UNIUNEA EUROPEANĂ

Programul Operațional Capacitate Administrativă
Competența face diferența!

Instrumente Structurale 2014-2020

National Unitary Methodology for Elaborating the Individual Closure Plans

English version

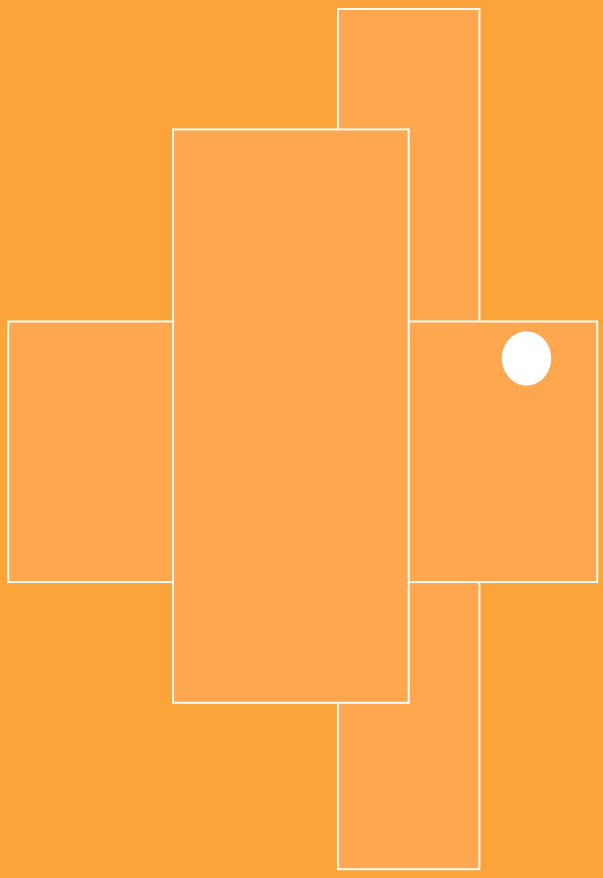
MINISTERUL MUNCII
ȘI JUSTIȚIEI SOCIALE

Autoritatea Națională pentru
Protecția Drepturilor Copilului și Adopție

Agreement for Provision of Technical Assistance on Development of Plans for the Deinstitutionalization of Children Deprived of Parental Care and Their Transfer to Community-Based Care (P156981)

OUTPUT #5:

Development of a methodology for the drawing up of individual plans of Residential Center closing



This report was prepared under the Reimbursable Advisory Services Agreement between the International Bank for Reconstruction and Development and the National Authority for the Protection of Children's Rights and Adoption, concluded on May 12, 2016, for the implementation of the project "Development of the Plan for the Deinstitutionalization of Children in Residential Care and Their Transition to Community-Based Care" - code SIPOCA 2, funded by the European Social Fund under the Operational Program for Administrative Capacity. This report represents Output 5 under the Agreement.

Acknowledgments

The methodology produced under the Reimbursable Advisory Services Agreement on Development of Plans for the De-institutionalization of Children Deprived of Parental Care and their Transfer to Community-based Care was prepared under the supervision of Mr. Cem Mete, with overall guidance from Ms. Tatiana Proskuryakova.

The preparation of this document wascoordinated by Mr. Emil Teșliuc, Mr. Vlad Grigoraș (task team leaders), and Ms. Manuela Sofia Stănculescu. The deliverable has benefitted from the contributions of Dumitru Alexe, Florentina Andrei, Felicia Andrioni, Simona Anton, Diana Mioara Ardelean, Georgiana Blaj, Diana Chiriacescu, Daniela Ramona Climescu, Bogdan Corad, Cristina Iulia Cornea, Diana Alina Cristea, Marinela Carmen Grigore, Andy Guth, Monica Lavinia Iagar, Elena Cătălina Iamandi Cioinaru, Roxana Irimia, Mirela Lavric, Eugen Lucan, Daniela Doinita Lupu, Monica Marin, Maria Corina Marutoiu, Marcela Neagu, Nicoleta Pop Soroceanu, Cerasela Predescu, Bogdan Simion, Otto Sestak, Emilia Maria Sorescu, Andreea Stănculescu, Steluța Udrea, and Elena Mihaela Zanoschi. The team also benefitted from the support of Andrei Zambor, Monica Ion, Oana Maria Caraba, and Corina Grigore.

The World Bank highly appreciates the excellent cooperation, guidance, and timely feedback from the ANPDCA representatives, in particular Ms.Gabriela Coman (President) and Ms. Elena Tudor (Project Manager) and Ms Cristina Cuculaș (responsible for monitoring Results 1 and 3). The World Bank is also grateful for the committed involvement of all public sector employees who offered feedback within consultation sessions.

The World Bank team would also want to thank to the DGASPC representatives who have drawn up closure plans and have participated in the consultation meeting on the closure methodology for placement centers in Brașov, in February 2018, as well as the 440 representatives of child protection services at local level and the accredited private bodies (SPAS, DGASPC, NGOs, local elected representatives) who participated in the eight regional consultation seminars in April 2018, where the multidisciplinary evaluation tools and the methodology for preparing closure plans placement centers was discussed in order to finalize it. The World Bank team also wants to thank UNICEF for all its support during the implementation of the technical assistance project.

Equal Opportunities and Equity

All project activities were designed and implemented for the equal benefit of girls and boys and women and men. Project staff and experts have been treated equally, regardless of their sex, ethnicity, or other characteristics.

Sustainable Development

During the project implementation, the World Bank team aimed to use resources rationally and effectively in order to protect the environment and ensure social cohesion. Each citizen or institution needs to be aware that the sustainable development is the only way to meet human needs without endangering the integrity of natural systems and the future of the mankind as a whole.

CONTENTS

LIST OF BOXES AND FIGURES

List of Boxes

List of Figures

ACRONYMS

AMP	Professional foster caregiver/ parent
ANPDCA	National Authority for Protection of Children's Rights and Adoption
CJ	County Council
CTF	Family-type homes
DGASPC	County Directorates of Social Assistance and Child Protection
EEG	European Expert Group on the Transition from Institutional to Community-Based Care
HCOP	Human Capital Operational Programme
HRP	Habilitation-Rehabilitation Plan
IPP	Individualized Protection Plan
ISJ	County School Inspectorate
ISP	Individualized Service Plan
MMJS	Ministry of Labor and Social Justice[1]
NGO	Non-Governmental Organization
OPA	Accredited private body
PIN	Program of National Interest (financed through MMJS funds)
ROP	Regional Operational Programme
SEN	Special educational needs
SEOSP	School and Professional Evaluation and Guidance Service
SIP	Specific Intervention Programs
SPAS	Public Social Assistance Services
WB	The World Bank

[1] Until January 2017, it was called the Ministry of Labor, Family, Social Protection, and the Elderly (MMFPSPV).

INTRODUCTION

The present methodologyhas been produced under the Reimbursable Advisory Services (RAS) Agreement on *Development of Plans for the De-institutionalization of Children Deprived of Parental Care and their Transfer to Community-based Care*, signed between the World Bank and the National Authority for the Protection of Children Rights and Adoption (ANPDCA) on May 12, 2016. The agreement relates to the SIPOCA 2 project coordinated by ANPDCA and financed from European funds, under the Administrative Capacity Operational Programme.

The following Chapters represent a methodologymeant to support the DGASPCs responsible for the implementation of children deinstitutionalization in the years to come.

The methodology for designing the plans for closing down individual residential centers, includes: (i) the alternative services that should be provided to children living in these institutions depending on their profile and (ii) the actions to be carried out by each particular residential center.

The purpose pursued is children's deinstitutionalization and not closing down the institutions

Although this is a methodology for closing down residential centers for children, the purpose pursued consists in the deinstitutionalization of children cared for by the state, and not the close down of the institutions per se. In other words, the entire process shall be centered on the child and on the assurance of a better life, a happier childhood and more opportunities for a full and harmonious development for all children living in those institutions.

Deinstitutionalization is the complex transition process from institutional childcare to childcare which is based on services which prevent the separation of children from their family and on a range of alternative services based on family and on community childcare. The planning of the deinstitutionalization process shall start from the best interest and individual needs of each child and each family.

Therefore, the close down of an institution shall go hand in hand with the establishment of new services capable of providing for the best form of alternative childcare in a family environment. Thus, the close down of an institution shall be treated as an opportunity to intensify the efforts 'to maintain or reintegrate the children back into the care of their families or, should this be impossible, to identify other suitable and permanent solutions, such as the adoption"[2] for all children who are currently institutionalized. Furthermore, the close down of an institution shall be mandatorily accompanied by the development and strengthening of community services preventing the separation of children from their families, so as to reduce the number of children separated by their families and who are in need of childcare provided under the public system.

The children and young people currently placed in institutions represent a very diverse group and family (re)integration may not be possible for some of them. A part of thesechildren should be further protected either in foster care or in small-size residential services such as Family-type homes or apartments.

The methodologymay be used irrespective of the funding source (European Funds, national budget, County Councils budgets, other source), and it is meant to support in the preparation of the closure plan to be assessed by ANPDCA.

[2] EEG (2012)

It is essential for the national child deinstitutionalization policy to be promoted at all levels – MMJS, DGASPC and County Councils, SPAS and Local Councils, to mobilize all relevant institutional actors, communities and civil society in order to intensify the prevention efforts regarding the separation of the child from his/her family and to ensure adequate support to all families, especially vulnerable ones, that have children under their care.

Purpose of the methodology

This material presents a methodology on how to actually close down a residential carecenter for children. This process should be child-centered and should be planned in the best interest of the children and young people living in these institutions. To this aim, closure of a residential care center implies the creation, development and strengthening of new services to provide the most appropriate form of alternative care for children in a family environment as well as various support services within communities.

Methodology structure

The first Chapter describes the background of the project and introduces the methodology. Chapter 2presents an overall image of the structure of an individual plan for the close down of a residential center, basically representing a map for navigating through the methodology.

The next Chapters follow the major phases of the deinstitutionalization process, which has as visible output the close down of institutions and development of alternative services. Chapters 3-5 cover the various stages of preparation. Thus, Chapter 3presents the initial phase of taking the decision of closing down. Chapter 4makes a thorough presentation on how to prepare the close down of centers, therefore considering the evaluation that must be performed for the purpose of understanding and sizing the needs of the children/youth and their families, as well as those of the communities and personnel of the residential center. Then, Chapter 5debates how the individual closure plan is to be prepared. First, the chapter shows how the aggregation of needs identified at child or youth level may be used for the planning of new alternative services and interventions during the project, including prevention services at community level. Secondly, it deals with the activities to be planned with regard to the human resources and buildings that become available following the close down of the residential center, as well as in regard to the human resources required for the development of the new services. At the same time, it highlights the potential risks that can appear in the implementation phase in order to include in the planning the measures necessary to prevent, reduce or eliminate these risks. Lastly, Chapter 5discusses the way in which the total budget of the closure plan is determined, and possible calls for funding.

Chapter 6moves to the implementation phase of the Individual plan for the close down and considers the transition, meaning preparing the children for relocation and the actual relocation of both children/youth, as well as the selected personnel. Finally, Chapter 7refers to three elements that are essential for the shutdown of residential centers to be a success through the frame of child deinstitutionalization. These elements are: (i) peer learning, exchange of good practices and dissemination of results, (ii) sustainability of newly developed services and activities and (iii) the monitoring and evaluation system of both children' progress, as well as of the newly established services.

The methodologyis based on the current legal framework and employs a toolbox which is aligned to the legal provisions and is known and used at present by the DGASPC experts. The methodology proposes new working instruments that are useful for the preparation of the Individual closure plans of residential centers. These new instruments are presented in Annex A. Moreover, the Methodology includes a Model of an individual closure plan (Annex B).

1. BACKGROUND

The National Authority for Protection of Children's Rights and Adoption (ANPDCA) through the Ministry of Labor and Social Justice (MMJS)[3] in Romania has asked for the World Bank's help to develop an operational plan to deinstitutionalize children living in classical residential units and to entrust them to other forms of care within their communities of origin.

Reducing the number of children in large and inadequate institutions remains a priority for the Romanian government over the coming years. The government has already committed itself to speeding up the deinstitutionalization process and has acknowledged this as a priority in various strategic documents including the *National Strategy on the Protection and Promotion of Children's Rights 2014-2020*, *the National Strategy on Social Inclusion and Poverty Reduction 2015-2020*, and the *Partnership Agreement*. In line with the European Commission's Social Investment Package and Recommendation "Investing in Children: Breaking the Cycle of Disadvantage," the ANPDCA has set the following priorities among others for 2014 to 2020: (i) To close down the classical residential centers for child protection and to transfer the children from these centers to community-based services and (ii) to provide children with early and preventive interventions that will enforce their right to grow up in a family environment and help them to achieve their full potential and make full use of their rights.

Romania inherited a disastrous child protection system from the Communist regime. Between 1945 and 1989 the state developed a network of large institutions, and poor families were encouraged to give their children (especially those with disabilities) into the state's care. Traditional patterns of child welfare, like placing a child in difficulty with a member of the extended family, were undermined. In the context of the country's pro-birth policies together with the economic depression in the 1980s, the outcome was disastrous. By 1989, over 100,000 children were living in institutions in very poor conditions. Moreover, even when the physical conditions were reasonably good, the institutionalization had a strong negative impact on the children's health, development outcomes, and psychological conditions because of depersonalization, rigid routines, and social distance.[4]

The government has made significant progress over the last 15 years in reducing the number of children in residential care and by developing family-based alternatives, but this progress stalled after 2010. The number of children in residential care (in public and private placement centers, including Family-type homes) has dropped from a peak of 57,181 in December 2000 to about 15,478 as of September 30, 2016. Nevertheless, during 2011, for the first time in 15 years, the number of children in residential care increased[5] because of the growing impoverished population and the limited budget available for family-based services. However, the rate has begun to decline once again over the last few years. Furthermore, the total number of children placed in public care in Romania (in special protection)[6] who benefit from family or residential type of protection services dropped significantly from around 98,000 children in 1997 to about 52,774 as of September 30, 2016. However, the total population of Romanian children also declined and, for that reason, the rates of children placed in public care have in fact been on a plateau (1,776 in 2000 and 1,641 in 2011), which is indicative of the failure of the system to reduce the number of children entering the protection system. Compared with other countries from Central and Eastern Europe and the Commonwealth of

[3] Until January 2017, it was called the Ministry of Labor, Family, Social Protection, and the Elderly (MMFPSPV).
[4] Johnson et al. (2006), Browne (2009), Tobis (2000), National Scientific Council on the Developing Child (2014).
[5] MMFPS, DGPC (2011: 1). The number of institutionalized children (in residential services) was 23,240 in 2011 compared with 23,103 in 2010.
[6] In Romania, the child public care system represents the set of measures, benefits, and services designed for the care and development of children who are deprived, with temporarily or indefinitely, of parental care or who cannot be allowed to be in the care of their parents in order to protect their best interests.

Independent States (ECE/CIS), Romania has an average rate[7] of children placed in public care. However, in absolute numbers, the child protection system in Romania is still one of the largest, being responsible for finding adequate care arrangements for about 60,000 children (of whom 52,000 children are in special protection).[8]

The closing of residential centers for child protection was slow, and the proportion of children placed in institutions (either classical or modulated) has remained unchanged after 2011. According to the *National Strategy on the Protection and Promotion of Children's Rights 2014-2020*:[9]"Child care institutions were restructured as efforts were made to provide family-based alternatives to residential child care and to prevent child separation. Large-sized classicalinstitutions (100 to 400 places) were reorganized in an attempt to make them smaller and to modulate them so as to offer more space to each child in a setting as close to a family environment as possible. The decrease in the number of children due to deinstitutionalization – especially through children's reintegration into their natural or extended family or their placement with a family or a person – 'humanized' institutions. Nonetheless, not all placement centers went through this kind of makeover; a lack of funding and experience slowed down the process to a stage-based implementation after 2007, as dictated by available funds or priorities set under county strategies. In 2011, 52 percent of children in residential care were living in classicaland modular institutions."[10] By the end of 2014, 50 percent of children in residential care still were living in institutions (residential centers).

The children deinstitutionalization reforms that have been implemented so far in Romania reveal five main lessons to be considered by decision-makers under this new wave of reform (see also Box 1). The main lessons learnt reveal that: (i) The planning underpinning the close down of centers and the development of new services shall rely on the specific needs identified for each child and family, as also on the consultation thereof; (ii) The close down of residential centers shall be mandatorily accompanied by the development and strengthening of community level services for preventing the separation of children from their families; (iii) A significant strengthening is required in regard to the monitoring and assessment of children's situation post-closedown, but also in regard to the quality of the newly-developed alternative services; (iv) NGOs are partners of a tremendous value in the field of child protection and therefore the deinstitutionalization shall be built mostly based on public-private partnerships; (v) It would be useful to organize information and awareness-raising campaigns at the level of the general public and local-level decision-makers, so as to increase the acceptance and integration of those children in the community, especially of the children with special needs.

As of March 31, 2015, children were still living in both classical and modulated centers.[11]According to the official statistics from the ANPDCA, there were 81 classical residential units where a total of 3,866 children and young people were in care. In addition, there were another 83 modulated residential units containing 3,492 children. Although the need to shut down these centers is unanimously accepted, the cost of this would be extremely high, and existing funds are utterly insufficient. Therefore, it is going to be necessary to set priorities to decide which centers to close

[7] Romania has 1,600 to 1,700 children in public care per 100,000 children in the population as a whole aged between 0 and 17 years old. This compares with an average of 1,850 children per 100,000 children aged between 0 and 17 years old for the ECE/CIS region and also for the countries of Eastern Europe and Central Asia (Transmonee 2015 database, Table 6.1.22).

[8] The remaining 8,000 or so children receive services such as guardianship, daycare, special supervision, counseling, prevention, and various other services that do not involve separation from family and protection in family-type or residential services.

[9]ANPDCA (2014: 30)

[10] According to HHC (2012), an "old type," "traditional," or "classical" institution refers to a residential center with more than 12 children or young adults, at least four children in each bedroom and common bathrooms for the residents of a floor. A "refurbished," "restructured," or "modulated" institution refers to a residential center with more than 12 children or young adults based on units that usually include a bedroom, a living room, and a bathroom. In comparison, a small group home (CTF) is a residential unit based on a family model with a living room, kitchen, and bathrooms.

[11] March 31, 2015 was the reference date considered when the project was designed in 2015.

first based on an in-depth assessment of their circumstances and of the quality of the services that they provide for their residents, an assessment that has yet to be carried out.

Box 1: The deinstitutionalization process as implemented so far and lessons learnt

In Romania, the first systematic efforts related to the deinstitutionalization and child protection system reform have started at the end of 1997, along with the establishment of the Child Protection Department at national level and of the Specialised Public Services for Child Protection at county level. Since then, the deinstitutionalization process has gone through several steps which reflected different reform options sometimes generating effects different from the ones desired onto the deinstitutionalized children, as well as onto the system as a whole.

In 1997, the child protection system was almost entirely focused on institutional childcare.

During the first deinstitutionalization stage (1997-2001), on account of scarce funding and the need to achieve some quick results, the actions taken with reference to alternative childcare envisaged the adoption of approaches which were more effective cost-wise: placement in the extended family,professional foster parenting and adoption. The family-type services recorded an extremely fast and impressive development. However, the capacity of professional foster parenting services was not able to develop at the same pace, and numerous cases were recorded when the children were placed with professional foster parents and foster families without a proper monitoring. Despite the fact that professional foster parenting was initially considered as a short to medium-term solution, as a step towards the reintegration or adoption of the child, over time, an increasing number of placements of this type have turned into solutions for an indefinite period. The extremely fast development led to significant discrepancies in the structure and quality of services provided nation-wide and, as a consequence, it is not surprising that professional foster parenting services were the first services to be regulated by minimum quality standards (in 2003– that is four years after such services started to be provided). Concurrently, although the placement in extended families has brought significant contribution to the deinstitutionalization process, no consideration has been given to the establishment of minimum quality standards for such services and, not even at the present moment, the preparation/training of relatives with whom the child is placed (and the assessment thereof under the training process) is not included under the mandatory training process for placement of the child within an extended family.

On the other hand, the transformation of large-size institutions into smaller (family-type) units, by the use of the so-called 'modulation', whereby a new form of residential-type childcare – i.e. the 'modulated' institution, was introduced into the child protection system, was deemed as an acceptable option. Over time, however, it has proven to be a compromise that failed in setting a clear delineation between the classical residential-type institution and the family-type alternative childcare proposed under the mentioned approach.

Adoption has also contributed to a significant extent to the deinstitutionalization process, but such contribution was mainly due to international adoptions, which, at the end of 2000, accounted for 95.8% of the total number of adoptions. This huge gap between domestic and international adoptions has raised major concerns which, doubled by the alleged fraudulent practices used for international adoptions, led to the ban on international adoptions, regulated by a moratorium adopted by the Romanian Government in 2001.

During these first reforms/ first period of deinstitutionalization, the planning process has extensively depended on the financial resources available for the replication of successful models for prevention/support and alternative childcare services provided by NGOs, and on the total number of children who were supposed to benefit from such services. Nor the children, nor the parents or their relatives were consulted during the initial planning process.

The second stage of reforms (2002-2007) is what we can call the accelerated step of deinstitutionalization. This step benefitted from an intense political and financial support from the European Union. An important feature of this step is given by the fact that it was supported by carefully designed public awareness-raising campaigns, consistently funded, and which led to an increased support to the process.

NGOs have proven to be essential partners in the deinstitutionalization process, by their direct contribution to the quick development of the support and alternative childcare services, with funds made available by the funding organisations, but also under the National Interest Program (PIN) mechanism, which, during this step, represented a very important financing source for some of the most active organisations of the civil society.

During this step, financial resources and costs were no longer a problem, and therefore the Family-type homes

became one of the preferred options for deinstitutionalization, thereby replacing a residential-type childcare option with another. Professional foster parenting and placement withinthe extended family continued to register a quick increase. However, this increase was not accompanied by a proportionate development of the capacity to provide the services, which led to important consequences onto the quality of support and monitoring services provided to families and to children placed in foster care.

The downing of large-size institutions, into smaller modules (called 'family-type') was again deemed an acceptable alternative, which leads however to awkward situations where several small family-type residential centers were operating (and still are) in the same large-size building (a deceitful deinstitutionalization).

The ban decided upon in 2005 on the institutionalization of children under 2 years of age was not substantiated by proper planning and caught the system off-guard. Due to the insufficient capacity of family-type alternative childcare services to cope with this new challenge, regrettable situations were recorded where older children were forced to transfer from the foster parents to the residential-type centers, so as to make room for the younger ones.

The excitement around the close down of institutions and around the deinstitutionalization process led, once more, to a planning process extensively based on figures (number of institutions to be closed down or number of children to be deinstitutionalized), rather than on the specific needs identified at the level of each beneficiary. Despite the consistent efforts made for the reassessment of all children in the system, the extremely quick implementation, doubled by the reduced capacity of the public services in the field of case management, often led to a superficial individual assessment and planning process, with solutions being copied from one casefile to another. Also at present, the system is confronted with many cases where unrealistic results are established at the level of beneficiaries (for example, the reintegration of children back into their families is maintained as the expected result, even when obvious that it is not possible). The same as in the previous deinstitutionalization step, the children and their relatives were not consulted during the planning process. There are cases in which the unrealistic expectations lead to an insufficiently prepared/ planned (forced) reintegration, with terrible results for the children (severe neglect and/ or abuse), further to which the children need to return without delay in the child protection system (when it is not too late).

This second deinstitutionalization step was faced with a new challenge, which consisted in the increasing number of young people leaving the system (beneficiaries aged over 18) and in the need to adequately prepare them for independent living and social integration. In parallel with the non-uniform approaches adopted in regard to case management and reintegration services, the situation referred to above required the design and launching of a package of minimum quality standards and guideline for case management, reintegration services and development of skills for an independent living. This package, however, was adopted in 2006, towards the end of the second step of deinstitutionalization. A large number of young adults who left the protection system during that period did not benefit from proper monitoring and support and ended up being unemployed and homeless. The minimum quality standards and the guidelines intended for services meant to prepare and support the young people leaving the system are not known and applied throughout the country even at present.

In 2005, the responsibility for the prevention and support services was transferred upon the local authorities. This amendment was not duly prepared, and was not accompanied by an adequate transfer of financial resources capable of supporting the capacity development at this level. Given the lack of capacity at local level to ensure proper support and monitoring, the action undermined the reintegration efforts.

During this second deinstitutionalization step, the capacity of DGASPCs was strengthened and consolidated so that, towards the end of that period, they have become one of the most important employers in the public sector and the main providers of social services at county level, leaving too little room (or even no room) for partnerships (with some exceptions) with organisations of the civil society and services provided by state-funded NGOs.

After 2007, the deinstitutionalization process continued to evolve, but at a much slower pace. Therefore, at the end of 2014, about one third of the children included public care were placed under residential services, of which about half were still living in residential centers (share similar to the one recorded in 2011).

Classical and modulated centers still need to be defined and acknowledged as such in a uniform manner across the country in order to make the new wave of deinstitutionalization both feasible and realistic. Furthermore, while the modulated centers are somewhat better than the classical ones in

terms of environment of care, the differences disappear with regard to quality of care. Thus, either modulated or the old-type centers provide the same quality of care (not very good) to their beneficiaries[12].

The closure of these centers is a process[13] that must be carefully and thoroughly planned in order to determine:

(i) The needs and opinions of children currently living in these centers

(ii) The alternatives to the care that is currently being provided in these centers that could be used after the centers have been shut down

(iii) The services that could be provided given what resources are available

(iv) The areas and levels of investment that will have to be made

(v) The training needs of existing staff and what new types of staff will have to be employed

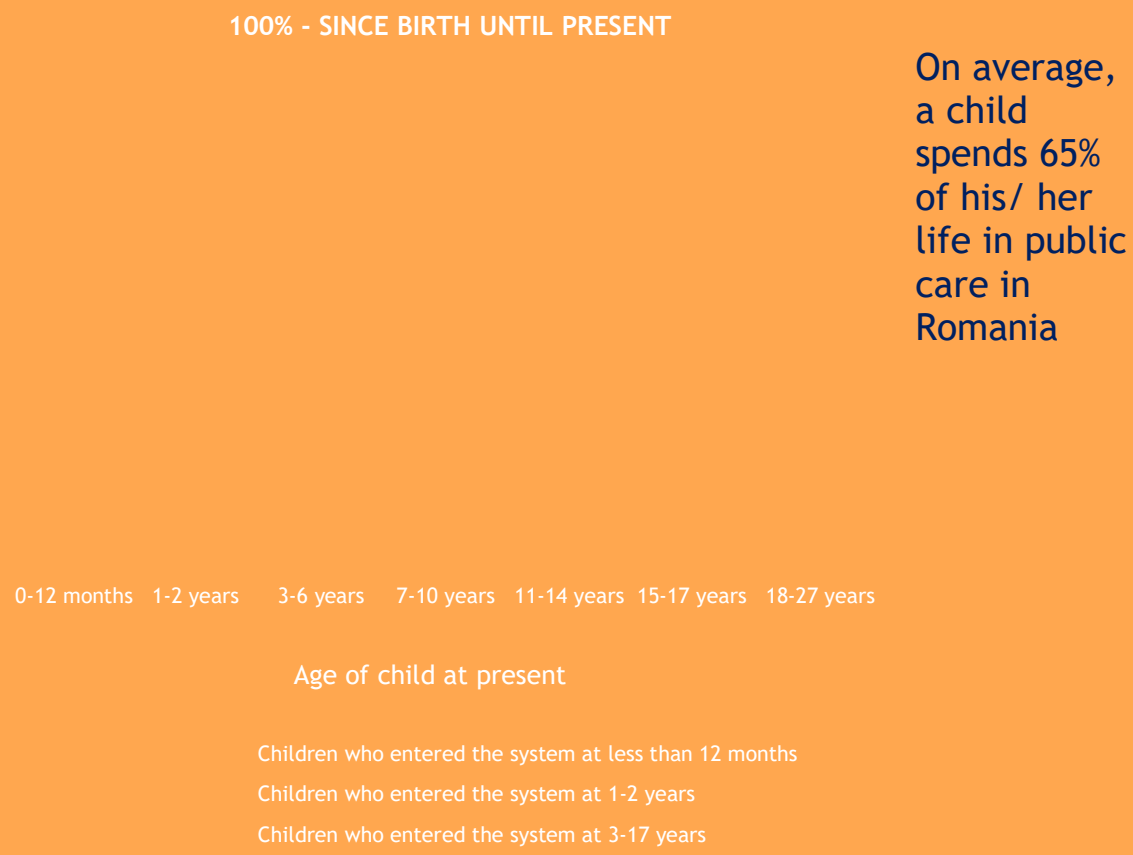
(vi) What preventive measures must be adopted or increased in order to reduce the number of children being admitted into the residential service system.

Each classical or modulated center must be closed in accordance with a methodology and a plan that takes into account all of these elements (particularly important being the needs of the children) and that also addresses the adequacy of the human, financial, and material resources available to that particular institution.

[12]Banca Mondială, 2017b

[13] As recommended by the European Group of Experts on the transition from institutional care to community care within the "Common European directions on the transition from institutional care to community-based care" and within the "Guidelines for the use of European Union funds for the transition from institutional care to community care" (EEG, 2012).

Figure 1: Average time spent in the system by the children in public care in Romania, as share of their entire life, depending on their age at system entry and by age groups at present



Institutional childcare is harmful for children...

- ☐ On average, a child spends 7.5 years in the public care system in Romania.*
- ☐ Children aged 0 to 12 months when entering the system have an extremly high likelihood of becoming 'children's systems' without real chances of leaving the system during their life course.*
- ☐ For children in the age group 0-3, every 3 months spent in the institution is equivalent to a 1-month delay in their development.**

Source: *Stănculescu et al (2016: 269). Study on the case files of children in public care (November-December 2014). The data is weighted (N=52,344 children). **Bucharest Early intervention Project, Harvard University – developingchild.harvard.edu

Box 2: Problems and Risks Associated with the Deinstitutionalization of Children: Opinions of the DGASPC Managers

Institutionalized children and their needs: 55 mentions

- Lack of self-confidence, impaired or low self-respect
- Absence of social skills. Children are not prepared for an independent life outside the childcare center.
- There is a category of children (usually of an older age, adolescents) that does not wish to go to the family; such children are accustomed to living in the centers, they have good conditions here and refuse to move to another environment
- Refusal of the children to leave the center (they have lived there for 17-18 years)
- Children are not in the middle of the process – they are not consulted and listened to, the solutions are imposed onto them, children are dissatisfied, therefore the deinstitutionalization process cannot be successful
- Possible trauma: 'breaking-up' the groups of friends; the trauma will occur if no solution is identified for the friends to stick together

Financial resources: 15 mentions

- It was ascertained that family-type alternatives are more costly
- The shift to family-type modules (homes, apartments) leads to non-compliance with the cost standards established for children with severe disabilities
- Lack of financial resources leads to the dissolution of Family-type homes and apartments for children with severe disabilities
- An analysis shall be performed in regard to the level of standards of cost
- Lack of financial resources required for the provision of quality social services
- Financial difficulties for the creation of alternative services
- Lack of resources required for the development of a sufficient infrastructure and for enabling the transfer
- Lack of financial resources for the construction/purchase of buildings for modules
- Lack of financial resources required for the deinstitutionalization of children included in the 0-3 age group from the residential center, which generates an insufficient number of AMP and an inadequate training level thereof
- Insufficient funds, allocated according to priorities pre-established under European programmes, from which it follows that the resources need to be allocated by the county authority - DGASPC
- Urgent definition and standardization, in terms of quality and quantity, of social services intended to children

Local Councils and the buildings of DGASPC: 14 mentions

- Political reluctance at county level with regard to the financial sustainability of social assistance, CTF or protected housing for children with disabilities
- Social security benefits are granted in default of a control on the management thereof (child benefits are used by parents for other purposes)
- Old buildings sheltering residential centers that cannot be adjusted to accommodate alternative options – what happens with these buildings upon deinstitutionalization?
- Certain centers are already modernized, how do we close down the center restored under the programme financed by MMJS, based on contracts containing clauses on maintenance of centers?

Source: Quotes from multi-purpose workshop organized by the World Bank on October 18 to 21, 2016 in Predeal.

2. MAP OF AN INDIVIDUAL CLOSURE PLAN OF A RESIDENTIAL CENTER

The negative effects exerted by the forms of institutional childcare onto the children development, as well as their lack of efficiency compared to the family-type childcare, were proven by great many studies, conducted not at national and international level.[14] Children growing up in institutions present delays in their physical, emotional, cognitive and social development.[15] There is however evidence to the fact that the deinstitutionalization of children at the earliest age possible and their placement in a family environment will considerably increase the chance for the child concerned to recover the development deficit, provided that the deinstitutionalization process shall be correctly planned and implemented[16]. Compliance with the institution close down steps, and with the sequence thereof, are important elements for the success of this action, of which final goal is to respect the right that all children develop in a family environment.

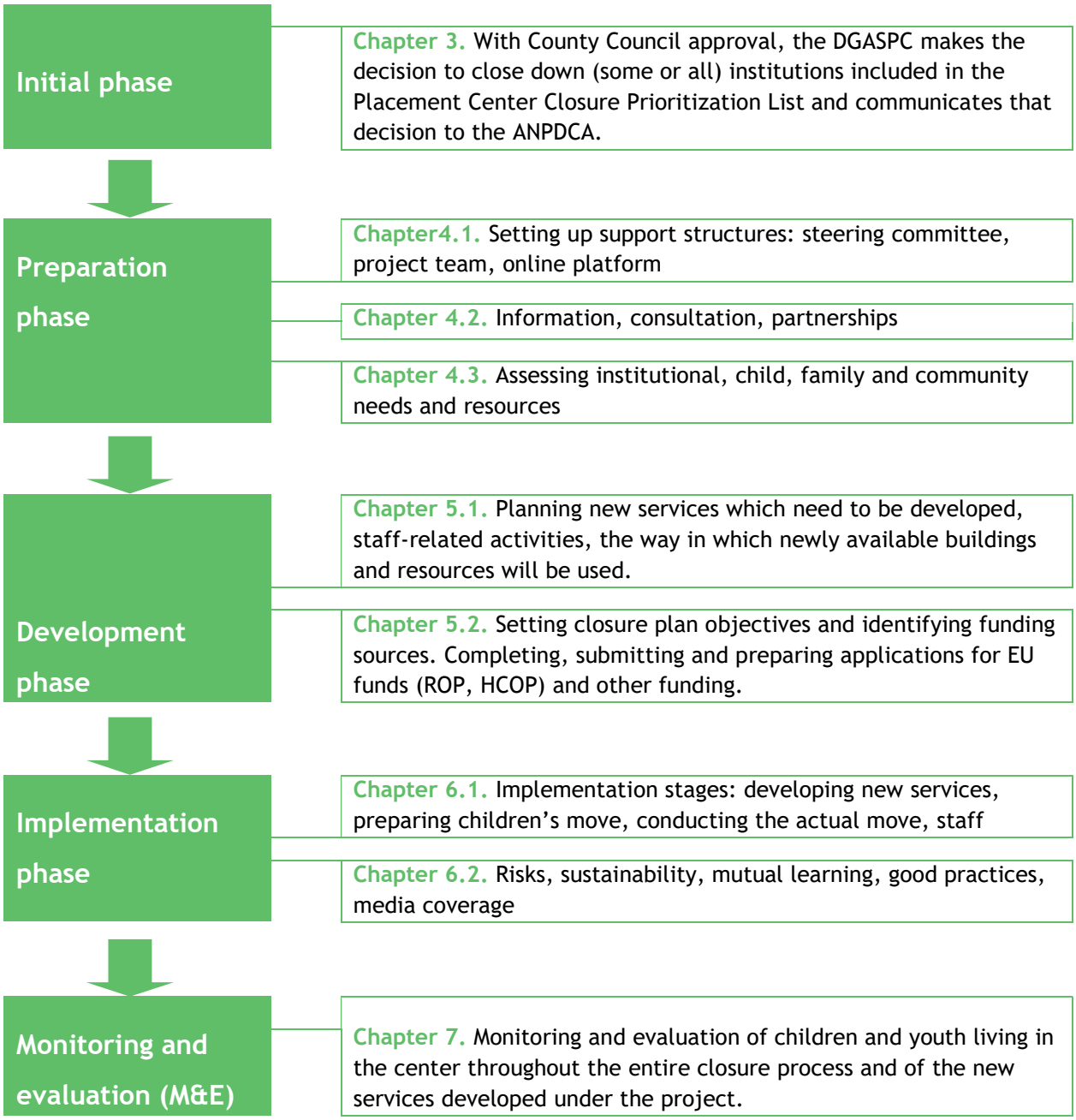
This Methodology sets out the individual closure plan for a placement center following the structure of a project which starts when the closure decision is made and ends when all the children living in the institution have been moved back to their families or to a new protection service, ensuring service access or continuity for each child and family.

Thus, the next chapters present the individual closure plan of a placement center, organized following the sequence: initiation, preparation, elaboration, implementation, and ending with what and how should be monitored and evaluated throughout the entire process. Each phase is briefly presented in Figure 3. An indicative estimation of the time needed to put a closure plan into practice is provided in Figure 2, with the mention that, in reality, this is expected to vary greatly as it depends on a number of factors, the most important ones being the number and profile of children in the institution. Thus, a residential center of approximately 30 children without special problems is expected to meet the estimation provided in Figure 2, whereas a center of 100 children, with many having special problems, will very likely require more time, especially in the preparation phase, which also involves evaluating each child from the institution and his/her family.

Figure 2: Indicative estimation of the time needed to implement the individual closure plan of a residential center for children

[14] For example, Tobis (2000).
[15] Dărăbuș et al. (2017)
[16] Browne (2009)

Figure 3: Structure of an individual closure plan for a residential center



3. INITIAL PHASE: DECISION TO CLOSE DOWN

Before making the decision to close down a certain child residential center (or certain centers), it would be useful for each county DGASPC to consider the current general state of child care services as a consequence of national policies and county-level actions implemented over time. Such a context analysis should be carried out at the level of each county with placement centers in the country, on the basis of the types of data included in Box 3 below.

Box 3: Rationale for closing down child care institutions – Relevant data for analysis

- Distribution of children in public care and DGASPC staff by residential care service *versus* family-type care service
- Distribution of children in special care and DGASPC staff by type of residential care service (residential centers *versus* small services - GH, apartments)
- Distribution of children and DGASPC staff by classical placement center *versus* modular placement center.

To run a context analysis, each DGASPC will use the County Social Service Development Strategy to understand (and update, where applicable) child care provisions and priorities for the upcoming years.

The county context analysis helps understand the service complex where a placement center (or several centers) will be closed down and the type of enablers and potential bottlenecks, besides any likely effects (including unwanted or unexpected ones) on other services which should be prevented or, on the contrary, stimulated.

At the same time, the analysis of the service system at county level is extremely relevant in order to show the way in which DGASPC projects the close down of one or more residential centers in the larger frame of child deinstitutionalization efforts. In other words, the analysis should highlight the measures and actions at county level which constitute the basis on which the whole process of closing down residential centers will be built, namely:

- ☐ Actions through which DGASPC supports the development/strengthening of social assistance services at the level of local communities
- ☐ Measures or activities carried out by DGASPC to reduce entries in residential centers. This aspect is even more important as the close down of an institution has to be accompanied by stopping entries into that institution.
- ☐ Correlated, what is the situation of family-type services and of small scale residential services at county level (Family-type homes, apartments)? Do these have the capacity to welcome new children or should new services be established?
- ☐ Measures or activities that DGASPC is carrying out to increase the yearly average number of family reintegration. What are the main problems, difficulties?
- ☐ The strategy and main actions of DGASPC to increase the quality of care for children and youth in public care services
- ☐ Actions through which DGASPC supports ISJ in the development of inclusive education and of support services through education.

- Awareness campaigns developed by DGASPC to increase the chances of children and youth deprived of parental care to successfully face the transition from institutional care to community-based care. But what would be the need for such campaigns?

The close down of a residential center is initiated by DGASPC, but the final decision rests with the County Council. Therefore, the actual action of launching and performing the close-down of the center concerned depends on the general director of DGASPC, but also on the political will manifested within the County Council.

The option of closing down a certain placement center should be considered solely after an institutional evaluation. In fact, ideally, the decision to close down or keep an institution open should only be made after the evaluation (of the institution, children, families, and communities) as this can point out the fact that permanent family care solutions may not be available for many children. For example, in a palliative care center where most children are brought in by their families as a last resort because they need specialized and constant medical care and where children are visited by their families, the main actions required are likely to be aimed at improving the environment and quality of care or reducing the number of children, not at the actual institutional closure.

Therefore, the decision expressed by the DGASPC at the beginning of the process and endorsed by the County Council, transmitted to ANPDCA, should then be regarded merely as an intention, putting the final decision on hold until the multidisciplinary evaluation of children is complete; this will show the best solutions for every child , addressing the new services that need to be created or improved.

In the case of a grant application (for example, from ROP or HCOP European funds) for the closure plan of a center, it is recommended to have a Decision of the County Council (HCJ) with regards to the closure, after all evaluations have been completed according to this Methodology. If the respective county begins the process of closing down multiple centers, a single HCJ is recommended, with a separate article for each center.

In exceptional cases where a DGASPC can not obtain such a HCJ after completing the evaluations, it will provide ANPDCA with a justification of the reasons, activities and actions undertaken for this purpose as well as the outcome thereof.

4. PREPARATORY PHASE 1: THE RESIDENTIAL CENTER CLOSURE PLAN

This chapter presents the way in which the close down of a residential center should be prepared, and considers: the creation of support structures for the actual close down of the institution, the information, consultation, partnership process with relevant actors for the children deinstitutionalization, and the evaluation that has to be carried out for understanding the needs of children and their families.

4.1. Developing support structures

As mentioned already, deinstitutionalization is a complex and lengthy process which involves a wide variety of partners and social stakeholders. During this process, closing down placement centers for children cannot be implemented without a good organization and mobilization of all relevant institutions. Therefore, we recommend the establishment of a project implementation team and a Steering Committee. These topics are presented hereunder.

4.1.1. Establishing a Steering Committee for the children deinstitutionalization process

Apart from the DGASPC representatives, the Steering Committee shall also include all partners involved in the process, as well as other persons with expertise and notoriety in the field of protection of children's rights.[17] Such a Steering Committee would ensure the transparency and visibility of the deinstitutionalization process and could contribute to a feeling of solidarity and mobilization of local level resources. But more importantly, its main role would be to bring together competent persons in fields such as education, health, social protection, employment, professional training services etc., who, through their expertise and resources, may help the children and the families in an integrated manner, thereby avoiding the loss of time and solutions.

The Steering Committee will not be involved in the day-to-day management activity, but will play a role on the making of key decisions and in the general monitoring of the process. Furthermore, given its composition, it is expected that the Committee plays the role of source of key information and support in the relation with the community, as well as with the stakeholder institutions which shall provide all contracts, agreements, certificates and approvals required for the activity to be performed in good conditions.[18]

Ideally, the Steering Committee shall be established upon the initiative or request of the DGASPC director (and based on inter-institutional protocols). If one DGASPC will implement several closure plans for residential centers, then a common Steering Committee can be established. This Committee should be chaired by the DGASPC director, as a person with a sufficient understanding of the process to be able to customize the messages according to the needs of each audience. The Steering

[17]Among the most important key stakeholders, we mention: County Council; Local Councils; consultative structures at community level; School Inspectorate; Public Health Directorate; health care facilities; civil society; Police; Firefighting Department, NGOs active in the field of child protection.

[18] We refer to: agreements and school transfers; sanitary permit and certificates; PSI (firefighting and safety) endorsement for the new buildings; transfer of the ownership right onto a land or building, among local and county-level authorities; building contracts; labor contracts for all employees; transfer of staff to or inclusion of new staff into the structures of the local administration (for example, personal assistants to be hired by the Local Council, or the young adults leaving the protection system).

Committee should meet regularly, in ordinary sessions (for example every three months), throughout the implementation period for closure plan(s) for the residential institution(s).

Establishing a Steering Committee is not mandatory, as it is based on local conditions. However, given the nature of the process of de-institutionalizing children, it is recommended.

4.1.2. Establishing the project team, elaborating and implementing the individual closure plan

The Project team may present different compositions, varying between phases. In a broad sense, the team shall include: (i) persons involved in the steps required for the preparation of the project (the most difficult task, which requires the largest volume of human resources is the performance of the multidisciplinary assessment of the child and his/her family), (ii) persons who can contribute to project writing[19] and (iii) persons who carry out the actual implementation of the project.

The role of the team consists in the development of an individual closure plan of the institution , broken-down in phases, with clear deadlines and allocated responsibilities. For the team to operate in an adequate manner, responsibilities and duties shall be defined for each team member (job descriptions), and working tools and procedures shall be established clearly for activities performed both inside and outside the team (communication, reporting, assessment, planning etc.).

The team preparing the closure plan shall be made of persons with specific experience and competencies and should include, as a minimum:

- ☐ A project manager
- ☐ A financial officer
- ☐ Minimum one experienced social worker
- ☐ Minimum one senior psychologist
- ☐ Minimum one human resources specialist

The **Project manager** is directly responsible for the efficient and timely implementation of the process steps. He/she is also responsible for monitoring the process and for measuring the progress achieved, based on the dated collected by the monitoring and evaluation expert during project implementation. He/she will inform the DGASPC leadership and the Coordination Committee on the progress achieved, conveying the adjustments and comments made by the Committee, to the team.

The Project Manager shall be experienced in project management and shall have sufficient knowledge on the professional issues, so as to be able to analyze, in a pertinent manner, all topics related to assessment, case management, children individualized protection plans, preparedness of children and personnel for relocation, development of human resources, adult education, training and occupational retraining, monitoring and evaluation.

The **social worker** (with diploma in social work) coordinates the social assessment of children, families and communities and contributes in an essential manner to the planning of new services, especially the ones at community level. The responsibility for the entire social assessment process is incumbent upon the social worker. He/she will communicate with the children, their families, communities and personnel, for the purpose of identifying the origins of children, the fluctuation and number of children, the relationship between the personnel and children, the reason of institutionalization, the

[19]Most likely, the projects for the close down of residential centers will be written by persons working within the DGASPC departments, who are specialised in the development of applications and projects for which funding is requested.

quality of family relations, the children's connections to their families, the services and status of communities from where the children originate. The social worker will provide information on the need for new services, on the type thereof and on the resources available at community level.

It is extremely important that the social worker be selected based on the practical experience in the field, and preference should be given to persons who have prior participation experience in similar projects (related to deinstitutionalization, preventing the separation of the child from his/her family, family support or reintegration back into the community).

The **psychologist** (with diploma in psychology and right to free practice) coordinates the psychological assessment of children and the assessment of personnel working within the institution. Psychologists shall correctly identify the development stage of each child, so that the transition process can be successfully planned, prepared and implemented. Together with the social workers, he/she will undertake the assessment meant to indicate the most suitable solution for the child concerned. He/she will also undertake preparatory actions needed to prepare the child for the new childcare settingor for the transfer in another service of social protection. The psychologist plays essential role as far as the preparation of the parents, social workers, etc from the moment when the decision is taken with regard to the closure of the center until the moment of the actual relocation of the child.

The **Human resources specialist** contributes to the assessment of the personnel working in the center[20], alongside the psychologist, and is responsible both for the preparation and development of personnel training plans and for the occupational retraining activities intended to the personnel who becomes available. One of the first actions undertaken by the human resources specialist shall consist in the presentation of the entire process, preferably together with the project manager, so that the personnel would understand and visualize the process, address questions and express its concerns.

The human resources specialist will also be responsible for the identification of training providers/programmes (based on the needs assessment and on the placement decisions taken following the assessment process). Subsequently, he/she shall prepare plans for the continuous training of personnel working within the new services, the main focus being placed on topics for which specialization sessions are required (topics such as abuse, behavior, development), aligned to the time intervals established for the reassessment of protection plans.

The **Financial Officer** shall preferably be an economist experienced in the financial management of projects. He/she shall ensure the functional character of the accounting system, the cash flow, the prompt execution of payments, the banking transactions and the financial reporting. He/she will monitor all financial activities and will draw-up the documentation for the financial reports.

The preparation team described above together with all those writing the project are developing the individual closure plan of the institution, based on the analysis of all data collected in the evaluation.

The team implementing the closure plan may be partly different from the preparation team, on account of the fact that it shall include a series of new specialists, depending on the results of the needs and resources assessment. As a minimum requirement, it is expected that the implementation team, apart from the personnel described above, shall comprise the following categories of specialists:

- A monitoring and evaluation (M&E) specialist is responsible for the cu collection and analysis of data which is relevant both in regard to the situation of children and families, and in regard to the newly-developed services. He/she shall work together with the project manager, but also with children's case managers. On a regular basis, the M&E specialist shall inform the relevant

[20] The assessment of the institution personnel is recommended to take into account the identification of the level of knowledge, skills and competencies of the staff working with the children. This information should lie behind the plans for training the personnel in view of facilitating the transition and undertaking the new attributions.

stakeholders on the progress achieved at the level of the entire process. Furthermore, he/she shall prepare the data to be used for the dissemination of results.

- ☐ A communication specialist might be needed in the counties where the resistance to change may endanger the success of the project (especially in the counties closing down two or more centers) and/or in counties where information and awareness-raising campaigns at the community level are needed.

- ☐ Other categories of specialists required for the development of the new services, for example speech therapist, kinetotherapist, behavioral psychiatrist etc., such as revealed by the children assessment.

During the project writing phase!

- **Consider the need for the training of the implementation team of the closure plan and, if needed, include a monitoring and evaluation specialist, and/ or a communication specialist, in addition to the specialists needed for the development of new services.**

4.1.3. E-cuib Online Platform

Within the SIPOCA 2 project, an IT application called "e-cuib" was developed, which is both a data collection tool and an IT application that provides assistance to produce individual closure plans for placement centers. Therefore, the e-cuib simplifies and improves the quality of the data collection process (by automatically entering data into databases, by offering the possibility of viewing the status of the data collection process, and by allowing aggregation of information for the production reports at placement center level).

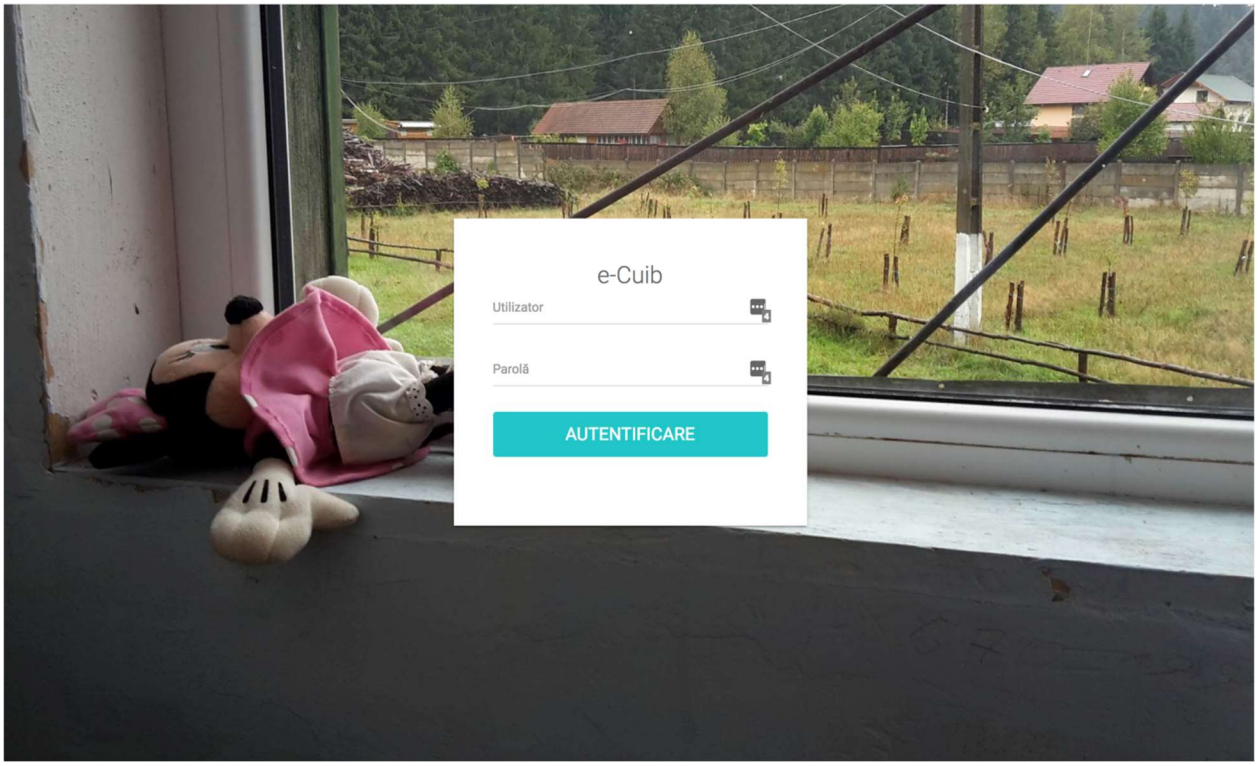
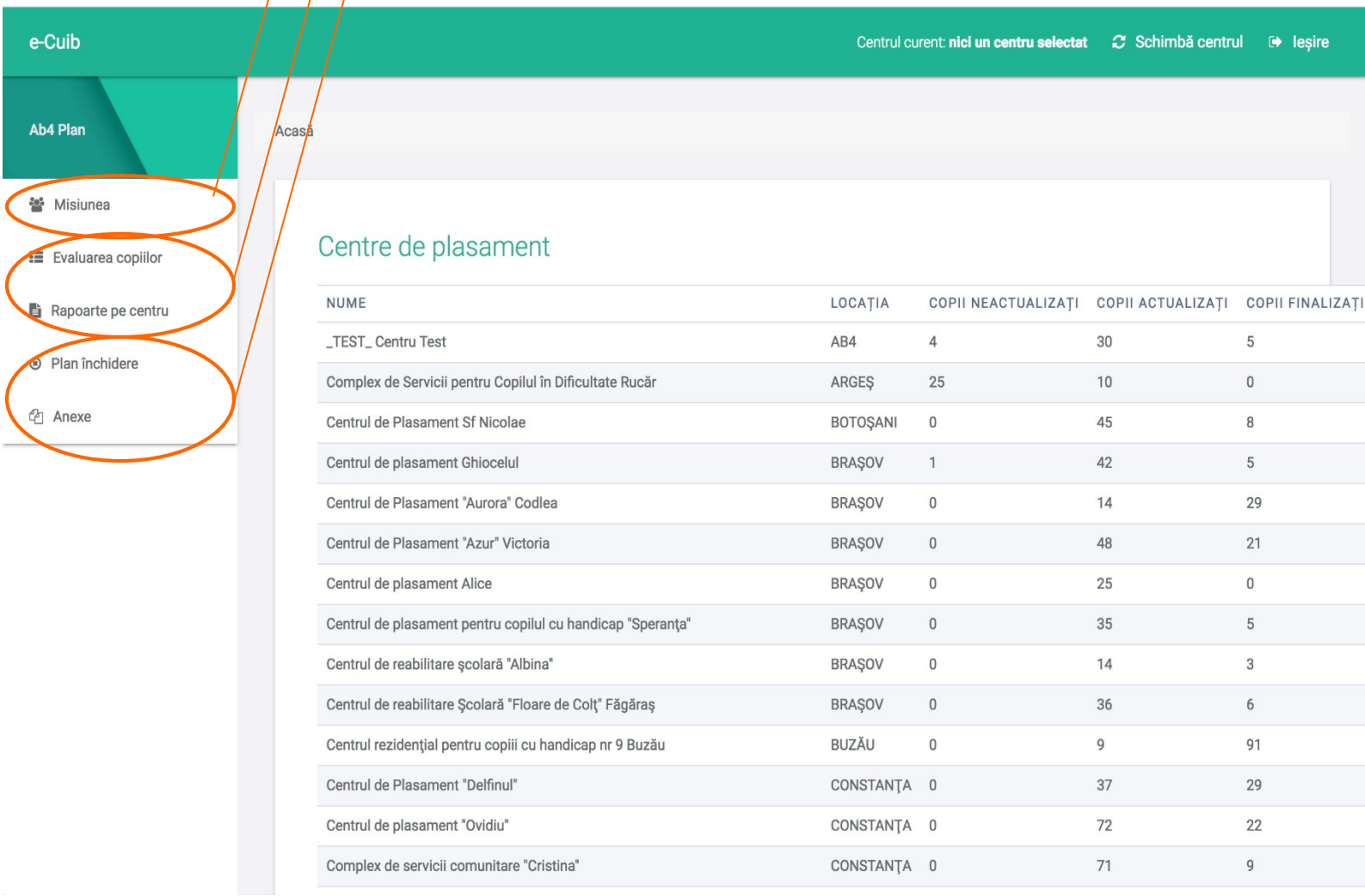


Figure 4: Screenshots of e-cuib

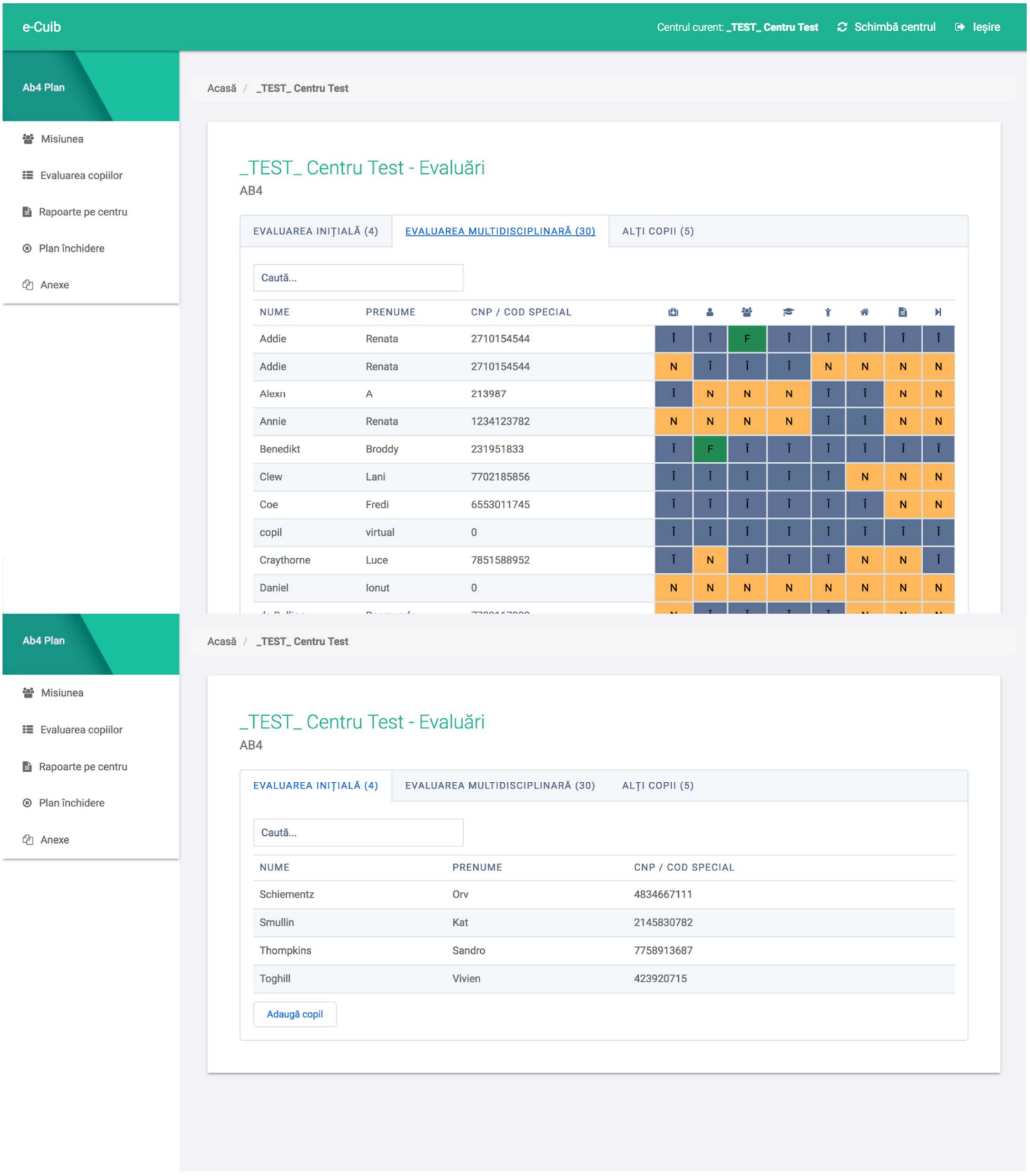
The mission is a general information page, including the principles of child deinstitutionalization.

