

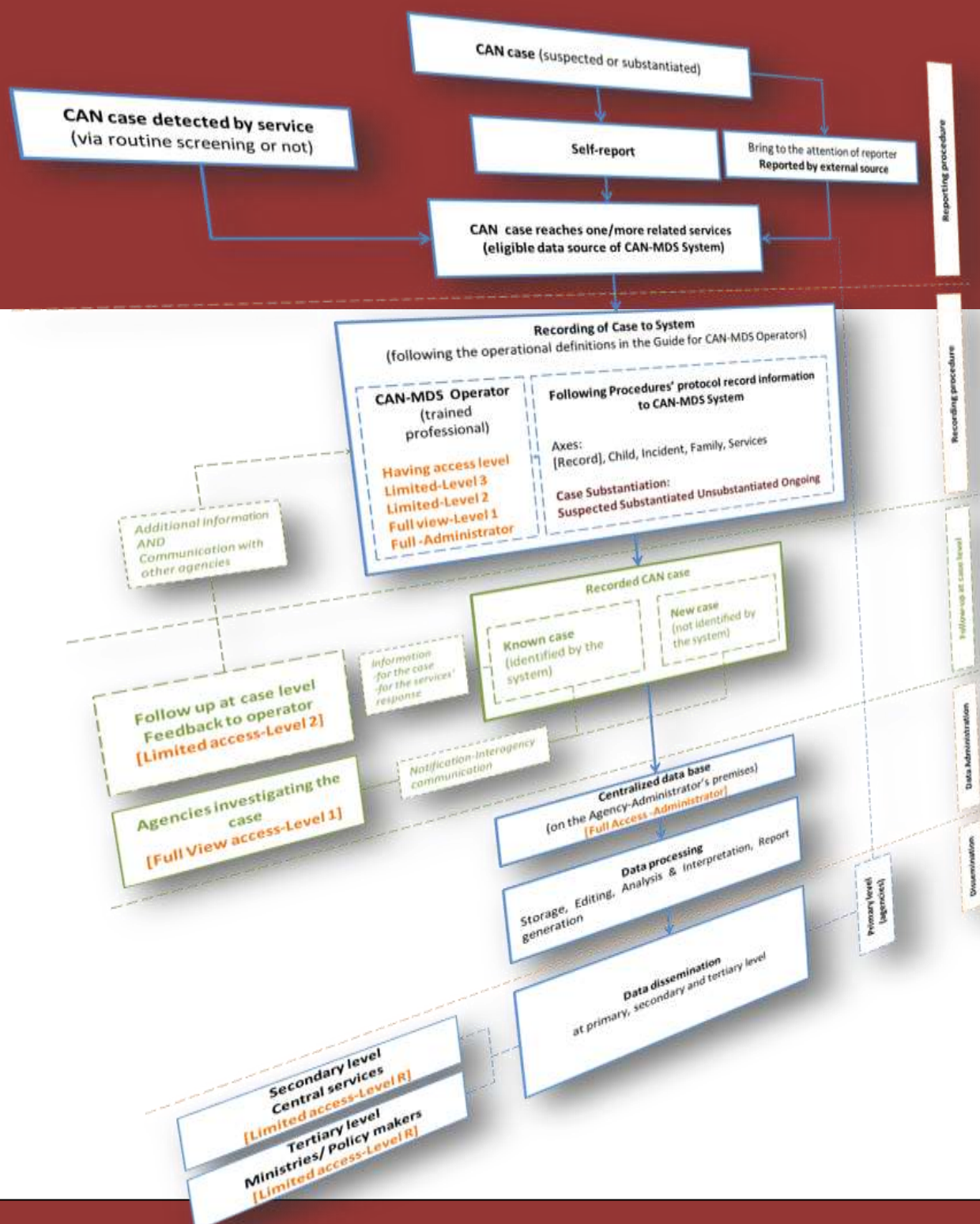


Co-funded by EU REC  
Programme 2014-2020



# CAN-MDS

## GUIDE FOR TRAINERS





## NOTE

**This Guide is part of the Master CAN-MDS Training Module.**

**National version can be developed by removing any information related to other countries (e.g. slides-examples). Concerning the language, the specific Manual can be used in English (after adaptation according country specifics) or to be translated in national languages (optionally).**

