Vulnerability tracking tools in the context of perinatality

Coordinator: Daniela Cojocaru [1]

Authors

Romanian team: Stefan Cojocaru (HoltIS), Madalina Belcescu (HoltIS), Alexandra Galbin (HoltIS), Iuliana-Odeta Zagan (HoltIS), SimonaTrofin (HoltIS), Ion Ionescu (A.I.Cuza University of Iasi)
French team: Stéphanie Destandau (Caminante), Philippe Didier-Courbin (Caminante), Richard Thibaut (Caminante), Chantal Hiriart (Caminante), Léonie James (Caminante), Pierre Lavignasse (Caminante), Anne-Marie Doucet-Dahlgren (Paris X Nanterre University).
Italian team: Chiara Sita (Universita di Verona), Rosanna Cima (Universita di Verona), Maria Livia Alga (Casa di Ramia), Elena Migliavacca (Casa di Ramia)
Spanish team: Nuria Fuentes-Peláez (UB-GRISIJ), Aida Urrea (UB-GRISIJ), Ainoa Mateos (UB-GRISIJ), Crescencia Pastor (UB-GRISIJ), Eduard Vaquero (UB-GRISIJ), Ana Isabel Baldero Martinez (Eduvic-Antaviana), Lluis March Planells (Eduvic-Antaviana)

[1] PhD Professor, A.I.Cuza University of Iasi, Romania, Department of Sociology and Social Work, dananacu@gmail.com

Summary

The present document is the result of the common reflection of the professionals and the academics, partners in the CAPEvFAIR project, on the tracking instruments of the vulnerability's dyad mother and child in the context of perinatality. The document starts with a description of the tracking phase of vulnerability in perinatality within the logical frame of the project, followed by the questions that were taken into consideration describing the tracking instruments, specific for each target group (addiction mothers, adolescent mothers, migrant mothers, mothers living in poverty). The synthetic presentation and the description of the instruments are systematized depending on the target groups, this being the contribution of the organizations that have the experience of working with specific aspects of vulnerability, partners within the CAPEvFAIR project from France, Spain, Italy, and Romania. This material can be used by various specialists that work with the mother and the child in the context of perinatality as a source of inspiration for adapting the provided instruments to a specific context. Templates of the instruments described are introduced in the annexes of the document.

Introduction

Vulnerability is a concept with many meanings and applications. The interpretations of various aspects of vulnerability and the recognition of its complexity are a base of action and analysis for the professionals (Fawcett, 2009). Although the term vulnerability is very used in policies, in literature has become implicit and leads to vague application when is associated with pregnancy, birth and postnatal period (Spiers, 2000; Briscoe, et. al. 2016).

The purpose of the tracking tool is to identify the first degree of vulnerability related to the mother-child dyad in the context of perinatality. The tracking tool is a general tool used for the identification of a vulnerability situation, it is followed by an assessment tool which analyses and evaluates the specificity of the vulnerability situation. Based on the assessment tool, an intervention plan is conceived and implemented. In this entire process, the observation plays an important role, which implies that both tracking and assessment continue during the entire support phase. Therefore, the procedure of support for mother and child has three phases which are cyclical. A tracking tool is applied in the initialization of support process, but if a new

dimension of vulnerability is detected during the process, the cycle starts over again. The logical frame of the phases involved in the support process assumed within our project is described in Annex 1.

The tracking tools are related to the three dimensions of vulnerability as defined in the first intellectual output of CAPEvFAIR project, the definition of vulnerability: biological, psychological (including psychiatric) and social. Depending on the context, the character of vulnerability will be more social or more psychological or biological (medical). Within our working meetings we identified the predominant feature of vulnerability for each of the field participants in the project based on their working experience with specific vulnerable groups (persons with addiction, adolescent mothers, migrant mothers, mothers living in poverty). We have used the field experience of each partner as a contribution to this set of tracking instruments in various contexts. What follows is the result of a common reflection between the professionals and the academics, both partners within the project, upon the tracking instruments used to identify the vulnerability in perinatality.

In our work we began by addressing some very important questions regarding the utility of a Tracking instrument:

- Who will use this instrument? (What type of professionals, what kind of institution?)
- Which is the target group? (the mother, the child, the dyad mother-child)
- What definition of vulnerability should we use? How to operationalize such a definition? Which are the criteria that there will be used? And how do you measure them?
- Which is the intended purpose/ How will be used further the findings?

Any instrument must be an answer to the needs of the beneficiary but also to the needs of the professional, considering the fact that every instrument includes a set of elements that represents the professional and the institution where he operates. An instrument will be different according to the educational background of the specialist (for example, if he is a doctor or a social worker) or according to the environmental context where it was created (institutional perspective, legal framework, cultural aspects). Nonetheless, trying to frame in an objective

manner a subjective aspect of one's life is a provocative challenge. But is it useful for the beneficiary?

Our common grounds refer to the women in perinatality and their children (0-6 years old) who are in a vulnerability situation. The indicators (referring to the three main topics specified above – biological, psychological and social) could be *observed by the professionals* or *expressed by the beneficiary* and can refer to various aspects of vulnerability. The instruments described below can be used as a starting point for each specialist involved in working with a mother/child in perinatality in one of the mentioned situations. These instruments are not the only ones that can be used, but they can be considered methodological resources that each professional can adapt and customize based on his professional background and the context where he works.

Therefore, we have decided not to create a new instrument that might not be useful for all the actors involved, but to put in common the expertise of each partner and to create a set of instruments that can apply to various aspects of vulnerability.

You will find four different sets of instruments that can be used in order to track the vulnerability, grouped by the predominant character of vulnerability in perinatality for:

- ✓ the pregnant women and/or the young mothers who have **addiction problems** (tools used and described by Caminante Association – France);
- ✓ the girls who are becoming mothers while they are still adolescents – **precocious motherhood** (tools used and described by Eduvic Association in Antaviana – Spain)
- ✓ the pregnant women or the young mothers who are **isolated, migrant and/or trafficked** (tools used and described by Casa di Ramia – Italy);
- ✓ the women/mothers and their children that live in **poverty** (tools used in the Romanian public system of social care and described by HoltIS - Romania).

All the tracking instruments cover a large area of vulnerability situations referring to the following aspects:

- The specificity of vulnerability for each target group: persons with addiction, teenage mothers, migrant mothers, mothers living in poverty;
- The focus on various perspectives: predominately medical, social, or psychological;
- The structuration degree: some instruments are very structured, (e.g. Observation Chart), other are less structured and allow the professionals to be flexible and to deeper explore with the women the vulnerable situations (e.g. Modified Todd Map, Orientarsi);
- The main subject analyzed: the mother's issues (e.g. Pre-admission medico-social file), children's issues (e.g. The Child Form, Case Notification Chart), or the issue related to the dyad mother-child (e.g. Video-interaction, Intervention Plan).
- Some instruments assume exclusively the vulnerability of the client (e.g. TEAV), while others are taking into account the mutual aspect of vulnerability, including the vulnerabilities of the professional (e.g. Modified Todd Map).

The sets of tracking tools are presented in the annexes attached to this material. Each of the instruments presented here starts with a brief structured description of the instrument regarding the following aspects: who uses that instrument, when is it applied, how is it used, why (what is its institutional role) and what type of vulnerability it captures.

The complete list of the tracking tools included in this material is attached below (with hyperlinks within the given document):

Specific target group involved	Instruments described in the material
Pregnant women and/or the young mothers who have **addiction problems**	The pre-admission medico-social file – description The pre-admission medico-social file – template
	The Child Form – description The Child Form – template
	The TEAV - Tableau d'Evaluation Assistée de la Vulnérabilité – description The TEAV - Tableau d'Evaluation Assistée de la Vulnérabilité – template
Adolescent girls who are becoming mothers – **precocious motherhood**	Video-intervention- description Video-intervention- observation guide
	Intervention Plan- description Intervention Plan- procedure
	Three Generation Genogram- description Three Generation Genogram- template
Pregnant women or young mothers who are **isolated, migrant and/or trafficked**	ORIENTING YOURSELF – description ORIENTING YOURSELF – template
	MODIFIED TODD MAP (MTM) – description MODIFIED TODD MAP (MTM) – template
Pregnant women/mothers (including young mothers) and their children that live in **poverty**	Observation Chart- description Observation Chart- template
	Medical Report- description Medical Report- template
	Case Notification Chart – Maternity hospital model description Case Notification Chart – Maternity hospital model template

