A set of Methodological Guidelines for the Regional Social Assistance Structures

CASE MANAGEMENT

PRACTICAL GUIDE

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PARTNERSHIPS FOR EVERY CHILD

Government of the
Republic of Moldova

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CASE MANAGEMENT

PRACTICAL GUIDE

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This guide includes instructions that describe the case management procedure for social services addressed to children and families and provides a set of unified forms that will be used in the work with users of social care services.

This guide is part of a series of methodological materials developed to support the professionals in the field of social assistance:

- Implementation of the foster care service. Practical guide.
- Organization and operation of the Commission for the Protection of the Child in Difficulty (*Gate-Keeping Commission*). Practical guide.
- Mechanism of professional supervision in social assistance. Practical guide.
- Case management. Practical guide.
- Implementation of the Support to Families with Children Social Service. Practical guide.

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INTRODUCTION

This guide is designed for social workers employed in the social services addressed to families and children. The guide contains a standard version of the case management methodology that is unified and basic for all social services used by all social workers involved in the provision of social assistance services. In this version, the case management methodology focuses on family strengthening and the development of family's competences, with the ultimate aim of achieving every child's well-being.

This integration of working methodology is a key element in the context of the integrated social service system. It will create the prerequisites for implementation of the referral mechanism. Ultimately, the "itinerary" of the child/case throughout the network of (alternative, placement, day-care) social services will not require every service to start the assessment from the scratch – the primary information collected at the community level will be used instead.

According to the case management methodology, the work with the case of the child and the family/the child's case starts in the community, with the initial and complex assessment, development and implementation of the Individual Assistance Plan (hereinafter IAP). These tasks are usually fulfilled by the community social worker[1]. When the case is referred to other specialized services (where necessary), the child's case will be referred to these services with an extract from the case file that was opened in the community, and the specialized service will continue working with the case using the information received from the community, adding information on the child in the specialized service. Upon the child's return to the community, the child's case file will contain an extract from the specialized service with recommendations for further work and monitoring methods; this extract will be inserted in the child's case file opened at the community level, and the community social worker will continue handling the case file in line with the recommendations or will work in parallel with the family during the child's stay in the specialized service.

Consequently, each community social worker will keep the child's case file that they initiated and worked on and will be able to demonstrate the work done. Every specialized service, in its turn, will keep the child's case file filled in within the specialized service and will be able to demonstrate the carried out interventions. Thus, the child's case file will reflect all the interventions of various services that had been delivered to the child and their family. This will ensure the continuity of case work in an integrated social service system.

This way, the case management methodology can be completed and adapted to the specifics of a specialized service, by extending the assessment and intervention indicators. At the same time, the baseline where the social assistance service delivery starts is standard case management described in this guideline, adapted to the child's well-being indicators and family protective factors.

Any specialist who has ever used the case management knows how complicated and often difficult this method is. In relatively "ordinary" situations and in emergencies, such as high risk, physical violence, sexual violence, psychosocial stress, family separation – the interventions are complex and imply very high responsibility. Social workers work under great pressure: the number of child protection cases is high, problems have various aspects, social assistance staff is often overloaded with work and the resources are often limited. Careful assessment and professional support from cooperating institutions (education, health, public order) and child social protection structures considerably increase the child's chances to be safe and to enjoy adequate conditions of development and education.

[1] In the Moldovan Social Assistance system, a *social worker (*qualified) is called "asistent social" (social assistant), while a *home carer* (not qualified) is called "lucrător social" (social worker). For the purpose of this Guide, the term *social worker* will be used to denote the specialist called in Moldova "*asistent social"*, and the term *care worker* will be used to denote "lucrător social".

This guide has been developed to ensure the implementation of quality standards for case management-based social services. The guide intends to provide advice on the case management methodology, aiming to ensure the child's well-being by strengthening their family. The guide promotes the idea of a coordinated and shared approach, using a common language shared by all professionals to identify concerns, needs assessment, approve actions and monitor the results, based on the child's well-being indicators. This approach places the child in the center of the intervention, providing a child-friendly language and focusing on common case management procedures that are used by all social services addressed to the child and their family.

This version of the case management methodology does not intend to formulate new tasks for social workers; on the contrary, it provides specific and useful information and guidelines for a more qualitative fulfillment of professional duties. At the same time, the practical information found in this guide represents a resource for a more efficient support that the specialists can provide together to children and their families.

The guide contains two parts: the first describes the general concept of case management methodology, as a key methodology of social work, while the second part presents a description of the use of standard methodology at all stages of case management.

I. CASE MANAGEMENT – KEY METHOD OF WORK IN SOCIAL CARE

1.1 General concepts of case management

What is case management?

Case management is the key work method used by the social worker and involves the child and family needs assessment in collaboration with the beneficiaries, the coordination, monitoring, and support for the beneficiary's access to social, education, healthcare, etc., services that meet their needs.

Case management is a method of organization and implementation of professional activity, offering individual approach to the child and their family in an adequate and systematic manner, at the right time, through direct support or referral, in line with the planned objectives.

Case management, as an approach, can also be used in the prevention or primary intervention programs.

Key points in the use of case management:

- It is focused on the individual needs of the child and their family, making sure that the problems are systematically addressed and is based on the family's ability to be resilient.
- The services are provided in line with the stages of the case management, with the child's participation and giving responsibilities to the family throughout the entire process of intervention.
- The coordinated involvement of services is ensured, support is provided and the necessary referrals are made – everything as part of an integrated system.
- The case manager makes sure that decisions are made in the best interest of the child; that the case is handled in line with the existing procedures and facilitates the coordination of the actions of all the professionals/stakeholders.
- All case managers are made accountable, in line with the regulatory and legal framework.

The use of case management depends on the number of social assistance services available at the community and regional level that can be recommended to beneficiaries. With adequate training and supervision, the case manager can tackle a variety of aspects focused on prevention and protection of the child, can collaborate with services and resources available in other sectors (education, health, public order) to compensate certain drawbacks, but can also involve the civil society in this process.

1.2 Fundamental principles of case management

The principles of case management that underpin the behavior and interaction with the child and the family during the case work are:

Do not harm. This principle ensures that all actions and interventions aimed at supporting the child and their family do not expose them to danger. At each stage of case management, the case manager should make sure that their behavior, decisions and actions made on behalf of the beneficiary do not harm the child or their family. In addition, the case manager should make sure that the collection, storage and sharing of data on the child, the family or their situation, does not expose them to other risks related to the use of personal data.

The child's best interest is paramount. This includes the child's wellbeing, physical and emotional safety and their right to positive development. In line with Article 3 of the UN Child's Rights Convention, the child's best interest should inform all decisions and actions made on his/her behalf; the social services providers should also pay attention to the way they interact with the child and their family. Social workers and service managers should constantly assess risks that "threat" the child's wellbeing, as well as the resources existing in the child's environment, but also the positive and/or negative consequences of actions (or inaction), to discuss them with the child and their

parents/carers when decisions affecting them are made. The best plan of assistance is the one preferred by the beneficiary. All actions should make sure the child's right to safety and development is not violated.

This principle should guide all decisions made during the case management process. There is often no "single ideal solution" for child protection, but rather there are series of choices that are more or less acceptable (for example, institutionalization) that should be balanced with the child's interest.

Non-discrimination

Adherence to the principle of non-discrimination means that the child is not discriminated (maltreated or denied access to the necessary service) due to individual characteristics or membership to a specific social group (for example, sex, age, social-economic situation, religion, ethnic background, disability). Children who need protection services should receive support from social services and qualified and trained social workers able to generate respect and non-discriminating relations with beneficiaries, to treat them with compassion, empathy and care.

Respect for ethical standards. Social workers should be aware that prevention or intervention activities must exclude discrimination, including practices that consolidate discrimination (preconceptions, negative language, subjectivism). Respecting professional ethical standards (Social Worker's Code of Ethics, Annex 8) will help the staff working with children and families provide qualitative services.

Asking for informed agreement/consent. This is the voluntary agreement of a person capable of giving own consent who makes free and informed choice. The informed consent is the expressed willingness to receive a service. In all cases, the consent of the child and their parents should be sought prior to providing them a social service.

To ensure informed consent, the social worker should make sure the child and the family fully understand the following: the available services and options, the potential risks and benefits of the received social services, the data that will be collected about the situation of the child and their family and the way it will be used, in the limits of confidentiality. The case manager should communicate with the child in a friendly manner and encourage them and their family to ask questions and seek answers that will help them to make the right decisions about their own situation (some recommendations related to informed consent are presented in Annex 9). Even for very young children (those under 5), efforts should be made to explain in an adequate language what information is sought, how it will be used and shared.

In certain situations, informed consent may be missing or denied. However, child protection interventions are necessary. For example, in case when a teenage girl is sexually abused by her father, it may happen that, because of loyalty to her father, she may not want any punitive action to be taken against him. However, this does not mean that the abuse that has occurred or is occurring can be ignored. When consent cannot be obtained and the relevant professionals and structures have the legal mandate to take action to protect the child, the child should be explained the reasons why such actions are taken and the participation of the child and other (non-violent) family members should be constantly encouraged.

Confidentiality. Confidentiality refers to sharing information and is based on the need to know. "The need to know" should be correlated with the limitation of information considered to be sensitive, and sharing it **only** with persons who need this information for their work on the particular child's protection. Any sensitive information collected on the situation of the child should be shared only based on the principle of the need to know and with as few persons as possible.

Observing the confidentiality forces the service provider to protect the collected data about the beneficiary in order to make sure that it can be shared only with the beneficiary's consent. For the case manager this means that data on individual cases is collected, stored and exchanged in a safe manner and in line with personal data protection policies/rules established by each organization/service. This involves a lot of vigilance concerning the storage of individual case files in

safe places, the non-disclosure of names and personal data of the child/family members and avoidance of informal conversations with curious colleagues.

Remember:

Confidentiality can be limited/broken when the case manager identifies problems related to the safety of the child or when it becomes necessary to contact other professionals (such as the health worker or police officer) or when they are required by law to report a crime (following the Guidelines on the inter-agency cooperation mechanism for identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation and trafficking – Government Decision No. 270 of 08.08.2014).

These limits should be explained to children and parents during the case work whenever this is necessary. In such cases, the case manager should closely collaborate with the representatives of law enforcement structures and with the mayor of the community in order to make decisions on the cases when the principle of confidentiality can be "broken".

Persons who unreasonably broke the principle of confidentiality may be called to account for incorrect actions, results of those actions, and for inaction.

Empowering of the child and family based on capacity development and existing resources. All children and their families have certain potential of resources and competences to help themselves and to individually identify solutions to their problems. The case manager should work with the families and children, where possible, motivating them to get involved and to play an active role in the entire process: at the stages of assessment and planning, seeking the opinions of beneficiaries and stimulating their capacity to build upon their own strengths and existing resources thus contributing to the development of their capacity of taking care of themselves (being resilient).

Children's understanding of resilience

Resilience is influenced by environmental aspects and factors that allow a child to recover and develop positively, in spite of adversities and traumatizing experiences. There are a series of internal and external factors that may contribute to the development of increased resilience, such as: good relation with parents/carers, good parenting skills, presence of educational opportunities and social relations. The positive interaction with the case manager may be a factor increasing a child's resilience. Resilient children show higher levels of self-confidence, self-appreciation and feeling of control over their life. The case manager can support and strengthen the child's feeling of control over their life and develop basic resilience, facilitating child participation based on the family's strengths and resources, acting with respect, care and empathy.

Justifying all intervention activities by the knowledge about child development, child rights and child protection (child's development at various stages of life, understanding vulnerability, risk factors, family dynamics, etc.) The knowledge about the child's rights helps the case manager to shape their involvement and communication with the child, depending on the child's age and capacity.

Facilitating child participation. The child has the right to opinion concerning their own experiences and the right to participation in decisions that affect their life. It is the social worker's responsibility to inform the child about their right to participate, including about their right not to answer delicate questions, and to demand the fulfillment of this right throughout the entire process of case management. The participation of the child in decision-making is in the child's interest. However, some decisions need to be taken even if they are against the child's will (for example, taking the child away from an abusive family). In such cases, the social worker should explain to the child the need of making such decisions, with care and empathy. The involvement of the child and the family into the planning and making decisions related to the proposed care services is essential, to make sure that they are adequate and efficient, and contribute to the development of the child and their capacity of being agent of their own protection.

It is important to know that a child's decision-making ability depends on the child's age, maturity, capacity, and level of development. Even a very young child can participate in decision-making, although this may take more time and require more skills from the social worker, to establish a relation with the child and support them express their views. The child has the right to be informed adequately, so that they can understand what is happening throughout the entire process of case management. The case manager is responsible for creating a safe and confidential environment for children so that they can participate in their own situation and encourage other children to express own opinions through various methods (games, drawings, conversations).

Coordination and collaboration. Child protection activities are more effective when organizations, structures and professionals work in collaboration and involve communities, families and children in joint efforts. The case manager contributes to the improved coordination and collaboration between all stakeholders in charge with child protection, including community leaders, departments, service providers, local NGOs. Standard work procedures, agreements on information exchange, procedures of cooperation contribute to the quality of the case management and make sure that the child's best interest and confidentiality are respected.

Observing the legal and regulatory framework on compulsory reporting. The Instructions on the inter-agency cooperation mechanism for the identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation and trafficking (Government Decision No. 270 of 08.04.2014) set out the requirements for stakeholders (community social workers, social workers employed by social services, teachers, nurses and doctors, police) on the compulsory reporting of cases of abuse, neglect, trafficking and exploitation of children to the local guardianship authority. These requirements may be challenging for social workers, when the information is sensitive and concerns may arise regarding the child's security and safety. Each service, organization and structure working with children should have its own child protection policies that must be respected at any time.

It has been mentioned that case management must not necessarily be applied in all situations related to children and their families. Case management involves considerable effort, time and resources, which may lead to the loss of clear understanding of situations and of the context and existing resources.

Table 1. Conditions for the use of case management

Case management is necessary when:	Case management is not recommended when:
The child's needs are affected or there is a risk that they may be affected and there is need for specialized individual intervention to meet the child's needs and to ensure necessary protection. There is need of support that will include short-term, mid-term or long-term actions. The intervention is focused on the individual rather than on the general community.	The support is concentrated on the child's fundamental needs, such as education, health, etc. (for example, distribution of food products, systematic medical checks, etc.) and is delivered within prevention activities. The contact between the social worker and the family will be limited to one or two sessions. The problem is transferred to other structures/organizations and is handled rapidly. There is no assumption that the child may need planned long-term intervention. There are already other services/procedures in place for solving the existing problems. In case the interventions and programs planned to be applied focus on groups rather than on concrete child and/or family.

1.3 Risks associated with the use of case management

When a case file is opened, the benefits for the child, family and community must be considered, as well as the **eventual risks associated with the use of case management:**

- It should be taken into consideration that children may be exposed to risks during the collection of data on the case. Depending on the sensitivity of the information and its relevance for case handling, the decision is made which information is necessary and what kind of data is irrelevant. The IAP should include methods of reducing risks the child and their family may be exposed to where confidentiality of information cannot be ensured. At the same time, every social service should have rules describing the conditions and duration of work on the case, protocols on information exchange between organizations/services, procedures for data/information processing mechanisms in the case of a service/organization closure.

  Sometimes, in the case management process, unintended consequences may occur, when there are no sufficient services in place for involvement and referral at local level. In such situations, the existing services (especially, residential) may appear as a "factor of attraction" that may lead, for example, to the child's separation from family and placement in those services, especially, when it is considered that the child may be provided better care in residential services. This should be considered and dealt with, in line with the "do not harm" principle.

- Case management may also create certain risks for the staff. Social services managers should pay attention to the safety and security of their staff. This may include rules reducing risks and guaranteeing security when, for example, the case manager makes home visits to families that face the risk of violence, to families with members who have mental health issues, aggressive families, or alcohol/drug-addicted families. In such cases, the social service managers should make sure the case manager does not perform such visits alone.

In order to carry out the initial and complex assessment, rapid needs assessment in emergency situations, recommend social services, map families with children in difficulty in certain communities, the difference between **vulnerability** and **risk** for children must be understood.

Difference between vulnerability and risk

Vulnerability and risk are not the same, but are closely related.

Vulnerability refers to physical, social, economical, and environmental factors that increase the susceptibility/predisposition of a child to protection problems and other threats and difficulties. Vulnerability factors may include: lack of parental care, disability or migration of parents, poverty, etc.

Risk indicates the probability that the threats related to internal (family and personality) and external (social environment) factors occur in combination with the existing vulnerabilities and all these can worsen the situation of the child and the family and create dangers that might require protection actions. Risk assessment requires a careful analysis of the entire situation of the child and family.

The case manager should be capable to assess the entire situation of the child and their family and determine the real risk level. At the same time, they should understand that the risk can grow and intensify. All these are necessary to differentiate cases that require more or less intense intervention or solutions planned in time.

Levels of risk to the child's wellbeing (based on parental skills and child's situation)

Imminent/high risk:

- the child is in imminent life danger, which may heavily impact their physical and/or psychic condition, is exposed to physical and/or sexual abuse, intense or long-lasting emotional abuse, trafficking, or is at risk of disease or death if left in their current circumstances without intervention of protection and even separation from family, as the last resort;
- the parent is not in control of own life, does not have plans for the future, feels desperate, worried, furious and this may affect the child physically and emotionally; is not involved in community groups, does not communicate and does not receive support from other persons, does not have knowledge about the child's development and about parenting roles, does not communicate and does not spend time with the child, is negatively predisposed and unhappy, cannot control own emotions, is isolated and retreated.

Medium risk:

- the child is in danger of getting into difficulty if they are left without an efficient plan of intervention and protection; there is a risk of separation from the family; there is no information that the child's life and health are in danger, the child's mood is flexible/changing;
- the parent is not in control of crisis and emergency situation, has difficulties in identifying own strengths and necessary resources, often feels unhappy, unhappy with life, frustrated, furious, which may affect their parental skills; does not take part in social groups, has few persons to seek support from when necessary, wants to know about the child's development, faces difficulties while establishing relations with the child, difficulties to come out of negative emotional conditions, has limited relations with other persons.

Low risk:

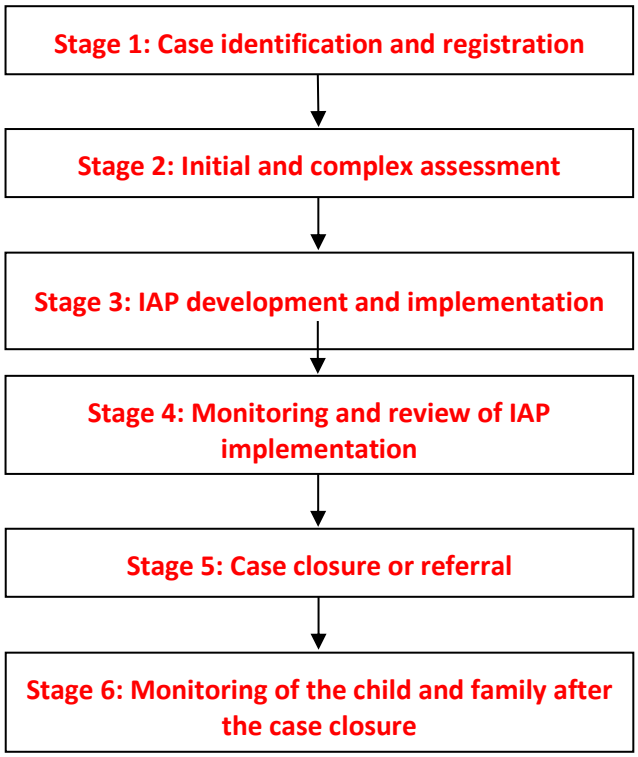
- The child lives in safe conditions; nevertheless, there are certain concerns that the child might be exposed to risk in case prevention and support services are not provided, with a focus on strengthening parents' knowledge and skills related to the child's upbringing, education, development and protection (for example, primary family support service, group activities for children/parents, awareness activities for parents, etc.); the child is generally positive and happy, can develop relations with other persons, can talk about own emotions;
- the parent is mostly in control and knows how and where to get support, has plans for the future, is happy with life, calm, in control of the child in various situations, has social relations and receives support when in need, knows how and where to get more information about child development, establishes contact and spends time in activities with the child, knows how to use resources available in the community, has sufficient income to provide the necessary conditions for the family.

The level of risk should also be determined in relation to immediate, short-term and mid-term harmful effect on the child. For example, certain forms of abuse, like emotional abuse, have lower short-term and mid-term impact, but can be highly harmful for the child in the long term.

II. STANDARD METHODOLOGY OF USING THE CASE MANAGEMENT

Case management follows a set of actions to identify and meet the needs of children and families in difficulty. Although it does not equally apply to every child, case management generally contains the following steps:

1. Case identification and registration,
2. Initial and complex assessment,
3. IAP development and implementation,
4. Monitoring and review of IAP implementation,
5. Case closure or referral,
6. Monitoring of the child and family after the case closure



2.1. Case identification and registration

This is a process of identification of the child/family in difficulty conducted by the community social worker and the child protection specialist, in active cooperation with the community members and professionals from community-based institutions: mayor's office, school, kindergarten, police, family doctor, NGOs, etc. This work can be also done by the social workers from community and specialized social services for children and families. To facilitate this process, the community social worker should have well-established and efficient collaboration relations with these stakeholders.

There is a variety of sources of identification of potential beneficiaries: direct reporting by children, families, relatives; identification by community social workers and child's rights protection specialists in mayor's offices; identification by social workers from various community and specialized social services; referrals from various structures, institutions, community members, etc.

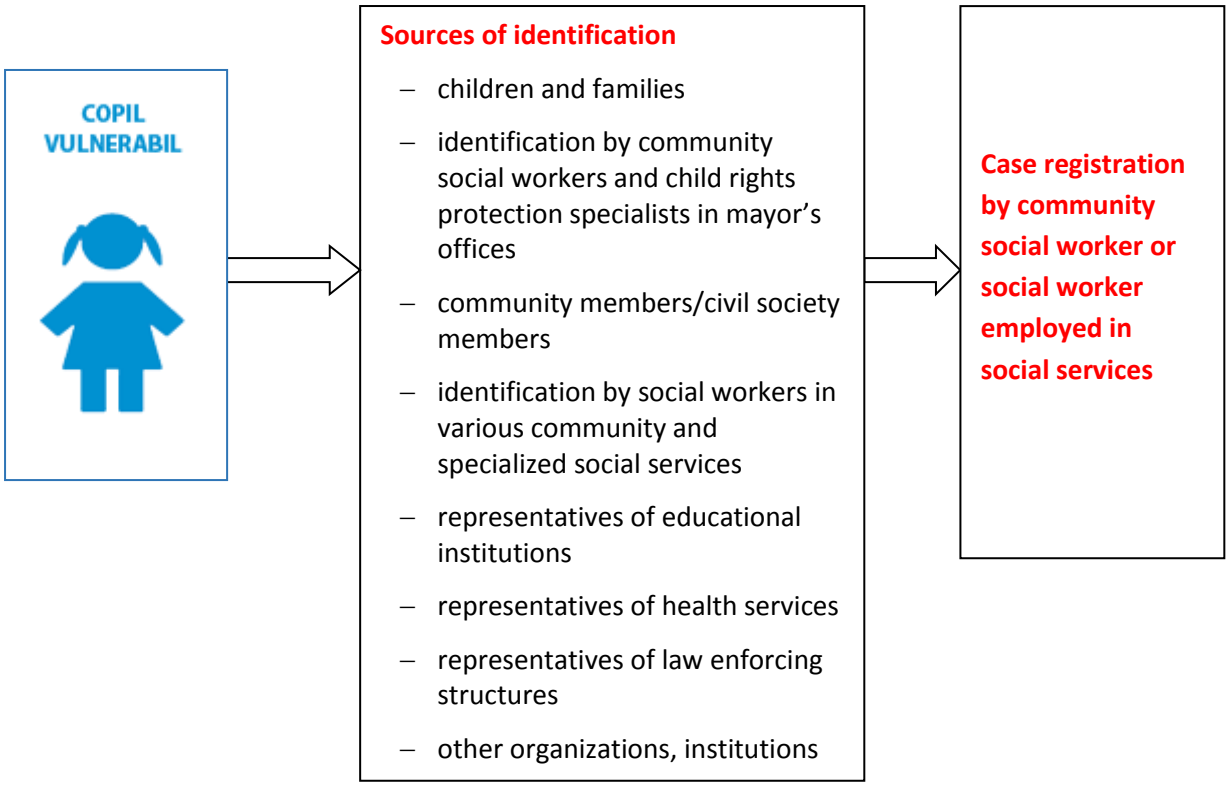


Image 1. Case identification sources

Cases may also be identified by representatives of educational, health, cultural, public order institutions/organizations, state labor inspection, other authorities and institutions that are in direct contact with children and families. **In cases where child violence, neglect, exploitation and trafficking is suspected, they must:**

a) register reports of other persons on cases suspected of child violence, neglect, exploitation and trafficking and/or self-identified cases of suspected child violence, neglect, exploitation and trafficking (hereinafter, suspected cases), applying sector procedures (according to the Instructions on the inter-agency mechanism of cooperation for the identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation and trafficking – Government Decision No. 270 of 08.04.2014);

b) to inform immediately, by telephone, the local guardianship authority and send to the guardianship authority, within 24 hours, the Report on the case of suspected child violence, neglect, exploitation and trafficking (hereinafter, Report). The Report shall be filled with the data available at the moment of case identification, namely, based on the information communicated by the source of suspected case report. The missing information shall be collected by the community social worker during the initial assessment.

The identified or referred cases are reported by the community social worker/child rights protection specialist employed in the mayor's office, or by the social worker in the specialized social service in line with the procedures of the service. The community social worker registers the identified case in the register, indicating the basic information about the person and defining the problem according to the information received from the person. The registration includes key information about the child and their family, indicating the problem reported by them.

Thus, the information on the cases that present concerns or risks for the child may come from completely different sources (a community member, practitioner, service, organization, structure), and from both administrative levels (community and district). Regardless of the source and channel of information reporting, it shall be checked and completed during the assessment conducted at community level by the community social worker and child's rights protection specialist of the mayor's office involving, where necessary, the multidisciplinary team.

By informing and raising the awareness of the community on the suspected cases of difficulty and risk, the community social worker increases the process of identification of potential beneficiaries and their access to social services.

2.2. Initial and complex assessment

Assessment is a process of data collection and analysis, aimed at forming professional opinion about the situation of the child and his/her family.

There are two types of assessment: initial assessment and complex assessment assessment. The assessments have separate forms: initial assessment of the child and complex assessment of the child and of the family. This guide also presents the social questionnaire form for material support (Annex 7).

To facilitate the filling of the forms, most of the information required in the form is filled in by ticking. The forms also contain narrative description to maintain the qualitative element of assessment.

The initial assessment is normally conducted by the community social worker and the child protection specialist employed by the mayor's office. In certain cases, other professionals can be involved as well. The complex assessment of the child and family can also be done by the community social worker and the mayor's office child's rights protection specialist, but also by representatives of specialized social services delivered to the child and their family. The following standard forms are recommended for these assessments: initial assessment (Annex 1) and complex assessment of the child and family (Annex 2). Specialized services can also adapt or extend the standard form of complex assessment in order to collect necessary information, to tackle specific situations and problems.

There may be situations (with high risk for the child), when initial assessment is not necessary, and the decision is taken to make the complex assessment from the very beginning.

Regardless of the type of assessment, it should include the same basic stages:

1. planning of the assessment (deciding when and how the assessment will be made);
2. data collection (what type of information will be collected, how the information is going to be collected and recorded);
3. verification of the information, in case when there are information discrepancies, the data will be incomplete or contradictory; during the data check, the social worker should identify contradicting information and try to eliminate ambiguities, through cross-checking (using more information sources);
4. data analysis (to what extent the collected information reflects the situation of the family and the child, their needs and what kind (if any) of risk exists;

5 key questions every social worker needs to answer when making the assessment:

1. What prevents the child's wellbeing?
2. Do I have all the necessary information to help this child and their family?
3. What can I do now to help this child and their family?
4. What can the structure/service I represent do to help this child and their family?
5. What additional support may be needed from other specialists, services or organizations?

Initial assessment of the child

The initial assessment is made:

i) based on the order of the local guardianship authority, or

ii) following the identification and registration of the case by the community social worker or by the child rights protection specialist employed in the mayor's office.

The initial assessment is made by the community social worker and/or the child rights protection specialist employed in the mayor's office. When needed, the local guardianship authority may decide to include health, education, public order, etc., specialists in the initial assessment.

In the case when violence, neglect, exploitation, or trafficking is reported, and if the report contains information about the existence of imminent danger for the child, the initial assessment should be performed immediately; in other cases it should be carried out within 24 hours (Government Decision No. 270 of 08.04.2014). For other cases, the initial assessment is made within 10 days (in line with Art. 16 of the Law of Social Services No. 123 of 18.06.2010). Practice shows that in milder cases, the primary information about the child and his/her family's situation is often collected during the registration of the case.

The initial assessment should primarily focus on the immediate needs of protection: physical health and basic safety, including food, accommodation, healthcare.