## Action's Identity

<b>Title</b>	Coordinated Response to Child Abuse & Neglect via Minimum Data Set: <i>from planning to practice</i> (CAN-MDS II)
<b>Grant agreement No.</b>	810508
<b>Funding</b>	With the financial support of the EU REC Programme (2014-2020)
<b>Duration</b>	24 months
<b>Project's website</b>	<a href="http://www.can-mds.eu">www.can-mds.eu</a>

## Deliverable's Information

<b>Workpackage</b>	2 Preparatory phase
<b>Activity</b>	Activity 1.2: Revision of Master CAN-MDS Training Module
<b>Deliverable No.</b>	Deliverable D2.2 (part of)
<b>Drafted</b>	Ntinapogias, A., Chouchourelou, A., Gray, J., Jud, A., Nikolaidis, G. & CAN-MDS II Action's Partners and IT Experts
<b>Deliverable title</b>	Master CAN-MDS Guide for Trainer
<b>Target group</b>	National CAN-MDS Administrative Authorities, National CAN-MDS Administrators, Partners and any stakeholder interested in developing and implementing a CAN-MDS System

Institute of Child Health  
Department of Mental Health and Social Welfare  
7 Fokidos Street, 115 26 Athens-Greece  
E-mail: [info@can-via-mds.eu](mailto:info@can-via-mds.eu)  
Website: [www.ich-mhsw.gr](http://www.ich-mhsw.gr)  
Project's Website: [www.can-mds.eu](http://www.can-mds.eu)

This Manual is part of the Master CAN-MDS Toolkit prepared in the context of the Action "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"