Mothers with an addiction problem	Pre-admission medico-social file
Description	It is a very detailed file where information about the mother is filled in by the professionals who refer this case to the Addiction center. It has specific information about the medical state of the person and the addiction issues.
Who	File **to fill out by the professionals who coordinate the application** of the woman in perinatality (with her child if need be)**.** **The file is examined in the CSAPA[2] by the staff in charge of admissions in the Addiction Centre** (physician-director; deputy director; 2 educators in charge of admissions).
When	During the pre-admission period: between the first contact of the person (and her team) with the Addiction Centre and the answer given for her admission application.
How	It is about a file to fill out which gives several pieces of information: - medical data (history, current treatment, …) - social data (accommodation, resources, health care…)
Why	To make a referral based on an addiction issue to a specific institution. Check the match between the mother's difficulties and our support offer (Ex: Patients who are physically or psychiatrically too sick; treatment for addiction which is not initialized upstream...can be obstacles)
What kind of	Tracking of the medical, psychological and social risks concerning the mother

[2] CSAPA = centre de soin, d'accompagnement et de prévention en addictologie (Support, prevention and health center specialized in addiction)

vulnerability	
Mothers with an addiction problem	The Child form
Description	It is a file that describes the situation of the child in a detailed manner, from current state to medical history.
Who	**The file is filled out by the team who coordinates the application concerning the child** or by **the team in charge of the child up to now** (maternity ward, neonatal nursery…)
When	During the **pre-admission period**: between the first contact of the person (and his/her team) with the addiction centre and the answer given for his/her admission application.
How	It is about **a file to fill out** which gives several pieces of information: - development of the child - his/her daily life - judicial measures - medical data
Why	- Tracking of the medical risks concerning the child (born or to be born) - Knowledge of the singularity (rhythm, habits…) of **<u>the child</u>** - Tracking of the difficulties as for the bonds and interactions mother-child - Knowledge of a prior professional assessment of a possible need for child protection (“concerning information”, “interim placement order”...)

- Check the agreement of the father (if he is known and present) with the mother's care project

What kind of vulnerability	Current psychomotor development of the child, His daily life and his habits, Current or ongoing judicial measure, Medical data

Mothers with an addiction problem	The TEAV - Tableau d'Evaluation Assistée de la Vulnérabilité
Description	It is a checking-form in the shape of a table that nominates different needs of the beneficiary and the level at which they are satisfied at the moment of the admission. The goal is to track the needs that aren't answered in a satisfactory manner and to answer to it.
Who	**The team in charge of admissions**
When	During the **pre-admission period**: between the 1st contact of the person (and her team) with the addiction centre and the answer given for her admission application.
How	Form filled out by the staff in charge of the admissions of the CSAPA, **during pre-admissions telephone interviews** with the mother in demand for care.
Why	- Tracking of other vulnerability risk factors (other than addiction) in the mother, to prioritize our interventions
What kind of vulnerability	Social, psychiatric, health, economic vulnerability: EDUCATION LEVEL RESOURCES/MEANS ABILITY TO SPEEK THE LANGUAGE OF THE COUNTRY OF RESIDENCE WRITTEN/SPOKEN INTEGRATION WHITHIN THE WORKPLACE ACCOMMODATION SOCIAL SECURITY PROTECTION PREGNANCY FOLLOW-UP PHYSICAL STATE LEVEL OF ADDICTION AND DEPENDANCE FAMILY ENVIRONMENT SOCIAL TIES/ PSYCHOLOGICAL STATE

Additional observations for the tracking tools used in working with mothers with addiction:
The tools presented above are "formal" tools that are systematically used and upstream of the care in order to check the match between the person's needs and the support offered by the Addiction center.
But once the person is admitted in the center, "living with" and "doing with" allow the education team to be able, over time, to identify additional vulnerabilities.
Sharing the daily life is a key point of the support within the CSAPA, and hence a key point of the difficulties tracking of the residents.
Example: difficulty of the mother to "protect" her child from the other residents of the center.
Example: difficulty of the child to express his/her needs (hyper- adaptability)).
Example: lack of communication between the mother and the child as for the interactions due to the child's needs (food, bath, baby-changing...).
Example: difficulty for the mother to identify her child's needs (in tears because of hunger, tiredness...).
Who? The education team
When? Throughout the support
How? By observing the behavior of the mother and/or her child
What type of risk? Biopsychological and social risks to the child / risks regarding the quality of the mother-child bond...

Adolescent mothers - Precocious Maternity	Video-intervention
Description	It consists of recording a sequence of the interaction mother/child, at the same center, during a situation of daily life created spontaneously. Also the recording can be done in the external Children/Youth Mental Health Center, CSMIJ, in which there are psychologists specialized in this technique, who give support to Antaviana professionals.
Who	Social professionals who work in Antaviana (social educators, as well as family Psycho-therapeutics) with an external supervisor The technique is applied by professionals (social educators and/or family psychotherapist) of the maternal residence Antaviana, as well as by external clinical psychologists from the Children/Youth Mental Health Center (CSMIJ), who carry out functions of training/supervision of the team of professionals of Antaviana. It is not obligatory for all mothers, it is a possibility for the professionals of the Centre, and the explicit consent of the mother is required to make the recording.
When	During the intervention/ when the young mother is in the centre. The team of professionals of Antaviana, or the external psychologist of the CSMIJ, propose the possibility of applying the technique when they consider it interesting, according to the following criteria: based on the mom situation and her relationship with her child, based on the personal moment of the mom and the process in Antaviana (continuity in the process in Antaviana and the desire to continue with the process of bonding with his child). No protocol defines when to use this technique, but mothers are proposed if they want to participate when it is considered that it may be useful for them to improve their relationship with their child, as well as if professionals consider they can intervene in an appropriate way.
How	1. Recording the interaction mother-child 2. Watching the scene (professional and mother) 3. Attending to the positives aspects 4.Watching the scene (professionals and supervisor) Once the sequence of the mother-infant interaction has been recorded, for 5 - 10 minutes, with a camera or mobile, these recordings are viewed by the rest of professionals of Antaviana, together with the external psychologist (with supervision-training functions), and are discussed during a session of team work. Then it is displayed and discussed directly with the "teen - mom" in the individualized tutoring space, with the

	psychologist. And/or in the psychotherapy space with the Antaviana family psychotherapist. This implies that the application of the "video-recording technique" is optional and requires the collaboration and explicit consent of the adolescent mother. Always granting the protection of data of all the professionals intervening in such process.
Why	To empower and evaluate the relationship and the attachment between the mother and the child. To intervene by putting attention and reflection in redeemable aspects, considered positive, of such interaction. To promote strength, maintenance and amplification of relationship patterns that favors the affective mother-child bond, and the psycho-affective development of the baby. Also to identify situations that could be built in a more positive way, in the sense that they could activate the resources of the mother and her baby, building a richer and more stimulating mother bond and a better psychological and psychomotor development of the baby. Other reasons that may result in the proposal for the video-recording, are related to perceptions, concerns, and alerts that could be generated in the team of professionals about the difficulties and the risks of mother-child interaction. With the aim of clarifying, reflecting and defining possible objectives and/or lines of intervention.
What kind of vulnerability	Underage mothers in the child protection system. The context of the maternal residence Antaviana is a context of protection and control (the young mothers and children are under the custody of the Administration). They are teen mothers (up to 18 years), with their children (up to approximately 4 years). The functions developed in the maternal institution Antaviana, are those of child protection, care, assessment and accompanying for the process of maternity.

Adolescent mothers - Precocious Maternity	Intervention Plan
Description	This instrument is a formal customized contract for families with children that are on residential centers under the child protection system. The characteristics of the families implied are related to the coincidence of different variables that define vulnerability situations: poor economic level, different difficulties in family dynamics that do not facilitate the proper exercise of the parenting (difficulties in conjugality, absence of one of the parents, lack of support from the extended family, lack of social network, migratory grief situations, psychopathology in parents). The main objective would be to work with the network of professionals in the community intervening not just with the mother and child (inside the centre) but also with the origin, extended and/or created family to promote: **a) The return to the family as the first choice whenever possible.** **b) When this is not possible**, **other non-internment options** are valued, taking into account first of all the skills and capabilities of the mother as well as the resources offered by Community environment (flats and/or residences protected by services and social organizations for adult mothers with children and social rental housings) **c) in coordination with the systems of protection, the separation of the child from his/her mother could be ultimately proposed, if it is valued that at that stage mother/child link building involves risks for the baby (temporary foster care in origin or extended family, foster care in unrelated families, pre-adoptive placement and/or internment on residential centers of protection).**
Who	Social workers, social educators and psychologist.
When	When a situation of vulnerability/risk for an adolescent mother is detected and its planned
How	Professionals, family and other significant people linked to the family (grandparents, aunts…) meet at the social services to identify the main and basic problems and needs. Professionals promote that families are aware of their own needs and

	problems, in order to take the best decisions to build the case plan. Professionals also work with the family in the definition of a working plan that takes into account very specific and well defined objectives. The objectives are timed.
Why	To work with the needs of the family to promote a healthy bond, based on existing parenting competences and those acquired during the intervention process.
What kind of vulnerability	Vulnerabilities related to the exercise of parenting functions and produced by different variables explained in the "Description" section.