In situations when child abuse is suspected, the community social worker and/or the child rights protection specialist employed in the mayor's office should hold a protection interview with the child during the initial assessment, involving, if necessary, other relevant specialists to solve problems related to health, emotional condition, or other major relevant issues, such as suspected abuse and other children in the family (according to the Instruction on the cross-agency cooperation mechanism for the identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation and trafficking (Government Decision No. 270 of 08.04.2014). In situations when child abuse is suspected, and when the local guardianship authority or the community social worker is not available, the initial assessment is carried out by a specialist from other sector, who identified the case or to whom the case was reported, with further submission of the information to relevant persons within 48 hours.

Initial assessment of the child is done in a standard form (Annex 1).

The main information blocks completed by the community social worker or the mayoralty's child's rights protection specialist include:

I. General data about the child and his/her family: name of the child, parents/carers, address of the child's location, child's home address (if different from the location), and phone number. The source of information (to be ticked): asking for information (support), self-identification, report form, institution, authority, specialist, physical entity that reported the case.

II. Reason for initial assessment. This indicates (by ticking) the child's wellbeing indicators: safe, healthy, achieving, nurtured, active, respected, responsible, included for which concerns were reported, based on the information contained in the report prior to the family visit.

III. Data about persons living together with the child at the moment of assessment. Along with personal data, relation to the child should be indicated, or other type of relation, and current occupation. All this data is collected in discussions with the adult/adults and the child.

IV. Information reflecting concerns related to the child's wellbeing (safe, healthy, achieving, nurtured, active, respected, responsible, included), identified by the community social worker/ child's rights protection specialist in the mayoralty, based on observations and discussions with adults and the child. This entry provides blank space where the community social worker/child's rights protection specialist can mention details or explanations if relevant. Details may extend or

describe the concern. For example, the community social worker may draw attention to the child's aspect, that is, whether the child looks clean and has clothes that correspond to the weather or season. Those details may be indicated in the special details box. Or, if the child is of school age, but does not attend school, this may raise concerns, consequently, this should be reflected in the details box.

V. Other comments. The community social worker/specialist in child's rights protection of the mayoralty indicates here any other relevant information that in their opinion has not been reflected elsewhere in the assessment form. This information may be collected from observations and discussions with the child and members of their family.

VI. Conclusions and recommendations following the initial data analysis that contains necessary interventions in the child's and family's situation. The recommended interventions imply:

- Child's emergency removal from the family and initiation of the child's case;
- Maintaining the child in the family, removing the aggressor, issuing a restraining order and opening the child's case file;
- Opening the child's case file;
- Providing social assistance within the primary family support service;
- Case closure if it is considered that no other actions are necessary.

Recommendations upon the results of initial assessment should correlate with the level of risk identified for each child. Based on the established risk level, the case will be attributed a level of priority to make sure he or she is treated accordingly and in relevant time. To justify the actions proposed in the conclusions and recommendation indicated in the initial assessment form, descriptions from the table below can be used.

Table 2. Planning based on level of the risk for the child

Level of risk	Description	Intervention and term
Imminent/high risk	The child needs urgent medical treatment, it is likely that he or she may be severely harmed or wounded, exposed to sexual abuse; is a child with disabilities, trafficked, or at risk of dying, is left in actual circumstances without intervention of protection.	Interventions (the child's or the abuser's removal) is done immediately after the identification of the child at imminent risk. The case is immediately reported to the local guardianship authority within 24 hours.
Medium risk	There are concerns that a child is harmed and there is no efficient intervention plan to ensure protection. The intervention is justified. However, there is no proof that the child is in imminent risk of severe harm or death.	Intervention takes place once the individual assistance plan is developed.
Low risk	The housing provides safety to the child. However, there are concerns related to possible danger for the child, in case if prevention services are not provided to remove the need of a protection intervention.	Actions are not limited in time, and are taken upon need.

During the initial assessment, the case manager states not only immediate risks faced by the child and his/her family, but also has to identify their strengths, existing resources, and necessary protection intervention. Initial assessment data provides background for further decision-making.

Special attention is paid to how the initial assessment occurs and to the child's and their family's involvement, because this is the primary opportunity for the community social worker to develop a positive relation with them. During the initial assessment, the community social worker needs to apply child-friendly interviewing skills, taking into account the child's age, to ensure the child's inclusion into the process. This is the first occasion for the community social worker to establish a relation with the child and the family that, will determine essential part of direct services provided within the case management process.

At the end of initial assessment, the fields with names and parent's/carer's signature are filled, as well as other fields indicating the name, position, date, signature of the person/persons who participated in the assessment process (if relevant).

After the initial assessment of the child, the community social worker and the child's rights protection specialist in the mayoralty, depending on the collected information (confirmed concerns, risk and degree of case complexity), may decide on:

- Referral of the case to ensure **child protection**, where imminent danger for the child's life and health is shown, or the child is not in safety and is victim of violence, abuse, exploitation, and there is risk of the child's separation from family. In this situation, action shall be taken in line with the Instruction on the inter-agency cooperation mechanism for the identification, assessment, referral, assistance, and monitoring of children victims and potential victims of violence, neglect, exploitation, and trafficking (Government Decision No. 270 of 08.04.2014).
- Providing **secondary family support**, where it is stated that the problem is determined by poverty, poor housing condition, social isolation of the family, while the parents express attachment to the child. The information on the provided family support is reflected in the child's case file.

In outstandingly difficult cases, the community social worker may consult and coordinate further necessary activities and actions with the supervisor, head of community social assistance, specialists of the Territorial Social Assistance Structure (hereinafter, TSAS).

Complex assessment

Complex assessment follows the initial assessment and offers a complex and deeper insight in the situation of the child and their family. Complex assessment looks beyond the immediate fundamental needs of a child. It should consider not only risks and hazardous/harmful factors, but also identify the strengths of the child, family, community environment, and necessary protection factors.

The period of complex assessment is stipulated in the Regulation of the social service. The complex assessment should be finished within at most 10 days (according to Art. 17 (2) of the Social Services Law No. 123 of 18.06.2010).

Complex assessment is done by the community social worker and the mayoralty's child's rights protection specialist, as well as by social workers from specialized social services involved in the child's and the family's case – where they become case managers. Taking into account the variety of aspects for the complex assessment, the participation of the multi-disciplinary team in this process is compulsory (Art. 20 (b) of the Law of special protection of children at risk and of children separated from parents, No. 140 of 14.06.2013). The membership of the multi-disciplinary team will vary in every separate case, depending on the specifics of the problem faced by the child and their family.

Complex assessment is recorded in a special form, in line with the case management methodology (Annex 2). Every specialized social assistance service may extend this form, adapting it to the area of provided services and required information.

The information sources for the complex assessment may vary and include: assessment data provided by community social workers or child's rights protection specialist of the mayoralty, assessment data provided by TSAS specialists as a result of referrals, reports/available information

on the child, observations and interviews with the child and family, discussions with the representatives of other organizations, specialists who know the situation of the child, assessments made by specialized social services practitioners. This data may be collected using various tools, including discussions, interviews, home visits, checklists, activities, question forms, special tools, etc. The purpose of the complex assessment is to identify the needs of the child and his/her family, in order to determine necessary interventions.

The approach based on the identification of the child's and family's needs, rather than identification of necessary services, is especially efficient when the community support resources are limited. The child's needs require support and encourage solution seeking, which is not based only on locally existing services. Using only the locally available services is a risk, as it may lead to providing the child and the family with irrelevant services, rather than meeting their real needs.

The standard complex assessment form contains two parts: complex assessment of the child's situation, and complex assessment of the child's family. This form requires additional information not contained in the initial assessment, or new information, related to the changes produced in the child's and family's situation since the initial assessment was made. The child's complex assessment is made for every child separately, while the family's complex assessment can be common for a bigger number of children in this concrete family.

A. Complex assessment of the child's family includes (Annex 2, Part A):

- ***Block 1 – General information*** about the child; requires the following information: name, date of birth, child's gender, address at the moment of assessment, IDNP/Number of the birth certificate (in case if IDNP is missing), or, mentioning of the fact that this data is missing. This information block also requires the specification of the child's status (temporary left without parental care, without parental care, separated from parents in the result of migration, separated from parents in the result of imminent danger, undefined status, or statement that this information request is not applicable).
- ***Block 2 – data on the child's contact with universal services*** (universal services are basic services that should be available to all children) – information is requested on the existing situation and previous experiences of contact with sectors: education, health, social assistance, public order structures, other organizations, such as NGOs, church, etc.

  As for the information related to the educational system, data is requested on the currently attended educational institution (and those attended previously), form, name of class teacher/educator, and for children with special educational needs (hereinafter, SEN) – the type of inclusive education (total, partial, home education, or not attending), name of support teacher, date when the Individual Educational Plan was written. Attendance and reason of changing the educational institution may point to a risk related to multiple changes and adaptation to new school environments, which may cause stress and trauma to the child.

  The health system compartment requires data on the medical institution where the child was registered – family doctor/nurse, other relevant specialized doctors, their contact information, and the latest consultation (date, reason). In addition, the reason why the child is not registered with the doctor is required, if applicable. As for previous experiences of health system contacts, information is requested on severe health issues, treatment provided to the child and term of ambulatory and rehabilitation treatment provided, if any.

  The compartment of social assistance system requires information of social services and payments currently provided to the child, name of the community social worker and/or child's rights protection specialist from the mayoralty. Information is requested on previous experiences of social services and payments afforded, if any, to the child and their family, and how these changed their situation. If applicable, information about the child's current separation from the biological family, and previous experiences of separation, is important for the case manager. This data

should include information about the currently or previously service provided to the child (Foster Care, Family-Type Home, guardianship, residential care). To facilitate the enumeration of social services provided to the child and his/her family, the social worker can use the Index of Social Services included into Annex 13.

The box related to public order structures requests information whether or not the child is currently registered with law-enforcement structures, name, contact data of the chief officer, and previous experiences of the child's contact with the law-enforcement structures.

The information to be included into this block of the form may be collected from different sources: discussions with the child and his/her parents/carers, existing documents analysis (medical card, other), interviews with local level representatives of the relevant structures (family doctor/nurse, class teacher/educator, chief officer, representatives of other organizations), and upon the request of the case manager or the local guardianship authority. To make an integral picture of the child's situation, the specialists appointed by local structures may be contacted individually or invited to the multi-disciplinary group meeting.

- ***Block 3 – areas of child's wellbeing*** – requests information on the 8 indicators of child's wellbeing.

The case manager should evaluate each area of child's wellbeing, based on the indicators reflecting those areas. The case manager appreciates each indicator included into the assessment form, according to three levels: yes – if the indicator is fulfilled, no – if the indicator is absent, and partially, if the indicator is present only in certain situations and aspects. When the response is NO or PARTIALLY, details are requested, to better understand the child's situation.

The case manager does not need special knowledge and competences to appreciate the level of implementation of every indicator of child's wellbeing, they may rely on own fundamental professional knowledge, experience, and possibility to consult relevant specialists on aspects that show difficulties. For example, the family doctor/nurse may be consulted on aspects of the child's health; school achievements may be consulted with the teaching staff, etc. The case manager only states concerns related to each indicator of wellbeing, while the identification of the risk level (imminent/high, or medium) will be done by the members of the multi-disciplinary team who will meet to discuss the concerns and the assessment data of the given case.

Details required for the complex assessment of the child's wellbeing indicators:

- Safe - evaluates the safety of the child's living conditions, school/kindergarten, community, existing conditions of security for the child with disabilities, and presence of a child's reference person to rely for help.
- Healthy – evaluates the conditions for physical and emotional health of the child, personal hygiene, adequate food and meals times, treatment in case of disability of chronic disease. Where necessary, recommendations are made for consultation with the family doctor/nurse.
- Achieving – examines the child's results in various activities, existing conditions for development and learning, the child's capacity to tackle problems, the degree of being prepared for independent life (depending on the child's age and potential). The assessment of this indicator does not require special techniques, and rather represents general appreciation of the indicator, based on the knowledge of general norms for each age and achievements of the child.
- Nurtured – appreciates the child's attachments, the parents'/carers' affection for the child, existence of a person to whom the child could talk, the child's appearance, etc. This information can be gathered in discussion with the child, observing the child's appearance and behavior, and the child's relations with the family members.
- Active – is evaluated by collecting information about the child's leisure activities, possibility to achieve interests and capacities, participation in family events and activities outside the

family, balance between learning/leisure/household responsibilities. Conclusion on this aspect does not require a calculation of the time invested to each type of activity, but only the statement of the child's participation in various activities (depending on the child's age and possibilities).

- Respected – examines the presence of self-respect with the child, respect from other persons in contact with the child (children and adults), whether the child's opinion is consulted in the family/school/community. The case manager collects this information in discussions/observations whether the child feels important, listened to, treated as individuality.
- Responsible – states whether the child assumes responsibility for own actions, has responsibilities in the family, is able to makes the difference between what is good and what is bad.
- Included – evaluates if the child communicates with peers/adults/colleagues, participates in community events, whether the child, including that with SEN, is integrated into the educational process. This information can be collected in discussions with the class teacher, parents/carers.

To collect data on the child's wellbeing, the case manager is mainly informed from the discussion with the child, parents, specialists (if relevant, the support teacher/class teacher/educator, nurse, family doctor, etc.). The case manager observes the following: whether the child feels important, listened to, treated as individuality; the child's appearance, relations with the family/carers, other children, etc.

For the complex assessment of the areas of child's wellbeing, the case manager can use the child self-assessment tool: the Table "Profile of child's well-being areas" (Annex 12). Using this tool, the child is asked to rank 1-10 the way they feel in different life situations. The tool offers to the child a description of each wellbeing indicator, to provide a better understanding of the situation. The result of the collected data is presented graphically in the form of a star, which will ensure better visual perception of the level of each wellbeing indicator in the child's understanding. This data can be confronted/compared with the information collected from adults – parents/carers, different specialists. This will help to remove the element of subjectivism and to formulate clear conclusions that also take into consideration the child's opinion.

- ***Block 4. Statements in the result of assessment*** – this is the most important structural element of the form of complex assessment of the child's situation. The case manager formulates here the child's needs for each wellbeing indicator identified in the result of the complex assessment. The child's needs results from the identified concerns related to the most important aspects of the child's life that cannot be currently met and require a different intervention. To formulate the statements based on the result of assessment, indicators for each wellbeing indicator are used. Correct formulation of the child's needs is the starting point in the IAP development.

  This informational block also reflects the actions taken for the child by the family, universal services, and the community prior to the complex assessment, and the way those actions influenced the child's situation.

  All child's strengths and weaknesses are reflected, as identified during the assessment and analysis of the collected information. The strengths show us the child's knowledge, skills, and abilities that help them to achieve and develop new competences. The child's identified strengths represent the foundation that will base the intervention planning and implementation during the casework, aiming to reduce the weaknesses/shortcomings. Examples of child's strengths may be: curiosity, child's activism as feature of behaviour, insistence and courage as features of character, desire to attend school, capacity to set relations with peers, etc. Weaknesses show that the child does not know, cannot achieve, or has shortcomings / characteristics that are missing or that can make

his/her progress more difficult. Weaknesses usually represent the aspect that should become the primary focus in the child's development and education. Examples of the child's weaknesses may be: incapacity to establish and maintain relations with peers, traumatizing experiences in the childhood, fear of speaking about own feelings and experiences, reluctance to attend school/kindergarten, etc.

To facilitate the process of the child's strengths and weaknesses identification, the case manager can use graphic presentation showed in the image below. The tool "My world triangle" describes three aspects of the child's life: the child's development and results achieved; aspect that reflects the child's social environment; and the aspect reflecting the support needed from the child's carers (presenting the contents for each aspect).

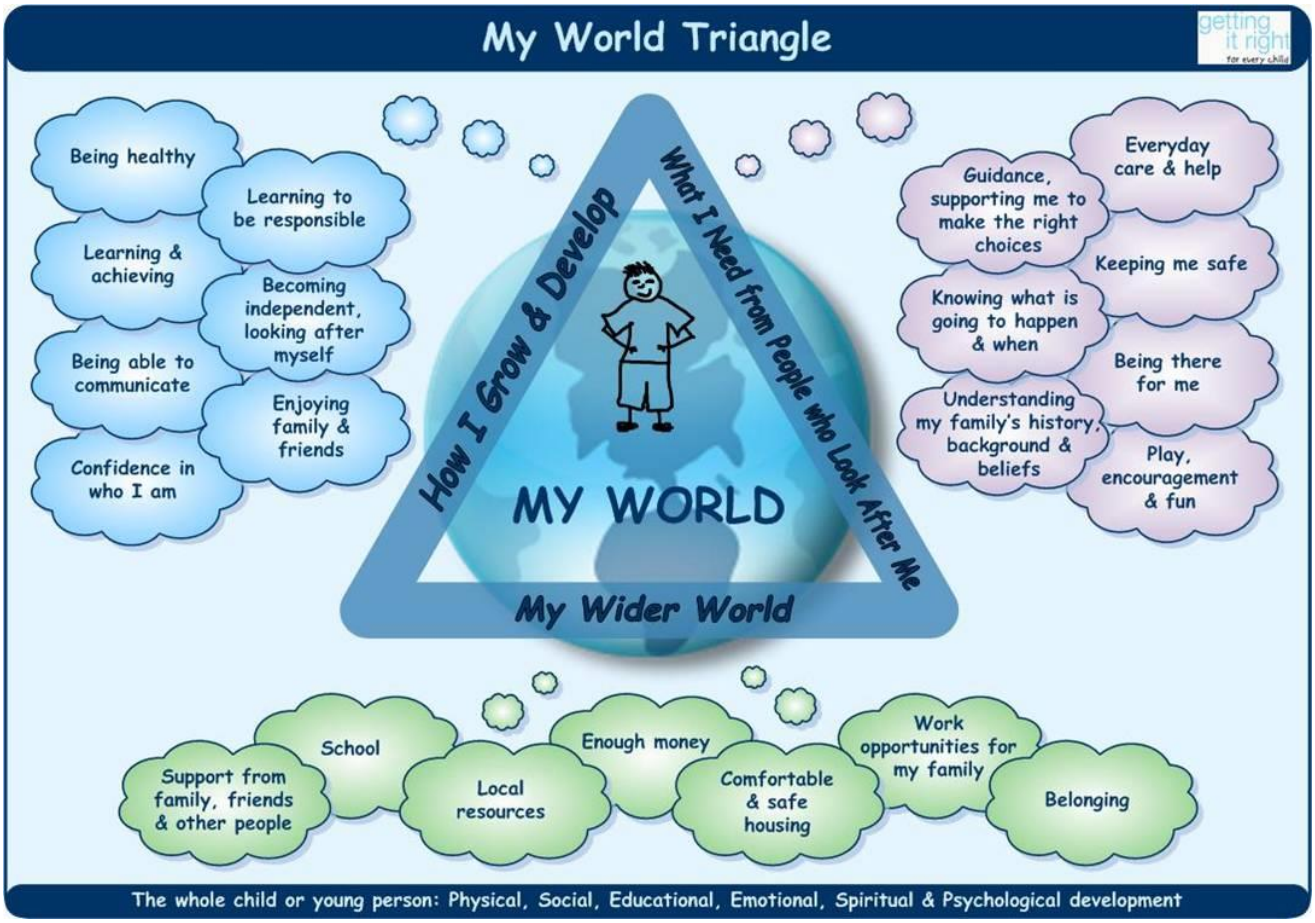


Image 2. "My world triangle".

This assessment tool helps the case manager to describe the child's situation, to focus on the child's well-being areas (see the indicators reflected in the clouds on the left side of the triangle. The family's situation is described with special focus on parenting skills that ensure protective environment to the child and favor his/her care and development (see indicators reflected in the clouds on the right side of the triangle). This assessment also needs to identify the family's support network, support resources at the community level (see the indicators reflected in the clouds on the bottom side of the triangle). The majority of the mentioned indicators are formulated from the child's perspective, which facilitates a better understanding of their situation.

The child's and the family's opinion about current situation will help to avoid the case manager's subjectivism while appreciating the child's situation and assessing the conditions and relations in the child's family. For example, the living conditions in a family may be seen as acceptable by the family members but be inacceptable to the case manager who visits this family. This is a difference in perceptions, life standards, and conditions seen as the accepted minimum. In this context, the situation as seen/appreciated by the child and his/her family is important to the case manager.

Participation of children in the assessment process

It is difficult to collect all information within only one session with the child. A small child or one in difficulty may need several meetings to feel comfortable enough in order to offer information, or it may take him/her some time to remember certain situations.

The case manager should use a variety of techniques (such as drawing, story-telling, unfinished sentences, etc.) to collect as much information as possible from the child, and in a way that makes him/her feel comfortable. Communicating with the child, the case manager should use clear and simple language, notions/words adequate to the child's age, and to make sure that the assessment is taking place in child-safe environment. The child should understand why they are being asked about certain things and how that information will be used. The case manager should explain the child that the information about the child will not be used without the child's or his/her parents'/carers' consent. While the child should be encouraged to participate and talk, he/she should not be put under pressure to do so, threatened, or punished if refuses to talk.

During the complex assessments, the child's wishes and preferences should be identified and considered, when decisions are made that concern him/her directly. This does not mean that the adults must do anything the child wants – this is the adult's responsibility to protect and promote the child's high interest – but the child, even if does not agree, should be helped to understand what was decided and how this decision was achieved.

- ***Block 5. The child's vision of their current situation and Block 6. The parents'/carers' vision of the child's current situation*** – their opinion is sought on the information reflected in the complex assessment data. This information helps to remove eventual discrepancies in the perception of the housing, family relations, the child's appearance, etc. Most of discrepancies may exist in the understanding and/or interpretation of the child's needs. All these may be determined by subjective views, influence of the case manager's personal and professional experiences. Some examples of the child's opinion about own situation: child X likes staying at home, is not respected by classmates, does not make part of a group, which makes him dislike going to school; child Z loves staying in the family of his temporary carer, but wants to meet his mom more often (the situation is real for children separated from family environment and placed in various forms of temporary protection).

  The time required for a complex assessment will vary, depending on the context and on the child's individual needs. Too hurried assessment may cause ignoring of important information. On the other hand, if the assessment requires too much time, this means that the child might continue to be at risk.

B. Complex assessment of the family includes (Annex 2, B):

- ***Block 1 – general data about the child's family*** (this information is also collected for the family that has the child in care, in the case when the child is not staying with his biological family) – type of family (biological, extended, third persons taking care of the child); family's status (complete by marriage, complete by concubine relations, incomplete by divorce/separation, incomplete by death of one of the parents, lonely mother), social assistance that was previously provided to the family (social services, social payments), description of problems faced by the family. The family's problems might include unemployment, substance abuse (alcohol, drugs), domestic violence, health issues of the parents, dependency on social assistance, contact with the public order system, indicating the reason, and other problems. Dependency on social assistance points to the family's incapacity to organize independent life style, to distribute own incomes, to plan expenses, incapacity to overcome everyday difficulties. These shortcomings will constitute the object of the case manager's work on the family strengthening tasks.
- ***Block 2 – family members*** (including persons who live together with the family). This information includes standard data (name, IDNP, date of birth), and details like type of relation of each family member to the child and their current occupation (if this is a student, then the name of the educational institution should be specified, if the person is employed, then the place of employment is indicated; or, whether is unemployed and registered with the employment structure, etc.). The information is collected during interviews with the family and by examining the confirming documents.
- ***Block 3 – other relevant persons in contact with the child*** who do not currently live with the child. This block requires general data about these persons (name, IDNP, date of birth), and the degree or other type of relation to the child, description of current occupation. In the context when many parents are employed abroad and maintain systematic relations with their children, using information technologies and phone connections, these contacts play an important role to the child and cannot be ignored during complex assessment. The information is collected within discussions with the child and family members, studying the confirming documents (if available).
- ***Block 4 - Housing conditions and the family's wellbeing*** – information is requested about the availability of housing, its condition and utilities, family's income, etc. This kind of information can only be collected during a home visit. The description of the accommodation also includes the assessment of living conditions necessary for the child (play area, space for homework), conditions that determine physical and hygiene effort (heating, electricity, housing equipment). Assessment of the living conditions is a very important aspect of assessment. However, this data needs to be correlated with other aspect of the family's life, such as relations, atmosphere in the family, communication with the child. In some cases, good living conditions may be stated, but these may be combined with neglect, violence to the child, and vice-versa. While describing the family's income, all possible sources of income are mentioned: salaries, pensions, payments, remittances, occasional incomes. It should be also stated whether the family has enough income to pay the utility bills (electricity, gas, etc.)

  To complete this informational block, the description of the family should be provided, providing information about the evolution of the biological family and the child, important events in the life of the family, crises experienced by the family in the past that influenced the child's development (relations, trauma events), analysis of the prevailing psycho-emotional condition of the family, description of relations in the family (harmonious relations, mutual support, spending time together, etc.). This information helps to formulate a statement about the family's wellbeing. To collect this information, the case manager can use various assessment tools recommended in the specialized literature (Annex 11). All information collected in this block helps to understand the relations within the family, the effects of trauma experienced by the family, and the way these experiences may influence the development of the child and the parental skills in the present.

- ***<u>Block 5 – Assessment of the protective factors of the family in which the child is growing</u>*** – provides information on the five family protective factors that, if strengthened, will help to ensure the child's well-being. The case manager should tick the response that reflects best the family's situation, according to each assessed factor. Three versions of response are proposed: Yes, No, Partially. The response "Yes" refers to situations when the capacity being assessed is expressed in all cases. "No" means that it is not present in any situation, or is totally absent, and the response "Partially" shows that the parenting skills being assessment are present only in some situations, or partially. Indicators for each family factor are separated for the mother and the father, which suggests that there may be situations where these skills are different. This information will be useful for the panning of the work with the parents, specifying the parent's gender and the developed skills.

The first family protective factor: Family Resilience

In the process of parental resilience assessment, the case manager should pay attention to the family's capacity of understanding its role in overcoming difficulties, in making constructive decisions about the life of the family as a whole, in analyzing past traumatic experiences and the way they affect their present; capacity of understanding and controlling stress, their role as parents, etc. The case manager's role is to make sure the involvement of the multidisciplinary team in the complex assessment of the family is as constructive as possible, and that the parents do not have doubts about their own capacities, otherwise it could considerably undermine the family resilience.

What should be evaluated in the case of parents/carers:

- Does the parent/carer have skills to solve everyday problems?
- Does the parent/carer have capacities to face stress, to control own emotions in stressful situations?
- Does the parent/carer have capacities not to allow stress influence their role as a parent?
- Does the parent/carer have self-care strategies to maintain own housing/household in good order?
- Does the parent/carer have capacities to seek and require support?
- Does the parent/carer have capacities to plan and manage the family budget?
- Does the parent/carer have capacities to recognize and require treatment in case of dependency (alcohol, drug)?
- Is the parent/carer motivated to seek employment, subsistence sources?

Additional questions that could be asked to the parent/carer:

- What helps you to cope with every-day life?
- Where do you get strength?
- How does this help you to raise and educate your children?
- Do you have a dream for yourself and a dream for your family?
- What concerns, shortcomings, failures do you struggle with every day? How do you solve them?
- How do you manage to accomplish the children's needs when you are under stress?
- How does your spouse help you?
- If you are under stress, what helps you most to relax?
- What do you do to take care of yourself when you are under stress?
- How do you manage to live with the income you have?

The information collected will help the case manager to formulate conclusions about the family's resilience, capacity to cope with problems, to appreciate the risk level related to the parental resilience, focusing on the main indicators of resilience. It should be mentioned that the information collected should be reflected in the conclusions for each family protective factor.

Table 3. Risk levels for parental resilience

Risk level	Functioning/Capacity to cope with	Identifying objectives/tasks	Emotional well-being	Capacity to control stress
High risk	The family often feels overwhelmed by the fact that they cannot control things	The family cannot think about future plans for the moment	The family feels so despaired that this can affect all its members	The family often feels anxious, tensioned, furious for losing control of the situation, and worries that this could harm the child physically or emotionally
Medium risk	When in emergency or crisis, the family has difficulties identifying its strengths and resources that could help them.	The family wishes to think about the future, but does not have specific objectives or plans	The family often feels unsatisfied with life, and this affects all its members	The family often feels anxious, tensioned, furious for losing control of the situation, and worries that this could affect their parental skills
Low risk / stability	The family can identify own strengths and use resources that help them to cope with crisis or emergency	The family has goals/objectives and progresses towards them	Although the family could have certain frustrations, they do not affect its members	Even though parenting skills are sometimes challenging, the family generally feels they are in control of the situation
No risk / safety	The family mostly feels they are in control of the situation, know where and how to get support when in need	The family understands objectives/goals for the future and can adjust them, if necessary, to successfully realize their plans	The family enjoys life	The family feels they are calm and in control of their own children in any situation

For the first protective factor, the case manager must formulate conclusions regarding the family's capacity to face problems (parental resilience).

The second family protective factor: Social support network of the family

For the assessment of the family's capacity to establish contacts and social connections, the case manager should state whether the family has a social support network and seeks the support in this social circle, whether the family is in anxiety or depression that prevents them from developing healthy social relations, whether the parents require and accept support from other persons, organizations.

What needs to be evaluated with parents/carers:

- Does the parent/carer have support relations developed with one or more persons (friends, relatives, neighbours, community, religious organization, etc.)?
- Can the parent/carer rely on their social network support when in difficulty (for example, when needs transport, care for the child, or has other needs)?
- Does the parent/carer want or is able to accept support from other persons?
- Does the parent/carer maintain positive relations with other persons who have children of the same age as theirs, or with similar problems or difficulties?
- Does the parent/carer support and help other parents/persons?
- Does the parent/carer participate in activities organized in the community?