Evaluating children and young people protected in placement centers and aggregate reports at central level (automated products).

Model for individual closure plans of placement centers and annexes.



NUME	LOCAȚIA	COPII NEACTUALIZAȚI	COPII ACTUALIZAȚI	COPII FINALIZAȚI
TEST Centru Test	AB4	4	30	5
Complex de Servicii pentru Copilul în Dificultate Rucăr	ARGEŞ	25	10	0
Centrul de Plasament Sf Nicolae	BOTOŞANI	0	45	8
Centrul de plasament Ghiocelul	BRAŞOV	1	42	5
Centrul de Plasament "Aurora" Codlea	BRAŞOV	0	14	29
Centrul de Plasament "Azur" Victoria	BRAŞOV	0	48	21
Centrul de plasament Alice	BRAŞOV	0	25	0
Centrul de plasament pentru copilul cu handicap "Speranţa"	BRAŞOV	0	35	5
Centrul de reabilitare şcolară "Albina"	BRAŞOV	0	14	3
Centrul de reabilitare Şcolară "Floare de Colţ" Făgăraş	BRAŞOV	0	36	6
Centrul rezidenţial pentru copiii cu handicap nr 9 Buzău	BUZĂU	0	9	91
Centrul de Plasament "Delfinul"	CONSTANŢA	0	37	29
Centrul de plasament "Ovidiu"	CONSTANŢA	0	72	22
Complex de servicii comunitare "Cristina"	CONSTANŢA	0	71	9



Note: Screenshots made in November 2017 for a virtual placement center with virtual children.

4.2. Information, consultation, partnerships

In such a complex endeavor, as is the one represented by the close down of a residential-type institution, which involves human, financial, material resources as well as image leverage, all social and political stakeholders must be informed and made part of the process. The larger the audience, the greater the chances for success, in the sense that people become supporters of the idea and facilitate a smooth and less traumatizing transition for the children.

4.2.1. Informing and consulting with relevant stakeholders regarding the need of closing down the institution

The main beneficiaries of the deinstitutionalization process are the children and young people in the institutions, along with their families, and they must not only be informed, but consulted on all the steps of the process.

The County Council representatives who must approve the close down of the centers (especially the president and the secretary – as the people usually in charge with the child protection field) can beallies in the deinstitutionalization process and must provide support to the DGASPCs in their actions aiming at informing, attracting and convincing the local authorities on the need to close down the institutions, but also on the importance of openingnew services. It is precisely in this latter case that the local authorities must provide support, both by means of SPAS-related activities, and by making available the lands or premises required for the development of the new services.

Special attention should be paid to the local authorities and Community Consultative Structures (or to other initiative groups) from source communities, from which, constantly, a large number of children enter the public care system.

The personnel of the institution, along with the associations and trade unions representing the employees, are as well relevant stakeholders to be informed in due time and consulted as early as in the preparatory step of the close down. In the first instance, they could display hostility and resist the process. This is a specific human reaction which, if correctly understood, could be settled by means of specific strategies. There are cases when the residential centers are located in quite small communities, where the institution is the main – if not the only – employer in the area. There are families where only one of the members has a job, and that person is the very employee of the residential center which is subject to close down. Those being the potential scenarios we will face in future, it is extremely important to inform and consult the employees on the human resources strategy and on the possibilities of involvement thereof in the new configurations of social services aimed to the special protection of the child or those for the prevention of the separation of the child from his/her family, in other words where they would fit in this picture.

A list of relevant actors which should be involved in the continuous project of information and consultation is available in Box 4.

Mass media may participate and support this approach, provided it is correctly informed from an early phase and the relation is maintained constantly throughout the process. For this purpose, we recommend the development of an online platform, as a democratic consultation tool, which shall contain daily updated information, with possibility of interaction and open dialogue functionality. Also, the information and consultation sessions represent an opportunity to raise awareness among the population and institutions that can either facilitate or obstruct both the process of reintegrating children into their families and communities and the process of preventing children's separation from their families.

Box 4: The relevant stakeholders to be informed and consulted during the deinstitutionalization process

Who?	Why?
Children and young people living in the center	Because they are the focus here and it is important that we know their opinion, fears, to answer their questions. There is no way that we can discuss about children/ young people, without children/ young people.
Families having children living in the center	For them to understand that children are much better in families/ family-type environments than in institutions. And because they have responsibilities in this regard.
County Councilors/ County Council	Because this is the authority coordinating the DGASPC and because the process pursued needs all support it can get from the County Council.
Local authorities **and Community Consultative Structures**	Because the community level services, which provide support to the families to prevent the separation of the child from the family, must be developed, especially in the source communities, which generate the largest number of children living in the residential center. Because they can be involved by making available the land for constructions, buildings with no use may become functional etc.
Residential center personnel	Because they could be the most determined opponents to the process by thinking they will lose their jobs. The personnel may build significant barriers to the process, due to their great influence onto the children.
Trade unions	Because they must support the children deinstitutionalization and because they can play an important role in the identification of viable training and employment solutions for the personnel becoming available further to the close down of the centers, either in the new services, or in the current services, or elsewhere.
DGASPC employees	Because DGASPC is the coordinating institution and each expert shall know the process and support it by any means.
NGOs	Because they represent valuable resources in terms of expertise, understanding, support and experience in partnership with DGASPC.
Local mass media	Because correct information settles a large part of the problems.
General population and public institutions	Proper information can sensitize the population and the institutions which can either facilitate or obstruct both the process of reintegrating children into their families and communities and the process of preventing children's separation from their families.

Box 5: Types of arguments justifying the close down of the residential center

Institutional arguments regarding the wellbeing of the child

Paradoxically, although the initial purpose pursued by the institutions was to provide shelter, food, security, and caring for the children's emotional needs, most of the institutions have failed in their mission and ended up doing more bad than good, mostly due to low quality services and institutional practices not encouraging autonomy and personal choices. Most often, institutionalized life blocks the child's development and creativity, depriving the child from his/her most elementary right, that is the right to grow up in a family or in a family-like environment, where he/she would benefit from the love and attention he/she needs, so as to develop in a beautiful and harmonious manner. The institution carries with itself a huge tribute that the children shall pay and which is translated into delays in the physical, emotional, social and cognitive development, lack of attachment to an adult person, low school performance compared to other children growing-up in a family environment, school dropout, antisocial behavior... and the list can go on.The institution as such will disappear but the infrastructure can be valorized and used, by developing other types of services that the community needs, with the clear and unequivocal statement that it will never be reopened as a residential center for children.

Legal arguments

The specialists on the protection of children's rights, theorists and practitioners alike, all know and are aware of the harmful effects exerted by residential institutions onto child development. Studies and research works were prepared, and examinations were conducted down to the deepest effects of institutionalization onto the child's mental state, cognition, affect, intellect, achievements and in general (onto) the child's harmonious development. All, with no exception whatsoever, conclude on a definite NO to institutions, opening the path to family-type alternatives, starting with the child's family – where this is possible – and continuing with foster families, substitutive family, adoption families etc.

There is a firm commitment undertaken by the Government, as well as a series of domestic and international measures which lead towards a world without residential centers, where children can live and grow. A series of documents and domestic and international treaties to which Romania is signatory – such as the UN Convention on the Rights of the Child, UN Convention on the Rights of the Persons with Disabilities, the Declaration of Madrid, European Union Charter of Fundamental Rights, Europe 2020 Strategy, European Disability Strategy 2010-2020, the European Social Charter, National Strategy for the Protection and Promotion of Children's rights for the period 2014-2020 – evoke human values and rights, scientific evidence and political commitment promoting the right of the children to grow-up safe and to enjoy their childhood in an 'environment encouraging the complete development of his/her personality and physical and mental capacities'.[21]

Another reference document[22] – Investing in children: breaking the circle of disadvantage, whereby support is proposed to be given to Member States for them to learn from each other's experiences and reformulate their policies in the field, whilst taking into account the different problems they are faced with and the local context.

Political arguments

The Governing Programme[23] for the period 2017-2020 aims at providing an implementation framework for deinstitutionalization and for the transition towards community childcare, a measure which is otherwise also included in the National Strategy for the Protection and Promotion of Children's Rights for the period 2014-2020. The Governing Programme also foresees an increased service coverage at local level, so that the vulnerable children can be identified early, to enable a quick intervention.

Following a logic of making the Governing Programme operational at local level, each public authority developed its own local Strategy in the social field, containing indicators and concrete measures in regard to deinstitutionalization and promotion of community services aiming at preventing relinquishment.

Arguments regarding social inclusion

Generally, closing down residential centers is part of wider efforts of humanizing society, of building an inclusive, harmonious, tolerant, careful and caring environment for those who cannot care for themselves.

---

[21]European Social Charter (revised), (STE. 163-1996: Article 17).
[22]European Commission (2013)
[23] http://www.cdep.ro/pdfs/oz/Program%20de%20Guvernare.pdf

To be considered that the development of a single plan and a single message to all receivers, irrespective of their level of understanding and knowledge, is not to be regarded as an appropriate solution; on the contrary, it is necessary that adapted and customized messages be developed for each individual target group: children and young people, children's families, institution personnel, associations and trade unions, local authorities, mass media, NGOs providing services. A series of relevant, political or institutional arguments on the importance and urgent nature of the deinstitutionalization process may be found in Box 5.

The consultation and involvement of social stakeholders are vital elements during the project preparation steps. Of course, their application must continue throughout the implementation period. As to the step related to the preparation of the center close down, we recommend that minimum two consultation sessions be organized. The meetings should be prepared, organized and moderated by the teamthat prepared the individual closure plan.

The first consultation should be organized in the beginning of the project preparation phase (as soon as the decision to close down a center was taken), with each individual type of relevant stakeholders (children and their families, authorities, personnel and their representatives, plus the employees within DGASPCs, NGOs and the mass media at local level). This meeting places the project in perspective and provides relevant information in respect of:

- ☐ The justification for the close down of the residential center
- ☐ Steps which need to be followed
- ☐ Which are the persons involved
- ☐ Which are the options provided to children and their families
- ☐ Which are the options provided to the personnel of the residential center closing down
- ☐ Which are the options as to the use of the building/buildings of the center, subsequent to its close down.

It is recommended that the second meeting be organized at the end of the preparation period, when the needs and resources assessment has been completed and the project drafted. This consultation session may be organized distinctly with each type of relevant stakeholders or with all stakeholders together. The agenda of this meeting shall comprise (as a minimum) information on:

- ☐ The presentation of the project
- ☐ The Individual closure plan of the center
- ☐ The planning of new services and interventions intended to children and their families
- ☐ The training courses and the employment options made available to the personnel becoming available
- ☐ The use of the residential center building/buildings, after the close down of the center.

Both in the case of the first meeting, but also in the case of the second, the manner of address and the accessibility of the language, depending on the invited target group, are vital. Especially in the case of children, the language shall be friendly and accessible to them, while also providing as many answers as possible to the issued they find unclear.

Checklist!

- **During the center close down preparatory step all concerned stakeholders have been informed and involved. At the end of each meeting, Minutes shall be drawn-up on the template presented in Annex 26 of the Model of an individual closure plan.**

4.2.2. Identification of partners

The responsibility towards children is not incumbent upon a single institutions or social stakeholder, but upon a network of institutions and persons that can contribute to the wellbeing of the child. The relevant institutional stakeholders are first of all DGASPC, NGOs, mass media, local authorities, trade unions, partners of the educational, medical, employment, academic environment system, all being committed to improve the life of the children. From this perspective, the project may have both formal partners, but also informal partners; such partners play a supporting role in the project and are representatives of the group institutional stakeholders that has developed over time different joint projects or actions with DGASPC.

Within the task of closing down a residential center, both the identification of the partners, and the identification of the roles and responsibilities incumbent upon them, are extremely important actions. Some of the partners can be identified at the very outset of the process, based on the previous experiences. But, most likely, the type of partners that is needed will only be known after assessing the children's needs and the resources of the center; it is this assessment that will indicate the Mayor's Offices/Local Councils and public institutions (education institutions, public health directorates, employment directorates etc.) as well as the NGOs with whom partnerships are required for a successful implementation of project activities.

An increased attention should be given to those source communities which generate the largest number of children living in the residential center or to other special protection services in the county, so as to develop services for the integration of children into their families/family environments, but also to provide for an effective system preventing the separation of the child from his/her family.

Essential to the development of new services is the partnership between DGASPC and the local authorities.[24] Such a partnership shall be governed by a partnership contract which shall clearly stipulate that the duration of the partnership agreement shall cover the project implementation period. As structural benchmarks, the partnership contract shall contain, as a minimum, the following elements: Parties; Object of the contract; roles and responsibilities in project implementation;[25] Co-financing of operations, payments; Contract duration; Partners' rights and duties; Ownership; and Final provisions.[26]

We recommend that the partnership agreement between DGASPC and the local authorities should contain a clause or section on the sustainability of local level services after the end of the project. It is expected that the newly-developed services continue to operate also after the end of project funding, which means that local authorities shall include those new services in the budget and organizational chart of the institution. Of course, at a later stage, the operation of the services may also be ensured by subcontracting to private providers/NGOs.

[24] The partnership between DGASPC and the Local Council will be approved in the meeting of the County Council, the meeting of the Local Council respectively.
[25] DGASPC, in its capacity of the main applicant, is responsible for the project implementation and for compliance with all provisions of the funding contract.
[26] It is important that the types of serviced required to be developed at local level, be defined according to the legal provisions. Of specific importance, here is the statement in Law 272/2004 on the protection and promotion of children's rights, which provides clear indications on the fact that the local authority may not develop residential-type services for children (for example, CTF).

The NGOs, as longtime partners of DGASPCs, may play an extremely important part and may provide consistent support for this approach, especially if we consider that the non-government sector has been a constant supporter of deinstitutionalization. The first models of institutions close down were from the NGO sector. In time, the sector activity got more professional and the NGOs specialised in narrow intervention fields, such as the development of services for children with disabilities, services for children whose parents are working abroad, services for abused children, family-type services, foster care, counselling, professional training services etc., which recommends them as holders of valuable expertise which could be made available to DGASPC.

In an ideal setting, NGOs would be complementary to DGASPC and would complement the offer of services which are missing at local level, would support the training of the residential institution personnel in coping with the challenges of new services, would constantly attend the meetings organized under the close down project and would provide an honest feedback on the process.

4.3. Assessment of needs and resources

During the preparatory step of the project concerning the close down of a residential center, the assessment of needs and resources is the most difficult task, as it requires time, effort, organization and the largest number of human resources.

The assessment is particularly important because:

-->**The assessment sets the direction of the deinstitutionalization process:**Without a clear assessment and analysis in regard to the institution, the children living there, the context around their living there and the circumstances that led to their placement within the institution, we will never be able to act onto the causes of separation and to stop the system-entry flow and we will never succeed in achieving an actual deinstitutionalization, even if we close down the institution.

-->**The assessment sends the following message 'nobody will be left behind, it will be better for everybody!':**The institutionalized children have already gone through enough to be subject to a new rejection, a new "abandonment". The personnel working in the institution is also affected by institutionalization, as people there go through the daily mechanical and dehumanizing routine, transforming them, from people-working-with-children, into employees-working-with-objects-of-labor. The personnel, the same as the children, must understand the need of change and the manner in which such change can materialize. Otherwise, the personnel may become the most stubborn opponents and may create significant hindrance, on account on their large influence onto the children. This is precisely why the assessment must ensure the favorable context in which the personnel working in the institutions may become an ally to the process.

-->**The assessment includes everybody:**In one way or another, all people that will be affected and all those who can contribute to the identification of better solutions, are all part of the assessment process.

-->**The assessment identifies the services to be developed:** As the goal is to plan a set of services which is based on what the children want, which would replace the institution and successfully cope with the needs that the institution ignored, it is vital to understand the children's needs at a certain moment in time and to assess the evolution thereof.

-->**The assessment identifies the training and occupational retraining needs of the personnel working in the residential center:**the transformation of the institution personnel into an ally requires a clear understanding of the training level, skills and knowledge of the personnel, but also of their willingness to learn. Once they are shown that the world does not come to an end when the institution is closed down, and that another structure will replace the institution, where children may progress and they can be more appreciated, it is possible that the personnel turns into a project supporter and provide support. The assessment identifies who is it that can produce the change, under what circumstances, and what is it that needs to be done in the field of training and occupational retraining – meaning the types of training programmes which are required to provide the labor needed for change and sustainability.

The assessment of needs and resources is governed by the principles shown in Box 6. The assessment of needs and resources requires the following steps:

- ☐ Assessment of the institution
- ☐ Establishing the Nominal List of children
- ☐ Assessment of the children's situation, based on the data comprised in the case files

- ☐ Multidisciplinary assessment of each child in the Nominal List
- ☐ Assessment of the natural and extended family and of the connection thereof with the child
- ☐ Consultation of children and families
- ☐ Conclusions Report and plan of services, benefits and interventions for each child and family in the target-group

The steps of the assessment are detailed in the sections below.

Box 6: Principles underlying the assessment of needs and resources

The assessment is focused on the child	All along an assessment, the child is the main focus, and his/her opinions are always taken into account. During an assessment, one needs to permanently work with the child, including by finding multiple proper methods depending on the child's age, sex and culture, for expressing their wishes and feelings and for understanding their experiences. Solutions should not be found only because the institution needs to be closed, but such solutions respond to the welfare and security of children.
The assessment is based on the child's development	The development of each child is significantly shaped by the experiences and interaction with a series of factors, some of them being specific factors (genetic inheritance, personality), while others can include problems of health, development, cultural, physical or emotional nature related to the environment in which the child lives.
The assessment takes into consideration the children and their families as a whole	To understand a child, one needs to rely on his/her family, cultural and community context in which the child develops. Therefore, an assessment needs to consider three areas: a) the child's development needs; b) the capacity of parents or of the substitute family to respond properly; and c) the extended family and his/her environment factors.
The assessment ensures equal opportunities	The assessment seeks to identify the specific needs of each child, irrespective of gender, age, ethnicity, religion, health condition, family of origin or any other aspects.
The assessmentinvolves work with the children and their families	No matter how difficult the situation of the family or the relation with it is, it is important to identify methods for its involvement in the assessment process, so that the result related to integration to be conclusive.
The assessment identifies strengths as well as risks and difficulties	The full understanding of a child's situation is extremely important, and one needs to identify both the positive and negative influences.
The assessment is based on a multidisciplinary, interdisciplinary and interinstitutional	The involvement of professionals from several areas and even from several institutions ensures a comprehensive, global assessment of children.

approach	
The assessment is based on data and evidence	Professionals use their knowledge from practice and from researches on the needs of children and of their families, as well as the results of services and interventions to justify the assessment.

Source: Mulheir and Browne (2013)

4.3.1. Assessment of the institution

The assessment of the institution is concerned with an analysis of resources available within the residential center, along with an analysis on the quality of services provided to the children, as well as with relevant data on the collectivity of children living in the center.

The assessment of resources available within the residential center mainly refers to:

- ☐ Lands and buildings included among the assets owned by DGASPC, County Council, local councils or other public authorities
- ☐ Other material resources of the center, which can be relevant to the close down project
- ☐ Human resources of the center
- ☐ Financial resources of the center

Relevant data on the collectivity of children in the center, concerns:

- ☐ Incoming and outgoing flow (indicating the origin of the children and their place of departure when leaving the institution, therefore the other protection services which influence or are influenced by the close down of the center) and
- ☐ Type of the center, depending on the dominant profile of children or on other variables.

The DGASPC project team will conduct a description of the conditions in the institution and will make a justification on their choice for closing it down considering the types of data described in detail within Box 7.

Box 7: Institutional Evaluation – Necessary data

- ☐ Center's capacity and national rank in terms of size (number of children)
- ☐ Location of the institution:
  - Accessibility
  - Center's location in relation to other services in the community (schools, medical services, church)
  - National rank in terms of isolation, segregation, accessibility
- ☐ Land used by the Center and belonging to the DGASPC, County Council, local councils, or other public authorities
- ☐ Center buildings belonging to the DGASPC, County Council, local councils, or other public authorities
  - Total number of Center buildings, number of buildings accommodating children
  - Age of the building(s) accommodating children
  - Whether it has been restructured and/or modulated and the year of restructuring, as well as how the building is structured (whether it has a modular design or not)
  - State of the building(s) accommodating children
- ☐ Center's infrastructure
  - Number of dormitories, number of beds, and maximum number of children in a room
  - Leisure facilities (library, daycare rooms, club, sports field, playground) and their equipment
  - State of restrooms, kitchen and dining room(s), how adapted they are to institutionalized children's needs and ages
  - Center's national rank in terms of infrastructure
  - Center's national rank in terms of child health and security
- ☐ Center's human resources
  - Number of employees and their qualification
  - Share of employees having benefited from training, when and in which area
  - Center's national rank in terms of staff
  - Center's national rank in terms of children's interaction with the staff
  - Center's national rank in terms of child development services and activities
- ☐ Implementation of minimum standards and case management at the Center
  - Whether the Center is accredited as a social service provider
  - Whether the institution holds a sanitary permit
  - Center's national rank regarding this dimension
- ☐ Center's national rank regarding the overall score for the environment of care
- ☐ Center's national rank regarding the overall score for the quality of care
- ☐ Center's national rank regarding the overall score for the quality of services
- ☐ Children's overall assessment of their life at the Center
- ☐ Center's financial resources
- ☐ Center's incoming and outgoing flows for the past 5 years
- ☐ Type of center, based on the prevailing child profile or other variables
  - Classical center, Classical with improvements center, partially modulated or modulated center
  - All-boys, all-girls or mixed center
  - Center for children aged 0-3, with or without youth age 18+
  - Center for children without disabilities, for children with disabilities, or for children with severe disabilities
  - Center for children with SEN or center that is functionally related to a special school
  - Center for children having committed a criminal offence or for children with behavioral disorders
  - Individual center, center in a community of social service beneficiaries or center belonging to a "cluster" of placement centers for children
  - Urban or rural center
- – Recommendation to close down or keep the Center open as formulated by the external evaluator DGASPC,including the rationale behind that recommendation

Note: the ranks mentioned in the Box were calculated under World Bank Result 2, April 2017 (SIPOCA 2 project).

4.3.2. Establishing the Nominal List of children living in the center

The close down of a residential center actually signifies the identification of adequate care solutions not for the number of children and young people living in the center, but for a Nominal List of children and young people, with names and surnames. It is our assessment that in this manner we will manage to prevent the use of practices that we identified in the field, namely the separation of children in the center in 'good children' and 'bad children', whereby only the 'good children' would be transferred under the new services, while the 'bad children' would be relocated, for example, in centers that are not closed down or would be 'socio-professionally reintegrated' once they turn 18.

The Nominal list of children and young people will be generated in e-cuib according to Annexes 5 and 6 of the Model of an individual closure plan, after the Synthetic Form with Key Information will be filled in and introduced for each child by the project team in collaboration with the center manager (see Annex A, Instrument 1).

The close down of an institution should be accompanied by stopping the entries into the institution concerned.

The closure plan of the placement center will draw on the findings of the evaluation conducted on the children included in the nominal list and on their families. For each institution that closes, a baseline representing the date of the multidisciplinary assessment of children will be established. Any entry into the center after T0 has to be stopped.

The closure plan would be prepared for children that are in the placement center at the time T0, according to their needs and the needs of their families. If the entries are not stopped, the closure plan would not be (or would only partially be) appropriate to the children in the placement center at T0, and would not meet the needs of children who entered at a later point.

Nevertheless, in the case of placement centers which are functionally related to special schools, it may be impossible to stop new children from entering the institution (at least at the beginning of school years) unless the center turns into a boarding service and children separated from their families are moved to a newly created service. Hence, for such placement centers, it is recommended to start the nominal list in June and close it in September, after the start of the new 2017-18 school year. Thus, in June the children who will leave the center as they finish school can be identified, and in September the list with the newly arrived school children can be completed, as a consequence of registering children with the school functioning nearby the center. Hence, for these centers, T0 shall be established around the end of September.

The nominal list of children for whom the multidisciplinary assessment will be conducted for all children with special protection in the placement center at T0 (regardless of whether they are present in the center or temporarily absent) and all children actually present in the center at the T0 moment (regardless of whether they have a protection measure in the respective placement center or not).

The nominal list of children living in the Center should not be confused with the target group of the EU-funded project.

If funding is requested under ROP and HCOP for closing down the residential center, the target group of the EU-funded project will include the beneficiaries of newly created structures and services. On the other hand, the nominal list related to institutional closure comprises children placed in the institution to be closed down. Some of them will be (re)integrated into their families or communities while the closure process is underway, so they may not necessarily benefit from the new structures or services developed under the EU-funded project.

Therefore, during project implementation, certain beneficiaries of the new services (GH, FC, daycare centers, etc.) may not be included in the nominal list of children from the closed down institution. For this very reason, we believe that, on the one hand, it is extremely important to monitor and evaluate the situation of each child in the initial nominal list so as to ensure that all children from the closed down institution will be better off at the end of the project than at the start of the closure process. On the other hand, we recommend that all children benefiting from the new structures and services during the project be subject to the same initial multidisciplinary evaluation (see sections 4.3.4-4.3.7.). These children will make up a dynamic list of beneficiaries of new structures and services developed under the project.

Checklist!

- **Each institution has set a time T0 (the date when the multidisciplinary assessment of children started, i.e. the end of September for centers in functional relationship with a special school).**
- **The Nominal List of children in a placement center includes all children with special protection in the center at the time T0 (whether they are actually present in the institution or temporarily absent) and all children actually present at the center at the time T0 (whether they have a measure of protection in the center or not).**
- **All children and young people included in the Nominal List (and their families) will be subject to the multidisciplinary assessment process, irrespective of whether they are or not subject to a protection measure.**
- **All children and young people included in the Nominal List will be monitored throughout the project implementation period, while the situation thereof will be assessed at the end of the project.**
- **Once the decision taken on starting the close down of an institution, the incoming flow into that institution will cease. An exception are placement centers which are functionally related to special schools, where new entries cannot be stopped until the institution is taken over by the County Council/County School Inspectorate and turned into a boarding service.**
- **The transfer to other services or the exit from the institution of any of the children and young people included in the Nominal List, during the period preceding the actual start of the close down process, as well as while implementing the closure plan, shall only be executed if proved that the action is in the best interest of the child (for example, the child is adopted or reintegrated back into his/her family), for the purpose of avoiding quick and inadequately prepared measures which would cause harm, of any kind, to the child. It is therefore recommended that ANPDCA provides the DGASPCs that close down residential centers with a template for an explanatory report.**
- **The nominal list of children and young people living in the Center to be closed down will be completed by a dynamic list of children who were not living at the Center but end up benefiting from the new services during the project. We recommend that all children in the**

dynamic list be subject to the same type of initial multidisciplinary evaluation, as presented in sections 4.3.4-4.3.7.

4.3.3. Establishing the multidisciplinary assessment team and planning of assessment activities

The project team under the institution close down project is the one coordinating all assessment activities, carefully monitors the implementation of the process and makes sure that the planning of individual assessments fits the deadlines decided upon for the preparation of the project.

The assessment activities per se (in regard to children, families and communities) will be however performed by a multidisciplinary team working under the coordination of the project team. This team should be nominated, along with the project team, by the DGASPC director.

The multidisciplinary team is made of the professionals involved in case management within the institution: social worker, psychologist, physician, legal advisor, psychopedagogue or educator and case manager – who also coordinates the team. Depending on the profile of the children in the institution (for example, children with SEN or with disabilities), the composition of the team may be enlarged so as to also include other professionals or specialist collaborators from institutions with duties in this field, according to the legislation in force.

The sizing of the multidisciplinary assessment team depends on the size of the institution to be closed down. In case of residential center for about 30 children without specific health problems, a team of six professionals (one social worker, one psychologist, one physician, one legal advisor, one education professional and one case manager) could be enough. Unlike the case presented before, a center with 90 children would probably need a larger team so as to be able to complete the project within a reasonable time interval, especially if the beneficiaries include children with disabilities or SEN.

Although each child is assigned to a case manager, for the purpose of performing a uniform assessment of all children and young people in the institution, it is preferred that the assessment be performed by the single multidisciplinary team, in collaboration with the children's case managers and with the personnel caring for the children in the center.

Checklist!

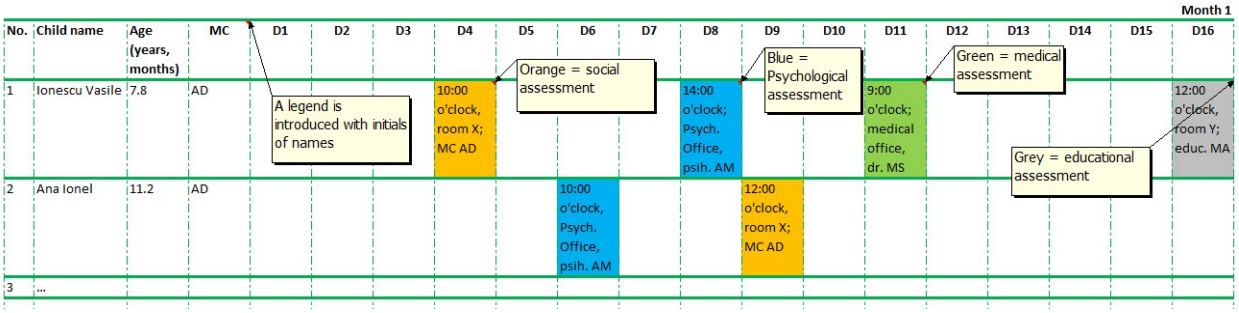
- **All children and young people included in the Nominal List have a case manager. If there is no case manager assigned (yet) to a child or young person, then this position will be taken by the case manager coordinating the multidisciplinary assessment team.**
- **The assessment activities discussed under sections 4.3.4 - 4.3.7will be performed by a single multidisciplinary team of which exact size and composition will be established depending on the number and specific profile of children and young people in the residential center to be closed down.**

Working within a multidisciplinary team is a method used to share information, cooperate and allocate tasks pursuing a common purpose – the identification of the most appropriate raising and caring option for the children in the childcare institution to be closed. This manner of working enables an equal participation in discussions and decision-making, while avoiding the lack or overlapping of needed interventions, ensuring the multidisciplinary nature of the assessment and of focused interventions and

also an efficient planning of activities, so that the assessment of all children in the center can be performed during the time interval planned for this purpose.

For simplification and organizational purposes, the planning of assessments, once agreed by the members of the multidisciplinary team, may be transposed into a table form, such as the one in Figure 5.

Figure 5: Template for the planning of assessment activities



The planning and implementation of the assessment shall take the following issues into account:

- ☐ Schedule of the child/young person;
- ☐ Heath condition of the child, the existence of a disability or SEN;
- ☐ Setting the date, time and place of the assessment, in advance, with the child/young person or the persons acting as the direct caretaker thereof (for the child with disabilities);
- ☐ Providing for an adequate framework (space) for conducting the assessment;
- ☐ Filling-in or, as the case may be, updating of the key-information included in the summary form after having been extracted from the child's file (history of the child);
- ☐ Allocation of a sufficient time interval for the adequate performance of the assessment, with no time pressure;
- ☐ The assessment shall be an interactive process, where the young person can express his/her opinions, feelings, beliefs, sufferings and fears etc.;
- ☐ Creation of a safety feeling for the child/young person, to remove his/her fears that something with negative influence might happen to him/her during assessment or afterwards, due to the close down of the institution;
- ☐ All information shall be carefully recorded;
- ☐ Establishing and using the same assessment tools for children of the same age/development level;
- ☐ Delivery of the assessment report (medical, psychological, educational, social) to the case manager coordinating the multidisciplinary team, within maximum 3 days from the assessment;
- ☐ Inclusion of all sheets and filled-in documents into the child's file.

Throughout the assessment, all professionals in the multidisciplinary team shall mandatorily take the measures required to prevent any events that could generate possible negative consequences onto the children's or young people's health or integrity, and the children/young people shall be involved and consulted depending on their intellectual development and understanding capacity.

The time needed for assessing all children in the institution depends of their number, age, particularities and living context, on the availability of professionals and of the use of working tools.

At the end of the assessment, the multidisciplinary team shall organize one or several meetings (if need be) to take the decision on the most appropriate solutions and to prepare the reports with conclusions (which also include the plan for services, benefits and interventions) for each child included in the Nominal List. The conclusions and recommendations are afterwards communicated to the project team, for it to prepare the institution's closureplan.

At a later stage, the multidisciplinary team could participate, under the project, in the reassessment of the situation in regard to the children included in the Nominal List, as well as of the newly-developed services and of the dynamic list of new children benefitting from these services.

4.3.4. Multidisciplinary assessment of each child or young person in the Nominal List

All children included in the Nominal List, with no exception whatsoever, shall be the beneficiaries of such an assessment which would substantiate the decision on the best caretaking solution. But, from the perspective of content and toolbox used, the multidisciplinary assessment we refer to under this Methodology and the complex assessment usually applied by DGASPCs only to children with disabilities and/or SEN are much alike, with just a few differences that we will adequately underline.

For the purpose of identifying the possibilities for reintegration, family integration[27]of the child or socio-professional integration of young people, the multidisciplinary team will perform an assessment of each child or young people included in the Nominal List, with the following components:

(A) medical assessment

(B) psychological assessment

(C) social assessment

(D) educational assessment

A professional multidisciplinary assessment, conducted within a multidisciplinary team as close as possible to the moment when the institution close down decision is made (T0 moment), is the fundament for the development of a Future individual plan for each child currently within the institution. Furthermore, the multidisciplinary assessment will provide support in the identification of possible therapy needs, of special educational needs and in the development of individual programmes meant to prepare the child for relocation, from the institution to his/her family or to another social protection service.

The multidisciplinary assessment of children will be complemented by an assessment in regard to the family (natural and extended), which will concern its capacity to provide the conditions needed for the

[27]Corroborating the provisions of Order no. 287/2006 approving the minimum mandatory standards regarding the center for preparation and support in regard to the child's reintegration or integration back into his/her family, and also the methodological guidelines for the implementation of these standards, with the provision set forth by Order no. 1733/2015 of 19 August 2015 approving the procedure for the establishment and payment of the monthly placement allowance, the term child integration (use of family type alternatives) refer to the placement of the child with the extended family, respectively with a relative up to the IVth degree included in relation to the child, with a professional foster caregiver, with a person or foster family which is part of the child's social network, respectively with relatives, other than the ones up to the IVth kinship degree included, acquaintances or friends of the family or of the extended family of the child, with whom the latter developed affectionate relations or alongside whom he/she enjoyed family life, or adoption of the child pursuant to the legal provisions.

growing-up, caring and education of the child, as well as the connection between the child and the family. This assessment is discussed in section 4.3.5.

Prior to performing the direct child assessment, each professional, member of the multidisciplinary assessment team, shall familiarize with as many information possible on the child, by using the data in the child's file (summary form with key information). Also, the professional shall discuss about the child with his/her case manager and with the social worker in the institution, or with any other professional within the institution, who is capable of providing thorough details on the child.

4.3.4.(A) Medical assessment

The medical assessment comprises the clinical examination conducted for the purpose of establishing the health condition, and it is performed by the family physician to whom the institutionalized child is enlisted with or by the pediatrician contracted by the DGASPC/institution.

The medical data is recorded in the Medical Record of the child/ young person in the protection system (the proposed template is presented in Annex A Instrument 2). As a minimum, this data shall contain the following: physical development of the child; details of the disability qualification certificate, if applicable; childhood illnesses; chronic illnesses or other health problems they currently suffer and receive treatment for; the history of vaccinations; medical history and hospitalizations in the last 12 months; risk behaviors; information about the health of parents.

The Medical Record shall also contain recommendations for medical services and specialized interventions for the current medical needs of the child (surgical interventions, medical recovery etc.) These recommendations are needed so as to predict – to the best of possibilities – what types of services need to be developed for the child, once the residential center closed down.

If, further to this medical reassessment, the family physician identified the presence of a possible disability and/or SEN and a complex assessment is required as to the child's health condition, the person making the assessment brings this information into the attention of the child's case manager in view of initiating the procedures needed for registering the degree of handicap of the child or advising on the school and professional orientation of the child..

Following the performance of this medical assessment, the family physician will update the Specific Health Intervention Programme.[28] It is recommended to collate the intervention on health with other national programs in the field of health, so that, for instance, all children with rare or genetic diseases to be included in the available national programs.

After the medical assessment is completed for all children in the Nominal List, and after it was submitted in e-cuib for each child, the multidisciplinary team will be able to download theMedical Assessment Report at Center Level, which will be automatically generatedbased on the model presented in Annex 7 of the Model of an individual closure plan.

Checklist!

- **All children and young people from the Nominal List benefitted of a medical assessment.**

[28]Standardized document.

- **The filling-in of the Medical Record (the proposed template is presented under Annex A Instrument 2) is mandatory for each child and young person included in the Nominal List and shall be attached to the child's file.**

4.3.4.(B) Psychological evaluation

The psychological evaluation of children in institutions in the context of deinstitutionalization has a number of specific features, namely:

- ☐ Assessing areas of psychological development of the child (memory, language, thinking, attention, affectivity, will, personality, behavior and educational needs) with the purpose to identify whether the child's level of development is corresponding to his/her actual age or whether there are delays in development that require specialized interventions for the preparation of deinstitutionalization and/ or psychological interventions after deinstitutionalization;
- ☐ Identifying the presence/ absence of a psychological symptomatology generated by the causes that led to the institutionalization of the child (abuse, neglect, family violence, etc.) and, if necessary, child-bearing traumas during institutionalization;
- ☐ Identifying relationships of attachment between the child and the trusted persons in the institution, school, extracurricular clubs, but also with members of the biological family, larger family or other people who can contribute to increasing the motivation of the child for deinstitutionalization;
- ☐ Identification of the protection factors (individual, family and community) that favor the building of the child's resilience in the process of de-institutionalization and favor adaptation to the new environment;
- ☐ Analysis of the child's motivation for deinstitutionalization, identification of his/ her attitude regarding deinstitutionalization and intervention proposals (counseling, psychoeducation, etc.) in order to increase motivation.

During the institution's closure procedure, a special attention shall be attached to the child's level of development and to their good psychological and emotional status. That is why, alongside the medical evaluation, it is very much important to identify any special needs, any delays in their development, any behavioural difficulties that the child experiences that need to be considered whenever the decision to provide a sort of protection alternative to institutionalisation is to be made. Also, during the psychological evaluation, the feelings and expectations that the child has about the current placement measure and about the future placement shall have to be analysed.

The lead psychologist of the project team shall manage the psychological evaluation of the children. The psychological evaluation shall be performed according to the law[29] by independent and licensed psychologists who are certified practitioners of clinical psychology, working for either public or private institutions.

Whenever a residential center is closed down, all of the children and young people from the institution must benefit of a psychological evaluation, so that we can make sure that we have identified all types of problems before deciding on the best solution for each child. The research data suggest that 4% of all children and youngsters in residential centers nationwide have never benefited (upon either entering the system or subsequently) of a psychological evaluation.

[29] Law No. 213/2004 governing the work of independent licensed psychologists and the creation, organisation and operations of the Psychologists' College in Romania, and Government Decision No. 788/2005 to approve the Methodological Norms that govern the enforcement of Law No. 213/2004.

The psychological evaluation is an integrative approach for which the results supplied by the psychological tests need to be correlated with data obtained by other methods: the clinical observations, interviews, analysis of the activity products (games, school activities, recreational activities, etc.), personality questionnaire/clinical inventories. Usually, clinical psychologists must adapt their set of instruments to the resources that they have for acquiring such instruments. Box 8 makes some recommendations in this respect.

Box 8: Types of psychological testing instruments

- The Battery of Neuropsychological Evaluation for Children aged 3-12 (NEPSY) – available for purchase at COGNITROM (http://www.cognitrom.ro/produs/evaluare-neuropsihologica-copii/).
- ECI-4 Questionnaire for the evaluation of children's mental health, for children of 3-7 years- available for purchase at COGNITROMhttp://www.cognitrom.ro/produs/evaluarea-psihiatrica-a-copiilor/
- CSI-4 Questionnaire for the evaluation of childrenof school age, for children of 7-12 years - available for purchase at COGNITROM http://www.cognitrom.ro/produs/evaluarea-copiilor-de-varsta-scolara/
- ASI-4 Questionnaire for the evaluation of the adolescent's symptoms (12-18 years) - available for purchase at COGNITROM (http://www.cognitrom.ro/produs/evaluarea-simptomelor-adolescentului/)
- Denver Developmental Screening Test (DDST II), instrument for detecting potential development problems of children of 0-6 years - available for purchase at TESTCENTRAL (https://www.testcentral.ro/ro/produse/teste-clinice/evaluarea-nivelului-de-dezvoltare/ddst-ii/#2479)
- Millon Pre-Adolescent Clinical Inventory (MPACI), instrument that allows the accurate identification of psychological problems in children of 9-12 years - available for purchase at TESTCENTRAL (https://www.testcentral.ro/ro/produse/teste-clinice/evaluare-psihopatologica-pe-axa-i-%C8%99i-axa-ii/mpaci/)
- Millon Adolescent Clinical Inventory (MACI) Multiaxial evaluation of personality characteristics and clinical syndromes in adolescents (13-19 years), according to DSM-IV symptomatology - available for purchase at TESTCENTRAL (https://www.testcentral.ro/ro/produse/teste-clinice/evaluare-psihopatologica-pe-axa-i-%C8%99i-axa-ii/MACI/)
- Achenbach System of Evidence-Based Evaluation (ASEBA) for children between 6-18 years - available for purchase at Romanian Psychological Testing Serviceshttp://rtscluj.ro/content/view/66/24/
- Clinical Evaluation System (SEC) - available for purchase at Romanian Psychological Testing Services (http://rtscluj.ro/content/view/45/19/)
- The WECHSLER (WISC IV) intelligence Scale for children aged 6-17 – available for purchase at the Romanian Psychological Testing Services (http://rtscluj.ro/index.php).
- The Raven progressive matrix (intelligence test) for children aged 6 or more – available for purchase at the Romanian Psychological Testing Services (http://rtscluj.ro/index.php).The
- HHC evaluation instrument is available in the Guide Dărăbuș et al. (2017)

The psychological evaluation form is to be prepared during the evaluation process and based on the findings and results of the psychological tests/instruments that are used and of collateral information obtained from educators, professors, etc. The action taken to assist children and their families are all tailored based on the psychological evaluation form in order for the decision-maker to be able to acknowledge and understand their peculiarities. The information so collected helps in building a better understanding of the child and family's general situation and therefore helps in making a more adequate decision for each child separately.

In what concerns the psychological evaluation forms, in practice there are several approaches. We recommend the following approaches:

- The psychological evaluation form included in Annex 8 to Order No. 1985/1305/5805/2016. In order to be able to plan activities as part of a residential center closure project, we consider that services need to be defined more specifically in terms of both duration and provider of the respective service. That is why, we recommend that the psychological evaluation form should be accompanied by a Psychological Service Plan that was incorporated in the Evaluation Form as can be seen in Annex A, Instrument 3.
- The psychological evaluation form for the child/ young person without disabilities and/or SEN (see Annex A, Instrument 4).

After the psychological evaluation of all children in the nominal list will be finalized and introduced in e-cuib for each child, the multidisciplinary team will be able to download the Psychological Evaluation Report at Center Level, which will be automatically generated, using the model presented in of the Model of an individual closure plan.

Checklist!

- **All children and young people from the Nominal List benefitted of a psychological assessment.**
- **It is mandatory to fill in the Psychological Evaluation Form (Annex 8 to Order No. 1985/1305/5805/2016) for each child or young person in the nominal list, the version from Annex A, Instrument 3 of this Methodology, that includes the Psychological Service Plan. For children without disabilities and without SEN, a psychological report is completed in accordance with Instrument 4 of Annex A. The psychological assessment document must be attached to the child's file.**

4.3.4.(C) Social evaluation of the child or young person

The social evaluation of the insitutionalised child requires looking especially at the child's history of institutionalisation; reasons why he/she was separated from the family; relationships kept with the family; data about family and siblings.

The social evaluation also includes aspects regarding the quality of the child's development environment within his/her current living environment/institution (housing; food; clothing; hygiene; physical and psychological security, etc.); environment factors (barriers and facilitators) and personal factors, in such a way as to best identify the conditions and services that need to be present or improved in the child's new living environment after leaving the institution.

Subject to the child's age and level of understanding, opinions need to be noticed and noted regarding relationships with the family, in such a way that the information received contributes significantly to the decision regarding the child's route after the institution closes down.

The principal social worker in the multidisciplinary team shall co-ordinate the children's social evaluation. He/she will co-operate with the child's case manager and the social worker at the institution. The social evaluation shall be completed with a Child or Young Person Social Evaluation

Sheet (suggested template in Annex A, Instrument 5).[30] The results of the child's social evaluation will be complemented with the results of medical, educational, and psychological evaluations, but also with the evaluations of the social evaluation of the family, in order to prioritize identification of the possibility of reintegrating the child with his family.

After completing the social evaluation of all children in the nominal list and introducing the data in e-cuib for each child,, the multidisciplinary team will be able to download a Social Evaluation Report at Center Level, that will be generated automatically, based on the template of Annex 9 from the Model of an individual closure plan.

Checklist!

- **All children and young people from the Nominal List benefitted of a social assessment.**
- **Filling in the Child's or Young Person's Social Evaluation Sheet (Annex 7) is compulsory for each child and young person on the Nominal List and must be enclosed to the child's file.**

4.3.4.(D) Educational evaluation

The educational evaluation is carried out for all children and youngsters on the nominal list. If there are children in the institution, who do not attend the classes of a form of education according to their age, the information will be filled in in the Model of educational fiche for the unschooled child (see Annex A, Instrument 6). The goals regarding the child's integration into the education system in the next period are necessary to establish the range of educational or social services that the child will need at the moment of the institution's closure.

Educational evaluation is carried out, as applicable, by the teacher who works directly with the child in the pre-preschool and preschool education units; the elementary education class assistant/teacher; the class master for the primary and high school education, working with the school adviser and the support and teaching assistant. In the case of unschooled children, the evaluation is carried out by the education specialist or the educator in the multidisciplinary team, working with the institution's educators who know the child.

The results of the educational evaluation for schooled children shall be noted in the Psycho-pedagogical Sheet for the schooled child or young person (Annex A, Instrument 7). The Sheet is based on Appendix 9 of Order no. 1985/1305/5805/2016.

After completing the educational evaluation of all children in the nominal list and introducing the data in e-cuib for each child, the multidisciplinary team will be able to download anEducational Evaluation Report at Center Level, that will be generated automatically, based on the template from Annex 10 of the Model of an individual closure plan.

Checklist!

- **All children and young people from the Nominal List benefitted of an educational assessment, whether they are schooled or not.**

[30] Which can be conducted using a variety of methods and techniques, such as: observation; interview; eco-map; genogram, or force field analysis.

- **For schooled children, thePsycho-pedagogical Sheet for the schooled child or young person (Annex A, Instrument 7) must be completed, and annexed to the child's case file.**
- **For unschooled children,the Model of educational fiche for the unschooled child must be completed (model proposed in Annex A, Instrument 6) and annexed to the child's case file.**

With a view to preparing the institution for closure, the education institutions will be timely identified, which are closest to the community where the child is going and can respond to the child's education requirements.

4.3.5. Evaluation of the natural and extended family, as well as of their relationship with the child

The recent study[31] produced by the World Bank with ANPDCA and UNICEF regarding children in the public care system in Romania confirms that the majority of separation cases are not based on one single cause, but rather on a complex aggregate of vulnerabilities. In most instances, the children get into public care as a result of child neglect or relinquishment (most often at the maternity hospital, right after birth). There are, however, cases of child abuse and exploitation (15% of the children in the protection system), as there are cases of avoidable entries (24% in total), mostly relating to structural factors such as the absence or under-development of prevention and support services in the community. Avoidable entries refer especially to the child's disability (with inclusive education or medical services being absent in the community); the parent's disability or serious illness (with support services being absent), or poverty and/or precarious housing of the family.

The family evaluation is meant to identify which of these situations the children and youngsters in the institution are in. Obviously, the best solutions will be different for a child relinquished at the maternity hospital some years ago, than for a child abused or exploited by his parents, or for a child who got into the system only because the family had no sufficient income or no adequate housing. Face-to-face communication with the parents or family and direct observation during the field visit can confirm and bring about better understanding of the causes of separation; the level and intensity of the contact between the children and the parents; the causes of the lack of contact; the parents' desires and aspirations regarding their children; the level of parenting capacity and skills. The same type of evaluation can indicate whether, and how we should work with the parents to strengthen their skills and talents, what to do to have them take, or keep their children home in the future.

The cases of exploitation and abuse, as well as the neglect cases (41% of the children in the protection system) require special attention when it comes to reintegration. Each case will need to be assessed individually, as sometimes it is not recommended bringing the child back to the abusing parent or relative, the best case being to merely maintain a connection between the child and the family, under constant professional supervision.

In other situations, especially in the instances of avoidable entries, it will be of key importance to help the family; in other words, the state to be willing to invest in the family, rather than in institutions or other types of services that keep the child outside the family environment. In case such situations are identified, where the child could be reintegrated if the family received social-economic support, the DGASPCs could, within the institution closure projects, adopt innovative solutions, possibly in

[31] Stănculescu et al (coord.) (2016).

partnership with NGOs that have up to now tested all sorts of such 'unconventional' services to empower families and prevent separation.[32]

The social worker in the project team will co-ordinate the social evaluation of the family (natural and extended). He/she will work with the child's case manager and they will agree upon how to organise the field visits and the communication with the children's families, if these are present.

In order to have a clear view of existing families, first of all, for each child/ young person a List of families will be filled in (see Annex A, Instrument 8). The list mentions the number of families or other persons identified for the child/ young person, the type of family, the degree of kinship between the family contact person and the child / young person, and the factual location where the family/ person can be found (if known).

In terms of work principles, for the evaluation of families it is important to bear in mind the following aspects:

- The families are involved in the evaluation process, and their opinions are listened to and taken into account
- The professional who conducts the evaluation records the relevant information, while avoiding value judgements
- The visits to the families are announced in advance
- The language is accessible, easy for the families to understand[33]
- The needs evaluation shall be conducted at household level,[34] with all its family nuclei, and the information gathered will refer to all members of the household.
- The evaluation is built on specific professional instruments - social inquiries, interview technique, structured discussion technique, document analysis, observation, etc.
- If the family lives in a smaller community, especially in the rural environment, the local SPAS and the consultative community structure, if any, will be contacted for collaboration in evaluating the family/families in the respective community
- The family is evaluated within the context of the community it belongs to, with all the existing resources and obstacles. Relevant information can also be obtained from talking to neighbours, to other people who are relevant to the family and the child, to the local authorities, as well as through analysis of some relevant documents.

To serve for the family's needs evaluation, we recommend using a household questionnaire based on the one presented in Annex A Instrument 9. This questionnaire is based on Appendix 2 of Government Decision no. 691/2015, as well as the results of the research conducted by the World Bank, ANPDCA

[32] The examples of 'unconventional' services are varied and include: purchasing a cow for a family with many children, in order to assure a daily supply of needed milk; paying a skilling training course for one/both of the parents in order to increase their chances of finding a job and thus, of taking care of the child and family; paying the family's rent for a set period of time; perform repair works on the house roof; pay for support services while one of the parents is sick in hospital, etc. However, we mention that, for most of these initiatives, there are no impact studies performed to measure the benefits of the intervention.

[33] About 20-23% of the mothers whose children are in the protection system suffer from mental health issues and/or physical disability. Over three quarters of them have completed the primary school at the most, and almost one out of four is illiterate. Stănculescu et al (coord.) (2016: 56-57)

[34] The household is a group of people who usually live together; in general are related; they keep house together; sometimes they work together in the household; they jointly consume and capitalize the products obtained; they participate fully or partially in generating and using the income and expenditure budget of the household.

and the UNICEF in 2014-2015,[35] respectively 2016 within the SIPOCA 2 project (Questionnaire 2). Specifically, the household questionnaire that we recommend includes information regarding the living conditions; the financial-economic resources; social status; health condition; parental practices; interest for and bonding with the child; level and quality of contact with the child; future plans for the child; risk potential of the reintegration.

One household questionnaires (Annex A, Instrument 9) will be filled in, as appropriate, with the following types of families that could take the child home: household or households where the mother and father are, the maternal grandmother's household and the paternal grandparents household. To these other relatives and significant persons for the child may be added.

After the evaluation has been carried out, the social worker will draw conclusions and make recommendations regarding the possibility of reintegrating the child into the natural/extended family. The children's desires and aspirations regarding their institutionalised children will be noted. The reaction to the social worker's recommendations will also be noted. If there is a consensus between the evaluating social worker and the family, with regards to the possibility of the child returning to the family, further meetings can be planned to establish a joint work plan for the child's reintegration during the institution closure project.

All the information gathered in the field, the conclusions and recommendations, as well as the opinions and reactions of the parents or families will be recorded in the final section of the instrument.

After the family assessment has been completed for all children on the nominal list and uploaded to the e-cuib platform for each child, the multidisciplinary team will be able to download the Evaluation Report of Families of Children and Young People at Center Level, according to the template of Annex 12 of the Model of an individual closure plan.

During the closure project, because all systems are evolving, including the family that might register changes in terms of their health condition; employment; number of members in the family, etc., it is necessary that the family's condition is assessed periodically and correlated with the children's chances of re-entering the family environment.

Checklist!

- **All children and young people from the Nominal List benefitted of a family evaluation.**
- **The completed household questionnaires (model proposed in Annex A as Instrument 9) areannexed to the child's case file.**

4.3.6. Consultation of children or youngsters and their families

Since the most affected by this decision are the children and the youngsters in the institution, we recommend that they be involved, in terms of their information and especially of their consultation at all stages throughout the institution closure.

[35] The study on the *Review and restructuring of the Romanian child protection system*, the results of which are widely presented in Stănculescu et al (coord.) (2016).

Children aged 10 or more must be involved in all stages of the process. The principles in working with adolescents and young people include: (i) building a relationship based on trust, a warm and supportive human relationship, (ii) conveying positive messages about oneself and others, (iii) highlighting the qualities and abilities of the young person, which will contribute to the development of self-confidence, emotional and social maturity.

We remind that in the social assessment (section 4.3.4.C) the child's views on family relationships are recorded so that the information received contributes significantly to the child's decision after the closure of the institution, according to their age and level of understanding. These views are of utmost importance given that reintegration into the natural family is considered to be the best permanent solution for the child and is treated as a priority.

Moreover, in the family assessment (section 4.3.5), the possibility and the possible risks associated with the reintegration of the child into the family are analyzed. The family is also consulted on the conclusions of the assessment. If there is a reintegration possibility found by the social worker and the family agrees with this recommendation, the family is effectively involved in the development of a joint working plan for reintegration.

Consultation of children/young people and their families starts from the first information and consultation session organized at the start of the institution closure plan and is a continuous activity until completion of the closure project. Thus, as discussed above, consultation of children, of the young people and their families is an important component of the multidisciplinary assessment activities. Further, setting up a Plan for the Future for each child and young person will also involve consulting with them. Then, during the implementation of the closure plan, the consultation will be part of the supervision process (including new services) as well as the final evaluation.

So not only that the opinions, fears, desires and concerns of children and young people are taken into account, but children, young people and families must be co-actors in the decision making process that will crucially affect their lives.

The child or young person with disabilities must participate in any decision taken on his behalf

Children with disabilities, just like all other children, have a hard time facing change, especially when persons of attachment are also changed in their lives. Often, children with complex disabilities or with high degrees of dependency, especially children with autistic spectrum disorders, with severe intellectual disabilities, with associated neuromotor deficiencies, develop extremely negative reactions to changes in daily routines, of the program, of persons caring for them. There is a misperception that a child with severe deficiencies (and especially a child with communication problems) can't take decisions, „does not understand what is happening to him/her", so it doesn't matter if he or she is consulted or not by the adults who are caring for him/her.

But the child has own opinions, preferences and desires and can communicate them clear enough to anzone who is interested and patient enough to understand. The child with disabilities suffers just like any other child when he/she doesn't understand what is happening, why he has to undergo a change, what can be expected in the near or distant future. Therefore, in the deinstitutionalization process, the child or young person will be encouraged and especially helped to take an active part to all the stages of the transition to the family or to the small group home from the community. He/she will be permanently encouraged to choose, to express what he/she desires, and will be able to change his/her mind, to request time for further consideration or adaptation, to revert to earlier decisions, if he/she considers they are better for him/her.

Checklist!

- All children and young people on the nominal list, along with their families, if any, have been informed, consulted and have participated in the life-related decision making throughout the process, from preparation, to the development and implementation of the closure plan of the residential center.
- Throughout the process of closing down the center, if the opinion of the child or young person differs from the specialist evaluations, it is the responsibility of the adults to find an alternative agreed by the child or young person, according to his age and level of maturity.

4.3.7. The Final report and the Plan for the Future for each child and youngster featured on the nominal list and his family

The Final report and the Plan for the Future for each child and youngster represents the final stage of the multidisciplinary assessment.

As a result of the integrative assessment that reflects the current situation of the child and his /her family, their resources and needs as well as the available community resources, a recommendation can be made on the best child care or placement solution. Additionally, once both the needs of the child and the family are identified, recommendations can be made regarding the services, benefits or other support measures necessary for the natural family / extended family with the child / children returning from the institution or needed to ensure the child's growth and the provision of appropriate care in a new living environment - foster family, adoption, apartments or Family-type homes.

4.3.7.(A) Final report

The first step is to draw up the Final report for each child or young person on the nominal list. The final report is similar to a detailed assessment report or, in the case of children with disabilities, a Complex Assessment Report of the child with disabilities on the format presented in Annex no. 12 of the Order no. 1985/1305/5805/2016.[36] In other words, the Final report represents a summary of the main data and conclusions in the multidisciplinary assessment report listed in Box 9.

Therefore, The Final report will highlight the specific needs of each child, using the same format the DGASPCs usually use:

- Medical needs, as emerged from the medical evaluation
- Emotional and developmental needs identified by psychological evaluation
- Care needs, including safety and well-being, highlighted by the medical and psychological assessment
- Educational needs resulting from the educational assessment
- Religious, cultural and linguistic needs identified by social assessment of the child
- Contact with family and contact with friends, identified by the social assessment and assessment of the natural and extended family

[36] This document is used to grade the child's disability.

At the same time, the Final report also summarizes the key information on the child's institutional history, family history, abuse, illness, disability or behavioral problems of the child or of family members, the capacity, the needs and the desire of the natural/ extended family to care for the child, the resources existing in the community, or the services that would be required to support the child and / or the family.

For teenagers aged 15 or over (legal employment age) The Final report should also take into account needs in terms of socio-professional integration or their training.

The particular difference between the Final report and the (complex) Assessment Report (commonly used) is that it ends with a conclusion on the child's real chances for the future, expressed clearly and without any constraints of confining itself to the aims of the Individualized Protection Plan IPP), as they are currently regulated.[37] Meaning that, based on the assessment it is possible for a child with serious disabilities and continuous specialized medical care needs that a recommendation be made to keep him/her within the social protection system providing him/her with all the services needed and keeping him/her in the connection with his family.

[37] According to the "Methodology norm of 06/07/2006 published in the Official Journal, part I no. 656 dated 28/07/2006 regarding the elaboration of the Individualized Protection Plan, the IPP goal for a child with a special protection measure may be (i) family reintegration, (ii) socio-professional integration of young people aged over 18 leaving the child protection system, and (Iii) adoption.