Adolescent mothers - Precocious Maternity	Three Generation Genogram
Description	This tool is useful both for vulnerability detection and for accompanying stages. It helps to identify areas of vulnerability at different levels and at the same time it allows to raise hypothesis and define objectives and intervention strategies. It also registers changes in the family as well as the chronology of significant family events. Professionals are allowed to take a picture, in a metaphorical sense, as a family tree, of the family situation according to criteria of bio-psycho-social model. This is, family data related to health, emotions-relations and social issues are collected for three generations.
Who	This tool is intended for professional use by: social workers, social educators, family therapists and psychologists.
When	At the vulnerability **detection stage** this tool Is used in different primary care services, in health basic areas services, basic social services and specialized services of protection. At the **accompanying stage**, the tool is used by professionals in the residential centres of educational action, in the mental health services, centres of care and early stimulation in the early stages of the psycho-evolution development.
How	The genogram is jointly built between the professionals and the different members of the family, distinguishing three generations (grandparents, parents and children), reflecting the type of relationship they have(conflicting, or harmonious), the dates of significant events (deaths, marriages, separations and divorces, couple relationships) the configuration of the different families (structure and organization) and data related to the place of origin, the current residence, studies, work, hobbies and health.

Why	In the **stage of detection**, this tool is used to identify, on the one hand, the strengths, resources and capacities of the socio-familial environment. On the other hand, it is very useful to know and obtain detailed information on the difficulties, shortcomings and, in general, conditions of vulnerability. Both at the stage of accompaniment as in the detection phase, this tool favours the construction of hypothesis and the possibility of establishing, by professionals and community resources, a work plan in the different areas in which the vulnerability is detected. In the **accompaniment stage**, it offers a different point of view to the women on their own reality. It allows identifying and rating changes throughout the intervention process to continue defining new lines and strategies.
What kind of vulnerability	In the **stage of detection**, it is useful in any situation where there is an initial assumption of risk of vulnerability. In the **accompaniment stage**, it is useful in all the situations in order to have a global view of the involved complexity.

Migration/trafficked mothers[3]	ORIENTARSI / ORIENTING YOURSELF
Description	ORIENTARSI/ ORIENTING YOURSELF is a tool to orient/guide the professionals. The aim is to get to know the user and, at the same time, to stay aware of our own perspective as professionals (where are we observing from? what is our frame of reference? which are our categories to evaluate vulnerability? What are the categories and concepts we use for assessing the vulnerability? What are the limits of our knowledge?) The tool can be used in two ways: a) Institution-centered or professional-centered: it helps to understand and contextualize the frames and cultural categories that are used in order to analyze the user's vulnerability, to identify the limitations of the observation and to give space to the users' perspectives. b) User-centered: allows the professional to identify what he/she knows and does not know about the user. If used by different actors, allows to gather information more effectively.

[3] In general it is important to remind that in case of social vulnerability caused by poverty, migration and human trafficking we need to change the scale of observation in the first approaches.
a) It is not possible to have only an individual approach
b) It is necessary to take into account the asymmetry between operators and users. Who has the power to define who is vulnerable, what are the first symptoms of a child's problems? Who can say if a mother cares or not for her baby? especially when the relation between operator and user is marked by cultural differences, the dialogue is very difficult and frequently mothers answer operators' questions as requested/expected by institutional practice. How can a mother define her situation from her own point of view without fear, need or shame?
Therefore, it could be useful to open a 'third, informal space' (like intercultural women center) that mothers can access freely without being considered as users, but as parents and women or teenagers. In such a space, mothers can gather all the information they need and the meeting with the operators can happen without standardized solutions. A very important tool is the group. Mothers can be welcomed in an informal group where they can easily meet other women who speak the same language.

Different professionals from the institutions involved can complete this form using different colours. The document can be a starting point for an integrated knowledge of the user and for a critical reflection on how the different roles, positions, institutional aims shape our knowledge in multiple ways. Some examples of questions guiding this reflection on the professionals' perspectives are:

- what do we know? In which ways we can share and refine our analysis?
- what would we need to know in order to better support the person/family?
- is our knowledge taking into account the person's experience and meanings? where is the user's voice?
- what language are we using?
- is there a dominant viewpoint we are using? Why are we using it?

This tool is divided into five sections (names, languages, families, migration, religion) to facilitate comprehension of the case.

Who

- professionals during training
- professionals with users
- professionals' team

When

- at the beginning of the relation professional/user
- when the professionals think together about the case

How

- in a private dialogue between professional and user
- exchange between professionals

Why

professional and users can build a common story, not already panned/designed by the institutions

What kind of vulnerability

- actual or past traumas
- family problems
- history of migration (through the detection of this point it is possible to show positive aspects of vulnerability)

Migration/trafficked mothers

MODIFIED TODD MAP (MTM)

The Todd Map is a tool employed in qualitative social research.

The aim is to analyse the subjective perceptions of professionals and users' relational networks: their quality, their values, their emotional intensity.

We use a code to identify these aspects:

- sentimental, emotional support 
- economic support €
- material support 
- esteem, respect 
- advices 
- Relationships: good _____ intermittent ..... conflictual 

This tool is also used in professionals' focus groups in order to make their perceptions and information about the mother visible to each other.

The tool was simplified into four parts: in order to understand through a visual tool the ways in which the context is

perceived by professionals:

1. the geography of social, healthcare services (and all the services involved)
2. information about family
3. information about friends and relations
4. social skills, studies and user's commitments (Born, 1997).

When the operator asks the user to design her networks, it is possible to detect the resources and ties in vulnerable situations that are often difficult to observe.

For this purpose, the MTM (Modified Todd Map) for professionals is a mediator between the professional and the mother. For the mother, the fact of being involved in the representation of her networks helps to move from a passive position to an active role of building knowledge "with" the professional.

When the MTM is used between operator and user 3 concentric areas are designed. The center is placed on the mother's name and the people she feels closer to. The different actors and places she identifies are marked in different ways depending on emotional intensity. It is possible to use the whole sheet as a topography of the relational world that the mother, with the help of the professional, can progressively enrich and complete.

Who

- professionals during training
- professionals with users
- professionals' team

When

You can use it after professional and user's first meetings or *during the accompaniment* when the professional think it useful.

How	• during training of focus group with a trainer/researcher • professionals' auto-supervision in a team • professional and user (both writing on the map): the map is visual so it can be completed by the user even if she doesn't know professional's language. They can use a code.
Why	• to be aware of how every professional works • to identify what the professional "don't know" • to see which institutions are implied or not in the case work, how and why
What kind of vulnerability	• low level of communication between institutions • professionals' lack of knowledge of very important aspects of users' life • lack of users' social links and networks

Mothers in poverty

Observation Chart

Description

The Observation Chart is an instrument established at national level in order to assess the manner of nurture and caregiving for the children in Romania. Within 2 years from the approval of this procedure at national level, the Public Service of Social Care (PSSC[4]) is obliged to visit at home every family from the community in order to identify all the children who are at various risk situations – vulnerable. This legal norm was designed in order to assess and analyse the situation of children in the community and to identify the situation of risk for the children with the purpose of preventing the child separation from the family by granting them services and benefits.

The people at local level, which through the nature of their profession get in touch with the child and notice any risk situations – the policemen, the GPs, the teachers, the local nurse, the school mediator, the sanitary mediator – they fill in the Observation Chart according their observations and send it in 48 hours to the local PSSC.

In maximum 72 hours after the social worker (from PSSC) has received the Observation Chart, he must make a family visit in order to evaluate the situation of the family and to complete the Chart of Risk Identification – an instrument for the whole family (vulnerability assessment).

Who

The Observation Chart can be filled in by the social worker or other representatives from the PSSC and also by all the professionals at local level (teachers, medical providers, policemen, etc.) that observe the child within their work and notice a risk situation for the child with the purpose of preventing child separation from the family.