Additional questions that the parents/carers could be asked:

- Do you get support from friends, relatives, community members, when you need it?
- Do you participate in any groups or organizations in the community?
- Where can you get advice or to whom can you just talk? How often do you meet them?
- Is it easy to you to ask for support/help when you need it?
- Do you find it difficult or problematic to make friends with someone? If it is difficult, which barriers do you face?
- What helps you to stay in touch/contact with people around you?

The collected information about this family protective factor can help to understand whether the family is capable to establish and use social relations to overcome difficulties.

Table 4. Levels of risk for the capacity of identifying social support relations

Risk level	Community groups	Family friends or community support	Social relations/connections
High risk	The family does not know and is not part of any community group	The family does not receive any external support	The family does not communicate with other persons (relatives, neighbors, other persons in the community)
Medium risk	The family knows but is not involved in community group activities	The family has few persons to call for help	The family does not communicate with other persons
Low risk / stability	The family has some contacts and somehow participates in community activities/groups	The family has stable social connections with persons in the community and receives support from them	The family has social connection with other persons, including relatives, friends, neighbors and other community members
No risk / safety	The family actively participates in community groups/activities with common interest, which helps them to build more social connections	The family receives support from relatives, friends, or other community members, if in need	The family has stable social connections with other parents, friends, neighbors, community members, and receives their support

In conclusion, the case manager should make a statement on the family's capacity to establish and maintain social connections with other persons in the community.

The third family protective factor: Parenting and knowledge of the child care and development needs

For the assessment of this family protective factor, the case manager should verify whether the parents have necessary knowledge and skills related to the care, development, and education of the child, know sources where this information can be accessed, have adequate expectations that correspond to the child's level of development, understand the importance of nourishing care of the child, etc.

What needs to be evaluated with parents/carers:

- Does the parent/carer encourage the child's healthy development?
- Is the parent/carer able to control the child's behavior, do they always know the child's location?
- Does the parent/carer prove adequate parental skills, does he/she have age-appropriate expectations from the child? What kind of discipline methods, communication, protection and supervision of the child are used?
- Does the child respond positively to the parents/carer's strategies/actions?
- Does the parent/carer have confident sources where he/she can get information about the growth, education, care of the child, in case if some problems and questions appear?
- Does the parent/carer participate in the child's school events, in parental groups?
- Does the parent/carer understand the child's specific needs (related to the child's development or behavior?)

Additional questions that the parents/carers could be asked:

- Do you think you have enough skills to meet your child's needs?
- What do you like about your child's up-bringing and care? What do you find difficult in this process?
- How did you learn parenting skills?
- Are you able to communicate and listen to your child in an open and respectful manner?
- How do you continue to learn about your child's development and care?
- Is there anything that worries you about your child's development or behavior?
- Do you think you offer enough time to your child?

The information gathered about this family protective factor may be helpful to understand whether or not the family is able to offer adequate conditions for the child's care, development, and education.

Table 5. Levels of risk for the capacity of creating adequate conditions for child care and development

Risk level	Parenting skills development	Time offered to the family	Discipline	Parent-child communication and attachment
High risk	The family does not have necessary information to understand the child's development and their parenting role	The family does not participate in fun and play activities with the child	The family is often worried, tensioned, and angry with the child because of their discipline issues	Does not have relation/contact with own child and communication with him/her does not function
Medium risk	The family wants to know more about their parenting role and their child's development	The family encounters difficulties with participating in fun activities with the child	The family is often worried, tensioned because the child does not respond to their disciplining efforts	Has difficulties while establishing relations with the child
Low risk / stability	The family knows how and where to get information if has questions concerning the child's development and their parenting role	The family spends limited time (sometimes) in fun activities with the child	Even if child disciplining may be challenging sometimes, the child, generally, responds	The family talks to the child and listens to him/her sometimes, and feels that they have contact with him/her
No risk / safety	The family seeks and regularly applies new information about their child's development and their role as parents	The family spends much time in fun activities with the child	The family applies effective discipline strategies with the child to which he/she responds	The family regularly communicates with the child and feels they are in close contact with him/her

Conclusions of the case manager on this protective factor are related to the family's capacity to offer care and to contribute to the development of their child/children.

The fourth family protective factor: concrete support in times of need

The case manager's role in the assessment of this protective factor is to determine whether the family know about the services provided in the community, to identify all barriers the family might face in

accessing necessary services, to analyze the family's previous experiences within the system of services, etc.

What needs to be evaluated with parents/carers:

- Is the parent/carer open to accessing and using community services?
- Did the parent/carer have positive experience with those services in the past?
- Does the parent/carer face any specific barriers (illiteracy, capacity to understand information, access to transport, etc.) that could prevent them from accessing services in the community?
- Does the family access health services (upon need)?
- Does the parent/carer make efforts to find employment (for those unemployed)?
- Are there any behavioral issues that the parent/carer could change in order to use the services more effectively (punctuality, readiness to communicate personal data, etc.)?

Additional questions that the parents/carers could be asked:

- Do you have sufficient income to ensure decent living of your family?
- What do you need to: stay in your home, maintain your employment, pay your heating, electricity, gas bills, etc.?
- Do you know services/resources in your community and how you can access them?
- What have you done to solve the problem/problems? Was it useful?
- How does solving those issues influences you as a parent/carer?

The information collected on this family protective factor may help the case manager to determine whether the child's family is at risk caused by incapacity to understand own needs of support and to access services/resources in their community.

Table 6. Levels of risk related to the accessing of necessary support in the time needed

Risk level	Knowledge and resources at the community level	Health services	Incomes	Availability of accommodation
High risk	The family does not know services/resources in their community	The family faces health issues, but does not call for medical services	The family does not have sources of income and cannot meet basic needs	The family does not have stable place to live
Medium risk	The family has little knowledge of the services/resources in the community, faces difficulties in accessing them	The family often does not require medical assistance when they need it	The family has income, but it is insufficient to meet its basic needs	The family is at risk of losing their accommodation or their housing is temporary, they do not know how they can find their next place to live
Low risk / stability	The family knows how to use community resources when they need support	The family requires medical assistance when they need it	The family has sufficient income to meet their basic needs	The family has sufficient resources to rent their accommodation

Risk level	Knowledge and resources at the community level	Health services	Incomes	Availability of accommodation
No risk / safety	The family knows what services and resources are available in the community and how they can be accessed	The family use medical assistance to prevent health issues	The family has sufficient income to meet their basic needs and has some money reserves	The family has sufficient incomes to ensure an accommodation

Conclusions on this protective factor are related to the family's capacity to identify and use social services in the community and region (social assistance, education, medical services, etc.)

The fifth family protective factor: Capacity of the parents/carers to develop the child's emotional and social competences

On this aspect, the case manager determines whether the parents are aware of the importance of the child's early attachments/relations and their role in the child's social and emotional development, understand the causes of the child's challenging behavior, their ability to include the child into activities that would encourage the child's age-adequate social and emotional development.

What needs to be evaluated with parents/carers:

- Does the parent/carer know how to encourage the child's social and emotional development and how to apply age-adequate non-discrimination strategies?
- Does the parent/carer create adequate environment for the child to feel safe to express own emotions? Does the parent/carer respond to the child's emotions?
- Does the parent/carer express empathy?
- Does the parent/carer set clear expectations and limits adequate to the child's age (for example, "Anybody hits anyone in our family")?
- Does the parent/carer separate/makes difference between the emotions and actions (for example, "It's normal to be upset sometimes, but do you ever hit anyone when you are upset")?
- Does the parent/carer encourage and develop the child's social competences and do they welcome the reward of good things?
- Does the parent/carer teach the child to solve problems ("How do you think, what could you do if another child called you names?")?

Additional questions that the parents/carers could be asked:

- What is your emotional relation with your child?
- How do you express love and affection to your child?
- How do you help the child express emotions?
- In what situation would you find difficulties to control your child's emotions?

The information collected for this family protective factor helps to identify whether the parents/carers have capacity to help their own child develop social and emotional competences according to the main indicators.

Table 7. Levels of risk for the building of the parents' capacity to develop the child's social and emotional competences

Risk level	Child's wellbeing and emotional development	Self-control	Relations with others	Communication and self-control skills
High risk	The child is negative and unhappy	The child often can't control own emotions	The child is isolated and retreated	The child doesn't exhibit own emotions
Medium risk	The child's mood is changing but is generally negativist and unhappy	The child has difficulties to recover/exit negative emotional conditions	The child has limited relations with others	The child has difficulties in expressing own emotions
Low risk / stability	The child's mood is changing, but he/she is generally positive and happy	The child is able to calm down alone	The child is able to develop interpersonal relations with other persons	The child can talk openly about own emotions when is asked
No risk / safety	The child is generally happy and positive	The child is able to stay calm in conflict and challenging situations	The child initiates/develops positive relations with others	The child often talks about own emotions (how he/she feels)

In conclusion, the case manager should express own opinion about the parents/carers' capacity to understand the importance and to contribute to the child's emotional and social development.

All conclusions related to the family protective factors should be correlated to the family's capacity to ensure the child's wellbeing. For example, the child's safety is not secured because the child is often left home alone, unattended, or the house is often visited by unknown persons; the child's inclusion is not ensured, because the child is not enrolled in a school or the child and family do not participate in activities organized by the community, etc.

The case manager should also know and be able to identify signs and symptoms of trauma experienced in the childhood and expressed differently in different stages of a child's or young person's life.

Signs and symptoms of trauma:

- 0-3 years old: food disorders, sleeping disorders, somatic issues, anxiety caused by separation, feeling of helplessness/passiveness, irritability/difficult to soothe the child, inhibited activism and mood, repetitive/post-traumatic games, regression in development, general fear, new concerns/easy to be scared, speech delays;
- 3-5 years old: general fear/new fears, helplessness, passiveness, unrest, impulsiveness, hyperactivity, physical symptoms (headache, stomach ache, etc.), difficulties in identifying factors causing the unrest, lack of attention concentration, difficulties in problem-solution, irritability, aggressive behavior;
- 6-12 years old: anxiety of fear, concerns related to own safety/other persons' safety, emotional unsteadiness/changing mood, easy to frighten, sad or upset, sleeping disorders, nightmares, learning difficulties, changes in school achievements, attention-seeking/clingy, returning to

behaviour typical for earlier age/regress, pretended trauma during play, the child says he/she doesn't care about what has happened/is happening;

- 13-18 years old: the person feels depressed, hardly imagines own future and has difficulties in making plans for the future, food disorders, self-mutilation/victimization (for example, self-cutting), over- or under-estimating danger, inadequate aggressiveness, learning difficulties, self-destructing behaviur, drugs or alcohol misuse, sexual impulsiveness (or provoking behavior), sleeping disorders, retreating from activities and relations, the child feels inhibited/secluded/detached from life, discusses traumatic events in details.

Trauma experienced by the child, that caused behavioral changes expressed in reactions and conduct, may influences the parents'/carers' capacity to understand the child's self-expression and choose forms of behavior that will recover the traumatic effects.

Table 8. Impact of child's trauma on parenting skills

Protective factors	Description
Parental resilience	Because trauma may influence the child's emotional development and reactions, the parent/carer might wrongly perceive the child's reactions to strengthen own resilience. Stress in parent-child relations caused by trauma can also undermine personal resilience.
Family's social support network	Parents/carers could face difficulties while creating or maintaining relations with other parents/carers, due to the child's behavior. Parents/carers could find difficult to establish social relations if others do not understand the effect of trauma on their child's behavior.
Parenting and child development competences	Parents/carers who do not know about trauma and its impact on the child could misinterpret his/her behavior.
Concrete support in times of need	Parents/carers could need additional concrete support to help the child recover. Expressions of trauma could affect the daily events and could negatively impact the child's work capacity, the parents' capacity to offer adequate child care, etc.
Parents'/carers'/capacity to develop the child's social and emotional competences	Parents/carers may fail to understand the emotional expression of the child who experienced trauma, or be unable to provide support to the child in setting relations with other children, in overcoming conflict situations.

It is important to understand the role of adults in the process of children's recovery after traumatic experiences; this recovery should start as early as possible. Presence of a child-supporting adult may have important effects to help the child go through stressful experiences without having negative impact on their own development. The case manager should also know that typical responses of the protection system to children's traumatic events, such as taking the child from the family or punishment for "misbehavior" might intensify those negative effects.

For the children included into the protection system, it is important that their development needs are met, that they have confident persons to rely on and to discuss with, who would help them to understand the impact of trauma on own development, to strengthen the competences of the families and carers in securing safety conditions for the children and supporting them in their personal development.

***Block 6. Statements on the results of assessment*.** Family's needs are described, in relation to the level of main parenting competences development, indicating the actions taken prior to the complex assessment, and their effects. In addition, the family's strengths and weaknesses are identified. This information is useful to plan and build the process of parenting capacities strengthening, capitalizing on the things that the family is capable and manages to do, and developing the missing capacities.

During the complex assessment of the family's situation, in the case of the child's family reintegration, all informational block are filled from the perspective of identification of the family's capacities to ensure adequate conditions for the child's growing and development. In this context, the family's situation may be compared between what it was at the time of the child's separation from the family, and the situation at the time when the decision was taken for the child's family reintegration.

The table below presents several examples of the thinking process that starts from the assessment of an indicator of a family protective factor to the formulation of the parents' needs, with the analysis of the action taken, to the formulation of recommendations on further family strengthening work.

Table 9. Examples of statements following the family situation's complex assessment

Family protective factor	Statement	Action taken	Further actions required
Parenting and child care and development	If the parent's answer to the indicator "has adequate expectations from the child" was "No", this means the parent does not have adequate expectations from the child, that is, requires from the child more that he/she can achieve within his/her individual potential and age (to help in the household, or, to have high marks at school, etc.). The **need**: the parent needs to know more about the child's specifics and possibilities at different stages of life.	The case manager talked to the parent	The teaching staff involvement is required to explain to the parent what may be natural for a child to achieve at a certain age, and what exceeds the child's possibilities.
Parenting and child care and development	If for the indicator "can effectively manage the child's behavior without applying violent forms of discipline" the case manager determined that the parent sometimes applies physical punishment when the child misbehaves (because it is likely that the parent, in their turn, were physically punished in childhood, or considers that this is a natural method of upbringing, etc.), The **need:** the parent needs to be informed about the impact of violent discipline methods on the child's development.	The case manager talked to the parent, to inform him/her about the effects of violence for the child's development	Discussions and explanations with the parents should continue. The teaching staff needs to be involved, to discuss to the parent and explain to him/her what are the consequences of abuse on the child's development: it is likely that the child may also become violent in relation to own children in the future.

Family protective factor	Statement	Action taken	Further actions required
Family support network	If the answer to the indicator "communicates and seeks advice of other parents with children of the same age or with similar childcare problems", was "NO", then the case manager states that the parent faces alone the problems related to their child's behavior, or does not have experience and does not receive advice on the solution of similar issues. The **need:** the parent needs to establish relations with other parents who face similar problems, to exchange experiences.	The case manager talked to the parent and advised them to be more active in their communication with other parents of their child's classmates.	Involvement of the support group of the parents with same-age children or with similar issues; involvement of the school psychologist or the teaching staff, to organize parents' groups to discuss issues related to child-upbringing, etc.
Concrete support in times of need	If the parent's answer to the indicator "had positive experiences in accessing the necessary service" was "NO", The **need:** then he/she needs support in contacting community services.	The case manager communicated to the parent and informed him/her about the existing community services.	During the case work with the family, services needed by the family should be identified. In addition, the reason why the parent did not access those services should be identified; the relation between the family and the community services/resources should be evaluated (if the family has not been ignored, or it may have been refused support by a specialist of a certain service), which determined the family never to ask for support again (school, medical institution, etc.). Then the case manager should talk to the specialists of this service.

The same algorithm of thinking is applied to the indicators for all family protective factors.

The complex assessment form finishes with the inclusion of data about the assessment process participants, their positions and institutions represented.

Detailed analysis and information interpretation within the complex assessment will offer the case manager an opportunity to identify the child's and the family's difficulties and needs, to explain what happened in certain areas, to understand the way the strengths and weaknesses influence every child and his/her family, to determine **"what should be improved and/or changed".**

Consequently, the complex assessment report represents a summary analysis of all data collected by the case manager on areas of child's well-being and on the development level of parenting competences necessary for the child well-being. This analysis reflects the case manager's concerns. All identified problems and concerns represent the foundation of the IAP development that should

include tasks on family protective factors strengthening, to help it become able to ensure age-adequate care and education to its child/children. The information reflected in the complex assessment should be verified and supported by proofs, to justify the formulated recommendations.

Annex 11 includes recommended work tools that the case manager can use for data collection and identified problems analysis.

The data of the complex assessment and the formulated recommendations should be communicated to the beneficiary; the beneficiary's opinions (child, parent/carer) should be considered and mentioned in the complex assessment form.

The complex assessment form finishes with the signature of the parent/carer (*Block 7*) and with the signatures of the persons who participated in the complex assessment process, mentioning the name, position, and institution represented (*Block 8*).

2.3. Development and implementation of the Individual Assistance Plan

"It is everyone's duty to promote, support, and protect the wellbeing of all children".
"Every social service for family and child should assume responsibility for own contribution to the wellbeing of the child, in order to respond to any call for support".
Child's rights protection specialist

It is recommended that the Individual Assistance Plan is written within three days after the complex assessment is finished.

The IAP should be inform by data of the assessment and recommended actions to meet the identified needs and to solve the identified problems. This should also include child monitoring actions taken under a determined schedule, depending on the risk level and the child's needs identified within the complex assessment. The actions included into the IAP should be scheduled for immediate/short-term implementation, or planned for medium term and long term.

In case when it is possible and even useful, a child-friendly written version of IAP should be provided, to make sure the child understands the planned actions. This is extremely important when some of the IAP actions are the child's responsibility.

Removing the risks related to the child often needs a family-centered approach that identifies the family's needs and capacities and contributes to its capacity-building, enabling it to offer protection and adequate care to the child. It is crucial that the IAP does not include actions that exceed the child's and the family's expectations from the assistance services that, in fact, are unavailable at the community/regional level or within the concrete service.

The child and the parent/carer should be involved to the maximum extent in the IAP development. If necessary, the case manager may call an official planning meeting involving other persons important for the child, and other service providers and competent authorities. In complex cases, the supervisor, service manager, service team members may also participate in such meetings. While preparing the planning meeting, the case manager should consider possibilities to ensure full and significant participation of the child and family.

Useful suggestions

The case manager is the main contact person for the child and his/her family during the entire process of service provision. Although the case manager cannot implement all actions included into the IAP, he/she is responsible for the coordination and monitoring of the actions implemented by the service specialists, other representatives of structures, organizations, and other relevant

persons. The case manager should make sure progress is made for the achievement of the identified objectives of the IAP, and that the decisions are made to the best interest of the child.

Ideally, the same case manager performs the assessment, planning, and monitoring. However, there may be circumstances when it could be necessary to replace the case manager. This may happen when the child/family cannot develop positive relation with the case manager (sometimes the family may be upset or disagree with the assessment results, especially if they are criticized or judged), the family changes their place of living, or the case is referred to another service and a different case manager is appointed.

IAP structure

IAP consists of two parts. The first part includes necessary actions for the improvement of each area of child's well-being. The second part of the IAP includes necessary actions for the solution of the identified problems, aimed at family strengthening and making parents accountable for the meeting of needs of every child in the family. IAP actions are based on the needs related to the areas of the child's well-being and to-be-developed parenting skills identified during the complex assessment. All those problems, united by risk levels, form the base of the IAP development.

In the actions panning process, the needs related to the child's well-being are transformed into objectives/desired outcomes, to the achievement of which all planned actions are oriented. The planned tasks and actions will contribute to ensuring the child's well-being and to the elimination of concerns that may affect it. In this context, the IAP must contain actions that will meet the needs related to all areas of child well-being: actions that will be realized by parents/carers, persons from the family's social network, specialists from different areas, involved social services, and community members (Annex 3).

The planned actions should be focused on reducing the weaknesses identified with the child and parents/carers, by consolidation of their strengths.

In the standard IAP model (in the part that refers to the child), the case manager should start from the child's needs and formulate necessary actions to meet them and to improve each area of the child's well-being, indicating the person/persons in-charge and the term of achievement. At the same time, actions planning will depend on the child's concrete situation, level of vulnerability or risk, the developed missing parenting skills, and the social context. The actions planning should focus on the elimination of the factors/causes that determined the concerns and needs related to the child's well-being and family strengthening.

Example:

For the area "child safety":

In the case when the concern is related to the child's safety in the family environment, the following need may be identified: the child is provided safe conditions at home.

In collaboration with the multidisciplinary team, the case manager can plan the following actions to create a safe environment at the child's living place:

- To ensure in emergency the child's safety, by separating him/her from family with subsequent placement into the extended family, or in alternative family-type care services (FC, FTCC), in a temporary placement centre, or, as a last resort, in residential care;
- To offer secondary family support – cash benefit for house refurbishment, procurements of first-need items, food support, employment facilitation;
- In case of a lack of parenting competences, the family support service may be provided: advice, recommendations; be involved into parental support groups or in parenting skills strengthening programs;

- In cooperation with the family doctor/nurse, make arrangements for the child to be registered with the doctor and receive necessary treatment; perform awareness-raising activities and primary prevention in terms of child care and food supply, etc.;
- In cooperation with the educator/teaching staff, ensure conditions for the child to attend kindergarten/school, do homework regularly; to ensure the child's participation in educational activities; to perform awareness-raising and primary prevention activities, making parents accountable for the child's school attendance, support and control of the child doing homework, etc.;
- In cooperation with the district police office, to monitor the behavior of the parents in line with the existing social norms; to ensure awareness and primary prevention activities, etc.

While formulating actions of the IAP, indicators for each child wellbeing indicator can be used, that can be transformed into objectives and actions aimed at the elimination of the identified concerns and meeting the identified needs for each area of well-being. The planned actions can be addressed to the parents/carers (what needs to be developed/strengthened with the parents to offer better care to the child), teaching staff/educators (how they can support the child to be achieving, active, respected; how they can help the parents to better perform their role as parents, what the school/kindergarten can do for children, to compensate the parents' incapacity or to supplement the parents' effort), family doctors/nurses (how to stimulate parents to offer adequate care to the children, how to contact specialized doctors, upon need, how to support parents in the development of hygiene-related skills with the children), etc.

The following example suggests models of actions for the development of respect with the child (respect for other persons, self-respect, forms that interact).

Example:

For the child's well-being indicator "respect":

In the case when the concern is related to the respect for the child in the school environment, the following need may be identified: the child to feel respected in various social environments, especially in the school environment.

In collaboration with the multidisciplinary team, the case manager can plan the following actions:

- provide support and advice to the parents/carers, to strengthen the child's self-respect: to appreciate and encourage the child regularly; to build life skills to resist new challenges and be able to overcome difficulties, in order to feel listened to and taken seriously by parents/carers and siblings; to respect the child's intimacy and personal area; to treat the child as an individual with own rights, needs, expectations, aspirations, etc.;
- In case of parental incompetence, to offer advice, recommendations, within the family support service; to involve the parents/carers into a parental support group or in parenting skills strengthening programs related to the prevention of physical abuse and domestic violence or their threat, non-violent forms of child discipline, etc.;
- In cooperation with the family doctor/nurse, to make sure that the child is involved and consulted in terms of available medical care and treatment, etc.;
- In cooperation with the educator/teaching staff, to ensure the prevention of child discrimination, labeling by other colleagues or adults at school and in the community, based on age, sex, ethnicity, religion, culture, disability, difficulty, accommodation, or origin; prevention of intimidation or harassment on behalf of school mates; provide support to feel listened to and taken seriously by the teaching staff/educators and school mates, etc.

Similar actions can be made in the case of other child wellbeing indicators.

While planning actions, the focus is on the consolidation of family protective factors, with the involvement of existent professionals, services and prevention programs, or other community resources, so that the family becomes stronger and more capable of ensuring wellbeing to their own child.

In the part of the IAP related to family strengthening, the case manager plans actions to meet the needs related to family protective factors. Parental resilience may be strengthened through: adoption of a positive, strengths-based attitude to the family; supporting the family as the main decision making factor in the case-work planning; encouraging the parents to analyze own traumatic experiences, for them to understand how those experiences are influencing them in the present; understanding that the role of a parent is, in itself, stressful. The case manager should offer support to the parents/carers, for their development of stress-control ability in their role as parents, capitalizing on their strengths, and support them in constructive decision-making.

In order to provide family support for the development/extension and more efficient use of the family support network, the case manager can apply a series of strategies, such as: encouraging parents/carers to extend their social network, as part of the IAP; support for the development of competences of social interaction, identification of supporters within a social network, who will be subsequently able to provide support; encouraging the family to overcome anxiety or depression and develop healthy social relations.

Any contact between the case manager and the family is a perfect opportunity to refer the family to resources that will help to strengthen their parenting and childcare and development skills, to offer them information on child care and development, to model and capitalize on efficient care. The case manager can recommend parenting education programs to the parents (in case if such programs are available), make home visits (as part of the IAP), provide support to the parents/carers in the formulation of adequate expectations from the child; involve the parents/carers into a dialogue when their expectations do not correspond to the child's stage of development and potential; underline the importance of nourishing care, help the parents/carers adequately appreciate the importance of their role; provide timely and adequate parenting education.

The case manager's role is not limited only to the referral of beneficiaries to the necessary support/services, but also includes the identification of any barriers the family may encounter while accessing those services. The support provided to the family in overcoming those barriers is crucial in order to meet the family's concrete needs. This support may include: support in understanding the child's and the family's needs, encouraging the family to seek sources of support, work with the family to help it understand their own experiences within the social services system and be aware of certain prejudices associated with them, support in accessing services (explaining eligibility criteria), filling forms or referral to other relevant specialists.

The case manager should support the parents/carers to be aware of early attachments/relations and of their role in the development of the parents'/carers' capacity of developing their children's social and emotional competences. This goal may be attained through: providing informative support, to help the parents/carers to develop communicative skills and be aware of the experienced trauma and its impact on the child's relations with adults and peers, inclusion of the child into activities for his/her social and emotional development (special classes in school, books, games, consultation, etc.), supporting families in solving problems related to the child's attachment and/or challenging behavior, allocating necessary time to explain and talk to the parents/carers about the child's difficult behavior.

Table 10. Examples and objectives of IAP activities for parenting competences strengthening

Family protective factor	Statements	Actions included into the IAP
Parental resilience	If the answer to the indicator "Knows how to plan and manage the family budget" was "NO", this means that the parent does not have family budget managing competences. The **need**: to inform and support capacity building in the family budget planning and management.	The case manager, together with the parent/carer: 1. Make the list of expenses and purchases necessary for the following month. 2. Prioritize the list, that is, decide what is of primary need, what is secondary, what purchases can "wait", etc. 3. Distribute the income to see what kind of purchases can be covered from this list, and whether some money reserves remain. 4. Decide what can be excluded from the list if there is not enough money, or what needs to be bough with the reserves. 5. The parent should make sure to complete the list of all expenses made during the month. 6. Discuss the way the parent will follow the list and the budget plan for the coming month. 7. Agree that the parent will come at the end of month with the initial list of planned procurements and the list of expenses of the previous month, for analysis. The above actions may be repeated until the parent gains the planned competences.
Family's social support network	If the parent's answer to the indicator "Participates in community activities" is "NO", this means that they do not have skills for the participation and interaction in the community, or are not informed about the activities organized in the activity. The **need**: to inform and support the parent/carer for the participation in community activities.	The case manager, together with the parent/carer: 1. Plan actions encouraging the parent's/carers' interaction with the community. 2. Involve the parent/carer into community activities (family day, child's day, etc.), encourage the parent/carer to participate in a parents' or children's contest, or involves them in other tasks within and event-organization activity.
Parenting skills and child care and development	If the answer to the indicator "Knows and understands the child's development and behavioral needs" was "NO", this means that the parent/carer does not know and does not understand the child's development needs. The **need**: to inform about the child's development needs.	The case manager, together with the parent/carer: 1. Identify the parents' shortcomings in their knowledge of the child's development and behavior. 2. Identify information sources that can be recommended to parents (published informative materials). 3. Facilitate communication with the educators/teaching staff that can provide necessary information and consultation. 4. Discuss with parents/carers about child education (within the limits of own competences), etc.

Family protective factor	Statements	Actions included into the IAP
Concrete support in times of need	If the answer to the indicator "Needs support in accessing services" was "NO", this means that the parent/carer does not understand the child's and the family's needs and does not know where to get support. The **need**: support in understanding the child's needs and in understanding where to get necessary support.	The case manager, together with the parent/carer: 1. Come to understand the causes of unawareness and not understanding of the child's and family's needs (illiteracy, low capacity to process and understand information, etc.). 2. Identify the child's and the family's needs. Explain to the parent/carer to help them understand those needs. 3. Discuss the barriers to accessing community services, exclude the personal factor in case if a specialist in the community hinders from the parent's participation in certain activities. 4. Identify the type of support, services necessary to meet the child's and the families' needs. 5. If necessary, involve other community practitioners: teaching staff, medical staff, etc. 6. Help the parents to access necessary services, etc.
The parents'/carers' capacity to develop the child's social and emotional competences	If the answer to the indicator "Encourages the child to express opinion and involves him/her in everyday decision-making" was "NO", this means that the parent/carer does not have competences for interaction with the child. The **need**: support in requesting the child's opinion in situations that concern him/her.	The case manager, together with the parent/carer: 1. Analyze concrete situations of interactions between the parent and the child, and their effects. 2. Explain the importance of listening to the child's opinion and his/her involvement into family activities and events. 3. Model new ways of communication with the child in various everyday activities.