Box 9: The assessment documents underlying the Final report

4.3.5. Multidisciplinary assessment of the child or young person:

(A) Medical assessment	☐ For all the children and young people in the nominal list, the Medical Record of the child/ young person in the protection system (template proposed in Annex A Instrument 2)
(B) Psychological assessment	☐ For all the children and young people with disabilities on the nominal list (including those newly identified), the Psychological evaluation form for disability, school and professional orientation and planning of benefits, services and interventions for children with disabilities and/or special educational needs(Annex 8 of the Order no. 1985/1305/5805/2016), accompanied by all the filled-in psychological tests (version proposed in Annex A, Instrument 3).
	☐ For the children without disabilities and/or SEN,the psychological evaluation form for the child/ young person without disabilities and/or SEN (see Annex A, Instrument 4)
(C) Social assessment of the child	☐ For all the children and young people on the nominal list, the Child or Young Person Social Evaluation Sheet (Annex A Instrument 5)
	☐ For the children with disabilities and/or SEN (including the newly identified), the Social Inquiry is also enclosed comprising aspects related to the operation, activities and the child's participation, obstacles or facilitators of this participation from the child's living environment (in compliance with Order no. 1985/1305/5805/2016)
(D) Educational assessment	☐ For the children in the institution who have not been enrolled in education, the Model of educational fiche for the unschooled child(Annex A, Instrument 6)
	☐ For schooled children,the Psycho-pedagogical Sheet for the schooled child or young person (Annex A, Instrument 7)

4.3.5. Assessment of the natural and extended family as well as the relationship with the child:

☐ For all children and young people on the nominal list, a List of families is filled in (see Annex A, Instrument 8)

☐ For children with a natural or extended family, the filled in household questionnaire for each identified family/person(template proposed in Annex A, Instrument 9)

Box 10: Checklist for the decision to reintegrate

Before carrying out a reintegration, the following items should be checked:

- ☐ Has the child's previous relationship with the family been checked?
- ☐ Is it known that there is no history of the child's abuse or of other children in the family?
- ☐ Have the criminal records of the family members been checked?
- ☐ The physical and material conditions of the family household comply with the child's minimum physical needs?
- ☐ Does the family want to take the child home?
- ☐ Has an individual child care plan been developed?
- ☐ Has a child and family care package been developed in compliance with the individual care plan?
- ☐ Has an integration preparation process been undertaken?
- ☐ Are the professionals involved in the training process sure that both the child and the family are ready for reintegration?
- ☐ Has the child had at least three visits at home (including overnight stays) before deciding to reintegrate?
- ☐ Do parents have a healthy relationship with the child (has this relationship been supervised/ observed)?
- ☐ Was a monitoring system established following the reintegration?
- ☐ Have the parents and the rest of the family been properly prepared?
- ☐ Depending on the child's age and capacity of understanding, has the child been explained to that he/she is about to return to the family?
- ☐ Has the child's consent been obtained?
- ☐ Steps have been taken to maintain contact, at least over a period of time, of the child with people, friends from the institution?
- ☐ If the child has special needs or disabilities, have arrangements been made to ensure that any therapeutic support he receives at present will continue to be provided?
- ☐ If the child has special education needs, have arrangements been made in cooperation with the County School Inspectorate / School in the community to ensure that the needs of the child with special educational needs can be met?
- ☐ If reintegration requires a significant geographical move and the child has to change school, has the child been enrolled in a new school?
- ☐ Was the child enrolled with a family doctor?
- ☐ If the child has ongoing medical needs, have measures been taken to ensure the continuity of the medical treatment required?
- ☐ If the child has disabilities, is the family prepared to meet the needs of the child?

*Source:*Adaptation after Mulheir and Browne (2013)

Or, for a child who is enrolled in the system in order for him/her to have access to a special school while fostering good family ties, the family has the capacity and willingness to reintegrate the child, but inclusive education or educational support services are not available in the home community nor in the surrounding area, the decision could be made to keep the child institutionalized until the completion of education. For an 18-year-old, the decision could be made to extend the protection measure until he/she succeeds in acquiring independent living skills, until he/she will get a job and / or dwelling, as the case may be, if he/she follows some form of education or if he/she is confronted with the risk of social exclusion.

The conclusions on the actual chances of the child to have a future which are comprised in the Final report must be realistic and can be made in clear and simple language and not limited by any type of administrative restriction. The only condition is that these conclusions represent the most appropriate approach in terms of observing the best interests of the child or the realization of his / her rights to family life, to enjoy the best possible health status that he/she can attain and to receive an education that can enable his/her development in undiscriminatory conditions, of his/her aptitudes and personality.

After the overall conclusion of the assessment has been outlined, it is necessary to clarify the need to revise the IPP's end in accordance with the legislation in force:

- *Family reintegration* of the child is realized when all IPP goals have been reached and the family wants and meets all the conditions for ensuring the child's growth and care. Reintegration in the family is achieved gradually to rebuild the attachment relationship and to avoid a possible trauma of the child in the event of a poorly prepared reintegration. It is recommended to verify the fulfillment of the issues listed in the Checklist (Box 10) before taking the final decision on reintegration.

- *Adoption* as the IPP purpose is decided after reaching the objective conclusion that despite all the efforts made, reintegration in the family is not possible.

- *Socio-professional integration of young people aged over 18.*

There are also *other purposes of the IPP* used in practice, which are not specified as such in the regulatory framework. A good example showcasing the IPP purpose for the young individual whose medical condition makes reintegration, adoption or socio-professional integration impossible, after reaching the age of 18 years he/she is transferred into the special protection system for adults.

To sum up, the Final report is structured on sections according to the child's needs, synthesizing the information and conclusions of an array of assessments and ending with the general remark on the actual chances the child has for the future and with the IPP purpose revisited.[38] The proposed Final report template is enclosed in Annex A Instrument 10.

Checklist!

All children and young people on the nominal list have a Final Report (template enclosed in Annex A, Instrument 10) which is included in the case file.

- **All children and young people in the nominal list have undergone a revised IPP purpose, if applicable.**

[38] We emphasize again that the Final report proposed in this Methodology to drafting the Individual closure plan of a placement center is similar with the Complex Assessment Report of the child with disabilities using the template presented in Annex 12 of the Order no. 1985/1305/5805/2016.

4.3.7.(B) Plan for the Future

The second step is to develop for each child or young person on the nominal list a plan for the Plan for the Future that accompanies the Final report. If the Final report focuses on issues and resources, the Plan for the Future focuses on the solutions, i.e. the best actual solutions for the child, services, benefits and other support measures needed for the child or young person and, where appropriate, for the natural or extended family).

The Plan for the Future is developed based on the elements that may affect the life and well-being of the child which are outlined in the Final report, including: living conditions in the new environment, access to community services, emotional security, physical integrity, the option to actively participate in all community activities, the wishes and aspirations of the child, the particular needs the child has in relation to his/her age and his/her institutional history.

The whole approach to develop the Plan for the Future must be centered on the child and on his / her particular needs. This principle has been stated many times without really being understood by professionals working with the child. But it is known that two children with the same deficiency or the same chronic condition will never have the same needs or the same preferences nor choices.

First, the Plan for the Future of a child or young person aims to identify in this order the possibilities of family reintegration (in the natural family), placement in the extended family, placement with a foster person or foster family that is part of the child's social network, adoption or placement with a care person/caregiver. If none of these options are suitable for the child/young person, the most appropriate residential type (CTF or community-based apartments or other residential institutions for children or adults) will be identified. For young people aged 18 or over, support for genuine socio-professional integration must be provided.

The Plan for the Future contains alternative (temporary) measures for children and young people for whom IPP goals (revised in accordance with the Final report) cannot materialize before the planned close down of the residential center.[39] These alternative measures should remain valid for as long as the children/young people need them, i.e. until they can reintegrate, they are adopted or they are able to integrate socio-professionally. They will be decided by the multidisciplinary team together with the family and the child /young person, the final solution being proposed by mutual agreement.[40]

The alternative measure for each child will be decided by prioritizing placement in the extended family, as it is important for children / young people to have the opportunity to experience family life while being provided with healthcare, education and optimal development. Placement (relocation) in another residential service must be the last resort only if all the other types of alternative measures cannot be achieved.

Alternative measures can be:

- ☐ Placement in foster care to a person or family, part of the extended family, namely a relative up to the fourth degree including the child
- ☐ Placement with a person or family that is part of the child's social network, i.e. relatives other than those up to the fourth degree, kin, acquaintances or friends of the family or extended family of the

[39] In most cases, it will be about children with IPP goals of family reintegration that cannot be achieved during the implementation of the institution's closure plan. It may well be that in some cases it takes more than three years to reach the IPP goals and to finalize the work plan with the family, and the success rate is also low, at least at present.

[40] Possible alternative measures and issues that address the advantages, disadvantages and risks of each of them will be discussed and analyzed.

child to whom he has developed attachment relationships or with whom he enjoyed family life experience.

☐ Placement with a professional foster caregiver, employee of DGASPC, or an accredited private body (OPA).

☐ Placement in residential care (small group homes, apartments, other residential services that meet the needs of children's care),[41] belonging to DGASPC (already set up or to be set up) or of partner OPA accredited as providers of social services under the legislation in force.[42]

☐ Other circumstances:

- *Maintaining the special protection measure for the young persons aged 18 but not older than 26 years who continue their studies in a form of daily attendance* education or/and require the maintenance of the special protection measure during the continuation of studies. In this situation, it is recommended that the young person will live in the dormitories of the educational institutions. If this is not possible, housing will be offered in existing or that are about to be established CTFs homes or apartments.

- *Maintaining the special protection measure for the young person aged 18 who is not in education, cannot return to his own family, who faces the risk of social exclusion and is ready to integrate socio-professionally.* In this situation, the young person receives, upon request, special protection for up to two years in order to facilitate his/her social integration. This right is forfeited if it is shown that the young person has been offered a job and/or a home at least twice, and he/she has refused or lost them for reasons attributable to him/her. These situations must also be considered when designing the number of residential care services.

Secondly, the Plan for the Future includes new services for the child/young person and the family. If it is deemed that the needs of the child/young person cannot be fully covered in the community (or surroundings thereof) where he/she will be transferred, an additional decision will be made on new services to be developed in the child's/young person's vicinity.

The services provided to the child or young person in the community should have an integrated nature. Often the services provided to the child belong to different areas (health, education, social protection, vocational guidance) and are provided by coordinated structures at local or county level. The care teams need to know the goals pursued in the transition process and work together to achieve them. Regular communication and tuning of specific approaches must be permanently subordinated to the IPP integration objective.

Additionally, before the actual move of the child or young person, the community must be prepared for it. As soon as the locality or community where the child transfers is known, it will be informed and sensitized in relation to the needs and particularities of the child's care (with or without disabilities). The neighbors, school, church, any person or group that can facilitate the child's adaptation to the new environment must be involved in the transition process. In this context, the child will be encouraged to actively participate in events, activities or programs taking place in his/her neighborhood, in the locality, in the groups of children or young people with whom he has direct contact.

The Plan for the Future for all children aged 12 or over should include skills development activities for independent living. Preparing for social and professional integration is a complex, long-lasting process that requires the targeted efforts of many specialists and is not always easy to achieve. It is advisable

[41] See GD no. 867/2015 for the approval of the Social Services Nomenclature, as well as the framework regulations for the organization and functioning of social services.
[42] Law no. 197/2012 on quality assurance in the field of social services.

that the development of skills for independent life be started as early as 12 years of age and should involve teamwork and active and real partnership between all the stakeholders involved: the child/young person, the care and education staff in the institution, social workers, psychologist, school teachers, or other professionals in the services, institutions or non-governmental organizations, who play an important role in streamlining the action. For adolescents aged 15 or over, the Final report already provides an insight into the degree to which they are prepared for socio-professional integration.

Further recommendations for the Plan for the Future for children with specific needs are presented in Box 11.

Once the solutions for (re)integration or placement and the new services needed by the child or young person have been set, it is necessary to specify whether or not to revise the Individual Protection Plan (IPP), Specific Intervention Programs (SIP) Habilitation-Rehabilitation Plan (HRP) and/or Individualized Services Plan (ISP), in line with current legislation. Therefore:

- *The Individual protection plan (IPP)* should be revised in line with the Plan for the Future to include all the benefits, services or other types of support the child and family can benefit from when deciding whether to reintegrate, adopt or integrate socio-professionally. Depending on the identified needs of the child and his or her family, the multidisciplinary team together with the family/legal representative of the child and child decide on a common working plan setting forth:
    - What are the general objectives on the areas of intervention (social, educational, medical etc.?)
    - Which agents determine the vulnerability of the child and the family which should be removed
    - What can be changed in family dynamics
    - What are the priorities
    - What actions should be taken
    - What is the time horizon allocated to achieving objectives and interventions?
    - What are the institutions which will collaborate for reaching the goals
    - When (date) does the delivery of services and benefits begin.
    - Who is the person responsible for each of the interventions from the Plan.
- *The specific intervention programs (SIP)* within the IPP should be revised from a social, health, educational, recovery and legal standpoint, setting forth the goals[43] on a short, medium and long term and related activities in order to achieve the child's reintegration, adoption or socio-professional integration. The actions to be taken to achieve the goals, their duration and the necessary/available resources to carry out these actions will be recorded. It is important to structure this information because in this way the case manager follows the responsibility showed by the family members, identifying the difficulties and preparing the family to overcome them, identifying and capitalizing family resources.[44]

[43] The objectives set for the change in the beneficiary's situation must meet the SMART conditions: be specific, measurable, achievable, time bound.
[44] Canțer (2014).

- *The habilitation-rehabilitation plan (ERP)*[45] for children with disabilities needs to be updated in line with the Plan for the Future to contain all measures to support the preparation and adaptation of the child at the various stages of transition, between different backgrounds and stages of individual development, depending on the type of transition[46], as well as approachesfor parents/legal representative and other important persons for the child. For children over the age of 16, the plan will also include the transition to adulthood. The ERP is integrated with the child's IPP.

Therefore, the Plan for the Future for each child and young person is based on the Final report that includes the revised IPP. The plan for the future is organized on sections corresponding to the (reintegration or placement) actions and new services established in agreement with the conclusion on the actual chances of the child in the Final report. Consequently, for every child or young person who cannot be (re)integrated into the family, the appropriate form of care is identified in an environment as close as possible to the family environment, as close as possible to his or her home, ensuring continuity of education and providing services (especially habilitation-rehabilitation), as well as maintaining family relations. The proposed template of Plan for the Future for a child or young person is included in Annex A, Instrument 11.

The Plan for the Future should only take into consideration the child's best interest and must be decided only together with the child/young person and the family. Within past processes of closing down large-scale residential centers, civil society representatives have reported situations showing that applying best interest of the child in the case of some family reintegration decisions was made rather to achieve the deinstitutionalization indicators and not in the best interests of the children.[47]

In fact, a study[48] on the child protection system reform from 2004[49] showed that: (i) many of the children placed with the extended family already lived in the respective family (and not in closed centers) at the moment in which the placement was officially carried out; (ii) 42% of children came to the extended family from residential centers, while 10% came from other forms of protection; (iii) about 21% of the relatives who had received children in their had not submitted requests in this sense, the child was simply brought to their home. Taking into account the low number of social workers in the communities (which has not improved significantly in the meantime) and the absence of community preparation activities, as well as the underdevelopment of support services, it could be concluded that sometimes the deinstitutionalization could have placed the child in a situation at risk. All of these factors are essential and have been taken into account in the methodology presented in the previous chapters.

Checklist!

- **All children and young people on the nominal list have a Plan for the Future (template proposed in Annex A, Instrument 11) that is enclosed in the case file.**
- **All children and young people on the nominal list have, as appropriate, revised/updated IPP, SIP, ERP and/or ISP and they are attached to the case file.**
- **The Plan for the Future alongside all other revised/updated plans (as appropriate, IPP, SIP, ERP, ISP) have been drafted in close collaboration with the family and the child/young person.**

[45] ERP is prepared by the Comprehensive Assessment Service and approved by the Child Protection Commission. The overall objective of the ERP is the personal and social development, maximizing potential, gaining the child's personal and social autonomy for social inclusion.
[46] Art. 65 of Order no. 1985/1305/5805/2016
[47]Save the Children (2008)
[48]IMAS (2004)
[49] The first deinstitutionalization stage was between 1997-2001, and the second between 2002-2007 (see Box 1).

Throughout the process of closing down the center, if the opinion of the child or young person differs from the specialist evaluations, it is the responsibility of the adults to find an alternative agreed by the child or young person

Box 11: Recommendations for the Plan for the Future for Children or Young People with Specific Needs

(A) Children aged 0-3 years without severe disabilities

According to the amendment of para. (1) and (2) of art. 64 of Law no. 272/2004 on the protection and promotion of the children's rights, the placement of the child under 3 years of age in an institution is forbidden. He/she can only be placed in the extended, substitute or professional foster caregiver(AMP) family. The only foreseen exception is for the child who is seriously disabled and dependent on care in specialized residential services. However, there are children aged 0-3 years without serious disabilities who are in institutions.

In most cases, these children have ended up in public care because they have been relinquished in the maternity, sometimes on account of their disability. Therefore, the family is either not known, or the child's disability is a major hindrance to his/her reintegration into the family. On the other hand, available data show that for the 0-3 year's age group adopters prefer children without health problems and only 1.2% are willing to adopt children with such problems[50]. In conclusion, none of the three IPP goals (family reintegration, adoption and socio-professional reintegration) is appropriate for these children.

Therefore, alternative measures that should be temporary may turn into long-term solutions in the absence of real chances to leave the child protection system. However, at the age of 0-3 years, placing the child in an institution is void of any justification. A family environment should be identified for them - relatives, the extended family, the substitute family or the AMP, while providing access in the community to all kinds of services they need so that they can benefit from individualized care and a stimulating environment that will increase their chances of recovering the development delays.

(B) Children with severe disabilities

The intervention system for the child with disabilities, regardless of the age, has the following steps: identification/assessment - intervention - reassessment - habilitation/rehabilitation - social integration. These steps are part of an ongoing process and they are not meant for one time actions, so they have to be planned and implemented in this way,[51] including in the Plan for the Future for the child or young person with disabilities.

In residential centers in Romania there is still a significant number of children with severe or associated deficiencies, who are graded as severely handicapped. Most of the time, these children's families are unprepared to face the challenges posed by the child's disability and decide to place the child in a specialized residential center. Other times, long years of institutionalization, in the absence of adequate habilitation or rehabilitation programs, lead to associated deficiencies or additional functional limitations. The reintegration process into the natural family is difficult but possible, and the success of reintegration depends heavily on the support services that the multidisciplinary team will identify (or develop) around the family (natural, extended or foster family).

We must not forget that in Romania at present, over 95% of children with severe disabilities are in family care. Testimonies from parents in different areas of the country show us that the family has a real "combatant's" path to follow over long periods of time to ensure that the child has access to the entire service network he or she needs. We should not expect the situation to be much different for deinstitutionalized children. Therefore, additional efforts must be made to simplify children's access

[50] ANPDCA (2014)
[51] UNICEF and RENINCO (2003).

to these to services (school, recovery, health services, leisure, sports, professional guidance, etc.) as much as possible.

Continuity of services is essential for the child, with a particular emphasis on the recovery services. The disabled child benefits from a number of specialized services in the residential environment, playing an important role in the habilitation or rehabilitation process and helping to develop self-service, self-care skills, independent living skills. In the case of extremely severe impairments or chronic illnesses or conditions, these services can help the child to maintain a good state of health (medical care, kinesiotherapy, speech therapy, sensory stimulation, specific therapies for children with TSA, etc.) or to participate in activities specific to his/her age (for example, support services in school). The transition process in the community must be organized in such a way as not to interrupt the provision of rehabilitation or support services for the children inclusion received prior to relocation.

Children with disabilities must have priority access to regular community services on equal bases with other children. Only in exceptional cases, when the child or young person prefers the services of a specialized service (special school, sheltered workshop, etc.), this solution will be chosen for the child. Severely disabled children can attend community school, or participate in cultural and sports programs, can attend school camps when they have adequate support services. This means, for example, that a support teacher is available in the school the child is attending, or that an interpreter of mimic language is available for the hearing impaired child during all the activities in the community where he/she needs to communicate with others.

Therefore, throughout the deinstitutionalization, the aspects listed below need to be carefully tracked:

- All support and recovery services required for a good integration of the child into the family and its inclusion in the destination community will be prepared and functional before relocating the child.
- The chronological age of the child or young person will always be taken into account when he or she participates in community activities, in the family type homes, or the services they receive. Young people or adolescents should be involved in age-specific learning, self-management, independent living, even when the intellectual deficiencies are significant. In this case, the objectives and requirements specific to these activities will be adapted to their level of understanding.
- The equipment, materials and technologies necessary for the daily need of the disabled child will be procured in time and provided to the family as soon as the child moves. Maintenance of assistive equipment should also be considered.
- The family must be closely accompanied during the first two years of the child's move. Often there are hidden costs or issues incurred by the transition that the multidisciplinary team (as well as the closure plan team) cannot fully anticipate. One parent may have to give up work to take care of the child. At times there are new situations or problems arising that the family cannot manage on their own. Support groups are important, the same as a reference person the family can rely on for competent advice. Brothers and sisters will also be monitored so that family dynamics are not a negative element in the process of de-institutionalization.

(C) Children with terminal illnesses

The residential structures also foster children with extremely complex care needs (chronic diseases with disabling effects, rare diseases, and terminal illnesses). These children need specialized medical or socio-medical services. According to the World Health Organization, palliative care[52] is the active and full care of patients whose disease is no longer responding to curative treatment. Control of pain and other symptoms, the psychological, social and spiritual issues are of major importance. The purpose of palliative care is to ensure the best quality of life for the sick and their families.

Palliative care[53] involves the prevention and suppression of suffering through early identification, correct assessment and treatment of pain and other physical, psycho-social and spiritual issues. It helps both the patient to live as normal as possible until his death and the family to cope with the patient's illness and death, including the mourning support service.

The specialized palliative care services are involved in caring for patients with more complex care needs, and involve staff with a higher degree of training and specialization.The palliative care center is a family support solution, for two reasons: it provides specialized treatment for the child whose illness is terminal, but also a respite and support service for family members, especially after long periods of the child's hospitalization or care.In Romania, however, children cannot be cared for in a nursing home/respite center (provided with beds) without going under the protection system, and this legislative provision still blocks the wider development of these much needed services.

The Plan for the Future for children in palliative care who do not have parental support should recommend keeping the child institutionalized during the illness unless a family can be identified that can manage the terminal stages of the child's illness at home. In this case, a team of professionals from the center will be established, which will provide home care services, upon the family request.For the children who have parental support, if the family requests it, then the children should be enlisted in the center or received in the center during periods when the family cannot provide care, by ensuring that family ties are preserved.

(D) Children in boarding schools (residential centers in a functional relationship with a special school)

Special education boarding schools currently foster several types of children with special education needs (SEN):

- Children with disabilities or learning difficulties under special protection who live in other localities far from the special school they attend and who return to their families during weekends and school holidays.
- Children with disabilities or learning difficulties who are under special protection and have no parental support
- Children with learning difficulties (with or without disabilities) who are not under special protection, recipients of boarding services alone.

For the first category of children, the hosting provided to children with SEN from different localities who are under their families' care should be maintained if the multidisciplinary assessment shows that the continuity of the child's education in the community of origin or in the immediate vicinity cannot be provided. If it is deemed that a solution can be found to continue education near the home, possibly with the provision of transport services, the protection measure[54] should be discontinued

[52]Terminal care is part of palliative care and involves caring for patients whose death is imminent and can occur within hours or days. Using this term to describe palliative care is inappropriate.
[53] Hospice Casa Speranței and the Institute for Public Policies (2011).
[54] It should be noted that these children are often under a special protection measure justified by the fact that they have access to education.

immediately and the child should (re)integrate into the family being provided with the necessary services.

Often, among these children there are also children without disabilities, coming from families with modest incomes, who prefer these boarding houses because they offer children accommodation and food, housing. If a multidisciplinary assessment highlights such cases and there are no solutions in the community or in the neighborhood for them to continue their education, then the Plan for the Future might consider transferring the child / young person to a social boarding school,[55] but only to the extent of boarding availability.

For the children without parental support, though, who stay in boarding school for long periods of time, they become residential centers. These children's transition to natural families, extended families or their placement (in families, in Family-type homes) is highly required. In many situations where families place children for long periods of time in boarding schools, they declare themselves unable to care for their children with special needs. These families believe that school can provide a safer environment and adequate childcare because it has specialized staff. In these cases, the (re)integration of children will aim to return children to their birth (or extended family, as the case may be), with an important focus on preparing them to appropriately respond to the child's needs. The child will still be able to attend the special school, but will return home during weekends and holidays. The support services required in this case will be: (i) family counseling, (ii) support for transport settlement between home and school, where applicable, and (iii) a family/child support group in the place of residence (church, neighborhood school, day center, neighbors or volunteers) to support the family in the process of (re)integrating the child, but also the child himself/herself, during the periods when he/she returns home.

If the child's multidisciplinary assessment shows that he or she can attend a regular school (with a support teacher, for example), steps will be taken to transfer him/her to a school in the home town, securing the necessary services.

If these children's (re)integration into the natural or extended family is not possible, a placement solution (placement family, professional foster care, CTF) will be identified for the child as close as possible to the school they are attending, and the transition process will be the same as with other types of residential centers.

In the case of pupils reaching graduation, the multidisciplinary assessment of children/young people will identify the professional integration measures that are best suited to the abilities of each child and a process of preparation for integration into the labor market (mediation, assistance, support for integration) will be initiated, assuring their hosting continuation in sheltered homes or Family-type homes and with support staff provision, where appropriate.

In the case of children attending special education but without a special protection measure, benefiting only from boarding services, details should be provided on how the provisions of GD 261/2000, as subsequently amended and supplemented, will be complied with, given that these children will not be able to benefit from the newly created services through the closure project of the institution.

(E) Young people 18+ years old

The solutions and services identified for young people protected under the provisions of Article 55 par. (2) and (3) of the Law 272/2004 on the protection and promotion of the children's rights,

[55]Law 79/2017 defines a new category of services - social boarding houses. These are "social services designed to provide housing and care to pupils, students and young people from families in difficulty", http://www.cdep.ro/pls/proiecte/docs/2016/pr230_16.pdf

republished[56], with the subsequent amendments and supplementations, should aim at reducing the risk of marginalization and social exclusion and finally integration and active participation in the community.

The Plan for the Future must be based on the socio-professional integration perspective identified in the Final report. The main services will primarily consider the following:

- ☐ Services for their social integration and assumption of the adult status, responsible for their own lives (to be guided to discover their own resources and potential, to build confidence in their own abilities, to understand the reality of the world in which they live, to become autonomous in thinking, in decision making, behavior and attitudes)
- ☐ Services for the development of independent life skills, depending on the outcome of the evaluation
- ☐ Access to education for the continuation of studies of young people attending pre-university and university education
- ☐ A job
- ☐ Medical assistance
- ☐ A dwelling
- ☐ Monitoring and post socio-professional integration support.

According to the regulations in force,[57] the Plan for the Future for 18-year-olds who have completed their studies but have not developed all the skills necessary for an independent life, should recommend maintaining temporary boarding in a protected system at their request for an additional period of two years. We emphasize that the decision should be taken in consultation with the young people, but the role of the specialists is to provide them the support needed to take the best decision.

During this two-year period, the Plan for the Future should include the necessary steps to be taken by the local authorities and relevant institutions to acquire a rented housing from the social housing fund, attending training courses and counseling and job mediation service in order for them to get employed[58], to obtain the due social rights[59] and the access to different services provided by the public institutions.[60] The steps aim to increase the degree of autonomy, to reduce dependence upon an adult or the residential institution and to reduce the complex of origin.

In addition to the Independent Living Skills Development Program, the Plan for the Future may also include the provision of supervised independent living (semi-independent living) to children/young

---

[56] Art. 55 par. (2): At the request of the young person, expressed after reaching maturity, if he/she continues his/her studies once in every form of daily education, special protection is granted, under the law, for the duration of his/her studies, but without exceeding the age of 26 for years. Art. 55 par. (3): A young person who has acquired full capacity and is under a special protection measure but who does not continue his/her studies and is not able to return to his/her own family, being faced with the risk of social exclusion, receives, upon request, up to 2 years of special protection in order to facilitate his/her social integration. This right is forfeited if it is proved that the young person has been offered a job and/or dwelling at least twice, and he/she has refused or lost them for reasons attributable to him/her.

[57] Law 272/2004 on the protection and promotion of children's rights.

[58] Government Emergency Ordinance 60/2016 has amended and supplemented the employment incentives provided by Law 76/2002 on the unemployment insurance system and the stimulation of employment, becoming more attractive for the beneficiaries.

[59] Law no. 196/2016 on minimum inclusion income, which includes minimum guaranteed income, family allowance and heating allowance will enter into force on April 1, 2018.

[60] See also the active measures set forth by Law no. 76/2002, as amended and supplemented, on the unemployment insurance system and the stimulation of employment.

people, possibly even by concluding partnerships with NGOs[61] carrying out specialized programs for the development of independent life skills and socio-professional integration.

These are apartments or studios being offered to young people over a certain period of time. There may also be a range of facilities that young people can benefit from: partial relief from paying utilities fees or paying a modest amount for rent over a certain period of time.[62] At the same time, there can also exist a series of facilities packages that the young people can benefit from: partial exemption from paying maintenance taxes or the payment of a modest amount of rent, the granting of a monthly budget that the young man administers and may use for food, clothes or medicines.[63]

(F) Children with behavioral disorders

Children and young people with behavioral disorders are more difficult to identify than the groups listed above. Sometimes, behavioral disorders are generated by the pathology of children diagnosed with ADHD, autism, children with tic disorders, obsessive-behavioral disorders, etc. Other times, however, the disorders may have old, unknown causes that have resulted in limited skills to deal with problems and solve them, a long history of adverse reactions, difficulties in controlling emotions, low self-esteem, low tolerance, frustration, unrealistic expectations, low adaptive abilities, problems in setting the daily routine.[64] Finally, there are cases where more rebellious, self-reliant teenagers with more special tastes and behaviors considered inappropriate by the institution's staff become labeled as "a child with behavioral disorders" in the absence of rigorous assessments. That is why we consider that classifying them in children with behavioral disorders and children without behavioral disorders should be approached with great care and not taken for granted.

More serious is however that, typology aside, there is a tendency of DGASPCs to group and bring together children with "behavioral disorders" (of all kinds) under a service that is dedicated to them and whose mission is to develop actions to reduce and eliminate such behaviors. First of all, such a solution is discriminatory because it is based on categorization based exclusively on limitations and malfunctions. Secondly, bringing together more children who share the same "problem" is counterproductive. Several children with behavioral disorders placed together do nothing but excite each other up to escalating situations that are difficult to control by adults and by the children themselves. Thirdly, such an approach does not respect the child's best interest because it is not directed to a child's/young person's interest, it does not provide an environment in which examples and situations should showcase "normality" and other positive examples.

We strongly recommend that the Plan for the Future for Children with Behavioral Disorders take into account the following:

- ☐ Avoid grouping children with behavioral disorders in CTF-like services, centers for children with behavioral disorders, homes for children with autistic spectrum disorders, etc. Children with behavioral disorders change their attitude, and positive results only occur when they are surrounded by other children who react normally.
- ☐ Medication should be prescribed exclusively by a specialist. Inappropriate medication just masks difficult behavior, it does not solve it.

[61] For example, assistive programs to prepare for an independent life of non-governmental organizations SOS Children's Villages, Concordia, Pro ACT Support.
[62] Dwelling may vary depending on the policies of the organizations that manage them.
[63] HHC and Save the children (2006).
[64] Behavioral disorders may also include limited ability to cope with loss, lack of adequate alternative responses, anger, throwing objects, psychiatric problems, defiance of staff, aggression, hitting, biting, fleeing, deliberate destruction of goods, and cruelty to animals and so on.

- ☐ A staff training program focused on proactive and less restrictive approaches is absolutely necessary. Positive behavior support strategies are most effective in treating disorderly behaviors.
- ☐ Children with behavioral disorders need support services and guidance from cognitive-behavioral therapists to help them express their anger adequately.

4.3.7.(C) How conclusions are drawn and by whom and who prepares the Plans for the Future

In short, the multidisciplinary team, made up of the professionals who carried out the expert assessments, is responsible both for the Final report and the Plan for the Future for each child and young person on the nominal list. Decisions will be taken in the meetings organized by the case manager who coordinates the team. Decisions will only take into account the best interests of the child or the realization of their rights to family life, education, health.

The final report is filled in a meeting of the multidisciplinary team attended by the child/young person case manager. In addition, members of the project team may be invited, in particular the senior social worker and senior psychologist. During the meeting, each member of the multidisciplinary assessment team presents the conclusions on the identified needs of the child and, by consensus, draws conclusions about the child's real chances for the future. If the review of the IPP goal is necessary, the child's case manager can take all the administrative steps to do so, and then report to the multidisciplinary team when the new IPP objective becomes available.

The final report is communicated to the child/young person according to his/her level of understanding and his/her family and includes all the comments they wish to make so that the information is there before the planning of the assistance planning required. The case manager who coordinates the multidisciplinary team is responsible for drafting the Final report which must be signed by all team members.

In the next phase, the multidisciplinary team must decide and draft the Plan for the Future for the child/young person that contains the most appropriate solution for the child to leave the institution. With the Final report as their starting point, the multidisciplinary team decides the measures and new services most suitable for the child/young person. The alternative measure for each child will be decided by prioritizing placement in the extended family, placing (moving) into another residential service being the last chosen solution, unless all the above cannot be achieved. The multidisciplinary team discusses with the family, including the child, the possible alternative measures for the situation where reintegration cannot be achieved, as well as the aspects that relate to the advantages, disadvantages and risks for each of them, the final solution proposed has to be mutually agreed upon.

A timetable, the steps to be taken, and the transitional measures, the responsible persons, the potential risks and the resources (human, financial, material and methodological) for each stage will be established for the decided and agreed upon measure.

The multidisciplinary team then decides whether IPP, SIP, ERP and/or ISP should be revised/updated, this task being taken over by the case manager of the child and, where appropriate, by the complex assessment service. He/she also integrates the ERP with IPP for children with disabilities. The case manager needs all these documents in order to follow up the accountability of family members, identifying difficulties and preparing the family to overcome them, as well as identifying and capitalizing on family resources.

The alternative measure will be reflected in each child's SIP and IPP, and the plans implementation is reviewed at least once every three months. In the case of children with disabilities, the revision of the habilitation-rehabilitation plan / individualized services plan takes place whenever required, following

regular re-assessments or occasioned by other intimation/ self-notices and mandatory under the provisions stipulated in Order no. 1985/1305/5805/2016 art. 77 paragraph (1).

The Final report and the IPP revised in tune with the Plan for the Future are submitted to the Child Protection Commission or, as the case may be, to the court, to decide on reintegration, socio-professional integration or, as the case may be, changing the placement measure of the child/young person. If deciding on the reintegration of the child into the family, the SIP will be developed for reintegration in collaboration with the SPAS in the locality where the child's family of relocation lives.

The case manager who coordinates the multidisciplinary team is responsible for drafting the Plan for the Future[65] to be countersigned by all team members. At the same time, he or she communicates the conclusions and recommendations (Final report and Plan for the Future) on all children in the nominal list to the team that draws up the institution's closure plan.

In the implementation stages of the closure plan, the multidisciplinary team will be able to participate in the re-evaluation of the situation of children and young people as well as in their monitoring and evaluation.

4.3.8. The evaluation of the staff working in the center

A human resources specialist should be part of the team that prepares the closure plan, as well as of the teams that draft and effectively implement it, as it was underlined in section 4.1.2. This specialist is in charge of the evaluation of the existing staff and of the selection and training of the new or old staff (see 4.3.8 and 7.1.2).

4.3.8.(A) Existing staff: Preparing the evaluation

One of the first actions carried out by the human resources specialist must be the presentation of the entire process, preferably together with the project manager so that the existing staff understands and visualizes the process, asks questions and expresses concerns. The importance of informing and consulting the staff has already been emphasized in section 4.2.1. However, the information and consultation activities are essential in order to prepare for the evaluation activities, and this is why we believe it is useful to insist on this topic.

The staff may delay a project, orienting it not towards transformation, but towards a simple realignment. Human resources can be a success factor or a cause for failure. Staff issues may affect the image of the project for closing down the center and, in general terms, the image of the deinstitutionalization process, which may lead to the demobilization or even antagonizing the community. The employees may create negative "motion" when thinking of losing their job, especially if it is the case of a rural community where the residential center represents one of the biggest employers. The staff can influence the children to oppose the process or may support the transition so that it is smooth, according to the plan.

The staff in the residential centers, regardless if we are talking about the director, professionals, caregivers or administrative and support staff, are not one of the most flexible categories of employees. Around two thirds of the employees of all residential centers in the country have worked in these centers for more than ten years, which means that a great part of them have already

[65] Template proposed in Annex A Instrument 10.

experienced the child deinstitutionalization waves taking place in the past. Through the Job Description, the staff must comply with a structure and some rather rigid procedures, focusing mostly on administrative issues rather than on children and their progress. Also, the share of specialists (social workers, psychologists, therapists and educators) is very small,[66] while the administrative staff represents a third of all the employees of the residential centers in the country (and most of them have vocational courses, in the best case). However, it is true that they all have contact with children, and some of them establish excellent relationships with them.

Among the first major changes that the deinstitutionalization process will generate is also the restructuring of the staff organizational chart. The new service model, which envisages firstly the prevention of the entries into the system and is focused on family services and family-type services (placement with the extended family, professional foster caregivers, internal adoption, reintegration and some small-size residential services), will not require the entire administrative apparatus that the institutions have. It will require a variety of employees with different qualifications, who would spend more time with the children, in activities that target their development.

Nevertheless, the staff is a trump. It includes employees in charge with the effective care of children and administrative issues, with different levels of influence and power. It is recommended that all employees be informed and be allowed to ask questions in order to freely express any fears and concerns. Transparency is essential, and the information of employees represents an important element in the transition process, in its first stage.

4.3.8.(B) Existing staff: Evaluation

The second action of the human resources specialist is staff evaluation. This must be carried out at the same time with the evaluation of children. During the staff evaluation, the human resources specialist together with the principal psychologist will focus on identifying the level of knowledge, competencies and skills of the employees working with children. This information will be the basis for the staff training plans, in order to facilitate the transition and the new tasks.

Box 12: Staff evaluation - Data necessary for the evaluation of the existing staff

C1. Surname, first name (or initials)
C2. Gender
C3. Age
C4. Total seniority in the child protection system
C5. Total seniority in the center
(Including the period when the institution may have had a different name or classification)
C6. At the moment, is she/he attending a school/faculty?
C7. The most recent level of higher education graduated
C7a. What was the specialization at graduation?
(Only for people with post-high school education, higher education or post-graduate studies)
C8. Attended training/specialization courses in the last 3 years?
If YES C8a. What was the topic of the latest attended courses?
C9. Does she/he need training/specialization courses?
C10. The regular working hours are ...?
C11. The normal duration of the working week in the residential center

[66] The total staff that effectively carries out specialized activities represents, as a country average, around 16% of the total staff in all the centres in the country: professional medical nurses represent 9%, doctors 1%, and other specialists 6%.

C11a. Of which, how many hours per week direct work with children?

Source: The Staff Master Table filled in based on Questionnaire 1A: HUMAN RESOURCES.

Beside the data above, staff evaluation must rely on qualitative methods (e.g., interviews and direct observation) which consider also the following:

- Total seniority of the employee in institutions for children or adults. Employees who have worked in an institution for approximately 20 years are rather institutionalized themselves than experienced. They did the same thing constantly, did not have the opportunity to test new theories, to apply new techniques or to tackle issues from a new angle. It is very possible they did very well their administrative tasks, they filled in all the files, they kept the files properly and they may have focused on the institutional routine: washing, feeding, sleep- repeatedly.[67]

- The type and level of knowledge of the employee. Are these enough to make the transition? Or for the requirements of the new positions in the services that are to be created or developed/improved? For what type of skills does he/she need training?

- The present work style and the possibilities and the will to adjust to the work style required by the services that will be improved or will be newly established

- The quality of the interaction between employee and children. There are residential center employees who like to work with children and have a certain capacity to interact with them. These employees are potential "supporters" of the center closure plan, being truly motivated to see changes to the benefit of children. They would have a lot to win from the training opportunities and could develop in their new role.

- The employee's potential to use abusive behaviors against children. As it was shown before, the records show that abuses are rather frequent in institutions. Without demonizing the existing staff, the numerous abuses are due to ignorance andlack of attention. There are cases when the employees are abusers that find it easy to work in the institutional environment.

- Employee's fears, concerns and plans for the future.

- The level of readiness to change and the will to change. These two issues should be discussed and established with the psychologist. They are extremely important and can become defining selection criteria, next to the performance during training, in order to decide which employees of the institution are suited for the new service. Otherwise, it is important to identify:

    - The capacity of the employee to work in a new professional environment. The employees of an institution are either caught in a daily routine that doesn't give them the chance to change, or have no contact with children and usually have a distorted image of the children's needs. The general opinion (of the employees) is that these institutionalized children are actually much better in an institution than in their own families. This attitude and the way children's needs are understood must change. If this capacity exists, and the employees are willing to understand the negative and long term effects of institutionalization and to try to adopt new behaviors and attitudes towards the children and families affected by institutionalization, then they would be valuable strengths and efforts should be made to ensure proper training and professional opportunities in the new services.

    - The capacity of the employee to make professional changes (participating to training or reconversion courses). Employees willing and capable to make a change are, most

[67] HHC (2012)

likely, those that will have good results during training. They will accept and assimilate new methods and techniques. However, the chance of a training/reconversion might be a convincing element also for the people that seem to be stuck in their belief that institutionalized care represents a better option. Note that it is possible for the staff in institutions to have never had training and to have never been exposed to changes during their entire professional activity in the institution. There is no budget dedicated to training, this representing an activity that interrupts the planned tasks, thus leading to the possibility for the institutions' employees to be ignored, even in the rare chances when such opportunities occur. There are very few cases when the institutional staff (in its entirety) has effectively participated to a pertinent training program, meant to improve interaction with children and the results for children. So, giving a training chance may make the difference at staff level.

All these criteria can be included in the staff evaluation process. The important thing is to use several methods and to grant enough time in order to observe the various interactions. Irrespective of the evaluation type, an essential element is that this be done by a team that has no stake in this process. Of course, the institution/human resources managers of DGASPC must be involved, but their opinion should not be the only decisional factor. Ideally, the human resources specialist and/or psychologist must be from outside the DGASPC, so that the evaluation be done from the most neutral perspective possible, based on a process resulting from observation (carried out by those in charge of training the child – therapist, psychologist) and tools, in order to have a clearer imager of the capacity of each employee to make the transition/to be taken by the new services.[68]

The conclusions of the evaluation must be communicated to the employee, and his/her feedback should be noted.

All this information must be handed over to the team that drafts the individual closure plan, in order to go to the final selection of the staff and the training of those that are transferred to the new services or to existing services for children or adults.

Checklist!

The staff evaluation process was well drafted by informing the employees, trade unions and their representatives.

- **The evaluation process was transparent, open and fair, giving the staff the chance to give feedback about the process, as well as about its result.**

[68] Examples of such tools can be found in Mulheir et al. (2004) or Dărăbuș et al. (2017).

5. PREPARATORY PHASE 2: DRAFTING OF THE INDIVIDUAL CLOSURE PLAN OF A CENTER

In this phase, the individual closure plan and the possible financing applications will be effectively drawn up. The mind-set remains focused on the child, but we go to finding solutions for each child or young person separately, to finding solutions at aggregated level: what services are there, what new services must be developed and how, what will happen with the staff, how will the land, buildings and other material resources of the center be used when it will be closed down?

The first step is to adjust the team. Until this phase, a plan preparatory team was needed, which involved, based on the number and profile of the children in the center, one or more multidisciplinary teams for the evaluation of children, youth, families and communities. In the phase of developing/ effectively writing the plan, the entire preparatory team is no longer needed. But, the people that effectively write the project should join this team, most likely from the compartments in the DGASPC that are specialized in developing applications and projects to attract financing. The role of the human resources specialist will also increase significantly. Moreover, social services management specialists are needed, who have a general image of the services available (under the subordination of DGASPC, of the local councils or of the NGO/OPA) at county level, as well as specialists that frequently interact with the local authorities and may help in establishing partnerships with them.

This is also the moment to hire specialists that are expected to play an important role in the implementation. After they are hired, these specialists must be trained, they must understand the activity plan that is being drafted/written, they must start preparing the tools, mechanisms and contacts that they need to perform their tasks successfully. The specialists we refer to are mainly the monitoring and evaluation specialist and the communication one (very much needed in the counties where two or more centers are being closed, so they have to manage more individual closure plans in a coordinated manner, and/or in the counties where resistance to change is considered a risk).

The role of the team that develops the individual closure plan is to write the phased plan, with clear deadlines and assigned responsibilities. As a reminder, in order for the team to work properly, the responsibilities and tasks of each team member must be defined (Job Descriptions), as well as the tools and clear working procedures within and outside the team (communication, reporting, evaluation, planning etc.).

The team that develops the individual closure plan starts from the information on the evaluation of the institution and from the Plans for the Future for the children and young people in the center, made available by the preparatory team.

Checklist!

The needs for the new staff include, if necessary, a monitoring and evaluation specialist and/or a communication specialist for the implementation of the closure plan, besides the specialists that are needed for the development of the new services.

5.1. Establishing the new services

Establishing new services envisages (i) planning the new services meant to meet the needs of the children and young people that will be moved from the center, (ii) planning the staff activities with regards to the staff existing in the center, but also to the staff needed for the proper operation of the new services, as well as (iii) decisions with regards to the way in which the material resources that become available by closing the center will be used. The entire planning process for the new services will be done only from the perspective of the child's best interest and not based on administrative or cost-efficiency reasons.

5.1.1. Planning the new services and activities for children and young people

As it is shown by the main lessons learnt from the child deinstitutionalization reforms carried out until now in Romania (Box 1), the closure of the residential centers must be accompanied by (i) the development of new services that must be created on specific needs identified for each child and family, as well as on their consultation and, at the same time, (ii) the development and consolidation of community level prevention services regarding child separation from the.

For each child and young person in the nominal list, the Plan for the Future[69] identifies the solution or the most appropriate alternative measure and the list of benefits and social or support services. Also, the Plan for the Future stipulates (at point IV) which of the necessary services exist and what new services should be developed in the individual closure plan of the center. Through theautomatic aggregation of this data after the introduction of the Plan for the Future for each child/young person in e-cuib, the general list of new services and activities will be established at center level, which will be available for download as a Summary using the template proposed in Annex15 of the Model of an individual closure plan.

No closure plan can be limited, until the end of the implementation period, to moving all in to small residential services. Irrespective of the specific characteristics of children and young people in any institution, a 3-year plan can be developed that will lead to adequate alternatives for a part of the children.

It is important that all those that prepare and implement the deinstitutionalization process have a common understanding of the word "institution." The European Expert Group on the Transition from Institutional to Community-Based Carewarns that institutional practices can be replicated both in a small group home with five residents, as well as in an institution with a big capacity, with more than 200 people. Thus, we talk of an "institution" when:[70]

- Children or young people are isolated from the outside community and/or are obligated to live there against their will;
- Children or young people do not have enough control on their own life or on the decisions that directly affects them;
- The institution's needs come before the individual needs of the residents.

[69] Annex A Instrument 11.
[70] EEG (2012)

Therefore, it is essential that the new residential services do not incorporate the "institutional" practices from old style institutions that are being closed. To this end, the quality standards for these services need to be strictly respected.

Moreover, in order to minimize the risk that the new structures be exposed to spatial and/or social segregation, the following rules will be envisaged:

- The new Family-type homes (CTF) or apartments must be located within the community, by taking into account the transportation means and the distance, so that they allow children's easy access to school/kindergarten, medical and leisure services.
- The new CTFs must not be built within the premises of the former residential center or immediately close to it (fence to fence)[71]
- The new CTFs must not be located in one of the Appendixes of the residential center that is being closed down
- There can't be more than two CTFs on a single parcel of land
- The new apartments must not be located in the building of the residential center that is being closed
- In an apartment building it is allowed to accommodate maximum 10% of the total number of apartments for children/young people
- The living space in the new CTFs or apartments will be sufficient, structured, arranged and equipped in compliance with the minimum standards in force and by paying special attention to the existence of a private space for each child/young person and the possibilities to customize it
- The new CTFs must have outdoor areas, like a courtyard, garden. The apartments should be close to or have access to outdoor areas for leisure (like parks, playgrounds, sport grounds)
- For the new CTFs, the outdoor areas should ensure child protection in a discreet way (e.g., fences have the regular height in the area, no bars are used etc.)

A special attention must be paid to restructuring the placement centers that are functioning besides special schoolsand can be transformed into boarding schools. Such boarding schools can be found on the EU territory, both for special as well as for regular schools and are units ancillary to the educational units. In these countries, they are child friendly accommodation units, which comply with all the quality standards and demands for a temporary accommodation structure, giving the child a solution for an efficient learning process in a different city than the one where the child lives.

Especially in the counties with more residential centers including the ones that function alongside special schools, there is a possibility that the needs and circumstances of some children from the centers that are being closed to require maintaining or transferring these children to the special boarding schools. Even if these boarding schools are to be changed into boarding school, actions have to be taken, though, to enhance the quality of care in these boarding units, as well as their monitoring and evaluation.

This is even more important as in the last years, numerous abuses and violations of the children's rights have been reported in such structures in the country. On the other hand, an insufficient preparation of the next lifecycle for the children in the senior years of the special schools most often leads to children finishing the school cycle be moved to a residential center for adults, in a system

[71]New CTFs can only be built in the yard of the former placement center if the building in which the former center is located is demolished or used for new non-residential services (for example, a recovery center).

that blocks the professional pathway or personal choices of the young person with SEN. The insufficient and poorly qualified staff is many times incapable to provide a qualitative care to children and young people. The optimization of the internal organization and a more efficient quality control system will be priorities for the restructuring of the special boarding schools.

Thus, at the end of this stage, it should be clear: (1) how many new AMPs are needed; (2) how many new CTFs or apartments will be built; (3) if applicable, what actions to improve the quality of services will be carried out in the boarding schools where children or young people from the nominal list will remain or will be moved to.

(A) For each of the new protection services the following must be planned...!

- **The name and address of the new service**
- **The place and role of this new service in the county/local child protection system**
- **The capacity of the new service**
- **The beneficiaries (children in the institution that is being closed and/or in other institutions that are being closed in the county and/or the children in the community)**
- **The location, accessibility, facilities that will be offered to children in the new service**
- **Human, financial, material methodological resources needed**

  The list of equipment, materials and support technologies needed will be included
- **Potential risks**
- **The completion date for the new service to receive children (in order to plan children transition).** *If there will be a funding application submitted for this service, it is possible that, depending on the financer, to have a minimum period of operation imposed before project completion. For example, in an NIPs, this period has to be of at least 3 months.*

(B) For each of the existing services (especially boarding schools) that will be improved/ developed, the following must be planned ...!

- **The name and identification data of the existing services that is to be improved/ developed in order to serve the children or young people in the institutions that are being closed down**
- **The number of children in the institution that is being closed (or in the institutions that are being closed) who will benefit from the proposed upgrades**
- **What are the actual upgrades and their justification**
- **Human, financial, material methodological resources needed**

  The list of equipment, materials and support technologies needed will be included
- **Potential risks**

- **The completion date for the upgrading activities (in order to plan children transition).**

Note: The new social protection services that must be planned according to the score above can be found at point I of the Summary of New Services and Activities (template proposed in Annex 15 of the Model of an individual closure plan).

In the second phase, the types of social services that must be ensured close to the child will be aggregated. The aggregation algorithm by types of social services[72] must respect the following rules:

- ☐ Only new services must be aggregated, not the existing ones (according to point IV of the Plan for the Future).
- ☐ In order to optimize the list of new services, an analysis of their distribution must be made based on the communities where the children will be moved (mentioned at point III in the Plan for the Future).
- ☐ Day care centers can be set up by DGASPC only for the disabled child. Day care centers for the child without disabilities can only be set up in partnership with DGASPC and local public authorities, with 50% funding from the County Council.
- ☐ If DGASPC drafts two or more individual closure plans, the aggregation of the new services must be coordinated at county level.

(C) For each of the new social services the following must be planned...!

- **The name of the new service**
- **The organization establishing the new social service**
- **The organization managing the new social service**
- **The means and methodology to establish, organize and operate the new service**
- **The place and role of this new service in the county/local child protection system**
- **The capacity of the new service (the maxim number of beneficiaries per month)**
- **The beneficiaries (children in the institution that is being closed and/or in other institutions that are being closed in the county and/or the children in the community)**
- **The location, accessibility, facilities that will be offered to children in the new service**
- **Human, financial, material, methodological resources needed**

With regards to the human resources, the number of the necessary staff, the position and function, the working hours will be provided, as well as if there will also be volunteers or not.

[72] Identified for each child/young person at point IV in the template proposed for the Plan for the Future in Annex A Instrument 11. The result of the aggregation with regards to the new social services are recorded at point III of the Summary of New Services and Activities at center level, template proposed in Annex 15 of the Model of an individual closure plan.

The list of equipment, materials and support technologies needed will be included.

- **Potential risks**
- **The completion date for the new service to receive children (in order to plan children transition).**
- **The management of the new service**

  Qualification and years of experience required for the coordinator/head.

Note: The new social services, including the new services for the prevention of child separation from the family within the community, which must be planned according to the score above, can be found at point III of the Summary of New Services and Activities (template proposed in Annex 15 of the Model of an individual closure plan.).

The aggregation algorithm by types of support servicesto families for raising and children care (in short support services)[73]follows the rules mentioned above for social services. At the end of this exercise, the number and type of new support services will be established, as well as the communities where these must be developed. To these, the following must be added:

- The activities to prepare the community,[74]including equipment, materials and support technologies needed in the community in order to move the child
- The number and type of material support for families,[75]including equipment, materials and support technologies needed in the family in order to move the child

The deinstitutionalization process can be a good opportunity to develop the so much needed support services, in the communities where the children in the institutions will go to, either with the help of nongovernmental organizations or by directly by the public authorities. The support services are insufficiently developed in many local communities in Romania, especially those for disabled people. Sexual education and education for family life, in the case of young people with severe disabilities (sensorial, neuromotor or associated, intellectual etc.) is a service like that. In the same way, the respite family center, which allows parents to leave their child in a protected and safe environment, when they want to solve personal issues or when they just need to rest. Sign language interpreters, as well as specialists in tactile signaling (for people with blindness or deafness) are rare in Romania. Such services would be beneficial also for the other families that take care of disabled children.

All the support and recovery services necessary to a good integration of the child in the family or in the desired community, must be prepared and operational before moving the children and young people from the institutions that are being closed.

[73] Identified for each child/young person at point V in the template proposed for the Plan for the Future in Annex A Instrument 11. The result of the aggregation with regards to the new support services are recorded in the Summary of New Services and Activities at center level, template proposed in Annex 15 of the Model of an individual closure plan.

[74]Identified for each child/young person at point VI Plan for the Future in Annex A Instrument 11. The result of the aggregation with regards to the activities to prepare the community are recorded in the Summary of New Services and Activities at center level, template proposed in Annex 15 of the Model of an individual closure plan.

[75] Identified for each child/young person at point Vin the template proposed for the Plan for the Future in Annex A Instrument 11. The result of the aggregation with regards to the support granted to families are recorded in the Summary of New Services and Activities at center level, template proposed in Annex 15 of the Model of an individual closure plan.

It is important to separate the support services issue from the building where they are rendered. Children and young people with disabilities must grow up and develop inside the community, just like any other child. Of course, these children frequently need specific habilitation, rehabilitation and support services for inclusion – in terms of school participation, medical recovery, development of competencies and skills for an independent life, choosing the professional career etc. However, they can benefit from these within the community and they must enjoy the same resources, support and opportunities like the rest of the children. The idea that the support services for them must be concentrated in a single building, because they would be easier to manage and access is logical in theory, and probably efficient, but does not help with the real inclusion of the child in the wider community around him/her.

Of course, it is important for the family (for any family, not just for those where there is a disabled child) that the services be concentrated, as much as possible, closer to home: school, clinic, medical recovery services, sports club, children's club, educational or vocational counselling practice etc. But this must not lead to concentrating disabled children in residential centers or services segregated campuses, just because there the specialized services are grouped close by and are thus "more accessible". The support network must be developed in the community, so that the child has multiple and diversified interactions, which help him/her adapt to more diversified contexts.

Moreover, before effectively moving children and young people, the communities must be ready. The activities to prepare the community for each child or young person are mentioned in the Plan for the Future at point VI.

For optimization purposes, the planning of the support services should rather be done at community level (where they will be developed) and not at service level.

(D) For each of the communities where support services / preparatory activities will be developed, the following must be planned ...!

- **Community's name and type**

How many children and young people from the closed institution are planned to be moved in this community.

How many children from other institutions that are being closed in the county are planned to be moved to this community.

Is the community a source community with major child separation risks?

- **The number and types of the new support services in the community**

The name of the new service	Type: 1. DGASPC 2. CL 3. NGO/OPA	In charge	Capacity (maximum no. of beneficiaries per month)	Beneficiaries 1. children in institutions 2. children in the community
Support service 1 ...	...	...	...	...
...				

- **The place and role of these new services in the county/local child protection system**
- **The location, accessibility, facilities that will be offered to children in the new services**
- **Preparatory activities for the community**

	In charge	Human resources	Financial resources	Material resources	Other resources
Activity 1: ...	...	...	...	...	...
...					

- **The number and type of material support for the families**

	In charge	Number of families	List of families (name, address)
Material support type 1: ...	...	...	...
...			

- **Human, financial, material and methodological resources needed per total**

With regards to the human resources, the number of the necessary staff, the position and function will be provided, as well as if there will also be volunteers or not.

The list of equipment, materials and support technologies needed will be included.

- **Potential risks**
- **The completion date for the new services and activities (in order to plan children transition).** *If there will be financing application submitted for these services, it is possible that, depending on the financer, different requirements be imposed.*

Note: The new support services that must be planned according to the score above can be found in the Summary of New Services and Activities (template proposed in Annex 15 of the Model of an individual closure plan).

At this moment, the following are planned, including with regards to the distribution in the territory: new child protection services, new social services, the existing services that will be improved, new services to prevent child separation, new support services and the material support for families, as well as the preparatory activities for the community needed to move children.

Starting from the planning of all new activities and services, an Action Plan will be drafted by identifying (the community) of the assigned responsibility and a related Gantt Graphic.

Checklist!

- **The rules to set up the new services and activities in section 5.1.1 have been respected, so that the new services and activities provided in the closure plan of a residential center do not contribute in any way to deepening the social or spatial segregation not to the extension or consolidation of some communities of beneficiaries of social services or vulnerable people (children and/or adults).**

5.1.2. Planning of staff-related activities

After the planning of the new services is finished, the necessary staff for the operation must also be planned, as well as the activities that will be performed for the staff from the center that becomes available.

During the first stage, an aggregation of all the human resources that are necessary for the development of all the new services, improvement of the existing services and activities for preparing the communities presented in the previous chapter (5.1.1 lists from (A) to (D)) is performed. The result that is obtained represents the necessary staff in order to put into practice the individual closure plan for the center. Since the entire assessment and planning process only took into account the higher interest of the child (as if all the necessary staff existed), it is most likely that the necessary staff differ in a significant manner from the existing staff at the level of the center, as well as at the level of DGASPC. For instance, it is possible that the necessary staff would include a series of specialists (such as specialists in cognitive-behavior therapies) who are not present at the level of the center or at the level of DGASPC. It is also possible that the necessary staff could require a significantly lower number of administrative staff (chefs, doorkeepers, cleaning ladies, drivers etc.) than the existing staff from the center that will be closed. As a result, in order to plan the personnel-related activities:

- ☐ The existing staff that can be transferred to the new services must be selected and the professional training program for the staff must be planned.
- ☐ The necessity to hire new staff must be identified and the selection and training process must be planned.
- ☐ If DGASPC develops two or several individual closure plans, the planning of the activities related to the staff must be coordinated at a county level.
- ☐ When the new personnel structure is established, regardless if the existing staff is employed or the new staff is recruited, an emphasis should not be laid upon the assurance of the administrative tasks and the administrative staff, but rather on the improvement of the employee-children relationship and on the assurance of sufficient specialized staff that can provide quality care services. The support staff – social workers and experienced psychologists – that can handle case management, periodical assessments and identification of measures of social protection in a family type service or in a service that ensures an environment as close as possible to the family one.