When

The Observation Chart is filled by the PSSC representative (social worker) in the following situations: a) direct solicitation made by the child or the family in any form (written/verbal/telephonic); b) at the notification of the parent that is the only legal guardian of the child and expresses his intention of leaving to work abroad; c) at the notification of other people except the family members (for ex. Neighbors); d) self-notification while working on another situation or based on press information.

[4] Public Service of Social Care is the public social service provider which is represented at every community level (both rural and urban).

How	The people at local level, which through the nature of their profession get in touch with the child and notice any risk situations – the policemen, the GPs, the teachers, the local nurse, the school mediator, the sanitary mediator – they fill in the Observation Chart according their observations and send it in 48 hours to the local PSSC. - By checking with yes/no various aspects of vulnerability. In maximum 72 hours after the social worker has received the Observation Chart, he must make a family visit in order to evaluate the situation of the family and to complete the Chart of Risk Identification – an instrument for the whole family (vulnerability assessment).
Why	To detect the child vulnerability and to notify the responsible authorities.
What kind of vulnerability	Subject: the child within the family. It refers to: a) social vulnerability (economic situation, social situation of the family, family living conditions, level of education of family members); b) biological vulnerability (the health situation for family members); c) psychological vulnerability (if within the family there are identified any risk behaviours – alcohol consumption, family members that are violent, imprisoned)

Mothers in poverty

Medical Report

Description

The role of the Medical Report is to notify and inform GDSACP Iași[5] about the medical and nurturing needs of the child and the date at which the child can be discharged, with the main goal of **imposing a protective measure.** Based on the medical recommendations – family care or admission in a special facility for children with special needs – GDSACP establishes a protective measure – kinship, foster care, specialized centre.

Institutional route – the Medical Report filled in by the doctor is sent to GDSACP together with the Case Notification Chart by the hospital Social worker. Based on the duration of hospitalization and the changes in the medical condition of the child, the Medical Report can be updated and retransmitted to GDSACP.

Who

The neonatologist or the paediatrician who looks after the child within the medical unit fills in the instrument based on his own observations and the Medical Observation Chart.

When

When a child admitted in the medical unit requires a protective measure initiated. These situations are established through hospital protocol and can be one of the following:

- The family of the child is in economical difficulty;
- The child was abandoned/found;
- There is a risk of family abandon;
- There is a suspicion of neglect for the child;
- The child needs a special medical treatment;
- Members of the family of the child (particularly the mother) has a medical condition;

Other situations that require the intervention of the social worker.

[5] GDSACP Iasi is a public unit at county level that provides social services in the area of child protection, family, disabled people, elders, and other categories of population in risk situation. Romania is organized into 40 counties (small provinces with local administration, but not independent by the Government) and Iasi is one of the counties.

How	It refers mainly to the current state of the child (when admitted to the hospital) – identification data, information about vaccines, blood results, indicators about weight and size at birth and at the moment of the instrumentation, the child health state, and the medical recommendations from medical, nutritional, nurturing and caregiver view. It is based on the Medical Observation Chart and the doctor's personal observations.
Why	To detect the child vulnerability and to notify the responsible authorities.
What kind of vulnerability	Subject of the instrument: the child in the hospital - **biological/medical vulnerability** – it refers to the special medical treatments or procedures that cannot be done in the family and/or if the mother/parents/family have medical conditions that don't allow them to take care of the child (mental illnesses, alcohol or substances abuse). - social vulnerability: it refers to the risk of child abandon, neglect, maltreatment, poverty, also if there already are some other children within a protection measure, etc. - emotional/behavioral vulnerability – there is a brief section about the relation between the mother and the child, mostly related to how/if the mother takes care of the child within hospital.

Mothers in poverty

Case Notification Chart – Maternity hospital model

Description	This is an instrument created by GDSACP and used by all the medical facilities in Iași county that have hospitalized children. It was established through a collaboration convention between the two institutions, based on a national law that specifies what sorts of situations are considered to be vulnerable for the child. This instrument is based on a Working Protocol that has the role of a Methodology, which is compulsory for the hospital social worker. This Protocol can be revised, updated or changed if there are any legal changes that request that. There isn't an instrument established at national level, but usually the social workers from the hospital notify the GDSACP (the social provider at county level) about the social cases identified in the hospital through a similar instrument. It is an official instrument that establishes the communication of the social case between the institutions, specifically the hospital and:

- GDSACP in order to establish a protective measure for the child, according to the law;
- PSSC in order to evaluate and monitor the situation of the child and the family (minor mothers, parents without identification documents, family with children in foster care).

Who

The Case Notification Chart is filled in by the social worker in the hospital or by the nurse/doctor (if the hospital does not have a social worker).

When

When one of the vulnerabilities mentioned in the Working protocol/Medical Report is noticed, at hospital admission, or during hospitalization.

How

It refers mainly to the current state of the child (when admitted to the hospital) – identification data, information about vaccines, blood results, indicators about weight and size at birth and at the moment of the instrumentation, the child health state, and the medical recommendations from medical, nutritional, nurturing and caregiver view.
It is based on the Medical Observation Chart and the doctor's personal observations.

1. The Case Notification Chart is filled in by the hospital social worker, based on :

- pieces of information from other medical documents (mother and child) – Medical observation chart
- interviews with the mother and the extended family (if present in hospital visits)
- Direct observation of the patients
- Discussions with the medical personnel regarding the mother and the child, behaviour during hospitalization, treatment compliance, relationship mother-child, lactation, if there are any visitor/not, etc.
- information from the local PSSC – from the residence community.

Why

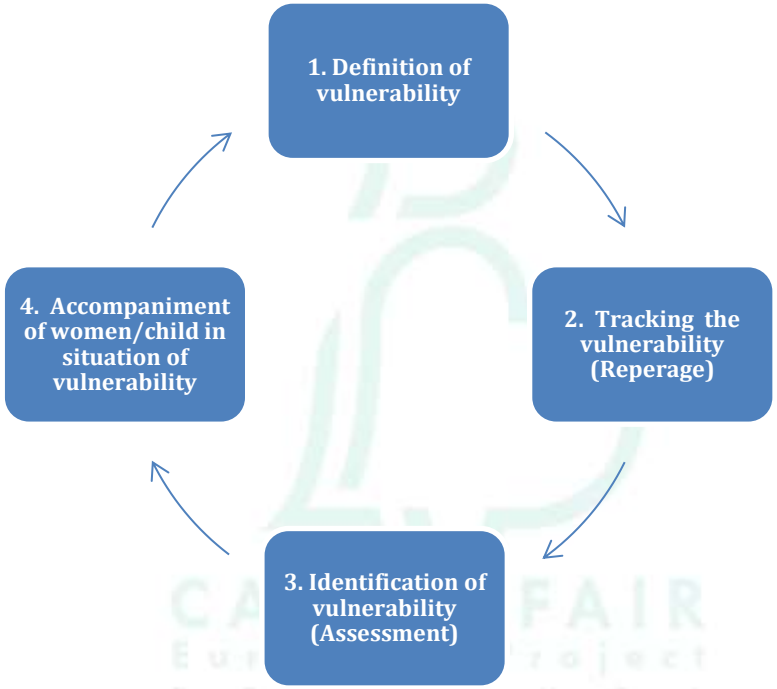
To detect the child vulnerability and to notify the responsible authorities and also to make recommendations for the child future. The Case Notification Chart contains a proposal from the hospital social worker regarding the future plans for **the child.**

What kind of vulnerability	Subject of the instrument: the mother and the child in the hospital - **Social vulnerability**: it refers to the risk of abandon, neglect, maltreatment, poverty, lack of identification documents for the parents, minor mother/parents, family with children in foster care. - biological/medical vulnerability – it refers to the health state of the child and if his medical condition needs a special protective measure: the child needs special treatment that cannot be implemented in the family or/and the family has medical issues that do not allow them to take care of the child. - emotional/behavioral vulnerability – it refers mostly to the mother's lack of interest for the child – causing the distress of the child, attachment traumas.

The list of annexes included in this document:

Annex 1 – The logical frame of the CAPEvFAIR demarche
Annex 2 – The pre-admission medico-social file
Annex 3 – The Child Form
Annex 4 – The TEAV – Table of assisted assessment of vulnerability
Annex 5 – Video-intervention – observation guide
Annex 6 – Intervention Plan
Annex 7 – Three Generation Genogram
Annex 8 – ORIENTARSI
Annex 9 – MAPPA MODIFICATA DI TODD (MMT)
Annex 10 – Observation Chart
Annex 11 – Medical Report
Annex 12 – Case Notification Chart – Maternity hospital model

Annex 1 – The logical frame of the CAPEvFAIR demarche



Annex 2 - The pre-admission medico-social file

Medical-Social File

For the medico-social team : please fill out carefully the application

Any file that is not complete will be rejected.