The case manager uses similar strategies to work on all indicators related to the parents' capacity to provide the child with safe, protective, and developing environment.

The case manager can use the following **strategies** to strengthen the family's protective factors:

Parental resilience development strategies: positive approach to work, based on the family's strengths, supporting the family as the main decision-maker, capitalizing on and supporting good ideas, focusing the work within the IAP on the family's independent actions, encouraging the parents/carers to analyse and recover traumatic experiences from the past, providing support in pro-active solution of problems related to the child up-bringing, support in understanding social phenomena that negatively impacted the family's situation.

Strategies for the development of the family's social support network: support the parents/carers to identify supporters in their social network and establish relations with them, develop skills of interaction and relation management, encourage the extension and consolidation of the social network as part of IAP, encourage the parents/carers to overcome barriers in the initiation of healthy social relations and in overcoming anxiety and depressiveness.

Strategies for the development of parenting skills in childcare and development: orient the parents, in the appropriate time, to resources that may offer them adequate informative support (programs, seminars, literature), analysis and explanation of appropriate parental behaviors, explain the

importance of nourishing care of the child, help in the identification of trustworthy specialists/persons the parents/carers may rely on when they need information on childcare.

Strategies for providing the family with concrete support in times of need: encourage the parents/carers to ask for support when they need it, support them to understand the experiences of contacting social services, support in the navigation within the social services system (information, support in service accessing).

Strategies for the strengthening of parents in the development of their children's social and emotional competences: support in understanding traumatic events in their own life and their impact on their relations with the child, capacity building of the parents/carers for the development of the child's social and emotional competences, support in connecting the family to resources that may favor the development of the child's social and emotional competences (literature, parental groups, child groups, etc.), support of the parents in issues related to the development of child attachment and challenging behavior control.

The case manager can also include into the IAP special activities with the parents/carers, focused on parenting competences strengthening.

Table 11. Examples of activities with parents/carers, for the strengthening of family protective factors

Family protective factor	Activities with parents
Parental resilience	• Ask the parent to note down self-care actions/strategies and make sure they take time for self-care every day (it has been determined that a parents who take care of him/herself better understands own child's need of everyday care). • Ask the parent to identify situations when he/she feels stressed and write a plan that will help them to stay calm and remain steady in such situations.
Concrete support in times of need	• Ask the parent to identify a concrete family need that, if met, will make his/her life easier. Suggest at least three possible solutions to meet this need (for example, structures/organizations they could apply for support, people they could ask for support, methods of reducing expenses, etc.). • Talk to the parent about the socio-economic status his/her family had when he/she was a child, and what its effects are in the present. Discuss things their parents did or did not do to protect from stress and poverty, to teach them value the money they have and to make sure their family needs will be met.
The family's social support network	• Together with the parent, make a social map that includes persons and institutions that could be sources of support and/or stress in their life. Identify together possibilities to reduce stress. • Together with the parent model real life situations to help them practice the competence of developing friendly relations. For this purpose, ask the parent to think of real situations, such as initiating a discussion during a school event, on a play area, or in a public area in the community.

Family protective factor	Activities with parents
Parenting capacity in childcare and development	• Ask the parent what hopes and dreams he/she has for own child. Discuss any worries related to the achievement of those hopes and dreams. Then discuss, what the parent is doing today (or what they want to do in the future) to achieve those dreams and hopes. • Identify a task/problem related to the child development and care that the parent finds difficult (for example, respecting mealtimes, bedtime for the child, making home work for the child, etc.). Share some information with the parent, on necessary strategies/actions to achieve this task. Ask them to practice those strategies and tell you about the results during your next meeting.
Parent's/carer's capacity in the development of the child's social and emotional competences	• Ask the parent to develop (write or tell) a situation of interaction/communication with the child. Start with experiences that usually make the child feel: happy, sad, worried, upset. Then ask the parent to describe what the child does when he/she feels those emotions, how the parent reacts and how the child responds. Identify and discuss models of positive and negative behavior in such interactions. • Ask the child to remember about an adult he/she loved as a child. What made /contributed to make this relation so important? Ask them what elements in this relation they could repeat in their relations with own child.

During the planning process, the case manager should be aware of the fact that the family might need certain services that are currently unavailable in the community or region. This may appear as information on the needs of the population for certain services/programs, and their development could be initiated at the proposal of the community social worker.

In the end of the IAP, the case manager asks for the child's opinion about the actions included into the IAP (depending on the child's age and capacity). It has been mentioned that a simplified, child-friendly version of the IAP can be developed, especially when this plan contains responsibilities of the child. In addition, the parents/carers are asked to express their opinion about the actions included into the IAP, and to give their consent to participate in its implementation. Signatures of the persons who participated in the IAP development are required, indicating the name, position, and organization represented.

A **collaboration agreement** is recommended to be signed at that stage between the parent/carer and the case manager (Annex 4). The use of an agreement in the relations with beneficiaries has the purpose of making beneficiaries accountable for and actively participate in necessary interventions, and be aware of own responsibility. Failure to comply with the terms of the agreement of collaboration may support the case manager's subsequent decisions on this case (ceasing financial support, extension of the term of intervention, re-assessment of the child's situation, etc.).

The collaboration agreement includes the beneficiary's consent to participate in the development and implementation of the IAP for the improvement of the child's situation; the beneficiary gives own consent for the personal information to be shared with other specialists involved in the solution of the problems encountered by the family, and consent for the interruption of the intervention in the case when the beneficiary fails to comply with the responsibilities assumed within the agreement.

The date of agreement conclusion is indicated and the signatures of both parties (the case manager and the parent/carer). The term of the agreement normally coincides with the term of the beneficiary's stay in the service and post-monitoring term stipulated for the real implementation of the IAP objectives.

In order to motivate the beneficiary comply with the conditions of the agreement, the case manager may introduce details into the agreement (if relevant), related to the responsibilities of the parties. These should be reflected in the Plan.

Examples of beneficiary's obligations: to allow the social worker make home visits to the beneficiary, not to abuse alcohol, to respect the schedule of the sessions with the social worker and other specialists, to inform the social worker about any changes in their family, social, or professional situation, to use the cash support strictly for the purpose of payment, to inquire weekly about the child's school progress, to take necessary action to find employment according to own qualification and abilities, to visit the family doctor who is observing the child, to cooperate with the family doctor, to make necessary repair works in their house, etc.

Examples of the social worker's obligations: to provide consultation to the beneficiary family members, to offer information and support for employment, to make periodical home visits to the beneficiary, to mediate conflict relations, etc.

IAP implementation. The case manager, in cooperation with other relevant professionals, works with the child, family, community, and any relevant service provider, to make sure the child and the family receive necessary support and services. The community social worker provides, within the Family Support Service, direct psychosocial support, advice, or recommendations (when needed), during periodical monitoring sessions and meetings with the child and the family. Friendly communication with the child, consultations on everyday challenges and difficulties, are resources for the family and represent key methods of developing a positive relation with the child and the family. These interactions, if produced correctly and systematically, represent a complex of actions providing psychosocial support and can contribute to the wellbeing of the entire family. In addition, the community social worker should accompany the child/family to visit the service provider, at least for the first session, in order to make sure that the referral is correct and the beneficiary is accepted by the requested service.

The image below presents different types of support and direct services that could be provided to the child and the family, to meet their needs of support and protection (the needs being identified during the assessment stage).

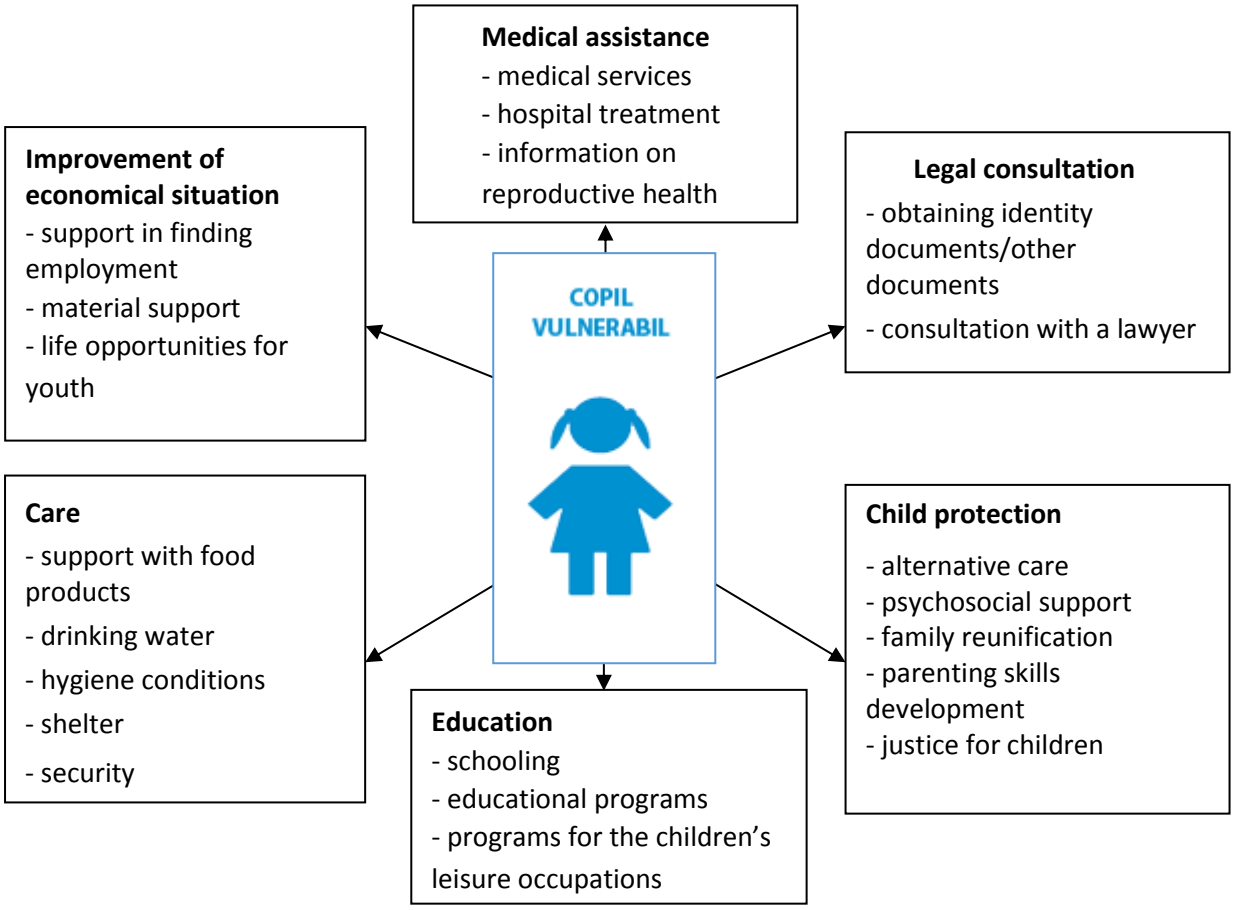


Image 3. Examples of support and direct services provided to the child and family

Referral and recommendations are effective when the case manager knows the services available in the community and in the region. Thus, the case manager needs to be periodically informed about the existing/developed/reorganized services within the community and regional network of services.

It is important to remember that while the beneficiary receives services at the community level, the case manager (community social worker, child's rights protection specialist working within the mayoralty, or the social worker of a community service) is generally responsible to follow the IAP implementation, in order to make sure the child's needs are known and met. In situations when the case is referred to region-level services, the case manager acts in line with the referral mechanism, submitting all documentation (extracts, reports), and following the standard operation/activity procedure, making also sure that the principle of confidentiality is permanently respected. The case manager should discuss with the child and parents/ carers about the way they prefer their information to be shared, and the term of this consent validity (for example, in some cases, consent may be given for a single report, mentioning that the information on the given case will not be shared any longer after this report).

In what follows, some recommendations are offered, that may be used by case managers who provide consultation to families whose children are affected by trauma.

Table 12. Protective factors for families with children affected by trauma

Protective factor	Needs of the parent/carer
Parental resilience	Parents/carers could need additional support to become confident of own forces and parenting skills, and to pay more attention to self-care, in the context of the child's post-traumatic behavior[2].
Parenting skills for childcare and development	In addition to universal knowledge about child development, the parents/carers could need support to understand the impact of trauma on the development of the child and to understand the need for additional care of the child.
Family's social support network	The child's exteriorized and hidden behavior could affect the parents'/carers' social relations and capacity to develop relations with other parents/carers or persons who could support them in childcare.
Concrete support in times of need	Parents/carers could need special therapeutic support for the child, and support to minimize the destructive nature of the child's behavior.
The parents'/carers' capacity to develop emotional and social competences of the child/children	A small child who experienced trauma will need additional support in social and emotional development. Parents/carers should be supported to understand how trauma affects the child's social behavior, to be able to act adequately in such situations.

The IAP implementation may require the mobilization of efforts and resources at the community level. In this context, the case manager should coordinate those efforts, mobilizing community leaders and creating adequate environment for mutual accountability, to promote protective factors, use common language and shared orientation in family strengthening, unify work tools and messages of communication, organize parent group activities, etc.

Remember:

- Work on child-parent interaction;
- Work to ensure long-lasting protection, rather than "immediate protection";
- Do not insist on "what we do", but rather, on "what comes out of it";
- Set out a limited term for the change process;
- Permanently monitor the child's development and well-being.

In situations of **case transfer** (for example, when the family and the child move to a different community), the child's case file should not be submitted to the social worker of the community where the family moved, until the family is contacted to confirm that they agree with the case transfer. The child and the family may choose not to have their portfolio transferred/submitted to a different community, and may prefer not to receive any further support (for example, when the child was victim of sexual abuse, and the family does not want this experience/trauma to be known in the new community). This should be clearly discussed with the child and his/her family. At the same time, the child's best interest should be considered, when decision is made on case transfer contrary to the wish of the child/family, in order to ensure the child's protection. A child's case transfer means to the community social worker who opened the case, that it is closed. Subsequently, the organization/structure/social worker who received the case will be responsible of complete monitoring and management of the child's case.

[2] Researches demonstrate that the parents who develop self-care skills while under stress show capacity to care of their own children in stress situations. As a result, the child develops self-care capacity in and post stress, which he/she preserves during entire life.

2.4. Monitoring of the Individual Assistance Plan implementation

Monitoring and review of the IAP implementation are components of the case management used to make sure the IAP is under implementation and that it is still relevant and meets the needs of the child and the family.

Monitoring of IAP implementation implies verification that the family and the child are receiving adequate services and that the support provided meets the identified needs. In addition, it is verified whether their situation is progressing positively, according to the IAP, is stable, or, on the contrary, is worsening. Monitoring is done regularly during the entire case work, to make sure the planned actions and services were implemented and provided and that they brought to meeting the needs of the children and to the strengthening of their families.

Examples of plan monitoring and implementation may include the following: making sure that the child received necessary medical assistance, was enrolled in school and is attending classes; the way in which the discussions with the child/parents influenced their behavior and attitude to the child, the child's relation with the parents is improving, etc.

At the same time, monitoring and implementation is essential to help the case manager identify any changes in the child's situation or family circumstances that could require the IAP revision or substitution. Monitoring also should consider the eventuality of new risk factors or of increased risk caused by certain past situations. This could determine the need for new emergency actions to be included into the IAP.

Monitoring starts with the child's case registration and initial intervention (aimed at meeting the child's immediate needs), and lasts until the child's case closure. Frequency of the monitoring visits and sessions and their duration will depend on the child's situation, specific needs, the identified risk level, and on the progress in the improvement of the child's situation. For example, if the child is placed into an alternative family-type centre for a limited term, regular phone conversations may be essential to verify the situation and the well-being of the child in placement.

Types of actions for the monitoring and implementation of the IAP:

- Discussions with the child and parents/carers.
- Scheduled home visits: as a rule, these are included into the IAP in order to provide direct services/support and monitoring. It is important to pre-establish the purpose of the visit and to have an understanding of the way this visit will be used to provide necessary support to the child and the family. The consequences of the home visit should be considered, to make sure the child and their family are not exposed to harm/risk (for ex., drawing the attention of the extended family members, neighbors, etc.).
- Unannounced home visits: these are very important for the monitoring of the family situation, especially when the family environment is instable/tensed/unpredictable, or the standard of care is not satisfactory. Moreover, these visits may offer better opportunity to observe the child or discuss individually with the child in the case when the parents/carers previously refused an interview.
- Telephone conversation: phone calls may be necessary, especially during the initial stage of the child's placement into a service, or for the work with children who live in remote or isolated communities.
- Confirmations from service providers that the child was referred to the planned service and is receiving necessary service.
- Informal monitoring in the community, for example, conversations with the child's teacher, if he/she is involved in the child's case within the IAP, or information gathering from community groups.

The data from monitoring visits and the collected information is registered in the Evidence sheet of the Individual Assistance implementation monitoring visits, attached to the child's portfolio (Annex 5).

IAP revision allows a change of situation and circumstances, makes sure that the IAP continues to be relevant and meets the child's and the family's needs. IAP is normally revised in the intervals established in the IAP, and in strategic moments (mentioned above), to allow the case manager and the supervisor/service manager (if appropriate), the child and/or the family, to see whether the situation of the child is progressing towards the achievement of the goals and specific objectives established in the IAP, or whether additional services for the child are necessary. IAP revision should be done with the participation and opinion consultation of the child and the family, to involve them into the decision-making referring to their own situation. Before organizing an IAP revision meeting, the case manager should make several monitoring visits to exclude the situational effect.

The first IAP revision session is normally organized after the first two months of implementation. Subsequent sessions are held every three months and whenever it is necessary (Standard 21 of the Family Support Service). In cases of emergency or when the situation is changing rapidly, IAP revision sessions may be held weekly.

For the revision of the IAP, the case manager analyses the changes in the family situations and determines whether the child and the family have achieved some progress, identifies the effects of the intervention on their situation, decides whether it is necessary to have an interview with the beneficiaries prior to the revision meeting.

The IAP form (both, for the child and for the family) includes areas where revision sessions should be described (Annex 3). For example, at the first IAP revision, the actions are ticked since the IAP development until the first revision. A column is left with the new term of implementation for the action/actions that have not finished or have not been realized yet. New planned actions are further described in the relevant area indicating IAP actions. For this, when developing the IAP, the case manager leaves space for each area of the child's well-being and for each family protective factor (column 2 of the form), to be filled after each revision. The same procedure is repeated for subsequent IAP revisions. This format will allow the case manager to see the entire picture of the planned activities and their implementation, as well as the changes in the IAP following each revision, until the closure of the child's case.

Every IAP revision session should start with the analysis of the implementation of the IAP and recommendations made at the previous case revision, and further on, with the child's/family's progresses since the previous IAP revision.

Recommendations for the organization of the IAP review session:

- Select the venue carefully. This may be the social worker's office, home of the beneficiary or a different area (school, a health centre, day-care centre, placement centre, etc.).
- Accidental meetings with the beneficiary cannot be considered IAP review sessions.
- An efficient IAP revision session lasts at least 30-45 minutes.
- Be careful about the persons you want to invite to participate in the meeting (other than the beneficiary), their presence may influence the discussion and the information provided.
- Formulate the goal of the meeting in advance. This may consist of the assessment of some additional aspects of a risk situation, the child's environment, some actions contained in the IAP or other unforeseen situations (for example, analysis of relations within the family where the child was reintegration after residential placement).
- As a result of discussion analysis, formulate clear and succinct conclusions about relevant aspects of the case and recommend actions for the following stages of the intervention.

- During the session, pay attention to any relevant information for the solution of the case, such as attitudes, behaviors, reactions, interpersonal relations, non-verbal language, conditions of the living environment, etc.

IAP revision sessions offer an opportunity to monitor and analyze all active cases that are in work, in order to compare the progress of different cases, to discuss different types of response/opinion/reaction, share the lessons learned about immediate responses on similar cases, and to make joint decisions in complex cases. The principle of confidentiality of the beneficiary's personal information should be respected during these sessions.

Any IAP review session may also be a case closure session.

2.5. Case closure or referral

The last step in the case management process is case closure or referral.

Specific criteria for case closure:

- IAP objectives are achieved;
- the family shows stability (for ex., stable family incomes, improved relations and conditions in the family, etc.);
- parents developed competence to ensure safe and protective environment to the child;
- there are no reasons of concern related to the well-being of the child in the family environment.

Other reasons for case closure:

- the family/the child no longer needs the support provided by the service, and there are no reasons to object to this desire (provided that there are no concerns about the child's safety);
- the child has become full of age;
- the child's death;
- the family moves to a different region of the country.

The decision on the cancelation of the service provided to the family and to the child should be based on progress in the following areas: the child and the family entered into relative stability, the child's fundamental needs are met, the child has developed self-respect in the family and community, the parents/carers have better knowledge of the child's needs, parenting skills are strengthened, relations in the family have improved, the parents are aware of their responsibilities about the care and education of the child, etc.

Case closure is not recommended immediately after the implementation of the IAP. Some time needs to be allocated to further monitoring visits, in order to make sure the child's well-being is improved and stable. The case management procedure implies that the case closure is coordinated with the supervisor or the service manager, to avoid untimely case closure.

After the case closure (closure of the child's portfolio), the child's portfolio is stored by the case manager in a safe place, until the child becomes full of age. Thus, the case may be reopened in any moment, whenever new information appears or the child's situation worsens. In the situation of the child's death the case should not be closed immediately: additional assessment is necessary, to make sure that there are no other children exposed to risk in the family.

There may be situations when the case is not closed, but is **transferred** to the social worker in a different community. This often happens when the family of a child moves to a different community, and the child and the family continues to need protection or support.

A case transfer means that the entire responsibility for the IAP coordination, assistance and monitoring of the child's situation, are transferred to a different community social worker who becomes the case manager. When a case transfer occurs, the first case manager will have to submit

to the new case manager a copy of the child's portfolio, with all necessary documents, and communicate this clearly to the child and family.

During the case transfer procedure it may happen that the child becomes "out of focus" of the specialists, and, consequently, be left without necessary services.

The duration of the case work and of each work stage differs, and is determined by the complexity of the case, family resources, social context, and possibilities of the social assistance system.

Referral consists in the case transfer and taking over by other specialized services relevant and adequate for the improvement of the child's situation. Cases are referred when the resources of the service provided to the child and his/her family have been exhausted, while their needs remain unsatisfied, and this implies other specialized interventions.

The mechanism of case referral within the social services system in most cases starts at the community level, and is initiated by the case manager, supported by the supervisor, who inform the head of community social assistance service (hereinafter, CSAS). Cases are referred to the manager of the required service (within the TSAS).

Cases referred to specialized services, after specialized intervention and solution of problems faced by the beneficiary, return to be monitored at the community level. The specialized service should transmit a summary to the community social worker, containing information about the interventions made, changes in the well-being of the child, and recommendations for monitoring.

2.6. Monitoring of the situation of the child and family after the case closure

Child's and family's situation is normally recommended to be monitored for 6 months after the intervention, and for 12 months in more difficult cases, such as child reintegration, cases of repeated abuse, etc. To maintain a record of child's and family's situation monitoring visits, the form presented in Annex 6 is recommended to be filled.

Monitoring of the child's and family's situation upon case closure is done to make sure their situation remains stable. In cases when this is not accomplished, the child's portfolio is opened repeatedly, and a new IAP is produced for this case.

Persons/families who previously received social assistance and entered repeatedly into difficulty, can apply again to the TSAS for support. If the person/family meets the eligibility criteria, then the case is reopened.

2.7. Documents associated with case management

The documents collected in each concrete case are placed into the child's portfolio. It normally includes standard/typical documents. However, every specialized service may develop and include specific documents into the child's portfolio, in line with the Regulation and minimum standards of quality.

Documents recommended to be included into the child's portfolio:

1. Case report form – when available;
2. Decision of the local guardianship authority regarding the initial assessment (indicating the nominal membership of the multidisciplinary team) – only when there is a case report form for this case;
3. The form of initial assessment of the child's situation;
4. Decision of the guardianship authority on the case registration of the child at risk and on the complex assessment (indicating the nominal membership of the multidisciplinary team);
5. Service manager's prescription on the inclusion of the family into the secondary family support service;

6. Form of complex assessment of the child's situation and of the family's situation;
7. Individual assistance plan;
8. Agreement of collaboration between the parent/carer and the service provider;
9. Evidence sheet of monitoring visits for the individual assistance plan implementation;
10. Prescription of the Service Manager on the case closure;
11. Evidence sheet of child's and family's situation monitoring visits after the child's case closure;
12. Copies of identity documents of the child and other relevant persons;
13. Excerpts from the child's portfolio, when the case is referred to other social services;
14. Other necessary documents.

In the case of protection services, the contents of the child's portfolio should include the following documents, additionally to those mentioned above and in line with the normative framework of a given service:

1. Copy of the case report form – on cases of violence, neglect, exploitation, and traffic;
2. Decision of the local guardianship authority on the child's emergency placement;
3. Decision of the territorial guardianship authority on the child's planned placement;

Other relevant documents.

III. Algorithms of working on cases at different risk levels

To generalize the presented materials, the case manager should organize their case work, integrating the stages of case management, work process/interventions according to different levels of risk (low, medium, high), and actions stipulated in the instruction on the mechanism of cross-sector cooperation for the identification, assessment, referral, assistance, and monitoring of children victims and potential victims of neglect, exploitation, traffic (Government Decision No. 270 of 08.04.2014) and other normative acts (The Regulation and minimum standards of quality of the Family Support Service, etc.).

Remember

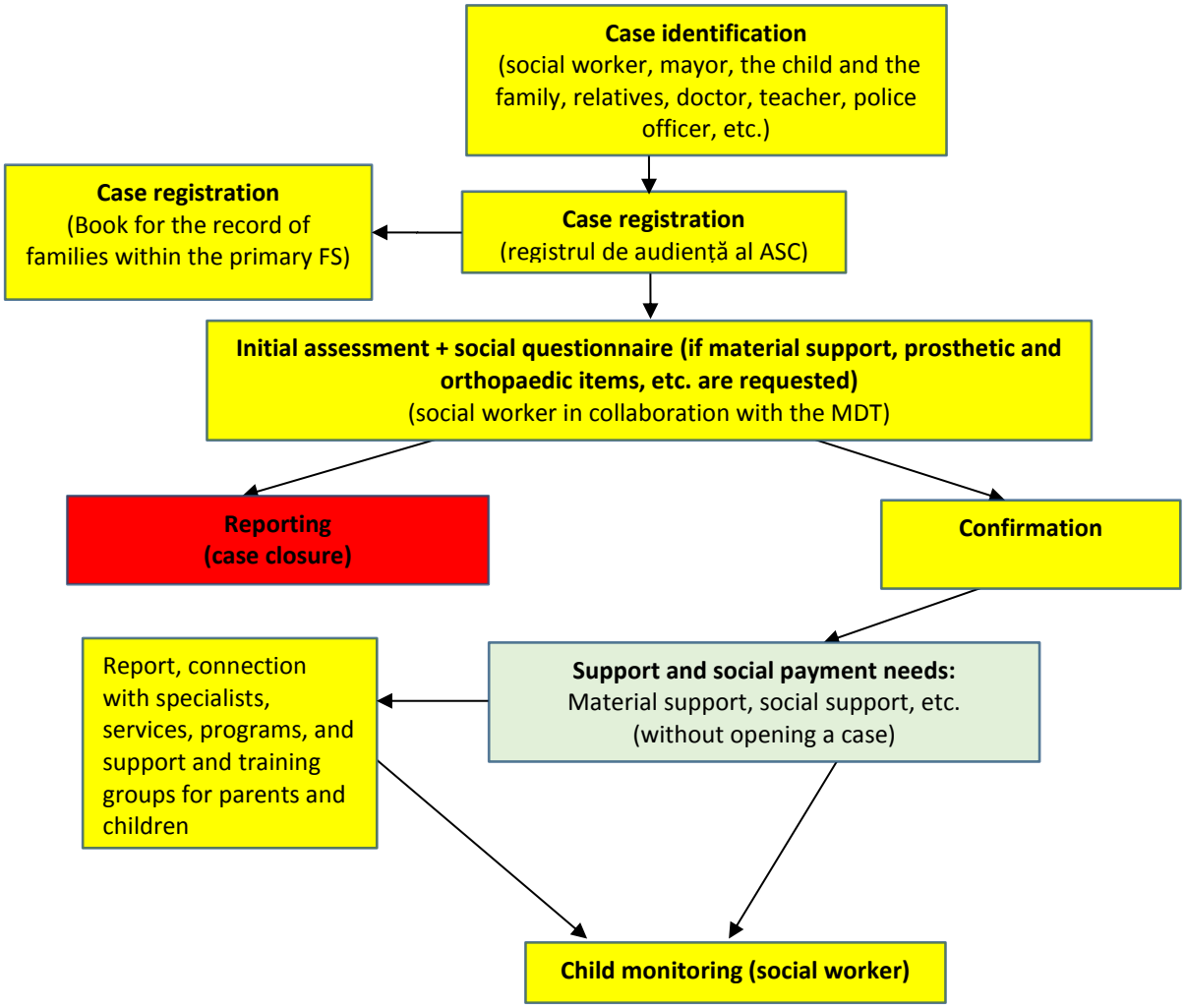
- All cases based on case management start in the community (identification, assessment, planning, implementation, monitoring), and finis also in the community (post-intervention monitoring of closed cases).
- All cases foresee initial and complex assessment to be done by the community social worker supported by the multidisciplinary team (MDT), if necessary.
- All cases in work imply the work of the MDT, if necessary, to increase the impact of the support provided to the child and to the family.
- Even when the cases are referred to the regional level, to make sure the child is offered specialized services, the community social worker continues to work with the family to achieve the child's family reintegration.
- All cases requiring a "flow" of the beneficiaries within the social services network should follow the mechanism of case referral.