#### COORDINATING ORGANIZATION

##### Institute of Child Health, Department of Mental Health and Social Welfare - GREECE

George Nikolaidis, Project Leader

Athanasios Ntinapogias, Project Coordinator/Principal Investigator

Arieta CHOUCOURELOU, Researcher & National CAN-MDS Administrator in GREECE

Metaxia Stavrianaki, Researcher

Aggeliki Skoumbourdi, Researcher

Fotis Sioutis, Senior Software Developer

Babis Perdikoulis, IT Engineer Web Developer

#### PARTNERS' ORGANIZATIONS

##### State Agency for Child Protection – BULGARIA

Eleonora Lilova, Local Coordinator

Milena Anastasova, Chief Expert

Yanko Kovachev, State Expert

##### South West University "Neofit Rilski", Faculty of Public Health and Sport – BULGARIA

Vaska Stancheva-Popkostadinova, Scientific leader and Local Coordinator

Maya Tcholakova, Researcher

##### Hope for Children - CYPRUS

Andria Neocleous, Local Coordinator

Sofia Leitao, Researcher

Christine MAVROU, National CAN-MDS Administrator in CYPRUS

##### Ministry of Labour and Social Insurance, Social Welfare Services - CYPRUS

Tapanidou Hara, Local Coordinator

Efthymiadou Marina, Researcher

##### Observatoire national de l'enfance en danger (GIPED) – FRANCE

Agnès GINDT-DUCROS, Global Project Manager

Anne-Lise STEPHAN, Local Coordinator

Michel ROGER, Computer Engineer

Elsie Joëlle MEHOBBA, Data Analyst

Claudine Burguet, Consultant

##### Departamentul de Asistență Socială și Medicală (DASM) – ROMANIA

Aura Diana Totelecan, Local Coordinator

Arianda Maneula Popa, Local Thematic Expert

Cristian Florin Iclodean Lazar, Local Administrator

##### Federatia ONG pentru copil (FONCP) – ROMANIA

Daniela Boșca-Gheorghe, Local Coordinator

Ivona Păun, Researcher

Rodika-Corina ANDREI, National CAN-MDS Administrator in ROMANIA

##### Babes-Bolyai University, Department of Sociology and Social Work – ROMANIA

Maria Roth, Local Coordinator

Gabriela Tonk, Researcher

##### Fundació AROA – SPAIN

Neus Pociello Cayuela, Local Coordinator

Susana Rodriguez Pereiro, Researcher

Joaquim MILLAN, National CAN-MDS Administrator in SPAIN

##### Expert on Ethical Issues

Andreas Jud, Ulm University-GERMANY

##### External Evaluator

Jenny Gray, UK

## Table of Contents

BACKGROUND INFORMATION .....	6
PREPARATION FOR CAN-MDS OPERATORS' SEMINARS .....	10
ORGANIZATION OF CAN-MDS OPERATORS' SEMINARS .....	20
SUGGESTED PROGRAMME FOR THE CAN-MDS OPERATORS' SEMINARS .....	22
OVERVIEW OF TRAINING SESSIONS .....	23
SESSION 1: CAN-MDS Rationale .....	24
SESSION 2: Tackling Underreporting .....	25
SESSION 3: Demonstration of CAN-MDS System .....	26
SESSION 4: CAN-MDS Piloting .....	27
DETAILED PRESENTATION OF TRAINING SESSIONS .....	29
PART 1 – DURATION: 30 MIN .....	30
PART 2 – DURATION: 30 MIN .....	38
PART 3 – DURATION: 120 MIN .....	51
PART 4 – DURATION: 30 MIN .....	65
PART 5 – DURATION: 60 MIN .....	95
PART 6 – DURATION: 60 MIN .....	136
PART 7 – DURATION: 30 MIN .....	153
PART 8 – DURATION: 15 MIN .....	163
PART 9 – DURATION: 210 MIN (3h 30 min) .....	169
WORKING WITH MOCK CASES .....	170
PART 10 – DURATION: 30 MIN .....	173
PART 11 – DURATION: 45 MIN .....	178
FURTHER READING .....	181



## BACKGROUND INFORMATION

The CAN-MDS Guide for Trainers is part of the CAN-MDS Training Module that was developed to facilitate capacity building activities related to the usage of CAN-MDS Surveillance System. It is meant to be used for the training of eligible professionals-operators of multiple disciplines who work with and/or for children in relevant sectors and are most likely to deal with cases of child maltreatment.

To this end, the material contained in the Guide is addressed to a variety of front-line professionals working in child protection, social welfare, health and mental health, justice, law enforcement and education, in public agencies or accredited NGOs. The first stage aim is to train selected professionals that will participate as operators during the pilot testing of the CAN-MDS system and, during later stages, to train expanded groups of relevant professionals who will be involved in the system according to their professional background and the sectors where they are working.

It is noted that this material is not intended to substitute in-depth training of professionals for subjects such as child maltreatment and its consequences in general. Professionals who are going to participate in the trainings are expected to be already familiar with such subjects at different degrees, given that some of them are already fully involved in the administration of CAN cases (identification, reporting, referral, investigation, treatment, judicial involvement and follow-up of cases) while others are mainly involved by making reports or referrals of CAN incidents. As far as the CAN-MDS System is concerned, this material is intended to sufficiently provide trainees with all the necessary information, knowledge and skills in order for them to become CAN-MDS Operators.

## LEARNING OBJECTIVES

The Guide for Trainers includes an overview of how to use both, the training material and the evaluation tools in the context of the Operators' seminars. Upon the completion of seminars professionals-trainees from multiple disciplines working with or for children in relevant sectors are expected to be:

- familiarized with the operational definitions of CAN based on CRC, Art. 19 and GC 13 of UN CRC (2011)
- informed about what is CAN and its specific types
- informed on how to recognize signs of child abuse and/or neglect
- aware of the procedures to be followed upon the identification of a (suspected) CAN case (recognizing; reporting; registering; providing services; referring to other agencies; follow-up of cases)
- aware on their role and responsibilities in the course of administrating a CAN case and under which circumstances a case should be reported either to authorities in charge (depending on country) or by the professionals themselves directly via the system
- aware of what is provisioned by the law as well as for professional mandates for reporting
- informed on what are the ethical principles governing CAN data collection, including the importance of data confidentiality, legislative provisions, and professionals' codes of ethics
- fully informed about the CAN-MDS system and how it operates, namely
  - which are the data elements comprising the minimum data set
  - which cases are eligible to be recorded in the system
  - what is the data entry procedure [record of (suspected) incident; information for child and family; services' response (institutional response and referrals made); how to communicate with and provide feedback to other professionals-operators (at case-level)]
  - how to use the system (working in real time with mock-CAN cases)
- fully informed on what is expected by them as system's Operators and how they will benefit by the system in their everyday practice depending to their roles and accountabilities