Personal Information

Last name:

..... First name: .....

Date of birth: Place of birth:

....

Address:

.....

Postal code:

.....

City/Town: Phone number:

....

Reference team

Name of the centre: .....

Address: .....

.....

Postal code: ..... City/Town: .....

Name of the doctor: ..... Function: .....

Phone number: ..... Fax: .....

Attending physician

Doctor: .....

Address: .....

.....

Postal code: ..... City/Town: .....

Phone number: ..... Fax: .....

MEDICAL PART

I. History

Medical :

Date	Observations

Surgical :

Date	Observations

Psychiatric :

(Please enclose the reports of hospitalization)

Date	Observations

II. Current state of the patient

Somatic:

……
……
……
……
……
……
……

Psychiatric:

……
……
……
……
……
……
……

Contact details of the current psychiatrist:
Name: …… Phone number: ……
Address: ……
……
Postal code: ……City/Town: ……

Allergies or special diet:

……
……
……
……
……

Tetanus vaccination:

Up to date: ❒ Yes ❒ No ❒ Don't know

Date of the last booster: .....

III. Addictology

According to the criteria DSM IV

You must tick 1 box at least per line:

	Never used	Simple Use		Abuse		Dependence	
		Current	Past	Current	Past	Current	Past
HEROIN							
CODEINE							
MORPHINE-BASED							
COCAINE							
CRACK							
ALCOHOL							
CANNABIS							
TOBACCO							
BZD and derivatives							
SEDATIVES							
HALLUCINOGENIC							
AMPHETAMINES							
OTHERS:							

Comments (if necessary): .....

.....

.....

Treatment of opiate dependence

· **Subutex** · **Methadone** · **Other: .....**

Date of the beginning of the prescription: .....

Date of the end of the prescription: ..... · Ongoing

Current dosage: .....

Initial prescribing doctor: .....

Current prescribing doctor: .....

In the last 3 months, is there a supposed or proven misuse of the substitution

treatment?

Illegal procurement (except medical prescription): ☐ Yes ☐No ☐ Don't know

Injection: ..... ☐ Yes ☐No ☐ Don't know

Nasal (snort): ..... ☐ Yes ☐No ☐ Don't know

IV. Paraclinica check-up

The most recent biological check-up (including serology HIV and hepatitis)

Last toxicological urine tests:

.....

.....

.....

.....

.....

Other recent paraclinical check-up:

.....

.....

Current treatment:

.....

.....

.....

.....

.....

V. Sick leave

(If ongoing)

Date of the last sick leave: ..... Sick leave end date: .....

Sick leave reason : .....

VI. Long-term illness

The application must be done for acceptance

❒ Yes ❒ No ❒ Application

Validity end date:

Application reason:

.....

Social part

Please enclose a situation report related to the concerned party's application and certificate of Public health insurance body / Universal medical cover / Long-term illness / Health mutual funds

Last name: ..... ***First name***: .....

Nationality: .....

Accommodation

❒ Independent
❒ With spouse
❒ With parents
❒ In an institution: .....
❒ Not stable living conditions
❒ Other: .....

Address (domiciliation): .....

Postal code: ..... City/Town: .....

Marital status

❒ In a couple
❒ Married
❒ Divorced
❒ Single
❒ Children to support: number .....
❒ Other: .....

Income

❒ Salary
❒ Allowance for adults with disabilities

❒ Unemployment insurance scheme

❒ No income ❒ Benefits office ❒ Disability pension

❒ Daily allowances ❒ Jobseeker's allowance

❒ Ongoing application: .....

Debts

❒ Amount: ..... € ❒ Ongoing ❒ Ongoing Schedule

❒ Creditor: .....

Excessive debt file: ❒ Yes ❒ No ❒ Ongoing

Social protection

N° Social Security: .....

Affiliation centre: ..... Health mutual funds: .....

N° affiliation organism: ..... Phone number: .....

Address : .....

Postal code: ..... City/Town: .....

Universal medical cover: ..... Validity end date: .....

(enclose certificate of the Public health insurance body /Health mutual funds

Departmental
Home for Disabled Persons

N° file :

..... N° beneficiary of the benefits office: .....

Benefits office in:

..... Phone number: .....

Address:

.....

Postal code:

.....

City/Town: .....

Validity end date:

.....

Disability rate: .....

Orientation: ❒ Mainstream environment

❒ Centres providing care through employment

Justice

Records: .....
.....
.....
Ongoing: .....
.....
Duty of care: ..... Probation: .....
Therapeutic order : .....
Purpose of the measure: .....
Name of the integration officer: .....
Address of Probation and Rehabilitation Section: .....
Postal code: ..... City/Town: .....
Phone number: .....

Other comments

.....
.....
.....

Annex 3 - The Child Form

Child File

For the medico-social team: please fill out carefully the application

Personal information

Last name: ..... **First name**: .....
.....

Date of birth: ..... Age: .....

Address: .....

Parental authority exercised by Mrs, Mr: .....

Family relationship (marriage, concubinage, single-parent…)**:**
.....

Brotherhood:.....

Current psychomotor development of the child

(Does he interact with others? / Does he turn in on himself? /, Is he smiling, sad, agitated?)

.....

.....

.. ..

His daily life and his habits

Daily meal (frequency, habits) and care (baby-changing, bath…):

……

……

……

Allergies: ……

Sleep rhythm (night, nap, cuddly toy…): ……

……

……

Motor awakening (crawling, walking, sitting without help…):

……

……

Form of child care (childcare centre, family, childminder…): ……

Current or ongoing judicial measure

(Enclose the photocopy of the information that raises concerns and/or the order of placement)

Measure : ……

……

Contact details : …… …… ……

…… ……

Medical data

Paediatrician, contact details:

……

……

Done and upcoming appointments: ……

Weight: …… **Height**: …… Blood group: ……

Current treatment: ……

Current medical problems: ……

……

……

Medical and surgical history: ……

……

……

Suivi en CMP/CAMSP: ……

Health insurance coverage, N°Security Social, contact details:

……

……

Comments

……

……

……

……

……

Annex 4 - The TEAV - TABLE OF ASSISTED ASSESMENT OF VULNERABILITY

Rating scale :

++ = very satisfactory + = Satisfactory - = Unsatisfactory - - = Very unsatisfactory

FACTORS OF VULNERABILITY	++	+	-	- -
EDUCATION LEVEL				
RESOURCES/MEANS				
ABILITY TO SPEEK THE LANGUAGE OF THE COUNTRY OF RESIDENCE WRITTEN				
SPOKEN				
INTEGRATION WHITHIN THE WORKPLACE				
ACCOMMODATION				
SOCIAL SECURITY PROTECTION				
PREGNANCY FOLLOW-UP				
PHYSICAL STATE				
LEVEL OF ADDICTION AND DEPENDANCE				
FAMILY ENVIRONMENT				
SOCIAL TIES				
PSYCHOLOGICAL STATE				

Annex 5 - Video-intervention – observation guide

Dawning items	Positive Discoveries	Negative Discoveries
Connection: Type of physical and emotional contact that is established		
Collaboration: Capacity or not to undertake joint activities		
Boundaries: How they are established, whether they are accepted or not and the conduct that leads to one option or another		
Negotiation: Both verbal and non-verbal, capacity to resolve conflicts in an agreed and communicative way		
Autonomy: Aspects of parent-child bonding, whether the parent is supportive and, therefore, the child can learn, whether the relationships generates powerlessness or independence, whether the parent offers help in a measured and ordered way and whether problems are assumed, and from here solutions are sought		
Space: How they situate and organize themselves in the space of affiliation, situation, body language and situation of objects		
Time: Pace of the sequence, how the activities are structured in time and how the action is organized		
Discourse: What they are say and how they say is taking into account the coherency with regard to age, whether there is a description of the action and verbalization of own emotions and those of the child, whether there is a negotiation and the child's opinion is taken into account, whether the quantity and quality of the information is adequate, whether the spoken information is true/logical and whether messages are clear, ordered and unambiguous.		