Case management follows four algorithms presented below, structured according to the level of risk identified by the case manager during the initial and complex assessment: Algorithm 1 for cases with low risk, Algorithm 2 for cases with medium risk, Algorithm 3A for cases with high risk, without removing the child from the family, and Algorithm 3B for cases with high risk, with the child's removal from the family.

Algorithm 1 presents graphically the stages of the case management and its work procedures for situations of **low risk**. All these cases are in the responsibility of the community social worker, and include actions implemented at the community level, focusing mainly on prevention and elimination of concerns and of the identified low risk. If relevant, the MDT can be involved in all cases, upon the social worker's, regardless of the identified risk.

Algorithm 1. Case management in situations of low risk

(The child is safe at home. However, there are some concerns that the child might be exposed to risk if no prevention and support service are provided, such as: primary family support, group activities for children/parents, etc.).



Algorithm 2 offers a graphical presentation of the case management stages and work procedures for situations of **medium risk**. These are normally cases with the risk of child-family separation. The work algorithm implies the involvement of the Family Support Service, if relevant, and alternative family type services, or other forms of material and financial support provided to families in order to overcome risks and prevent the child's separation from his/her family.

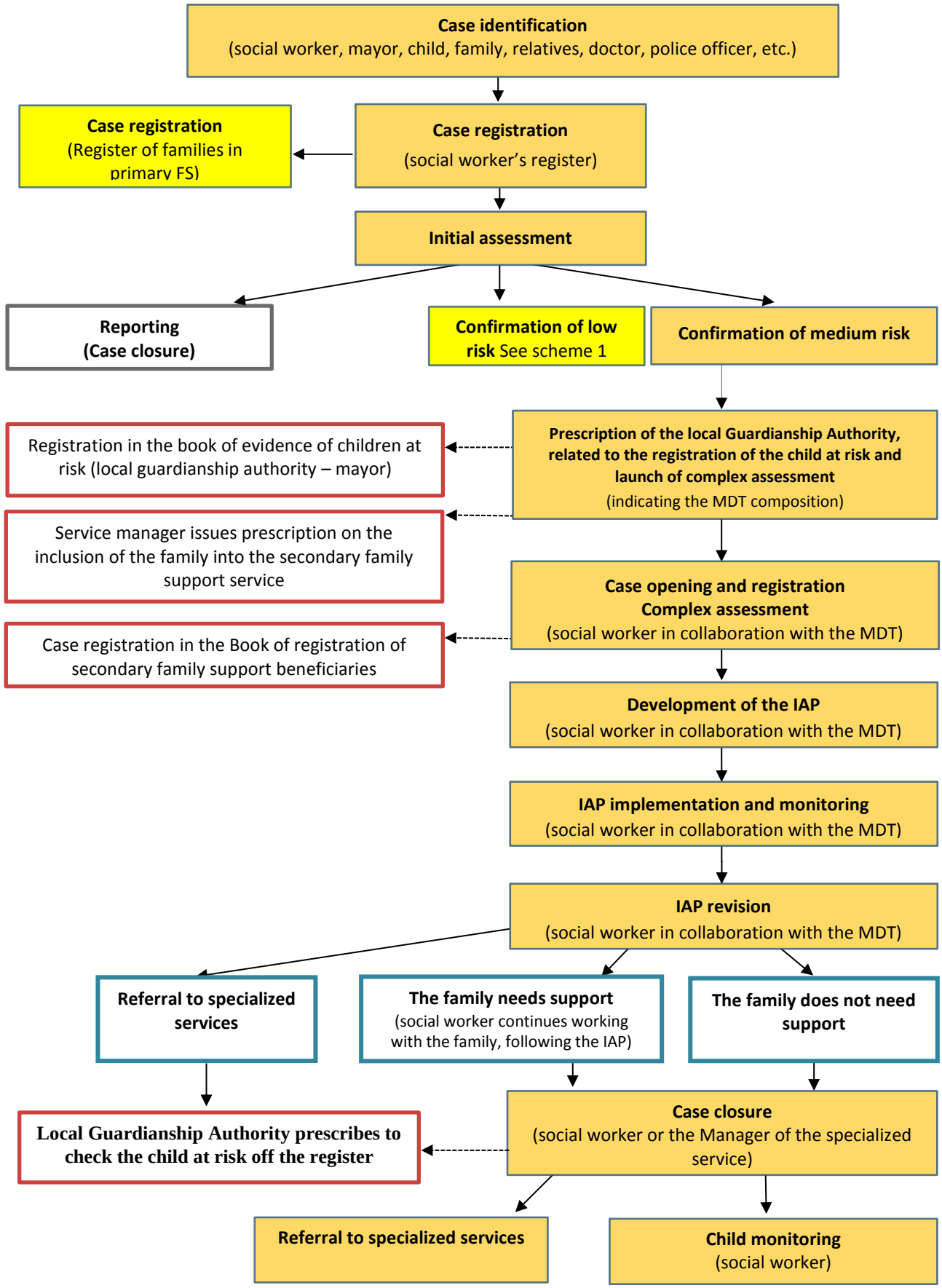
If, following the result of the initial assessment, the case manager determines that the case represents medium risk, then the local guardianship authority – the mayor – is expected to produce a decision regarding the registration of the child at risk and initiation of the complex assessment, indicating the nominal membership of the MDT. The case manager informs the manager of the Family Support Service, and inquires their prescription for the initiation of the child's case. The case manager initiates the child's case and registers it in the Book for the registration of family support beneficiaries. Further work is based on the case management procedure (complex assessment, IAP development and implementation, monitoring and revision of IAP until the child's case closure).

During the IAP implementation, the case manager may require the involvement of specialized region-level services in order to provide specialized support to the child. They will also continue to work with the child's family within the child's case initiated at the community level.

In situations when it is not possible to solve the problem of the child and/or his/her family within the process of IAP implementation at the community level, the case is referred to specialized services existing at the regional level, following the established referral procedure.

Algorithm 2. Case management in situations of medium risk

(Identified need for a long-term intervention based on individual assistance plan. There is no information stating that the life and health of the child are at risk. There is risk of the child's separation from family.)



Algorithm 3 offers a graphic presentation of case management and work procedures for **high risk** situations. These are normally cases that could imply two models of actions. The first model (Algorithm 3A) reflects intensive support provided to the child and family in order to change the family situations and strengthen its parenting skills, aiming to improve the child's well-being (situation when the child remains in the family). The second model (Algorithm 3B) is applied to cases of imminent danger for the child's life and health, according to the Instruction for the mechanism of cross-sector cooperation for the identification, assessment, referral, assistance and monitoring of children victims and potential victims of violence, neglect, exploitation, traffic (GD No. 270 of 08.04.2014), and includes the child's emergency removal from family and his/her placement into alternative family-type services, continuing the support provided to the family in order to overcome difficulties and reintegrate the child into the family.

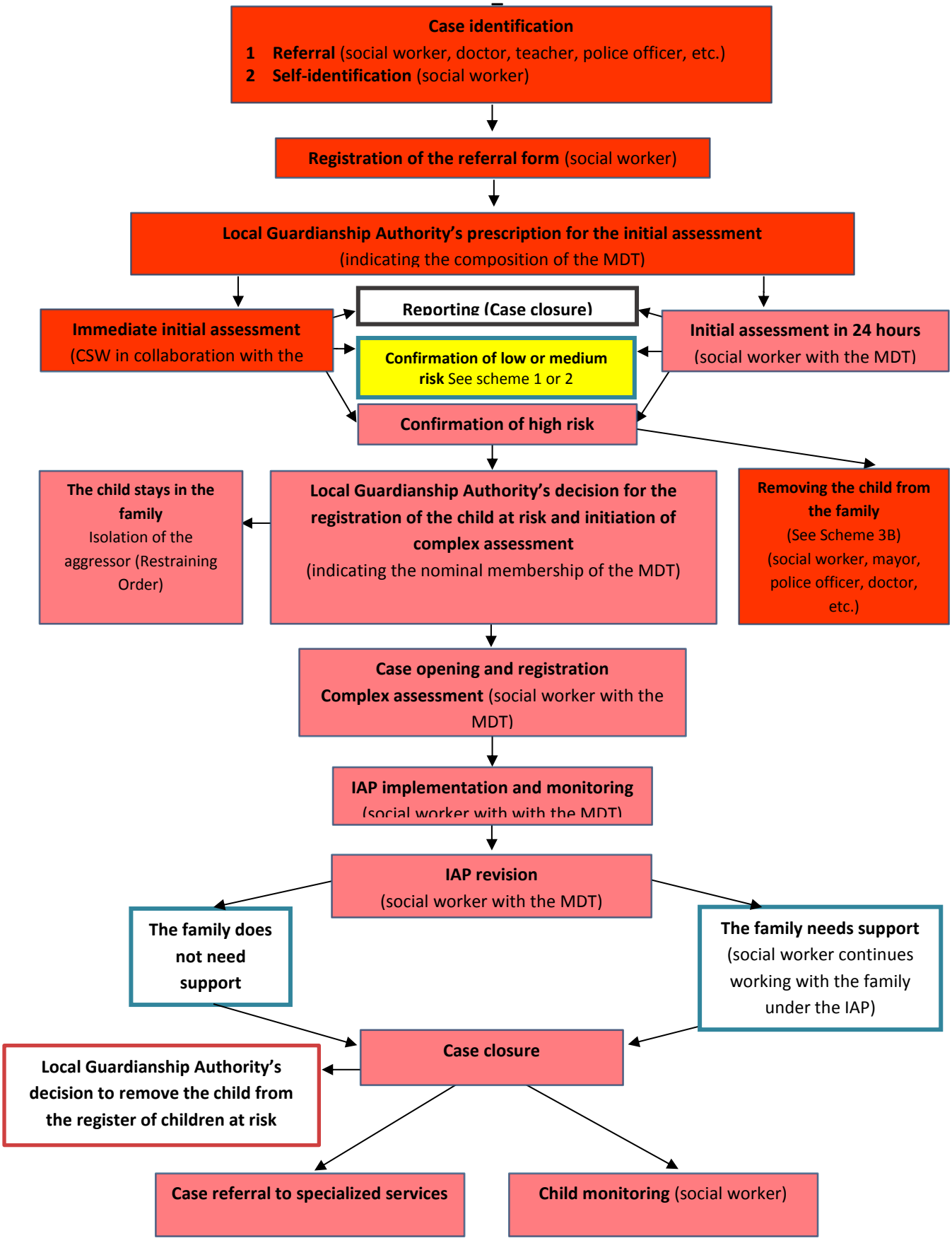
The algorithm of work on high risk cases, without the child's removal from family refers to imminent danger for the child's life and health: these may be cases of violence and severe neglect. The decision for the child's continued stay in the family can be determined by the removal of the abuser from the family, but also by a statement about existing potential of change/elimination of danger, with the support of the police. In such situations, the case management procedure is applied, based on the prescription of the local public authority (mayor) related to the registration of the child at risk and initiation of the child's case.

The most difficult cases are those with high risk, implying the child's removal from the family. A child can be taken out of his/her family as immediate/emergency measure, at the moment of identification of imminent risk. The case is subsequently registered and child's and family's complex assessment is initiated. In order to ensure principles of child protection, in line with the Law of special protection of children at risk and children separated from parents (Law No. 140 of 14.06.2013), all actions are based on the decision of the local public authority (mayor), related to the child's emergent removal from family and emergency placement, record of the child's case, opening of the child's portfolio and initiation of complex assessment of the child and his/her family.

Following the complex assessment of the child's and family's situation and development of the IAP, the case may be referred to the TSAS, with recommendation for the child's planned placement. This is done after the case is examined by the Commission for the Protection of the Child in Difficulty (Gate-keeping commission). At the same time, the community social worker continues working with the child's family, to prepare it for the process of the child's family reintegration.

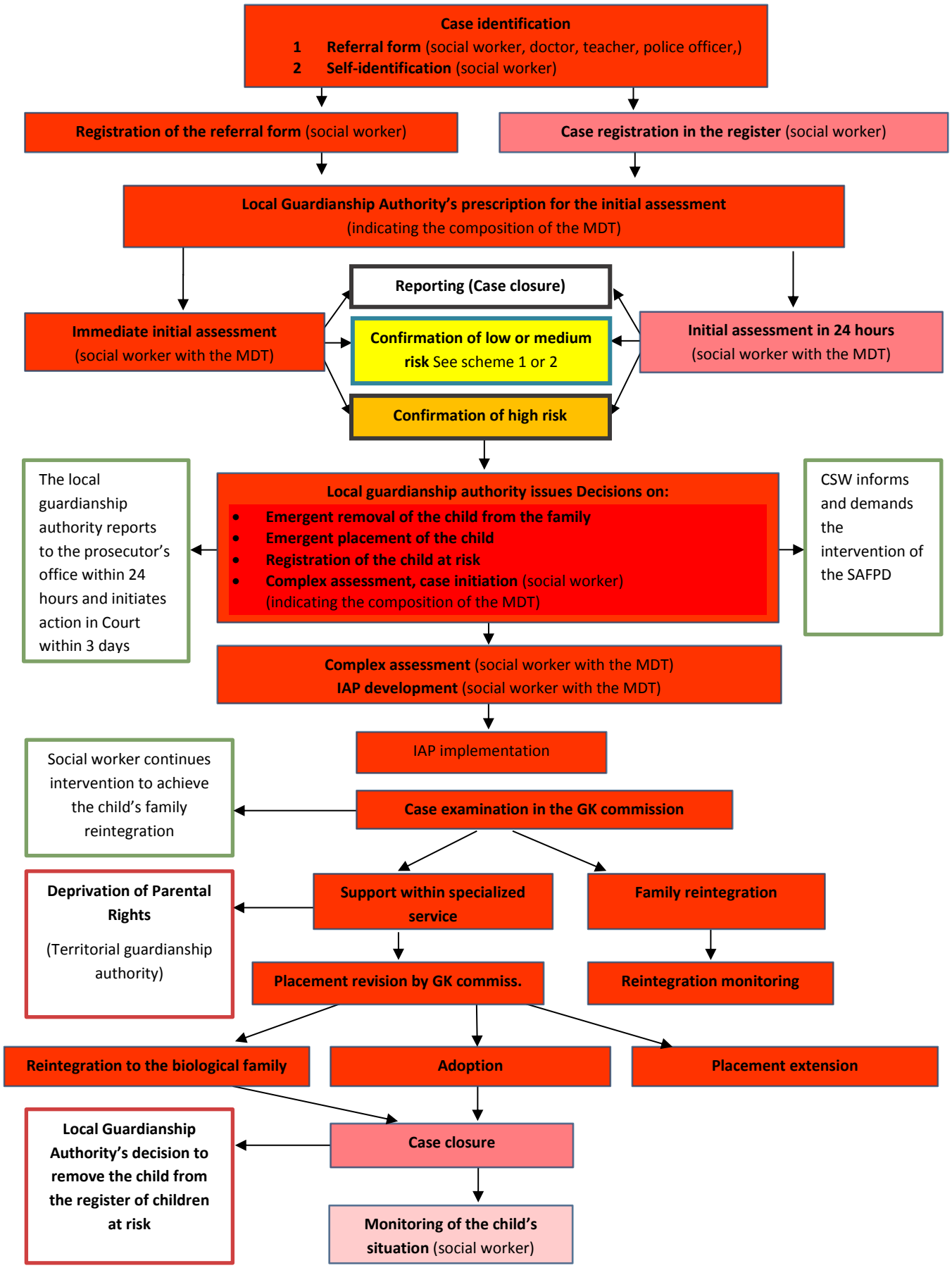
Algorithm 3A. Case management in high risk situations, without the child's removal from family

(the child is in imminent danger to life, with impact on physical and/or psychic health)



Algorithm 3B. Case management in high risk situations, with the child's removal from family

(the child is in imminent danger to life, with impact on physical and/or psychic health)



The algorithms of work described above provide standard models containing work stages and strategies, but also provide for certain modifications and adjustments, depending on the specific situation. In all situations, it is the case manager's responsibility to identify the risk level and select work strategies and algorithm. To increase the effectiveness of case work, the case manager has possibility to involve the local MDT and ask for the support and consultation of the supervisor, head of CSAS, or the specialized social service manager.

ANNEXES

Annex 1
Initial assessment of the child[3]

Date: _____20__

I. General data:

Name of the child _____

Child's date of birth _____

Name of the:

Mother _____
Father _____
Carer[4] _____

Child's home address, phone number_____
_____

Domicile (if this is different from actual home address) _____
_____

_____

Case identified through/by:

☐Report
☐Self-identified
☐ Case report form
☐ Institution, authority, specialist, physical entity _____

II. Reason for initial assessment (prior to the family visit): (tick the well-being that arise concerns or that represent the object of the report)

		Details
Safe	☐	
Healthy	☐	
Achieving	☐	
Nurtured	☐	
Active	☐	

[3]The initial assessment is carried out for all children in the family, in separate forms for each child. Initial assessment is operated only in the case of children who are in the biological family or in guardianship/kinship care.
[4] Carer is the person in whose custody the child is at the moment of assessment (guardianship/curator, foster carer, parent-educator, etc.)

Respected	☐	
Responsible	☐	
Included	☐	

III. Persons living together with the child at the moment of assessment: (from the discussion with the adult/adults and the child)

	Name	**Date of birth**	**Kinship relation to the child, other type of relation**	**Occupation**
1				
2				
3				
4				
5				

IV. Tick the areas of well-being that arise your concern: (from observations and discussions with the adults and the child):

		Details
Safe	☐	
Healthy	☐	
Achieving	☐	
Nurtured	☐	
Active	☐	
Respected	☐	
Responsible	☐	
Included	☐	

V. Other comments: (mention other relevant aspects of the child's | family's situation that have not been described above)

VI. Conclusions and recommendations: (analyze the information obtained and suggest necessary intervention for the child and the family)

Required actions	**Tick**	**Arguments** *(describe):*
Emergency removal of the child from the family, opening of the child's case file.	☐	
Maintenance of the child in the family, removal of the aggressor, opening of the child's case file.	☐	
Opening of the child's case file.	☐	
Provision of social assistance (primary family support).	☐	

No actions are required.	☐	

VII. Parent's/carer's signature:	
Name	**Signature**

VIII. Initial assessment was conducted by:		
Name	**Position and institution**	**Signature**

Annex 2
Complex assessment[5]

Period of assessment: from_____ to_____

A. Complex assessment of the child[6]

I. General data:	
Name of the child	
Date, month, year of birth	
Sex	□ F □ M
Address (the child's place of living at the moment of assessment)	
Child's IDNP/serial number of birth certificate (if there is no IDNP)	
Status of the child: □ temporarily without parental care; □ without parental care; □ separated from parents in the result of migration; □ separated from parents in the result of imminent danger; □ undetermined status; □ does not apply.	

II. Data on the child's contact with services:

Education

Actual situation	**Previous experience**		
1. The child is enlisted in educational facility: □ kindergarten □ primary school □ secondary school □ lyceum □ college □ vocational school □ special school □ residential care □ is not included into the educational system Name of institution:	**Educational facilities attended previously by the child[7]:**		
	Institution	**Child's age when enlisted**	**Reason of transfer to a different institution**

[5] For children in residential care, placement centers, FC, CTFH, in the process of reintegration, only Item I is completed (General data) and Item II (data on the child's contact with community services).
[6] Fill in the Complex Assessment for each child in the family in separate forms.
[7] Is filled in if the child attended other educational institutions before the current institution.

<table>
<tr><th colspan="4">II. Data on the child's contact with services:</th></tr>
<tr><td rowspan="3">Date of enrollment:
Class/year of study:
Current class teacher/educator (Name):
Contacts:
Child with SEN □ Yes □ No
Confirmed by (Name, number of document)_____</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>2. The child is provided inclusive education[8]:
□ total
□ partial
□ home education
Support teacher (name):
Contact data:
Individual Educational Plan (IEP) developed:
□ Yes □ No
IEP developed on (date) _____</td><td colspan="3"></td></tr>
<tr><th colspan="4">Health</th></tr>
<tr><th>Current situation</th><th colspan="3">Previous experience</th></tr>
<tr><td>1.Medical institution the child is registered with:_____
_____
2. Family doctor/nurse (name):_____
_____
Contact details: _____
_____
□ Is not registered with family doctor, reason:_____
_____
3. Is registered with specialized doctor:
□ disability
□ chronic disease
□ other health issues
Name and profile of specialized doctor:_____
_____
Date of the most recent specialized medical consultation:_____
_____
Reason for applying for specialized doctor's consultation:
□ is not registered with specialized doctor, reason: _____
_____</td><td colspan="3">The child received treatment in:
□ stationary, duration_____
□ sanatorium, duration _____
□ rehabilitation, duration _____
□ ambulatory, duration _____</td></tr>
</table>

[8] To be completed for children with SEN who do not attend any educational institution

Social assistance	
Current situation	**Previous experience**
The child is receiving social assistance: □ social services □ payments □ the child is not receiving social assistance	The child received social assistance: □ social services □ payments □ the child did not receive social assistance
Separated from biological family	**Previous experience of separation from biological family**
The child is separated from biological family: □Yes □No □ FC □ FTH □ Guardianship □ Residential care	The child was separated from biological family: □Yes □No □ FC □ FTH □ Guardianship □ Residential care:
Public order	
Current situation	**Previous experience**
□ The child is registered with law-enforcement structures □ The child is not registered with law-enforcement structures District police officer (name): _____ _____ Contact detailes: _____ _____	□ The child was registered with law-enforcement structures □ The child was not registered with law-enforcement structures

III. Child's wellbeing: (tick options for each child wellbeing indicator and provide details)				
1. Safe				
The child feels/is safe at home (is not exposed to domestic violence, parents/carers apply non-violent discipline forms)		Yes □	No □	Partially □
The home where the child lives is adequate for his/her up-bringing and development (is connected to electricity, is heated, the roof is not leaking, has adequate conditions for sleeping, etc.)		Yes □	No □	Partially □
Parent/carer ensure necessary conditions of security, protecting the child from trauma and accidents at home (the rules for the use of stoves, electric heaters, gas stations, etc., are respected)		Yes □	No □	Partially □
The child feels safe at school/kindergarten (is not exposed to violence, discrimination from children and/or adults, there is no risk of accidents, trauma)	Not applied □	Yes □	No □	Partially □
The child feels safe in the community (is not afraid to go out in the community/in case of a small and disabled child – is attended while going out)	Not applied □	Yes □	No □	Partially □
The child with disabilities who is incapable of self-service, or the child aged 0-5, is always supervised by an adult	Not applied □	Yes □	No □	Sometimes □
The child has a reference/confident person to call on in case of need	Not applied □	Yes □	No □	Sometimes □

Parent/carer always knows where the child is situated (when he/she is out of home)		Yes □	No □	Sometimes □
Please, provide details in cases when the answer is "No", "Partially", or "Sometimes".				
2. Healthy				
The child has individual personal hygiene items (toothbrush, comb, towel, body linen) that is stored clean and in conditions of hygiene		Yes □	No □	Partially □
The child has developed skills to maintain personal hygiene, clean clothes, and the rooms where lives	Not applied □	Yes □	No □	Partially □
The child with health issues makes periodical investigations and treatment/rehabilitation	Not applied □	Yes □	No □	Partially □
The child has regular meals, corresponding to own needs		Yes □	No □	Partially □
The child knows and understands own health needs and has developed self-care skills (medicine-taking, diets, etc.)	Not applied □	Yes □	No □	Partially □
The child has a healthy way of life (does not consume alcohol, drugs, does not smoke, goes in for sport, has healthy diet)	Not applied □	Yes □	No □	Partially □
Please, provide details in cases when the answer is "No", or "Partially".				
3. Achieving				
The child is provided conditions for age-adequate development and learning (toys, books, textbooks, space, etc.)		Yes □	No □	Partially □
The child makes effort to finish a task (knows how to find solutions, overcome difficulty)	Not applied □	Yes □	No □	Partially □
The child attends educational facility	Not applied □	Yes □	No □	Partially □
The child makes progress according to own potential	Yes □	No, but makes effort □		No □
The child receive additional support in school, if needed	Not applied □	Yes □	No □	Partially □
The child is supported and encouraged by parents/carers to develop new skills, do homework, practice various activities	Not applied □	Yes □	No □	Partially □

The child is learning to be independent	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child has aspirations for the future, wants to continue education, to have a job	Not applied ☐	Yes ☐		No ☐
Please, provide details in cases when the answer is "No", or "Partially".				
4. Nurtured				
The child is attached to at least one of the parents/carers/other person		Yes ☐	No ☐	
The child has an adult person to discuss with, share motions and feelings with	Not applied ☐	Yes ☐	No ☐	
The child is treated with affection by others (hugs, emotional warmth, stroking)		Yes ☐	No ☐	Partially ☐
The child has neat aspect (clean and weather-appropriate clothes, combed, with hear cut)		Yes ☐	No ☐	Partially ☐
The child is optimistic, communicable, and positive in relation to others	Not applied ☐	Yes ☐	No ☐	Partially ☐
Please, provide details in cases when the answer is "No", or "Partially".				
5. Active				
The child is involved in leisure activities (recreation, sport, dancing, music, etc.)	No ☐	Does not apply ☐	In the family ☐	At school ☐	In the community ☐
The parent/carer encourages the child's participation in activities within the family, school and community (cultural, sport, play, interest activities)		Not applied ☐	Yes ☐	No ☐	Partially ☐
The parent/carer ensure balance between learning activities, household responsibilities, and recreation		Not applied ☐	Yes ☐	No ☐	Partially ☐
Please, provide details for cases when the answer is "No" or "Partially"				
6. Respected				
The child feels respected, listened to, and taken seriously (in the family, at school, in the community)		Not applied ☐	Yes ☐	No ☐	Partially ☐

The child feels involved in decision-making concerning own life (in the family, at school, in the community)	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child is supported to express own opinion (in the family, at school, in the community)	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child respects those around and understands other's opinion, helps others	Not applied ☐	Yes ☐	No ☐	Partially ☐
The parent/carer respects the child's intimacy and personal space	Not applied ☐	Yes ☐	No ☐	Partially ☐
Please, provide details for cases when the answer is "No" or "Partially"				
7. Responsible				
The child assumes responsibility for own actions, makes difference between what is good and what is bad	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child follows rules and instructions – in the family, at school, in the community	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child has responsibilities adequate to own age and potential, in the family, at school, and in the community	Not applied ☐	Yes ☐	No ☐	Partially ☐
Please, provide details for cases when the answer is "No" or "Partially"				
8. Included				
The child communicates with peers, feels part of a group (friends, colleagues, neighbors, community)	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child is in systematic contact with significant adults who support him/her and whom he/she trusts	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child participates in family activities and events	Not applied ☐	Yes ☐	No ☐	Partially ☐
The child with SEN is supported in the process of development and learning	Not applied ☐	Yes ☐	No ☐	Partially ☐

Please, provide details for cases when the answer is "No" or "Partially"

IV. Statements on the results of the assessment		
Affected wellbeing indicators		**What action was taken before the complex assessment (by the family, community, universal services)**
Safe		
Healthy		
Achieving		
Nurtured		
Active		
Respected		
Included		
Responsible		

Child's strengths	Child's weaknesses

V. Child's view of own current situation (to be filled depending on the child's capacity to understand and maturity, regardless of their age)

VI. The parents'/carers' view of the child's current situation

B. Complex assessment of the family's situation[9]

I. General data about the situation of the child's family (this table shall be also filled for the carer's family)					
Type of family	Biological family □		Extended family □		Tertiary persons □
Family status	Complete (marriage) □	Complete (concubine) □	Incomplete (divorce/separation) □	Incomplete (death of one of the parents) □	Lonely mother □
Type of social assistance previously provided to the family	Social services: - - -		Cash benefits: - - -		

Family problems:

□ unemployment

□ alcohol, drugs misuse

□ domestic violence

□ health issues of parents

□ dependency on social assistance

□ parents are monitored by law-enforcement structures

Reason:

□ Other (please, provide details):

II. Family composition (Including, other persons who live together with the family)					
Name, given name	IDNP	Date of birth	Relation to the child (kinship, other type of relation)	Occupation	Describe (place of studies, place of employment, unemployed and registered at the employment agency, etc.)

[9] To be filled as component of the same case file. To be also filled for the family where the child is to be reintegrated.

III. Other relevant persons in contact with the child, who currently do not live with the child (including, biological family members who do not currently live with the child)					
Name, given name	IDNP	Date of birth	Relation to the child (kinship, other type of relation)	Occupation	Describe (place of studies, place of employment, unemployed and registered at the employment agency, etc.)