## CONTENT

The Guide for Trainers is consisted by the following sessions:

### SESSION 1: CAN-MDS Rationale

- the necessity for CAN data collection
- the role of multiple sectors, disciplines and how they inter-relate
- *CAN-MDS Operator's Manual*

### SESSION 2: Tackling Underreporting

- justifying the need for CAN reporting & exploring the reasons leading to underreporting
- definition of violence and how to recognize CAN cases
- responding to CAN disclosure, reporting CAN, legal framework & national mandates to report

### SESSION 3: Demonstration of CAN-MDS System

- *CAN-MDS Data Collection Protocol* & tools
- demonstration of Operator's interface
- Ensuring understanding of CAN-MDS
  - working with mock cases
  - reviewing mock cases and clarifications

### SESSION 4: CAN-MDS piloting

- why different level of access: role, responsibilities and mandates of operators' groups in management of CAN cases
- what is expected by CAN-MDS Operators and what Operators can expect by CAN-MDS

## FOLDER 'Training Module CAN-MDS' - CONTENT

- CAN-MDS Training Module
- CAN-MDS Guide for Trainers

### Sub-folder "1. CAN-MDS Toolkit"

#### Manuals

- CAN-MDS Operator's Manual (National version)
- CAN-MDS Data Collection Protocol (National version)
- CAN-MDS Step by Step Guide for Administrators

#### e-apps

- CAN-MDS – Operator's App ([www.can-mds.infowood.gr](http://www.can-mds.infowood.gr))
- CAN-MDS – Administrator's Interface ([www.can-mds.infowood.gr/admin](http://www.can-mds.infowood.gr/admin))

### Sub-folder "2. Evaluation Tools"

#### Evaluation Questionnaires

- Questionnaire 1a\_Operators\_evaluation\_EN\_pre\_questionnaire
- Questionnaire 1b\_c\_Operators\_evaluation\_EN\_post\_follow-up\_questionnaire



## Sub-folder "3. Presentations"

PowerPoint presentations [\*.pptx]

### PRESENTATION

PART 1:	The necessity for CAN data collection	SESSION 1: CAN-MDS Rationale
PART 2:	The role of multiple sectors, disciplines and how they inter-relate	
PART 3:	CAN-MDS Operator's Manual	
PART 4:	Justifying the need for CAN Reporting & Exploring the reasons leading to underreporting	SESSION 2: Tackling Underreporting
PART 5:	Definition of violence and How to recognize CAN cases	
PART 6:	Responding to CAN disclosure and reporting CAN; Legal framework & national mandates to report	
PART 7:	Data Collection Protocol & tools	SESSION 3: Demonstration of CAN-MDS System
PART 8:	Demonstration of Operator's app interface	
PART 9:	Ensuring understanding of CAN-MDS	
PART 10:	Why different level of access: role, responsibilities and mandates of operators' groups in management of CAN cases	SESSION 4: CAN-MDS piloting
PART 11:	What is expected by CAN-MDS Operators and what Operators can expect by CAN-MDS	

## Sub-folder "4. Supportive material"

- 2 Mock (vignette) cases including material
  - for actors ( "referrals" or "sources of information")
  - for trainees (professionals-operators of CAN-MDS)
    - [Handout 2\_Instructions for a CAN case reported to an Agency by a source of information, suggested questions and prompts for collecting required information for CAN-MDS; pp. 46-48]
  - recording forms
    - [Handout 1\_Checklists\_ANNEX I & II of Data Collection Protocol; pp. 49-50]
- Note: for detailed information on use of mock cases in trainings' evaluation, please see instructions in SESSION 3: Demonstration of CAN-MDS System and Presentations, Part 9: Ensuring Understanding of CAN-MDS.