The essential element during the selection and training of the staff (old or new) is to implement and to strengthen a new care model that does not assume the institutional practices of “institution”. The closing the residential centers will represent a real success in the deinstitutionalization of children only if the quality of the care services (and not only the care environment) provided by the new services will differ from the old model of institutionalized care, approaching a model that places children in the residential center above all and focuses at the level of the care services on the needs and the desires of the child in all the adopted decisions, including administrative, logistics and legal decisions.

The human resources specialist[76] who is part of the team which develops the individual closure plan is responsible for the selection and the training of the old or new staff.

The selection of the existing staff must be performed through consultation with the employees and with their union or representatives. On the one hand, the selection must be based on competency criteria, taking into account the knowledge, competencies and working style of the employee (as it results from the assessment of the personnel) related to the requirements for the available positions inside the services that will be established or improved. On the other hand, the selection must take into account the options and the future plans of the employees.

From a numerical perspective, it is possible that the staff from the institution about to be closed are sufficient to cover the staff needs of the new services. However, the selection of the existing staff will most likely require decisions concerning:

(i) The need for a higher number of professionals: social workers, psychologists, teachers, therapists (physical therapists, occupational therapists, etc.) for the new services. Some of the positions can be filled in by the existing personnel, after a proper training, while other positions will require a more formal training and the recruitment of professionals.

(ii) The need for a lower number of administrative positions for the new services. On the one hand, some administrative positions are occupied by persons who are willing and capable of moving to a new structure/service, especially as professional foster parents, but also to the new residential services of reduced size (family type cases), as tutors/caregivers. On the other hand, some of the positions classified as administrative or medical – nurses, night caregivers – can be transformed into positions that offer effective care, by means of training and reorganizing the job description so that it would include more care tasks and activities with the children.

(iii) In total, the structure of the staff can be maintained at approximately the same numeric level, aspect that will ease the financial decisions of the County Council.

There is no one size fits all type of process when it comes to the selection of the personnel. The assessment of the staff (Section 4.3.9.B) offers sufficient indicators that can be used during the selection process, from the effects of the institution on the employee up to his competencies, the quality of the interaction with the children or his/her degree and desire for change. Anyway, in the end, several alternatives should be brought into discussion for each employee, according to the model proposed in Box 13, from which the selection team and the employee should agree on the final option.

Box 13: Alternatives proposed for the selection of the existing personnel

		Estimated year/month until when the employee will work for the center	Final option selected	Future need to commute **
1.	Retirement, if possible			
2.	Exit from the protection system and finding a new workplace on their own, after attending re-training or re-skilling courses			
3.	Exit from the protection system and withdrawal to the household			
4.	Transfer inside DGASPC, to other services/ departments than the ones mentioned above			
5.	Transfer inside an existing DGASPC service for adults			

[76] It is preferable that the same specialist would also be part of the training team and the team that implements the individual closure plan for the center.

		Estimated year/month until when the employee will work for the center	Final option selected	Future need to commute **
6.	Transfer inside an existing DGASPC service for children that cannot be improved			
7.	Transfer inside an existing DGASPC service for children that will be improved			
8.	Transfer inside a newly-founded DGASPC service			
9.	Other options, more exactly ...			

Note: *According to the amended Labor Code, Title II Individual Labor Contract, Chapter 5, Section 5, the DGASPC units can lay off at least 30 employees, within a period of 30 calendar days, because of one or several reasons independent from the employee, since the unit has at least 300 registered employees. **The colored cells indicate the options that are not applied to the need to commute.

As an efficient strategy, the distribution of certain employees of the center that do not fit inside the new services to other existing services inside DGASPC is recommended (options 4, 5 and 6 from Box 13).

In parallel, new staff will most likely be necessary. Depending on the existing staff that is selected for the child care services that are about to be improved and for the newly-established services, the necessity and the type of new staff that must be recruited, selected and employed can be determined. Enough time must be assigned for this stage, taking into account the fact that certain categories of personnel, especially AMP and specialists are very hard to find in some counties. DGASPC partners can play a very important role in this matter.

In the end, when the necessary staff (existing and new) is ensured, the training stage can be initiated. The planning of training activities must take into account all the types of staff with specific needs:

(i) the existing staff that must benefit from re-training of re-skilling before leaving the system (option 2 from Box 13);

(ii) the existing staff that will be transferred to other existing services for children or adults, services that will not be improved as part of the individual closure plan for the center (options 4, 5 and 6 from Box 13); and

(iii) the new staff plus the employees from the centers that have been selected to work inside the new services or inside the services that will be improved (options 7 and 8 from Box 13).

The planning of training activities will include information similar to the ones from Annex 20 of the Model of an individual closure plan.

The training program is essential for the removal of the old institutionalized care model from the new services. The employees of the residential centers rarely had the opportunity to attend relevant training courses and when this opportunity arouse, they did not have the chance to apply the acquired information and they were not properly motived. Routine affects the senior personnel, which cannot break this cycle and feels overwhelmed by the number of children and tasks. The new staff quickly loses enthusiasm and adopts the observed practices and the practices that are rewarded. The control is focused on the administrative performance and the files are verified more often than the children. The following items are verified: materials, files, linens, cleanliness, order, weekly menu, quantities of consumables. The children are perceived through their files, which are very thick and often incorrect. Their wellbeing and their development are judged according to how well the staff managed to fill in numerous documents which establish what and how actions must be performed in order for the child to develop properly, case that rarely occurs.

Time and constant effort are needed in order to change such a routine. It is essential to understand the context and the limits imposed for the staff by the institution in order to develop and to implement a training program for the initiation of the change process.

The training of the entire staff within the new services (transferred from the center and newly employed) is important. The staff that is not trained risks to go back to the practices adopted by the institution, cancelling the effects of the movement and the effects of the new services. In any case, a tendency towards relapse will exist, but if there is a training program implemented, these types of tendencies are controllable and reversible. The training, having as basis a complex plan for the current and new personnel, would create a mechanism that allows the transition of the existing staff towards the corresponding positions, but also access to the superior positions (from the training perspective) for the basic staff (nurses, night caregivers, etc.).

It would be ideal if the training is official and recognized, being supplied by an organization or by certified trainers. They will provide a structure that allows the identification of the best solution that answers the training/requalification needs of the current and new personnel. The human resources specialist is responsible for the drafting and the development of the staff's training plans. He/she will also be responsible for identifying the training suppliers/ programmes as well as making sure that the staff attends the training. Subsequently, he/she will develop continuous vocational training plans for the staff of the new services, mainly focusing on the aspects that require up-skilling sessions (such as aspects related to abuse, behavior, development), aligned to the assessment periods for the protection plans.

The training program, especially the one dedicated to the employees of the new services, must lay emphasis upon the relevant professional standards[77] and professional competencies[78]. The professional competencies contain general competencies and specific competencies. The general competencies are the ones referring to the general knowledge and skills required by a professional in order to work with children in a proper manner. For example: (i) children rights and legal provisions, (ii) development of protection plans, (iii) communication with children, (iv) safety and security of children. Specific competencies describe the actual care act, as detailed as possible. The specific competencies represent the knowledge and skills required in order to work efficiently in certain domains or in certain situations with children. They mostly depend on the profile of the children, on their needs and on their development stage. For example: (i) creating a family environment for the child, (ii) maintaining harmonious relationships with the biological family; (iii) developing the social skills of children (iv) development of autonomy, (v) behavior management, (vi) child development. The minimum training curriculum establishes the minimum knowledge and skills that must be acquired by a new employee in order to work efficiently. The examples previously stated can be perceived rather as a guide than as a complete program and the trainers should be encouraged to develop programs on this basis. This minimum curriculum is also useful for additional training, such as re-certification.

The training program that will be planned for all the categories of staff (Annex 20 of the Model of an individual closure plan) should contain several types of training, depending on their needs. While some

[77] Professional standards are not the same as care standards. Professional standards represent the amount of competencies that a person needs in order to fulfill his/her responsibilities in an efficient manner. They describe the steps of a successful task completion (at least at a minimum level of quality and with a certain number of results that must be described as well), but also the knowledge and skills that a person must possess before performing a certain profession. Professional standards are very important for the development of training programs: the competencies they describe should represent the final result of a successful training program (HHC, 2015)

[78] The professional competencies represent the acquired skills possessed by a person in order to fulfill his/her tasks in an efficient and effective manner. They contain key principles for each profession, they establish a quality milestone at the level of the profession and they describe what should and shouldn't be done. To possess professional competencies means to be able to use your acquired or learned skills in various situations and contexts with the purpose of obtaining the results specified in the job description.

employees might need introductory training and basic notions, others will need specialized or continuous training.

Induction training presents benefits for the employees from the institutionalized environment who are ready for the transition to alternative care. The introductory training packages contain pertinent information on institutionalization and its effects, legislation concerning child protection, general principles of the performed activity inside the alternative services, new practices and working procedures. This type of training allows the clarification of the process and the next stages, establishing some expectations that will facilitate the transition towards the new working environment. The courses are adapted to the features of each service. In the case of every new service that will be established after the deinstitutionalization process, an emphasis should be laid upon the practical application of the minimum care standards, the development of procedures, the understanding of the roles and responsibilities of the care staff and the coordination of each service, granting a special attention to the development of the child, the independent life skills and the behavioral support.

An important part of the training process is represented by the practical sessions (which confer profoundness and weight to the theoretical aspects) that offer the professionals the capacity to lead the process further. The team that implements the project will need skills that allow the transmission of new techniques and ideas concerning the case, counseling, behavior and development plan management for children. Solid professional knowledge should be complemented by the capacity to offer supervision and to train trainers.

The introductory training is necessary, but it is not sufficient to remove the old institutionalized care model. For this purpose, the introductory training must be followed by numerous successive monitoring sessions, positive stimulation, supervision and individual support.

Post-movement monitoring[79] represents a service that offers support for the staff with the purpose of ensuring the success of the transition for children. The post-movement period is both important and difficult because it implies the adaption to a completely new environment. In the absence of adequate support, the placement can fail. It is recommended to offer support to the employees for a period of at least 6 months in order to ease the accommodation process and to solve any problem in a timely manner. The child must be at the center of the monitoring process, and the higher interest of the child must represent the first priority for the specialists who monitor the entire process.

The planning of training activities must not be limited to the inductive training and to the post-movement monitoring. During the closure plan, as a support for the new services, a continuous training plan should also be developed along with the adaption of the materials and knowledge to the needs of the employees that must answer to the various and changing needs of the protected children. Certain aspects (such as abuse and behavior, up-skilling courses intended for foster parents) require constant information. Some aspects underwent important modifications inside the more advanced care systems (behavior management, autism, etc.), and the employees must be informed in a timely manner. There are also other topics identified by the employees as relevant for their activity and training packages must be developed for these specific needs as well. The training of the staff of the new services should be performed at least once a year, in compliance with the quality standards in force.

Additional to the training activities, a set of key standards and competencies should be created/developed during the post-training period (at the workplace). They would allow the revision of the progress, the establishment of the performance indicators and the implementation of a control/supervision mechanism focusing more on the performances of the staff in what concerns obtaining of *results for children* than on the administrative results. Along the same lines, the assessment of the staff of the new services should be performed every year by using this set of key

[79]Dărăbuș et al. (2017)

standards and competencies in order to encourage the new working methods and to verify the progress registered in the increase of quality services, as well as to remove the old institutionalized care model.

As last remark, the planning of the activities related to the staff should dedicate enough time for the induction training and selection of the personnel. Otherwise, the process risks to be cumbersome due to the fact that the staff issues will affect the children, the community and the entire transition process. The personnel-related activities are not completed after the induction training, since they must be continued with post-movement monitoring, positive stimulation, continuous training, individual support, specialization along with the development of services, respectively with the supervision and annual assessment performed on the basis of a set of key standards and competencies. All the activities must be stated in the closure plan of the center and they must be financed in a proper manner.

In the end, the Action Plan and the Gantt Chart built with all the new services and activities must be supplemented with personnel-related activities.

Checklist!

- **Allstaff that is affected by the closing of the center benefited from training programs according to their decided future option (see Annex 20 of the Model of an individual closure plan).**
- **All the employees of the new services and, if applicable, the employees of the services that will be improved benefited from the induction training followed by post-movement monitoring, individual support, carried out on a regular basis through continuous training, specialization and assessment of performance, during the entire implementation period for the closure plan.**

5.1.3. The manner in which the buildings and other resources that become available will be used

The team that develops the project in collaboration with the Director of DGASPC must analyze the alternatives related to the use of the buildings, lands and other resources for the development of other social services.[80] For example, a day care/service center can be established, as well as a counseling center, recovery center/service, community center for integrated services, social homes for young people who leave the protection system or families with low income and a many children, administrative office for mobile teams etc. Briefly, the resources can be used, depending on the specific conditions, for various services for children or adults, with a pertinent justification.

[80] The data concerning buildings, lands and infrastructure that should be analyzed includes: Positioning of the institution (accessibility, the position of the center as compared to other services from the community); Lands of the center that are registered in the patrimony of GDCPSA, the County Council, the local councils or any other public authorities (total number of buildings inside the center, number of buildings inside which the children are accommodated, age of the buildings where the children are accommodated, if the building was restructured and/or modulated and the year when it was restructured, as well as if the building is organized on modules or not, the condition of the building(s) in which the children are accommodated); Infrastructure of the center (number of bedrooms, number of beds and maximum number of children per room, facilities for spending free time and their endowments, condition of the toilets, kitchen and dining rooms, the extent to which all of them are adapted to the needs and ages of the children inside the institution).

The only condition imposed is that residential services for children will not be established under any circumstances. The only exception that is allowed refers to the small individual buildings that allow the establishment of maximum two apartments with maximum 16 children/young people. The exception is not applied for the centers that are composed of several small buildings in the same yard, since the respective yard would become a "nest" of apartments.

In case the functional state of the building is very poor/damaged and requires large investments for the necessary repairs or rehabilitations in order to make the building safe and usable, the option to demolish the building can be taken into consideration.

If the resources of the institution become available and they are not used by DGASPC, the future use of the building will be mentioned (or the future use of the land, in case the demolition of the building is decided). In the case of transfer or lease, the contract will contain a clause through which the future user is not allowed to establish or to perform residential services for children within the building.

Every decision concerning the building or the lands must be included in a decision of the County Council/Local Council.

Checklist!

- **No residential services for children are established inside the building(s) of the center that will be closed.**

5.1.4. Potential risks: Identification and prevention, reduction or elimination methods

This section brings into discussion the aspects that might lead to delays in the implementation of the individual closure plan for the center and/or to the non-fulfillment of the proposed objectives. The main objective is to prevent, reduce or eliminate the negative aspects that might endanger the successful implementation of the individual closure plan due to the deinstitutionalization process applied to children.

It is not realistic to assert that the closure process will be a smooth one. Most probably, in most of the cases, all kind of delays will be registered, the solutions for some children or young persons will have to be revised not only once, but several times, the change of the care model will require a lot of time and it is possible that some of the employees might not adapt. Also, a press case might occur and radically change the position of the County Council or of certain local councils. The exclusion culture is so deeply rooted in many communities that the movement of the children might not be successful, despite of all the efforts.

Closing a residential center for children requires a realistic analysis of the risks that might occur during the implementation and might considerably reduce the achievement of the planned results. The risks can be of various types and can cover the social context inside which the child protection system operates, the protection system itself, DGASPC, the institution, the technical aspects that relate to the manner in which the construction or the training contracts are performed, the financing risks or the natural risks. For this reason, we encourage DGASPC units that close residentialcenters to perform a complex and careful analysis of the potential risks before starting the implementation process, so that the closing plan also contains prevention, reduction or elimination measures for the identified risks.

Examples of potential risks are presented below.

(A) Structural risks

- ☐ Legal changes that might influence the implementation of the project, including changes related to the educational system, the health system, the public administration system etc.
- ☐ Reduced degree of accessibility to the public area, as well as to the information and communication environment for persons with disabilities
- ☐ Stigmatizing attitude from the community in relationship to certain specific groups (children with disabilities, parents with social problems, ethnical minorities, etc.)
- ☐ Reintegration of the children inside families might not be sustainable, due to reasons such as: family (natural, extended, substitute) loses the income sources, family loses home after a fire, family decides to leave abroad

(B) Institutional risks

- ☐ Insufficient collaboration between sectors or authorities during the implementation of the project
- ☐ Limited capacity of active discovery of health risks among the community children and a limited offer of preventive services
- ☐ Reduced capacity of assuring the case quality management and other alternative services
- ☐ Staff and/or children that oppose to the closing of the center
- ☐ Recruitment of certain types of specialists is not possible
- ☐ Employment and/or training of the staff is not performed in due time

(C) Technical risks

- ☐ Delays of the new constructions in the execution phase or a weak quality of these works that might result in non-fulfillment of the services established in the children's Plans for the future and young people inside the center at the required quality standards

(D) Financial risks

- ☐ Incorrect estimation of the budget in the funding request stage
- ☐ Lack of the necessary co-financing
- ☐ Absence of rigorous estimations concerning the costs implied by the alternative services from the local authorities

(E) Natural risks (for example, seismic risk or other natural hazards).

For each potential risk identified, the team that develops the closure plan should: (i) evaluate the probability of the plan to manifest, (ii) explain how the respective risk can affect the closing of the center and the results of this process, (iii) present the prevention, reduction or elimination modalities.

Checklist!

- **The Action Plan and the related Gantt Chart contain all the prevention, mitigation or elimination measures for the identified risks.**

5.2. Objectives and financing of the closure plan

Once the assessment is performed and the new services and activities that must be developed have been established and planned, the objectives of the individual closure plan can be established and the financing sources can be identified. The funding applications can be initialized. These topics are presented in the following two sections.

5.2.1. Establishment of the objectives for the individual closure plan

The general objective answers the following question: "*what expectations do we have by performing this project?*". The general objective refers to the final impact of the project ("*end of the road*") and does not include details concerning the manner in which the objective will be achieved or concrete information on the manner in which the objective will be accomplished.[81] As a result, the finality of the performed actions for the closing of a residentialcenter for children is represented by **the assurance of the wellbeing of the child and by the identification of the best alternatives that allow the complete and harmonious development of the child.**

One or several specific objectives correspond to a general objective. The specific objectives represent directions that will lead to the results necessary for the achievement of the general objective. The specific objectives must be of SMART (specific, measurable, achievable, relevant and time-based)[82]. The specific objectives must be established in a solid manner based on the information and data resulting from the assessment of the children and the families, as well as based on the already existing services and resources. Thus, we recommend that when setting the objectives the following aspects should be taken into account:

- ☐ What residential services (CTF, apartments) will be developed for the children in the residentialcenter that will be closed
- ☐ What family services will be developed for the children in the residential center that will be closed
- ☐ What social services will be developed for the children in the residential center that will be closed
- ☐ What support services and other types of support should be provided to the families in order to (re)integrate in a sustainable manner the children from the residential center that will be closed
- ☐ What services to prevent the separation of the child from the family will be developed and where (in what communities) in order to reduce the future requests for care inside the public system
- ☐ What institutional mechanisms must be developed in order to ensure the post-institutionalization monitoring and the assessment of the children and the family, as well as the newly established services

If one or several financing applications are submitted for the individual closure plan of a center, a selection of the relevant specific objectives must be performed for each application.

[81] In formulating the general objective, you must take into account the fact that it must be short because in most funding applications the corresponding section allows a maximum number of 50 words.
[82] In formulating the specific objectives, you must take into account the fact that they must be short because in most funding applications the corresponding section allows a maximum number of 150 words.

Attention!

- **One or several funding applications for European funds or other funds can correspond to an individual closure plan of a center.**
- **For the funding applications, the formulation of both the general objective and the specific objectives will also take into account the specific objectives of the financing body[83] and the instructions from the Applicant's Guide.**

5.2.2. Identification of the financing possibilities and funding applications

Concerning the modality to finance a closing procedure for a residential center, during the first stage, the documentation concerning the following aspects is necessary:

a) What funds are already available?

b) What other funds will become available when the center will be closed?

c) What funds are necessary and what are their sources?

d) Does the situation of double financing costs appear?

It is important to mention the fact that, on a short term, there is the situation of "parallel costs" or double costs, generated on the one hand by the operation of the institution that is subject to the closing procedure and on the other hand by the costs related to the development and operation of the newly established services. This parallel financing of the two structures must be accepted and the necessary amounts must be secured.

Besides the parallel costs, there are costs related to the capital investment and they refer to those initial development costs for new services that do not exist at the level of the community.

The easiest way to decide on the necessary funding applications is to set a table with all the planned activities that will be performed for the founding and operation of the new services (registered in the Summary of new services and activities at the level of the center)[84] and the possible financing sources for which these activities would be eligible, based on the template from Annex23 of the Model of an individual closure plan.

For this purpose, each new service must be organized on expense categories: infrastructure, facilities, salaries, operation costs, equipment, materials and assistive technologies, induction training. These different expense categories can have various financing sources. Moreover, the establishment of the expenses must be performed during the entire period of the closure plan for the center. While some expenses only occur once, others represent monthly expenses (such as operating expenses) or annual (such as continuous training expenses).

The activity list for the closure plan must be mandatorily complemented with the mutual learning activities, exchange of good practices, dissemination of results, monitoring and evaluation, which will be developed in detail only at the beginning of the implementation phase, after the communication specialist and the assessment specialist are employed and trained. Thus, there is a risk that these activities will not be properly funded.

[83] For example, in the case of European funds, the specific objectives of the Priority Axis from ROP and/or OPHC will be taken into consideration.
[84] Model proposed in Annex 15 of the Model of an individual closure plan.

The list of activities organized on types of expenses must be correlated with the related Action Plan and Gantt Chart.

Having as basis the list of activities organized on types of expenses, the total budget for the closure plan can be established. All the expenses included in the total budget must be justified and detailed properly, from the perspective of the calculation algorithm. They must be reported to the activities for which they were intended. The estimation of the costs must be realistic and based on evidence. For example, the supporting documents concerning the proof for real estate market research, in the case of acquisition of houses or apartments or the assessment of the costs, in case of construction of buildings; list of facilities for acquisition of goods; structure of the staff inside the services that will be created and level of salaries; training cost per trained person etc.

Once the available financing sources were identified and the costs were estimated, the funding applications that will be filled in can be decided. In the case of each financing application, the eligible activities are selected, the application partners are designated and the relevant information is extracted from the closure plan. Then, the requested budget represents the sum of estimated costs for the selected activities from the closure plan, activities that are included in the financing application. The requested budget must be distributed both on types of activities and on application partners, but each sponsor has specific requirements for the calculation, presentation and budget justification mode.

Checklist!

- **The total budget of the individual closure plan is realistic, but it contains all the necessary activities for succeeding in the deinstitutionalization of the children, more exactly for moving all the children and young people in optimal conditions from the center to the new care environments that are as close as possible to the family environment.**
- **The funding applications for all the available sources were completed and submitted in order to assure the support of the new services and activities through multiple financing mechanisms.**

6. IMPLEMENTATION PHASE OF THE INDIVIDUAL CLOSURE PLAN

During the implementation phase, we proceed to the effective application of the closure plan, as scheduled in chapter 5. The implementation phase is extremely complex because the care of the children remained in the center must be assured in complete safety and security conditions, in parallel with the construction of new structures and with the development of new services. If several funding applications were submitted for the closure plan, it is possible that the answers will arrive in a staggered manner and that the financial resources will become available at another pace than the one stated in the plan. Thus, the Action Plan and the Gantt Chart will have to be adjusted in compliance with the availability of the resources. Then, the surveillance of the performance of new constructions must be assured, in parallel with the preparation process for the transition of the children and the personnel. At the same time, the recruitment of new employees and the training of the entire staff commence. Some of the new services will become available before the constructions are finalized, while others can be developed only afterwards. In the end, during the next stages, we have to organize the effective movement, the implementation of the post-movement monitoring and, subsequently, the assurance of the operation of all the new services at the quality standards, as well as the monitoring and evaluation activities.

For this reason, at the beginning of the implementation phase, another adjustment of the team is performed. Up to this phase, a team responsible for developing the plan was necessary, being followed by a team responsible for setting/writing the plan. For the implementation, some professionals who attended the development and/or the setting of the plan can remain inside the team (for example, the project manager, the financial manager, the case manager who coordinated the assessment of the children, families and communities, the human resources specialist, the principal psychologist) and the monitoring and evaluation specialist must mandatorily join the team. Depending on the case, a communication specialist will also be part of the implementation team.[85]

The team responsible with the implementation of the individual closure plan for a residential center must have a global image of the closure process and must assure the coordination between the various teams and the various partners that are involved. The team responsible with the implementation of the individual closure plan for a residentialcenter must not overlap perfectly with the team or teams designated in the funding applications. This overlap can be partial or total, depending on the specific conditions from each county and on the specific requirements of the sponsors. The same thing applies to the partners. Each funding application can have specific partner groups, depending on the involved activities. Coordination is mostly necessary in the counties where DGASPC sets two or several individual closing plans and registers several funding applications with various partners for each plan.

In order for the implementation team to operate in a proper manner, the responsibilities and tasks for each family member (Job Description) should be defined, as well as the clear instruments and working procedures inside and outside the team (communication, reporting, evaluation, planning, etc.).

The implementation stages are the ones already planned in the Action Plan and the Gantt Chart, made available by the development team (Chapter 5). In any case, some new services or activities do not require additional financial resources, while others cannot be initiated until the approval for the

[85] Very necessary in the counties that close two or several residential centers, so they have to manage several individual closing plans in a coordinated manner and/or the counties where the resistance to change is considered a risk.

funding applications is obtained. These answers can be staggered, aspect that might lead to the need of adjusting the initial plans. After the necessary adjustments are performed, the implementation stages will have some time coordinates on which the organization of all the future activities will be based. On the one hand, after obtaining the funds, the public procurement activities, as well as the construction, equipment and substantiation activities of the new services will follow the established calendar. On the other hand, the transition of the children and the selected staff towards the new services must be prepared and, subsequently, performed under conditions that assure the wellbeing of the children and the reduction of traumas. These aspects will be discussed in the following sections.

6.1. Transition of the children: Preparation

Approximately 45% of the children from residential centers[86] have in their institutional history two or several movements from one service to another and this aspect has negative effects on their confidence and on their self-esteem. Moreover, less than 40% of the children from residential centers had a single case manager during the period spent within the system.[87] Approximately 30% had 3-9 case managers. For this reason, there are few cases in which the case managers represent attachment or trustworthy persons for the children and the young people inside the residential centers in Romania.

Besides, the trust of children in adults is reduced because their life changes seemed to have occurred without any explanation. These children often feel insecure. Change is difficult for everybody, especially for children, but if the reasons that led to the change are understood and the advantages of the change can be demonstrated, it is easier to accept the change. Despite the fact that children are usually looking forward to change, there are often elements in the new situation that might present adaption difficulties for children. Also, the child might develop feelings of loss in relation to the familiar elements from the past.[88] The loss of the attachment figure plays a major impact on the subsequent development of the personality of the child.[89]

When children are not explained the events that are about to come, the trauma significantly amplifies. For this reason, children must receive as much information as possible related to the imminent movement and they must be involved to a certain extent in the preparation process for the movement. In short, the movement preparation refers to the understanding of the movement process, both by the children and by the staff members, so that the movement is accepted and understood easily and the change is perceived through its positive aspects. Thus, the trauma is reduced.[90]

The preparation of the children for the movement must be performed by a team of specialists and must be coordinated by the psychologist, who will collaborate with the staff of the residential center and with their case managers.

The best method to prepare the child/young person for the movement is to develop an Individual Preparation Program suited to his/her needs and to his/her individual situation. The proposed model for the Individual Preparation Program can be found in AnnexA Instrument 12. The multidisciplinary assessment of the child/young person supplies all the necessary information for this purpose.[91] The Individual Preparation Program must be discussed with the child/young person, depending on his/her age and development level, as well as with his/her family. Moreover, an estimated date of the

[86] Children and young people from all the residentialcenters in the country on October 31, 2016.
[87] World Bank (2017b)
[88] Mulheir and Browne (2007)
[89] Muntean (2013)
[90] Dărăbuș et al. (2017)
[91] Specific information concerning any types of special needs for the child (medical, therapeutic, educational, behavioral), family circumstances and the desire of the parents/relatives of the child, information on the desires of the child, affiliation to a group of brothers and/or to a group of friends inside the residential center.

movement is necessary in order not to start the preparation program too early or too late. In case the movement of the children is performed in a small group home (CTF), the preparation program must take into account the date when the house will be ready and equipped.[92]

Ideally, the groups of brothers and the groups of friends will be placed together and will benefit from a common movement preparation.

The Individual Preparation Program for the movement has three main objectives:

- ☐ Establishing a relationship with adults based on trust, through:
    - consistency and purposefulness during the preparation process
    - active involvement of the child in the preparation process and in the decisions related to the movement
    - post-movement support.
- ☐ Recovery of the development delays and reduction of unwanted behaviors, to the possible extent, through:
    - individualized recovery plans
    - behavior programs.
- ☐ Familiarization of the child to the new context, through:
    - gradual introduction of the child in the family or in the new environment
    - in the case of a movement to CTF, visiting the new location and involvement of the child in selections that can be managed easily (furniture, colors, location of personal objects, etc.)
    - gradual accommodation of the child/young person to the persons who will take care of him/her
    - accommodation of the child/young person to the persons who are new in his/her life and assurance of access to education, health, recovery services etc.

The NGOs[93] with experience in the deinstitutionalization of children have developed various innovative instruments that can be used for the preparation of the movement. Among them, we would like to mention "the book of life" (the life story written with the child/young person), "the life road" or "working with the mirror", methods that help children of all ages construct self-esteem, develop a sense of identity and history, understand and conceptualize the past, present and future, foresee the next movement as part of a continuous changing process inside their life, make plans concerning the new placement and make their own choices.

The movement preparation program contains a behavior management element and an element that supports the moral development of the child/young person. For this reason, the preparation program must also contain a clear set of interaction rules both for children/young persons and for the involved personnel. The transmission and the assimilation of these basic rules are very important for the success of the transition. The interaction rules are the ones that can transform group work into teamwork, making the process a positive experience for all the people involved. For this purpose, it is

[92] As planned in the draft corresponding to Section 11.1.1 for each of the new services and activities stated in the Summary proposed in Annex 15 of the Model of an individual closure plan.
[93] For example, LUMOS (2015), Dărăbuș et al. (2017).

essential not only to introduce rules, but also to present them in a positive manner. Any discipline or control problem must be based on positive encouragement and on joint responsibility.[94] As a result, it is recommended that the interaction rules:[95] (i) are simple and easy to follow, (ii) are communicated in an adequate manner, (iii) refer to positive actions rather than to prohibited actions, (iv) offer rewards for positive behavior instead of applying punishments for difficult behavior.

Especially in the case of children with special needs, it is important that the preparation programs are developed according to their level of knowledge and to their preferred communication method. A simple presentation of the process is not enough to help them understand the new experiences they are about to face. However, it is important to understand the fact that any child can take part in the movement process, no matter how severe his disability is and irrelevant of the development problem that he faces.

In parallel with the preparation of the children, the preparation of the new life environments must also be performed: family (natural, extended, substitutive, including AMP), community and/or the staff that will ensure the care of the child inside the new residential services. It is important that the persons who will be responsible for taking care of the children attend the Individual Preparation Program of the children.

Checklist!

- **All the children and young people from the nominal list attended an Individual Preparation Program for movement (template proposed in Annex A Instrument 12) that is attached to the case file.**
- **The groups of brothers and the groups of friends have been placed together and benefited from a common training for movement. If not, a justification must exist and it must be attached to the file of the children/young people.**
- **Along the entire closing process of the center, if the opinion of the child or the young person differs from the assessment performed by the specialists, it is the responsibility of the adults to find an alternative solution agreed by the child or by the young person.**

6.2. Transition of the children: Effective movement

Once the new life environment (family, AMP, CTF etc.) and the child are prepared for the transition, the effective movement can be organized. Inside the effective movement process:

- ☐ It is essential that the person who moves the children is a person well known by the child and the child should have already seen the house/place where he/she will move, according to the movement preparation plan.

[94] Otherwise, the vicious circle of prohibition rules that are respected by children/young people only for the fear of not being grounded, rules that are imposed without explanations and without being understood, cannot be broken.
[95] Dărăbuș et al. (2017)

- It is recommended for the persons who will take the children into care and who attended the Individual Preparation Program of the child to get involved in the effective movement of the child. If the new caregiver did not attend the preparation program of the child, then the specialists (one or several) inside the preparation team must also be involved in the movement process and they must be available to spend several hours inside the house in order to help the respective child calm down.

- The new caregiver should, within the limit of the possibilities, make sure that the family routine before the placement (such as dinner time, bed time) is respected, at least for a period of time. As the child becomes familiar to the new placement, the daily program can be modified so that it responds to the needs of the child.

- The child can be helped in performing the movement by involving the transition object inside the process. For example, plans can be set for the movement of the teddy bear into the new house and the child can be encouraged to "take care of the teddy bear, because he is afraid of the movement". Once the child has moved, the transition object acts as a link between the old placement and the current placement, helping the child feel that he was not completely "separated" from the past.

- The most important factor that will ensure the success of the movement project is that the movement is positive for the child. Although the life of the child is improved as a result of the movement process, he/she will pass through a difficult process of learning new rules, knowing a less familiar place and new people. Thus, the child can miss various things and/or people (for example, friends).

- The families or the teams CTF must be prepared for cases in which the children or the young people with disabilities wish to come back (even temporary) to the institution. This process must be performed with patience and it must be adapted to the rhythm of the child. The transition project must be planned in a flexible manner and it must be focused on the rhythm of the child, who will fit easier in a place where he is received with love, warmth and respect, a place with activities and opportunities that interest the child and present pleasure for him.

Post-movement support is essential for the success of the new placement. The team of specialists (coordinated by the principal psychologist) that took part in the movement preparations should be involved in the post-movement process as well, through regular visits and continuous involvement in the life of the child.[96] The visits can be reduced as the child becomes more attached to the new caregiver. The frequency of the visits can be reduced according to the individual needs of each child, but also to the needs of the new caregivers. Once the specialists are certain of the fact that the respective child feels safe and that the caregivers are certain of their role, the visits can be reduced to a monthly basis. It is essential for both caregivers and child to know and that they can contact the specialists inside the preparation team for support whenever necessary. Moreover, as children grow and develop, new problems occur and the caregivers might need guidance, in case of unexpected changes in the behavior of the child. These regular visits can be used by the team of specialists for the assessment of the development of the child and of the level of attachment towards the caregiver so that the new placement is efficient.

The post-movement support must be registered in a Report based on the template proposed in AnnexA Instrument 13. The post-movement support must be correlated to the post-movement monitoring that is recommended for a period of at least 6 months in order to ease the accommodation process and to solve any problem in a prompt manner. The child must be placed inside the center during the entire support and monitoring process and the superior interest of the child must represent the first priority.

[96] The team should collaborate closely with the case manager of the child, who will take over the monitoring of the progress registered by the child after the intensive post-movement period is finished.

As the movement process is performed, a situation can be reached in which the center still operates and generates costs, having a very small number of Beneficiaries. The most exposed persons to such a risk are the children with special needs, especially the bedridden children. Often, the lack of stimulation and the lack of attachment lead to autistic tendencies, including stereotypical behaviors, such as auto-aggression or aggression. Their needs are extremely complex and these children need long periods of therapy and recovery before the initiation of the movement process.

The assumption of the closure process for aresidential center also implies the assumption of the fact that the institution will not be closed, even if a single child remains inside the institution. Moreover, the child will not be moved until the mostproper plan for the respective child is found and until the movement is in the benefit of the child.

Checklist!

- **All the children and the young people from the nominal list were moved in optimal conditions and the ones remaining in the center were provided care services in a safe and secure manner, without rushing the movement due to cost-efficiency and/or administrative reasons.**
- **All the children and the young people from the nominal list received post-movement support that was registered in a Report based on the template proposed in Annex A Instrument 13, which is attached to the case file.**

6.3. Transition of the selected personnel: Preparation and effective movement

The existing staff from the center has a few months at its disposal in order to prepare the children and at the same time get ready for exiting the system or being transferred to the new workplace within DGASPC. During this period, the staff must be supported in order to understand the process and to take part in all the tasks that must be fulfilled. The Employees must fulfill their old responsibilities and they must learn the basics of the new position, in case they are selected. The time of the staff must be managed carefully and a step-by-step process must be implemented in order to apply the new requirements, in compliance with the new care framework for children, also making sure that the care services for the children are performed in a safe and secure manner.

The transition of the staff represents a problem due to various reasons.[97] One of these reasons is represented by the fact that this process is not performed at the same time for everybody. At a certain point, some employees will have already worked inside the new services, while others will continue their activity inside the institution. In this case, rumors and suspicions might be generated. The employees within the institution can consider that they are left behind and that no available positions will remain for them. During this stage, it is important for the new structure of the positions to be reconfirmed and for the training program to be continued in a step-by-step manner, adopting an open attitude in relationship to the duration of the process.

The movement of the staff must be performed on a step-by-step basis, depending on the movement of the children from the institution. It is vital for the transition process to be closely monitored by the team responsible for the implementation of the closure plan. The planning must be carefully respected and the implementation team should intervene and perform the necessary changes in order to make sure that there are no delays and that there is a clear training plan for the staff subject to the transition.

[97] Mulheir et al. (2004)

7. THREE ESSENTIAL ELEMENTS FOR A SUCCESSFUL DEINSTITUTIONALIZATION

There are several mechanisms that must be operational since the initial implementation stages until the actual closure of the center, in order to ensure the success of the child's deinstitutionalization. They refer to mutual learning, sharing of best practices and the dissemination of results, up to ensuring the sustainability and the monitoring and evaluation system. This chapter is dedicated to the three mechanisms.

7.1. Mutual learning, sharing best practices and disseminatingresults

Network cooperation and collaboration must represent continuous work activities within the child de-institutionalization reforms. In the preparation phase of closure plans, communication and exchange of ideas between DGASPCs should be intensified to ensure consistency in the way closing down of residentialcenters is addressed.

In the development and implementation phases network cooperation and collaboration activities should be funded, DGASPCs being encouraged to organize various study exchanges, such as field visits in the country (in other counties) or abroad.

A series of regional workshops or workshops by type of center could be beneficial (for example, challenges and possible solutions for closing down centers for children with severe disabilities or solutions for de-institutionalization of teenagers with behavioral disorders, etc.). All DGASPCs that close down residential centers (especially those funded by European funds) should be required to participate in such workshops, where each DGASPC should make case presentations to receive feedback and ideas from colleagues. The participation of NGOs with experience in child protection (such as those in the DGASPC Monitoring Committee) would add value. It is only through direct and constant interaction with various partners that the current fragmentation between counties can be reduced in terms of approaching de-institutionalization of children.

All DGASPCs in the country (whether or not having residential centers) should be encouraged to create on their web pages a sheet dedicated to the de-institutionalization of children in order to share with others their experience. DGASPCs that close down residential centers can display individual closure plans, activities and goals, photos, documenting changes in communities where they are involved, success stories, failures, and lessons learned.

The continued dissemination of the results obtained by children and youngsters in the new services created in the community or in those where they are transferred after the closure of the institution is essential[98]. These services do not have "a life of their own", isolated from the rest of the community, but are part of the community and bring benefits to the community (by creating jobs, generating social cohesion, providing space for civic involvement and volunteering, etc.). It is important that the need for these services be well understood by community members for a local community to progressively invest in support services for children and youngsters. They must directly perceive the added value of the newly created services for their community.

[98] See also Section 4.1.3.

The communication specialist in the closure plan implementation team would have the primary role in communicating with local communities. He/she could provide support to local councils in formulating specific communication strategies and plans to advertise[99] these services, which could include, for example:

- ☐ Display of new services in the mayoralty current communication channels (website, local newspaper, local TV station, quarterly magazine, city mayoralty notice, posters, at the neighborhood school included, etc.). It will always insist on the benefit of the new service for the entire community, not just for children or youngsters who are direct beneficiaries.
- ☐ Inviting the professionals or beneficiaries of the new services to activities organized by the mayoralty in various professional or social contexts.
- ☐ Printing informative brochures about new services available to local citizens, at PSSA or schools, family doctor's offices, churches, etc.
- ☐ Open Day events in the newly-created services in the community.

The better known the service in the district or in the immediate vicinity, but also at local level, its acceptance and support by both the citizens and the local council will be greater.

On the other hand, it is the communication specialists that should identify and document examples of good practice or innovative solutions as well as of possible failures that can be communicated and disseminated on the national online platform to the benefit of all those interested. Thus, the communication specialist would be primarily responsible for the visibility of DGASPC activities and results in children's de-institutionalization.

Checklist!

- **All DGASPCs that close residential centers properly ensure the visibility of the activities and the results of the implementation plan.**

[99] The child protection measures as public or subject in the audiovisual programs and the observance of the legal measures for protecting minors are permanently monitored by the National Audiovisual Council (NAC). The failure to observe these measures for the protection the minors shall be sanctioned after the programs are broadcasted. NAC ensures the observance of the child's higher interest, the observance of the right of the child to express himself/herself, the observance of the child's right to a private life. The normative acts which are relevant for children's rights in the field of audiovisual are the following: UN Convention on the rights of the child, Directive of the Audiovisual Media Services, Audiovisual Law no. 504/2002, subsequently amended and supplemented, the NAC Decision no. 220 of February 24, 2011 regarding the Code for regulating the audiovisual content.

7.2. Sustainability

An individual closure plan for a residentialcenter is successful in terms of child deinstitutionalization if the services, activities and practices developed within the project continue after the funding has been discontinued.

The European[100] study on the transition from residential care to community care for persons with disabilities has highlighted several principles that prove to be relevant for all types of residential structure reforms in terms of transition costs and of sustainability of new community services. It is important to consider them, because they reflect lessons learned during institutional transformation processes in many European countries.

First Lesson Learned: New services need to be sustained in the medium and long term through multiple funding mechanisms, and especially the services created in the community and the already existing ones, becoming accessible to children and youngsters when moving them to the community. As a first step, the existing services will need to be provided with additional funds to succeed in incorporating the problems of new beneficiaries, to the appropriate quality standards (to this purpose subsidies, dedicated funds or grants, amounts of the "money follows the beneficiary" type etc.). As a later stage, the support for these services as well as for the newly created services should be directed (progressively or staggered) to local authorities, but they should also be duplicated by the possibility of allocating clear amounts by type of activity or thematic micro-grants, indirect funding (tax deductions, utility costs, etc.), donations from natural persons or legal entities.

Detailed analyses of costs in the new services will be carried out annually and taking over of costs by local budgets will be planned in advance, possibly by adopting a measure of progressive increase of the contribution from the local budget, for a period of 3-5 years.

Second Lesson Learned: Transition costs are high and, most of the time, they involve duplicated funding of old and new services. That is why, most of the time, states are helped by international funds or dedicated investments to organize well a deinstitutionalization process that is so complex. However, once the transition has been completed, local communities must be carefully monitored and supported (partially or fully) by the state budget for an agreed period of time so that the services created locally be not at risk of underfunding or degradation/closure.

Third Lesson Learned: Funding mechanisms of the "money follows the beneficiary" type have good chances for long-term sustainability. But once this form of funds transfer from the institution to the local community has been decided, the charging of all services provided to the child and his/her family, or that of the small group home type services, should be reviewed periodically. Depending on the local context, the initial cost for each child may decrease or increase. They are influenced, for example, by the distance to the closest recovery services, by the existence or absence of community mobile teams of intervention and support, by the way the family copes with the return of the child, etc. We must also not forget that the needs of each child change over time, and the cost of the services required in the years following the move may increase in turn.

The de-institutionalization process success lies in permanently adapting the support services to the needs of the child and the family. A rigid administrative approach to the cost of these services per beneficiary without careful consideration of the used cost standards may sometimes compromise the entire effort of moving the child into the community.

Fourth Lesson Learned: Measures to be taken into account for the long-term sustainability of community services are not just financial. They concern continuous improvement of service quality, investment in staff continuous training, attracting qualified staff and volunteers (where necessary),

[100] Mansell et.al (2007)

investment in technologies, and innovative ways of working, assistive equipment. An effective policy in this regard can often lead to long-term savings in terms of the current running costs of a community service.

The main problem of sustainability therefore arises in many European countries, not only in Romania, mainly in relation to services developed in the community. But deinstitutionalization involves precisely moving from care in institutions (whether of small dimensions, such as CTFs) to community care. Therefore, the focus is on developing services preventing child separation from family, community and support services.

Accordingly, increased attention should be paid to the budgets of municipalities, towns and communes in Romania. At present, the territorial administrative units do not receive from the state budget amounts dedicated to the development of social services but must cover these costs from their own budgets. As their own budgets are often insufficient, the additional financial pressure by the newly created services without effective support from the county council or the state budget can lead to a rapid withdrawal of local council support as soon as the deinstitutionalization project is finalized[101]. Therefore, ensuring the sustainability of services developed in the community poses a risk to most communities in Romania, especially in rural and small urban areas.

In view of the above, the individual closure plan should include a sustainability section specifying the modality of financial self-sustaining after the termination of external funding for each newly established service[102] is no longer available (especially for community support services but not limited to) according to the template proposed in Annex17 of the Model of an individual closure plan.

Checklist!

- **All the newly established services, and particularly the community support services, from the Summary of new services and activities at the center-level are being analyzed on sustainability, on the proposed model Annex17 of of the Model of an individual closure plan.**

[101] The case of homes for the elderly, established consequently to the dismantling of some sanitary units, shall be analyzed, for preventive purposes, within the National Interest Program (NIP) approved by GD no.212/2011. The long-term sustainability of some of these homes was significantly jeopardized by the lack of careful local budget planning prior to the closure of NIP projects.

[102] The list of new services in the Summary of new services and activities at the level of the center (template proposed in Annex 15 of the Model of an individual closure plan).

7.3. Monitoring and Evaluation (M&E)

Monitoring and evaluation are activities that in any process of change provide indications on the accomplished progress, on what is operational, what is not operational and why. Therefore, they must be continuous activities since the early phases of implementation of the individual closure plan of the center.

The child must be placed at the core of the monitoring and evaluation process, and the child's best interest must be the first priority for specialists who monitor and evaluate the whole process.

The following sections deal with monitoring children's progress, monitoring new services, and evaluating the impact of the closure plan. Monitoring of financial aspects is not addressed in this Methodology, since, as a rule, it is part of the current DGASPC activity, and differs from one donor to another and does not pose any particular problems.

7.3.1. Monitoring children's progress

Monitoring the progress of children is the sixth stage of case management. Monitoring is therefore a current activity of the case managers for all the children in the protection system, which is well regulated by several normative acts (Box 14).

Box 14: Monitoring children with various placement solutions/measures, according to the regulations in force

In the case of placement, the case manager monitors the Individual Protection Plan (IPP), verifies the start and supply of services or actions included in the Specific Intervention Programs (SIP), maintains permanent contact with the various SIP responsible persons, reacts to any problem, ensures the information flow within the team or between the team and the child/family/person responsible for the child. For this purpose, the case manager uses the standard Monitoring Report tool displayed in Appendix no. 1 of the Order no. 1733/2015 on the approval of the Procedure establishing and paying the monthly placement allowance.

With the end of the special protection measure by reintegrating the child into his/her family, the tasks related to the follow-up of the development of the child, as well as the way the parents exercise their rights and fulfill their obligations regarding the child, are the task of the public social service (PSSA) organized at the level of the municipalities and towns or of the persons with social assistance duties in the specialized apparatus of the mayor, respectively DGASPC for the sectors of the municipality of Bucharest, for their domicile or, as the case may be, for the parents' residence. Reintegration monitoring should be done on a monthly basis for a minimum of 6 months, and the observations should be made using the Child Situation Record Sheet, displayed in Appendix no. 1 of Order no. 286/2006 on the approval of the Methodological Norms regarding the elaboration of the Service Plan and the Methodological Norms regarding the elaboration of the Individualized Protection Plan. The benefits and services necessary for the child and his/her family to support reintegration are contained in the Service Plan, a document prepared by the PSSA Case Prevention Officer.

Monitoring children registered with a degree of disability that are included in a habilitation-rehabilitation plan (HRP) is performed with the purpose to verify the accomplishment of the plan objectives, to identify difficulties to implement the plan and to find remedies, so that the child benefits of an optimum habilitation-rehabilitation. The monitoring of the plan is ensured by the case manager for both children who will continue to benefit from a foster care measure, as well as for children reintegrated into the family, and the mayoralty at home does not yet have a PSSA. If there is a PSSA, then the monitoring of the habilitation-rehabilitation plan of the child reintegrated in the family is carried out by the PSSA Prevention Officer.

For school/vocational oriented schoolchildren for whom an individualized service plan has been approved, monitoring is accomplished by the psycho-educational services case manager.

The Monitoring Report form for children in families, classified as disabled and/or school-oriented, is provided in Appendix no. 17 of Order no.1985/1305/5805/2016. For children who continue to benefit from a placement measure, use the standard tool of the Monitoring Report displayed in Appendix no. 1 of Order no. 1733/2015

regarding the approval of the Procedure establishing and paying of the monthly placement allowance, which is supplemented with the specific aspects of the habilitation-rehabilitation objectives.

Individual monitoring reports must include information on the progress of the child's situation - progress, stagnation, regression, and are made quarterly for children in public care, or whenever they find it difficult to implement the plan.

The post-service monitoring in view of the cessation of the special protection measure is carried out by the PSSA preventive case officer for a period of 3 months after the child's exit from public care, based on a monitoring plan developed by the case manager in consultation with the PSSA prevention case officer, the involved professionals, the parents/legal representative (legal guardian) and the child. In the post-service monitoring process, the PSSA prevention officer checks the quality of the child's social integration and collaborates with the members of the consultative structures of the community the child lives with the family. Along the post-service monitoring, the PSSA prevention officer conducts at least one visit to the child's home and prepares the parents/legal representative and the child to close the case from the special protection perspective.

For the adopted child, post-adoption monitoring is carried out by the person responsible for the child from the adoption/post-adoption department for a minimum of 2 years.

In the case of socio-professional integration of young people, the monitoring will be carried out for a period of at least 6 months.

However, a minimum of 6 months of intensive monitoring is required within the individual closure plan of a residential center. Post-movement monitoring[103] is correlated with post-movement support to ease the process of adaptation and resolving any problems in a timely manner and the results should be recorded in a Report according to the model proposed in AnnexA Instrument 13. In other words, post-movement has primarily an educational and support role for the child/young person and the family or caretakers.

Just like in the post-movement support, the team of specialists, coordinated by the principal psychologist who participated in the preparation of the move, should also be involved in post-movement through regular visits and continuous involvement in the child's life. The team should work closely with the child's case manager who will take over the child's progress monitoring after the post-movement intensive monitoring period has ended. Visits can be reduced as the child becomes more and more attached to the new caregivers. The frequency of visits can be reduced according to the individual needs of each child, but also according to the needs of new caregivers. Once specialists are confident that the child feels safe and caregivers are sure of their role, visits can be reduced monthly. At the same time, monitoring activities can return to the standard timetable provided by the current regulations, this being mainly the task of the child's case manager.

Post-movement monitoring represents the process of continuous verification of the progress made in implementing the Plan for the Future[104] and the progress made by the child in the new living environment. Despite the need to deinstitutionalize children, highlighted by numerous national and international studies, there is still little research evidence to display only positive effects of such a process on the subsequent course of the child or young person. Practices show that there are many situations where services or measures taken in the community (placement to foster parents or Family-type homes) can generate as many child deprivation and marginalization situations. This happens when family or CTF practices reproduce the old institutionalized care model (lack of control and autonomy of children, lack of personal choices, avoidance of failures and daily success, poor communication between adults and children, etc.). Monitoring is intended to identify early and take corrective action in such situations.

[103] Also see sections 11.1.2 și 12.1.

[104] We would like to remind that the Plan for the Future of a child/young person is correlated with the Individualized Protection Plan (IPP) and with the Specific Intervention Programs (SIP) within IPP, and, as the case may be, the Habilitation-Rehabilitation Plan (HRP) and the Individualized Service Plan (ISP)

Post-movement monitoring is a service that provides support, not one meant to control the child's placement. The period immediately following the move is important and difficult at the same time, as it involves adaptation to a totally new environment. For visits to the child's new living environment it is very important to regularly observe and record the child's progress/situation. It is necessary to verify the extent to which the child has adapted in the new environment, if the child's attachment relationship has been established in the foster family or in the small group home/apartment, otherwise, if there is no change for the better in the child the change of intervention may be decided. Although the preparation of the child's movement has been done in detail, it is unlikely that all the measures identified for the institutionalized children to be successful, given the consequences of previous separation traumas that can make some of the children distrust the change for the better or the creation of new attachment relationships.

Therefore, monitoring the progress of children/youngsters must cover all areas: health, nutrition, recovery, developmental delays, education, life skills, social, emotional development, self-esteem, behavior, family and community participation, living conditions. However, key indicators[105] include: severe and persistent health problems, isolation, lack of participation, and the presence of negative reactions that may indicate that a child is struggling with the new situation, is not comfortable and has difficulty in adapting.

In the case when the monitoring system discovers that the situation of the child does not improve, corrective measures must be taken immediately and the plan for the future of the respective child must be adjusted accordingly.

In order to ensure that children's moving is beneficial, especially for 0-3 year old, re-evaluation is essential along the implementation of the closure plan to determine progress in recovery, compensation and education. Re-evaluation should be done by reference to the objectives set up following the initial/previous evaluation. The re-evaluation takes place whenever necessary, according to the evolution of the child's situation, but it is recommended to be done for a maximum of 3 months because these children are progressing rapidly, with the specification that the periods for acquiring specific abilities (motor, cognitive, behavioral, relational, etc.) may sometimes be longer or it could be necessary to insist on insufficiently stabilized progress. The re-evaluation must be followed by the change of the child's Plan for the Future.

Monitoring and evaluating children's progress is often based on objective (factual), measurable indicators, are result-oriented (*outcome*). These indicators are necessary, but not sufficient. The way children themselves perceive or appreciate the quality of their own lives is equally important. Subjective indicator monitoring is generally considered "weak" or "doubtful", as opinions may change radically over time. Moreover, the ability of children to appreciate the quality of their own lives has often been questioned. It was assumed that, on the one hand, adults know well what is good for the child, and on the other hand, they have gone through their own childhood and "can put themselves in the child's shoes" when defining the criteria for childhood well-being and quality of life. These premises do not take into account the fact that our societies are constantly changing and our subjective perceptions about "quality of life" may differ from one generation to the next.

Therefore, the real and active participation of children and youngsters in the post-movement monitoring process is essential.

Box 15: Examples of subjective indicators that capture the views of children about the quality of their own lives

1. Does the child feel safe? *[never/most of the time/always]*

2. Does the child feel well cared for? *[never/most of the time/always]*

[105] Mulheir and Browne (2013)

3. Does the child feel that adults consider him/her important? *[never/ most of the time/always]*

4. Does the child feel like he/she has a say in it? *[never/ most of the time/always]*

5. Does the child have responsibilities? [*yes/no*]

6. Suppose this scale is a representation of your life. The tip of the ladder is the best possible life for you, and the base of the ladder is the worst possible life for you. Please indicate on the scale where you are right now, marking the appropriate circle.

7. How did the child/young person feel last week? [never/one day/some days/most of the days/every day]

a. He/she was happy

b. He/she was sad

c. He/she liked school

d. He/she was full of energy

e. He/she didn't have who to play with

f. He/she was tired

g. He/she didn't sleep well, he/she kept waking up during the night

h. We spent time with the family and friends

i. He/she was satisfied by his/her own person

8. The general level of happiness. On the following scale from 1 - very unhappy to 5 - very happy with your own life (friends, family, school), please indicate where you are right now?

We consider it important that the whole monitoring process be a participatory one and include also the children's views alongside the objective indicators. And here we do not just refer to the post-movement period. Children's opinions should be added also to the standard visits after the intensive monitoring period alongside the tools currently provided in the specific child protection legislation. Examples of such subjective indicators that can reflect the children's views are provided for in Box 15.

7.3.2. Monitoring the performance of the newly established services

The first monitoring indicator for the newly established services checks whether all children and young people in the nominal list benefit from all the services recommended in their Plans for the Future[106]. As the Plans for the Future are adjusted according to the way children adapt (or not) in the new living environment, it may be necessary to adjust the Summary[107] of the new services and activities at the center level. By default, changes to the Action Plan, to the Gantt chart, and to the total budget of the individual closure plan may be necessary. If the multidisciplinary evaluation of children and youngsters was correctly carried out and service planning relied on it then deviations are expected not to significantly affect the budget and not to cause major delays.

[106] Annex A Instrument 11.
[107] Annex 15 of the Model of an individual closure plan.

In order to monitor the performance of the newly established services, it is first necessary to carefully check the compliance with the minimum quality standards for each type of service. However, because often the minimum quality standards are not met, for whatever reason, we recommend applying a methodology similar to that used in this report to measure the quality of services (the care environment and the care quality).[108] We also consider it essential that service performance monitoring includes also measuring the level of children's/young people's satisfaction with their lives in the new living environment as well as measuring the level of job satisfaction among the staff.

Checklist!

- **The entire monitoring process is a participatory one that takes into account the children's/young people's and staff's views.**

7.3.3. Evaluation of the closure plan of the center

The individual closure plan of a center should plan and budget, from the very drafting phase, an impact assessment study for a five year-period from the start of implementation.

Ideally, in order to measure the impact on the level of children's and youngsters' development, after five years it would be necessary to repeat the multidisciplinary assessment carried out for the preparation of the individual closure plan[109]. Such an assessment of all children and youngsters in the nominal list would be much easier to do if all the recommendations in this Methodology were followed and the progress of children and young people would have been registered (and annexed to the case file, even if it is officially shut down) throughout the implementation period.

Regarding the newly established services, a research carried out by a research company/institute or by an NGO or a DGASPC in another county with the view to assess to what extent the old model of institutional care has been eliminated (or not) and to what extent staff are affected by institutionalization (or not).

Finally, with regard to communities where prevention and support services have been developed, especially in source communities, the impact should be measured, in particular, on reducing (or not) the number of child protection entries/returns. At the same time, the rate of survival of the services set up in the community and their sustainability should be analyzed. Such a study should be complemented by field research in these communities conducted by a research company/institute, both at the level of households with children in care (regarding, for example, parenting practices, disciplinary methods, etc.) and at level of authorities (to investigate attitudes and actions that address the management and development of social services, especially those dedicated to children).

[108] Service quality is a result of the care environment and care quality. The care environment is organized in four dimensions: (i) isolation, segregation; (ii) infrastructure; (iii) children's health and safety; (iv) staff. The care quality considers the following three dimensions: (i) child development services and activities; (ii) interaction between children and caregivers; (iii) implementation of minimum quality standards and case management. See World Bank (2017b).

[109] The Concluding Report for each child should be reworked for each in order to compare the 2017 situation with the 2022 situation.

Checklist!

- As early as the drafting phase, an impact study, five years after the start of the implementation of the closure plan is planned and budgeted to cover the impact on the development of children and youngsters in the nominal list, the impact on the care model of the new services and the impact at the level of the communities, especially with regard to preventing the separation of the child from the family.

- All the children and youngsters in the nominal list were monitored along the project period and their situation was assessed at the end of the project.