IV. Living conditions and wellbeing of the child				
The family lives in	Own housing □	Live with the extended family/other persons □	Temporarily rented accommodation □	Temporary accommodation, not rented □
Housing	No. of living rooms_____		Of them heated _____	
The house needs	Current repair □	Capital repair □	Details:	
The housing provides conditions for homework	Yes □ No □			
The housing provides play area for children	Yes □ No □			
The housing is connected to electricity	Yes □ No □			
The housing provides conditions for hygiene	Yes □ No □			
The housing has household equipment	Yes □ No □			

(cooking machine, fridge, etc.)					
Family incomes	Salary Yes □ No □	Pensions Yes □ No □	Payments Yes □ No □	Remittance Yes □ No □	Occasional income Yes □ No □
The family has enough money to pay utility bills (electricity, gas, etc.)	Yes □ No □				

Family history (describe the evolution of the child's biological family, analyzing important events in the family's life, including serious crises at the level of relations and traumatic events that could influence the child's development, analyzing the prevailing psycho-emotional situation in the family and relational style: harmonious relations, mutual support, spending leisure time together, etc.)

V. Assessment of protective factors in the family where the child grows and develops

1. Parental resilience (tick the appropriate answer/answers that reflect the family situation)

	Mother/carer				**Father/carer**			
has necessary skills for the solution of everyday problems	Yes □		No □	Partially □	Yes □		No □	Partially □
can control own emotion under stress	Yes □		No □	Partially □	Yes □		No □	Partially □
cares of own self	Yes □		No □	Partially □	Yes □		No □	Partially □
maintains the accommodation and the household in good order	Yes □		No □	Partially □	Yes □		No □	Partially □
recognizes that needs support in order to cope with household or child care issues	Yes □		No □	Partially □	Yes □		No □	Partially □
recognizes that has problems with alcohol/drugs misuse and is aware of the need of alcohol/drug dependency treatment	Not applied □	Yes □	No □	Partially □	Not applied □	Yes □	No □	Partially □

is able to plan and manage the family budget	Yes □	No □	Partially □	Yes □	No □	Partially □
is responsible, works, seeks opportunities to earn sources for living	Yes □	No □	Occasionally □	Yes □	No □	Occasionally □
Make conclusions on the family resilience (family's capacity to cope with difficulties)						

2. The family's social support network (make an Eco-map (Annex 11) to identify social stakeholders and relations with the people around or with institutions that may provide sources of support or stress for the family)

	Mother/carer			**Father/carer**		
is communicable, able to set up and maintain relations	Yes □	No □	Partially □	Yes □	No □	Partially □
has friends and is in good relations with the neighbors	Yes □	No □	Partially □	Yes □	No □	Partially □
knows how to ask for help from friends, neighbors, when faces a difficult and accepts the support offered	Yes □	No □	Partially □	Yes □	No □	Partially □
communicates and asks for advice from parents who have children of the same age or face similar problems in childcare	Yes □	No □	Partially □	Yes □	No □	Partially □
offers support to other persons	Yes □	No □	Partially □	Yes □	No □	Partially □
participates in community events	Yes □	No □	Partially □	Yes □	No □	Partially □
Make conclusions on the family's social support network						

3. Parenting skills in child care and development

	Mother/carer			Father/carer		
knows and understands the child's development and behavioral needs	Yes □	No □	Partially □	Yes □	No □	Partially □
has adequate expectations from the child	Yes □	No □	Partially □	Yes □	No □	Partially □
communicates with the child without barriers	Yes □	No □	Partially □	Yes □	No □	Partially □

can efficiently manage the child's behavior, without applying violent discipline forms	Yes □	No □	Partially □	Yes □	No □	Partially □
always knows where the child is	Yes □	No □	Partially □	Yes □	No □	Partially □
seeks information/advice on child up-bringing and development	Yes □	No □	Partially □	Yes □	No □	Partially □
participates in parents meetings, communicates with teaching staff, participates in preschool or school activities of the child (offers support to the child in doing homework, reads together with the child, etc.)	Yes □	No □	Partially □	Yes □	No □	Partially □
involves, encourages and supports the child's interests and occupations	Yes □	No □	Partially □	Yes □	No □	Partially □
Make conclusions on the family's parenting skills in child care and contribution to the child's development						

4. Concrete support in times of need

	Mother/carer				Father/carer		
is able to protect own and child's rights and interests	Yes □		No □	Partially □	Yes □	No □	Partially □
had positive experiences in accessing necessary services	Not applied □	Yes □	No □	Partially □	Yes □	No □	Partially □
needs support in accessing services (illiteracy, reduced capacity to perceive information, etc.)	Yes □		No □	Partially □	Yes □	No □	Partially □
needs new competences in order to find employment (training, initiation of a business)	Yes □		No □	Partially □	Yes □	No □	Partially □
Has medical insurance	Yes □		No □		Yes □	No □	
knows where and how to obtain medical assistance	Yes □		No □	Partially □	Yes □	No □	Partially □
Make conclusions on the parents'/carers' capacity to contact different services (social, medical, educational assistance, etc.)							

5. Parents'/carers' capacity to develop the child's emotional and social competences						
	Mother/carer			Father/carer		
encourages the child to express emotions and answers to them	Yes □	No □	Partially □	Yes □	No □	Partially □
encourages the child to express opinion and involves him/her in everyday decision-making	Yes □	No □	Partially □	Yes □	No □	Partially □
teaches the child to manage aggressiveness	Yes □	No □	Partially □	Yes □	No □	Partially □
teaches the child to communicate to other children	Yes □	No □	Partially □	Yes □	No □	Partially □
supports the child to understand the difference between what is good and what is bad, and sets up clear rules and limits for acceptable behavior	Yes □	No □	Partially □	Yes □	No □	Partially □
Make conclusions on the parents'/carers' capacity to understand the importance and to contribute to the child's emotional and social development						

VI. Statements resulting from the assessment

1. Family protective factors that are affected		What action was done prior to the complex assessment (by the family, community, universal services)
Parental resilience		
Family's social support network		
Parenting skills in childcare and development		
Concrete support in times of need		
Parents'/carers' capacity to develop the child's emotional and social competences		

Family's strengths	Family's weaknesses

VII. Parent's/carer's signature	
Name, given name	**Signature**

VIII. Complex assessment of the child and family was done by:		
Name, given name	**Position and institution represented**	**Signature**

Annex 3
Individual Assistance Plan

Date of the planning meeting of the multidisciplinary team:_____									
I. Individual assistance plan for the improvement of the child's wellbeing[10] (formulate the identified problems for areas of child's well-being, and necessary actions for their solution, based on the results of the child's complex assessment)				**Date of IAP revision**		**Date of IAP revision**		**Date of IAP revision**	
Child's name									
Affected wellbeing indicators	**Actions**	**Person in-charge/persons in-charge**	**Term of achievement**	**Achieved (tick)**	**New term**	**Achieved (tick)**	**New term**	**Achieved (tick)**	**New term**
Safe									
-									
-									
-									
-									
-									
Healthy									
-									
-									
-									
-									
-									

[10]The Individual assistance plan is filled in a separate form for each child of the family.

Achieving									
-									
-									
-									
-									
-									
Nurtured									
-									
-									
-									
-									
Active									
-									
-									
-									
-									
-									
Respected									
-									
-									
-									
-									
-									

Responsible - - - - -									
Included - - - - -									

Participants in the revision meeting	**Organization, function**	**Signatures**		

Child's opinion about the actions included into the plan (to be filled depending on the child's age and capacity)

Parent's/carer's opinion about the actions included into the plan and their agreement to involve in the achievement of the established actions	
Signature	

II. Family strengthening actions plan (formulate the identified problems at the level of family protective factors and necessary actions for their solution and family strengthening, based on the analysis of the family's complex assessment results).				**Date of IAP revision**		**Date of IAP revision**		**Date of IAP revision**	
Affected family protective factors	**Actions**	**Person in-charge/persons in-charge**	**Term of achievement**	**Achieved (tick)**	**New term**	**Achieved (tick)**	**New term**	**Achieved (tick)**	**New term**
Parental resilience - - - - -									
Family's social support network - - - -									
Knowing and applying principles of childcare and development - -									
Concrete support in times of need - -									

-									
Capacity of the parents/carers to develop the child's social and emotional skills -									

Persons present at the revision meeting	**Organization, function**	**Signatures**		

Parent's/carer's opinion about the actions included into the plan and their agreement to involve in the achievement of the established actions	
Signature	

Participants in the development of the Individual assistance plan of the child and his/her family		
Name, given name	**Position and institution represented**	**Signature**

Annex 4
Collaboration agreement between the parent/carer and the case manager

Concluded between:

Social Worker_____and

The Undersigned, _____

This is to confirm that

participated in the assessment the child's and our family's situation and in the development of the Individual assistance plan, and I agree to involve in the implementation of activities pointed out in the Individual assistance plan, in order to solve problems encountered by my family and improve the situation of my children;

I give my consent for my personal data and information related to my family and to my children to be shared with other specialists who can contribute to the problem solution;

I also agree that disregard of assumed responsibilities determines the termination of the social worker's intervention.

Date signed

Beneficiary's signature

Social Worker's signature

Annex 5
Evidence sheet of visits to monitor the Individual Assistance Plan implementation

Evidence sheet of visits to monitor the Individual Assistance Plan implementation					
Date of monitoring action	Monitoring action	Actions included into the IAP	The term of action implementation	Progress or its absence, and reason	Conclusions, recommendations, new identified needs

Annex 6
Evidence sheet of visits to monitor the child and family after case closure

Evidence sheet of visits to monitor the child and family after case closure			
Date of monitoring action	Monitoring action	Statements	Conclusions and recommendations

Annex 7
Social questionnaire (for material support) [11]

Date: _____20

The commission examining living and social conditions: (Name and position of commission members)

_____
_____
_____

Researched the living conditions of the family

_____

Living on the address _____

_____

Phone.

_____

And stated the following:

FAMILY COMPOSITION

Name	Date, month, year of birth	Social status of the person	IDNP	ID	Degree of relation (kinship)

LIVING CONDITIONS

Legal status of the accommodation (underline): state-owned, rented. Type of accommodation: hostel, estate house, apartment in a block of apartments. Other (please, specify)

_____

Number of rooms _____ Living area_____

Total area _____

_____

[11]Social investigation, approved by Order No.71 of 03.10.2008, Ministry of Labor, Social Protection and Family

Other immovable property:

_____

Agricultural land _____ Allotment near the house

_____

Goods: TV ____ Fridge _____ Washing machine _____ (years since produced)

_____

Other goods (car, agricultural machines) ____ (years since produced)

_____

Conditions.

Connections:

Natural gas network_____,

heating _____,

electricity _____,

water ____

Other _____

_____

Hygienic and sanitary condition:

_____

Family's monthly income (indicate the source and amount):

_____

_____

_____

_____

_____

Family pathologies (alcohol, drug abuse, domestic violence, child abuse, neglect of parenting duties)

_____

_____

_____

_____

Problems faced by the family. From the words of family members

_____

_____

_____

_____

_____

_____

_____

_____

Support provided to the family:

Date	Type of support	Organization that provided support	Reason for application	Amount, volume

Conclusions

_____

_____

_____

_____

_____

_____

_____

Recommendations

_____

_____

_____

_____

Signatures of family members: _____ _____

_____ _____

_____ _____

Annex 8
The social worker's code of ethics[12]

The goal of the Code:

- identifies standards of the social worker's professional behavior and practice;
- charters ethical responsibilities in social work activities;
- protects and promotes interests of users, as well as professional interests of social services providers.

CONTENTS

[12] Code of Ethics approved by the Association for the Promotion of Social Assistance, at the meeting of 25.04.2005, and further, by the Decision of the Collegial Board of the MLSP of 29.11.2005

CHAPTER 1. ETHICAL PRINCIPLES

1.1 General ethical principles

Art. 1 Every human being represents unique value, which implies unconditioned respect.

Art. 2 Every person has responsibility to contribute, within their possibilities, to the well-being of the society, and to exert their right to demand its full support.

Art.3 Every person has the right to self-realize, within the limits that do not affect other person's self-realization.

1.2 Specific ethical principles

Art. 4 The social worker must to respect and promote principles of ethics and social equity.

Art. 5 The social worker, in their activity, must respect the rights of other persons, in line with the rights and values stipulated in the national legislation, in the Universal Declaration of Human Rights, and in other international conventions.

Art. 6 The social worker is responsible to use to the maximum extent own human qualities and professional knowledge, in order to help individuals, groups, communities, and the society, in their development and in the solution of conflicts at the personal and social level.

Art. 7 The social worker should provide optimum assistance to persons in difficulty, without any discrimination (on the grounds of sex, age, race, nationality, ethnical or religious identity, disability).

Art. 8 The social worker must rely on the principle of confidentiality and responsible use of information obtained in their professional activity.

Art. 9 While performing their professional duties and revealing a violation of legal provisions, the social worker must report this situation to the relevant parties.

Art. 10 The social worker must to collaborate with law-enforcement structures for the prevention of eventual criminal acts.

Art. 11 The social worker should actively involve the beneficiary in learning about their interests, ensuring their autonomy, dignity, and human development.

Art. 12 In their work with the beneficiary, the social worker should give priority to their interests, without damaging interests of other involved persons.

Art. 13 The social worker should stimulate the beneficiary to assume responsibility for the identification of solutions of their problems and actively support the beneficiary in this process. The social worker should orient the beneficiary for the awareness of risks and eventual consequences.

Art. 14 The social worker can recommend certain solutions for the problems of the beneficiary to the extent that it does not affect interests of other involved parties, and only after a systematic and responsible assessment of the needs of the parties involved in the conflict.

Art. 15 In their activity, the social worker shall not offer direct or indirect support to political groups, forces, or structures of power to manipulate or oppress the opinion of other human beings.

Art. 16 The social worker should make decisions that have explicit ethical justification and militate for those decisions to be accepted and respected by others.

Art. 17 The social worker must promote the principles of this code, contributing to the awareness and their implementation both within their professional community, and by other persons and institutions.

Art. 18 The social worker should support the parties in constructive solution of conflict situations, avoiding the need of a court settlement.

CHAPTER 2. PROFESSIONAL STANDARDS

2.1 Moral standards

Art. 19 The social worker should practice their profession with high moral standard of honesty, dignity, and competence.

Art. 20 The social worker should maintain a high standard of moral conduct in the community. Any form of manipulation is inacceptable. The social worker should respect the liberty of choice of any individual, group, or community.

Art. 21 The social worker should protect the beneficiary from eventual abuse caused by the difficulties experienced by them.

Art. 22 The social worker should have behavior that does not affect their professional image.

2.2 Professional standards

Art. 23 The social worker should be active in problems identification, using professional knowledge to help persons, groups, and the community in difficulty to achieve acceptable levels of normality in well-being.

Art. 24 The social worker should protect the interests of beneficiaries, supported them in own and fully aware decision-making.

Art. 25 The social worker should continuously improve own professional competence, practical skills and abilities; contribute to the development of a stimulating environment for on-going education within the professional community.

Art. 26 The social worker should avoid situations that may damage the public favorable image of the profession; it is inacceptable that they admit or encourage discrediting of the profession.

Art. 27 The social worker is responsible for the quality and content of the services they provide.

Art. 28 The social worker should resist any political or ideological pressure and other influences that may affect professional performance.

Art. 29 The social worker should not admit their personal issues to influence decisions in their professional activity.

Art. 30 The social worker has duty for own self and for own family, to develop capacity to differentiate between professional activity and their personal and family life.

Art. 31 The social worker should develop capacity of self-awareness and of the awareness of others.

Art. 32 The social worker should continuingly subject to constructive critical examination the theories, methods, and practices in their professional area.

Art. 33 The social worker should sustain with information and available data their scientific research in the area.

Art. 34 The social worker involved in scientific research should respect the anonymity and intimacy of investigated persons, in order to remove any moral or material prejudice to which they may be exposed.

Art. 35 As a trainer, supervisor, or a more experienced colleague, the social worker must support the process of training and education of specialists in the area.

Art. 36 Specialists involved in the professional training of social workers should inspire respect and love for the profession, contributing to the dissemination and adherence to the norms of this Code.

2.3 Standards in the social worker's relations with beneficiaries

Art. 37 The social worker should be respectful with the beneficiary and recognize their freedom of choice.

Art. 38 The social worker must provide assistance, taking into consideration the values of the community to which the beneficiary belongs.

Art. 39 The social worker must assist persons in difficulty, without any discrimination, within the limits of the institution they represent.

Art. 40 The social worker should offer complete and exact information to the beneficiary, related to the offer of the social services available in the institution they represent.

Art. 41 In case they cannot provide the required assistance, the social worker should explain the reason of refusal to the beneficiary.

Art. 42 When put in the situation of expressing own religious or political options, the social worker should do it in a way that the beneficiary feels absolutely free to express own options.

Art. 43 The social worker should cooperate with the beneficiary about the assistance provided. In case if the beneficiary is not able to decide on own needs, the social worker should inform their legal representative. In case if the interests of other persons or of the community at in danger, the social worker is authorized to intervene without informing the beneficiary.

Art. 44 The social worker should win the beneficiary's confidence, convincing them that the established relation is used for the purpose of pursuing their legal rights, promotion of their wish and interests. The social worker shall collect only information that is relevant for the social assistance intervention.

Art. 45 The social worker, cooperating with other persons, should communicate only relevant information, and only with the client's consent and in line with the stipulations of the Art. 8, except cases described in articles 10, 43, and 46.

Art. 46 A social worker, summoned to witness in a court, will or will not make statement, respecting the provisions related to the professional secret contained in this Code. A social worker can make statement against any assisted persons in the conditions when they appreciate that there is danger for one's life, while in case of doubt, they may consult the relevant structure from their professional community.

2.4 Standards of work relations

Art. 47 The social worker must work and cooperate with agencies that have policies and work principles corresponding to adequate professional standards provided in this Code.

Art. 48 The social worker should respect professional and ethical standards of the institution they represent, if this does not contradict the provisions of this Code.

Art. 49 The social worker should contribute to the responsible and qualified achievement of the objectives of the organization they represent, to the development and improvement of professional and ethical standards in social assistance.

Art. 50 The social worker should contribute to the legal needs meeting of the beneficiaries within the institution they represent, or, where this is impossible, to seek other sources of support.

2.5 Standards in relations with colleagues and other professionals

Art. 51 The social worker should collaborate with colleagues and specialists from other areas.

Art. 52 The social worker should promote and respect professional standards.

Art. 53 For the purpose of mutual improvement, the social worker should disseminate knowledge, experience, ideas among colleagues, specialists, and volunteers.

Art. 54 The social worker should provide support to young specialists, for their professional integration.

Art. 55 The social worker should recognized and respect the merits and competences of colleagues, accept differences in opinion and practice, expressing eventual critics in adequate manner.

Art. 56 As a manager, the social worker should respect professional opinions, capacity, experience, and merits of colleagues, creating an atmosphere of free and responsible debate.

Art. 57 In the process of the colleagues' activity assessment, the social worker should prove equity, correctness, and professionalism.

Art. 58 The social worker should contribute to ensuring collegial climate, in conditions of respect and mutual support. In conflict situations, they should actively contribute to their resolution in collegial manner, in accordance with professional standards.

Art. 59 In relations with colleagues and other specialists, the social worker should base on loyalty and mutual support of reputation.

Art. 60 Working with beneficiaries, the social worker should not exceed the limits of professional competence; in the same time, the social worker should militate against their replacement as specialist by specialists from other areas.

Art. 61 The social worker who has evidence that his/her colleague affects through their behavior the interests of the beneficiary, or violates professional standards, must report this fact to the competent authority that will solve the issue.

2.6 The social worker's responsibility in front of the community

Art. 62 The social worker is responsible before the assisted persons and before the community.

Art. 63 The social worker must support the assisted persons in their social and cultural integration, restoration of relations with the family and community, reducing social dependency, and contribute to the understanding of their social rights and obligations.

Art. 64 The social worker is responsible to support the community in understanding the problems faced by certain categories of the population, eventual inequities and lawlessness, and opt for a shared attitude, by finding constructive solutions.

Art. 65 Based on democratic values, the social worker must respect the cultural background, historical experience, fundamental options of the community in which they work.

Art. 66 The social worker should contribute with own professional experience to the development of social programs and policies.

Art. 67 The social worker should opt for the creation of a "society for all", free from discrimination, exclusion, and marginalization.

RESPONSIBILITY OF THE COMMUNITY OF SOCIAL WORKERS FOR THE PROMOTION OF THE SOCIAL WORKER'S PROFESSION

Art. 68 The social worker has moral obligation to adhere to a professional community for the promotion and development of the profession, professional rights and obligations.

Art. 69 The community of social workers should promote the stipulations of this code and monitor their implementation.

Art. 70 The community of social workers must act to prevent the practicing of the social work profession by persons who do not have the relevant professional qualification.

Art. 71 The community of social workers should militate to make sure that only professional social workers are employed in social services providing organizations.

Art. 72 The community of social workers should contribute to the development of mechanisms and procedures of social services providers' assessment and accreditation.

Art. 73 The mission of the community of social workers is to promote cooperation with all specialists, contributing to the profession development.

Art. 74 The community of social workers should promote on-going professional training, and be responsible for the quality of the provided services.

Art. 75 The community of social workers should participate in the development of minimum standards of quality for social services and in the assessment of the quality of those services.

Art. 76 The community of social workers should recognize and stimulate the need of collaboration between social workers and other specialists, in the interest of the beneficiary.

Art. 77 The community of social workers should advocate for the creation of conditions allowing social workers to know and respect the provisions of this Code.

Art. 78 The community of social workers should promote and support the process of social services creation and development.

Art. 79 The community of social workers should act to ensure the social recognition of the profession and to achieve the official institution of the professional status.

Art. 80 The community of social workers must develop the following types of services:

- dissemination of this Code;
- analysis of situations of possible violation of the Code's provisions;
- responsible and collegial analysis of cases of this Code's provisions;
- prevention and application of relevant sanctions.

Art. 81 The community of social workers applies sanctions:

1. personal notice;
2. reporting to institutions where the social worker is employed;
3. information of the entire professional community about the breaches.

Annex 9
Guidelines for obtaining informed consent

Since the very beginning of the case management process, the social worker is responsible to explain their role and inform the child and the family about available services that could be helpful to them. Very often, the children and their parents do not fully understand what the social worker's role is and what is going to happen in their lives. This may cause fear and uncertainty among children and carers, related to their "inclusion" into the services. In this context, an important part of case management belongs to regulations that guide the services (for example, protocols of confidentiality) and the procedure of obtaining the consent of the parents/carers and of the children, for further social intervention. Children and parents/carers can give their consent to participate only when they fully understand the specifics of the services, their benefits and related risks. There are normally three areas in the case management where the beneficiary's consent is required. The consent of the beneficiary is also called "informed consent":

- At the beginning of the case management process (prior to the assessment).
- As part of case management (the permission/consent of the child and parents/carers is required for the social worker to collect and store information about their case during the case management).
- During the case referral (when the information about the beneficiary is shared with other service providers who can help the child and the family and respond to their specific needs).

In order to give their consent and participate in the case management, the children and their parents/carers should be offered the following explanations:

- The social worker's role and responsibilities in the case management;
- The components of the case management, for example, problem identification, needs identification, the support required to meet those needs, including, benefits and limitations of the services provided;
- The meaning of confidentiality and description of situations when and why confidentiality cannot be ensured; the conditions for necessary and compulsory reporting;
- The way the beneficiary's information security will be ensured, the way in which that information will be used;
- The case manager should always offer to children and their parents/carers an opportunity to ask questions during their conversations.

How the consent of the child and parents/carers can be obtained

In order to obtain the consent of the child and parents/carers, the case manager should explain to them the need of data collection, storage and exchange. The procedure of consent offering should be simple. The case manager should know how to obtain consent/permission in line with the legal provisions, taking into account the child's age and level of maturity, and in the non-offending presence of the parents/carers.

As a general principle, the permission/consent to continue the case management is required from both the child and the parent/carer, except cases when their involvement is considered inappropriate. Permission/consent to continue case management actions and other interventions (including, referrals) is required in line with the "informed consent" principle, from carers and elder children.

"Informed consent" is voluntary agreement of a person with legal capacity to give own consent. In order to offer "informed consent", an individual should have necessary capacity and maturity, know about the services provided, and be able to offer consent. In the case of younger children, the parents/carers are usually required to give their consent for the child to be offered services.

"Informed consent" is the expressed willingness to receive a certain service.

Guidelines for the obtaining of informed consent/agreement from a child and his/her parents/carers

The age till which the parents'/carers' consent is required for a child depends on the national legal framework. This means that when the child is under the age of required legal consent (12 in the Republic of Moldova), then the consent of the parents/carers is required.

For children aged 0-5

Informed consent for the child in this age category should be required from parents/carers or any other trustworthy adult who is significant for the child's life. In case if such a person is not present, the service provider or any other specialist (child's rights protection specialist, medical worker, etc.) may give consent for actions that ensure the child's health and well-being. Young children are not able to make decisions on the importance of care and treatment, which is why informed consent is not required from them. However, the service provider should further try to explain to the child what is going to happen, in general and adequate manner.

Children aged 6-11

The children of this age group are usually insufficiently mature to offer informed consent for the services to be provided to them. However, they are able to express their "willingness" to access the service. This is why, in the case of children of this age group, their permission should be sought to continue the service provision and actions that concern them directly. For the children of this age category, the parents' written informed consent is required, along with the agreement of the given child, based on the awareness/information about the service/actions. Where it is not possible to obtain informed consent from a parent/carer, another adult of reference is identified with the help of the child.

For children aged 12-14

Children of this age group have more advanced cognitive capacity, and therefore, they can be mature enough to make decisions and offer informed consent in order to continue the provision of services for their benefit. Standard practice should seek to obtain informed consent from the child, related to the service provision, and written informed consent from parents/carers. In case the case manager considers that the parent's/carer's involvement may negatively impact the child or is contrary to the child's interest, the case manager should try to identify another adult of reference, significant for the child's life, who can and wants to offer informed consent, along with the child's written consent. If this is not possible, the informed consent of this given child may be valid, if the case manager states that the child is sufficiently mature. In this case, the social worker may continue interventions and support, under the guidance of their supervisor.

For teenagers aged 15-18

Children aged 15-18 are generally considered sufficiently mature to make decisions, which is also provided in legal norms. A teenager can offer informed consent based on the understanding of the matter. At the same time, ideally, parents/carers should offer their informed consent of the proposed care services and interventions.

Special situations

In case if the request of informed consent from the parent/carer is not to the child's best interest, the social worker should identify a reliable adult with significant role in the child's life, who could offer consent. If there is no reliable adult in this sense, the social worker should determine the decision-making capacity of the child, based on the level of his/her maturity and understanding.

In case if the social worker considers that the child is at risk and needs services, and the consent of the child and parents/carers is missing, the social worker will not consider the willingness of the child and parent/carer, and will continue the case management procedure. In the situation when the child and/or parents/carers hesitate to apply to the social assistance structure, the social worker should formulate additional questions to determine the causes of hesitation in accessing services. It is likely that the child and/or parents/carers fear losing confidentiality due to compulsory reporting. The case manager should allocate time to discuss with the child and parents/carers about fears and concerns related to the case management procedures, and offer clear and precise response to eliminate any emerging fears.

Annex 10
Case manager's competences

Abilities	Competences
Personal Competences	
Self-awareness	Knows own strengths and weaknesses, and own resources; sets up tasks for the development of own skills; critically reflects on own performance, using supervision.
Stress and emotions control	Expresses own feelings and emotions in adequate manner, knows the signs of stress, learns to manage stress for the exteriorization of tension and efficient functioning, uses supervision to discuss stress and work aspects.
Flexibility and opening to change, adaptation to cultural differences	Cultural sensibility: works efficiently with people who are experiencing or experienced adversity, knows how to avoid stereotypical responses and prejudices in own behavior, demonstrates openness and interest for the exploration of diverse cultures.
Analysis, critical and creative thinking, decision-making	Identifies creative solutions and shows initiative. Problem solution: approaches difficult problems from various perspectives. Decision-making: collects relevant information prior to decision-making, verifies assumptions, and makes decisions based on the amount of work and responsibilities.
Responsibility and honesty in work	Personal integrity: does not abuse of own power or position, resists unjustified political pressure in decision-making, demonstrates coherence between principles and behaviors, works without seeking personal benefits. Responsibility: works with responsibility, in line with the ethical principles and code, shows respect to beneficiaries, takes responsibility for actions, honors engagements, shows openness and transparency.
Social competences	
Negotiation, problem management and conflict control	Negotiation: applies principles of negotiation for results achievement, adapts own style to cultural differences in terms of negotiation, suggests alternative methods in working for the benefit of other people. Problem solution: copes with problems as they emerge, supports others in problem-solution. Assumes the role of "advocate in the child's rights protection": expresses own opinion in delicate and controlled manner, proving sensibility in working for the benefit of other people.
Work and coordination within a team or network	Collaborates with colleagues to contribute to the team development, respects others' opinions, promotes their abilities in joint actions, offers and receives constructive response.
Exhibiting empathy, kindness and authenticity	Empathy: expresses self-care and concern for others, responds in accordance with their physical and emotional condition. Culture sensibility: actions non-discriminatingly.