INTERVENTION PLAN: ROAD MAP

1. Firstly, we receive the proposal of attention for a pregnant teenager or a teenager who has already had her child, by the competent authorities in the area of protection for children and adolescents (General Directorate for children and adolescents Attention- DGAIA), WHEN DIFFERENT TEAMS of professionals of the social services or specialised in protection for children and adolescents have detected situations of risk and/or vulnerability. This proposal arrives to our residence when the teenager mom has been declared in helplessness on the part of her family and the General Directorate for Children and Adolescents has taken over her custody.
2. Immediately we get in touch and coordinate with the team specialised in attention to childhood and adolescence in order to know in detail and get first-hand information on the follow-up, study and technical evaluation of the family socio-economic situation of the teenager mother or mother-to be who enters in the residence.
3. We receive the visit to the maternal residence of the teenager and her family so that they know the place where the young mother is going to live and the general objectives of the intervention that will take place during her stay in the residence.
4. In this first stage, emphasis is placed on the importance of the involvement of the own (nuclear, extensive or created) family in the process of the young mother. This is done both to resolve the identified difficulties and shortages (that have been the reason for the proposal of protection and guardianship on the part of the General Directorate for Children and Adolescents), in order to promote the construction of a more healthy bond between the teenager and her parents, and especially to reinforce the bond between the teenage mother and her child.
5. We establish a period of adaptation, of a month and a half, of the young mother and her child at the residence.
6. We define an individual work plan that addresses the objectives of the different areas in which to focus the intervention of different professionals (family roles, emotional-relational development, intellectual and everyday life learning skills, and physical development)
7. Weekly spaces of individual and family therapy and tutoring are established inside the maternal residence.

8. We get in touch with external resources of the territory and with the network of public health care professionals in order to facilitate a comprehensive care of the highest quality (basic areas of health, medical specialists, maternity hospitals, mental health centers for children and youth, centers of stimulation and psychomotor development, nurseries, colleges, centers of integration and training and labour insertion)
9. During all the stay of the young mother in the residence, a continuous assessment of the process is realized. In this assessment the different professionals of the residence (education team and technical team made up of the direction, the psychotherapist and the tutor) intervene. Work is carried out in coordination with the professionals of the Childhood and Adolescence Attention Team.
10. A forecast about the completion of the process of intervention is established, it can be extended to a maximum up to the coming of age of the young mother. Exceptionally, when the processes in the residence are close to the age of the mother, an extension of their stay at the residence can be proposed beyond the legal age, with the approval of the professional teams and if the young mother agrees.
11. The different possible proposals for young mother and her child release contemplated are: a) The return to the family as a first choice whenever possible; b) When this is not possible, other options are evaluated, taking into account first of all the skills and capabilities of the mother and also the resources offered by the community environment (residences protected by services and social organisations for adult mothers with their children and houses with social rental); c) In coordination with the systems of protection, it could be proposed in the last instance the separation of the child of his/her mother, if it is considered that at this stage the construction of the maternal bond implies risks for the baby or child (foster care in origin or extensive family, foster care in other families, pre-adoptive and/or foster care in residential centres of protection.
12. The professionals and the girls from the Centre organize a farewell ritual for the young mother and her child which consists of:
    - a special lunch chosen by the mother,
    - a gift for the mother and child (in reference to the release proposal)
    - an album of photos of their process in the residence with dedications from the whole team of professionals and her companions.
    - at the end of the celebration, a "emotional" space takes place where each participant can express what they consider meaningful.

Annex 7 Three Generation Genogram

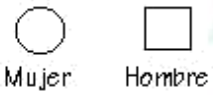
GENOGRAM: A USEFUL TOOL TO BUILD A COMPLEX LOOK ON FAMILIES AND THEIR SOCIO-CULTURAL CONTEXT

BUILDING GENOGRAM WITH THREE DIFFERENT LEVELS.

1. Structure drawing. The base of genogram is the graphic descripton on how different members of a family are biological and legally linked between generations. This drawing is the construction of figures that represent people and lines describing their relationships.

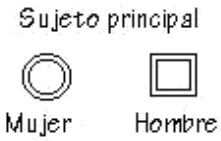
The different symbols used to build genograms are described below.

1) Each member is represented by a square or a circle depending on his/her gender.

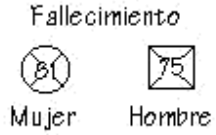


Woman Man

2) The "**identified patient**" is represented by a double-line square or circle



3) For a **dead person** a "X" is drawn inside.

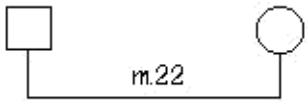


4**) Children**

Pregnancy **Dead-born** **Abortion**

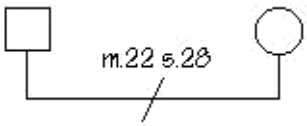
Boy-Girl Spontaneous - Induced

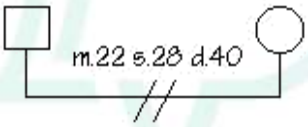
5**) Biological and legal relationships** among family members are drawn by lines connecting them.



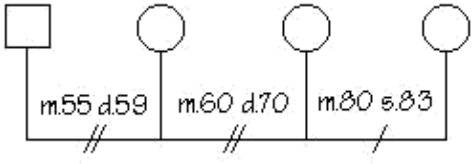
6) If a couple **live together but are not married** a dotted line is used.

7) **Slashes** mean an interruption of the marriage: one slash for separation, two slashes for divorce.

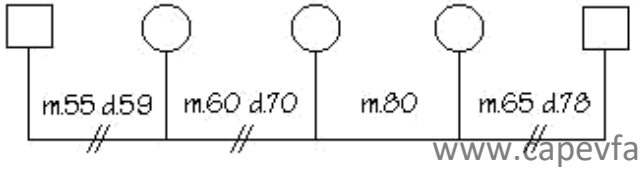




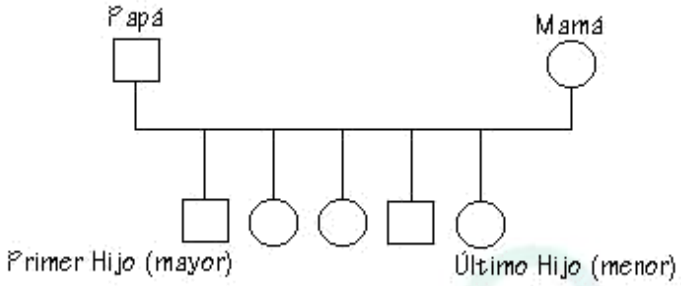
8) **Multiple marriages** can be represented as follows. A HUSBAND or a wife with several partners: The current marriage is connected by a **straight line** and former partners with **a line cut by two slashes**.

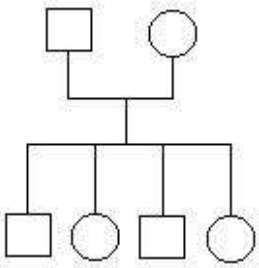


If, for instance, **one of the partners** has had a **former marriage**, then:



9) If a couple has **several children**, the figure of each child is connected to the line that connects the couple. From left to right, from the oldest to the youngest child.

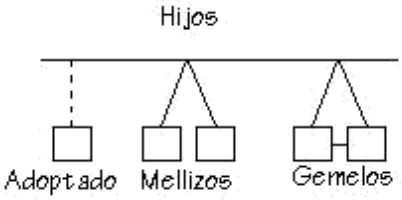




(**for largest families**).

I. A dotted line is used to connect **an adopted child** to the parents line.

J. **Dizygotic twins** are represented by the connection of two convergent lines to the parents line; if they are **monozygotic (identical) twins**, they are connected **by an horizontal line.**



12) To indicate the **family members that live together**, a dotted line is used to group them.

2.Information register. WHAT INFORMATION TO COLLECT?

1-Information on the nuclear family and the context where the problem appears.

Who is living at home? Firs names, last names, ages,

Relationship among the members (sub-systems)

Where do the other family members live.

Births, marriages, divorces, separations, retirements. Migratory movements.

Motives, satisfaction level, issues pending of resolution.

Losses. Motives. Causes.

Names, ages, education, profession and satisfaction level, timetables, hobbies, daily activities, social life, health, civil status, former partners,...

Chronology of significant facts (dates).

2- Extended Family (1st, 2nd and 3rd generation)

3-Questions related to the problem.

Temporality of the problem. When did it start, evolution, chronology?

Which family members know about the problem?

Responses of every member to face the problem.

Did anyone have the same problem?

Resources deployed and results. Who?

Do they receive help from the social context/administration

3. Description of relationships.

The third level in the construction of the genogram comprises the drawing of the relationships among the members of the family. Descriptions are based on reports from the family members and on direct observations.

Different types of lines are used to symbolize different kinds of relationships between two family members.

Due to the fact that the linking patterns could be quite complexes, frequently it is useful to draw them in separated genograms:.

FUSED: Three parallel lines.

UNITED: Two parallel lines.

DISTANT: A discontinuous line.