REFERENCES

1. ANPDCA - Autoritatea Națională pentru Protecția Drepturilor Copilului și Adopție (2014) *Strategia națională pentru protecția și promovarea drepturilor copilului 2014-2020*. Available at: http://www.mmuncii.ro/j33/index.php/ro/transparenta/proiecte-in-dezbatere/3172-2014-02-03-proiecthg-strategiecopii
2. Banca Mondială (2016) *Supplemental Concept Note Romania*, Reimbursable Advisory Services (RAS) on Development of Plans for De-Institutionalization of Children Deprived of Parental Care and their Transfer to Community-Based Care.
3. Banca Mondială (2017a) *Output #1: Descriptive Report on the Evaluation of the Existing Resources of Residential Centers*, February 2017, Reimbursable Advisory Services (RAS) on Development of Plans for De-Institutionalization of Children Deprived of Parental Care and their Transfer to Community-Based Care.
4. World Bank (2017b) *Output #2: Operational Plan for the Closing of Residential Centers*, May 2017.
5. Browne, K. (2009) *The Risk of Harm to Young Children in Institutional Care*, London: Save the Children. Available at: http://www.savethechildren.org.uk/sites/default/files/docs/The_Risk_of_Harm_1.pdf
6. Comisia Europeană (2013) *2013/112/UE: Recomandarea Comisiei din 20 februarie 2013 Investiția în copii: ruperea cercului vicios al defavorizării*. Available at: http://eur-lex.europa.eu/legal-content/RO/TXT/PDF/?uri=CELEX:32013H0112&from=RO
7. Dărăbuș St., Pop, D., Stegeran, B. and Tohătan, R. (2017) *Închiderea instituțiilor pentru copii. Intervenție, implementare și plan de acțiune*, HHC Romania Printing House. Available at:https://childhub.org/ro/biblioteca-online-protectia-copilului/studiu-hhc-inchiderea-institutiilor-pentru-copii-interventie.
8. EEG - European Expert Group on the Transition from Institutional to Community-based Care (2012) *Common European Guidelines on the Transition from Institutional to Community-based Care*. Bruxelles. Available at:http://www.deinstitutionalisationguide.eu/
9. Ghebuță, A.,Tuduri, R.,Apreutesei, M. and Ifrim, R. (2009) *Ghid de bune practici pentru integrarea socială și profesională a tinerilor (post)instituționalizați*, Fundația Cote. Iași: Casa de editură Venus. Available at:http://www.abilitatideviata.ro/upload/pag_pdf36.pdf
10. HHC - Hope and Homes for Children (2015) *Developing Foster Care*. Training guide for Tabasco State.
11. HHC România - Hope and Homes for Children (2012) *Audit of Social Services for Children in Romania. Executive Report*, HHC Romania Printing House. Available at:http://www.hhc.ro/fisiere/centrumedia_fisiere/Raport-Executiv_Auditul-Serviciilor-Sociale-pentru-Copii-din-Romania_-2012.pdf
12. HHC România - Hope and Homes for Children și Salvați Copiii (2006) *Manual de proceduri privind inserția socio-profesională a tinerilor care părăsesc sistemul de protecție a copilului*, Publicație a Grupului la Nivel Înalt pentru Copiii României și a Autorității Naționale pentru Protecția Drepturilor Copilului, realizat cu sprijinul Agenției pentru Strategii Guvernamentale, Baia Mare: Editura EuroPrint. Available at: http://hhc.ro/fisiere/centrumedia_fisiere/Manual_de_proceduri_privind_reinsertia_socio-profesionala_a_tinerilor_care_parasesc_sistemul_de_protectie_a_copilului_.pdf
13. Hospice Casa Speranței and Institutul pentru Politici Publice (2011) *Standarde de calitate pentru îngrijirea paliativă. La domiciliu, în unitățile cu paturi și ambulatoriu*, Cu sprijinul Open Society Institute New York , în cadrul Programului de Sănătate publică (2008-2009). Brașov. Available at: http://www.studiipaliative.ro/wp-content/uploads/2013/09/Standarde-de-calitate-pentru-ingrijirea-plaitaiva.pdf
14. IMAS (2004) *Reformarea sistemului de protecție a copilului din România*, Raport ANPCA și UNICEF.
15. Johnson, R., Browne, K. and Hamilton-Giachritsis, C. (2006) "Young children in institutional care at risk of harm", in *Trauma Violence Abuse*, Jan:7(1), pp. 34-60. Available at: http://journals.sagepub.com/doi/abs/10.1177/1524838005283696?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&
16. LUMOS (2015) *Moving to My New Home*, Available at: https://wearelumos.org/content/moving-my-new-home-1
17. Mansell, J., Knapp, M., Beadle-Brown, J. and Beecham, J. (2007) *Deinstitutionalisation and community living - outcomes and costs: report of a European Study. Volumul 2: Main Report*. Canterbury: Tizard Centre, University of Kent. Available at:

https://www.kent.ac.uk/tizard/research/DECL_network/documents/DECLOC_Volume_2_Report_for_Web.pdf

18. MMFPSPV - Ministerul Muncii, Familiei, Protecției Sociale și Persoanelor Vârstnice și DGPC - Direcția Generală de Protecția Copilului (2011), *Buletin Statistic din 31 decembrie 2011*.
19. Mulheir, G., Wilson, B., Pop, D.M., Dărăbuș, Șt., Misca, G. and Browne, K. (2004) *DE-INSTITUTIONALISATION OF CHILDREN'S SERVICES IN ROMANIA: A GOOD PRACTICE GUIDE*, UNICEF Report August 2004. Available at: http://www.hopeandhomes.org/wp-content/uploads/2016/12/Deinstitutionalisation-of-Childrens-Services-in-Romania-2004.pdf
20. Mulheir, G. and Browne, K. (2007) *De-institutionalizing and transforming children's services. A guide to good practice*. Birmingham: University of Birmingham.
21. Mulheir, G. and Browne, K. (2013) *De-institutionalising and transforming children's services: A guide to good practice*, European Union Daphne Programme NGO Working Group on Children without Parental Care.
22. Muntean, A. (2013) *Atașamentul și adopția copiilor separați de părinții biologici*. Iași: Polirom.
23. Salvați Copiii (2008) *RAPORT ALTERNATIV La cel de-al treilea și al patrulea Raport periodic înaintat de România Comitetului ONU pentru Drepturile Copilului 2003-2007*, București: Organizația Salvați Copiii. Available at: http://salvaticopiii.ro/upload/p0001000400010001_Raport_Alternativ_SCR_RO.pdf
24. Stănculescu, M. S. and Marin, M. (2012) *Helping the invisible children.Evaluation Report*. UNICEF, București: Vanemonde. Available at: http://www.unicef.org/romania/Raport_HIC_engleza.pdf
25. Stănculescu, M.S., Grigoraș, V., Teșliuc, E. and Pop, V. (coord.) (2016) *România: Copiii din sistemul de protecție a copilului*. București: Editura Alpha MDN. Available at: http://www.unicef.ro/wp-content/uploads/Copiii-din-sistemul-de-protectie-a-copilului_UNICEF_ANPDCA_BM_2016.pdf
26. Tobis, D. (2000) *Moving from Residential Institutions to Community Based Social Services in Central and Eastern Europe and the Former Soviet Union*. Washington: The World Bank. Available at: http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172671461088/MovingFromResTobis.pdf
27. UNICEF and RENINCO (2003) *Set de instrumente, probe și teste pentru evaluarea educațională a copiilor cu dizabilități*. București: Editura MarLink. Available at: http://primaria-cernavoda.ro/Fisiere/Anunturi/Resurse%20Umane/Set%20de%20instrumente,%20probe%20si%20teste%20pentru%20evaluarea%20educationala%20a%20copiilor%20cu%20dizabilitati.pdf
28. UN - United Nations (2010) *Guidelines for the Alternative Care of Children*. Available at: http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf

ANNEX A: INSTRUMENTS FOR THE CLOSURE PLAN

Instrument 1: Synthetic Form with Key Information

NR. CHEST ☐

CODCP. Placement center code ☐

A2A. Placement center name _____

QK1A. Child surname _____

QK1B. Child first name _____

QK2. Child date of birth: ☐☐☐☐☐☐☐☐

D D M M Y Y Y Y

QK3A. Child PIN ☐☐☐☐☐☐☐☐☐☐☐☐☐

QK3B. Child's PIN presents errors? ☐(1) Yes ☐(2) No

QK4. Child gender ☐(1) Male ☐(2) Female

QK5. Child ethnicity

☐(1) Romanian

☐(2) Hungarian

☐(3) Roma

☐(4) Other

☐(9) Undeclared or does not know

QK7. Child citizenship _____

QK8. Child's community of origin (parents actual residence)

a. Country (acronyms): _____

b. County (acronyms): _____

C. Locality (TAU): _____

SIRSUPM: SIRSUP Code: _____

	d. Village _____ *Attention! There are villages also in towns/cities* _____ SIRINFM: SIRINF Code _____ ☐(-1) Domicile is not known

QM1. Mother's situation	☐(1) Person present in the family ☐(2) Personworking abroad ☐(3) Person left for studies or work in the country ☐(4) Person in the hospital for a short term period ☐(5) Person in the hospital for a long term period ☐(6) Personin a residential service ☐(7) Personwho is homeless ☐(8) Personwho is in prison ☐(9) Nor specified/not known ☐(10) Divorced/separated person ☐(14) Deceased person ☐(15) Dissapeared person ☐(16) Unknown person ☐(17) Other situation than the above
QM1alta. Other situation than the above, namely…	_____
QM2. Is the mother in one of the following situations…	☐(11) Person deprived of the exercise of parental rights ☐(12) Person to whom the penalty of the prohibition of rights was applied ☐(13) Person under judicial interdiction ☐(14) In none of the situations

IF QM1<14 or QM1=15 or QM1=17	
MAMA. Mother's name and surname	_____
CNP_MAMA. PIN mother ☐(9)Don't know	☐☐☐☐☐☐☐☐☐☐☐☐☐
KCSM2. Actual residence of the mother	a. Country (acronyms): _____ b. County (acronyms): _____

C. Locality (TAU):	
SIRSUPM: SIRSUP Code:	
d. Village *Attention! There are villages also in towns/cities*	
SIRINFM: SIRINF Code	
☐(-1) Domicile is not known	

QT1. Father's situation

☐(1) Person present in the family
☐(2) Person working abroad
☐(3) Person left for studies or work in the country
☐(4) Person in the hospital for a short term period
☐(5) Person in the hospital for a long term period
☐(6) Personin a residential service
☐(7) Person who is homeless
☐(8) Person who is in prison
☐(9) Nor specified/not known
☐(10) Divorced/separated person
☐(14) Deceased person
☐(15) Dissapeared person
☐(16) Unknown person
☐(17) Other situation than the above

QT1alta. Other situation than the above, namely… _____

QT2. Is the father in one of the following situations …

☐(11) Person deprived of the exercise of parental rights
☐(12) Person to whom the penalty of the prohibition of rights was applied
☐(13) Person under judicial interdiction
☐(14) In none of the situations

IF QT1<14 or QT1=15 or QT1=17

TATA. Father's name and surname _____

CNP_TATA. PIN father

☐(9)Don't know

KCST2. Actual residence of the father	a. Country (acronyms): _____ b. County (acronyms): _____ C. Locality (TAU): _____ SIRSUPM: SIRSUP Code: _____ d. Village *Attention! There are villages also in towns/cities* _____ SIRINFM: SIRINF Code _____ ☐(-1) Domicile is not known

REPREZ. Who is the child's legal representative?

☐(1) Mother/ father/ parents
☐(2) DGASPC Director
☐(3) County Council President
☐(4) Himself/herself (child 18 and over, with judgment)
☐(5) Parental rights suspended, awaiting a court decision
☐(6) Another situation, namely: ……

IF REPREZ<5 or REPREZ>5

ACT1. According to decision regarding legal representative no.... _____

ACT2. Released by … _____

DATA_IN_SP. The date of the last (most recent) actual entry in public care

D	D	M	M	Y	Y	Y	Y

CAUZE. What were the causes for the child and family separation?

MULTIPLE ANSWER

☐(1) Death of one or both parents
☐(2) Parent(s) in detention
☐(3) Mother/ parents institutionalized
☐(4) Deprivation of parental rights
☐(5) Child neglect
☐(6) Child abuse
☐(7) Child exploitation
☐(8) Parent(s) are abroad
☐(9) Disorganized families (families in which one or several of the following events occur: divorce, separation, infidelity, parents' lack

of interest towards the children, one parent abandons the family, the father does not recognize the child, out-of-wedlock pregnancy)

☐(10) Teenage mother/ parents

☐(11) Parents' alcohol and/or substance abuse

☐(12) Parents' promiscuous and/or criminal behavior

☐(13) Family violence

☐(14) Parents with disabilities and/or mental problems

☐(15) Child abandoned in the maternity and/or another medical center

☐(16) Children with disabilities, SEN or behavioral disorders

☐(17) Poverty

☐(18) Improper housing, no stable home, vagrancy

☐(19) Absence of education services suitable for the child, in the community

☐(20) Absence of medical, recovery/rehabilitation services, in the community

☐(21) Other causes, namely…

CAUZE_alta. Another cause, namely … _____

PRINC_CAUZ. Of the above mentioned, which was the main cause of the child's entry into the protection system? ☐

WRITE THE CORRESPONDING CODE→

COPIL_MP. Does the child have a special protection measure at moment T0?

☐(1) Yes, in this PC

☐(2) Yes, but not in this PC

☐(3) No

COPIL_PREZ. Is the child present in the center at moment T0? ☐(1)Yes ☐(2) No

If COPIL_MP=1 and COPIL_PREZ=2

COPIL_PLECAT. Where is the child?

☐(1) He is temporarily absent leaving for studies (in the country or abroad)

☐(2) He is temporarily absent being left to treatment (in the country or abroad)

☐(3) He is temporarily missing being fled from the center

☐(4) He is temporarily missing being gone due to other situations

COPIL_PLECAT_alta. Other situations, namely… _____

If (COPIL_MP=2 or COPIL_MP=3) and COPIL_PREZ=2

MOTIV. The reason why the child is in the placement center _____

If COPIL_MP=1 or COPIL_PREZ=1

DATA_IN_CP. The date of the last (most recent) actual entry in this placement center

D	D	M	M	Y	Y	Y	Y	

MANAGER_CAZ. Name and surname of the case manager _____

COPIL_HANDICAP. Does the child have a disability qualification certificate? ☐(1) Yes ☐(2) No

If Yes

COPIL_GRAD. What is the disability level?

☐(1) Mild ☐(2) Medium ☐(3) Accentuated ☐(4) Severe

COPIL_TIP. What is the disability type?

☐(1) Physical ☐(3) Hearing ☐(5) Somatic ☐(7) Psychic ☐(9) Associated

☐(2) Visual ☐(4) Deafblindness ☐(6) Mental ☐(8) HIV/AIDS ☐(10) Rare diseases

COPIL_IMOB_PAT. Is the child immobilized in bed? ☐(1) Yes ☐(2) No

COPIL_CES. Does the child have SEN? ☐(1) Yes ☐(2) No

A1N. Surname of person responsible for completing the questionnaire _____

A1P. First name of person responsible for completing the questionnaire _____

A1F. Position of person responsible for completing the questionnaire _____

Instrument 2: Medical Record of the Child/ Young Person in Public Care

1. DATA ON THE CHILD/ YOUNG PERSON

Name: _____ **First name:** _____

Gender ☐(1) Male ☐(2) Female

Date of birth DD MM YYYY

DATA_IN_SP. The date of the last (most recent) actual entry in public care

D	D	M	M	Y	Y	Y	Y

COPIL_HANDICAP. Does the child have a disability qualification certificate? ☐(1) Yes ☐(2) No

If Yes

COPIL_GRAD. What is the disability level?

☐(1) Mild ☐(2) Medium ☐(3) Accentuated ☐(4) Severe

COPIL_TIP. What is the disability type?

☐(1) Physical ☐(3) Hearing ☐(5) Somatic ☐(7) Psychic ☐(9) Associated

☐(2) Visual ☐(4) Deafblindness ☐(6) Mental ☐(8) HIV/AIDS ☐(10) Rare diseases

2. GENERAL INFORMATION

2.1. Weight at birth (in grams)
COMPULSORY FOR CHILDREN OF <=5 YEARS _____

2.2. Length at birth (in cm)
COMPULSORY FOR CHILDREN OF <=5 YEARS _____

2.3. Current weight (in kg) _____

2.4. Current length (in cm) _____

2.5. Deficiencies or congenital malformations

2.6. Current diagnosis

IF THE CHILD HAS DISABILITIES AND/ OR SPECIAL EDUCATIONAL NEEDS, ACCORDING TO ANNEX 7 OF ORDINANCE NO. 1985/1305/5805/2016, THE FULL DIAGNOSIS IS NOTED,AS FORMULATED ON THE BASIS OF THE ANNUAL PHYSICAL EXAM AND CURRENT MEDICAL CERTIFICATES

2.7a. Treatments recommended by the family doctor and followed by the child at present

2.7b. Treatments recommended by specialist doctors and followed by the child at present

IF THE CHILD HAS DISABILITIES AND/ OR SPECIAL EDUCATIONAL NEEDS, ACCORDING TO ANNEX 7 OF ORDINANCE NO. 1985/1305/5805/2016

2.8 Anamnesis (the pathological and heredocolateral histories, in short)

IF THE CHILD HAS DISABILITIES AND/ OR SPECIAL EDUCATIONAL NEEDS, ACCORDING TO ANNEX 7 OF ORDINANCE NO. 1985/1305/5805/2016

2.9 Clinical exam (in short)

4. What childhood diseases did the child have?

1. Measles ..... ☐(1)
2. Chicken pox/varicella ..... ☐(1)
3. Scarlet fever ..... ☐(1)
4. Mumps ..... ☐(1)
5. Rubella ..... ☐(1)
6. Others, specify ..... ☐(1)

5. Vaccinations:

Age	**Vaccine**	Yes	No	Don't know
0-24 hours of life	Hepatitis B – Vaccination against Hepatitis B (in maternity)	☐(1)	☐(0)	☐(9)
1-7 days	BCG vaccine type Calmette Guerin - administered in the maternity	☐(1)	☐(0)	☐(9)
2 months	Hexavalent diphtheria-tetanus-pertussis-acellular-poliomyelitis-hemolytic B Hepatitis B vaccine (DTPa-VPI-Hib-Hep B)	☐(1)	☐(0)	☐(9)
2 months	Conjugated pneumococcal vaccine – administered by the family doctor	☐(1)	☐(0)	☐(9)
4 months	Hexavalent diphtheria-tetanus-pertussis-acellular-poliomyelitis-hemolytic B Hepatitis B vaccine (DTPa-VPI-Hib-Hep B)	☐(1)	☐(0)	☐(9)
4 months	Conjugated pneumococcal vaccine – administered by the family doctor	☐(1)	☐(0)	☐(9)
11 months	Hexavalent diphtheria-tetanus-pertussis-acellular-poliomyelitis-hemolytic B Hepatitis B vaccine (DTPa-VPI-Hib-Hep B)	☐(1)	☐(0)	☐(9)

Age	Vaccine	Yes	No	Don't know
11 months	Conjugated pneumococcal vaccine - administered by the family doctor	☐(1)	☐(0)	☐(9)
12 months	Measles-Mumps-Rubella (MMR) - administered by the family doctor	☐(1)	☐(0)	☐(9)
5 years	Measles-Mumps-Rubella (MMR) - administered by the family doctor (second dose)	☐(1)	☐(0)	☐(9)
6 years	Tetravalent diphtheria-tetanus-pertussis-acellular-poliomyelitis (DTPa-VPI) / inactivated poliovirus vaccine (VPI) - administered by the family doctor	☐(1)	☐(0)	☐(9)
14 years	Diftero-tetanic vaccine for adults / diphtheria-tetanus-pertussis acellular vaccine – is administered by the family doctor	☐(1)	☐(0)	☐(9)

9. How many chronic diseases does the child suffer from?
FILL IN THE NUMBER OF CHRONIC DISEASES WHICH HAVE BEEN DIAGNOSED →

IF THE NUMBER OF DISEASES >0 LIST THEM ALL IN THE TABLE BELOW AND CHECK THE CURRENT STAGE OF THE DISEASE FOR EACH!

10A. NAME OF THE DISEASE	10B. CURRENT STAGE OF THE DISEASE			
	Initial	Evolutive	Stabilized	Terminal
1.	☐(1)	☐(2)	☐(3)	☐(4)
2.	☐(1)	☐(2)	☐(3)	☐(4)
3.	☐(1)	☐(2)	☐(3)	☐(4)
4.	☐(1)	☐(2)	☐(3)	☐(4)
5.	☐(1)	☐(2)	☐(3)	☐(4)
6.	☐(1)	☐(2)	☐(3)	☐(4)
7.	☐(1)	☐(2)	☐(3)	☐(4)

11. Is the child…
☐(1) …movable?
☐(2) …not movable?
☐(3) …in need of specialized transportation?

12. Does the child have health issues which…	Yes	No
1. … put his/her life in danger?	☐(1)	☐(0)
2. … requires the existence of a nearby hospital?	☐(1)	☐(0)
3. …requires frequent assessments, investigations or medical examinations?	☐(1)	☐(0)

ANSWER TO 13 IF THE CHILD REQUIRES FREQUENT ASSESSMENTS, INVESTIGATIONS OR MEDICAL EXAMINATIONS

13. At what time interval does the child have to be evaluated/ investigated?

14a. Does the neuropsychometric development of the child/young person correspond to his/her age? ☐(1) Yes ☐(0) No ☐(9) Don't know

IF NO AT 14A
14b. Which are the poorly developed areas or where the child registers a delay?

15. Nutrition disorders (diet, allergies, intolerances etc.)

15a. Does the child have a special diet? ☐(1) Yes ☐(0) No ☐(9 Don't know

IF YES AT 15A

15b. What diet?

_____

15c. How many types of allergies does the child have? ☐ ☐(0) None ☐(9) Don't know

IF THE ANSWER TO 15C IS DIFFERENT FROM NONE OR DON'T KNOW, ENUMERATE THE TYPES OF ALLERGIES

15d. Type of allergy

1. _____
2. _____
3. _____

15e. How many intolerances does the child have? ☐ ☐(0) None ☐(9) Don't know

IF THE ANSWER TO 15E IS DIFFERENT FROM NONE OR DON'T KNOW, ENUMERATE THE INTOLERANCES

15f. Intolerances

1. _____
2. _____
3. _____

16. Dental problems

16a. Does the child have dental problems? ☐(1) Yes ☐(0) No ☐(9) Don't know

IF YES AT 16A

16b. Which dental problems?

_____

16c. Does the child wear a dental retainer? ☐(1) Yes ☐(0) No ☐(9) Don't know

17. Ophthalmic problems

17a. Does the child have ophthalmic problems? ☐(1) Yes ☐(0) No ☐(9) Don't know

IF YES AT 17A

17b. Which ophthalmic problems?

_____

17c. Does the child wear glasses? ☐(1) Yes ☐(0) No ☐(9) Don't know

18. Hearing deficiencies

18a. Does the child have hearing deficiencies? ☐(1) Yes ☐(0) No ☐(9) Don't know

IF YES AT 18A

18b. Which hearing deficiencies?

_____

18c. Does the child have a hearing aid? ☐(1) Yes ☐(0) No ☐(9) Don't know

19. MEDICAL HISTORY FOR THE PAST 12 MONTHS

Tick each (type) of disease that the child suffered from in the past 12 months and fill in the treatment received in the last columns

	19a. Diseases that the child suffered from in the past 12 months	Yes	No	Don't know	19b. Treatment		
					CODE 1	CODE 2	CODE 3
1.	Childhood diseases	☐(1)	☐(0)	☐(9)			
2.	Hepatitis	☐(1)	☐(0)	☐(9)			
3.	Rheumatism	☐(1)	☐(0)	☐(9)			
4.	Epileptic seizures	☐(1)	☐(0)	☐(9)			
5.	Pertussis	☐(1)	☐(0)	☐(9)			
6.	Dysentery	☐(1)	☐(0)	☐(9)			
7.	Endocrine diseases	☐(1)	☐(0)	☐(9)			
8.	Diseases of the blood, lymphatic system or immune system	☐(1)	☐(0)	☐(9)			
9.	Diseases of the cardiovascular system.....	☐(1)	☐(0)	☐(9)			
10.	Diseases of the respiratory system.....	☐(1)	☐(0)	☐(9)			
11.	Diseases of the digestive system	☐(1)	☐(0)	☐(9)			
12.	Diseases of the genitourinary system	☐(1)	☐(0)	☐(9)			
13.	Depression	☐(1)	☐(0)	☐(9)			
14.	Oligophrenia	☐(1)	☐(0)	☐(9)			
15.	Schizophrenia	☐(1)	☐(0)	☐(9)			
16.	Other diseases of the nervous system	☐(1)	☐(0)	☐(9)			
17.	Diseases of the skin	☐(1)	☐(0)	☐(9)			
18.	Psychiatric disorders	☐(1)	☐(0)	☐(9)			
19.	Cancer.....	☐(1)	☐(0)	☐(9)			
20.	TB	☐(1)	☐(0)	☐(9)			
21.	Other, specify:	☐(1)	☐(0)	☐(9)			
22.	Other, specify:	☐(1)	☐(0)	☐(9)			
23.	Other, specify:	☐(1)	☐(0)	☐(9)			

TREATMENT CODES FOR 19B

0. None
1. Medical teatment
2. Neuro-motor recovery
3. Surgery
4. Orthopedic
6. Psychotherapy
7. Psychological recovery
8. Ophthalmology
9. Audiology
10. O.R.L.
12. Physiotherapy
13. Endocrinology
14. Gastroenterology
15. Neurology
16. Other (specify, which)

19c. What was the overall result of the recommended and followed treatments? (including compliance with treatment, child and family satisfaction, family reasons when the recommended treatment was not followed, etc.)

19d. Has the child suffered from any transmissible disease? ☐(1) Yes ☐(0) No ☐(9) Don't know

IF YES AT 19D

19e. What diseases?

1. _____
2. _____
3. _____

19f. Has the children had any biological testing in the past 12 months? ☐(1) Yes ☐(0) No ☐(9) Don't know

Only for girls, **19g. In the past 12 months...**		Yes	No	Don't know
1.	… she was pregnant	☐(1)	☐(0)	☐(9)
2.	… she gave birth	☐(1)	☐(0)	☐(9)
3.	… she had an abortion	☐(1)	☐(0)	☐(9)

20. HISTORY OF HOSPITALIZATIONS FOR THE PAST 12 MONTHS

20a. How many times was the child hospitalized in the past 12 months? _____ ☐(0)Never ☐(9) Don't know

FILL IN 20B ONLY IF THE CHILD WAS HOSPITALIZED AT LEAST ONCE IN THE PAST 12 MONTHS.

20b. Specify for the first 3 hospitalizations by their duration, the reason for each and the number of hospitalization nights.

	No. of hospitalization nights	Hospitalization reason
Hospitalization 1		
Hospitalization 2		
Hospitalization 3		

21. HEALTH RISKS

21a. Does the child…	Yes	No	Don't know
1. …Smoke?	☐(1)	☐(0)	☐(9)
2. …Consume alcohol?	☐(1)	☐(0)	☐(9)
3. …Consume drugs?	☐(1)	☐(0)	☐(9)
4. …Have a sexually active life?	☐(1)	☐(0)	☐(9)

21b. What are the main risks for the child's health, be they environmental or behavioral??

1.

2.

3.

22. DATA ON THE PARENTS

22a. Does the child's mother…	Yes	No	Don't know / Not applicable
1. … have a disability qualification certificate?	☐(1)	☐(0)	☐(9)

IF THE CHILD'S MOTHER HAS A DISABILITY QUALIFICATION CERTIFICATE

22b. Disability type

☐(1)	Physical	☐(6)	Mental
☐(2)	Visual	☐(7)	Psychic
☐(3)	Hearing	☐(8)	HIV/AIDS
☐(4)	Deafblindness	☐(9)	Associated
☐(5)	Somatic	☐(10)	Rare diseases

22c. Disability level

☐(1)	Mild
☐(2)	Medium
☐(3)	Accentuated
☐(4)	Severe

22c. Does the child's mother …	Yes	No	Don't know / Not applicable
2. … suffer of any chronic disease that affects her parental abilities?	☐(1)	☐(0)	☐(9)

IF THE CHILD'S MOTHER IS DIAGNOSED WITH CHRONIC DISEASES THAT AFFECT HER PARENTAL ABILITIES

22d. What chronic diseases does the mother have?

1.

2.

3.

22a. Does the child's father …	Yes	No	Don't know / Not applicable
1. …have a disability qualification certificate?	☐(1)	☐(0)	☐(9)

IF THE CHILD'S FATHER HAS A DISABILITY QUALIFICATION CERTIFICATE

22b. Disability type

☐(1)	Physical	☐(6)	Mental
☐(2)	Visual	☐(7)	Psychic
☐(3)	Hearing	☐(8)	HIV/AIDS
☐(4)	Deafblindness	☐(9)	Associated
☐(5)	Somatic	☐(10)	Rare diseases

22c. Disability level

☐(1)	Mild
☐(2)	Medium
☐(3)	Accentuated
☐(4)	Severe

22c. Does the child's father …		Yes	No	Don't know / Not applicable
2.	… suffer of any chronic disease that affects her parental abilities?	☐(1)	☐(0)	☐(9)

IF THE CHILD'S FATHER IS DIAGNOSED WITH CHRONIC DISEASES THAT AFFECT HER PARENTAL ABILITIES

22d. What chronic diseases does the father have?

1.

2.

3.

23. Recommendations

23a. Does the child have medical needs for which medical services and / or specialized interventions are recommended?	Yes	No	9. Don't know

If Yes,

23b. Recommendations of medical services and specialized interventions for the current medical needs of the child		**Yes**	**No**	**23c. Specify the medical need of the child for whom this service is recommended.**
1.	Permanent medical assistance	☐(1)	☐(0)	
2.	Treatment and supervision from the family doctor	☐(1)	☐(0)	
3.	Treatment and supervision from the specialist doctor	☐(1)	☐(0)	
4.	Surgery	☐(1)	☐(0)	
5.	Prosthesis	☐(1)	☐(0)	
6.	Kinetotherapy	☐(1)	☐(0)	
7.	Other types of medical recovery	☐(1)	☐(0)	
8.	Logopedy	☐(1)	☐(0)	
9.	Psychotherapy	☐(1)	☐(0)	

23b. Recommendations of medical services and specialized interventions for the current medical needs of the child		Yes	No	23c. Specify the medical need of the child for whom this service is recommended.
10.	Counseling and psycho-pedagogical assistance	☐(1)	☐(0)	
11.	Assistive devices and equipment	☐(1)	☐(0)	
12.	Family planning services	☐(1)	☐(0)	
13.	Sexual education services for young people	☐(1)	☐(0)	
14.	Other (specify, which)	☐(1)	☐(0)	
15.	Other (specify, which)	☐(1)	☐(0)	

25. Do you consider it would be necessary for the child to undergo a medical assessment by specialist doctors for a disability qualification certificate?

☐(1)Yes ☐(0) No ☐(9)Not the case, he already has one

Date of filling in the instrument

DD	MM	YYYY

Name and surname of the doctor _____

Doctor signature and stamp _____

ADMINISTRATIVE CHAPTER

26a. The child/young person has a SIP for health **1. Yes** **2. No**

***If yes*,**

26b. Has the SIP for health been revised following the present evaluation? ☐(1) Yes ☐(0) No

***If the SIP has been revised*,**

27. What objectives, measures were modified or added to the SIP for health?

28. Has the Medical record been annexed to the child's case file? **1. Yes** **2. No**

29. What documents are attached to the Medical record in the child's case file? _____

1.	Referral note.....	☐(1)
2.	CES service	☐(1)
3.	Health SIP	☐(1)
4.	Test results.....	☐(1)
5.	Other (indicate)	☐(1)

Instrument 3: Template of a psychological evaluation sheet in view determining the degree of disability, providing professional and school counselling, and planning the benefits, services and interventions for children with disabilities and/or SEN[110]

Medical unit/ Individual practice _____

Registration no ☐ Date ☐☐ ☐☐ ☐☐☐☐
DD MM YYYY

Child's name and surname: _____

Gender ☐(1) Male ☐(2) Female **Date of birth** ☐☐ ☐☐ ☐☐☐☐
DD MM YYYY

I. Medical diagnostic:

According to the medical document: .....

II. Psycho-diagnostic:

SECTION 1 - Assessment of the child's personality (The assessment methods used shall be used for each area assessed, for instance: clinical observation, interview, survey, tests, scales and scores achieved)

A. Mental processes:

1. **Sensory area** (for instance: Neuropsychological assessment battery for children aged 3-12 - NEPSY, Wechsler Intelligence Scale for Children - 4th edition - WISC - IV)

• **Sensory development:**

- sensory integrity or impairment (description)

.....

- presenting the deficiencies observed (checked or stated)

.....

[110] Annex 8 of Order no. 1985/1305/5805/2016. Filling-in suggestions in the paranthesis

• **Perception:**

.....

• **Psychomotor development** - description based on age and impairment:

Fine motor skills: describe the possibility to perform fine and accurate gestures of:

- *Grabbing, picking, releasing, throwing, reaching an object;*

.....

- *Unilateral or bilateral handling*

.....

- *Dominant laterality*

.....

Gross motor skills: Description about:

- *Orthostatism, static and walking deficiencies, balance issues*

.....

- *Coordination deficiencies*

.....

- *Walk (unassisted or with support, what is the distance covered independently)*

.....

- *Traveling with the public transport means is done independently or with a caretaker*

.....

• **Representation:**

.....

.....

2. **Logical area** (for instance, NEPSY)

• **Thinking** (including operational level) - assess the operational context, compared to the chronological age

- operational status

.....

- the child's actual potential - what he/she knows to do, what they can do:

- *Recognize/ name objects*

.....

- *Group the objects/ based on which criteria*

.....

- *Knows the facial/body scheme*

.....

- *Indicates/ names/distinguished colors*

.....

- *Can count alone or asks for help*

.....

- *Recognizes symbols (numbers, images, characters, letters, words)*

.....

- *Capacity to make decisions alone*

.....

- *Capacity to issue hypothesis*

.....

- *Capacity to face responsibilities*

.....

- *Capacity to deal with crises situations and/or stress*

.....

- *Time management capacity when carrying out the daily/routine schedule*

.....

- *Capacity to complete a simple task, alone or with support*

.....

- *Capacity to complete a complex task, alone or with support*

.....

- *Orientation in time and space*

.....

- **Memory:**

- type of memory

.....

- mnesic capacity

.....

- **Attention:**

- stability

.....

- focus

.....

- **Motivation:**

- type

.....

- specific signs:

.....

• **Imagination:**

- development compared to the chronological age

.....

- content, usefulness and usage

.....

• **Will area:**

- manifestation and context

.....

- negative manifestation

.....

b) Mental activities:

• **Language and communication** - speech and communication deficiencies/ disorders, which affect the relations with the environment

- How the child communicates or expresses himself/herself when interacting with other people/ the environment

.....

- Vocabulary: active, passive, development

.....

- Acquiring speaking skills/ delays in speaking (phonetic, lexical, semantic, grammar)

.....

- Pronunciation difficulties

.....

- Instrumental impediments (writing/reading, simple/complex mental calculation, solving simple/complex problems)

.....

- Uses sign language in communication (if applicable)

.....

- Uses Braille language in communication (if applicable)

.....

- Understands a simple and/or complex message which is uttered and/or written

.....

- Communicates through/by perceiving messages/ pictures/ drawings

.....

• **Games (clinical observation):**

.....

• **Learning** (for instance, NEPSY):

.....

• **Work** (for instance, clinical observation WISC-IV)

.....

• **Creativity**

.....

CONCLUSIONS:

• **Intellectual development level (psychological test used)**

.....

• **Development age**

.....

• **Development coefficient**

.....

• **Psycho-motor development level**

.....

c) Mental traits:

• **Temper features** (for instance, clinical observation)

.....

• **Skills/ abilities, interests, aspirations (for instance, clinical observation):** highlighting the individual potential

.....

• **Attitudes/behavior:**

.....

• **Psycho-motor development level**

- Manifestations, concerns

.....

- Behavioral problems, child's reactivity

.....

- Presence/absence of behavioral, gestural and/or verbal stereotypes

.....

- Presence of the hyperkinetic behavior

.....

- Other behavioral disorders

.....

• **Character**

.....

d) Emotional area:

• controlling emotions (stability/ instability, maturity/immaturity)

.....

• type of affection (dependent/ autonomous)

.....

• capacity to emotionally adapt to life contexts (according to the age)

.....

• pathology of emotionality: crisis, anxiety, depression, blockage, psycho-somatic nervousness, etc.

.....

• feelings, passions

.....

SECTION 2 - Adaptive social behavior

a) Family relations (together with the social evaluation sheet) - existing parents, their involvement and relationship with them

.....

b) Siblings, their involvement and relationship with them

.....

c) Reference person for the child

.....

d) How they relate to the child (a-c)

.....

e) Child's behavior while in family, in respect to the family members (relationship with the parents, siblings, other relevant people)

.....

f) Child's attitude towards himself/herself

.....

g) Aggressiveness/ self-aggressiveness

.....

h) Child's ability to adjust to the environment and people

.....

i) Child's future plans

- Level of autonomy (personal hygiene, getting dressed/undressed, level of dependency/ independence from another person, sphincter control, etc)

.....

- Maturity level

.....

- Parents' influence on the child's development

.....

j) Capacity to make effort and endurance to effort

.....

SECTION 3 - Social integration

a) Relation with the school (based on the discussion with the child, the parents and, if applicable, pedagogical evaluation given by the teacher)

.....

b) There are friendship relations

.....

c) Child's involvement in extracurricular activities (for instance, sports, creative activities)

.....

d) Belonging to other social groups (for instance, religious cults)

.....

Conclusion: Psycho-social maturity

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

SECTION 4 - Other relevant clinical observations

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

SECTION 5 - Psychological profile

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

Assessment of the child's psychological development areas

Investigated area	Level of development				The child/youngster needs stimulation/ optimization	
	Normal development	Slight delay	Medium delay	Severe delay	Yes	No
1. Memory	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
2. Language	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
3. Thinking	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
4. Attention	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
5. Emotionality	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
6. Will	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
7. Personality	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
8. Behavior	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)

SECTION 6 - Recommendations for the child's habilitation-rehabilitation plan (by also mentioning, for services, the specific objective)

	Recommendations of psychological services and other associated interventions, for the child/youngster's current psychological needs	Yes	No	Special objective of the service	Specialist that will provide the service	Institution from which the specialist is coming
1.	Support/socializing group for the child	☐(1)	☐(0)			
2.	Speech therapy services for the child	☐(1)	☐(0)			
3.	Occupational therapies for the child	☐(1)	☐(0)			
4.	Socializing activities for the child	☐(1)	☐(0)			
5.	Teaching-educational activities for the child	☐(1)	☐(0)			
6.	Psychotherapy necessary for the child's habilitation-rehabilitation	☐(1)	☐(0)			
7.	Psychological re-evaluation and re-evaluation date	☐(1)	☐(0)			
8.	Child's psychiatric evaluation	☐(1)	☐(0)			
9.	Other service for the child, mention ……	☐(1)	☐(0)			
10.	Other service for the child, mention ……	☐(1)	☐(0)			
11.	Other service for the child, mention ……	☐(1)	☐(0)			

…..					
12. Psychological guidance/ support group for the person/family that will look after the child	☐(1)	☐(0)			
13. Type of therapy for the person/family that will look after the child, mention…… …….	☐(1)	☐(0)			
14. Other service for the person/family that will look after the child, mention…… …….	☐(1)	☐(0)			
15. Other service for the person/family that will look after the child, mention…… …….	☐(1)	☐(0)			
16. Other service for the person/family that will look after the child, mention…… …….	☐(1)	☐(0)			

SECTION 7 - Administrative chapter

1.Who did the psychological evaluation?

☐(1) A psychologist from CP ☐(2) A psychologist from DGASPC ☐(3) An independent psychologist

2. Was the psychological evaluation fiche attached to the child's file? 1. Yes 2. No

Evaluation date | | | |

DD MM YYYY

Psychologist's Name and surname _____

Psychologist's signature and seal _____

Instrument 4: Psychological evaluation fiche for the child/ young person with no disabilities and/or SEN

Data on the child/ young person:

Child's name and surname: _____

Personal identification number

Gender

☐(1) Male
☐(2) Female

Date of birth

DD MM YYYY

Entry date in the special protection system

DD MM YYYY

CAUZE. What were the causes for the child and family separation?

MULTIPLE ANSWER

☐(1) Death of one or both parents
☐(2) Parent(s) in detention
☐(3) Mother/ parents institutionalized
☐(4) Deprivation of parental rights
☐(5) Child neglect
☐(6) Child abuse
☐(7) Child exploitation
☐(8) Parent(s) are abroad
☐(9) Disorganized families (families in which one or several of the following events occur: divorce, separation, infidelity, parents' lack of interest towards the children, one parent abandons the family, the father does not recognize the child, out-of-wedlock pregnancy)
☐(10) Teenage mother/ parents
☐(11) Parents' alcohol and/or substance abuse
☐(12) Parents' promiscuous and/or criminal behavior
☐(13) Family violence
☐(14) Parents with disabilities and/or mental problems
☐(15) Child abandoned in the maternity and/or another medical center
☐(16) Children with disabilities, SEN or behavioral disorders
☐(17) Poverty
☐(18) Improper housing, no stable home, vagrancy
☐(19) Absence of education services suitable for the child, in the community
☐(20) Absence of medical, recovery/rehabilitation services, in the community
☐(21) Other causes, namely…

CAUZE_alta. Another cause, namely…

I. Evaluation of the child's/ youngster's psychological development areas, in accordance with their age:

Investigated area	Level of development				Evaluation method/tools	Stimulation/ optimization needs	
	Normal development	Slight delay	Medium delay	Severe delay		Yes	No
9. Memory:	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
10. Language	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
11. Thinking	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
12. Attention:	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
13. Emotionality:	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
14. Will	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
15. Personality	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)
16. Behavior	☐(1)	☐(2)	☐(3)	☐(4)		☐(1)	☐(0)

9. Education needs identified, depending on the development stage

10. Special talents/ skills

11. Conclusions related to the delays in development

12. Proposals for psycho-socio-educational stimulation, for recovery

ALSO MENTION THE CHILD'S OPINION, IF HE/SHE WANTS TO CONTINUE THE TRAININGS/PREPARATION AFTER THE DEINSTITUTIONALIZATION

II. Reasons for the institutionalization

1. Consequences (cognitive, behavioral, emotional, social, etc.) caused by the traumas that lead to the child's institutionalization, identified by the psychologist of the center/ documents issued by other specialists.

IF PRIOR PSYCHOLOGIC EVALUATIONS WERE CONDUCTED/ MEDICAL DOCUMENTS ISSUED, ETC., MENTION THE DIAGNOSTIC, NAME OF THE INSTITUTION, NAME OF THE SPECIALIST AND DATE.

2. Signs (cognitive, behavioral, emotional, social, etc.) **of significant incidents** (abuse, neglect, autolytic behaviors, delinquency, human trafficking) **that occurred during the institutionalization, which require intervention** (psycho-education/ counseling/ psychotherapy).

☐(1) Present ☐(0) Absent

3. Psychological interventions (psycho-education/ counseling/ psychotherapy) during the institutionalization:

Year	Problem identified	Type of psychological intervention	Results		
			No improvements	Slight improvements	Improved
			☐(1)	☐(2)	☐(3)
			☐(1)	☐(2)	☐(3)
			☐(1)	☐(2)	☐(3)
			☐(1)	☐(2)	☐(3)
			☐(1)	☐(2)	☐(3)

III. Attachment relations

1. Persons the child trusts/ resource persons (staff from the institution, from school, trainers) that could be involved in the preparation for deinstitutionalization:

	Name and surname	Position	Brief presentation of the relation/ How they can be involved

1.			
2.			
3.			

2. Relations (attachment) with the family members (biological, extended or other people outside the institution), that were kept during the institutionalization, which could increase the child's motivation for deinstitutionalization:

	Name and surname	Kinship/ relationship	Brief presentation of the relation/ How they can be involved
1.			
2.			
3.			

IV. Protection factors fostering the development of the child's resilience:

1. Individual protection factors:

2. Family protection factors:

3. Environmental (community) protection factors:

V. Analysis of the child's/ young person's motivation for deinstitutionalization:

1. Desires, hopes, expectations:

2. Fears, worries:

3. Child's attitude towards the deinstitutionalization:

Reject	Distrust	Indifference	A little faith	Optimism
☐(1)	☐(2)	☐(3)	☐(4)	☐(5)

4. Conclusions related to the child's motivation for deinstitutionalization

5. Intervention proposals (support, psychological) to increase motivation

VI. Recommendations

Support needed to ensure the child's/ young person's mental health:

1 Only psycho-education/ preventive psychological support..... ☐(1)

2. The psychological support can be provided by the family ..... ☐(1)

3. Psychological support from specialized services (counseling, psychotherapy, etc.)..... ☐(1)

4. Requires psychiatric evaluation ..... ☐(1)

5. Requires psychiatric treatment ..... ☐(1)

6. Other recommendations ..... ☐(1)

VII. Administrative chapter

1.Who did the psychological evaluation?

☐(1) A psychologist from CP ☐(2) A psychologist from DGASPC ☐(3) An independent psychologist

2. Was the psychological evaluation fiche attached to the child's file? 1. Yes 2. No

Evaluation date | | | | DD MM YYYY

Psychologist's Name and surname _____

Psychologist's signature and seal _____

Instrument 5: Social evaluation sheet of child or young person

A. Data about the child

Name and surname of the child: _____

Personal identification number | | | | | | | | | | | | | |

Child gender
☐(1) Male
☐(2) Female

Date of birth | | | | (DD MM YYYY)

Date of last entry in the special protection system | | | | (DD MM YYYY)

CAUSES What were the causes of the child's separation from the family?

MULTIPLE ANSWER

☐(1) Death of one or both parents
☐(2) Parent(s) in detention
☐(3) Mother/ parents institutionalized
☐(4) Deprivation of parental rights
☐(5) Child neglect
☐(6) Child abuse
☐(7) Child exploitation
☐(8) Parent(s) abroad
☐(9) Disorganized families (families in which one or several of the following events occur: divorce, separation, infidelity, parents' lack of interest towards the children, one parent abandons the family, the father does not recognize the child, out-of-wedlock pregnancy)
☐(10) Teenage mother/ parents
☐(11) Parents' alcohol and/or substance abuse
☐(12) Parents' promiscuous and/or criminal behavior
☐(13) Family violence
☐(14) Parents with disabilities and/or mental problems
☐(15) Child abandoned in the maternity and/or another medical center
☐(16) Children with disabilities, SEN or behavioral disorders
☐(17) Poverty
☐(18) Improper housing, no stable home, vagrancy
☐(19) Absence of education services suitable for the child, in the community
☐(20) Absence of medical, recovery/rehabilitation services, in the community
☐(21) Other causes, namely…

CAUSES_other Other cause, namely… _____

B. Institutionalization history

B1. Which of the following paths was followed by the child before entering public care (PC) for the first time?

- Maternity → Family with a stable home → PC ..... ☐(1)
- Relinquished in maternity after birth → PC ..... ☐(2)
- Maternity → Family → Relatives → PC..... ☐(3)
- Maternity → Family → Children relinquished by parents in a pediatric ward / other institution → PC ..... ☐(4)
- Maternity → Family → Unrelated persons → PC..... ☐(5)
- Maternity → Family without a stable domicile or home → PC..... ☐(6)
- Maternity → Family → Children left alone at home → PC ..... ☐(7)
- Maternity → Family → Children found on the street/in public areas → PC ..... ☐(8)
- Maternity → Family → Children fled from home/homeless children → PC ..... ☐(9)
- Maternity → Family: Single mother institutionalized (in a medical or social facility) → PC ..... ☐(10)
- Other route, namely: ..... ☐(11)
  .....
- Unknown ..... ☐(99)

B2. Through which kind of protection services did the child go, from his/her last (most recent) entry into the system until now? *Multiple answer*

1. Placement with relatives up the 4th degree ..... ☐(1)
2. Placement with other families/people ..... ☐(1)
3. Placement with foster caregivers(FC)..... ☐(1)
4. Apartments ..... ☐(1)
5. Family-type homes (FTH) ..... ☐(1)
6. Placement centers ..... ☐(1)
7. Emergency placement centers ..... ☐(1)
8. Maternal centers ..... ☐(1)
9. Other services, namely: ..... ☐(1)
   .....

B3. Child's pathway in the system: How many distinct stages are there in the child's pathway in the system from his/her last (most recent) entry until now? ☐

The number of stages shows the number of relocations undergone by the child. The pathway is broken down by stages, based on the changes in the measure, service or supplier (for instance, transfer from a FC to another, or from a center to another) or any combination of these.

B3a. Briefly present the child's pathway in the system, since entry until now. For instance, a child that entered the system in 2010, has been placed in the following services: Emergency placement center (EPC), FC Floarea Ana, FC Ionescu Dan, EPC, Speranta Placement center, FTHRază de Soare, Speranta Placement center. So, from 2010 until now, the child has gone through 7 stages.)

B4a. During his/her time in the system, has adoption ever been mentioned as a final outcome in the ICP	☐(1)Yes	☐(0)No	☐(9)Don't know

and has the child been declared as adoptable?

IF YES AT B4a

B4b. Is the child currently undergoing the adoption process (irrespective of the stage)? ☐(1)Yes ☐(0)No

B5a. Have there been any measures taken during the past 12 months to reintegrate the child into his/her natural or extended family? ☐(1)Yes ☐(0)No ☐(9)Don't know

IF YES AT B5a

B5b. What steps have been made? TICK ALL STEPS

1. Identification of parents/ relatives up to the 4th degree..... ☐(1)
2. Organization of meetings between the child and his/her family or relatives ..... ☐(1)
3. Visiting the parents/ relatives ..... ☐(1)
4. Allowing the child to spend a set amount of time at his/her parent's/ relatives' ..... ☐(1)
5. Counseling the parents in view of improving the child-family relations ..... ☐(1)
6. Counseling the child in view of improving the child-family relations ..... ☐(1)
7. Other steps, namely: ..... ☐(1)
.....

C. Child's link to his/her family

C1. How many siblings does he/her have? ☐

FILL OUT TABLE 2 IF THE NUMBER OF SIBLINGS IS >0.
TABLE C2[111]

No.	Full name	Gender (M/F)	Date of birth (DD/MM/YYYY)	Where is the sibling? 1. In the system in the same placement center 2. In the system, in another service 3. with the family 4. single independent adult 5. adult with his/her own family 6. Other situation (for instance, in jail)	There are ties to the child 1. Yes, constant 2. Yes, occasional 3. No	*Only for the siblings that are independent adults or adults with their own families* **Is the brother/sister a resource for child's reintegration?** 1- yes 2-no
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
...						

C3. Atmosphere and environment in the child's natural family:

1. Harmonious, pleasant relations between parents/ parents and children

[111] If Instrument 9 was filled out, the siblings in the household should be mentioned in the table below with code *"3. In the family"* for question *"Where is the brother/sister?"*.

2. Relations with punctual small, transient conflicts
3. Strong family disagreements, frequent conflicts
4. Broken or about to be broken family
5. Other situations: .....
-1. Don't know

Questions for all children above 3!

C4. How does the child/young person feel/ think about his/her parents and siblings?	Interrupted relation	Indifference	Conflicting relation	Good/ pleasant relation	Not applicable, they do not exist
1. With the mother:	**1**	**2**	**3**	4	**-7**
2. With the father:	**1**	**2**	**3**	4	**-7**
3. With the siblings:	**1**	**2**	**3**	4	**-7**

C5. Are there attachment figures, beyond the natural family, that could serve as resources for the child's reintegration?

1. Yes 2. No

If Yes,

C5a. Who are they? *Multiple answer*
1. Grandparents
2. Aunts/ uncles
3. Other relatives up to the 4th degree
4. Other relatives (5th degree and above)
5. Other non-related persons (for instance, former FC)

C6. The child would like to go/ go back to...?	Barely or to a very small extent	To a small extent	To a large extent	To a very large extent	Not applicable, they do not exist
1. Natural family	**1**	**2**	**3**	4	**-7**
2. Family of other relatives, up to the 4th degree	**1**	**2**	**3**	4	**-7**
3. Family of other attachment figures, related (5th degree or above) or non-related	**1**	**2**	**3**	4	**-7**

D. Free time, concerns and risky behaviors

	D1. The child has good friends in the foster care center and he does not want to part with them … 1. Yes 0. No	**D2. The child is in a romantic relationship with someone from...** 1. Yes 0. No
a. The placement center?		
b. ...Other protection services?		
C...the community?		

D3. How does the child spend his/her free time?(ONLY FOR CHILDREN THAT ARE 7 OR OLDER)

a. Hobbies, interests: _____

b. Extracurricular activities: _____

c. Others: _____

D4. What abilities, qualities, talents does he/she have?

D5 APPLIES ONLY TO CHILDREN ABOVE 6

D5. Since the last entry in public care and until present, has the child exhibited one of the following behaviours at risk:	Yes	No	Unknown
a. Sexual activity	☐(1)	☐(0)	☐(9)
b. Underage mother or underage father, was pregnant, or had already had children	☐(1)	☐(0)	☐(9)
c. Consumption of alcohol	☐(1)	☐(0)	☐(9)
d. Use of drugs or other psychotropic substances	☐(1)	☐(0)	☐(9)
e. Smoking	☐(1)	☐(0)	☐(9)
f. Experiences of beatings or violence with other children or young people	☐(1)	☐(0)	☐(9)
g. Was in a "gang" or a group of friends with behaviour at risk	☐(1)	☐(0)	☐(9)
h. Had fled from the center or another protection service	☐(1)	☐(0)	☐(9)
i. Engaging in crime	☐(1)	☐(0)	☐(9)
j. Street work, begging	☐(1)	☐(0)	☐(9)
k. Practicing commercial sex	☐(1)	☐(0)	☐(9)
l. Suicide attempt	☐(1)	☐(0)	☐(9)
m. Other deviant behaviors, namely:.....	☐(1)	☐(0)	☐(9)

D6a. In how many events from the Special Incidents Register was the child involved in during the year 2017? ☐ ☐(0) None

IF THE ANSWER TO D6A IS NOT NONE, THEN LIST THE RECORDED EVENTS

D6b.Special incidents:

4. _____
5. _____
6. _____

E. Independent life skills

Life skills field	**E1. Skills acquired?** -7. Not applicable, the child is too young -1. Does not know 1. Knows 2. Maybe 3. Does	*If E1>0,* **E2. Assessment of the independent living skills acquired, in respect to the age** 0. Insufficiently developed 1. Sufficiently developed
Daily living skills related to eating and preparing meals		
Daily living skills related to personal hygiene		
Daily living skills related to clothing		
Daily living skills related cleanness of the living space		
House management skills (taxes, fees, bills, using household appliances, etc.)		

Life skills field	**E1. Skills acquired?** -7. Not applicable, the child is too young -1. Does not know 1. Knows 2. Maybe 3. Does	*If E1>0,* **E2. Assessment of the independent living skills acquired, in respect to the age** 0. Insufficiently developed 1. Sufficiently developed
Skills related to community resources (transport, shops, cinema, institutions, orientation in space, etc.)		
Cash management skills (using money, asking for the change, the receipt, credits, card, etc.)		
Social development skills (building friendship, social relations, etc.)		
Skills for professional and vocational integration (writing a CV, looking for a job, attending job fairs, keeping a job, etc.)		

E7. Which are the child's wishes related to? (ONLY FOR CHILDREN OVER 7YEARS OLD)

a. Family _____

b. Education _____

c. Profession _____

F. Conclusions

F1. Conclusions of the evaluation:

G. Recommendations

a. Does the child have social needs for which social interventions and/or services are recommended?	1. Yes	2. No	9. Don't know

If Yes,

b. Recommendations of services and social interventions for the current needs of the child	**Yes**	**No**
7. Day care centers supporting the integration/reintegration of children back into their family	☐(1)	☐(0)
8. Day care centers for children with disabilities	☐(1)	☐(0)
9. Day care centers for independent life skills development	☐(1)	☐(0)
10. Guidance, supervision and social reintegration centers for juvenile criminal offenders below the age of criminal responsibility	☐(1)	☐(0)
11. Counseling centers for abused, neglected, exploited children	☐(1)	☐(0)
12. Drop-in counseling and support centers for parents and children/pregnant women in difficulty	☐(1)	☐(0)

b. Recommendations of services and social interventions for the current needs of the child	Yes	No
16. Drug prevention, evaluation and anti-drug counseling centers	☐(1)	☐(0)
17. Addiction recovery centers	☐(1)	☐(0)
18. Therapeutic community centers	☐(1)	☐(0)
19. Multipurpose centers/services	☐(1)	☐(0)
21. Community-based integrated service centers	☐(1)	☐(0)
72. Mobile teams	☐(1)	☐(0)
14. Parent education services	☐(1)	☐(0)
18. Psychological counseling services	☐(1)	☐(0)
25. Abuse, neglect and exploitation prevention services	☐(1)	☐(0)
26. Counseling services for domestic violence prevention and control	☐(1)	☐(0)
27. Perpetrator support services	☐(1)	☐(0)
55. Social enterprise	☐(1)	☐(0)
71. Social housing services (youth housing units (ANL), social housing units, emergency housing units, etc.)	☐(1)	☐(0)
81. Legal aid services	☐(1)	☐(0)
23. Others, namely:	☐(1)	☐(0)

H. Administrative chapter

1. Has the social evaluation sheet been attached to the child's file? **1. Yes** **2. No**

2. Apart from the social evaluation sheet, what other documents are attached to the child's file?

6. Environmental factors sheet ..... ☐(1)
7. Ecomap ..... ☐(1)
8. Genogram ..... ☐(1)
9. Others, namely ..... ☐(1)

Date when the sheet was filled out

DD	MM	YYYY

Name and surname of the person filling in the sheet _____

Position _____

Signature _____

Instrument 6: Template of an education evaluation sheet for an out-of-school child

Child's name and surname: _____

Personal identification number

Gender ☐(1) Male ☐(2) Female **Date of birth** DD MM YYYY

CHILD_DISABILITY Does the child have a disabilities certificate? ☐(1) Yes ☐(2) No

CHILD_SEN Does the child have SEN? ☐(1) Yes ☐(2) No

1. Why is the child currently not enrolled in education?

2. Have he/she ever been enrolled? ☐(1) Yes ☐(0) No

If Yes

2a. Which is the last form of education he/she attended? ☐(1) Mainstream ☐(2) Inclusive ☐(3) Special

2b. How many grades has he/she completed? _____ grades

2c. At what age did he/she stop going to school? _____ years

For children over 5,

3. Level of school acquisitions:

	Absent	Poor	Good	Very good
a. Reading skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
b. Writing skills:	☐(1)	☐(2)	☐(3)	☐(4)
c. Computation skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
d. Skills related to understanding a text read:....	☐(1)	☐(2)	☐(3)	☐(4)

3e. Special skills or interests, talents 1. Yes 2. No

*If Yes, **which?***

For all children,

4. Education goals for the next 12 months

5. Administrative chapter

Has the education sheet been attached to the child's file? **1. Yes** **2. No**

Date when the sheet was filled out

DD	MM	YYYY

Name and surname of the person filling in the sheet _____

Position _____

Signature _____

Instrument 7: Model of Psycho-Pedagogical Sheet for the Child or Young Person in Schooling

A. Data about the child

Name and surname of the child: _____

Personal identification number | | | | | | | | | | | | | |

Child gender ☐(1) Male ☐(2) Female

Date of birth DD MM YYYY

COPIL_HANDICAP. Does the child have a disability qualification certificate? ☐(1) Yes ☐(2) No

COPIL_CES. Does the child have SEN? ☐(1) Yes ☐(2) No

A1. Is the child enrolled in kindergarten or school? ☐(1)Kindergarten ☐(0)School

A2. Educational institution _____

A3. Form of education ☐(1)Mass ☐(2)Inclusive ☐(3)Special

A4. In what class/group is the child at present? _____

A5. Educational history		Yes	No
a.	**School absenteeism in the last year (more than 10 unmotivated absences per semester, in one discipline)**	☐(1)	☐(0)
b.	**Flunked subjects (failed exams) in the previous school year**	☐(1)	☐(0)
c.	**History of repeated school years throughout the educational path**	☐(1)	☐(0)
d.	**Existing risk of school dropout or early school leaving**	☐(1)	☐(0)
e.	**School discrimination or abuse (from the teachers or school mates)**	☐(1)	☐(0)
f.	**Rejection of school enrollment**	☐(1)	☐(0)

B. Educational path:

	B1. Name of the institution	**B2. Period**	**B3. Observations**
1. Ante-preschool education institutions			
2. Preschool education institutions			
3. Schools			

B4. Altogether, how many education institutions has the child/young person attended since he/she has been in the child care system and has been enrolled in education?