## Sub-folder "5. Templates"

- Template 1a\_Programme\_1st day of 2-day Seminar for CAN-MDS Operators
- Template 1b\_Programme\_2nd day of 2-day Seminar for CAN-MDS Operators
- Template 2a\_ Attendance form\_1st-day Seminar for CAN-MDS Operators
- Template 2b\_ Attendance form\_2nd-day Seminar for CAN-MDS Operators
- Template 3\_ Certificate of Attendance

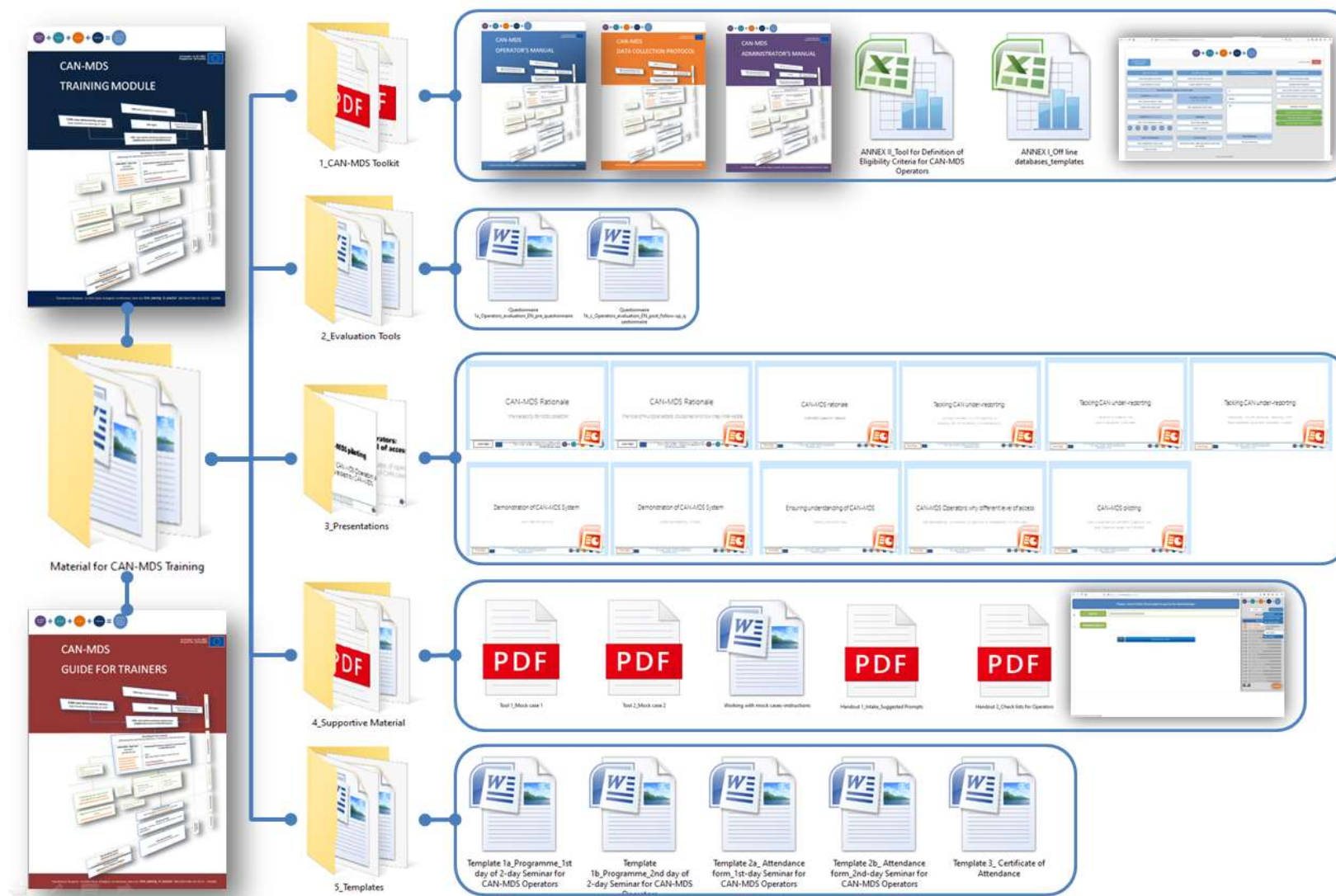
Also, for the preparation of simulation

- CAN-MDS Step by Step Guide for Administrators
- ANNEX I\_Off line databases\_templates
  - DB2 (Agencies-Data Sources)
  - DB3 (Professionals-Operators)





## Available material for training of CAN-MDS Operators





## PREPARATION FOR CAN-MDS OPERATORS' SEMINARS

## TRAINING ROOM, EQUIPMENT & TRAINEES' GROUPS

1. It is suggested that each group consists of 15-20 trainees (max)
  - a. Meeting room setup: U-shaped style is suggested (placing the tables end-to-end with one opening at one end to allow presentations that are visual so that everyone can see and at the same time trainees can use their computers)
2. Make sure in advance that the training room is equipped with a
  - a. computer, projector and a screen for ppt presentations to be projected, and with:
  - b. wireless network (and password to be provided to trainees)
  - c. adequate number of power plugs with adaptors for laptops
3. **IMPORTANT**: Ask in advance from trainees to bring in their laptops or tablets<sup>1</sup>

## PROVISION OF MATERIAL TO TRAINEES IN ADVANCE

1. Provide material in advance: sent to professionals-trainees the national version of the
  - a. CAN-MDS Operator's Manual
  - b. CAN-MDS Data Collection Protocol

## PREPARATION OF OPERATORS' AND AGENCIES' ACCOUNTS IN ADVANCE

1. Identify the professionals-trainees per Agency that will participate in the training (and, later, in the piloting of the system) and ask them to provide you with information to
  - a. Fill in DB2 Agencies-Data Sources<sup>2</sup> - **use this information to create Agencies' IDs**