SEPARATED: A line tangentially cut by another line

TROUBLESOME: A zigzag line that connect both individuals.

TROUBLESOME FUSED: Three parallel lines with a zigzag line inside

Interpersonal relationships
Very close – Very close but troublesome – Troublesome – Close – Broken - Distant

Annex 8 - ORIENTING YOURSELF

ORIENTARSI/ ORIENTING YOURSELF

AREA DELLA NOMINAZIONE/NOMS/NAMES

COGNOME/NOM DE FAMILLE/SURNAME
NOME/PRENOM/NAME
ALTRI NOMI SIGNIFICATIVI/AUTRES PRENOMS/OTHERS NAMES
(si è a conoscenza del significato dei nomi? / connaissez-vous les significations des prénoms/do you know what names mean?)

ETA'/AGE:
Luogo di nascita/LIEU DE NAISSANCE/ PLACE OF BIRTH :
Nazionalità/NATIONALITE/NATIONALITY:

AREA DELLE LINGUE/LANGUES/LANGUAGES

Lingua madre/langue maternelle/mothertongue
altre lingue *parlate/autres langues/others languages*
lingue dei genitori*/langues des parents/parents' languages*

AREA DELLA FAMIGLIA/Famille/Family

Nascite dei genitori/Naissances des parents/Birth of parents
Nascite dei figli/Naissances des enfants/Birth of children
Relazione tra i genitori/Relations entre les parents/Relations between parents
Relazione con i nonni-nonne/Relations avec grand-parents/Relation with grandparents

AREA DELLE MIGRAZIONI/Migrations

Interne allo Stato di nascita/A l'intérieur de l'Etat où on est né/Inside the country of birth

All'estero/A l'étranger/Abroad

In Italia/En Italie/In Italy

Tempo di permanenza in Italia/Temps de séjour en Italie/ Time of residence in Italy

Rientro nel Paese di provenienza (e/o in altri Paesi) per motivi …./Retour au Pays d'origine (et/ou dans d'autres Pays) pour des raisons…../Return to the country of origin

Frequenza dei rientri/Fréquence des retours/Frequency of return

Contatti con i familiari che si trovano in altri Paesi/Contact avec des membres de la famille à l'étranger/Contacts with family members abroad

AREA DELLE RELIGIONI/Religions

Appartenenza/appartenenze religiosa-e/Appartenances religieuses/Religious belief

Frequentazione di luoghi di culto/Fréquentation des lieux de culte/ Attendance of places of worship

STORIA PERSONALE/Histoire personnelle/Personal history

Che storia conoscete? (lavoro, studi, saperi, conoscenze, desideri, difficoltà…)

Quelle histoire connaissez-vous? (travail, étude, savoirs, connaissances, désirs, difficultés…)

What do you know about the personal history ? (work, studies, knowledges, desirs, difficulties…)

PRESENTAZIONE SINTETICA DELLA SITUAZIONE/Présentation synthètique de la situation/

Brief description of the situation

Motivo per cui si è rivolto/a al nostro servizio (è avvenuto un incidente …, è stata accompagnata da …, …)

Pourquoi s'est-il adressé à notre bureau?

Reason why he/she come to to service

Altre osservazioni che riteniamo utili

Autres observations utiles

Other comments

Problematica maggiore rilevata:

Problématique reperée
Major problem

RETI/RESEAUX/NETWORKS

ALTRE ISTITUZIONI e professionisti COINVOLTI/Autres institutions ou professionnels impliqués/ Others institutions:

1) _____Do manda di intervento:
Intervention request_____

2) _____
Domanda di intervento:
_____

3) _____

Domanda di intervento:
_____

Quali soggetti (non istituzionali) avete coinvolto? Con quale domanda?

Quels sujets non institutionnels avez-vous impliqués? Pourquoi?

Which non institutional actors have you involved? Why?

1:_____

_____

2:

_____

_____

3:

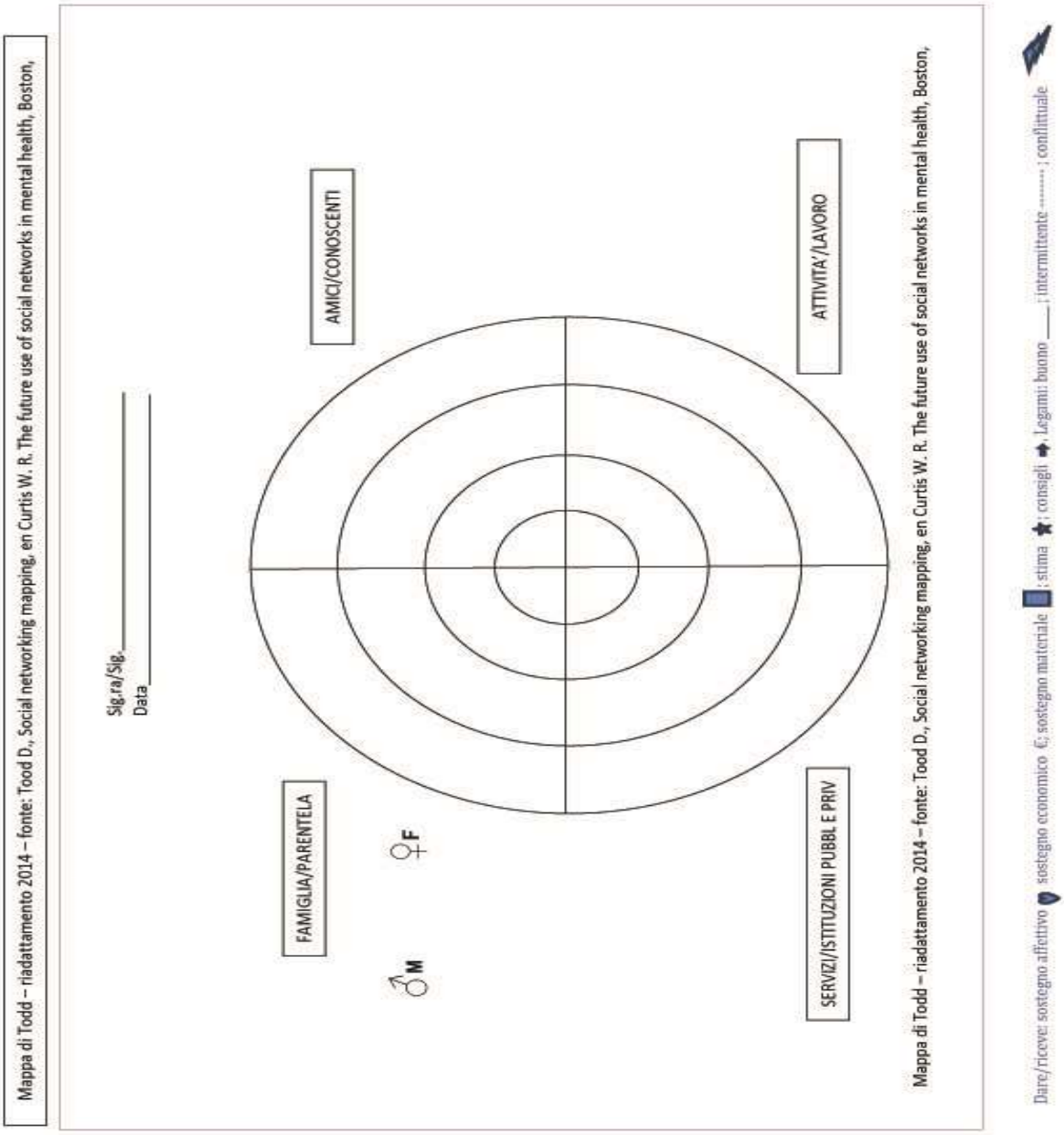
_____

Le professioniste, i professionisti che hanno steso il documento (nome e cognome – funzione)/Indicate professionals' names, surname and fonction

data/date:

e-mail:

Annex 9 - MODIFIED TODD MAP (MTM)



Observation chart
|_|_|_|_|
(chart identification number)

Surname and name of the head of the family under observation:

County: . . . . . .

City/town/village: . . . . . .

Street: . . . . . nr. . . . . .

Telephone: . . . . . .

Signature: . . . . . .

Surname and name of the person filling in the chart:

Position: . . . . . .

Signature: . . . . . .