B5. Passed during the previous year: ☐(1) Yes ☐(2) No

B6. Since he/she has been in the child protection system, how have their school results evolved?

1. School results were good..... ☐(1)
2. School results were constantly good ..... ☐(2)
3. School results were constantly average..... ☐(3)
4. School results were constantly poor..... ☐(4)
5. School results were bad ..... ☐(5)

Only for children with a disabilities certificate and/or SEN!

C. Health state:

1) Overall health

2) Medical observations important for the education process:

Only for children with a disabilities certificate and/or SEN!

D. Psycho-pedagogical evaluation:

1) Psycho-motor development (motor coordination, body scheme, laterality, perceptive-motor structures, orientation in time and space/ Fundamental landmarks for early childhood development from birth till 7 years old):

2) Other specific features (specific deficiencies and behaviors):

3) Cognitive processes and working style:

a) Thinking:

- Understands notions: ☐(1) basic ☐(2) complex
- Defines notions ☐(1) basic ☐(2) complex
- Operates with notions: ☐(1) basic ☐(2) complex
- Understands the cause-effect relations: ☐(1) Yes ☐(2) No
- Other thinking specificities

b) Memory:

Types of memory: ☐(1) Short-term ☐(2) Long-term ☐(3) Visual ☐(4) Auditory ☐(5) Mixt

Other memory specificities

c) Language and communication:

Vocabulary: ☐(1) limited ☐(2) average ☐(3) rich

Oral expression: ☐(1) Does not communicate orally ☐(2) difficult ☐(3) Grammatically incorrect ☐(4) Clear, correct

Language impediments _____
Other language specificities _____

d) Attention:
- Understands notions: ☐(1) Attention disorders ☐(2) Does not show any attention disorders

- Other specificities (focus, stability, volume, etc.) _____

e) Motivation to learn: ☐(1) Extrinsic ☐(2) Intrinsic
Other specificities: _____

f) Receptiveness, participation and involvement:
☐(1) Actively and intently participates ☐(2) Unequal, fluctuating interest ☐(3) Passive
☐(1) Difficult to train ☐(2) Unequal, absent
Other specificities: _____

4. **Social relations:**
☐(1) Sociable, communicative ☐(2) Secluded, isolated, little communication ☐(3) Turbulent ☐(4) Verbal aggressiveness ☐(5) Physical aggressiveness
Other specificities: _____

For all children!

E. Education acquisitions level (skills, interests):

	Absent	Poor	Good	Very good
1. Reading skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
2. Writing skills:	☐(1)	☐(2)	☐(3)	☐(4)
3. Computation skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
4. Skills related to understanding a text read:	☐(1)	☐(2)	☐(3)	☐(4)

E5. Special skills or interests, talents 1. Yes 2. No

*If Yes, **which?***

F. Student's school and extra-school results?
F1. Subjects where he/she got exceptional results, awards:

F2. Involvement in extracurricular activities and the results achieved:

F3. Support received by the child (therapies in centers, in kindergarten or school, homework support, tutoring, etc.) **during the school year (from educators, teachers, parents, etc.)**

F4. Behavior during the past and current school activities:

Only for children/ young people without disabilities and/or SEN!

F5. Child's attitude towards learning

1. Child shows interest and is attracted to learning; he/she likes to learn ..... ☐(1)
2. Child is hard-working, acknowledging the need and importance of acquiring knowledge ..... ☐(2)
3. Child shows an apparent positive attitude; good school results, if there, are the result of constant tutoring from educators/ staff/ parents ..... ☐(3)
4. Child has a disguised attitude towards learning; he/she does not learn to acquire knowledge, but to get good grades ..... ☐(4)
5. Child does his/her homework superficially, haphazardly, without any interest or concern for its quality for some subjects, whereas for other subjects he/she has good and very good grades..... ☐(5)
6. Child shows no interest or even rejects intellectual work, doesn't care about the poor grades, is not disciplined during the class ..... ☐(6)

For all children!

G. Conclusions

G1. Conclusions of the evaluation:

H. Recommendations

1. **Observations and recommendations, including in respect to type of schooling and the need to attend a certain type of school in order to improve things (for instance, vocational or arts and crafts school focused on: sports, mechanics, music, arts, pastry, bakery, etc.)**

2a. Does the child have any education needs* for which some services/activities are recommended in view of improving things/ solving the problem?	1. Yes	2. No	9. Don't know

** Education needs also include managing situations related to school abuse or discrimination, school motivation, difficulties in fitting-in in school, special skills and talents, special education needs.*

If Yes,

	2b. Services/ activities recommended for the child's current education needs	**Yes**	**No**	**2c. Mention the education need for which this service is recommended**
16	School guidance and counseling services	☐(1)	☐(0)	
17	Career/vocational guidance and counseling services	☐(1)	☐(0)	

	2b. Services/ activities recommended for the child's current education needs	Yes	No	2c. Mention the education need for which this service is recommended
18	Education support services	☐(1)	☐(0)	
19	School after school services	☐(1)	☐(0)	
20	Second chance	☐(1)	☐(0)	
21	Services assessing employment skills	☐(1)	☐(0)	
22	Labor market mediation and counseling services	☐(1)	☐(0)	
23	Job-seeking support, including accompaniment	☐(1)	☐(0)	
24	Adult vocational training services	☐(1)	☐(0)	
25	Sports club activities, football team. similar	☐(1)	☐(0)	
26	Activities at the children's center, dance groups, other leisure activities	☐(1)	☐(0)	
27	Other, namely.....	☐(1)	☐(0)	
28	Other, namely.....	☐(1)	☐(0)	

I. Administrative chapter

1. Has the education sheet been attached to the child's file? 1. Yes 2. No

2. Has the sheet been signed by a teacher from the school attended by the child?
1. Yes 2. No

Date when the sheet was filled out

DD	MM	YYYY

Name and surname of the person filling in the sheet _____

Position _____

Signature _____

Instrument 8: List of families/ attachment figures for the child/ young person

Q1. What's the status of the identification of families/ attachment figures for the child/young person?	1. Has not started yet - **Attention! Service for the identification of families/ attachment figures for the child/young person - STOP** 2. Ongoing - **Attention! Service for the identification of families/ attachment figures for the child/young person** 3. Completed
For codes 2 or 3 for Q1	
Q1a. Date when the process started	|__|__||__|__||__|__|__|__|
For code 3 to Q1,	
Q1b. Date when the process ended	|__|__||__|__||__|__|__|__|
For codes 2 or 3 for Q1	
Q2. Have you identified families/ attachment figures for the child/young person?	1. Yes 2. No - STOP
For codes 1 for Q2	
Q2a. Altogether, how many families/ attachment figures for the child/young person have been identified? *Count households!*	|__|__|
Fill out the following information for each family/ person:	
Q3. Type of family/ attachment figure for the child/young person *Multiple answer*	1. Mother and father (maybe plus other relatives) 2. Only mother (maybe plus other relatives) 3. Only father (maybe plus other relatives) 4. Only adult siblings (maybe plus other relatives) 5. Maternal grandparents (maybe plus other relatives) 6. Paternal grandparents (maybe plus other relatives) 7. Aunts/ uncles (maybe plus other relatives) 8. Other relatives up to the 4th degree 9. Other relative above the 4th degree 10. Other non-related persons
Q4. Contact person's name and surname	……
Q5. Kinship between the contact person and the child/young person	1. Mother 2. Father 3. Brother/sister 4. Grandparent 5. Uncle/aunt 6. Other relative up to the 4th degree, namely: 7. Other relative above the 4th degree, namely: 8. Other non-related person, namely...

Q6. Do you know the address of the family/attachment figure?	1. Yes 2. No
For code 2 to Q6,	
Q6a. Explanation	…… **Attention! Service for the identification of families/ attachment figures for the child/young person - STOP**
For code 1 to Q6,	
Q7. Write down the address:	
Q7a. Country	…….
Q7b. County	……
Q7c. Town/ commune	…….. **SIRSUP**……..
Q7d. Village	…….. **SIRINF**…….
Q7e. Street……**Q7f. Number**…….	**Q7g. Building**……..**Q7h. Entrance** …… **Q7i.Apartment**…….
Q8. Has there been a meeting between the social worker and the family/attachment figure, to discuss their involvement in raising and educating the child/young person?	1. Yes 2. No **Attention! Meeting/ discussion with the family/ attachment figure / steps towards the (re)integration - STOP**
For code 1 to Q8,	
Q9. Has the family/ attachment figure expressed their intention to actually get involved in raising and educating the child/young person?	1. Yes 2. No **Attention! Working with the family/ attachment figure, in view of improving the relationship with the child/young person - STOP**

For code 1 to Q9, also fill out Instrument 9. Assessment of the needs of the family/attachment figure and of their bond to the child/young person.

Instrument 9: Questionnaire evaluating the needs of family or person of attachment and its relationship with the child/ young person

The survey is to be filled out for every family/ attachment figure identified for the child/ young person that expressed the desire to actually get involved in raising and educating the child/ young person (as resulting from Instrument 8 for the child/ young person).

Questionnaire evaluating the needs of family or person of attachment and its relationship with the child/ young person

County: **Commune:**	**Village:**
Name of the head of the household	
Address:	**Phone:**

The responsible for the QUESTIONNAIRE is the reference person (the person providing the data) from the household, referred to as a contact person in Instrument 8. List of families/ attachment figures for child/ young person.

The household is a group of people who usually live together, generally have kinship relationships, do household work (they do housekeeping together), sometimes work together in the household, jointly consume and capitalize products, participate in full or in part in making and using the household's income and expenses budget.

Contact information for the QUESTIONNAIRE responsible of the household (contact person in Instrument 8. List of families/ attachment figures for child/ young person:
Name and surname .....
Telephone.....
Email.....

Kinship between the person responsible for the survey and the child in the protection system:

1- father
2- mother
3- brother
4- sister
5 - sister/brother-in-law
6 - maternal grandmother
7 - maternal grandfather
8 - paternal grandmother
9 – paternal grandfather
10 - uncle/aunt
11 - cousin
12 – other relative up to the 4th degree
13 – other relative above the 4th degree
0 - not related

A. Household composition

It is filled in for all the members of the household. The reference person (the person providing the data) is the QUESTIONNAIRE responsible from the household, aged 15 and over, preferably the person who is the main caregiver of the children in the household.
The household is a group of people who usually live together, generally have kinship relationships, do household work (they do housekeeping together), sometimes work together in the household, jointly consume and capitalize products, participate in full or in part in making and using the household's income and expenses budget.

Each individual in the household receives a unique household registration code from 1 to n	Registration of household members will start with the head of the household, the first couple, if any, and will continue with the children from the oldest to the youngest. This structure will be repeated for each family in the household.	1 - yes 0 - no	1 - head of the household 2 - husband/ wife/ concubine 3 - son/ daughter 4 - son/daughter-in-law 5 - grandson/granddaughter 6 - father/mother/ parent-in-law 7 - sibling/ brother/sister-in-law 8 - another relative 9 - children in foster care 10 - not related	1-male 2-female	Write down the full date of birth			1 - yes 0 - no	***If ACTE1 = 1***
Person's code within the household	**Name and surname of the person**	**Contact person in Instrument 8**	**Relationship with the head of the household**	**Gender**	**Date of birth**			**The person has a birth certificate?**	**Personal identification number**
CPERS	NAME	**CONTACT**	REL	SEX	AAAA	LL	ZZ	ACTE1	Personal identification number
01									
02									
03									
04									
05									

	For people above 13 years old 1- yes 0 - no	1 - Romanian 2 - Hungarian 3 - Roma 4 - German 5 - other	1 - married 2 - concubine 3 - divorced 4 - separated 5 – not married 6 - widow	*For people above 9 years old* *Write the education level completed, NOT the ongoing one* Write the level of education graduated rather than the one in progress. 1 – not a graduate of education 2 - primary (1-4 classes) 3 - gymnasium (5-8 grades) 4 - professional, apprenticeship or complementary 5 - 1st grade high-school (grades 9-10) 6 – high-school (9-12 grades) 7 - post-secondary or technical 8 - short-term college / college 9 - long-term academic (including masters) 10 - PhD	1 - yes 0 - No 7 - not applicable, does not have children under 26
Person's code within the household	**The person has an identity card?**	**Ethnicity**	**Marital status**	**The last and highest education form graduated**	**Does the person have at least a child under 26 in special care?**
CPERS	ACTE2	NAT	STACIV	NIVE	OTHERCHILD
01					
02					
03					
04					
05					

B. Family nucleus

	1. wage earner 2. another status of wage earner (day laborer, black market worker etc.) 3. employer 4. self-employed in non-agricultural activities (including certified natural person, family association, freelancer) 5. self-employed in agriculture 6. family support 7. registered unemployed 8. unregistered unemployed (no longer receiving unemployment benefits/allowance and seeking job) 9. old-aged pensioner 10. other type of pensioner 11. pupil, student (Note! Include also children attending kindergarten). 12. housewife 13. person in work incapacity 14. another status of inactive person (pre-school pupil not attending the kindergarten, dependent)	1 - is autonomous, i.e. eat, dress, move alone 2 - needs support for performing basic activities 3 - depends entirely on others	*For persons that have codes 2 or 3 for AUTONOMY* 1. Yes 0. No	The family nucleus can be comprised of: (1) a single person, above 18; (2) adult couple (married or in a consensual union); (3) adult couple (married or in a consensual union) or a single person. that are looking after other persons of 18+, pupils, students or dependents; (4) adult couple (married or in a consensual union) or a single person, that are looking after children and other dependents. Every person should be included in a family nucleus.
Person's code within the household	**Main occupational status in the latest 12 months**	**In day-to-day basic activities, the person ...**	**Does the person benefit from the support of another person (caregiver)?**	**Set the family nuclei and assign each family nucleus a code from 1 to n.**
CPERS	OCUP	AUTONOMIE	INGR	COD_NUCLEU
01				
02				
03				
04				
05				

C. Data about members of the household

1. Children and parents from the household

It shall be filled in with data relating to all the members of the household. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	For persons under 18 1. Yes 0. No	*If MOMPREZ = 1*	*If MOMPREZ = 0* 2 – working abroad 3 – left for studies or work in the country 4 – admitted in the hospital for a short term period (under 45 days) 5 – person hospitalized/ placed in care for the long term (over 45 days) 6 - person imprisoned 10 - divorced/ separated and moved 11- deceased 12 - missing person or legally declared dead 13 - unknown person 22 - person in an institution / care center, etc. long-term	*If MOMPREZ = 0*	*For persons under 18* 8 - person deprived of the exercise of parental rights 9 - the person to whom the penalty of the prohibition of rights was applied 10 - person under judicial interdiction 0 - in none of the situations
Person's code within the household	**The mother is present in the household?**	**Note the mother's code (CPERS)**	**Where is the mother?**	**From what year the mother is no longer present in the household?**	**Is the mother in any of the following situations?**
CPERS	MOMPREZ	MOM	ASKMOM	ANMOM	SITMOM
01					
02					
03					
04					
05					

	For persons under 18 1. Yes 0. No	*If DADPREZ = 1*	*If DADPREZ = 0* 2 – working abroad 3 – left for studies or work in the country 4 – admitted in the hospital for a short term period (under 45 days) 5 – person hospitalized/ placed in care for the long term (over 45 days) 6 - person imprisoned 10 - divorced/ separated and moved 11- deceased 12 - missing person or legally declared dead 13 - unknown person 22 - person in an institution / care center, etc. long-term	*If DADPREZ = 0*	*For persons under 18* 8 - person deprived of the exercise of parental rights 9 - person subject to the criminal punishment of denying him/her parental rights 10 - person under a court injunction 0 - none of the situations	*For persons under 18* *The caretaker can be a minor (older brother, sister) or themselves if there are no adults in the household!* Clearly note the name of the main caretaker for each child in the household aged under 18 years.	*For persons under 18* 1 - father/ mother 2 - sibling/ brother/sister-in-law 3 - grandfather/ grandmother 4 - uncle/aunt 5 - another relative 0 - not related 100 - his/her own person
Person's code within the household	**The father is present in the household?**	**Note the father's code (CPERS)**	**Where is the father?**	**From what year the father is no longer present in the household?**	**Is the father in any of the following situations?**	**Who is the main caretaker for the children in the household?**	**What is the relationship between caregiver and child?**
CPERS	DADPREZ	DAD	ASKDAD	ANDAD	SITDAD	MAINRESP	RELRESP
01							
02							
03							
04							
05							

2. Parents absent from home

It shall be filled in with data relating to all the members of the household. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	For persons under 18 0 - no parent 1 - one parent 2 - both parents	*For persons under 18* *For codes 0 or 1 for HOME* 0 - no parent 1 - only the mother 2 - only the father 3 - both parents	*For codes 1 or 2 for STRANGER* 1 - every week 2 - every month 3 - a few times a year 4 - once a year 5 - less often than once a year 0 – never, the mother no longer communicates with the child	*For codes 1 or 2 for STRANGER* 1 - every week 2 - every month 3 - a few times a year 4 - once a year 5 - less often than once a year 6 - when she comes home / visiting 0 – never, the mother does not contribute financially	*For codes 1 or 2 for STRANGER* 1 - Yes 0 – No	*For codes 1 or 2 for STRANGER* 1 - every week 2 - every month 3 - a few times a year 4 - once a year 5 - less often than once a year 0 – never, the mother no longer communicates with the child	*For codes 1 or 2 for STRANGER* 1 - every week 2 - every month 3 - a few times a year 4 - once a year 5 - less often than once a year 6 –when coming home/visiting 0 - never, the father no longer communicates with the child	*For codes 1 or 2 for STRANGER* 1 - Yes 0 - No
	How many parents does the child have at home?	**How many of the child's parents are working abroad?**	**How often does the mother talk to the child (face to face, phone, Internet)?**	**How often does the mother send him/ her money or packages?**	**The mother does activities together with the child, they go on trips, spend holidays together?**	**How often does the father talk with the child (face to face, on the phone, on the Internet)?**	**How often does the father send him/ her money or packages?**	**The father does activities together with the child, they go on trips, spend holidays together?**
CPERS	ACASA	STRAIN	MTALK	MPAC	MACTIV	DTALK	DPAC	DACTIV
01								
02								
03								
04								
05								

	For persons under 18 1 - Yes 0 - No	*For persons under 18* 1 - Yes 0 - No	*For persons under 18* 1 - Yes 0 - No	*For persons under 18* 1. Yes 0. No	*For persons under 18* 1. Yes 0. No	*For persons under 18* 1. Yes 0. No	*For persons under 18 and for code 1 at PLECAT* Clearly mention name of the country	*For persons under 18 and for code 1 at PLECAT*
	The child's mother is a minor?	**If the child has been placed for a period of time in the protection system, is he/she now reintegrated into the family?**	**Child in placement with the relatives?**	**Child in placement with other persons?**	**Child in placement with the relatives?**	**Has the child been away from the country once or on several occasions, for periods longer than 3 months, beyond the school holiday period?**	**Where was he/she last?**	**For how long was he/she away last time?**
CPERS	CMIN	REIN	PLAS1	PLAS2	MATERN	PLECAT	CAND	CAT
01								
02								
03								
04								
05								

3. Health in general

Fill in with data on all household members. The reference person (the person providing the data) is the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	1. Yes 0. No	1. Yes 0. No For example, TB, HIV, diabetes, mental illness, etc.	*For code 1 at BCRON,* 1. Most of the time, yes 2. Most of the time, no	*For code 1 at BCRON,* 1. Yes 0. No For example, diabetes, oncology, etc.	*For code 1 at BCRON,* 1. Yes 0. No	1. Yes 0. No	*For code 1 at DIZ,* 1 - Psychical 2 - Visual 3 - Auditory 4 - Deafblindness 5 - Somatic 6 - Mental 7 - Psychic 8 - HIV/AIDS 9 - Associated 10 - Rare disease	*For code 1 at DIZ,* 1. Yes 0. No	*For code 1 at DIZ,* 1. Yes 0. No	*For persons who have CTF=1* The year of the last evaluation is noted!	*For persons who have CTF=1* 1 - mild 2 - medium 3 - accentuated 4 - severe
	Person registered to the family doctor	**A person suffering from a chronic illness**	**The person manages to pay the medicines/ services required for continuous treatment**	**The person benefits from a National Program**	**The person benefits from the specialized care he/she needs**	**The person suffers from a handicap/ deficiency/ disability which significantly limits her quality of life and participation in social life?**	**Type of disability**	**The person benefits from the specialized care he/she needs**	**Person with a disability certificate**	**Year of obtaining the disability certificate**	**Degree of disability**
CPERS	MEDIC	BCRON	MEDS	PRGN	INBC	DIZ	DIZTIP	INDIZ	CTF	ANCTF	GRADHAND
01											
02											
03											
04											
05											

	For code 1 at DIZ, 1. Most of the time, yes 2. Most of the time, no	*For code 1 at DIZ,* 1. Most of the time, yes 2. Most of the time, no	1. Yes 0. No	*For persons of over17 years* 1. Yes 0. No	*For persons of over17 years* 1. Yes 0. No *Include all alcoholic drinks: beer, wine, spirits, etc.*	*For persons of over17 years* 1. Yes 0. No		1. Yes 0. No
	The person manages to provide own treatment, medicines, equipment needed	**The person manages to get to the specialized doctor/ recovery sessions as often as necessary**	**The person consumes fresh vegetables and fruits daily**	**The person consumes meat, milk, eggs daily**	**The person consumes alcohol daily**	**The person smokes daily**	**Health state subjective evaluation, on a scale from 1 (very bad) to 10 (very good).**	**Has the person undergone a routine medical check during the past 6 months?**
CPERS	TRAT	RECUP	VEG	CARNE	ALC	TUTUN	SAN	CONTROL
01								
02								
03								
04								
05								

4. Children's health

Fill out with data on the children in the household. The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

	Only for children (<18 years) Fill out in grams	*Only for children (<18 years)* Fill out in cm	*Only for children (<18 years)* 1 - yes, all 2 - yes, some 3 - no, none 9 - Don't know	*Only for children (<18 years)* 1 - yes 0 - No	*Only for children (<18 years)* Multiple answer: 1 - neglect 2 - physical abuse 3 - sexual abuse 4 - psychic or emotional abuse 5 - exploitation 6 - street work or begging	*Only for children (<18 years)* *The questions refers only to meals in the family* 1 - a single meal per day 2 - two meals per day 3 - three meals per day	*Only for children (<18 years)* 1 - yes 0 - No	*Only for children (<18 years)* 1 - from shops, bought by parents/caretaker 2 - from second hand shops 3 - from relatives, neighbours or others from the community 4 - from elsewhere, namely....	Only for code 4 for CLOTHES	*Only for children (<18 years)* 1 - yes 0 - No	*Only for children (<18 years)* 1 - twice a day 2 - once a day 3 - several times a week 4 - when he remembers 5 - on special occasions 6 - do not wash	*Only for children (<18 years)* 1 - every day 2 - several times a week 3 - once a week 4 - less frequently
	How much does the child currently weight?	**What's the child's current height?**	**Has the child been administered all the mandatory vaccines?**	**Has the child been admitted to hospital on several occasions during the past 12 months, as a solution for problems such as lack of family supervision during the agricultural works season or the impossibility of heating the house in winter time?**	**The child has experienced...**	**During the past two weeks, how many meals has the child had?**	**Is the child properly fed?**	**Where do most of the clothes he/she wears come from?**	**From elsewhere, namely....**	**Is the child properly dressed?**	**How often does the baby wash his teeth?**	**How often the baby bathes?**
CPERS	KILO	H	VACCALL	HOSP	TRAUMA	MESE	KWA	HAINE	HAINEalt	KWB	IG3	IG4
01												
02												
03												
04												
05												

5. Development of the child up to 1 year of age, inclusive

It shall be filled in with data relating to children under 1 year, inclusive. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	Only for children <12 months or = 12 months	*Only for children <12 months or = 12 months* Write the APGAR score, from 1 to 10, or write "don't know"	*Only for children <12 months or = 12 months* 1. Yes 0. No	*Only for children <12 months or = 12 months* 1. Yes 0. No	*Only for children 3 months old or above* 1. Yes 0. No	*Only for children 6 months old or above* 1. Yes 0. No	*Only for children 9 months old or above* 1. Yes 0. No	*Only for children 2 months old or above* 1. Yes 0. No	*Only for children 2 months old or above* 1. Yes 0. No	*Only for children 2 months old or above* 1. Yes 0. No	*Only for children of 2 or above* 1. Yes 0. No
	Baby weight at birth (grams)	**What was the child's APGAR score at birth?**	**Does the child receive vitamin D drops?**	**Does the child receive iron syrup?**	**Does the child keep his/her head up?**	**Does the child sit?**	**Does the child walk on all fours?**	**Does the child giggle?**	**Does the child laugh at you?**	**Does the child startle at noise?**	**The child track objects?**
CPERS	KG	APGAR	VITD1	FE	LNN3	LNN6	LNN9	GANG	RAS	NOISE	FLW
01											
02											
03											
04											
05											

	Only for children under 6 months 1 - yes, only from the chest 2 - Yes, from chest and supplement (cow's milk, milk powder) 3 - I'm not breastfeeding him	*Only for children 6 months old or above* 1 - yes 0 - No	*Only for code 1 for DIVERSIFICATION* 1. Yes 0. No	*Only for code 1 for DIVERSIFICATION* 1. Yes 0. No
	Do you breastfeed your baby?	**Have you started the food diversification after 6 months?**	**Do you give him a little meat every day?**	**Do you give your baby two eggs a week?**
CPERS	MILK1	DIVERSIFICATION	MEAT1	OU1
01				
02				
03				
04				
05				

6. The development of children aged 1 to 5 years old

Fill out with data related to children aged 1 to 5. The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

	Only for children > 12 months and < 5 years 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No	*Only for children > 12 months and < 5 years* 1. Yes 0. No
	Is the child receiving drops of Vitamin D?	**Is the child walking?**	**Does the child talk?**	**Does the child hear?**	**Does the child see?**	**Does the child smile/laugh?**	**Do you feed him/her meat every day?**	**Is he/she eating eggs two-three times a week?**
CPERS	VITD5	WALK	TALK	HEAR	SEE	SMILE	MEAT5	OU5
01								
02								
03								
04								
05								

7. The development of children aged 6 to 17 years old

Fill out with data related to children aged 6 to 17. The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

	Only for children > 5 and <18 years old 1. Yes 0. No	*Only for children > 5 and <14 years old* 1. Yes 0. No	*Only for children > 5 and <14 years old* 1. Yes 0. No	*Only for children > 5 and <14 years old* 1. Yes 0. No	*Only for children > 5 and <14 years old* 1. Yes 0. No	*Only for children > 13 and <18 years old* 1. Yes 0. No	*Only for children > 13 and <18 years old* 1. Yes 0. No	*Only for children > 13 and <18 years old* 1. Yes 0. No	*Only for children > 13 and <18 years old* 1. Yes 0. No
	Has the child been at the family doctor in the latest year?	**Has the child had breakfast daily in the latest 30 days?**	**Does the child walk, run for at least an hour a day?**	**Does the child watch TV for more than an hour a day?**	**Does the child stay on computer for more than an hour a day?**	**Have you talked with your family, friends, at school (with colleagues or teachers) about the differences between boys and girls?**	**Have you talked with your family, friends, at school (with colleagues or teachers) about the sexual activity?**	**Have you talked with your family, friends, at school (with colleagues or teachers) about menstruation?**	**Have you talked with your family, friends, at school (with colleagues or teachers) about conceiving children?**
CPERS	CONS13	MD	STILa	STILb	STILc	ADOLDIF	ADOLSEX	ADOLMENS	ADOLSAR

01									
02									
03									
04									
05									

8. Education of children in the household

It shall be filled in with data relating to the members of the household up to 18 years old. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	1. Yes 0. No	Mark the appropriate response: 0 - everything is allowed 1 - discussion, appeals to understanding 2 - punishment by deprivation (does not give him/her sweets, he/she is not allowed to watch television, to play, etc.) 3 - screams at the child 4 - threatens with punishment 5 - beats the child 6 – call the child names 7 - you affectionately take him/her in your arms 8 - no measure, indifference 9 - another method, namely...	*For code 9 to question DISCIP*	*For children >6 years old who are pupils (OCUP=11)* 1 - never 2 - sometimes 3 - most often 4 - always	1 - never 2 - sometimes 3 - most often 4 - always	*For people under 11* 1 - never 2 - sometimes 3 - most often 4 - always
	Does the child sometimes stay alone at home or only with sisters and brothers (without any adult)?	**The most commonly used method for disciplining the child**	**Other discipline methods**	**How often do you help the child with his/her homework?**	**How often do you spend time with the child doing what he/she likes?**	**How often do you caress the child, hold him/her and/or read bedtime stories?**
CPERS	CSING	DISCIP	DISCIPalt	TEME	TIMP	POV
01						
02						
03						
04						
05						

	Only for children aged >=3 years and < 6 years 1. Yes 0. No	*For code 1 to GRAD* 1. Yes 0. No	*For code 0 to GRAD* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years* 1. Yes 0. No	*For code 0 to SCHOOL* 1. Yes 0. No	*For code 1 to SCHOOLEVER* 1 - abandoned school 2 - was expelled	*For code 1 to SCHOOL* 1 - public school, including integrated education 2 - special school (schooling center for inclusive education)	*For code 1 to SCHOOL*	*For code 1 to SCHOOL* 1. Yes 0. No
	Is the child enrolled in the kindergarten?	**Does the child go to kindergarten daily?**	**Has the child ever been enrolled in kindergarten?**	**The child is enrolled in school?**	**Has the child ever been enrolled in school?**	**Why is he/she currently not in school?**	**The type of school that the child attends**	**What grade does the child attend?**	**Does the child go to school daily?**
CPERS	GRAD	GRADF	GRADEVER	SCHOOL	SCHOOLEVER	SCHOOLNOW	TYPESCH	CLASS	SCHOOLF
01									
02									
03									
04									
05									

	Only for children aged >=6 years and < 18 years, who are students (OCUP=11) and don't go to school on a daily basis (SCHOOL=0) 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are older than 1st grade* Note the note.	*Only for children aged >=6 years and < 18 years, who are older than 1st grade* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are older than grade 0* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are older than grade 0* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are not students* 1. Yes 0. No	*ABN=1* 1. Yes 0. No
	Is the child not always going to school because he/she has to go and work or look after his/her younger siblings or help out at home?	**Does the child have a school bag, notebooks, books and the necessary supplies?**	**What was the score for behavior in the latest school year?**	**Has the child failed some subjects in the last year?**	**Did the child repeat a school year?**	**Does the child intend to drop out of school?**	**Does the child have a school guidance certificate?**	**a. abandoned school?**	**Did the child drop out of school to work?**
CPERS	ABS	RECHIZ	PURT	CORIG	REPET	ABNINT	CESb	ABN	ABNWORK
01									
02									
03									
04									
05									

	Only for children aged >=6 years and < 18 years, who are students (OCUP=11) 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No	*Only for children aged >=6 years and < 18 years, who are students (OCUP=11)* 1. Yes 0. No
	Does the child benefit from the "High School Money" program?	**Does the child benefit from the "EURO 200"program?**	**Does the child benefit from the "Professional Scholarship" program?**	**Does the child benefit from the "Croissant and Milk" program?**	**Does the child benefit from the "School supplies" program?**	**Does the child benefit from the "Scholarship" program?**
CPERS	BANIL	EURO200	BURSAPROF	CRNLP	RECHIZSC	PRBURSE
01						
02						
03						
04						
05						

9. Adult education from the household

It shall be filled in with data relating to the members of the household aged 11 years and over who are not students. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	For persons with (AGE>10) and (OCUP<>11) 1. Yes 0. No	*For persons with (AGE>10) and (OCUP<>11)* 1. Yes 0. No	*For persons with (AGE>10) and (OCUP<>11)* 1. Yes 0. No
	Does the person know how to read?	**Does the person know how to write?**	**Does the person know how to do basic arithmetic calculations?**
CPERS	CITIT	SCRIS	OPMAT
01			
02			
03			
04			
05			

10. Income Sources

It shall be filled in with data relating to all the members of the household. The reference person (the person providing the data) shall be the person in the household aged 15 and over, preferably the person who is the main caregiver of the children in the household.

	For persons aged >15 and <64, that have codes 1, 2, 3, 4, 5 for OCUP 1. Yes 0. No	*For persons aged >15 and <64, that have codes 1, 2, 3, 4, 5 for OCUP* 1. Yes 0. No	*For persons aged >15 and <64, that have codes 8, 12 or 14 for OCUP* 1. Yes 0. No	*For persons aged >15 and <66* Medical leaves, maternity leaves and in kind incomes shall be included. Lei	*For persons aged >15 and <66* Reference period - latest month Profit, crafts income, trade, service supply, free lancing, intellectual property shall be included. Lei	*For persons aged >15 and <66* Include day labor incomes Lei
	Do you have a labor contract?	**The person has a stable income**	**Does the person take care of own children or of other dependents outside the household?**	**Wages. Person that in the last month received a salary**	**Income from independent non-agricultural activities**	**Income from independent agricultural activities**
CPERS	CONTRM	VENST	CARE	SAL	VFIRM	VAGRIC
01						
02						
03						
04						
05						

	For persons with AGE > 15 and AGE<66 Reference period - latest month Lei	Reference period - latest month Allowances for single parent families, complementary allowances shall be included. Lei	Reference period - latest month Lei	*Only for students* Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Social support pensions, survivor pensions, IOVR pensions shall be included. Lei	Reference period - latest month For veterans and war widows, for politically persecuted persons, for martyr heroes and their offspring Lei
	Unemployment benefit /vocational integration support /support allowance	**Allowances for children**	**Family support allowance**	**Scholarships for pupils and students**	**Social insurance pensions for old age**	**Pensions for farmers (cooperative pensions)**	**Other types of pensions**	**Indemnities assimilated to pensions**
CPERS	AJSOM	ALOCPC	BS9	BURSA	PMUN	PAGR	PALTE	INDEM
01								
02								
03								
04								
05								

	Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Lei	Reference period - latest month Heat subsidy, wood Lei	Reference period - latest month Lei	Reference period - latest month For instance, support received by people with extremely severe medical conditions, for medical treatment and surgeries. Lei
	Monthly placement indemnity	**Monthly indemnity for persons with severe and accentuated handicap**	**Monthly indemnity for adult companions of persons with severe handicap**	**Monthly food indemnity for HIV or AIDS patients**	**Social support (Minimum guaranteed income)**	**Support for home heating**	**Emergency support**	**Other benefits, support**
CPERS	BS1	BS2	BS3	BS4	BS10	BS11	BS12	BS13
01								
02								
03								
04								
05								

	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No
	Food support from the European Union	**Daycare center**	**Social canteen**	**Powdered milk for babies**	**Other indemnities provided for by special laws**
CPERS	BS5	BS6	BS7	BS8	BSx
01					
02					
03					
04					
05					

11. Teenage at-risk behaviors

Fill out with data on the members that are above 13 years old and under 18. The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No	1. Yes 0. No
	Teenager had fights or violent incidents with other kids or youngsters	**Teenager is part of an at-risk group**	**Teenager has ever ran away or left home**	**Teenager has had problems with the police**	**Is the teenager sexually active?**	**Teenager is an underaged mother, is pregnant or had children**
CPERS	ADVIOLENCE	ADGRUP	ADRUN	ADPOL	ADSEX	ADMOM
01						
02						
03						
04						
05						

12. Behavior at risk in the family

	1. Yes 0. No	*Only for WOMAN=1* 1. Yes 0. No 99 - Does not have a husband/partner	*For persons above 13 years old* Multiple answer, please circle all appropriate codes: 1. Alcohol addiction 2. Drug addiction 3. Experiences with police or criminal history 4. Prostitution experiences 5. Begging experiences 6. Domestic violence
	Do you have or have you ever had a partner with whom to have sexual intercourse?	**Has your husband/partner ever hit you?**	**Does the person have problems related to...?**
CPERS	WOMAN	**VIOLENCE**	**POTRISC**
01			
02			
03			
04			

13. Data about 10 year old girls and over and women in the household who have had a partner
A. Contraception and births

It shall be filled in with data on women, 10 years of age and over, who have had a partner. It shall be filled in with the woman, possibly in the presence of the caretaker, for those younger than 15.

	For code 1 at WOMAN 1. Yes 0. No	*For code 1 at WOMAN*	*For code 1 at WOMAN*	*For code 1 at WOMAN*	*For code 1 at WOMAN and NRKIDS > 0*	*For code 1 at WOMAN and ALIVEKIDS > 0*	*For code 1 at WOMAN and ALIVEKIDS > 0*
	Do you use contraceptive methods?	**How many live births have you had in your life?**	**Number of children that died**	**Number of children alive, irrespective of their age**	**Number of children born by you who are alive and under the age of 26 now**	**Number of children born by you who are alive and under the age of 26 now, living in your household**	**Number of children born by you who are alive and under 26 years of age now, not living in your household**
CPERS	CONTACEPT	NRKIDS	NRDEAD	NRALIVE	ALIVEKIDS	INHOMEKIDS	KIDSOUT
01							
02							
03							
04							
05							

	KIDSOUT>0	KIDSOUT>0	KIDSOUT>0	KIDSOUT>0	KIDSOUT>0	WOMAN == 1 and ALIVEKIDS > 0 1. Yes 0. No	WOMAN == 1 and ALIVEKIDS > 0 1. Yes 0. No	*For code 1 at WOMAN* 1. Yes 0. No	*For code 1 at WOMAN* 1. Yes 0. No
	Out of your children aged under 26 who do not live in your household, how many are in the child protection system?	**Out of your children aged under 26 years of age who do not live in your household, how many live with other relatives, without a protection measure?**	**Out of your children aged under 26 years of age who do not live in your household, how many live with other persons, without a protection measure?**	**Out of your children aged under 26 years of age who do not live in your household, how many were left in the maternity or in a medical center (and the mother does not know of their whereabouts)**	**Out of your children aged under 26 years of age who do not live in your household, how many are in a different situation (e.g. Married, living elsewhere)**	**Have you ever made an institutionalizati on request for any of your children?**	**Have you ever been the subject of any Child Protection Service investigation (DGASPC)?**	**Are you pregnant?**	**Have you given birth in the latest 12 months?**
CPERS	KIDSOUT1	KIDSOUT2	KIDSOUT3	KIDSOUT4	KIDSOUT5	KIDINST	ANCHET	PREG	BIRTH12
01									
02									
03									
04									
05									

13. Data about 10 year old girls and over and women in the household who have had a partner
B. Pregnant women

It shall be filled in with data on women, 10 years of age and over, who have had a partner. It shall be filled in with the woman, possibly in the presence of the caretaker, for those younger than 15.

	PREG == 1	PREG == 1 1. Yes 0. No	PREG == 1 1. Yes 0. No	PREG == 1 1. Yes 0. No
	What month of pregnancy are you in?	**Is your pregnancy registered with your family doctor?**	**Did you go to prenatal checks?**	**Did you want to get pregnant?**
CPERS	LUNSAR	MDSAR	CONTPR	PLAN
01				
02				
03				
04				
05				
06				
07				
08				
09				
10				

14.Children separated from their families

To be filled out for all children under 26 that ended up in child care (if at least one person in the household has at least a child under 26 sent to the special protection system - OTHERCHILD=1), including for the child in the nominal list for whom the Survey for assessing the family/attachment figure's needs was filled out. This will be automatically put on the first line in table CPERS=1. Fields with information from the initial evaluation (marked in grey) will be automatically filled out.

		1- Male 2 - Female				1 – Yes 0 - No	*If ACTE1=1*	*For people above 13 years old* 1 – yes 0 - Nu
Child code	**Name and surname**	**Child gender**	**Year of birth**	**Month of birth**	**Day of birth**	**The person has a birth certificate?**	**Personal identification number**	**The person has an identity card?**
CPERSCHILD	NAME	SEX	AA	LL	ZZ	ACTE1	Personal identification number	ACTE2
01								
02								
03								
04								
05								

	1 - Romanian 2 - Hungarian 3 - Roma 4 - German 5 - other	1 - married 2 - concubine 3 - divorced 4 - separated 5 – not married 6 - widow	*For people above 9 years old* *Write the education level completed, NOT the ongoing one* Write the level of education graduated rather than the one in progress. 1 – not a graduate of education 2 - primary (1-4 classes) 3 - gymnasium (5-8 grades) 4 - professional, apprenticeship or complementary 5 - 1st grade high-school (grades 9-10) 6 – high-school (9-12 grades) 7 - post-secondary or technical 8 - short-term college / college 9 - long-term academic (including masters) 10 - PhD	1 - Placement center 2 - Family-type home/ apartment 3 - Placement with the relatives 4 - Placement with other people 5 - Foster care 9 - Don't know
Child code	**Ethnicity**	**Marital status**	**The last and highest education form graduated**	**The child is in which protection service?**
CPERSCHILD	NAT	STACIV	NIVE	SERVP
01				
02				

03				
04				
05				

	For people under 18 1 - Yes 0 - No	*For code 1 to MOMPREZ*	*If MOMPREZ = 0* 2 – working abroad 3 – left for studies or work in the country 4 – admitted in the hospital for a short term period (under 45 days) 5 – person hospitalized/ placed in care for the long term (over 45 days) 6 - person imprisoned 10 - divorced/ separated and moved 11- deceased 12 - missing person or legally declared dead 13 - unknown person 22 - person in an institution / care center, etc. long-term 99 - don't know	*For code 0 to MOMPREZ*	*For persons under 18* 9 - person subject to the criminal punishment of denying him/her parental rights 10 - person under a court injunction 0 - none of the situations	*For people under 18* 1 - yes 0 - Nu	*For code 1 to DADPREZ*	*If DADPREZ = 0* 2 – working abroad 3 – left for studies or work in the country 4 – admitted in the hospital for a short term period (under 45 days) 5 – person hospitalized/ placed in care for the long term (over 45 days) 6 - person imprisoned 10 - divorced/ separated and moved 11- deceased 12 - missing person or legally declared dead 13 - unknown person 22 - person in an institution / care center, etc. long-term 99 - don't know	*For code 0 to DADPREZ*	*For people under 18* 8 - person deprived of parental rights 9 - person subject to the criminal punishment of denying him/her parental rights 10 - person under a court injunction 0 - none of the situations
Child code	**The mother is present in the household?**	**Note the mother's code (CPERS)**	**Where is the mother?**	**From what year the mother is no longer present in the household?**	**Is the mother in any of the following situations?**	**The father is present in the household?**	**Note the father's code (CPERS)**	**Where is the father?**	**From what year the father is no longer present in the household?**	**Is the father in any of the following situations?**
CPERSCHILD	MOMPREZ	MOM	ASKMOM	ANMOM	SITMOM	DADPREZ	DAD	ASKDAD	ANDAD	SITDAD
01										
02										
03										
04										
05										

15. Relation of household with children currently in the protection system

To be filled out for all children under 26 that ended up in child care (if at least one person in the household has at least a child under 26 sent to the special protection system - OTHERCHILD=1), including for the child in the nominal list for whom the Survey for assessing the family/attachment person's needs was filled out. This will be automatically put on the first line in table CPERS=1.

	1 - Yes 0 - No	1 - Yes 0 - No	Multiple answer: 1 - Yes, someone from Child Protection 2 - Yes, a social worker from the town hall 3 - yes, a representative of an NGO 4 - Yes, somebody else 5 - No, no one	1. Yes, I would take him back anytime 2. Yes, but I could not take it now 3. No, I do not want to take it back	*Multiple answer* 1. Build/ expand or repair the house 2. Receive a social housing (no payment) 3. Increase household incomes 4. Raise the small children 5. Ensure child's access to education services suitable for his/her 6. Ensure child's access to recovery, rehabilitation or specialized medical services 7. Something else, namely...	*For code 7 to PZ1b*
	In the past 6 months, has anyone from the household visited the child?	**In the past 6 months, has anyone from the household contacted the child by phone?**	**After the kid left home, did anyone talk to you about the child's situation?**	**At the moment, someone in the household wants to take the child back?**	**Under which conditions could the child go back to his/her family?**	**Namely: ....**
CPERS	KIDVIS	KIDPHONE	DS5	PZ1	PZ1b	PZ1b1
01						
03						
04						
05						

	1. Yes, but only in visit 2. yes, but I do not know for how long 3. Yes, it will turn away 4. No, I do not think he will come back				*Multiple answer* 1 - relatives 2 - friends, neighbors 3 - the church 4 - City Hall / SPAS 5 - DGASPC 6 - NGO 7 - other people from the community 8 - other people outside the community 9 - No, no one	*D6<9*
	What do you think the child wants to come back ever to in your family?	**In total, how many visits did the child during the last 12 months?**	**In the past 6 months, how many times the case manager or another specialist from DGASPC (including the center) visit you at home in relation to the child's situation?**	**In the past 6 months, how many times has your household been visited by SPAS about the child's situation?**	**Your household received some support from someone to get your child home (to repress / reintegrate)?**	**What kind of support?**
CPERS	PZ2	HOWVIS2	**RELDGASPC**	**RELSPAS**	**DS6**	**RELSPASb**
01						
03						
04						
05						

D. Data about household

1. Incomes and expenses

Data referring to the household is filled in. The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

For codes 1 or 2 at ECON,
ECON1. How big are at present the savings in comparison to the total household income, with approximation?
1- less than the value of a monthly income
2 - approx. 1-2 monthly incomes
3 - approx. 2-3
4 - approx. 4-6
5 - approx. 7-12 monthly income
6 - more than the annual revenue
9 - IDK/NA
SUPR. If tomorrow, your household's income would be considerably reduced, by a quarter to say, for a period of 3 months or more, how long do you think you would manage to face this? 1 - Less than a week
2 - one week - less than 1 month
3 - 1-3 months
4 - 3 - 6 months
5 - 6 - 12 months
6 - one year or more
7 - IDK/ NA

VENG. Last month, the total amount of money earned from salaries, pensions, allowances, benefits, sales, etc. by all the members of the household (respondent included), was of about ...	lei
CONS. How much does your household spend on food in a typical month?	lei
AGRIC. Do you have a garden or a household, relatives or countryside friends from where do you get or receive food?	1 – yes 0 – no
VNEED. Would you be able to cope with current spending with your net monthly income in the past month?	1 – yes 0 – no
VENSUB. How do you assess the current income of your household?	1 - it is not enough for the strict necessities 2 - it is enough for only strict necessities 3 - it is enough for a decent living, but we cannot afford the purchase of more expensive goods 4 - we manage to buy some more expensive goods, but with restrictions in other areas

	5 - we manage to have everything we need, without restrictions from anything
ECON1. As an estimate, what are your current savings?	lei
GOODS The family owns:	1 - a car 2 - farm land, forest, grazing land 3 - real estate
REM1. . How often does money of the household come from the members having left to work abroad?	1 - every month 2 - once every two months 3 - every three months 4 - less often or as many times as they can 5 - only when they come to the country 6 - never 0 - there are no members leaving abroad
For codes 1-5, **REM2.Approximately what total amount is sent per year (lei)?**	lei

2. Living conditions

It shall be filled in with data relating to the entire household.The reference person (the one providing the data) is someone from the household, at least 15 years old, if possible the main caretaker of the children in the household.

L1. How often could you not heat your home and suffer from cold this winter?	1. daily 2. several times a week 3. once a week	4. several times a month 5. less often 6. never
L2. How often did you not have what to put on the table and the children suffered from hunger in the last 6 months?	1. daily 2. several times a week 3. once a week	4. several times a month 5. less often 6. never
L3. How many rooms does your home have, apart from kitchen, bathroom, lounges and other annexes?	|__|__|	
L4. How many rooms are slept into?	|__|__|	
I.4A. Number of beds in which only children sleep	|__|__|	
L4b. Number of beds in which only adults sleep	|__|__|	
L4c. Number of beds in which adults and children sleep	|__|__|	
L4d. Has it happened in the last 6 months for a family member to have to sleep elsewhere (on the floor, in the stable, on a bench) because he/she didn't have room in the bed?	1 – yes 0– no	
L4e. Every bed is equipped with all necessary equipment (sheets, blankets, pillows, etc.)?	1 – yes 0– no	

L5. Is there a special place for children where they can do homework/play in your household?	1 – yes 0- no
L7. Does the number of rooms in your home satisfy your household needs?	1 – yes 0- no
L_Buc_a. Does the house have a designated space for cooking?	1 – yes 0- no
L_Buc_b. Does the house have the proper appliances for cooking (cooker, cooking stove, fridge, etc.)?	1 – yes 0- no
L8a. How many couples are there in your household?	|__|__|
L8b. How many single persons aged 18 and over are there in your household?	|__|__|
L8c. How many girls aged between 12 and 17 (that are not in a couple) are there in your household?	|__|__|
L8d. How many boys aged between 12 and 17 (that are not in a couple) are there in your household?	|__|__|
L9a. Do you have problems with your household (roof leakage, damp walls, and rotten/damaged windows/floors)?	1 – yes 0- no
L9b. Are the rooms lighted naturally?	1 – yes 0- no
L9c. Does the house have a bathroom or a shower?	1 – yes 0- no
L9d. Do you have the toilet inside connected to the sewage system?	1 – yes 0- no
L9e. Is the housing connected to the electricity system?	1 – yes 0- no
L9f.Is the housing connected to an uncontaminated water system?	1 – yes 0- no
L9g.Is the housing connected to the sewer system?	1 – yes 0- no
L9j. Does the house have a TV set?	1 – yes 0- no
L9k. Is there a computer in the house that kids can access?	1 – yes 0- no
L9l. Is there an internet connection?	1 – yes 0- no
BOOKS. Do you have books for children at home?	1 – yes 0- no
TOYS. Do you have adequate toys for the children?	1 – yes 0- no
L9m. Does your housing have access to a proper garbage collection system?	1 – yes 0- no
IG1a. Does every member of the household, children included, have access to soap?	1 – yes 0- no
IG1b. Does every member of the household, children included, have access to shampoo?	1 – yes 0- no
IG1c. Does every household member, children included, have access to toothbrush and toothpaste?	1 – yes 0- no
GEO1. The house is located:	1 - in downtown 2 - between the center and the outskirts 3 - at the outskirts 4 - outside the locality, in a colony
GEO2. About 2000m around the house, there are:	1 - one or several inhabited dwellings 2 - a forest 3 - a landfill 4 - a river, a pond 5 - buildings no longer in use, ruins
GEO3. Is the housing located in a flood risk area?	1 – yes 0- no
GEO4. Is the housing located in an area of landslide risk?	1 – yes 0- no
L_DEBT. Does the household have debts for utilities and/or rent (if the case)?	1 – yes 0- no
***If Yes for L_DEBT*,** **L_DEBT_LEI. What's the total debt?**	 lei
L10. Type of housing ***Attention! Do not read the questions. To be filled out by the social worker, based on his/her assessment through direct***	1 - house, villa 2 - block apartment, studio

observation!	3 - improvised shelter 4 - Other situation
L10ALT. Other situation, namely	.....
L11. Housing ownership	1 - family owned 2 - owned by other relatives 3 - rented from the state 4 - rented from a private person 5 - social housing or received free of charge 6 - improvised shelter 7 - housing occupied without the owner's
For code 1 to L11. Write down the owner's CPERS **PROPLOC. Who owns the house?**	|__|__|
For code 1 to L11 **ACTELOC. Does the person that owns the place have official documents proving the ownership?**	1 – da 0 – nu

3. Social worker's assessment

To be filled out by the social worker, based on his/her assessment through direct observation!

OBS1. Household hygiene is...	1 - very poor 2 - poor 3 - average 4 - good 5 - very good
OBS2. Living conditions are...	1 - very poor 2 - poor 3 - average 4 - good 5 - very good

E. (Re)integration chances for the child/ young person on the nominal list for whom Instrument 9 was filled out

A3. How would you assess the real chances of (re) integrating the child into a family?

1. Very possible in a relatively short period of time
2. Possible if the child has access to education
3. Possible if the child has access to the necessary medical services
4. Possible if family support is provided to the family in order to grant the child a home or some house arrangement
5. Possible if other material support is offered to the family, and especially:
6. Possible under other circumstances, namely:
7. Not possible at all

IF "NOT POSSIBLE AT ALL", CODE 7 FOR QUESTION A3

A3b. Why family (re)integration is not possible?

A4. Has the conclusion above been communicated to the family? 1. Yes 2. No

---

A5. And has the family agreed with this conclusion? 1. Yes 2. No

---

B4. Has any working plan been established with the family? 1. Yes 2.No

F. Administrative chapter

1. Has the survey been attached to the child/young person's file? Yes2.Nu

2. Name of the person filling in the survey

3. Position

4. Filled out on (date):

Instrument 10: Proposed model of Conclusive Report for children and young persons from the nominal list

Data I. Data about the child, family and legal representative

QK1. Child name and surname: _____

QK2. Date of birth: |__|__||__|__||__|__|__|__|

QK3A. PIN |__|__|__|__|__|__|__|__|__|__|__|__|__|

QK3B. Does PIN present errors? **1. Yes** **2. No**

QK4. Gender **1. Male** **2. Female**

QK5. Ethnicity _____

QK7. Citizenship _____

QK8. Community of child provenience:

Country: _____ **City/commune** _____

County: _____ **Village:** _____

QM1. Situation of the mother

Mother's name and surname: _____

PIN mother |__|__|__|__|__|__|__|__|__|__|__|__|__|

QT1. Situation of the father

Father's name and surname: _____

PIN father |__|__|__|__|__|__|__|__|__|__|__|__|__|

REPREZ. Child's legal representative: _____

ACT1. According to decision regarding legal representative no.: _____ **ACT2. Released by:** _____

DATA_IN_SP. The date of the last (most recent) actual entry into public care |__|__||__|__||__|__|__|__|

CAUZE. What were the causes of child separation from the family?

PRINC_CAUZ. Of the above mentioned, which was the main cause of the child's entry into the protection system?

COPIL_MP. Does the child have a special protection measure at moment T0?

COPIL_PREZ. Is the child present in the center at moment T0?

If COPIL_MP=1 and COPIL_PREZ=2

COPIL_PLECAT. Where is the child?

Dacă COPIL_MP=1 sau COPIL_PREZ=1

DATA_IN_CP. The date of the last (most recent) actual entry in this placement center |__|__||__|__||__|__|__|__|

MANAGER_CAZ. Name and surname of case manager

COPIL_HANDICAP. Does the child have a disability qualification certificate?

If Yes,

COPIL_GRAD. What is the disability level?

COPIL_TIP. What is the disability type?

COPIL_IMOB_PAT. Is the child immobilized in bed?

COPIL_CES. Does the child have SEN?

II. Relevant data from the evaluation

(A) Medical assessment of the child

12. Does the child have health issues that…		Yes	No
4.	…put his/her life in danger?	☐(1)	☐(0)
5.	…requires the existence of a nearby hospital?	☐(1)	☐(0)
6.	…requires frequent assessments, investigations or medical examinations?	☐(1)	☐(0)

23. Recommendations

23a. Does the child have medical needs for which medical services and/ or specialized interventions are recommended?	1. Yes	2. No	9. Don't know

If Yes,

23b. Recommendations of medical services and specialized interventions for the current medical needs of the child		**Yes**	**No**	**23c. Specify the medical need of the child for whom this service is recommended.**
29.	Permanent medical assistance	☐(1)	☐(0)	
30.	Treatment and supervision from the family doctor	☐(1)	☐(0)	
31.	Treatment and supervision from the specialist doctor	☐(1)	☐(0)	
32.	Surgery	☐(1)	☐(0)	
33.	Prosthesis	☐(1)	☐(0)	
34.	Kinetotherapy	☐(1)	☐(0)	
35.	Other types of medical recovery	☐(1)	☐(0)	
36.	Logopedy	☐(1)	☐(0)	
37.	Psychotherapy	☐(1)	☐(0)	
38.	Counseling and psycho-pedagogical assistance	☐(1)	☐(0)	
39.	Assistive devices and equipment	☐(1)	☐(0)	
40.	Family planning services	☐(1)	☐(0)	
41.	Sexual education services for young people	☐(1)	☐(0)	
42.	Other (specify, which)	☐(1)	☐(0)	
43.	Other (specify, which)	☐(1)	☐(0)	

(B) Psychological assessment of the child

Assessment of the child's psychological development areas

Investigated area	Level of development				The child/youngster needs stimulation/ optimization	
	Normal development	Slight delay	Medium delay	Severe delay	Yes	No
17. Memory	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
18. Language	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
19. Thinking	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
20. Attention	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
21. Emotionality	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
22. Will	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
23. Personality	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)
24. Behavior	☐(1)	☐(2)	☐(3)	☐(4)	☐(1)	☐(0)

Doar pentru copiii cu dizabilități și/sau CES

SECTION 6 - Recommendations for the child's habilitation-rehabilitation plan (by also mentioning, for services, the specific objective)

Recommendations of psychological services and other associated interventions, for the child/youngster's current psychological needs	Yes	No	Special objective of the service	Specialist that will provide the service	Institution from which the specialist is coming
17. Support/socializing group for the child	☐(1)	☐(0)			
18. Speech therapy services for the child	☐(1)	☐(0)			
19. Occupational therapies for the child	☐(1)	☐(0)			
20. Socializing activities for the child	☐(1)	☐(0)			
21. Teaching-educational activities for the child	☐(1)	☐(0)			
22. Psychotherapy necessary for the child's habilitation-rehabilitation	☐(1)	☐(0)			
23. Psychological re-evaluation and re-evaluation date	☐(1)	☐(0)			
24. Child's psychiatric evaluation	☐(1)	☐(0)			
25. Other service for the	☐(1)	☐(0)			

child, mention …… ….. 26. Other service for the child, mention …… ….. 27. Other service for the child, mention …… ….. 28. Psychological guidance/ support group for the person/family that will look after the child 29. Type of therapy for the person/family that will look after the child, mention…… ……. 30. Other service for the person/family that will look after the child, mention…… …….. 31. Other service for the person/family that will look after the child, mention…… …….. 32. Other service for the person/family that will look after the child, mention…… …….. ☐(1) ☐(0)					

Only for children without disabilities and without SEN

I. Support needed to ensure the child's/ young person's mental health:

10. Only psycho-education/ preventive psychological support..... ☐(1)
11. The psychological support can be provided by the family ..... ☐(1)
12. Psychological support from specialized services (counseling, psychotherapy, etc.)..... ☐(1)
13. Requires psychiatric evaluation ..... ☐(1)
14. Requires psychiatric treatment ..... ☐(1)
15. Other recommendations ..... ☐(1)

(C) Social assessment of the child

B2. Through which kind of protection services did the child go, from his/ her last (most recent) entry into the system until now?*Multiple answer*

1. Placement with relatives up the 4th degree ..... ☐(1)
2. Placement with other families/people ..... ☐(1)
3. Placement with foster caregivers(FC)..... ☐(1)
4. Apartments..... ☐(1)
5. Family-type homes (FTH) ..... ☐(1)
6. Placement centers ..... ☐(1)
7. Emergency placement centers ..... ☐(1)
8. Maternal centers ..... ☐(1)
9. Other services, namely: ..... ☐(1)
.....

B3. Child's pathway in the system: How many distinct stages are there in the child's pathway in the system from his/her last (most recent) entry until now?
The number of stages shows the number of relocations undergone by the child. The pathway is broken down by stages, based on the changes in the measure, service or supplier (for instance, transfer from a FC to another, or from a center to another) or any combination of these.

Questions addressed to all children over 3 years of age!