Support and motivation of persons/groups	Recognizes and works with sensible issues. Adapts work techniques and methods to approach children and families, collaborates with them and directs them towards common goals, generates and maintains their motivation.
Communication and listening to others	Communication: uses clear and coherent verbal expression; actively listens others, reflecting on the things that communicates to them; uses appropriate tone, style, and format to fit the audience, overcomes language barriers. Generating trustfulness: creates and maintains an environment in which others can speak and act without fearing consequences. Cultural sensibility: treats all persons correctly, respectfully, and with dignity. Promoting child participation: treats children in a friendly manner, demonstrates respect, makes sure the time and environment are favorable and efficient for communication; uses clear and child-friendly language; understands possible risks related to security and protection, understands issues related to various contexts; understands and shares advantages of child participation in decision-making concerning them.
Methodological competences	
Promotion of participation and cooperation in case management	Encourages children and families to participate in the needs and resources identification during assessment, helps them to make informed decisions during the entire case management process, actively involves interested parties and encourages their participation. Understands the importance of coordination with service providers, in order to provide complex support to children.
Planning, implementation, and revision of interventions	Develops, implements, and revises plans with children, families, and other persons, as necessary. Knows how to help families offer adequate support to children. Understands the barriers faced by families while accessing services.

Technical competences	
Knowledge of the relevant theoretical base for the work with children and families	Knows and understands the local context, including development of the child in the community environment, dynamics of relations in the context, cultural practices affecting the child's well-being. Understands the concerns related to child protection: has good knowledge about indicators and consequences of abuse, neglect, exploitation, and violence against children; knows the theoretical base of childcare and protection; identifies factors that increase the vulnerability and risks leading to resistance in various situations and during different stages of development. Understands the child protection planning process: understands basic principles and approaches in child protection, own responsibilities in child protection, relation to other sectors, basic roles and responsibilities of agencies involved in child protection. Adopts an approach based on child's rights protection: knows the national and international legal framework and Conventions on childcare and protection, challenges related to the complex approach of child's rights, considering the limited time and resources. Understands the concerns related to child protection: applies methods to make sure that the confidential information and documents containing sensible data are stored in safe conditions, makes sure the UN standards related to sexual exploitation and abuse of children are respected, makes sure that the violation of confidentiality is tackled immediately.
Knowledge and application of the case management methodology	Knows principles and stages of case management, documentation of the case management process, requirements related to data protection, exchange of information, and process of collaboration with other professionals in the case management process.

Annex 11
Additional work tools that can be used in the case management process

During the case management process, the social worker can use a variety of specific work tools recommended for certain stages of the casework.

The following tools can be used at the stage of initial assessment: documentation, observation, interview, and phone conversation. The following can be recommended at the stage of complex assessment: documentation, observation, phone conversation, interview, genogram, eco-map, problem tree. During the implementation of the intervention plan, the following tools are recommended to be used: phone conversation, observation, interview, consultation, support group. Tools that can be used for monitoring are observation, interview, and phone conversation.

Tool 1. Registration

Documentation is a tool used for data collection, through the analysis of different documents, applied during the entire process of casework. Documentation provides relevant information for the case. It complements other tools used during the casework, such as interview, observation, genogram, etc.

Recommendations:

- For the casework to be more efficient and to know the beneficiary, the social worker can collect as many relevant documents as possible, in addition to those required by case management: civil status documents, legal documents, photos, police reports, audio records, etc.
- The collected documents should be analyzed so as to avoid case "overloading" with irrelevant documents that do not contribute to the problem solution.
- Documentation should take into account the contents and context of the problem.
- A basic casework rule is that any intervention and decision of the social worker should be justified by documents attached to the portfolio of the beneficiary.
- "Personal" documents included into the portfolio should not be made public, to respect the principle of confidentiality.

Tool 2. Observation

Observation is used in social assistance for the collection of factual information, that is, data that confirms or denies the information collected with the use of other tools, like documentation, interview/conversation. Observation is more important in the initial stages of casework, but it can also be applied during the entire case management.

Observation involves paying attention to the beneficiary's verbal and non-verbal behavior, type and structure of relations with others, attitudes, emotional conditions and reactions.

There are two types of observation: direct, realized during direct contact with the beneficiary, and indirect observation, allowing the social worker to collect information about the beneficiary in their absence. For example, the social worker makes a home visit, and in the absence of the beneficiary, observes the physical condition of the housing, hygiene conditions, tidiness, aspect of the children or other family members, etc.

A special form of observation is participative observation, done with the involvement in social events during which the social worker can observe interpersonal and inter-family relations, behavior and attitudes of the beneficiary in different groups.

Recommendations:

- The information obtained exclusively by observation is not relevant if it is not confirmed/validated by other tools/techniques.
- Existing experience in social work can reduce the social worker's risk of being subjective.
- During observation, all channels of information perception should be involved: visual contact with the beneficiary, specific smell of untidy housing, room temperature, etc.
- Information registration, analysis and synthesis should be done as soon as possible after the meeting with the beneficiary.

Tool 3. Interview

Interview is a conversation between the social worker and the beneficiary. Its purpose is to collect necessary primary information for the research of the issue, and to identify subsequently methods of problem solution. The goal of the interview is to give priority to the beneficiary to express own opinions, emotions, feelings related to their problem. An interview helps to collect information, in order to clarify a situation or to evaluate the results of actions implemented together with the beneficiary.

Compared to other tools, interview sets up relative equality between the interlocutors, where the social worker is interested to establish a comfortable climate and a non-dominated relation, which facilitates the process of communication with the beneficiary.

Interview can be used in all stages of casework:

- During the stage of assessment – to obtain information related to general data about the beneficiary (identity, civil status, health condition, family structure, etc.), situation of the beneficiary, features of the problem (nature, causes, duration), a historical background of the beneficiary and their family, system of relations in the family and community, resources that can be involved in problem resolution;
- During the stage of intervention, interview can be used at a session of the multidisciplinary team, or with the beneficiary, to support them in changing their behaviors that caused a crisis situation and to help them restore their psycho-social balance;
- During the stage of monitoring – to observe the achievement of objectives of the individual care plan and to monitor the progress achieved by the beneficiary.

During the interview, the social worker formulates specific questions and registers only relevant responses, often using the assessment/registration sheet. At the same time, interview is an element of flexibility; it is used according to flow of the discussion. Interview also contains elements similar to consultation, because during the problem identification, the social worker will guide the beneficiary, will raise their responsibility, and will help them to understand that their participation in the problem resolution is essential.

Interview may be held in the social worker's office, but in order to obtain more relevant information, it should be done during a home visit. There are several types of interview, including scheduled interview (done at the initiative of the beneficiary or social worker) and unscheduled interview (following a report from a person or institution).

Recommendations:

- In order to obtain desired outcomes, the social worker should prepare for the interview: think over the questions, identify a secure space for the interview with the beneficiary. The structure of any interview contains a series of specific questions for the interview initiation, process, and closure. Thus, in the beginning and in the end of the interview, general questions will be formulated, aimed at creating emotional comfort, such as "How do you feel today?" or "Did you find the office easily?" The social worker's introduction and the interview goal presentation are important elements of an interview initiation, and may stimulate further communication with the beneficiary. Questions related to the contents of the interview should be clear, concise, and subject-bound, arranged in a logical sequence within the interview guide. The social worker will use augmentative questions during the interview, to help the beneficiary explore experiences and externalize their feelings (for example, "What do you feel for your husband?").
- Questions should be as clear as possible, and be adapted to the language of the beneficiary, in order to enable the social worker collect as complete and accurate information as possible. For this purpose, the social worker shall note down the relevant answers with fidelity (as they are provided by the beneficiary) and integrally.
- Interview is based on certain rules and principles describing the process itself, the social worker's skills and behavior in the construction of trust-based relations with the beneficiary, listening and support of the beneficiary, etc.
- One of the most important conditions of an interview is for the interviewee to give their consent for the participation in the interview. If the beneficiary is a child under 10, then it is recommended that at least one of the parents give their consent for the interview.
- The social worker should inform the beneficiary about the confidential nature of the information provided during the interview.
- Interviewing imposes certain requirements for the social worker's conduct and attitude. This includes patience, benevolence, tolerance, and spirit of intuition; an interviewer should avoid critics or other actions that are unpleasant for the beneficiary, so-called "advice", judgments based on values, contradicting discussions.

Tool 4. Telephone conversation

Phone conversation is one of auxiliary techniques of data collection and initiation of contact between the social worker and social services beneficiary. It is based exclusively on verbal communication, and is used quite frequently to maintain relation, especially in remote areas.

Phone conversation may be conducted wherever necessary, or upon any request of the beneficiary or at any stage of case management. The most frequent situations when phone conversation is used include: case identification – it may be used by the potential beneficiary, any other person (neighbor, relative), or institution (mayor's office, NGO, etc.); data collection during the process of assessment; phone scheduling of family visits, etc.

Recommendations:

- This tool cannot be used in communication with any beneficiary and in any context, for ex., this type of communication is not possible for persons who do not have a phone, with persons who have neuro-psychic and behavioral disorders, persons deprived of freedom, those minor of age, persons who wish to preserve anonymity, persons with hearing and/or speech disorders, etc.

- Phone conversation has certain limitation for the case solution process. Although it requires short time and may deliver information of first necessity, information about certain aspects related to the situation of the beneficiary (community, family, accommodation), and their non-verbal behavior is difficult to be perceived using this tool. That is why, in order to avoid confuse situations, the social worker is not recommended to use this tool to the detriment of home visit, consultation, interview. Any information resulting from the use of this tool should be confirmed and completed with data collected by the use of other methods and instruments.

Tool 5. Genogram

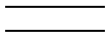
Genogram is a data-collection tool indicating family relations, using graphical symbols denoting family structures, relations between family members. This tool is used for the structuring of the collected data.

Genogram is specifically used at the stage of assessment, for the identification of the beneficiary's relational problems. Genogram can be also repeated, during stages of intervention and monitoring, in cases when important changes are produced in the family structure (death, divorce, new family members, eventual concubine relation, marriage), or when interpersonal relations in the family change essentially.

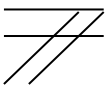
A series of specific symbols are used in a genogram:

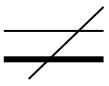

Person of male sex

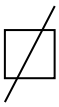

Person of female sex


Marriage

Concubine relation


Divorce


Separation in fact


Death of man


Unknown sex

Family structure and relations between family members can be represented for both (parents and children) or three generations (grandparents, parents, and children).

Recommendations:

- Any case portfolio should normally contain a genogram, to facilitate better visualization/interpretation of the family structure. This may constitute a starting point while establishing resources and plan for the given case.

- During the genogram representation, in order to facilitate the communication with the beneficiary, the case manager should formulate simple and clear questions, creating a comfortable atmosphere for the discussion, and securing necessary conditions for the adequate data collection (for example, “How many siblings do you have?”, “What are their names?”, “Let’s put it according to their age”, “How many of them are married?”, “Do all of them have children?”, etc.).
- Any genogram must be accompanied by a legend (brief description), so that it can be read/interpreted by any practitioner who will work on this case.
- Simple genogram (representation of two generations in the family system) may be also done when the beneficiary is a child, while complex genograms (for the representation of several generations), are recommended to be done with adult beneficiaries. The genogram is normally done together with the beneficiary, while in exceptional cases (when the beneficiary is a child, or cannot communicate, or is ill), with other persons involved in the case solution.

Tool 6: Ecomap

Ecomap is a graphical, schematic representation of individual relations with the social environment (persons/specialists and institutions/organizations with which the person interacts). It provides a clear image of the beneficiary’s resources that may be useful for the intervention, depending on the quality and intensity of relations.

The ecomap uses a series of specific symbols to represent types of relations

Balanced relation

Very strong relation

Stressful relation


Tensioned relation

One-way relation

Mutual relation

Recommendations:

- Ecomap is done closer to the end of the assessment process, when the social worker already has sufficient information to appreciate the type and quality of the beneficiary’s relations with other persons or institutions.
- Ecomap can be constructed in the presence of the beneficiary, but is finished by the social worker after detailed analysis of the information collected from a bigger number of resources.
- While constructing the ecomap, the beneficiary is placed in the centre, then their relations with the persons (family members, friends, colleagues, other relevant persons with whom they interact) or institutions (church, school, police, workplace, etc.) are represented. The social worker appreciates strong, mutual relations as strengths, and stressful, tensioned, and one-way relations – as weaknesses.

- Construction of the ecomap requires the involvement and communication with the beneficiary, and, contrary to the genogram, the data provided by the beneficiary should be verified and completed with information communicated by other persons. For example, if the beneficiary states that their relation with the parents is very good, that they love and respect their parents, and that those feelings are mutual, the social worker should verify this information in a conversation with the parents of the beneficiary. For instance, it may be found, that in fact, while under the influence of alcohol, the beneficiary systematically abuses physically or verbally their mother. In this condition, the relation cannot be appreciated as strong and balanced, as the beneficiary suggests.
- Ecomap should be accompanied by a legend describing the symbols used for its construction (just like in the case of genogram).
- It is recommended that any portfolio includes a genogram or an ecomap allowing rapid visualisation and interpretation of the family structure, which may serve as a starting point in the identification of resources and action plan for the given case.

Tool 7. Support group

Support group is a form of social intervention that implies voluntary and structured participation of relevant persons in the discussion, for the identification of solutions of the problems faced by the participants. This tool is used in order to create conditions for reciprocal communication of information, advice, mutual encouragement and emotional support.

Support group may have several forms, depending on the characteristics of group members and on the problem that needs to be approached during the support group discussion.

Support group for beneficiaries is a group made of beneficiaries encountering similar difficulties, such as single mothers, families with many children or with disabled children, persons with disabilities, etc. The sessions discuss issues happening to these persons, methods to overcome the encountered problems, while group members share their experiences, useful information, etc. The group is usually conducted by the social worker and is periodically organized in a relevant setting. Maximum duration of a session is 90 minutes, and the group size is 7-9 persons.

Support group for professionals is a group with similar rules in terms of duration, size, moderating person, while the group members can be community social workers, practitioners from different areas (care workers, psychologists, medical doctors, etc.). The purpose of these sessions is to discuss certain challenges encountered in the professional practice, and to identify possible solutions in various social cases, intervention strategies, specific methods, etc. This type of group also represents mutual psycho-emotional support preventing professional burnout (for example, periodically organized support group of community social workers, where community social workers and doctors unite to discuss issues of HIV/AIDS prevention/therapy, etc.).

Using this method, in various forms of application, requires in-depth training.

Tool 8: ”Problem Tree” (adapted for the analysis of problems faced by the child and his/her family)

“*Problem tree*” is a simple and efficient tool that can be used for the analysis of causes of problems faced by the child and his/her family, identification of the major problem and causal relations/connections between them.

Drawing of the problem tree is an activity involving the social worker and the child and/or family, done within a conversation where problems and relations are identified and analyzed. This activity can be also organized for a group of practitioners (representatives of different institutions), involved in a concrete casework.

The result of this activity is a graphical presentation of problems outlined as “causes” and “effects”, shown in a diagram along with the central problem that represents the core situation of the child and family (see image below).

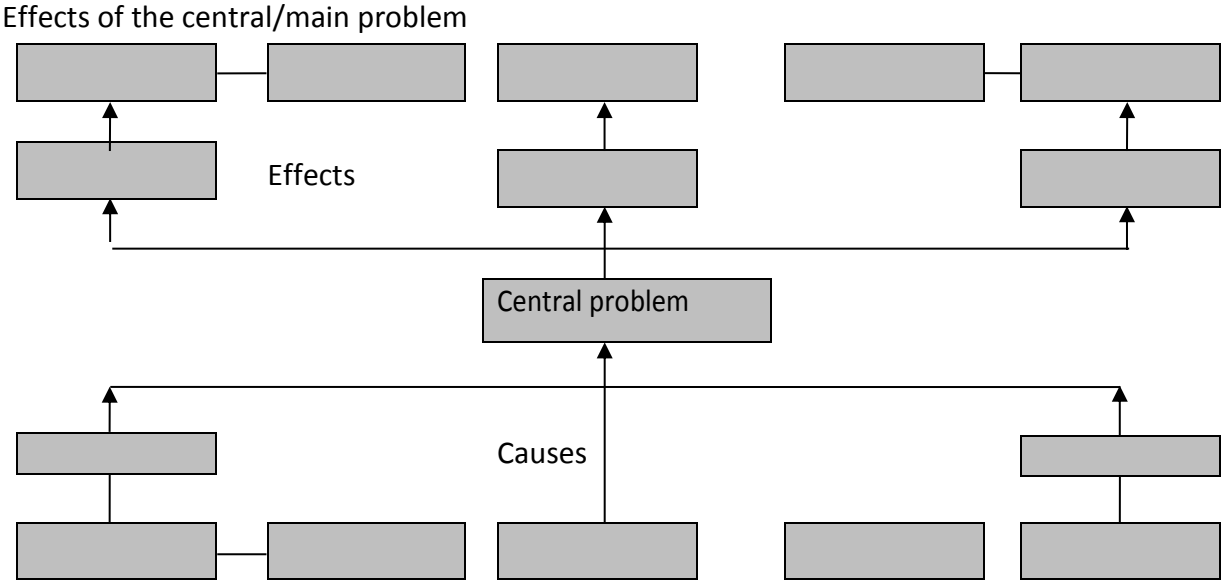
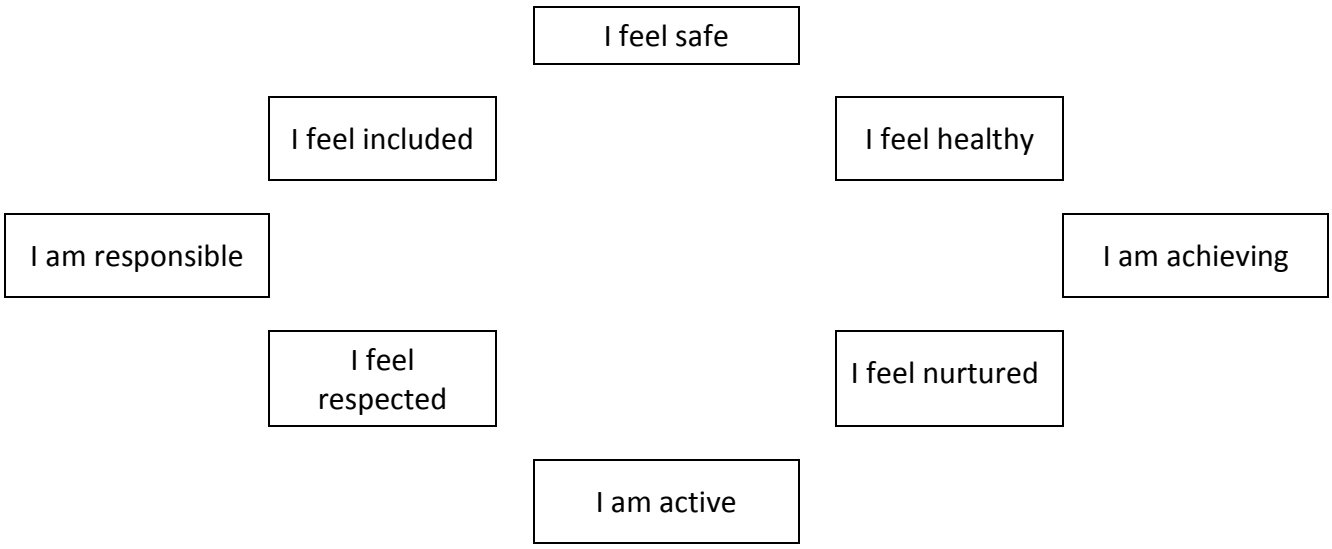


Image 4 “Problem tree”

Stages of the problem tree diagram building:

1. **All major problems** faced by the child and his/her family that constitute the object of the analysis are discussed. These should be concrete, already existing problems, and not eventual, imagined, or future issues. The problems represent an existing negative situation, and not absence of a solution.
2. **Identification of the central problem**. The identified problems are analyzed, and the central problem (or group of problems) is identified in agreement with all participants.
3. **Discussing causes and effects of the central problem.** The participant present the main causes of the central problem, then arrange them in the priority order. Their relation to the central problem is further analyzed. Some of them can be identified as causes that generate the general problem, others may be effects caused by the problem.
4. **Identification of causal relations/links.** Relations between causes and effects are analyzed, to understand the way in which the problems correlate and how the identified problems link to the central/main problem. In most cases, it is noticed that things are very complicated, relations between problems are often bi-directional and that most problems do not have a simple, linear progression.
5. **The diagram should be drawn on a sheet of paper**, using lines and arrows to show the relations between causes and effects.

Annex 12
"Profile of child wellbeing indicators" chart



Assessment score

1 – Is not at all true to me

10 – Is very true to me

I feel safe

Feeling safe means:

- Feeling protected from harm at home or at school
- People who take care of you teach you how to protect yourself from harm
- You are not afraid to go out for a walk in the community
- You know when the risk appears and you try to protect yourself from danger
- People who take care of you know who you are and where you are when you go out

I am healthy

Being healthy means:

- You mostly have healthy food
- You do a lot of exercises
- You have possibility to spend time out of doors
- People who take care of you help you if you are sick
- People who take care of you offer you a possibility to eat and do exercises for you to feel healthy
- You love life
- You feel that you are able to solve different problems that may appear in life

I am achieving

Achieving means:

- You are learning new skills at school
- You are sure that you can do well
- You are trying to do very good things
- You have hobbies and interests apart from school that help you learn new things and develop new skills
- Adults in your life encourage you to do very well
- If you encounter difficulties in doing your homework, there is someone who can help you
- You get help when you need it in order to de well at school

I feel nurtured

Feeling nurtured means:

- Feeling that people who live together with you take care of you and support you
- People who take care of you are able to ensure that you have enough food to eat and clothes to wear
- That you live in a clean and warm house
- Regardless of whether they agree with you or not, those who live with you always listen to you when you tell them about things you need
- You are learning to take care of yourself and to make decisions about your own life

I am active

Being active means

- Having fun when you have free time
- Having an opportunity to participate in leisure and sport activities organized in your neighbourhood
- Adults in your life help you to find possibilities to practice your favorite hobbies when you have free time

I feel respected

Feeling respected means

- Knowing that people are listening to you when they make decisions that concern you directly
- You are involved in decisions that concern your life
- You are supported by those around you, when you need to express your opinion and decisions

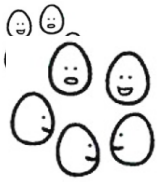
I am responsible

Being responsible means

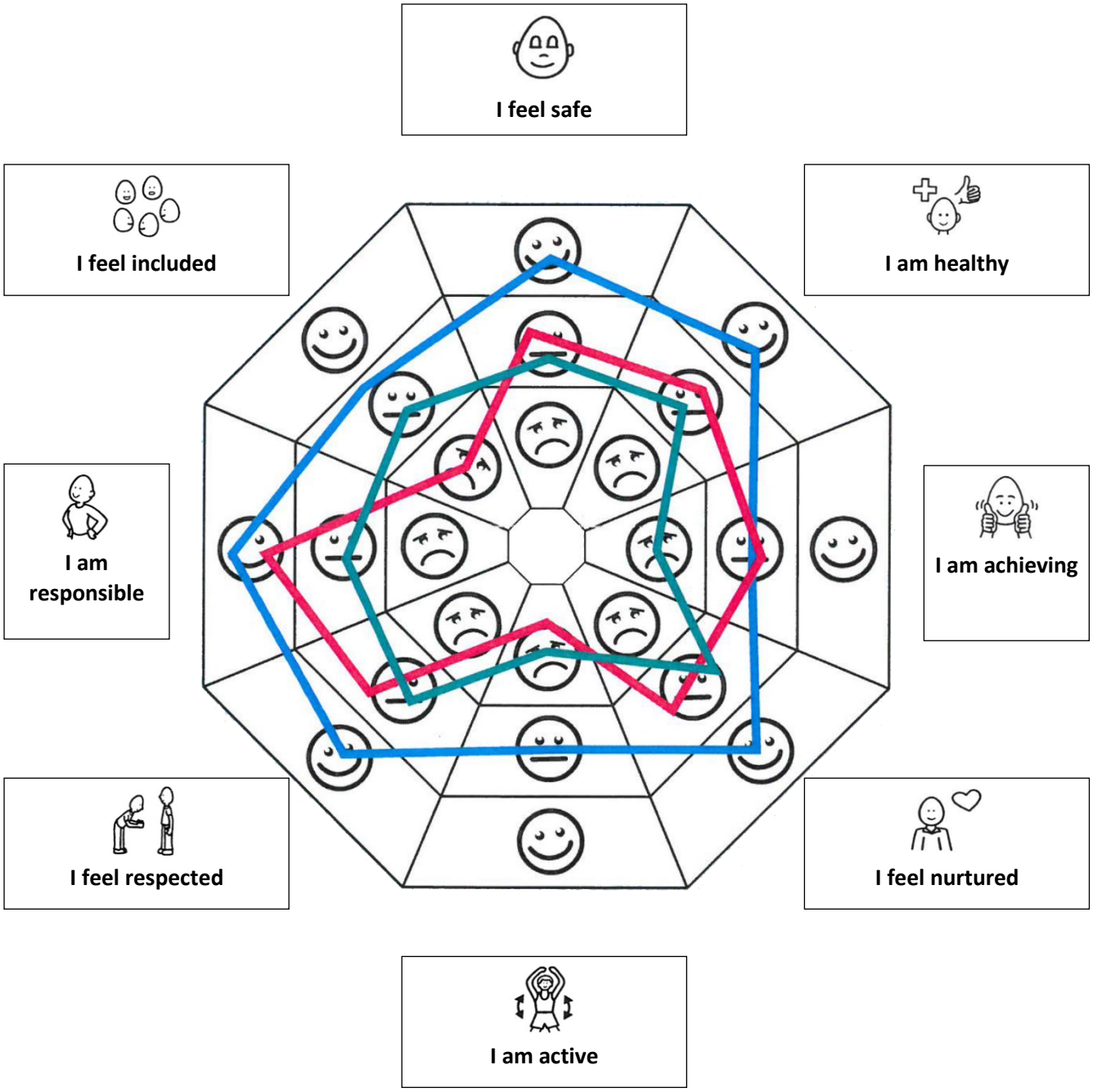
- You listen to others and try to understand their opinion
- You are able to distinguish between good and bad
- You can control your behaviour
- You are careful and you help those around
- Adults are confident that you do what they entrusted to you
- You are able to follow rules at school and at home
- You know what others expect from you
- Through their behaviour, the adults you're your life offer a good example to you

Version for small children

NOTE

You are safe 
You are healthy 
You are achieving 
You are cared for 
You are active 
You are respected 
You are responsible 
You are included 

Example of graphical presentation of the results of each child's wellbeing self-assessment



Annex 13
Index of social services[13]

No.	Code (SIAAS)	Name of service	Normative framework	Definition of social service	Beneficiaries	Social services provided	Approximate structure of the specialized staff
1. TYPE OF SOCIAL SERVICES: PRIMARY SOCIAL SERVICES							
1.		Community social assistance	Framework regulation of the activity of community social assistance service, approved by the order of the Minister of Social Protection, Family and Child (currently, Ministry of Labor, Social Protection and Family), No. 54 of 10 June 2009.	The community social assistance service provides social assistance to persons, families, and social groups, at the community level, to prevent and overcome difficulty.	a) Community as a whole; b) Persons, families and social groups in difficulty, within the community.	a) Identification of persons in difficulty and facilitating their access to social payments and services; b) Support and mobilization of the community for the solution of difficult situations.	- head of service - supervising social worker - community social worker - other specialists
2.		Home care socia service	Order and Standard Regulation regarding sections of social support at the domicile of lonely old persons and citizens incapable of work, approved by the Order of the Minister of Labor and Social Protection (currently, Ministry of Labor, Social Protection and Family), No. 16 of 22 April 1994	Social homecare is provided at the client's home, to help them with everyday activity and support them to participate in community activities.	Lonely elderly persons (pensioners) and persons with disabilities.	a) information; b) consultation; c) mediation and representation; d) communication; e) delivering food products offered by other services or purchased; f) support in cooking meals; g) home support (during washing, house clean-up, shopping, ensuring personal hygiene, etc.); h) attendance/support in various institutions; i) other services necessary to create opportunities for a person who lives in own house.	- head of service - social worker - care worker - other specialists

[13] Index approved by Order of MLSPF No. 353 of 15.12.2011

3.		Social canteen	The Law on social canteens No. 81 – XV of 28.02.2003, and Government Decision on the approval of the Standard Regulation related to the functioning of social canteens No. 1246 of 16.10.2003	Social canteens are legal entities that provide free services to socially vulnerable persons, assist persons (families) who cannot ensure themselves with food at home, due to a lack of independence or to lack of incomes. The food can be provided through the home delivery of hot meals, offering hot meals in dining-rooms, community facilities, or other provision areas.	Socially vulnerable persons whose monthly income for the previous year constituted 1-2 minimum age pension: a) persons who reached pension age (homeless, without legal supporters, without income or with low income); b) disabled persons; c) children under 18 (from families with many children, one-parent families, and families considered socially vulnerable, based on the social investigation done by territorial social assistance structures).	a) preparing and serving daily meals per number of persons (usually, dinner); b) purchasing basic raw meals, agricultural food products, at the acquisition costs; c) free home delivery of meals to socially vulnerable persons who, due to objective reasons (stated in the social investigation, cannot come on their own to the social canteen; d) cooking and delivering food through mobile service centers.	- care workers - social workers - other specialists
4.		Community social assistance centre	Normative framework is under development.	Community social assistance centre (multifunctional) is a public institution created at the community/municipal level, that develops and provides a wide range of social services to persons/families in difficulty.	Persons, families, and social groups in difficulty, within the community.	a) information; b) consultation; c) counseling; d) family and community reintegration; e) development of occupational skills; f) meals.	- social worker - care worker - specialists, depending on cases of beneficiaries - administrative staff - auxiliary staff