Date the chart was filled in:

Day |_|_| Month |_|_| Year |_|_|_|_|

Time interview started: |_|_| : |_|_|

Time interview ended: |_|_| : |_|_|

1. ECONOMIC SITUATION

a. The family is in a state of poverty	1. YES	2. NO
b. One or both parents are unemployed (with of without benefits)	1. YES	2. NO
c. The family receives social benefits	1. YES	2. NO

2. SOCIAL SITUATION

a. In the family there is an underage mother or a pregnant underage girl	1. YES	2. NO
b. Single-parent family	1. YES	2. NO
c. One or both parents are working abroad	1. YES	2. NO
d. Both parents are deceased, unknown, who have lost their parental rights or whose parental rights have been terminated by a criminal court, declared incompetent by a court of law, missing or declared dead by a court of law, in the absence of a guardianship or another special protection measure	1. YES	2. NO
e. The family has one or several children who have returned to the country after a migration experience of over one year	1. YES	2. NO
f. The family has one or several children in the special protection system	1. YES	2. NO

g. The family has one or several children reintegrated from the special protection system	1. YES	2. NO
h. The family has members with sensory, neurological or intellectual deficiencies that significantly limit their quality of life and their participation in social life	1. YES	2. NO
i. At least one family member (including adults) does not have identity papers (birth certificate)	1. YES	2. NO
j. The family has one or several members serving a prison sentence	1. YES	2. NO
k. The family faces any other situation that may indicate a vulnerability	1. YES	2. NO

Please detail any other situation:

3. HEALTH STATUS

a. The family has one or several members with chronic and transmissible illnesses	1. YES	2. NO
b. The family has one or several members that are not registered with a GP	1. YES	2. NO
c. In the family there is a pregnant woman who is not registered with a GP	1. YES	2. NO
d. The family has an infant that is not registered with a GP	1. YES	2. NO
e. The family has one or several children that are not registered with a GP	1. YES	2. NO
f. The family has one or several children that are not vaccinated	1. YES	2. NO
g. The family has one or several children with no chronic and transmissible illnesses and with several hospitalization periods	1. YES	2. NO
h. The family faces any other situation that may affect the child's health status	1. YES	2. NO

Please detail what other types of problems are there in terms of health:

4. EDUCATION LEVEL

a. One or both parents are illiterate	1. YES	2. NO
b. The family has one or several children of school age who does not attend a mandatory education school	1. YES	2. NO
c. The family has one or several children who have left school early	1. YES	2. NO

d. The family has one or several children who do not attend school regularly or who have repeated school years	1. YES	2. NO
e. The family has one or several children with poor academic performance (having to repeat exams etc.)	1. YES	2. NO
f. The family has one or several children with a history of sanctions in school (being expelled, being penalised for bad behavior etc.)	1. YES	2. NO
g. The family has a large number of pre-kindergarten/kindergarten/school age children	1. YES	2. NO
h. The family has one or several children with special education needs	1. YES	2. NO
i. The family faces any other situation that may affect the child's to education.	1. YES	2. NO

Please detail what other types of problems are there in terms of education:

5. LIVING CIRCUMSTANCES

a. The family occupies illegally a living space (this includes buildings erected without permit)	1. YES	2. NO
b. The family lives in improper circumstances: building in advance state of degradation, living in spaces that are not meant for habitation (storage sheds, pump houses, manholes, derelict buildings etc.)	1. YES	2. NO
c. The family does not have enough living space in relation to the number of its members; the living space is overcrowded	1. YES	2. NO
d. The family does not have access to utilities, especially a source of water, electricity and heating	1. YES	2. NO
e. The family does not have the minimum equipment for cooking and/or heating, nor minimum furniture	1. YES	2. NO
f. The household is not well maintained, lack of hygiene	1. YES	2. NO

6. AT-RISK BEHAVIOURS

a. The family has a history of reports/complaints recorded and confirmed by the local public authorities or by the police, regarding the antisocial behavior of a family member, such as misdemeanours or felonies, exploiting minors through begging etc.	1. YES	2. NO
b. The presence of aggressive behavior in the family, from one or several family members and/or of a history of domestic violence, attested by complaints or protection/restriction orders	1. YES	2. NO

c. Alcohol is being consumed in excess in the family.	1. YES	2. NO
d. In the family there is consumption of psychotropic substances or the family has a history of consumption or abuse of such substances	1. YES	2. NO

MEDICAL REPORT

I. CHILD IDENTIFICATION DATA:

Name and surname of the child: _____
Date and place of birth: _____
Personal Numeric Code: _____
Gender: _____

INFORMATION REGARDING PREGNANCY:

Pregnancy duration _____ Type of birth_____

Aspect of child_____ APGAR Score_____

Weight/Size/Head circumference at birth: W= _____gr, S=_____cm, HCN=_____cm

Diagnostic at birth:

_____

_____

_____

ADMISSION DATE: _____

VACCINES (Immunisation): _____

ALIMENTATION (duration):

Natural _____

Artificial (Baby Formula) _____

VITAMINES: Vitamin D_____

Results for the compulsory laboratory investigations: (date_____/____/____):

Presence of antibodies for HIV 1/HIV 2 _____ Hepatitis B/C _____

Syphilis_____ Examination of excrements for parasites and eggs

_____

Pharyngeal exudate _____

DIAGNOSYS AND TREATMENT DURING HOSPITALIZATION:

- infectious and contagious illnesses _____
- other illnesses (age specific)_____
- chronical illnesses _____

II. MEDICAL FAMILY HISTORY:

MOTHER (no of pregnancies, no of births, illnesses declared, health state at the moment):

_____

_____

_____

How she maintains the relationship with the child/medical personnel

FATHER: health state _____

His opinion towards the child/ whether he is interested about the child or not _____

MEDICAL HISTORY OF THE SIBLINGS:_____

CLINICAL EXAMINATION:

_____

_____

CURRENT HEALTH CONDITION (diagnostic, current weight, results for the laboratory investigations):

_____

_____

_____

_____

CHILD NEEDS REGARDING DIFFERENT ASPECTS:

- medication: _____
- nurturing:_____
- alimentation:_____
- accommodation: in the family _____

  in a centre for children with special needs _____

MEDICAL RECOMMENDATIONS:

_____

_____

_____

_____

RECOMMENDATIONS REGARDING CHILD CARE:

1. requires special care _____
2. in the familial environment _____

SPECIAL RECOMMENDATIONS (periodical medical re-evaluations, other interventions:

_____

_____

_____

_____

Date: _____ Pediatrician

_____

Annex 12 - Case Notification Chart – Maternity hospital model

CASE NOTIFICATION CHART

I. Information about the child:

- Name and surname of the child: _____
- Date and place of birth: _____

Personal Numeric Code _____

- *There will be mentioned if there is a Birth Certificate, if the child is baptized, if he is visited and who visits him (the statute of the person that visits the child in the hospital)*

- Health state (diagnosis, weight and stature indicators, weight at birth): (the Medical Report will be attached)

- Date of case entry in the medical unit: _____
- Reason for the admission in the medical unit:

_____

- Date when the social worker from the medical unit took the case:_____
- Child needs:

1. medical _____
2. alimentation _____
3. social _____

- Risk(s) that the child is exposed to:_____

_____

- Contact data of the resource people:

Maternal grandparents: _____
Paternal Grandparents: _____
Other people: _____

II. Information about the parents:

	Mother	Father
Name and surname		
Personal Numeric Code		
Date and place of birth		
Legal residence		
Real residence		
Studies		
Profession		
Occupation		
Workplace		
Nationality/Ethnicity		
Religion		
Previous convictions (if any)		
Health state		
Civil state (married, concubinage, divorced, widow, single-parent family)		

III. Steps made by the social worker from the medical unit:

- Counseling for the parents/resource people _____
- Psychological evaluation ____
- Notification of Public Service of Social Work: on the phone (contacted person)_____, in written _____
- Notification of Police: on the phone (contacted person)_____, in written _____
- Notification of General Directorate of Social Assistance and Child Protection: on the phone (contacted person)_____, in written _____
- Counseling for the family members: nuclear family _____ extended family_____

IV. Information about the relationship within the family:

_____
_____
_____
_____

V. Recommendations:

_____
_____
_____
_____

VI. Documents attached to this Chart:

Medical Report, Mother`s request (if any), Documents of identification (copies) for the mother/father/other relatives concerned.

Manager, **Social Worker,**

References:

Born M., Lionti A-M. (1997). *Aide aux mères en situation de pauvreté*, Bruxelles, Fonds Houtman.

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Fawcett, B., Meagher, S. Goodwin & Phillips, R. (2009). *Social Policy for Social Change.* Melbourne and Basingstoke: Macmillan.

Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches, *Journal of Advanced Nursing*, Blackwell Science Ltd.

Todd, D. (1970). Social networking mapping, in Curtis W. R. *The future use of social networks in mental health*, Social Matrix Inc.