C4. How does the child/ young person feel/ think about his/ her parents and siblings?	Interrupted relation	Indifference	Conflicting relation	Good/ pleasant relation	Not applicable, they do not exist
1. With the mother	**1**	**2**	**3**	4	**-7**
2. With the father	**1**	**2**	**3**	4	**-7**
3. With the siblings	**1**	**2**	**3**	4	**-7**

C5. Are there attachment figures, beyond the natural family, that could serve as resources for the child's reintegration?
1. Yes 2. No

If Yes,
C5a. Who are they?*Multiple answer*
1. Grandparents
2. Aunts/ uncles
3. Other relatives up to the 4th degree
4. Other relatives (5th degree and above)
5. Other non-related persons (for instance, former FC)

C6. The child would like to go/ go back to...?	Barely or to a very small extent	To a small extent	To a large extent	To a very large extent	Not applicable, they do not exist
1. Natural family	1	2	3	4	-7
2. Family of other relatives, up to the 4th degree	1	2	3	4	-7
3. Family of other attachment figures, related (5th degree or above) or non-related	1	2	3	4	-7

D. Free time, concerns and risky behaviors

	D1. The child has good friends in the foster care center and he does not want to part with them … 1. Yes 0. No	**D2. The child is in a romantic relationship with someone from...** 1. Yes 0. No
a. The placement center?		
b. ...Other protection services?		
C...the community?		

E. Independent life skills

Life skills field	**E1. Skills acquired?** -7. Not applicable, the child is too young -1. Does not know 1. Knows 2. Maybe 3. Does	*If E1>0,* **E2. Assessment of the independent living skills acquired, in respect to the age** 0. Insufficiently developed 1. Sufficiently developed
Daily living skills related to eating and preparing meals		
Daily living skills related to personal hygiene		
Daily living skills related to clothing		
Daily living skills related cleanness of the living space		
House management skills (taxes, fees, bills, using household appliances, etc.)		
Skills related to community resources (transport, shops, cinema, institutions, orientation in space, etc.)		
Cash management skills (using money, asking for the change, the receipt, credits, card, etc.)		
Social development skills (building friendship, social relations, etc.)		
Skills for professional and vocational integration (writing a CV, looking for a job, attending job fairs, keeping a job, etc.)		

D5 APPLIES ONLY TO CHILDREN ABOVE 6

	D5. Since the last entry in public care and until present, has the child exhibited one of the following behaviours at risk:	Yes	No	Unknown
a.	Sexual activity	(1)	(0)	(9)
b.	Underage mother or underage father, was pregnant, or had already had children	(1)	(0)	(9)
c.	Consumption of alcohol	(1)	(0)	(9)
d.	Use of drugs or other psychotropic substances	(1)	(0)	(9)
e.	Smoking	(1)	(0)	(9)
f.	Experiences of beatings or violence with other children or young people	(1)	(0)	(9)
g.	Was in a "gang" or a group of friends with behaviour at risk	(1)	(0)	(9)
h.	Had fled from the center or another protection service	(1)	(0)	(9)
i.	Engaging in crime	(1)	(0)	(9)
j.	Street work, begging	(1)	(0)	(9)
k.	Practicing commercial sex	(1)	(0)	(9)
l.	Suicide attempt	(1)	(0)	(9)
m.	Other deviant behaviors, namely:	(1)	(0)	(9)

	.....			

E7. Which are the child's wishes related to? (ONLY FOR CHILDREN OVER 7 YEARS OLD)	
a. Family	
b. Education	
c. Profession	

F. Conclusions

F1. Conclusions of the evaluation:

G. Recommendations

a. Does the child have social needs for which social interventions and/or services are recommended?	1. Yes	2. No	9. Don't know

If Yes,

b. Recommendations of services and social interventions for the current needs of the child	**Yes**	**No**
7. Day care centers supporting the integration/reintegration of children back into their family	(1)	(0)
8. Day care centers for children with disabilities	(1)	(0)
9. Day care centers for independent life skills development	(1)	(0)
10. Guidance, supervision and social reintegration centers for juvenile criminal offenders below the age of criminal responsibility	(1)	(0)
11. Counseling centers for abused, neglected, exploited children	(1)	(0)
12. Drop-in counseling and support centers for parents and children/pregnant women in difficulty	(1)	(0)
16. Drug prevention, evaluation and anti-drug counseling centers	(1)	(0)
17. Addiction recovery centers	(1)	(0)
18. Therapeutic community centers	(1)	(0)
19. Multipurpose centers/services	(1)	(0)
21. Community–based integrated service centers	(1)	(0)
72. Mobile teams	(1)	(0)
14. Parent education services	(1)	(0)
18. Psychological counseling services	(1)	(0)
25. Abuse, neglect and exploitation prevention services	(1)	(0)
26. Counseling services for domestic violence prevention and control	(1)	(0)
27. Perpetrator support services	(1)	(0)
55. Social enterprise	(1)	(0)
71. Social housing services (youth housing units (ANL), social housing units, emergency housing units, etc.)	(1)	(0)
81. Legal aid services	(1)	(0)

23. Others, namely:	(1)	(0)

(D) Educational assessment of the child

A0. Is the child/young person schooled? 1. Yes 2. No

If Yes at A0,

A1. Is the child enrolled in kindergarten or school? ☐(1)Kindergarten ☐(0)School

A2. Educational institution _____

A3. Form of education ☐(1)Mass ☐(2)Inclusive ☐(3)Special

A4. In what class/group is the child at present? _____

If No at A0,

2. Was he/she ever schooled? ☐(1) Yes ☐(0) No

IF YES

2a. Which is the last form of education he/she attended? ☐(1) Mainstream ☐(2) Inclusive ☐(3) Special

2b. How many grades has he/she completed? _____ grades

2c. At what age did he/she stop going to school? _____ years

E. Education acquisitions level (skills, interests):

	Absent	Poor	Good	Very good
1. Reading skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
2. Writing skills:	☐(1)	☐(2)	☐(3)	☐(4)
3. Computation skills:.....	☐(1)	☐(2)	☐(3)	☐(4)
4. Skills related to understanding a text read:	☐(1)	☐(2)	☐(3)	☐(4)

E5. Special skills or interests, talents **1. Yes** **2. No**

Only for schooled children/young people

H. Recommendations

2a. Does the child have any education needs* for which some services/activities are recommended in view of improving things/ solving the problem? 1. Yes 2. No 9. Don't know

***** *Education needs also include managing situations related to school abuse or discrimination, school motivation, difficulties in fitting-in in school, special skills and talents, special education needs.*
If Yes,

2b. Services/ activities recommended for the child's current education needs	**Yes**	**No**	**2c. Mention the education need for which this service is recommended**
School guidance and counseling services	☐(1)	☐(0)	

	2b. Services/ activities recommended for the child's current education needs	Yes	No	2c. Mention the education need for which this service is recommended
2.	Career/vocational guidance and counseling services	☐(1)	☐(0)	
3.	Education support services	☐(1)	☐(0)	
4.	School after school services	☐(1)	☐(0)	
5.	Second chance	☐(1)	☐(0)	
6.	Services assessing employment skills	☐(1)	☐(0)	
7.	Labormarket mediation and counseling services	☐(1)	☐(0)	
8.	Job-seeking support, including accompaniment	☐(1)	☐(0)	
9.	Adult vocational training services	☐(1)	☐(0)	
10	Sports club activities, football team. similar	☐(1)	☐(0)	
11	Activities at the children's center, dance groups, other leisure activities	☐(1)	☐(0)	
12	Other, namely.....	☐(1)	☐(0)	
13	Other, namely.....	☐(1)	☐(0)	

Only for unschooled children

4. Education goals for the next 12 months

(E) Family evaluation and chances of family (re)integration

Q1. What's the status of the identification of families/ attachment figures for the child/young person?	1. Has not started yet - **Attention! Service for the identification of families/ attachment figures for the child/young person - STOP** 2. Ongoing - **Attention! Service for the identification of families/ attachment figures for the child/young person** 3. Completed
For codes 2 or 3 for Q1 **Q2. Have you identified families/ attachment figures for the child/young person?**	1. Yes 2. No - STOP
For codes 1 for Q2 **Q2a. Altogether, how many families/ attachment figures for the child/young person have been identified?** *Count households!*	|__|__|

Fill out the following information for each family/ person:

Nr. crt	Q3. Type of	Q6. Do you know	*For code 1 to Q6,*	*For code 1 to*	Has I8

	family/ attachment figure for the child/young person	the address of the family/attachment figure?	Q8. Has there been a meeting between the social worker and the family/attachment figure, to discuss their involvement in raising and educating the child/young person?	*Q8,* Q9. Has the family/ attachment figure expressed their intention to actually get involved in raising and educating the child/young person?	been filled in?
1					
2					
3					

No	Risk 1 Yes/ No	Risk 2 Yes/ No	Risk 3 Yes/ No	Risk...n Yes/ No	A3. How would you assess the real chances of (re) integrating the child into a family?	B4. Has any working plan been established with the family?
1						
2						
3						

Administrative chapter

Has the conclusive report been attached to the child/young person's file? 1. Yes 2. No

Date | | | | DD | MM | YYYY |

Person having filled in the report _____

Position _____

Signature _____

Accountability of the final report by the multidisciplinary team

Full name	**Signature**
_____	_____
_____	_____
_____	_____

Attention! The final report must be countersigned by all members of the multidisciplinary team that carried out the evaluation.

Instrument 11: Summary of the solutions in the Plan for the future of children and young people on the nominal list

The plan for the future is elaborated on the basis of elements that can affect the life and wellbeing of the child, which are exposed in the Conclusive report.

I. Data on the child/ young person

Child's name and surname: _____

Personal identification number | | | | | | | | | | | | | |

Gender ☐(1) Male ☐(2) Female

Date of birth DD MM YYYY

COPIL_HANDICAP. Does the child have a disability qualification certificate? ☐(1) Yes ☐(2) No

COPIL_CES. Does the child have SEN? ☐(1) Yes ☐(2) No

QK8. Community the child comes from

a. Country (acronyms): _____

b. County (acronyms): _____

C. Locality (TAU): _____

SIRSUPM: SIRSUP Code: _____

d. Village

Attention! There are also villages in towns/cities _____

SIRINFM: SIRINF Code _____

☐(-1) Domicile is not known

Entry date in the special protection system DD MM YYYY

QK5. Child's ethnicity

☐(1) Romanian
☐(2) Hungarian
☐(3) Roma
☐(4) Other
☐(9) Not stated or Unknown

Mother's name and surname: _____

PIN mother | | | | | | | | | | | | | |

Father's name and surname: _____

PIN father | | | | | | | | | | | | | |

REPREZ. Who's the child's legal representative?

☐(1) Mother/ father/ parents

☐(2) DGASPC Director

☐(3) County Council President

☐(4) Himself/herself (child 18 and over, with judgment)

☐(5) Parental rights suspended, awaiting a court decision

☐(6) Another situation, namely:
.....

II. Conclusive report

1. The main conclusions from the Conclusive report used in the elaboration of the Plan for the future

2. IPP finality reviewed in line with the assessment conclusions

IF FOLLOWING THE EVALUATION, IT WAS NECESSARY TO REVIEW IPP FINALITY, TICK THE REVISED IPP

1. Family reintegration ..... ☐(1)
2. Socio-professional integration ..... ☐(2)
3. Adoption ..... ☐(3)
4. Other, specify ..... ☐(4)
.....

III. The solution for the future of the child, on the basis of the Conclusive report

1. Decided solution:

1. (Re)integration into the child's natural family ..... ☐(1)
2. Direct socio-professional integration for 18+ youngsters who are prepared ..... ☐(2)
3. Adoption ..... ☐(3)
4. Integration into the extended family without a protection measure ..... ☐(4)
5. Family placement to relatives up to grade IV ..... ☐(5)
6. Placement to other families/persons ..... ☐(6)
7. Placement to a Professional Foster Caregiver ..... ☐(7)
8. Placement in a Small Group Home or an apartment ..... ☐(8)
9. Exceptional placement in another residential service (DGASPC or PAO) when the complex needs of the child can't be covered through other measures (such as transfer in a facility for adults) ☐(9)
10. Other alternative measures (ex. transfer in a different county) ☐(10)

For code 10,

1a. Which measure?……

1b.Justification for this measure……..

2. Was the solution agreed upon with the family?	☐(1)Yes	☐(0)N0	☐(9)Not the case
3. Was the solution agreed upon with the child/young person?	☐(1)Yes	☐(0)N0	☐(9)Not the case

For future solutions related to moving the child into a family (codes 1, 3, 4 and 5 to point III)

4. Data on the family/ person of attachment where the child will be moved

Attention! The assumption is that the family where the child will be moved is one of the families/ attachment figures identified for the child/ young person, who want to get involved in raising and educating him/her. Consequently, the family where the child will be moved should also be listed in Instrument 8 and have Instrument 9 filled out.

Q3a. Type of family/attachment figure	1. Mother and father (maybe plus other relatives) 2. Only mother (maybe plus other relatives) 3. Only father (maybe plus other relatives) 4. Only adult siblings (maybe plus other relatives) 5. Maternal grandparents (maybe plus other relatives) 6. Paternal grandparents (maybe plus other relatives) 7. Aunts/ uncles (maybe plus other relatives) 8. Other relatives up to the 4th degree 9. Other relative above the 4th degree 10. Other non-related persons
Q4. Contact person's name and surname	……
Q7. Write down the address:	
Q7a. Country	…….
Q7b. County	……
Q7c. Town/ commune	……..**SIRSUP**……..
Q7d. Village	…….. **SIRINF**…….
Q7e. Street…….**Q7f. Number**……. **Q7g. Building**……..**Q7h. Entrance** …… **Q7i.Apartment**……	

For future solutions related to moving the child into child protection (codes 7, 8, 9 and 10 to point III)

5. Data on the child protection service where the child will be moved

Q3b. Protection service...	1. The service exists 2. New service that should be created/ developed/ procured
If the service exists (code 1 to Q3b),	
Q8a. Service name	
Q8. Write down the address:	
Q8b. County	……

Q8c. Town/ commune ……..**SIRSUP**……..
Q8d. Village ……..
SIRINF…….
Q8e. Street…….**Q8f. Number**……. **Q8g. Building**……..**Q8h. Entrance** …… **Q8i.Apartment**……..

IV. Social and prevention services to be provided near the child:

Service	**A. Does the child need this service or has it been recommended by a specialist during the evaluation?** 1. Yes 2. No	*If Yes,* **B. Service....** 1) The service exists 2) New service that should be created/ developed/ procured	*If code 2,* **C. Where should it be created/developed/procured?** Drop down with localities and variable *SIRSUP*
I. PROTECTION SERVICES			
1.Professional Foster Caregiver			
2. Small Group Home			
3. Apartment			
II. SOCIAL SERVICES			
Center-type			
4. Maternal center			
5. Other residential services for children (CPRU etc.)			
6. Day care centers supporting the integration/reintegration of children back into their family			
7. Day care centers for children with disabilities			
8. Day care centers for independent life skills development			
9. Guidance, supervision and social reintegration centers for juvenile criminal offenders below the age of criminal responsibility			
10. Counseling centers for abused, neglected, exploited children			
11. Drop-in counseling and support centers for parents and children/pregnant women in difficulty			
12. Sheltered housing			
13. Institutions for adults (CITO, CRRN, CIA, socio-medical facility, inpatient palliative care center, etc.)			
14. Day or night shelters			

Service	**A. Does the child need this service or has it been recommended by a specialist during the evaluation?** 1. Yes 2. No	*If Yes,* **B. Service....** 1) The service exists 2) New service that should be created/ developed/ procured	*If code 2,* **C. Where should it be created/developed/procured?** Drop down with localities and variable *SIRSUP*
15. Drug prevention, evaluation and anti-drug counseling centers			
16. Addiction recovery centers			
17. Therapeutic community centers			
18. Multipurpose centers/services			
19. Community–based integrated service centers			
20. Mobile teams			
21. Other (specify)…			
Interventions/ activities			
22. Parent education services			
23. Psychological counseling services			
24. Speech therapy services			
25. Physical therapy services			
26. Other habilitation/rehabilitation services			
27. Abuse, neglect and exploitation prevention services			
28. Counseling services for domestic violence prevention and control			
29. Perpetrator support services			
30. Meals on Wheels or social canteen services			
31. Social enterprise			
32. Social housing services (youth housing units (ANL), social housing units, emergency housing units, etc.)			
33. Home renovation or improvement support			
34. Legal aid services			
35. Support for parents / legal representative to prepare the necessary documents for the disability certificate for adults with disabilities			
36. Counseling and support groups for families, young people or children in difficulty			
37. Transport to social services in other localities			
38. Accommodation of the parent during the habilitation-rehabilitation of children in centers			

Service	**A. Does the child need this service or has it been recommended by a specialist during the evaluation?** 1. Yes 2. No	*If Yes,* **B. Service....** 1) The service exists 2) New service that should be created/ developed/ procured	*If code 2,* **C. Where should it be created/developed/procured?** Drop down with localities and variable *SIRSUP*
from other localities			
39. Adoptive family training programs			
40. Occupational therapy			
41. Other, namely…			
III. EDUCATIONAL AND MEDICAL SUPPORT SERVICES			
Center-type			
42. Kindergarten			
43. Primary school			
44. Primary school with supportive educational services/integrated special education			
45. Lower secondary school			
46. Lower secondary school with supportive educational services/integrated special education			
47. Special school			
48. High-school			
49. Technical high-school			
50. Standby medical center			
51. Hospital, polyclinic			
53. Other, namely…			
Interventions/ activities			
54. School counseling and guidance services			
55. Professional/vocational counseling and guidance services			
56. Supportive educational services			
57. School after school services (*afterschool*)			
58. A Second Chance			
59. Job skills assessment services			
60. Labor market counseling and mediation services			
61. Job search support, including accompaniment			
62. Professional training services for adults			

Service	**A. Does the child need this service or has it been recommended by a specialist during the evaluation?** 1. Yes 2. No	*If Yes,* **B. Service....** 1) The service exists 2) New service that should be created/ developed/ procured	*If code 2,* **C. Where should it be created/developed/procured?** Drop down with localities and variable *SIRSUP*
63. School sporting club, football team and similar activities			
64. Children's club, folklore ensemble, other relevant leisure activities			
65. Social activities and leisure			
66. Instructive-educational activities			
67. Transport to the school in another locality			
68. Activities for the development of independent living skills			
69. Family planning services			
70. Sex education services for youth			
71. Social ambulance			
73. Other, namely…			
IV. OTHER SERVICES			
74. Monitoring and support post-reintegration			
75. Monitoring and support post-adoption			
76. Monitoring and support post-socio-professional integration			
77. Other, namely…			

Only if the child/ young person is to be moved into a family (future solutions for point III with codes 1, 3, 4 and 5).

V. Social benefits that must be ensured for the child/ young person and family where he/she will be moved

[MULTIPLE ANSWER]

1. Placement benefit ..... ☐(1)
2. State child allowance ..... ☐(2)
3. Child raising allowance..... ☐(3)
4. Allowance for family support..... ☐(4)
5. Guaranteed minimum income..... ☐(5)
6. Aid for heating ..... ☐(6)
7. Material/emergency support ..... ☐(7)

8. Other material and non-material aid, namely: ..... ☐(8)
.....

VI. The community where the family/ protection service is, where the child will be moved

a. City/ Commune…….SIRSUP.

Attention! Select the same town/commune as the one mentioned in section III.4 question Q7c, if the child is to be moved to a family, or in section III.5 question Q8c if the child is to be moved into an already existing protection service, or the one mentioned in section IV Column C if the child is to be moved into a new service (FC, FTH or AP) that has to be created, developed or procured.

b. Does DGASPC envisage to carry out (maybe in partnership) any preparatory activities in the community where the child/young person is to be moved?

1. Yes 2. No

If Yes,

C. Which community preparatory activities?

d. Has a support group/network or a reference person been identified in the community where the child will be moved, to support the child's deinstitutionalization process? ☐(1)Yes ☐(0)No

IF YES.

e. Who participates in this support group/ network/ who is the reference person?

Name and surname	Contact details
1. ...	...
2. ...	...
3. ...	...
4. ...	...
5. ...	...

VII. Revise plans in line with the Plan for the Future

	Yes	No	Not the case
1. **Has the Individualized Protection Plan (IPP) been reviewed by introducing all the benefits, services or other types of support that**	☐(1)	☐(0)	☐(9)

the child and the family can benefit from when reintegration, adoption or socio-professional integration is decided?			
2. Have the specific intervention programs (SIP) under the IPP been reviewed by setting short, medium and long-term objectives and related activities to achieve the reintegration, adoption or socio-professional integration of the child?	☐(1)	☐(0)	☐(9)
3. Has the habilitation-rehabilitation Plan (ERP) for children with disabilities been updated?	☐(1)	☐(0)	☐(9)
4. Has the Individualized Service Plan (ISP) for children with disabilities not classified as disabled and with ESCs been updated and correlated with the PAR?	☐(1)	☐(0)	☐(9)

VIII. Administrative chapter

Has the future plan been attached to the child's file? 1. Yes 2. No

Filled out on (date): | | | |
|---|---|---|
| DD | MM | YYYY |

Name and surname of the person filling in the sheet _____

Position _____

Signature _____

Accountability of the final report by the multidisciplinary team

Name and surname	**Signature**
_____	_____
_____	_____
_____	_____

Attention! The final report must be countersigned by all members of the multidisciplinary team that carried out the evaluation.

Instrument 12: Template proposed for the Individual Movement Preparation Program

I. Identification data

1. Data about the child

Last name and first name:	Personal identification number:
Gender: 1. Male 2. Female	Ethnicity:
Date of birth: dd/mm/yyyy	Religion:
Place of birth: Country County	Town/commune Village
Citizenship:	

2. Mother

Last name and first name::	Personal identification number:

3. Father

Last name and first name::	Personal identification number:

4. Legal representative

Last name and first name::	Personal identification number:
Decision on the legal representative no.	Issued by

II. Solution/measure of placement finally decided

(According to the Plan for the Future, Point III, Annex B, Instrument 11)

III. Approximate date of movement: |__|__|/|__|__|/|__|__|__|__|

IV. The new living environment after the movement

1. The level of preparation of the new living environment

	Level of preparation	Estimated completion date	Not applicable
a. Family preparation			
b. AMP preparation			
c. CTF preparation			
d. Community preparation			
e. The new social services required for the child/youngster (point IV of the Plan for the future)			
f. Support services to be provided in the vicinity of the child (point V of the Plan for the future)			
g. Material support for the family (Section VI of the Plan for the future)			

2. Person who shall take care of the child after the movement

Last name and first name:	Relationship with the child:	
Personal identification number:	Position:	Occupation:

V. Brothers/sisters and friends in the care centers (*see also the Social evaluation of the child, model proposed in Annex B Instrument 5)*

Fill in zero in the cells where it is not applicable	a. Brothers/Sisters	b. Good friends that the child/youngster doesn't want to part from
1. Number of those staying in the same closure center, out of whom:		
- will be moved and will live with the child/young person		
2. Number of those living in the protection system out of the protection center, out of whom:		
- will be moved and will live with the child/young person		

VI. Preparation program for the child's/young person's movement

1. Team of specialists who prepares the child/youngster

Last name and first name:	Profession:
1.	
2.	
...	

2. Does the person who will take care of the child after the movement participate to the child's preparation?	1. Yes 2. No
3. Is the preparation program common with that of the child's brothers/sisters?	1. Yes, |__|__| brothers/sisters 2. No
4. Is the preparation program common with that of the friends in the care centers?	1. Yes, |__|__| friends 2. No

5. Preparation meetings

	Objective	Way of unfolding	Date	Tool/working method	Has the person that will take care of the child participated?	Person in charge
Meeting 1						
Meeting 2						
….						

6. Presentation of the context of the new placement

	Objective	Description	Date	Observations regarding the child's behavior during the activities	Has the person that will take care of the child participated?	Person in charge
Activity 1						
Activity 2						
…						

7. Getting familiar with the context

	Objective	Description	Date	Observations regarding the child's behavior during the activities	Has the person that will take care of the child participated?	Person in charge
Activity 1						
Activity 2						
…						

8. Positive interaction rules

	Has the rule been properly communicated to the child/youngster? Yes/No	*If YES* Progress registered by the child in acquiring the rule	Has the rule been properly communicated to the new caregiver? Yes/No	*If YES* Progress registered by the caregiver in acquiring the rule
Rule 1		...		...
Rule 2		...		...
...		...		...

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name: Position:

First name: Signature:

Accountability of the conclusive Summary of new services and activities by the team of specialists

Last name and first name

Signature

Last name and first name

Signature

...

Attention! The Individual Program of preparation for the movement must be countersigned by all members of the team of specialists having carried out the preparation.

Instrument 13: Template proposed for the Support and post-movement report

I. Identification data

1. Data about the child

Last name and first name:	Personal identification number:
Gender: 1. Male 2. Female	Ethnicity:
Date of birth: dd/mm/yyyy	Religion:
Place of birth: Country County	Town/commune Village
Citizenship:	

2. Mother

Last name and first name::	Personal identification number:

3. Father

Last name and first name::	Personal identification number:

4. Legal representative

Last name and first name::	Personal identification number:
Decision on the legal representative no.	Issued by

II. Solution/measure for placement finally decided

(According to the Plan for the Future, Point III, Annex B, Instrument 11)

III. Effective movement of the child

1. Date of the movement:|__|__|/|__|__|/|__|__|__|__|

2. Person who shall take care of the child after the movement

Last name and first name: Relationship with the child:

Personal identification number: Position: Occupation:

3. Team having carried out the effective child/youngster movement

Last name and first name:	Occupation:
1.	
2.	
...	

4. Has the person who shall effectively take care of the child participated in the effective movement of the child/youngster? 1. Yes 2. No

IV. Post-movement support

1. Post-movement support team

Last name and first name:	Profession:
1.	
2.	
...	

2. Schedule of the post-movement support visits

Visit	Date	Who paid the visit? (name)	Was the visit regular or requested for some reason?	*If applicable* Who and why requested the visit?	Conclusion regarding the level of child development	Conclusion regarding the level of attachment to the caregiver
VS1.						
VS2.						
…						

V. Post-movement monitoring

1. Post-movement monitoring team

Last name and first name:	Profession:
1.	
2.	
...	

2. Schedule of the post-movement monitoring

Visit	Date	Who paid the visit? (name)	Was the visit regular or requested for some reason?	*If applicable* Who and why requested the visit?
VM1.				
VM2.				
…				

For each post-movement monitoring visit the following Report shall be filled in

A. Date when the visit took place: |__|__|/|__|__|/|__|__|__|__|

B. Who paid the visit? Last name and first name...

C. Was the visit regular or requested for some reason? 1. Regular 2. Requested

If the visit was requested

Who and why requested the visit?

C1. Last name and first name:	C2. Relationship with the child or the capacity:
C3. Reason of the request:	
...	

D. Conclusions regarding the implementation of the Plan for the future

What are the services, benefits or interventions in the Plan for the future of the child/youngster that are not implemented in the grid or implemented in an unsatisfactory quality?

D1.

D2.

D3.

D4.

E. Conclusions on the child's/youngster's progress by domain

E1. Health and nutrition

...

E2. Risk of neglect, abuse, exploitation or any other form of violence

E3. Education

...

E4. Independent life skills

...

E5. Emotional and spiritual development

...

E6. Recovering delays in development

...

E7. The relationship with the person/family that takes care of the child/youngster

...

E8. Maintaining the relationship with the family

...

E9. Social network/community participation

...

E10. Risk factors that may adversely affect the situation

...

E11. New elements that can cause major changes in the situation of the child and/or family

...

E12. Have positive aspects and strengths of the family been sufficiently developed so that they can face future threats to the child's safety

...

F. Child's/youngster's views about the quality of his/her own life

G. Global conclusion on the progress in child's/youngster's development

1. Good	2. Satisfactory	3. Various difficulties	4. Major difficulties

H. Global conclusion on the care quality

1. Good	2. Satisfactory	3. Various difficulties	4. Major difficulties

If G>2 or H>2, corrective action is mandatory.

I. What corrective measures are recommended?

MCorect1: _____

MCorect2: _____

... _____

J. Has the Plan for the future for the child/youngster been properly adjusted? 1. Yes 2. No

K. Details of the corrective actions, according to the adjusted Plan for the future

	Estimated date of the beginning	Person in charge	Human resources	Financial resources	Material resources	Other resources
MCorect1: ...		...	...	...	...	...
MCorect2: ...		...	...	...	...	...
...						

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name: _____ Position: _____

First name: _____ Signature: _____

Mention whether corrective measures are taken

Accountability of the post-movement monitoring report by the post-movement monitoring team

Last name and first name

Signature

(Preferably in collaboration with the post-movement support team to make sure that the decision was made on the basis of more informed opinions regarding the child's situation)

Last name and first name

Signature

...

Attention! Any post-movement monitoring report that involves corrective measures must be countersigned by all members of the post-movement monitoring team, and preferably, by the post-movement support team.

ANNEX B: MODEL OF AN INDIVIDUAL CLOSURE PLAN FOR PLACEMENT CENTERS FOR CHILDREN IN ROMANIA

Our main message

The present document presents a model of an individual closure plan for placement centers for children in Romania. In our opinion, the goal of closing placement centers for children is to improve the situation of children and young people living there, not the closure of institutions per se. Thus, no institution should be closed before better solutions are identified for each child and young people person in the respective center.

Children and young people in institutions are a very diverse group, and (re)integration is not possible for some of them. Such children should be further protected, either by being placed in professional foster care or in small residential services (family-type homes or apartments).

1. INFORMATION ON DGASPC AND ITS PARTNERS

1.1. Main applicant

Main applicant's name[112]	(DGASPC)
Registered office	[locality, street, no, sector/county]
Institution legal representative	
Person responsible with the individual plan for closing down the placement center for children	
Position help within the institution	

1.2. Partners

[See chapter 4.2.2 from The Methodology]
Number of partners […]

The following information shall be filled out for each of the partners involved in the individual plan for closing down the placement center for children.

Partner's name	Registered office: [locality, street, no, sector/county]	Institution legal representative	Person responsible with activity coordination, from the partner's side	Position held by the responsible person within the institution

IN CASE OF A FUNDING APPLICATION
Select relevant partners for implementing the project for which funding is being requested.

[112] DGASPC is the main institution responsible with closing down children's homes. For applications submitted for EU funding or from a National Interest Program (NIP), DGASPC is the main applicant. For other funding sources, the main applicant for a funding request could also be an organization, such as an NGO partnering with DGASPC.

2. GENERAL INFORMATION ON THE INDIVIDUAL CLOSING DOWN PLAN

2.1. Institution to be closed down

- Name of the institution to be closed down
- Registered office: [locality, street, no, sector/county]
- Type of institution, depending on the children's profile or other variables

Name of the institution	
Registered office	[locality, street, no, sector/county]
Legal representative	
Short presentation of the institution using the information from Annex 1	

Attach the Type of institution according to the dominant profile of children or other variables, *based on the model in* **ANNEX 1.**

The data provided by the World Bank to ANPDCA under the SIPOCA 2 project will be automatically generated in e-cuib.

2.2. General and specific objectives of the individual closing down plan

[See chapter 5.2 from the Methodology]

- General objective:

Not more than 50 words.

- Specific objectives:

Not more than 50 words for each specific objective.

IN CASE OF A FUNDING APPLICATION

Select the specific objectives for which funding is needed. Some donors might also request the expected outcomes, which should match the selected objectives.

2.3. Implementation period: [In months]

3. Decision to close down the placement center for children

3.1. Rationale for closing down the placement center for children in the county

The general overview is referring to the:

- Analysis of the services system in the county, in line with the *Individual plan for closing down the placement center*
- Relevant child protection objectives for the following years, in line with the *County Strategy for social services development*
- A succinct presentation, analysis and interpretation of data from Annex 2 with regards to the placement center that is closing down.

Attach the Motivation for closing down institutions for children in the county, *based on the model in* **ANNEX 2.**

The data provided by the World Bank to ANPDCA under the SIPOCA 2 project will be automatically generated in e-cuib.

3.2. Team implementing the individual closing down plan

[*see chapters 4.1.2 and 6 from the Methodology*]

Provide the following information on the implementation team:

Name	Surname	Institution name (DGASPC, partner or independent expert)	Appointment decision in the team, signed by the legal representative of the institution	Position held within the institution	Position within the team	Synthetic presentation of main tasks within the team

IN CASE OF A FUNDING APPLICATION

The team implementing the project for which funding is requested could differ from the teams that prepared or drafted the Individual plan for closing down the placement center for children, but it should be coordinated with the Plan implementation team, especially since an Individual closing down plan could have several funding applications associated to it (so several project teams). Every donor requests specific information on the project team.

3.3. Steering committee for the children deinstitutionalization process, at county level

[See chapter 4.1.1 from The Methodology]

Specify if a coordinating committee of the process for the deinstitutionalization of children existed at county level.

If not,

The entity that played this part at county level is […]

If yes,
Provide the following information on the Steering Committee:

Date when it was set-up	Number of members	Institutions that are part of the committee	Surname of the President	Name of the President	Responsibilities of the Steering Committee under the Individual plan for closing down the placement center for children

IN CASE OF A FUNDING APPLICATION
The Steering Committee can be unique at county level. Consequently, if several placement center for children are to be closed down in a county (each with its own individual closure plan), the Steering Committee could be the same for all funding applications associated to all the individual closing down plans.

3.4. Information and consultation activities

[See chapter 4.2.1 from The Methodology]

Present a synthetic table with the information and consultation sessions organized during the preparation of the Individual plan for closing down the placement center. This synthesis should use the information of Annex 3 with regards to: the number of sessions, the phase of the closure process when they were organized,[113] the date and location of the information and consultation session, who the moderators were, types of participants.[114] Information may be added with regards to the main themes and results of these sessions. Justifying documents for the information and consultation sessions can be surveyed by ANPDCA (such as minutes, attendance lists).

- Type of relevant stakeholders involved (children and their families, county counselors, local authorities and consultative community structures, staff and their representatives plus the DGASPC employees, NGOs and local media)
- Number of participants (by type of relevant stakeholders)

Attach the Activities for information and consultation, *based on the model in* **ANNEX 3.**

[113]The phases of the closure process refer to: (1) project preparation phase, in parallel with the evaluation process, and (2) at the end of the preparation period, after the evaluation of needs and resources has been finalized.
[114]Type of relevant stakeholders involved may include: children and their families, county counselors, local authorities and consultative community structures, staff and their representatives plus the DGASPC employees, NGOs and local media.

4. PHRASING AND SIZING THE PROBLEMS (ASSESSMENT OF NEEDS AND RESOURCES)

4.1. Team preparing the individual closing down plan

[See chapters 4.1.2 and 4.3.3 from The Methodology]

Provide the following information on the team conducting the multidisciplinary assessment of children, families and communities.

Name	Surname	Institution name (DGASPC, partners or independent experts)	Appointment decision in the team, signed by the legal representative of the institution	Position held within the institution	Position within the team	Synthetic presentation of the main attributions within the team that show the specialists composing the team

4.2. Evaluation of the institution and justifying the decision to close it down

[See chapter 4.3.1 from The Methodology]

A description of the institution to be closed down, which will include the following:

- Placement center for children capacity;
- Number of children protected in the center;
- Location (including information regarding isolation, segregation, accessibility);
- Institution land and buildings, owned by DGASPC, the County Council, local councils or other public authorities;
- Infrastructure;
- Human resources (information regarding: a) staff, b) staff-children interaction, and c) child development activities and services);
- Implementation of minimum standards and case management in the center;
- National rank received by the placement center for children for: a) care environment general score, b) care quality general score and c) service quality general score;
- Children's global assessment of the life they lead in the home;
- Financial resources of the placement center;
- Flows of entry/exists (that show where the children come from and where they go, so which would be other child protection services that influence or could be influenced by closing down the institution);
- Institution eligibility for EU funds (if the placement center for children has received during the past 5 years public funds to develop and upgrade the infrastructure);
- Other special operating problems, because of which the institution should be closed down.

Attach The evaluation of the institution and justification its closure, *based on the model in* ANNEX 4.

The data provided by the World Bank to ANPDCA under the SIPOCA 2 project will be automatically generated in e-cuib.

4.3. Multidisciplinary evaluation of institutionalized children and young people

Main findings of the evaluation activities

Present a summary of the method applied (techniques, tools, participation of children, young people and families) and the main findings of the assessment activities carried out for preparing the closing down plan, using the layout provided below.

4.3.1. List of individual children and young people in the placement center for children at the time of closure

[*See Chapter 4.3.2 and 10.3.3 of the Methodology*]

The Synthetic Form with key information [see 4.3.2. of the Methodology] will be filled in for each children and young people person in the placement center. On the basis of this information, the collective of children and youth protected in the center is presented (whether they have a special protection measure or not), at the moment at the time when the decision to close down the placement center was taken. Also indicate in the synthetic presentation, using the information from the nominal list:

- The total number of children and young people persons that will be affected by the closure of the placement center for children and their distribution by gender and age group;

Attach The nominal list of children and youth in the placement center, based on the model in **ANNEXA 5.**

Present the measures and activities undertaken by DGASPC to halt entries into the placement center that is closing.

Attach the DGASPC Director's order on measures to stop entries into the placement center.

The nominal list of children and young people in the placement center after T0 is automatically generated in e-cuib, based on the model in **ANNEX 6.**

IN THE CASE OF A FUNDING APPLICATION

The nominal list of children in the placement center should not be mistaken for the target group of the EU funded project. If funding from ROP and OPHC is required for the closure of a placement center for children, the EU project target group shall be comprised of the beneficiaries of the new facilities and services set up.[115] *Conversely, the nominal list for closing down a placement center for children includes the children that were institutionalized in the closing institution. During the closing down process, some of them will be (re)integrated in the family or community, so it follows logically that not all of them will necessarily be beneficiaries of the new facilities or services created in the EU funded project.*

4.3.2. Medical evaluation

[*See Chapter 4.3.4(A) of the Methodology*]

[115]It is expected that new beneficiaries of the new services will be included in the project (CTF, AMP, day care centers etc.) that were not included on the nominal list children in the closed institution. For this reason, we believe that it is paramount to monitor and evaluate the situation of each individual child, such as to ensure that all the children in the closed down institution will fare better at the end of the project than when the closure started. On the other hand, we recommend that all children who become beneficiaries of the new facilities and services in the project should be subject to the same initial multidisciplinary assessment. These children will thus be included in a dynamic list of beneficiaries of the new facilities and services developed in the project.

Summarize the findings of the medical reports on the children and young people included in the nominal list. Also provide the following information:[116]

- Number of children and young people of the nominal list that were subject to medical evaluation and have the related documents filled-in and attached to the case file;
- Distribution of children and young people from the institution by disability and age.

Attach the Medical Assessment Report at Center Level, *based on the model in* **ANNEX 7.**

4.3.3. Psychological evaluation

[*See Chapter 4.3.4(B) of the Methodology*]

Present the main findings of the psychological evaluation of the children and young people from the nominal list. Provide the following information:[117]

- Number of children and young people on the nominal list that were subject to psychological evaluation and have the related documents filled-in and attached to the case file;
- Distribution of children and young people in the institution by development delay and age;
- Distribution of children and young people in the institution by mental health issue and age.

Attach the Psychological Evaluation Report at Center Level, *based on the model in* **ANNEX 8.**

4.3.4. Social evaluation of the child[118]

[*See Chapter 4.3.4(C) of the Methodology*]

Present the main findings of the social evaluation of the children and young people included on the nominal list. Also provide the following information:[119]

- Number of children and young people on the nominal list that were subject to social evaluation and have the related documents filled-in and attached to the case file;
- Distribution of children and young people in the institution by age and relevant characteristics identified in the social evaluation (number of admittances in the system at 0-12 months, number of re-entries in the system, frequent relocations during the time spent in the system, risk of abuse or violence in or outside the institution, siblings and/or friends, independent life skills etc.).

*Attach the So*cial Evaluation Report at Center Level, *based on the model in* **ANNEX 9.**

4.3.5. Educational assessment

[*See Chapter 4.3.4(D) of the Methodology*]

Present the main findings of the educational assessment of children and young people of the nominal list. Also provide the following information:[120]

---

[116]As per the consolidated data from the Medical Assessment Report at Center Level(Annex7).
[117]As per the consolidated data from the Psychological Evaluation Report at Center Level (Annex8).
[118] The social evaluation provides information of the child's institutionalization history, reasons for being separated from the family, child's opinion on his/her relationship with the family, data on siblings and relation with them, legal status, risk behaviors, independent life skills. In the case of disabled children, also provide data from the social investigation, including: parents/legal guardian's option for certification of disability level, educational and career guidance provided by COSP (Educational and Career Guidance Centre) and/or habilitation/rehabilitation services, in the context of their information; Environmental factors considered to be facilitators of barriers for the disabled child – annex to the social investigation, with a template provided in Annex no. 6 to Order no. 1985/1305/5805/2016; Identification of the risk of abuse or violence on the child in or outside the institution (school, community where the institution is located) or violation of the child's rights.
[119]As per the consolidated data from the *So*cial Evaluation Report at Center Level (Annex9).

- Number of children and young people on the nominal list that were subject to educational evaluation and have the related documents filled-in and attached to the case file;
- Distribution of children and young people in the institution by age and relevant characteristics identified by the educational evaluation (not in education, in special and integrated mainstream education, truancy issues, poor school performance, drop out risk or other major educational difficulties).

Attach the Educational Evaluation Report at Center Level, *based on the model in* ANNEX 10.

4.3.6 Family evaluation
[*See Chapter 4.3.5 of the Methodology*]

The Report on the assessment of children's and young people's families at Center Level *is automatically generated in e-cuib, based on the model in* ANNEX 11.

Present the main findings of the evaluation of the families of the children and young people on the nominal list who want to be involved in raising and educating the children (from ANNEX 11). Also provide the following information:[121]

- Number of children and young people on the nominal list who benefitted from the identification of families/ persons of attachment;
- Number of children and young people on the nominal list who benefitted of family evaluation and have the related documents filled-in and attached to the case file;
- Distribution of children and young people from the institution by age and chances of family (re)integration, taking into account the opinions of the children/young people and families.

Attach the Family Evaluation Report at Center Level, *based on the model in* ANNEX 12.

4.6.1. Conclusive report
[*See Chapter 4.3.7(A) of the Methodology*]
Based on the Conclusive Reports[122] for Children and Young People in the Center, the main outcomes of the multidisciplinary assessment are presented, focusing on the real future chances of children and young people in the center.

4.6.2. Plan for the future
[*See Chapter 4.3.7(B) of the Methodology*]

Describe the method used for preparing the Plans for the future for the children and young people in the institution, as well as the manner in which they were directly involved in the process. Indicate the logical association between the real needs and opportunities of the children/young people (from the Conclusive report), opinions of children, young people and their families, and the final solutions. The logical link between the needs and the real future chances of children/ young people is shown (from the Concluding Report), the opinions of children, young people and their families and the solutions decided. The main results are also presented and the following are specified[123]:

[120]As per the consolidated data from the Educational Evaluation Report at Center Level (Annex 10).
[121]As per the consolidated data from the Family evaluation report by institution (Annex 7) and the filled-in and updated Summary form of key information.
[122] See the model proposed in the Methodology, Annex A Instrument 10.
[123] According to data aggregated from the Plans for the future of children and Young people proposed in the Methodology, Annex A, Instrument 11.

- Distribution of children and young people in the center by age and PIP goals after revision (family reintegration, socio-professional integration, adoption, others);
- Distribution of children and young people by age and future solutions best suited to children/ young people.

Attach the Plan for the Future Report at Center Level for children and young persons in the nominal list, *based on the model in* **ANNEX 13.**

Describe the solutions identified for the children and young people in the closing institution. Explain how will continuity be ensured in the education and services provided to the child, as well as in maintaining his/her connections with the family.

4.4. Evaluation of the staff in the institution to be closed down

[See chapters 4.3.8 and 5.1.2 from The Methodology]

Describe how the staff appraisal was carried out, the Methodology used (techniques and tools) and main outcomes. Mention how the staff was prepared for the changes incurred by closing down the placement center for children and how they were involved in the appraisal process.

Attach the Report for the staff appraisal and selection center, based on the model in **ANNEX 14.**

5. NEW SERVICES AND ACTIVITIES PLANNED UNDER THE INDIVIDUAL CLOSING DOWN PLAN

In the section below give the name and a detailed description of every new service or activity that is to be carried out in view of achieving the outcomes stating, where applicable, each partner's role in these activities.

5.1. The individual closing down plan development team

[See chapters 4.1.2 and 5 from The Methodology]

Provide the following information on the team in charge of developing the individual closing down plan:

Name	Surname	Institution name (DGASPC, partner or independent expert)	Appointment decision in the team, signed by the legal representative of the institution	Position held within the institution	Position within the team	Synthetic presentation of main tasks within the team

5.2. New services and activities: Description and sustainability

[See chapter 5.1.1 from The Methodology]

The Report regarding the summary of new services and activities at center level, according to the plans for the future of children and young people from the placement center, is automatically generated in e-cuib, based on the model in **ANNEX 15.**

The summary of new services and activities, as reflected in the Plans for the future of all children and young people on the list, shows the necessary of services to ensure their adequate protection.

The link between the necessary of services (Annex 15) and the Plan of New Services established through the project (Annex 16) is shown. Show how you make sure that the new services and activities:

- ☐ will include, in their design, institutional practices different from the old care model (form the old-type institutions);
- ☐ will contribute to the reduction of social or spatial segregation;
- ☐ will not contribute, in any way, to expanding or strengtheningthe community of social services beneficiaries or vulnerable people (children and/or adults).

Mention other services subordinated to DGASPC, local councils or NGOs that will contribute to achieving the objectives in the individual closing down plan (complementary services, in place, needed to reach the objectives, to which children/young people will have access after the relocation, such as recovery/rehabilitation services or education institutions).

Attach the Plan of new services and activities that will be realized within the project, based on the model in **ANNEX 16.**

For every new service or activity mentioned in the Plan from ANNEX 16, make a synthetic

description and analysis of sustainability, following the template in **ANNEX 17.**

5.3. Community activities

[See chapter 7.2 from The Methodology]

The Summary of activities in the community at center level, according to the Future plans of children and young people, is automatically generated in e-cuib, following the template in **ANNEX 18.**

The Plan of activities in the community to be carried out within the framework of the project is presented in a synthetic way. Activities aim to prepare the community to increase the acceptance of children coming from placement centers as well as the support that must be provided to families where they will be moved.

Attach the Plan of activities in the community to be carried out within the framework of the project, *following the template in***ANNEX 19.**

5.4. Staff-related activities from the center that is closing, and from the new services

[See chapter 5.1.2 from the Methodology]

The data from Annex 20 will be synthetically presented, including:

- ☐ Number of employees in the institution to be closed down, that should undergo professional reconversion or retraining before leaving the system;
- ☐ Plan of professional reconversion or retraining courses;
- ☐ Number of employees in the institution to be closed down, selected to work in the new services (see Annex 14);
- ☐ Number of staff to be hired in the new services, as well as the selection procedures;
- ☐ Training plan for the new services and activities, with the general induction, followed by post-relocation monitoring, individual support, periodic continuing training, specialization and performance assessment, during the entire implementation of the closing down plan.

*Attach the Plan of staff-related activities, following the template in***ANNEX 20.**

6. ACTION PLAN AND GANTT DIAGRAM FOR THE INDIVIDUAL CLOSING DOWN PLAN

Apart from the new services and activities that are to be set-up and developed and the staff-related activities, the action plan should also include measures for the prevention, mitigation and elimination of potential risks, as well as mutual learning activities, exchanges of best practices and dissemination of results.

IN CASE OF A FUNDING APPLICATION
From the Action plan and the Gantt diagram associated to the individual closing down plan, select those services and/or activities for which funding is requested.

6.1. Potential risks

[See chapter 5.1.4 from Methodology]
Present in maximum 1 page the risks that could generate delays in the implementation of the individual closing down plan and/or because of which the objectives set might not be met. Identify the measures for the prevention, mitigation and elimination of potential risks, which are included both in the Action plan and in the Gantt diagram, as well as in the total budget of the Individual closing down plan.

6.2. Mutual learning, exchanges of best practices and disseminating the results

[See chapter 7.1 from Methodology]
Present in maximum 1 page the cooperation, communication and dissemination activities which are included both in the Action plan and in the Gantt diagram, as well as in the total budget of the Individual closing down plan, namely:

- Network cooperation and collaboration activities, at the DGASPC level (exchanges of information, field visits, regional workshops, workshops by type of placement center for children, etc.);
- Ongoing communication and awareness raising activities with the communities involved in the implementation of the individual closing down plan (website, local newspapers, local TV stations, city hall boards, posters or printouts at the neighborhood schools, seminars, local information and awareness raising campaigns, etc.);
- Other dissemination activities (input for the national ANPDCA platform, support for Local Councils to develop tailored strategies and communication plans, etc.).

All these activities must be concrete and measurable, respecting all the rules of visual identity and communication of the funding institution.

6.3. Activities plan and Gantt diagram for the individual closing down plan

The Activities plan and Gantt diagram for the individual closing down plan set clear deadlines and responsibilities for all activities related to:

- Setting-up or developing the new services and activities
- Ensuring the sustainability of the new services and activities
- Recruiting, selecting and training the staff
- Preventing, mitigating or eliminating potential risks
- Mutual learning, exchanges of best practices and disseminating the results.

Plus:

- Monitoring and evaluation of the entire process
- Using the buildings and other resources no longer in use after the institution was closed down

Attach the Action plan associated to the Individual closing down plan, that has the full list of activities necessary in view of reaching the objectives, as shown in **ANNEX 21.**
Attach the Gantt diagram[124] associated to the Individual closing down plan, that has the full list of activities necessary in view of reaching the objectives, as shown in **ANNEX 22.**

[124] Ensure that the timeline covered by the Gantt diagram (number of months) matches the implementation period under 2.3

7. TOTAL BUDGET OF THE INDIVIDUAL PLAN FOR CLOSING DOWN THE PLACEMENT CENTER FOR CHILDREN

[See chapter 5.2.2 from the Methodology]

7.1. Total budget broken down by list of activities, funding source and partners

The total budget for the individual closing down plan should cover all activities needed to have a successful deinstitutionalization of children, that is moving all children and young people from the center to new care environments, that are as close as possible to the family environment.
All expenditures included in the total budget should be well justified and detailed, both in terms of calculation algorithm and of the activities for which they were envisaged.The cost estimate should be realistic and evidence-based. For instance, documents in proof of real estate market surveys, if houses or apartments are bought, or cost assessments, if new units are being built; list of endowments for the purchase of goods; organization chart of the staff in the services to be created and salary levels; training costs, per person trained, etc.

Attach the total budget broken down by the entire List of activities needed to reach the objectives (ANNEX 23) and the funding sources.
Attach the total budget broken down by the entire List of activities needed to reach the objectives (ANNEX 24) and the funding sources, DGASPC and partners.

IN CASE OF A FUNDING APPLICATION
Select the services or activities for which funding is requested. The requested budget is the sum of all costs estimated for the activities selected from the closing down plan, which are included in the funding application. The requested budget shall be broken down by type of activity and partner, but every funding entity has specific requirements in terms of budget calculation, presentation and substantiation.

7.2. Total cost of the individual plan for closing down the placement center for children [In RON]

	DGASPC	Partner 1	Partner 2	...	Partner n	Total
Funds requested from ROP (Regional Operation Program)						
Funds requested from OPHC (Operation Program Human Capital)						
Own contribution						
Other national sources						
Other international sources						
Total						

8. MONITORING AND EVALUATING THE INDIVIDUAL CLOSING DOWN PLAN

8.1. Monitoring children's progress

[See chapter 7.3.1 from the Methodology]

Describe how the post-relocation monitoring will be carried out (associated with the post-relocation support) for every child and young person on the nominal list. We recommend:

- ☐ Monitoring of the children's/young people person's progress to cover all elements: health, nutrition, recovering development delays, education, life skills, social and emotional development, self esteem, behavior, family and community participation, living conditions. However, the key indicators,[125] are linked to: severe and persisting health issues, isolation, lack of involvement and presence of negative reactions that reveal a child is struggling with the new situation, that he/she is not comfortable with it and has accommodation problems;
- ☐ If the monitoring finds that the child's situation has not improved, immediate corrective measures should be taken and the child's Plan for the future should be properly adjusted;
- ☐ Especially for children aged 0-3, in order to make sure that the children's relocation is beneficial, it is essential to conduct reevaluations throughout the implementation of the closing down plan, as to assess recovery, compensation and education progress;
- ☐ The entire monitoring process will be a participative one, that also includes children's opinion, apart from the objective indicators. And here we don't refer only to the post-relocation period. Children's opinions should be added to the standard visits conducted after the intense monitoring period, together with the tools currently provided by the child protection-specific legislation.State the subjective indicators that will be used to reflect the children's opinions.

Attach the list of key indicators, objective and subjective, used to monitoring children's progress (**ANNEX 25**).

8.2. Monitoring the performance of the newly created services

[See chapter 7.3.2 from the Methodology]

Describe how the performance of the newly created services will be monitored.

8.3. Evaluating the closure plan of the placement center

[See chapter 7.3.3 from the Methodology]

We recommend that, from the preparation phase, you include and budget for an impact study five years after initiating the implementation of the closing down plan, targeting:

- Impact on the development of children and young people on the nominal list;
- Impact on the care model from the new services;
- Community-level impact, especially in terms of preventing child-family separation.

[125] Mulheir and Browne (2013)

9. IMPLEMENTATION OF THE INDIVIDUAL CLOSING DOWN PLAN

9.1. Start date of implementation of the individual closure plan of the center

Once the funding is obtained, a T0 is set as the start date for implementation, which will be used in the planning of the training process and the actual moving of the children staff from the placement center that is closing.

9.2. Preparing the children for relocation

[See chapter 6.1 from the Methodology]

Describe how the children and young people in the center will be prepared for the relocation, as well as how they were directly involved in this process. We recommend you produce an Individual program preparing the relocation of every child and young people person from the nominal list, attached to the case file. The Program will include information on the placement solution agreed in the Future plan, the name of the person that will look after the child in the new environment, the team that will support the child during the relocation preparation period, planning the relocation preparation sessions, the new placement presentation activities and the activities of getting used to this new environment.

9.3. The actual relocation of children

[See chapter 6.2 from the Methodology]

Describe how the children and young people in the institution are actually going to be relocated. State:(i) how siblings and best friends in the placement center for children are to be tackled; (ii) rules (procedure) to be used if a child or young people person does not agree with the relocation or wants to come back to the placement center.
We recommend for all children and young people on the nominal list to benefit from post-relocation support and monitoring, which should be recorded in a Report attached to the case file.

9.4. The actual staff relocation

[See chapter 6.3 from the Methodology]

Describe how the staff is actually going to be relocated and how this will be correlated with the training plan (see point 5.4) and with the children relocation.

10. OTHER RELEVANT ISSUES

10.1. Future use of buildings and other resources that became available once the home was closed down

[See chapter 5.1.3 from the Methodology]

Mention if the building of the placement center for children to be closed down is also used by other services subordinated to DGASPC or other authorities and how the building is to be used after the close down, like services that will be provided in that location (if applicable). At the same time, mention the future use of other resources (pool, orchard, workshops, etc) that become available when the institution is closed down.
The only condition is that the building(s) of the placement center for children not to be used to set up residential services for children.

Attach the formal decision approved by the County Council/Local Council.

10.2. Other relevant aspects

Mention any other issues you deem relevant for successfully meetings the objectives in the individual plan for closing down the placement center for children.
The individual closing down plan should be owned and signed by DGASPC and all its partners (from point 1.2).

DGASPC:

Surname	Position
Name	Signature

Partner 1

Surname	Position
Name	Signature

...

PRINCIPLES OF CHILD DEINSTITUTIONALIZATION

Residential care should be considered as a last resort care option	**Residential care should be considered as a last resort care option, offered only temporary either in placement centers, or in small residential services (Family-type homes or apartments), with the aim of identifying a permanent family type solution as early as possible. The fact that any newly created residential unit triggers a need to keep it occupied should be taken into account.**
Children are the main beneficiaries of deinstitutionalization processes	Therefore, the process of closing down institutions must, first and foremost, be centered on children and their families.
Children need to participate in and be consulted throughout this process, their views being listened to	All the conditions need to be provided to involve children in decisions that concern them, in accordance with their age and level of maturity. Children with disabilities, too, need to be encouraged to express their views, their capacity to evolve has to be valued, and focus should be maintained on their developmental potential while showing trust in this potential.
Children should preferably develop in their biological family	Whenever possible, children should be reintegrated into their biological family, be cared for within their extended family, or be adopted.
Children and family need to be considered as a whole	Children's needs and circumstances cannot be separated from family needs and circumstances. Hence, situation assessment and planning interventions or new services need to look at the family and child as a whole.
Family support services need to be available in the community and prevention services need to be strengthened	Children and their parents may need support and specialized services to prevent separation and family disruption, as well as to ensure the child's sustainable reintegration. Family support services need to be available in the community and adapted to the individual needs of each child and family.
Deinstitutionalization should start with a multidisciplinary analysis of specific needs for each individual child	No child will be transferred from an institution without being subject to a process of individual and family multidisciplinary assessment. Based on such assessments, a conclusive plan will be drafted, which will include a service plan, and measures to ensure moving the child in optimum physical and psycho-emotional conditions will be planned and implemented.
Planning new services should rely on the needs identified for each individual child, and not on administrative priorities	Where and how new services are developed, and everything related to their planning needs to correspond to the needs of the children who benefit from these services, which has to prevail over any other aspects, irrespective of their nature.
Under a closure, no child will be transferred to a larger institution	The practice of moving "bad children" to centers that are not closed down and transferring "good children" to the new services, as it sometimes happens, will not be accepted.
Quality standards need to be followed	Quality standards have been developed for most of the services; these should be followed both at the planning stage and at the implementation one.
In making any planning,	Children are extremely sensitive to changes, therefore, their moving in

top priority should be given to the stability of children, and changes should be reduced to a minimum	the closure process should be a positive experience and the last moving, as much as possible. This means that all children will be moved in a long run in a prepared and planned manner in family type alternative services or in small residential services (apartments, Family-type homes).
The planned results need to be realistic	The new services, planned interventions and their expected results need to be realistic and to consider all options (e.g., including their transfer to specialized institutions for adults, where the case).
The pursuit of the child's interest and the improvement of the children's living conditions must to be demonstrable	Such improvement needs to be obvious, quantifiable and sustainable. Temporary and partial solutions are not sufficient. The result for each child needs to represent what the child needs in order to reach his/her maximum potential, not a slight improvement compared to the current situation.
Children need to be protected against harm or abuse	Reintegration in the natural family or placement to relatives should not be done at any cost. Children will not be placed in risk or abuse situations. For instance, if one of the reasons for the child placement was abuse or neglect in the family, the child will be reintegrated in the family only if a rigorous inquiry proves that the situation has changed and the child is no longer exposed to risk, in parallel with a strict monitoring plan after reintegration.
Children need to keep contacts with their families	Children who can no longer be reintegrated in their natural family or cannot be cared for in their extended family should be able to maintain contact with their family members. Therefore, a form of alternative placement should be found, in order to avoid moving the child geographically far away, and visits should be facilitated when this is in the child's interest.
Children will be reunited with their siblings when this is possible	**No group of siblings will be separated as a result of the closure process. Groups of siblings will remain together or will be reunited as much as possible and according to the interest of each child.**
Special attention needs to be paid to youth who leave the system	This involves a step-by-step careful planning, and ensuring adequate support (qualification, employment, housing, etc.), counseling and monitoring services until social integration is secured. The planning will be realized together which each young person about to leave the system.
Post-deinstitutionalization monitoring and evaluation are vital	The monitoring and evaluation of the situation post-deinstitutionalization needs to be ensured for each child and family, as well as for all newly created services.
Buildings of centers should no longer be used for residential care of children	Options for the subsequent use of the buildings should not include, under any form, options of group residential care. Where possible, it can be considered to split these buildings into completely independent apartments for persons leaving the system (and not only) with accessible housing options.
Deinstitutionalization requires a multidisciplinary approach	Integrated interventions are necessary in all aspects of family life (sometimes applied by several bodies): housing conditions, family and social relations, physical and mental health and economy/capacity to generate incomes.
Deinstitutionalization is not an autonomous process	Profound changes concerning the attitude towards the child, family life and relinquishment are necessary. The deinstitutionalization process needs to be implemented together with attempts to change attitudes, social and cultural norms related to family life and relinquishment. The promotion of acceptance of responsibilities by the parent and ensuring general and specialized support needed by parents

	have a great importance.
NGOs can be extremely valuable partners for the entire deinstitutionalization process	Organizations of the civil society can always bring innovation, flexibility, quality and speed, which are so necessary in the deinstitutionalization process. Moreover, NGOs have the ability and capacity to outreach the local communities, to swiftly adapt responses to the identified needs and to develop capacity where this is necessary. For all these reasons, ways of involving private providers of social services in a long run and to build public-private partnerships should be considered. The creation of an open market for the provision of services based on contracting/outsourcing could offer a fast and flexible response to needs and, at the same time, would secure sustainability of actions of the civil society and of the private sector in providing high quality services. The role of NGOs should not be limited to the direct provision of services. NGOs should be partners of DGASPC in the efforts of closing down the residential centers and, more generally, of child deinstitutionalization. Their participation can add value to all the process phases (from preparation, plan elaboration, financing requests, to implementation) and especially as part of the monitoring and evaluation process.