2. TYPE OF SOCIAL SERVICES: SPECIALIZED SOCIAL SERVICES							
5.		Centre for social assistance of child and family	Normative framework under development.	Centre of social assistance to child and family is a local public service working within the territorial social assistance structure, providing methodological and practical support in the implementation of policies and in the provision of social services to families with children and to children in difficulty.	Families with children at risk; Children separated from the family environment and children without parental care; Community social workers; Staff of social services for family and child; Local public authorities.	a) methodological and practical assistance in the case management of families in difficulty, families with children at risk, children separated from family environment, and children left without parental care; b) methodological assistance in the management and delivery of social assistance services to families with children in difficulty; c) support to specialists from territorial social assistance structures, in the collection/analysis and systematization of data and information on family and child protection.	- social worker - psychologist - lawyer
6.		Day-care centre for children at risk	The Framework regulation for the organization and functioning of the day-care centre for children at risk is currently being promoted.	Day-care centre for children at risk is a public or private institution of social assistance, providing day-based services to children at risk, aiming at their social and family (re)integration, or prevention of family separation of children at risk.	Children at risk, aged 1,5 – 18, left without parental care, under family-type protection, or children separated from family environment due to circumstances that can severely affect their harmonious development.	a) services for the development of cognitive, communicational, and behavioral skills; b) support in school inclusion; c) counseling of family members/carers; d) professional orientation; e) meals.	- social worker - psychologist - pedagogue - administrative staff - auxiliary staff
7.		Day-care centre for	Government decision No. 824 of 04.07.2008, on the approval of Minimum	Day-care centre for children with disabilities is a public	a) Children with disabilities, aged 0-18, in need of special support from the family and	a) services for the development of cognitive, communication, behavioral skills;	- social worker - psychologist - pedagogue

		children with disabilities	Standards of Quality for social services provided in day-care centers for children with disabilities. The framework regulation on the organization and functioning of the Day-care centre for children with disabilities is being promoted.	or private social assistance institution providing day-care services for the recovery/rehabilitation of children, aiming at their social (re)integration and at the prevention of the children's separation from family environment and social exclusion.	community, due to their sensorial (hearing, eye-sight), physical/motor, mental/intellectual, psychic or behavioral limitation. b) The child's parents/ legal representatives, in cases when the legal representation of the child is required.	b) recovery/rehabilitation services; c) support in the educational inclusion; d) consultation of family members/carers; e) leisure activities; f) meals; g) professional orientation; h) day-to-day transport; i) home recovery services (when needed);	- medical worker (according to the child's needs) - administrative staff - auxiliary staff
8.		Temporary placement centre for children at risk	Government Decision No. 1018 of 13.09.2004, regarding the approval of the Framework regulation of the temporary placement centre for children. Government Decision No. 450 of 28.04.2006 on the approval of Minimum Standards of Quality for the care, education, and socialization of children in temporary placement centers.	Temporary placement centre for children at risk is a public or private social assistance institution that provides temporary placement services to children, aiming at their social and family (re)integration.	Children separated from their family environment	a) Accommodation, support, meals; b) Services for the development of cognitive, communicational, and behavioral skills; c) Support for the educational inclusion; d) Consultation of family members/carers; e) Professional orientation.	- social worker - psychologist - pedagogue - medical worker (according to the needs of the children) - administrative staff - auxiliary staff.
9.		Temporary placement centre for children with disabilities	Government Decision No. 823 of 04.07.2008, on the approval of Minimum Standards of Quality for social services provided in placement centers for children with disabilities. Framework regulation on the organization and functioning of the Placement Centre for	Temporary placement centre for children with disabilities is a public or private social assistance institution providing temporary placement services to children, aiming at their recovery, rehabilitation, and	Children with disabilities, aged 0-18, in need of special support from the family and community, due to their sensorial (hearing, eye-sight), physical/motor, mental/intellectual, psychic or behavioral limitation.	a) Accommodation, support, meals; b) Services for the development of cognitive, communicational, and behavioral skills; c) Support for the educational inclusion; d) Support for the educational inclusion; e) consultation of family members/carers;	- social worker - psychologist - pedagogue - medical worker (according to the needs of the children) - administrative staff - auxiliary staff

			children with disabilities is in being promoted.	social and family (re)integration.		f) leisure activities; g) professional orientation; h) home recovery services (if required);	
10.		Day-care centre for elderly persons	The normative framework is under development.	The centre is a public or private institution providing day-based social services, focused on the care, recovery, rehabilitation, and family and community (re)integration.	Beneficiaries of these institutions are elderly persons.	a) information; b) consultation; c) art-therapy; d) occupational therapy; e) consultation of family members; f) physiotherapy; g) music therapy; h) group activities; i) game therapy; j) medical assistance; k) daily transport.	- social worker - psychologist - nurse - caregiver - other specialized staff (as needed) - administrative staff - auxiliary staff
11.		Day-care centre for adults with disabilities	The normative framework is under development.	Accommodation and day-care for adults with disabilities, including a wide range of social services.	Adults with disabilities (18 years and up) and their families.	The services vary, depending on the needs of the beneficiaries, including: a) information; b) consultation; c) art-therapy; d) behavioral therapy; e) cognitive therapy; f) occupational therapy; g) consultation of family members; h) physiotherapy; i) music therapy; j) group activities; k) game therapy; l) daily transport; m) professional orientation and vocational training, etc.	The centre has a staff structure in line with its mission and with the needs of the beneficiaries: - social worker - psychologist - occupational therapist - physiotherapist - other specialized staff - administrative staff - auxiliary staff
12.		Day-care centre for the rehabilitation of perpetrators	The normative framework is under development.	The centre for the rehabilitation of perpetrators is a public institution implementing programs focused on	Persons (adult men) who are perpetrators of domestic violence	a) psychological consultation; b) psychiatry assessment; c) legal consultation; d) social assistance; e) facilitation of access to specialized services for	- personal auxiliary - psychologist - lawyer - social worker - psychiatrist - administrative staff

				violent behavior prevention and change.		alcoholism or dependency treatment; f) mediation between victim and perpetrator; g) social rehabilitation and reintegration; h) psychotherapeutic treatment.	- auxiliary staff
13.		Day-care centre for elderly persons	The normative framework is under development.	The centre is a public or private institution providing day-based social services, including care, recovery, rehabilitation, and family and social (re)integration.	Beneficiaries of these institutions are elderly persons.	a) information; b) consultation; c) art-therapy; d) occupational therapy; e) consultation of family members; f) physiotherapy; g) music therapy; h) group activities; i) game therapy; j) medical assistance; k) daily transport;	- social worker - psychologist - nurse - caregiver - other specialized staff - administrative staff - auxiliary staff
14.		Placement centre for adults with disabilities	The normative framework is under development.	Continuous insuring of minimum conditions for subsistence, protection, care and assistance, helping adult disabled persons to develop and include into the community.	Adults with disabilities (18 and up) with high level of dependence on protection, care, and continuous specialized support, including those declared incapable who cannot self-care and serve themselves without continuing assistance and support in the community, with reduced social abilities.	a) accommodation; b) care; c) hygiene; d) meals; e) clothes; f) health services; g) education according to the potential of development; h) information; i) other services supporting them to assimilate the knowledge and skills necessary for social integration.	- social worker - psychologist - care worker - nurse - caregiver - other specialized staff - administrative staff - auxiliary staff
15.		Placement centre for homeless persons	The normative framework is under development.	Ensuring urgent needs (nutritional, health, hygiene), support in professional orientation and social integration.	Adults who do not have a place to live (persons who sleep in streets, in parks, stations, building entrances, abandoned cars, canals, etc., beggars).	a) night accommodation; b) underwear; c) meals; d) information; e) consultation;	- social worker - psychologist - lawyer - administrative staff - auxiliary staff

						f) support to obtain identity documents.	
16.		Rehabilitation centre for victims of domestic violence	Government Decision No. 1200 of 23.12.2010, on the approval of Minimum Standards of Quality of social services provided to the victims of domestic violence. Government Decision No. 129 of 22.02.2010, with regard to the approval of the Framework Regulation for the organization and functioning of rehabilitation centres for victims of domestic violence.	Rehabilitation centre for victims of domestic violence is a specialized institution providing temporary placement and assistance, socialization and family and or/community reintegration to victims of domestic violence.	a) Victims of domestic violence: women, men, and mother-and-child /father-and-child couples; b) Children (only attended by parent or legal representative). The centre will be specialized according to the beneficiaries' sex criteria (rehabilitation centers for women victims of domestic violence, rehabilitation centers for men victims of domestic violence, depending on the case).	a) accommodation, protection, and temporary placement of victims of domestic violence; b) personal hygiene; c) legal, social, psychological, emergency health assistance; d) informational support for those seeking a place to live, a kindergarten, or a school; e) informal education for the development of necessary life skills and social integration; f) socialization and development of relations with the community and/or family; g) facilitating access and advising beneficiaries about social protection services; h) developing, together with the beneficiaries, individual plan of protection against any form of intimidation, discrimination, abuse, and exploitation; i) support for parent-and-child couples, in the development of their autonomy, to facilitate their access to family and/or community; j) monitoring post-integration situation of beneficiaries in families and communities.	- social worker - psychologist/psych o-pedagogue - lawyer - medical worker - administrative staff - auxiliary staff
17.		Maternal centre	Government decision No. 1019 of 02.09.2008, on the approval of Minimum standards of quality for the	Maternal centre is a public or private institution providing social protection to mothers and babies, to	a) mother-and-baby couples in one of the following situations: mothers with new-born children, with	a) accommodation, support, and meals; b) support for the development of child up-bringing and care skills; c) psychological consultation;	- social worker - psychologist - pedagogue

			social services provided in maternal centers. The framework regulation on the organization and functioning of the Maternal Centre is being promoted.	prevent child abandonment and facilitate the development, maintaining and strengthening of family bonds.	abandonment intentions (single mothers, under age mothers, victims of traffic, mothers from low-income, marginalized families, etc.); homeless mothers with children; mother with children facing material and/or relational difficulties; b) abused or neglected mother-and baby couples: mothers and/or babies under various forms of domestic abuse; children maltreated physically/psychically through neglect, unawareness, and/or due to material difficulties, etc.; c) mother-and-baby couples included into family strengthening programs: situations when the child was placed into various forms of protection (family-type, residential care) and intermediary complex assistance and support is required for the mother, to achieve definitive mother-and-baby reunification; d) pregnant women in difficulty, in the last term of pregnancy, facing one or	d) medical assistance; e) legal assistance; f) support for the family, social, and professional (re)integration.	- medical staff (according to the child's needs) - lawyer - administrative staff - auxiliary staff

					several difficulties mentioned above.		
18.		Foster Care service	Government Decision No. 1361 of 07.12.2007, on the approval of the Framework Regulation of the foster care service. Government Decision No. 1479, of 25.12.2008, on the approval of Minimum standards of quality of the foster care service. Government Decision No. 924 of 31.12.2009, on the allocations to children in foster care.	Foster care is a social service providing substitute family care to children, in the foster carer's family.	Children who temporarily or permanently experience at least one of the following situations: a) are temporarily or permanently deprived of their family environment; b) their special needs cannot be assured by their biological family; c) are o can become victims of a form of violence, human trafficking, abandonment, neglect, or ill treatment, exploitation while in the care of one or both parents, legal representative, or any other person in-charge with their care; d) are under 14 and committed a violation of the criminal law, but are not legally responsible and are in at least one of the situations described under letters a), b), or c); e) are aged 14-18, and subject to criminal punishment without imprisonment, or were released from criminal punishment and are in at least one of the situations	a) care and up-bringing of the child in the conditions of a substitute family environment; b) meeting the age criteria and minimum standards of quality; c) facilitating socialization and (re)integration of the child into biological, extended, adopting family, or any other form of family care.	- foster carer - specialist of the territorial social assistance structure

					described under letters a), b), or c).		
19.		Family type home for children	Government Decision No. 937 of 12.07.2002, on the approval of the Framework Regulation of family-type homes. Government Decision No. 812 of 02.07.2003, on the approval of Minimum standards of quality for family-type homes. Government Decision No. 152 of 13.03.2003, with regard to the salary of parent-educators of family-type homes for children. Government Decision No. 1733 of 31.12.2002, on the norms of material assurance of orphans and children left without parental care and placed in family-type homes.	Family-type home for children is an institution based on complete family that provides family-type care in the family of the parent-educator, to orphans and children left without parental care.	Children without parental care, aged 0-18.	a) child up-bringing and care in a substitute family environment, in line with the age criteria and minimum standards of quality b) facilitating child socialization and (re)integration into biological, extended, adopting family, or any other form of family-type care.	- parent-educator - specialists of territorial social assistance structures
20.		Community home for children at risk	Normative framework is under development.	Community home for children at risk is a public or private institution providing temporary placement, to ensure the up-bringing and education in a family-type environment to children separated from parents or left without parental care.	Children aged 10-18, temporarily or permanently experiencing at least one of the following situation: a) are temporarily or permanently deprived of their family environment; b) their special needs cannot be assured by their biological family; c) are o can become victims of a form of violence, human trafficking, abandonment, neglect, or ill treatment, exploitation while in the care of one or both parents, legal representative, or any	a) accommodation, support, and meals; b) development of cognitive, communication, and behavioral competences c) educational inclusion support; d) consultation of family members/carers e) professional orientation; f) support for the family and community (re)integration.	- educator - specialists of territorial social assistance structures

					other person in-charge with their care;		
21.		Community home for persons with disabilities	Government decision No. 936 of 08.10.2010, on the approval of the Framework regulation for the organization and functioning of the "Community Home" social services and its minimum standards of quality	On-going assurance of minimum standards of subsistence, protection, care, and assistance, facilitating the development and community integration of persons with disabilities.	Children with mental disabilities and depending on continuing protection, care and specialized support adequate to their age and development, and adults with mental disabilities, including those declared inapt, who cannot self-support, self-care, and self-cater without continuing community assistance and support, due to reduced social competences.	a) accommodation b) care c) hygiene d) meals e) clothes f) health services g) education adequate to the potential of development h) information i) other services facilitating the awareness and necessary skills for social integration	- social worker - psycho-pedagogue - psychologist - care worker - nurse - other specialized staff
22.		Asylum for disabled elderly	Government Decision on the approval of the Standard Regulation of the asylum for elderly persons and disabled persons No. 1500 of 31.12.2004.	Asylum is a temporary or permanent placement institution, providing social and health care services to elderly and to physically impaired persons. The institution provides social protection, recovery services, capacity maintaining and social (re)integration services.	Elderly persons and disabled persons over 18 of age, mainly those who do not have legal guardian, who have low self-care capacity, need specialized care or support from other persons, and cannot achieve worthy, active, and participative life independently due to their mental health condition.	a) accommodation; b) meals; c) care; d) assurance with clothes and footwear; e) occupational therapy; f) cultural activities; g) life skills development activities; h) recovery activities; i) physiotherapy; j) medical assistance.	- social worker - medical worker - lawyer - nurse - cook - administrative staff - auxiliary staff
23.		Respite care service for children with disabilities	The normative framework is under development	Respite care service is a social service providing support to family members of disabled children, by periodical temporary placement of those children.	Children with neuro-physical disabilities, severe and/or chronic impairments, with high level of dependency on external support, including children with: - cerebral spastic infantile paralysis; - autism; - micro or macrocephaly; - inborn maladies - residual encephalopathy;	a) accommodation, support, meals; b) cognitive, communication, and behavioral development services; c) recovery/rehabilitation services; d) educational inclusion support; e) family members/carers consultation.	- social worker - psychologist - pedagogue - medical worker (according to the children's needs) - administrative staff - auxiliary staff

					- Down syndrome; - delayed psycho-physical development; - mental delay; - congenital or acquired brain malformations. Parents/carers and family members of children with disabilities		
24.		Respite care service for disabled persons	The normative framework is under development	24/24 support, care, and supervision provided to persons with severe disabilities, within specialized centers or other social services, in order to offer respite of maximum 30 days per year to their carers.	Persons with severe disabilities, selected according to established criteria by the multidisciplinary team of specialists, in collaboration with the territorial social assistance structures, in line with the Regulation of the service organization and functioning.	a) accommodation; b) care; c) hygiene; d) meals; e) clothes; f) medical services; g) information; h) other services related to awareness-raising and social integration skills development.	- case manager who coordinates the service - social psycho-pedagogue - nurse - caregiver - with the involvement of the community social worker and other community specialist, where necessary.
25.		Mobile team for the support of persons with disabilities	Government Decision No. 722 of 22.09.2011, on the approval of the Framework Regulation of the organization and functioning of the "Mobile Team" social service and its minimum standards of quality.	Providing home-care assistance and support to persons with disabilities, based on their identified needs, and consultation and support of the persons involved into their inclusion.	Persons with disabilities, meeting the Services users selection criteria, as described in the Service's Regulation of organization and functioning, and persons involved in their inclusion.	a) consultation; b) recovery; c) medical and psycho-social rehabilitation, in order to increase the level of autonomy, prevent institutionalization, and achieve social inclusion.	- case manager who coordinates the service - psychologist - physiotherapist - other specialized staff, upon case
26.		Family placement for adults with disabilities	The normative framework is under development.	Providing substitute family placement to disabled adults, which includes housing or personal care,	Disabled persons aged 18 and over, who temporarily or permanently lack the possibility of living together with their biological or extended family, or of living independently,	Facilitating the potential development of self-service, autonomy, and social integration of adults with disabilities.	- specialized family assistant

				development of self-service and life skills, to achieve their community integration.	due to their special care and support needs.		
27.		Personal assistance	The normative framework is under development.	Providing necessary individual assistance services to children or adults with severe disabilities, who require support for their social integration (including areas of social protection, labor, medical assistance, training and education, awareness, infrastructure accessibility, etc.).	Persons with severe disabilities who need care, permanent supervision for their social integration, including areas of social protection, labor, medical assistance, training and education, awareness, infrastructure accessibility, etc.).	a) personal care, personal hygiene, food, dressing and undressing, etc.; b) mobility – moving within the house, lifting and sitting down, transfer, manipulation of wheelchair; c) basic housekeeping tasks: support while cooking meals, doing up the house, washing clothes, shopping, paying bills, etc. d) participation in the social life: support while traveling in the community and communication with others, access to community services, recreation, cultural life, association, education, and work activity; e) supervision and guidance: support for time and space orientation, safety assurance, self-management of behavior and relations with others.	- Personal assistant
28.		Family support	The normative framework is under development.	Family support is a social assistance service providing complex support to families with children, for the prevention of the child's separation from family environment and/or the	a) vulnerable children and families at risk of family separation and social exclusion due to economic, social, medical, behavioral issues; b) children separated from their family environment, placed or	a) information; b) individual or group consultation c) educational support for the prevention of school abandonment; d) referral to professional orientation services and	- community social worker - supervising social worker - pedagogue/psycho-pedagogue

				child's (re)integration into family.	at risk of being placed into classical residential institutions; c) members of biological/extended families or their carers (guardians/curators, foster carers, parent-educators).	employment, parenting skills development, family therapy; e) financial and material support.	
29.		Protected home	Government Decision No. 711 of 09.08.2010, on the approval of the framework regulation for the organization and functioning of the social service "Protected home" and its minimum standards of quality.	Development of necessary skills for independent life, social and professional integration into the community of persons with mental disabilities.	Persons with mental disabilities caused by psychic disorder (mental illness of mental deficiency), who are aware and able to manage own actions, are not declared inapt by legal instance, are at least 18 years old, do not have own home or need improved living conditions, and who, if periodically supported, can be able to live independently in the community.	a) information; b) consultation; c) mediation and representation; d) communication; e) other necessary services to ensure independent life opportunities.	- community social worker - care worker
30.		Guardianship/kinship care	Family Code No. 1316 of 26.10.2001. Civil Code No. 1107 of 06.06.2002.	Kinship care and guardianship is a form of protection provided to children left without parental care, for their education and care, as well as for the protection of their legal rights.	Children left without parental care.	a) care and up-bringing of children in a substitute family environment; b) legal representation of the child's rights and interests; c) administration of the child's movable and immovable property.	- Tutor/guardian
31.		Centre for psycho-social assistance of children – victims of violence, abuse, and exploitation.	The normative framework is under development.	The centre for psycho-social assistance of children – victims of violence, abuse, and exploitation, provides complex services to children, for the prevention and treatment of trauma caused by violence, abuse, and exploitation.	Children – victims of violence, abuse, and exploitation; Children who committed acts of violence, abuse, and exploitation; Family members.	a) therapy and psychological consultation; b) information; c) support for educational inclusion; d) support for the family and social (re)integration; e) legal support.	- psychologist/psycho-pedagogue - social worker - lawyer - administrative staff - auxiliary staff

32.		Centre for youth social reintegration	The normative framework is under development.	The centre for youth social (re)integration is a public or private institution providing specialized social services aimed at the (re)integration of young persons in difficulty.	Orphans or children left without parental care; Young graduates of residential institutions; Youth in conflict with the law; Ex-imprisoned youth; Youth from socially vulnerable families.	a) service for the development of cognitive, communication, and behavioral skills; b) professional orientation; c) psychological consultation; d) consultation of family members; e) legal assistance; f) meals;	- social worker - psychologist - pedagogue - lawyer - administrative staff - auxiliary staff.
33.		Assisted social home	The normative framework is under development.	The assisted social home is a service providing temporary accommodation to young people and facilitating their development of independent life and self-care skills.	Orphans or children left without parental care; Young graduates of residential institutions; Youth in conflict with the law; Ex-imprisoned youth; Youth from socially vulnerable families.	a) accommodation; b) provision of food products; c) life skills development support; d) monitoring	- social worker
34.		Social centre for HIV, HIV/TB, HIV/UDI infected persons.	The normative framework is under development.	The centre is a facility providing a wide range of day-based social, medical, referral, legal, and psycho-social, services to women, men, and children infected and affected by HIV/AIDS, their families, and community members in difficulty.	Persons infected and affected by HIV/AIDS; Persons with HIV/TB; Persons with HIV, users of injectable drugs.	a) psycho-social support and ARV treatment awareness; b) “peer-to-peer” counseling; c) Consultation; d) legal services, including, self-support groups, consultations on professional orientation, employment, training, seminars for HIV positive persons; e) social homecare support (based on individual care plan); f) consultation and referral to other social services in critical situations; g) temporary placement for PTH in exceptional cases.	- medical staff (infectiologist, therapist, venerologist, gynecologist, nurse) - educators (pedagogues, equal-to-equal consultants, animators for child activities - social worker/care worker - psychologist - lawyer - administrative staff - auxiliary staff

3. TYPE OF SOCIAL SERVICES: HIGH-NEED SOCIAL SERVICES							
35.		Psycho-neurological residential institution for adults with mental disabilities	The framework regulation of the functioning of the Psycho-neurological residential institution for adults with mental disabilities, subordinated to the Ministry of Social Protection, Family and Child, is approved by the Order of the Minister of Social Protection, Family and Child (currently, Ministry of Labor, Social Protection and Family) No. 44 of 09.06.2008.	The psycho-neurological residential institution provides temporary or permanent placement and socio-medical services to adults with mental disabilities, to meet the specific individual needs to its users. The services include social assistance, recovery and development, maintaining capacities and social (re)integration.	Persons with mental disabilities, at least 18 years old, mainly left without legal guardians, who have low self-care capacity, need specialized care or support from other persons, and cannot achieve worthy, active, and participative life independently due to their mental health condition.	a) accommodation; b) food; c) care; d) providing clothes and footwear; e) occupational therapy; f) cultural activities; g) life skills development activities; h) recovery activities; i) physiotherapy; j) medical assistance.	- social worker - health worker (including, nurse and caregiver) - lawyer - cook - administrative staff - auxiliary staff
36.		Residential home for children with mental deficiencies	The framework regulation of the Residential home for children with mental deficiencies, approved by the Order of the Minister of Social Protection, Family and Child, No. 45 of 13.06.2008.	The residential home for children with mental deficiencies is a public social assistance institution providing residential services to children with mental disabilities, aimed at their recovery, rehabilitation, social and family (re)integration.	Children with mental disabilities aged 4-18.	a) accommodation, support, food; b) cognitive, communication, behavioral development services; c) recovery/rehabilitation services; d) support for inclusive education; e) consultation of family members/carers; f) leisure activities;	- social worker - educator - medical staff (according to specific needs of children) - cook - administrative staff - auxiliary staff
37.		Centre for assistance and protection of victims and potential victims of	Government Decision No. 1362 of 29.11.2006, regarding the approval of the framework regulation of the organization and functioning of centers for the assistance and	The centre is a specialized institution providing services, including accommodation, housing, personal hygiene, meals, legal support, social,	Victims and potential victims of human traffic, citizens of the Republic of Moldova and apartheids who had the right to permanent residence in the Republic of Moldova at the moment of their entry on the territory of a foreign	a) secured temporary accommodation; b) food; c) emergency medical care; d) psycho-social and legal consultation;	- psychologist - social worker - lawyer - nurse - administrative staff - auxiliary staff

		human traffic	protection of human traffic victims.	psychological, and emergency medical assistance, security and protection, and assistance for the users' integration.	state (women, children, parents/children, men).	e) ensuring basic material needs (personal hygiene items, clothes, footwear); f) (re)integration assistance	
38.		Regional centre for professional rehabilitation of persons with disabilities	The normative framework is under development.	Provides a complex of services, including medical, professional, social and pedagogical orientation, to achieve the rehabilitation, recovery, or compensation of affected functions of the body and work capacity of a disabled person	Persons with disabilities who cannot engage in work activity according their qualification	a) information; b) consultation; c) medical rehabilitation; d) professional orientation and training; e) art-therapy; f) behavioral therapy; g) cognitive therapy; h) occupational therapy; i) physiotherapy; j) music therapy; k) group activity; l) game therapy, etc.	- social worker; - psychologist; - health worker; - occupational therapist; - physiotherapist; - administrative staff; - auxiliary staff.
39.		Republican experimental prosthetic, orthopedic, and rehabilitation centre (CREPOR)	Government decision No. 87 of 31.01.2002; Government decision No. 567 of 26.07.2011; Statute of CREPOR approved by the Ministry of Social Protection, Family and Child;	Provides technical aids to citizens, offers consultation, treatment, and rehabilitation to persons with disabilities and to war veterans, to maintain health condition and to achieve social inclusion.	Persons with disabilities and war veterans, patients with physical disorders and disabilities;	a) consultation; b) treatment; c) rehabilitation; d) technical aids;	- personal auxiliary - medical staff - engineer - administrative staff - auxiliary staff
40.		Centre for the recovery/rehabilitation of pensioners and disabled persons	The regulation of the Rehabilitation centre for pensioners and disabled persons "Speranta", Vadul lui Voda, approved by the Ministry of Labor, Social Protection and Family, No. 31 of 19.08.1999, and Regulation of Activity of	Rehabilitation/recovery centre is a specialized medical and social institution that provides to its users recovery, depending on their specific disease (circulatory system and motor system).	Elderly and disabled persons, citizens of the Republic of Moldova, foreign citizens, apartheids or refugees who have residence in the Republic of Moldova, are at least 18 years old, and are registered with social assistance and family protection departments/sections.	a) meals; b) accommodation; c) rehabilitation after myocardial infarction; d) rehabilitation after brain infarction; e) physiotherapy; f) multifunctional diagnosing; g) radiology and imagistic;	- medical staff (including specialists, nurses, caregivers) - lawyer - engineer - cook - administrative staff

			the rehabilitation centre for pensioners and disabled person “Victoria” in Sergeyevka, Ukraine, approved by the order of the Ministry of Social Protection, Family and Child No. 209 R of 01.10.2007.			h) psychotherapy; i) acupuncture; j) rheumatology; k) sub-aquatic massage; l) electric sleeping; m) mud therapy; n) paraffin treatment;	- auxiliary staff
41.		Republican asylum for pensioners and disabled persons/Republican centre for the rehabilitation of labor and war veterans	The Regulation of the Republican centre for disabled and pensioners in Chisinau, approved by the Ministry of Labor and Social Protection on 05.01.2004 and the Regulation of the Republican rehabilitation centre for war and labor veterans in Cocieri, Dubasari, approved by the Ministry of Labor and Social Protection on 04.01.2004.	The Asylum/Centre is temporary or permanent placement facility providing social and medical services to old and physically disabled persons, ensuring social protection, recovery, maintaining capacity and social (re)integration.	Elderly persons and disabled persons, at least 18 years old, mainly, those who do not have legal guardians, who have low self-care capacity, need specialized care or support from other persons, and cannot achieve worthy, active, and participative life independently due to their mental health condition.	a) accommodation; b) meals; c) care; d) clothes and footwear; e) occupational therapy; f) cultural activities; g) life skills development activities; h) recovery activities; i) physiotherapy; j) medical assistance.	- social worker - medical staff (including, specialists, nurses, caregivers) - lawyer - cook - administrative staff - auxiliary staff