supervision and structured professional coaching systems, including psychosocial risk management and burnout prevention mechanisms;
- **Mixed Service Delivery Model**: Develop a regulated mixed model combining public provision with contracted CSO/private services, while maintaining strong statutory control over decision-making and quality assurance;
- **Transition and Aftercare**: Establish structured aftercare frameworks extending beyond age 18, integrating housing, education, employment, and mental health support.

PREMS 163926

ENG

www.coe.int

The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

COUNCIL OF EUROPE

CONSEIL DE L'EUROPE