Sources: Mulheir and Browne (2007), UN (2010), EEG (2012), ANPDCA (2014).

ANNEXES

ANNEX 1: Type of institution according to the dominant profile of children or other variables

	Data for the placement center that is closing
The national rank of the placement center in the final prioritization list	
The name of the placement center that is closing	
County	
Locality	
Classification by center structure (organized into modules/ units or not)	
Classification by "classic" and "modulated" categories	
Classification of the center as being for girls only, for boys only or mixed	
Classification according to the existence of children under 3 years in the center	
The proportion of young people aged 18+ in the total number of children in the center	
Classification by categories of children with disabilities*	
Children's centers with SEN or in a functional relationship with a special school**	
Proportion of children in the placement center with behaviors at risk	
The center is part of a "nest" of placement centers or a community of various social service beneficiaries***	

Notes:
* By definition:
- Placement centers for children without disabilities are institutions where children with disabilities represent 0-49% of the total number of children in the center (with a national average of 12%).
- Placement centers for children with disabilities consist of institutions designated as residential centers for children with disabilities and former boarding facilities of special schools taken over by DGASPC from the Ministry of National Education (MEN), with over 50% of the beneficiaries being children with disabilities, of which less than half have severe disabilities.
- The centers for children with severe disabilities are institutions designated as residential centers for children with disabilities and former boarding facilities of special schools taken over by the DGASPC from MEN, with more than 70% of the beneficiaries being children with disabilities, of which over half are severely disabled.
At national level, 85% of all institutionalized children with disabilities in Romania and almost all children with severe disabilities (97%) are concentrated in 75 placement centers, 28 of which are centers for children with disabilities and 47 for children with disabilities severe disabilities.
** Centers that have a functional relationship with a special school - the two institutions are located in immediate proximity (the same building or yard) and most school-aged children living in that placement center go to that special school.
*** Of all 167 child placement centers in the country, only 47 institutions are individual, meaning they are located in independent buildings. The other centers work alongside other social service institutions for children and adults, especially for those with disabilities, within distinct communities that are often spatially and socially segregated from the community. These centers are considered to be part of a community of different social service beneficiaries. The "nests" of centers include two or more placement centers for children, possibly nearby a community of various social service beneficiaries. In

Romania there are 12 clusters of centers that comprise 30 institutions for children, four of which are very large.

ANNEX 2: Motivation of the closure of children's institutions in the county

	Data for the county where the placement center is located
The county where the placement center is located	
Total DGASPC employees at 31.03.2016 (www.copii.ro) (number)	
DGASPC employees in Residential Services on March 31, 2016 (number)	
Percentage of employees in residential services out of total employees DGASPC, at 31.03.2016 (%)	
Proportion of employees in placement centers for children out of total employed in residential services at county level (%)	
Total staff in placement centers at county level, at 31.10.2016 (number)	
The proportion... out of total staff in placement centers (CP) at county level, on 31.10.2016:	
% employees in classical placement centers	
% employees in classical placement centers with improvements	
% employees in partially modulated placement centers	
% employees in fully modulated placement centers	
Total children in public residential services on 31.03.2016 (www.copii.ro) (number)	
Proportion of children in placement centers in total children in public residential services at county level (%)	
Total number of children with special protection measure in placement centers, whether present or not, on 31.10.2016, out of which:	
% children in classical placement centers	
% children in classical placement centers with improvements	
% children s in partially modulated placement centers	
% children in fully modulated placement centers	

ANNEX 3: Information and consultation activities

This annex contains the minutes of the information and consultation sessions along with the centralized aggregate report on the number of relevant actors who participated in these sessions.

1. Centralized aggregate report on the number of relevant actors who participated in information and consultation sessions

	In the preparation phase	At the end of the preparation phase	Total
Number of minutes			

Number of participants in the information and consultation sessions by type of actors relevant to the process of de-institutionalization of children and according to the stage in which the meetings were organized:

Types of relevant actors	In the preparation phase	At the end of the preparation phase	Total
1. Children or young people in the center to close (from the list)			
2. Children or young people in the special protection system from services other than the center which is closing			
3. Families or individuals towards whom the children/ young people on the list have developed attachment relationships			
4. The staff of the center that is closing			
5. Representatives of DGASPC staff (trade unions, associations)			
6. County Council			
7. County level public institution (ISJ, DSP, AJOFM etc.)			
8. Local level public institution (SPAS, schools, doctors etc.)			
9. Community advisory structures in the county			

10. NGOs/ civil society			
11. Mass media			
12. Other type of relevant actor (which)…			

[The minutes are filled in for each of the information and consultation meetings organized by DGASPC]

Date of the meeting: |__|__|/|__|__|/|__|__|__|__|

The meeting was organized:

1. in the preparation phase, in parallel with the evaluation process
2. at the end of the preparatory phase, after the evaluation of needs and resources has been completed

The place where the meeting took place (institution, address):

Meeting moderator:

Name and surname Function Institution

Participants:

Mention the name and type of actor for each participant.

No.	Participant name	Type of relevant actor
1		
2		

ANNEX 4: Assessing the institution and justifying the choice for closure

	Data for the placement center
The national rank of the placement center in the final prioritization list	
The name of the placement center that is closing	
County	
Locality	
(A) CENTER SIZE	
Capacity of the center (number of places) according to the functioning authorization	
The total number of children actually present in the center, whether or not they have a special protection measure in the center	
CENTER POSITIONING	
The center is more than 1,5 km away or 15 minutes walking distance from the nearest school, the nearest hospital and the town hall	
The center was either not equipped with external access ramps or had an insufficient number	
LANDS OF THE CENTER	
Total surface of the land of the center (including the center building/buildings) (square meters) (5)	
Facilities that exist on the site of the institution:	
a. Playground in the open air	
There is an outdoor playground - it is used in common with the other placement centers or is used only by the center	
b. Sports ground	
There is a sports ground - it is used in common with the other placement centers or is used only by the center	
c. Swimming pool	
There is a swimming pool - it is used in common with other placement centers or is used only by the center	
d. Other facilities	
There are other facilities – they are used in common with other placement centers or is used only by the center	
Other facilities (specify)	
THE BUILDINGS OF THE CENTER	
The buildings of the center:	
a. Total number of buildings, out of which:	
b. Number of buildings in which children are accommodated	
c. Total surface of buildings, of which: (square meters)	
d. Total surface of buildings in which children are accommodated: (square meters)	
Within the institution, the space where the children are housed is: in a part of a building, in a building or in several, namely: ?	
Landmark / building code 1	
Landmark / building code 2	
Landmark / building code 3	
Year of building construction … for the unique building where the children are housed	
Year of building construction … for landmark / building code 1	
Year of building construction … for landmark / building code 2	

Year of building construction … for landmark / building code 3	
Year of last consolidation, expansion, major repairs or upgrading … for the unique building where the children are housed (6)	
Year of last consolidation, expansion, major repairs or upgrading … for landmark / building code 1 (6)	
Year of last consolidation, expansion, major repairs or upgrading … for landmark / building code 2 (6)	
Year of last consolidation, expansion, major repairs or upgrading … for landmark / building code 3 (6)	
The general state of the interior space … for the unique building where the children are housed	
The general state of the interior space … for landmark / building code 1	
The general state of the interior space … for landmark / building code 2	
The general state of the interior space … for landmark / building code 3	
CENTER INFRASTRUCTURE	
Total area of bedrooms (square meters)	
Total number of bedrooms … for the unique building where the children are housed	
Total number of beds… for the unique building where the children are housed	
Total number of bedrooms... for landmark / building 1	
Total number of beds … for landmark / building 1	
Total number of bedrooms... for landmark / building 2	
Total number of beds … for landmark / building 2	
Total number of bedrooms... for landmark / building 3	
Total number of beds … for landmark / building 3	
Average number of beds per bedroom	
Average number of children per bedroom (7)	
Maximum number of children in one bedroom	
Maximum number of children in one bedroom (8)	
Average area per child (9)	
HEALTH AND SECURITY OF CHILDREN IN THE CENTER	
Does each module have at least one leisure room (whether or not it is separated from the table space)?	
Where do kids in the center have their meals?	
Is there a bathroom - for every room, - for every second room - for every module?	
There is no hot water supply in the center building (or at least one of the buildings housing children) or it is provided only according to a schedule	
Children's privacy in toilets and / or showers is not ensured	
Children's spaces are rarely personalized, only a few (less than 33%) have photos, posters or drawings on the wall beside their bed (10)	
Not all children living in the center received a general health assessment in the previous year	
The building of the center (or at least one of the buildings housing children) had one or more of the following problems: dark, lack of natural light, roof leakage, damp walls, damaged sheds to be replaced, cracked walls and / or old paint	
Children with disabilities (children with disabilities represent over 20% of all children living in the center) lacked access to sanitary facilities (toilet bowl, sink, shower or bathtub)	

HUMAN RESOURCES OF THE CENTER	
Total number of center staff (13)	
The ratio between the total number of staff and the number of children present in the center (14)	
Proportion of employees who have undergone training/ specialization in the last 3 years (%) (15)	
Teaching and care staff who work directly with the children as a share of the total staff of the center (%) (16)	
Specialists (social workers, psychologists, speech therapists, physiotherapists, etc.) in the center as a share of the total staff of the center (%) (17)	
Nurses for children with disabilities	
Human resources were a weak point of the center (for example, if the staff were inadequate, poorly qualified, poorly paid or indifferent)	
SERVICES AND ACTIVITIES FOR THE DEVELOPMENT OF THE CHILD AVAILABLE IN THE CENTER	
There is a special area dedicated to visits to the center	
No child in the center was provided (inside or outside the center) with any rehabilitation service including psychological therapy, kinetotherapy and massage, speech therapy, psychomotor therapy and manual skills, occupational therapy and expressive psychotherapy, support psychotherapy, relaxation psychotherapy, cognitive-behavioral or educational therapy	
Any of the children who lived in the center during the school year had to repeat the year, had flunked subjects, dropped out of school or left school	
There isn't a birthday party organized in the center for celebrating each child's birthday	
INTERACTION BETWEEN PERSONAL AND CHILDREN IN THE CENTER	
The center did not have a procedure for complaintsfrom children or to listen to the views of children on the quality of the services they receive at the center	
Over the past 2 years, the center has recorded suspicious of cases of child abuse in the Special Incident Register and / or has reported such cases to the police or prosecutor's office	
In the past 2 years, any employee of the center was fired, transferred to another service, subject to disciplinary action, or investigated or, as the case may be, sued for ill-treatment of the minor	
MINIMUM STANDARDS AND CASE MANAGEMENT IMPLEMENTED IN THE CENTER	
The institution was accredited as a social service provider	
The center did not have a license	
The families of over 40% of all children living in the center whose files identify the family for the possible (re) integration of the child have not received at least one visit from the child case manager or other DGASPC specialist during the previous 12 months.	
National Rank obtained by the Center regarding the IMPLEMENTATION OF MINIMUM STANDARDS AND CASE MANAGEMENT - World Bank, Result 2, April 2017 (22) (within the SIPOCA 2 project)	
(B) ENVIRONMENT OF CARE	
The national rank achieved by the center on THE ENVIRONMENT OF CARE - World Bank, Result 2, April 2017 (19) (within the SIPOCA 2 project)	
(C) QUALITY OF CARE	
The national rank achieved by the center on THE QUALITY OF CARE - World Bank, Result 2, April 2017 (23) (within the SIPOCA 2 project)	
THE QUALITY OF SERVICES IN THE CENTER	

The national rank achieved by the center on THE QUALITY OF SERVICES IN THE CENTER - World Bank, Result 2, April 2017 (24) (within the SIPOCA 2 project)	
CHILDREN'S VIEWS	
The global evaluation for the life within the center that children have carried out, from 1 to 10 "just as in school" (25)	
DGASPC FEEDBACK	
Closing priority according to DGASPC in the county where the center is located (26)	
ENTRIES IN THE CENTER IN THE LAST 5 YEARS	
A. Total number of entries, in:	
year 1	
year 2	
year 3	
year 4	
year 5	
AA. Entries in the family, in:	
year 1	
year 2	
year 3	
year 4	
year 5	
EXITS FROM THE CENTER IN THE LAST 5 YEARS	
B. Total number of exits, in:	
year 1	
year 2	
year 3	
year 4	
year 5	
BB. Family reintegrations, in:	
year 1	
year 2	
year 3	
year 4	
year 5	

Notes:
(1) The indicator used to measure the size of the placement center was the number of children actually present in the center on 31 October 2016, regardless of whether or not the child had a special protection measure established within that center.
For all 30 centers that are part of a "nest" of centers, the total number of children living in the nest was used instead of the number for each center.
(2) The LOWER the rank, the HIGHER the SCORE, the HIGHER the closure priority of the center. The higher the number of children in the center, the less likely it is that the center offers a close family environment; therefore the closure priority of that center is even greater. The ranking shows the place that the placement center has in the order of priority of the closure at national level. For example, a 15-rank center, compared to all CPs in the country, ranks 15th in the priority order of closure on this ranking dimension.
(3) The centers were considered spatially segregated if they were located on the outskirts of a community or separated from the community by a natural or built barrier such as a river, forest, orchard or high hedges.
(4) The more negative characteristics out of the 5 considered, the higher the physical and/ or social isolation a center has, and thus the greater is the priority of its closure. See note 2 for details on rank interpretation.

(5) If the center is located in the same building / yard with other centers, only the center of the center is mentioned.
(6) Building consolidation, roof repairs, installation of new windows, central heating installation, sanitary change, expansions, etc. are included. Annual hygiene, painting, and current repairs are not included etc.
(7) This is not the case with a placement center in the process of being established. The zero value shows centers in the process of renovation or reorganization, where children were moved to other services.
(8) For centers at the time of external evaluation undergoing renovation or reorganization, the assessment refers to the services where the children in these centers were actually living.
(9) This is not the case with centers in the process of being set up or undergoing refurbishment or reorganization (where children were moved to other services).
(10) The images, panels, or cutouts displayed by Center staff were not considered, but only those displayed by children.
(11) The higher the number of infrastructure-related negative aspects in a center (in total 16 negative aspects were considered), the lower the quality of physical conditions available to children, the greater the closure priority. See note 2 for details on rank interpretation.
(12) The higher the number of negative elements in a center (22 negative aspects were considered), the more precarious the health and safety conditions for children are, and the greater the priority of its closure. See note 2 for details on rank interpretation.
(13) In most cases, this total number refers to people employed by the center and working (full-time or part-time) at the center. In addition, 23 centers have between 1 and 15 employees of the center that do not actually work at the center (but in another DGASPC social service). These employees are not included in the total number of staff considered here. A total of 56 centers reported personnel employed by DGASPC (or other entities, such as NGOs) working full time or part-time at the center (usually specialists). Only part of these centers included all or some of these employees in their staff records of the residential center. For a unitary presentation, only persons employed by DGASPC (or other entities) working full-time in the center were counted in the total number of staff. Generally, others refer to DGASPC specialists (such as psychologists) who provide "as needed" or "as much as possible" services in many other social protection services besides that center without a clear division of time and professional responsibilities.
(14) If the ratio of total staff and number of children in the center was less than 1 = care personnel related issue.
(15) If less than 52% of center employees have attended one or more training or specialization courses in the last three years = care personnel related issue.
(16) If the teaching and care staff working directly with the children represented less than 55% of the total staff of the center = care personnel related issue.
(17) If the center's specialists represented less than 6% of the center's total staff = care personnel related issue.
(18) The LOWER the rank, the HIGHER the SCORE, the GREATER the closure priority of the center. The more a center has more problems with care staff (the total 9 were considered negative), the lower the quality of child care and therefore the closure priority. The rank shows the place that the center has in the order of priority of the closure in question at national level.
(19) The LOWER the rank, the HIGHER the SCORE, the GREATER the closure priority of the center. Ranking ranges for the overall care environment that was calculated for each center as the arithmetic mean of the scores for the four sub-dimensions presented above: (1) isolation and accessibility, (2) infrastructure, (3) health and safety, and (4) care staff. The rank shows the place that the center has in the order of priority of the closure in question at national level.
(20) The lower the rank, the higher the score, the greater the closure priority of the center. The more one of the 23 negative aspects considered, the fewer the services and activities that the child's development center provides, and the greater the priority of its closure. The rank shows the place that the CP has in the order of priority of the closure in question at national level.

(21) The lower the rank, the higher the score, the greater the closure priority of the center. The more negative aspects a center has (out of 6 considered), the more likely it is to apply an abusive and punitive system, and the greater the closure priority. The rank shows the place that the center has in the order of priority of the closure in question at national level.
(22) The lower the rank, the higher the score, the greater the closure priority of the center. The more negative aspects a center has (out of the nine considered), the more deficient is the implementation of standards and case management, and the greater the closure priority of the center. The rank shows the place that the CP has in the order of priority of the closure in question at national level.
(23) The lower the rank, the higher the score, the greater the closure priority of the center. Rankings for overall quality of care were calculated for each center as the arithmetic mean of the scores for the three sub-dimensions presented above: (1) child development services and activities, (2) child / staff interactions, and (3) standards and case management. The rank shows the place that the CP has in the order of priority of the closure in question at national level.
(24) The lower the rank, the higher the score, the greater the closure priority of the center. The ranges for total score for service quality were determined as the arithmetic mean of the scores on the three dimensions discussed above: (A) center size, (B) care environment, and (C) quality of care. The rank shows the place that the CP has in the order of priority of the closure in question at national level.
(25) The overall score for each center was calculated as the arithmetic mean of the scores of all children participating in focus groups on the following eight themes: living conditions and cleanliness, personal belongings, food, school, physician, leisure activities, relationship with center educators and relationship with other children in the center.
World Bank Researchers held 133 focus groups with 949 children in all but 44 placement centers. In 20 of these 44 institutions, focus groups could not be organized because all children were too young (between 0 and 10 years), while in 19 other centers the children had severe disabilities. The other five institutions were either closed or not within the research sphere. In 116 focus groups, 843 children indicated their own scores for centers, between 1 and 10 ("as if at school, if you took less than 5 dropped the test, if you took 10, you passed the maximum mark"). In the other 17 group discussions, the scores could not be collected (because children could not complete the questionnaires because in most cases they could not write), but the evaluator noted the views of the children. For this reason, for some centers there is no opinion of the children.
(26) Index computed based on two indicators. The first indicator was calculated as a proportion of DGASPC staff working in placement centers of all DGASPC staff using official ANPDCA data from March 31, 2016 (www.copii.ro). This indicator is determined at county level and is allocated to all centers in the county. It was assumed that the higher the percentage of DGASPC employees working in placement centers in the total DGASPC staff, the greater the DGASPC option for child protection in placement centers (and not in services) family type). This indicator takes higher values for centers located in counties with a larger number of placement centers.
For the second indicator, scores were allocated starting from the priority of the closure of the placement centers in the county expressed by DGASPC general managers (based on various criteria) in the counties that have at least one placement center for children.
By combining the two indicators, the highest closure priority is given by the institutions with many centers and which are in the first place in the closure plans of DGASPC. At the opposite extreme, the lowest closure priority belongs to centers in counties with a single center and is not considered a priority by DGASPC. To facilitate interpretation, both indicators ranged from zero to 100, and the combined index was determined as their average.
(27) Each DGASPC external evaluator provided an opinion on each center visited, justifying this opinion in a report. They assessed what should be done for each center - whether it should be closed or not - only on the basis of its own expertise and experience, and not of decision-making or strategic thinking. This indicator was not included in the analysis itself but was presented as an independent opinion of a colleague of child protection specialist.
(28) Centers that have benefited in the last five years of public funds for the development or modernization of the infrastructure are not eligible for European funds through the ROP.

ANNEX 5: Nominal List of children and young people in the residential center

Filled-in on: |__|__|/|__|__|/|__|__|__|__|

Person filling-in the Nominal List:

Name and surname | Position | Institution

Children and young people who have entered the multidisciplinary evaluation process

No.	Name and surname	CNP	The child is present at T0 1-Yes 2-No	The child has a protection measure at T0? 1-Yes, in this PC 2-Yes, but not in this PC 3-No	Name of the current case manager
	NAME	CNP	COPIL_PREZ	COPIL_MP	MC
1					
...					

Note: In the nominal list of children and young people entering the multidisciplinary assessment process, only children and young people who are present or have a protection measure in the center are included (COPIL_PREZ=1 or COPIL_MP=1).

ANNEX 6: The nominal list of children and young people in the institution after T0

Nr.	Name and surname	CNP	The child is present at T0 1-Yes 2-No	The child has a protection measure at T0? 1-Yes, in this PC 2-Yes, but not in this PC 3-No	Name of the current case manager
	NUME	CNP	COPIL_PREZ	COPIL_MP	MC
1					
...					

WILL BE FILLED IN AND PERMANENTLY UPDATED UNTIL THE END OF THE PROJECT: The dynamic list of children who were not in the closing institution but who benefitted from the new services set up during the project.

Signature: _____

ANNEX 7: Medical Assessment Report at Center Level

After completion of the medical evaluation for each child/ young person in the nominal list, a table is automatically generated in e-cuib, where all the children and young people in the nominal list are on the lines and the following information will be in the columns:

- Full name
- Personal Identification Number
- The date and the practitioner's name who performed the medical assessment
- The assessment outcome has been written down in a Medical Record (yes or no)
- If the Medical record/ the Brief medical recordif enclosed in the child's file(yes or no)
- If the child has a disability certificate (yes or no). If yes, the disability grading of the handicap.
- If the child/young person needs a medical assessment from specialist doctors to receive a grading of the disability level (yes or no)
- If the child has medical needs for which medical services and / or specialized interventions are recommended (yes or no)
- If the child/ youngster is immobilized in bed (yes or no)
- If the child has life-threatening health problems. (yes or no)
- If the child has health problems that require a nearby hospital (yes or no).
- If the child has health problems that require frequent assessments, investigations or medical tests (yes or no).
- If the child has PIS (yes or no). If Yes, if the Health Specific Intervention Program is put in the child's file (yes or no)

Additionally, at aggregate level, for all the children and young people on the nominal list the following will be calculated:

(Number)	0-3 years	4-6 years	7-10 years	11-14 years	15-17 years	18+ years
Children/ young people with a disability qualification certificate, out of which:						
Children/ young people with severe disability						
Children/ young people with accentuated disability						
Children/ young people with medium disability						
Children/ young people with light disability						
Children with physical disabilities						
Children with somatic disabilities						
Children with hearing disabilities						
Children with visual disabilities						
Children with mental disabilities						
Children with neuropsychiatric disabilities						
Children with associated						

disabilities						
Children with HIV/AIDS						
Children with rare diseases						
Children with deafblindness						
Children / young people who need assessment for disability						
Children / young people with medical needs for whom specialized services are recommended						
Children / young people who are immobilized in bed						
Children / young people with life-threatening health problems						
Children / young people with health problems requiring the existence of a nearby hospital						
Children / young people with health problems requiring frequent evaluations, investigations or medical examinations						

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled in the report

Name	Title
Surname	Signature

ANNEX 8: Psychological Evaluation Report at Center Level

After completion of the psychological assessment, a table generated in e-cuib with all the children and young people's names from the nominal list included in the rows, while the columns contain the following:

- Full name
- Personal Identification Number
- Date and who performed the psychological assessment
- The result of the assessment has been written down in a Psychological Assessment Sheet (yes or no)
- If the Psychological Assessment Sheet has been attached to the child's file (yes or no)
- If the child has delays in development (any kind of delay - values 2, 3 or 4 in any of the areas investigated) (yes / no). If she needs psychiatric assessment (yes / no).
- If he / she has psychological needs for which services are recommended (for children without disabilities - code 3 or 5 for question VI and for children with disabilities code 1 to at least one service in the table in section 6, without taking into account the service on psychiatric evaluation)

Additionally, at aggregate level, for all the children and young people in the nominal list:

(Number)	0-3 years	4-6 years	7-10 years	11-14 years	15-17 years	18+ years
Children/ young people with developmental or memory delays (codes 2, 3, 4)						
Children/ young people with language developmental delays						
Children/ young people with thinking developmental delays						
Children/ young people with attention developmental delays						
Children/ young people with affectivity developmental delays						
Children/ young people with willingness developmental delays						
Children/ young people with personality developmental delays						
Children/ young people with behavioral developmental delays						
Children/ young people who need a psychiatric evaluation						
Children/ young people who have needs for which						

psychological services or connected interventions are recommended						

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled in the report:

Name	Title
Surname	Signature

ANNEX 9: Social Evaluation Report at Center Level

After completion of the social assessment, a table is automatically generated in e-cuib, placing in the rows the names of children and young people in the nominal list and inserting in the columns the following information:

- Full name
- Personal Identification Number
- Date of birth
- Name of the person who performed the social assessment
- The result of the social assessment was written down in a Social assessment sheet
- If the Social assessment sheet has been enclosed in the child's file(yes or no)
- Has he/she entered the protection system when he/she was0-12 months (yes or no) - automatically calculated
- Has he/she gone through 3+ steps during the time spent in the protection system (yes or no)
- Does he/she have siblings in the center or in the protection system (yes or no)
- Does he/she have friends in the center that he/she does not want to part from(yes or no)
- Is he/she going through an adoption process(yes or no)
- Does the child have services and/or social interventions recommended (yes/no)
- In case of the young persons of over 18, does he/she have independent life skills insufficiently developed (yes or no)

Additionally, at aggregate level, for all the children and young people in the nominal list we calculate:

(Number)	0-3 years	4-6 years	7-10 years	11-14 years	15-17 years	18+ years
Number of children and young people introduced into the system at the age of 0-12 months						
Number of children and young people with 3+ stages in the system(who have been frequently moved)						
Number of children and young people with siblings in the center						
Number of children and young people with siblings in the system (but not in the center)						
Number of children and young peoplewho have good friends in the center they do not want to part from						
Young persons of 15+ who are in a couple						
Number of children undergoing the adoption process						
Number of young people aged 18+ with insufficiently developed independent life skills						
Number of children and young people who have recommended social services and/or interventions						
Number of children and young people whose social assessment has highlighted						

major difficulties						

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled in the report:

Name	Title
Surname	Signature

ANNEX 10: Educational Evaluation Report at Center Level

After completing the educational assessment, a table is automatically generated in e-cuib, including in the rows all the children and young people in the nominal list while entering into the columns the following data:

- Full name
- Personal Identification Number
- The date of birth
- Function of the person who performed the educational assessment
- The assessment outcome has been written down in a: Psycho-pedagogical record (yes or no)
- If the Psycho-Pedagogical Record is included in the child's file (yes or no)
- If the child is in schooling (yes or no).
- If the child is not schooled, has he ever been in school (yes or no), what is the last form of education, and how many grades has he finalized?
- If the child is schooled, where does he go to school, what type of education is he following, what grade is the child in, is he at risk of early abandonment or drop out (yes or no)
- Level of school acquisitions for reading, writing, calculus and understanding
- The child has abilities, special interests, talents (yes or no)

Additionally, at aggregate level, for all the children and young people in the nominal list:

(Number)	4-6 years	7-10 years	11-14 years	15-17 years	18+ years
Total children / young people with disabilities and/ or SEN, of which:					
- are not schooled					
- are schooled in special education					
- schooled in mass education					
- schooled in inclusive education					
- with problems of absenteeism, poor school results, risk of school dropout					
- with good or very good reading skills					
- with good or very good writing skills					
- with good or very good calculus skills					
- with good or very good skills for understanding of written text					

- with abilities, special interests, talents					
Total children/ young people without disabilities and without SEN, out of which:					
- are not schooled					
- are schooled in special education					
- schooled in mass education					
- schooled in inclusive education					
- with problems of absenteeism, poor school results, risk of school dropout					
- with good or very good reading skills					
- with good or very good writing skills					
- with good or very good calculus skills					
- with good or very good skills for understanding of written text					
- with abilities, special interests, talents					

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled in the report:

Name	Title
Surname	Signature

ANNEX 11: Report on the assessment of children's and young people's families at Center Level

After completing the list of families/ attachment persons identified for each child/ young person in the nominal list, a table is automatically generated in e-cuib where all the children and young people on the list are on the lines and the columns the following information shall be filled in:

- Last name and first name
- Personal identification number
- Total number of families/ attachment persons that were identified for the child/ young person *Attention! The total number of families / attachments must be equal to the sum of numbers by type.*
- Number of families / attachment persons identified by type:
    - mother and father (0/1)
    - only mother (0/1)
    - only father (0/1)
    - adult brother/ sister (number)
    - maternal grandparents (0/1/2)
    - paternal grandparents (0/1/2)
    - aunts / Uncles (number)
    - other relatives up to grade IV (number)
    - other relatives above grade IV (number)
    - other unrelated persons (number)

- If there is at least one family/ person of attachment whose actual address is unknown (i.e. identification efforts must be continued) - yes/ no
- If there is at least one family/ person of attachment for whom re (integration) needs to be done (aid for which there was no meeting between the social worker and the family/ person of attachment to discuss their involvement in raising and educating child / young) - yes/ no
- If there is at least one family/ person of attachment for work with the family to improve the relationship with the child (i.e. the family has expressed the option of not actually getting involved in raising and educating the child/ young person) - yes/ no

Based on the list of family/ person of attachment identified for each child/ young person in the nominal list, a table is automatically generated in e-cuib, which calculates aggregate information as follows:

(Number)	**0-3 years of age**	**4-6 years of age**	**7-10 years of age**	**11-14 years of age**	**15-17 years of age**	**18+ years of age**
Children / young people for whom the process of identifying families / persons of attachment has not yet begun						
Children / young people for whom the process of identifying families / persons of attachment is ongoing						
Children / young people for whom the process of identifying families / persons of attachment is						

finalized						
Children / young people for whom there were identified no families / persons of attachment						
Children / young people for whom there were identified families / persons of attachment						
Children / young people for whom the process of identifying families / persons of attachment needs to be continued (for which the identification process has not yet begun or is underway or for which the factual address of all identified attachment families / persons is unknown)						

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name: Position:

First name: Signature:

ANNEX 12: Family Evaluation Report at Center Level

After completion of the families/ persons of attachment identified for the children and young people on the nominal list that want to be involved in their raising and education, a table is automatically generated in e-cuib. On the lines shall be all the children and young people in the nominal list and in the columns the following information shall be filled in:

- Last name and first name
- Personal identification number
- Date and person having carried out the family assessment
- Number of families/ persons of attachment identified that want to be involved in the child's/young person's raising and education
- Number of I9 instruments (Questionnaire for evaluating the family needs) filled in on the field for families/ persons of attachment that want to be involved in the child's/young person's raising and education
- Number of I9 instruments (Questionnaire for evaluating the family needs) archived in the child's case file
- Whether the child's family (re)integration is possible in the short time (in at least one of the families/ persons of attachment identified) (yes or no)
- Whether the child's family (re)integration is possible only under certain conditions, in the medium term (in at least one of the families/ persons of attachment identified).
- *If yes*, has a working plan been established with the family to minimize the risks in the situation of family (re)integration? (yes or no)
- Whether the child's family (re)integration is not possible (in any of the families/ persons of attachment identified)

Moreover, for the purpose of an aggregated level, the following calculations shall be added for all the children and youngsters in the nominal list:

(Number)	**0-3 years of age**	**4-6 years of age**	**7-10 years of age**	**11-14 years of age**	**15-17 years of age**	**18+ years of age**
Children/ young people for whom family needs were assessed (I8 completed)						
Number of children/ young people for whom family (re)integration is not possible (in any of the families/ persons of attachment identified)						
Number of children/ young people for whom family (re)integration is possible in the short time (in at least one of the families/ persons of attachment identified)						
Number of children/ young people for whom family (re)integration is possible under certain conditions, in the medium term (in at least one of the families/ persons of attachment identified)						

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name:	Position:
First name:	Signature:

ANNEX 13: Plan for the Future Report at Center Level for children and young persons

After completion of the multidisciplinary assessment, based on the Conclusive Reports for each child/ young person on the nominal list, a table is automatically generated in e-cuib where all the children and young people on the list are on the lines, and the following information will be in the columns:
- Full name
- Date of birth
- The Plan for the future was filled in (yes/no)
- The Plan for the future was archived in the child's file (yes/no)
- IPP purpose

In addition, for all children and young people in the nominal list the following will be aggregated:

(Number)	**0-3 years**	**4-6 years**	**7-10 years**	**11-14 years**	**15-17 years**	**18+ years**
Children/ young people with IPP purpose: family reintegration						
Children/ young people with IPP purpose: adoption						
Children/ young people with IPP purpose: socio-professional integration						
Children/ young people with another IPP purpose						

The solutions established in the Plan for the Future

Nominal list of children and young people who will be reintegrated in the natural family

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people 18+ who will benefit from socio-professional integration

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people who will go into adoption

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people who will be integrated in their extended family, without a protection measure

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people who will benefit from a family placement to relatives up to grade IV

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people who will benefit from a placement to other families/persons

No.	Surname	Name	PIN
1			
...			

Nominal list of children and young people who will be transferred to Professional Foster Caregivers

No.	Surname	Name	PIN	PFC name	County	Municipality/ City/ Commune	Village
1							
...							

Nominal list of children and young people who will be transferred to a Small Group Home or an apartment

No.	Surname	Name	PIN	PFC name	County	Municipality/ City/ Commune	Village
1							
...							

Nominal list of children and young people who will be moved in other residential services when the complex needs of the child can't be covered through other measures (such as transfer in a facility for adults)

No.	Surname	Name	PIN	Name of service	County	Municipality/ City/ Commune	Village
1							
...							

Nominal list of children and young people are who will benefit from other alternative measures

No.	Surname	Name	PIN	Measure
1				
...				

PERMANENT SOLUTIONS OR ALTERNATIVE MEASURES PROPOSED FOR CHILDREN / YOUNG PEOPLE (according to the Plans for the future, point III)

1. (Re)integration or placement

Number of children and young people from the nominal list with the solution:	0-3 years	4-17 years	18+ years
-reintegration in the natural family			
- socio-professional integration			
- Adoption			
- integration in the extended family, without a protection measure			
- family placement to relatives up to grade IV			
- placement to other families/persons			
- placement to a Professional Foster Caregiver			
- placement in aSmall Group Home or an apartment			
- exceptional placement in another residential service (DGASPC or PAO) when the complex needs of the child can't be covered through other measures (such as transfer in a facility for adults)			
- other alternative measures (ex. transfer in a different county)			

2. Was the solution agreed with the family?

Number of children and young people in the nominal list for whom the solution:	0-3 years	4-17 years	18+ years
- Yes, it was agreed with the family			
- No, it was not agreed with the family			

3. Was the solution agreed with the child/young person?

Number of children and young people in the nominal list for whom the solution:	0-3 years	4-17 years	18+ years
- Yes, it was agreed with the child/young person			
- No, it was not agreed with the child/young person			

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name: Position:

First name: Signature:

Accountability of the final report by the multidisciplinary team

Full name

Signature

Full name

Signature

...

Attention! The Plan for the Future Report at Center Level *Children and Young People must be countersigned by all members of the multidisciplinary team that carried out the evaluation.*

ANNEX 14: Evaluation and Staff Selection Report at Center Level for the Placement Center that is closing

Data regarding the placement center staff at the time of taking the decision to close the institution:

- The total number of employees (full-time or part-time) of the placement center closing
- Distribution by gender
- Distribution by age
- Distribution of staff by number of years spent in residential social services (for children or adults) (0-2 years, 3-5 years, 6-10 years, 11-14 years, 15-19 years, 20+ years)
- Distribution by level of education
- Distribution of personnel by type (nursing staff - nurses, supervisors, etc; education; nurses; doctors; other specialists - social worker, psychologist, kinetotherapist, etc.; administrative staff - chef, guard, administrative staff, driver, heating responsible, etc.).

After completing the process of informing, analyzing and consulting staff and their representatives, the table below will be completed with the options finally agreed for staff:

		Estimated year/month until when the employee will work for the center	Final option selected	Future need to commute **
1.	Retirement, if possible			
2.	Exit from the protection system and finding a new workplace on their own, after attending re-training or re-skilling courses			
3.	Exit from the protection system and withdrawal to the household			
4.	Transfer inside DGASPC, to other services/ departments than the ones mentioned above			
5.	Transfer inside an existing DGASPC service for adults			
6.	Transfer inside an existing DGASPC service for children that cannot be improved			
7.	Transfer inside an existing DGASPC service for children that will be improved			
8.	Transfer inside a newly-founded DGASPC service			
9.	Other options, more exactly ...			

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the Summary:

Last name: Position:

First name: Signature:

This model is found in the Methodology in Box 13.

ANNEX 15: Summary of New Services and Activities at Center Level

By aggregating the new services and activities specified in the Plans for the future of all children and young people in the center that is closing, this Summary is generated automatically in e-cuib.

Service	Total number of children for which a new service will be developed/ established/ purchased	Number of children for which a new service will be developed/ established/ purchased in…			
		Locality 1	Locality 2	Locality 3	Locality n
I. PROTECTION SERVICES					
1.Professional Foster Caregiver					
2. Small Group Home					
3. Apartment					
II. SOCIAL SERVICES					
Center-type					
4. Maternal center					
5. Other residential services for children (CPRU etc.)					
6. Day care centers supporting the integration/reintegration of children back into their family					
7. Day care centers for children with disabilities					
8. Day care centers for independent life skills development					
9. Guidance, supervision and social reintegration centers for juvenile criminal offenders below the age of criminal responsibility					
10. Counseling centers for abused, neglected, exploited children					
11. Drop-in counseling and support centers for parents and children/pregnant women in difficulty					
12. Sheltered housing					
13. Institutions for adults (CITO, CRRN, CIA, socio-medical facility, inpatient palliative care center,					

Service	Total number of children for which a new service will be developed/ established/ purchased	Number of children for which a new service will be developed/ established/ purchased in…			
		Locality 1	Locality 2	Locality 3	Locality n
etc.)					
14. Day or night shelters					
15. Drug prevention, evaluation and anti-drug counseling centers					
16. Addiction recovery centers					
17. Therapeutic community centers					
18. Multipurpose centers/services					
19. Community–based integrated service centers					
20. Mobile teams					
4. Maternal center					
Interventions/ activities					
22. Parent education services					
23. Psychological counseling services					
24. Speech therapy services					
25. Physical therapy services					
26. Other habilitation/rehabilitation services					
27. Abuse, neglect and exploitation prevention services					
28. Counseling services for domestic violence prevention and control					
29. Perpetrator support services					
30. Meals on Wheels or social canteen services					
31. Social enterprise					
32. Social housing services (youth housing units (ANL), social housing units, emergency housing units, etc.)					
33. Home renovation or improvement support					
34. Legal aid services					
35. Support for parents / legal representative to prepare the					

Service	Total number of children for which a new service will be developed/ established/ purchased	Number of children for which a new service will be developed/ established/ purchased in…			
		Locality 1	Locality 2	Locality 3	Locality n
necessary documents for the disability certificate for adults with disabilities					
36. Counseling and support groups for families, young people or children in difficulty					
37. Transport to social services in other localities					
38. Accommodation of the parent during the habilitation-rehabilitation of children in centers from other localities					
39. Adoptive family training programs					
40. Occupational therapy					
41. Other, namely…					
III. EDUCATIONAL AND MEDICAL SUPPORT SERVICES					
Center-type					
42. Kindergarten					
43. Primary school					
44. Primary school with supportive educational services/integrated special education					
45. Lower secondary school					
46. Lower secondary school with supportive educational services/integrated special education					
47. Special school					
48. High-school					
49. Technical high-school					
50. Standby medical center					
51. Hospital, polyclinic					
53. Other, namely…					
Interventions/ activities					
54. School counseling and guidance services					

Service	Total number of children for which a new service will be developed/ established/ purchased	Number of children for which a new service will be developed/ established/ purchased in…			
		Locality 1	Locality 2	Locality 3	Locality n
55. Professional/vocational counseling and guidance services					
56. Supportive educational services					
57. School after school services (*afterschool*)					
58. A Second Chance					
59. Job skills assessment services					
60. Labor market counseling and mediation services					
61. Job search support, including accompaniment					
62. Professional training services for adults					
63. School sporting club, football team and similar activities					
64. Children's club, folklore ensemble, other relevant leisure activities					
65. Social activities and leisure					
66. Instructive-educational activities					
67. Transport to the school in another locality					
68. Activities for the development of independent living skills					
69. Family planning services					
70. Sex education services for youth					
71. Social ambulance					
73. Other, namely…					
IV. OTHER SERVICES					
74. Monitoring and support post-reintegration					
75. Monitoring and support post-adoption					
76. Monitoring and support post-socio-professional integration					

Service	Total number of children for which a new service will be developed/ established/ purchased	Number of children for which a new service will be developed/ established/ purchased in…			
		Locality 1	Locality 2	Locality 3	Locality n
77. Other, namely…					

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled the summary of new services:

Last name: Position:

First name: Signature:

Accountability of the Summary of New Services and Activities at Center Level by the team elaborating the individual closure plan

Full name

Signature

Full name

Signature

...

Attention! The Summary of New Services and Activities at Center Level *must be countersigned by all members of the multidisciplinary team that carried out the evaluation.*

ANNEX 16: Plan of new services and activities that will be realized through the project

The Plan of new services and activities should take into account the service needs coming out of the Plans for the future for children and young people as outlined in the Summary of New Services and Activities at Center Level (Annex 15) as well as the specific project financing conditions (available budget, timeframe in which the services must be implemented, etc.).

Service	**Will the service be realized within the project?** 1. Yes 2. No	*If Yes,* **How many services will be developed?**
I. PROTECTION SERVICES		
1.Professional Foster Caregiver		
2. Small Group Home		
3. Apartment		
II. SOCIAL SERVICES		
Center-type		
4. Maternal center		
5. Other residential services for children (CPRU etc.)		
6. Day care centers supporting the integration/reintegration of children back into their family		
7. Day care centers for children with disabilities		
8. Day care centers for independent life skills development		
9. Guidance, supervision and social reintegration centers for juvenile criminal offenders below the age of criminal responsibility		
10. Counseling centers for abused, neglected, exploited children		
11. Drop-in counseling and support centers for parents and children/pregnant women in difficulty		
12. Sheltered housing		
13. Institutions for adults (CITO, CRRN, CIA, socio-medical facility, inpatient palliative care center, etc.)		
14. Day or night shelters		
15. Drug prevention, evaluation and anti-drug counseling centers		
16. Addiction recovery centers		
17. Therapeutic community centers		
18. Multipurpose centers/services		
19. Community-based integrated service centers		
20. Mobile teams		

Service	**Will the service be realized within the project?** 1. Yes 2. No	*If Yes,* **How many services will be developed?**
21. Other (specify)…		
Interventions/ activities		
22. Parent education services		
23. Psychological counseling services		
24. Speech therapy services		
25. Physical therapy services		
26. Other habilitation/rehabilitation services		
27. Abuse, neglect and exploitation prevention services		
28. Counseling services for domestic violence prevention and control		
29. Perpetrator support services		
30. Meals on Wheels or social canteen services		
31. Social enterprise		
32. Social housing services (youth housing units (ANL), social housing units, emergency housing units, etc.)		
33. Home renovation or improvement support		
34. Legal aid services		
35. Support for parents / legal representative to prepare the necessary documents for the disability certificate for adults with disabilities		
36. Counseling and support groups for families, young people or children in difficulty		
37. Transport to social services in other localities		
38. Accommodation of the parent during the habilitation-rehabilitation of children in centers from other localities		
39. Adoptive family training programs		
40. Occupational therapy		
41. Other, namely…		
III. EDUCATIONAL AND MEDICAL SUPPORT SERVICES		
Center-type		
42. Kindergarten		
43. Primary school		
44. Primary school with supportive educational services/integrated special education		
45. Lower secondary school		
46. Lower secondary school with supportive educational services/integrated special education		
47. Special school		
48. High-school		

Service	**Will the service be realized within the project?** 1. Yes 2. No	*If Yes,* **How many services will be developed?**
49. Technical high-school		
50. Standby medical center		
51. Hospital, polyclinic		
53. Other, namely…		
Interventions/ activities		
54. School counseling and guidance services		
55. Professional/vocational counseling and guidance services		
56. Supportive educational services		
57. School after school services (*afterschool*)		
58. A Second Chance		
59. Job skills assessment services		
60. Labor market counseling and mediation services		
61. Job search support, including accompaniment		
62. Professional training services for adults		
63. School sporting club, football team and similar activities		
64. Children's club, folklore ensemble, other relevant leisure activities		
65. Social activities and leisure		
66. Instructive-educational activities		
67. Transport to the school in another locality		
68. Activities for the development of independent living skills		
69. Family planning services		
70. Sex education services for youth		
71. Social ambulance		
73. Other, namely…		
IV. OTHER SERVICES		
74. Monitoring and support post-reintegration		
75. Monitoring and support post-adoption		
76. Monitoring and support post-socio-professional integration		
77. Other, namely…		

Date: |__|__|/|__|__|/|__|__|__|__|
Person who filled in the Annex:

Last name: Position:

First name: Signature:

ANNEX 17: Description and sustainability of new services

For each new service in the Plan of new services and activities (Annex 16), a description of the service will be made, as well e sustainability analysis using the following grid of indicators.

A. SYNTHETIC DESCRIPTION:

- Name .....
- City/commune….SIRSUP
- Address where the service will be set up/ established (can remain unidentified) .....
- Institution/Organization that sets up the new social service (DGASPC/other, which…)
- Institution/Organization that will manage the new social service (DGASPC/other, which…)
- Service capacity (maximum number of beneficiaries per month):
- Number of children and young people on the list who will benefit from this service
- In the first 6 months of operation, the beneficiaries will be only children and youngsters from the nominal list (yes or no)?
- Beneficiaries (M and / or F)
- How many beneficiaries will be:
  - Children or young people with special needs (disabilities and/or SEN)
  - Children under 3 years
  - Young people 18+ years
- Accessibility.
  - *Show to what extent the rules are respected to minimize the risk of new structures being exposed to spatial and / or social segregation, as per the Methodology section 5.1.1*
- Facilities that will be offered to children in the new service
- How continuity of services will be ensured for children and young people moved from the center
- Human, financial, material, methodological resources needed. *In terms of human resources, the number of staff required will be specified. The list of necessary equipment, materials and assistive technologies will be included.*
- Potential identified risks and measures to prevent, mitigate or eliminate them
- Estimated Date of the new service when it will be ready to receive children (to be able to plan the transition of children). If funding requests are made for this service, it is possible that, depending on the funding institution, a minimum running time will be imposed before the project is completed. For example, within NIPs this duration can't be less than 3 months.

Questions regarding sustainability

How long will the continuity of the service be ensured after the ROP / POCU project has been completed?

6 months	12 months	18 months	24 months	30 months	36 months	42 months	48 months	54 months	60 months	> 5 years	Don't know/ Can't estimate

C What measures/actions will be taken to ensure continuity?

a.

b.

c.

...

Which institution will ensure continuity of service (DGASPC, partners, CC (if not partner), LPAs (other than partners, non-partner NGOs), other entities (other than partners)/ unknown/ not identified?

What are the funding sources planned to ensure the continuity (sustainability) of the service after the conclusion of the ROP / POCU project (own DGASPC contribution, other national sources (which?), Other international sources (which?)/unknown/ not identified?

7. Global conclusion of sustainability analysis

1. Good	2. Satisfactory	3. Various difficulties	4.Major difficulties

...

Date: |__|__|/|__|__|/|__|__|__|__|

Person having filled in the report:

Last name:	Position:
First name:	Signature:

ANNEX 18: Summary of community activities

By aggregating the community activities specified in the Plans for the future of all children and young people in the center that is closing, this Summary is generated automatically in e-cuib.

At an aggregate level for each commune where the children will be moved to a family (which in the Plan for the future at point III will have solutions with codes 1, 3, 4 and 5) will be calculated:
1. Total number of children/ young people going to a family (point 4 - Q7c of the Plan for the future)
2. Total number of children for whom the following benefit must be ensured...
   - Placement benefit
   - State child allowance
   - Child raising allowance
   - Allowance for family support
   - Minimum Guaranteed Income
   - Aid for heating
   - Material/emergency support
   - Other material and non-material aid, namely...

- List of communes where the children/ young people on the nominal list will be moved (point VIa of the Plan for the future)
- For each commune where the children/ young people on the nominal list will be moved, it will be mentioned whether the DGASPC will carry out community preparation activities (Vib point of the Plan for the future)

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled in the Annex:

Last name:	Position:
First name:	Signature:

ANNEX 19: Community Action Plan

The Community Action Plan should take into account the needs for community activities specified in the Plans for the future of children and youth as shown in the Summary of community activities (Annex 18), as well as the specific project financing conditions (available budget, timeframe in which the activities must be implemented, etc.).

COMMUNITY PREPARATION ACTIVITIES

Community training activities to be carried out within the project. It includes equipment, materials, and assistive technologies needed in the community to move the child.

	The community from the county that will be prepared *Drop down with localities and variable SIRSUP*	If community preparation activities are carried out within the community through the project Yes/ No	What does the activity consist in (descriptive)
APrep1 ...			
Aprep2 ...			
...			

SOCIAL BENEFITS

Aid to be provided for families and children under the project. This includes equipment, materials, and family assistive technologies needed to move the child.

For each type of support*, fill in:

- Within the project there are families where the children who will be moved will benefit from ... type of help?
- If Yes, In what communities?
- For each community - Locality Name (SIRSUP) and Number of Beneficiary Families

* Type of aid:

- Placement benefit
- State child allowance
- Child raising allowance
- Allowance for family support
- Minimum Guaranteed Income
- Aid for heating
- Material/emergency support
- Other material and non-material aid, namely...

Person having filled in the report:

Last name:	Position:
First name:	Signature:

Attention! The Community Action Plan must be countersigned by all members of the team that is elaborating the individual closure plan of the placement center.

Accountability of the Community Action Plan by the team that is elaborating the individual closure plan of the placement center

Full name	Signature
...	

ANNEX 20: Plan of activities related to the staff

	Number of employees in the center closing down who have been redistributed / transferred to these new services and who will receive training	Number of people who will be employed in these new services and will receive training	Other relevant people (for example, SPAS, APO) who will benefit from training	Number of planned training sessions	Course topics	The period during which the training courses are planned * **(T1-T36, T0 = date when implementation of the closure plan begins)**
PROTECTION SERVICES (in the Plan from ANNEX 16)						
FP - induction training						
- post-relocation monitoring						
- continuous training (1/year)						
- specialization						
FTH: - induction training						
- post-relocation monitoring						
- continuous training (1/year)						
- specialization						
AP: - induction training						
- post-relocation monitoring						
- continuous training (1/year)						

	Number of employees in the center closing down who have been redistributed / transferred to these new services and who will receive training	Number of people who will be employed in these new services and will receive training	Other relevant people (for example, SPAS, APO) who will benefit from training	Number of planned training sessions	Course topics	The period during which the training courses are planned * **(T1-T36, T0 = date when implementation of the closure plan begins)**
- specialization						
SERVICII SOCIALE ȘI DE PREVENIRE (from the Plan of new services ANNEX 16)						
SSoc1: - induction training						
- continuous training (1/year)						
- specialization						
...						
SPrev1: - induction training						
- continuous training (1/year)						
- specialization						
...						
COMMUNITY PREPARATION ACTIVITIES (in the Plan from Annex 19)						
APrep1.- induction training						
- continuous training (1/year)						

	Number of employees in the center closing down who have been redistributed / transferred to these new services and who will receive training	Number of people who will be employed in these new services and will receive training	Other relevant people (for example, SPAS, APO) who will benefit from training	Number of planned training sessions	Course topics	The period during which the training courses are planned * **(T1-T36, T0 = date when implementation of the closure plan begins)**
...						
OTHER STAFF-RELATED ACTIVITIES						
- professional requalification/ reconversion courses for those leaving the system		x	x			
- induction training						
- continuous training (1/year)						
- specialization						

Date: |__|__|/|__|__|/|__|__|__|__|

Who filled out the Plan:

Surname Position

Name Signature

ANNEX 21: Plan of activities

The activities plan sets clear deadlines and responsibilities for all the activities necessary to achieve the objectives in the individual closing down plan

1. Foster Caregivers(from Annex 16)

Foster Caregivers	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

2. Family-type homes (from Annex 16)

FTH	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

3. APARTMENTS (from Annex 16)

Apartments	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

4. SOCIAL SERVICES (INCLUDING PREVENTION) (from Annex 16)

Social services	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							

Operation							
Salaries							
Staff training							

5. COMMUNITY PREPARATION ACTIVITIES (from Annex 19)

Community preparation activities	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

6. FAMILY AID (from Annex 19)

Family aid	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

7. ALTE ACTIVITĂȚI

Other activities	Activity	Responsible	Partner 1	Partner 2	Partner 3	Partner 4	Partner 5
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Requalification/ professional reconversion for staff who have not been selected to work in new services							
Staff training							
Ensuring the sustainability of the new services							

Preparing and actually moving children and staff into new services							
Local information and awareness campaigns for the population							
Other measures to prevent, mitigate or eliminate identified risks							
Mutual learning activities and exchange of good practices							
Dissemination / publicity of results							
Monitoring the progress of children							
Monitoring the performance of newly established services							
Impact Assessment Study (5 years after the start of implementation)							
Activities related to the use of buildings and other available resources							
Other relevant activities							

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled out the Plan:

Surname Position

Name Signature

ANNEX 22: Gantt Diagram

The Gantt diagram assigns clear deadlines for the entire list of activities required to achieve the objectives of the individual closure plan.

1. Foster Caregivers(from Annex 16)

Foster Caregivers	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Staff training			

2. Family-type homes (from Annex 16)

FTH	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Staff training			

3. APARTMENTS (from Annex 16)

Apartments	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Staff training			

8. SOCIAL SERVICES (INCLUDING PREVENTION) (from Annex 16)

Social services	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment,			

materials and assistive technologies			
Operation			
Salaries			
Staff training			

4. COMMUNITY PREPARATION ACTIVITIES (from Annex 19)

Community preparation activities	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Staff training			

5. FAMILY AID (from Annex 19)

Family aid	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Staff training			

6. OTHER ACTIVITIES

Other activities	Activity	Starting period (T1-T36)	Finalization period (T1-T36)
Infrastructure			
Endowments			
Equipment, materials and assistive technologies			
Operation			
Salaries			
Requalification/ professional reconversion for staff who have not been selected to			

work in new services			
Staff training			
Ensuring the sustainability of the new services			
Preparing and actually moving children and staff into new services			
Local information and awareness campaigns for the population			
Other measures to prevent, mitigate or eliminate identified risks			
Mutual learning activities and exchange of good practices			
Dissemination / publicity of results			
Monitoring the progress of children			
Monitoring the performance of newly established services			
Impact Assessment Study (5 years after the start of implementation)			
Activities related to the use of buildings and other available resources			
Other relevant activities			

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled out the Annex:

Surname	Position
Name	Signature

ANNEX 23: Total budget of the closure plan organized by funding sources

1. Foster caregivers(from Annex 16)

Foster caregivers	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Staff training								

2. Family-type homes (from Annex 16)

FTH	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Staff training								

3. APARTMENTS (from Annex 16)

Apartments	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								

Staff training								

4. SOCIAL SERVICES (INCLUDING PREVENTION) (from Annex 16)

Social services	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Staff training								

5. COMMUNITY PREPARATION ACTIVITIES (from Annex 19)

Community preparation activities	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Staff training								

6. FAMILY AID (from Annex 19)

Family aid	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Staff training								

7. Other activities

Other activities	Activity	ROP (in lei)	HCOP (in lei)	DGASPC contribution (in lei)	Other national sources (in lei)	Which	Other international sources (in lei)	Which
Infrastructure								
Endowments								
Equipment, materials and assistive technologies								
Operation								
Salaries								
Requalification/ professional reconversion for staff who have not been selected to work in new services								
Staff training								
Ensuring the sustainability of the new services								
Preparing and actually moving children and staff into new services								
Local information and awareness campaigns for the population								
Other measures to prevent, mitigate or eliminate identified risks								
Mutual learning activities and exchange of good practices								
Dissemination / publicity of results								
Monitoring the progress of children								
Monitoring the performance of newly established services								
Impact Assessment Study (5 years after								

the start of implementation)								
Activities related to the use of buildings and other available resources								
Other relevant activities								

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled out the Annex:

Surname	Position
Name	Signature

ANNEX 24: Total budget of the closure plan organized by DGASPC and partners (in lei)

1. Foster caregivers(from Annex 16)

Foster caregivers	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

2. Family-type homes (from Annex 16)

FTH	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

3. APARTMENTS (from Annex 16)

Apartments	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

4. SOCIAL SERVICES (INCLUDING PREVENTION) (from Annex 16)

Social services	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment,							

materials and assistive technologies							
Operation							
Salaries							
Staff training							

5. COMMUNITY PREPARATION ACTIVITIES (from Annex 19)

Community preparation activities	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

6. FAMILY AID (from Annex 19)

Family aid	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Staff training							

7. Other activities

Other activities	Activity	DGASPC (in lei)	Partner 1 (in lei)	Partner 2 (in lei)	Partner 3 (in lei)	Partner 4 (in lei)	Partner 5 (in lei)
Infrastructure							
Endowments							
Equipment, materials and assistive technologies							
Operation							
Salaries							
Requalification/ professional reconversion for staff who have not been selected to							

work in new services							
Staff training							
Ensuring the sustainability of the new services							
Preparing and actually moving children and staff into new services							
Local information and awareness campaigns for the population							
Other measures to prevent, mitigate or eliminate identified risks							
Mutual learning activities and exchange of good practices							
Dissemination / publicity of results							
Monitoring the progress of children							
Monitoring the performance of newly established services							
Impact Assessment Study (5 years after the start of implementation)							
Activities related to the use of buildings and other available resources							
Other relevant activities							

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled out the Annex:

Surname	Position
Name	Signature

ANNEX 25: List of indicators to be used for monitoring children's progress

Objective indicators

1.
2.
3.
…

Subjective indicators

1.
2.
3.
…

Date: |__|__|/|__|__|/|__|__|__|__|

Person who filled out the Annex:

Surname	Position
Name	Signature

ANNEX 26: Minutes on the stakeholder information and consultation sessions on the close down of the residential center for children - Template

[The Minutes shall be drawn-up for each information and consultation meeting organized by DGASPC]

Meeting date: |__|__|/|__|__|/|__|__|__|__|

Meeting venue:

Meeting moderator:

Name and surname	Position	Institution

Persons attending the meeting:

For each participant, indicate: name, position and institution/type of stakeholder that he/she represents

Topics presented during the meeting:

Questions and problems raised by participants:

Were answers provided to all questions/problems raised by participants? 1 . Yes 2. No

IN CASE OF FAILURE TO PROVIDE ALL ANSWERS

Indicate why the answer could not be provided and whether there is a possibility that the answer be provided at a later stage:

Conclusions of the meeting:

Signature: _____

Project co-financed by the European Social Fund through the
Administrative Capacity Operational Program 2014-2020!

Project title: Development of Plans for the De-Institutionalization of Children Deprived of Parental Care and their Transfer to Community-Based Care
Project code: SIPOCA 2
Beneficiary's name: National Authority for the Protection of Children's Rights and Adoption
Publication date: August 2018