  - b. Fill in DB3 Professionals-Operators<sup>3</sup> - **use this information to create Operators' IDs****Note:** before starting to create Agencies' and Operators' accounts, be sure that the default language of your Administrator's account is set in your national language setting

**Note:** in all documents and presentations insert logos of your organization; do not delete EC flag and disclaimer (also, ensure adequate visibility of EU funding)

<sup>1</sup> except for the case you have access in a room with adequate PCs

<sup>2</sup> ANNEX I\_Off line databases\_templates of the Step by Step Guide for CAN-MDS Administrators

<sup>3</sup> As above



## EVALUATION AND DOCUMENTATION OF SEMINARS



## EVALUATION

**Building of operators' capacity** via **seminars** will be evaluated via 3 questionnaire-based measures (pre- & post-training & after piloting) in terms of the seminars' **effectiveness** in improving

- knowledge of participants (e.g. on CAN definitions, CRC & UN.C.GC.13 content, relevant legislation, ethics on CAN cases' administration, mandatory reporting);
- sensitization (e.g. on roles & accountabilities, importance of reporting CAN);
- skills via mock cases (e.g. recognition of CAN cases based on signs; procedures for reporting; registration of cases; use of the CAN-MDS system);
- attitudes (e.g. about corporal punishment or routine screening for CAN) and
- self-evaluation of misunderstandings and false beliefs identified & corrected and establishing of intended behavior (action to be taken) when dealing with suspected CAN cases.

Apart from the formal evaluation which is based on the pre- and post- training, a follow-up measure will take place after the end of the piloting. Moreover, the data that will be collected through mock-cases-recording will be used to assess accuracy, validity and reliability of data collection via CAN-MDS.

## DOCUMENTATION of SEMINARS

- Be sure that you have the attendance forms signed by all trainees and trainers for both days of each seminar
- Take some photos from each seminar (in case that some trainees do not agree, avoid faces or use a filter to blur faces afterwards).

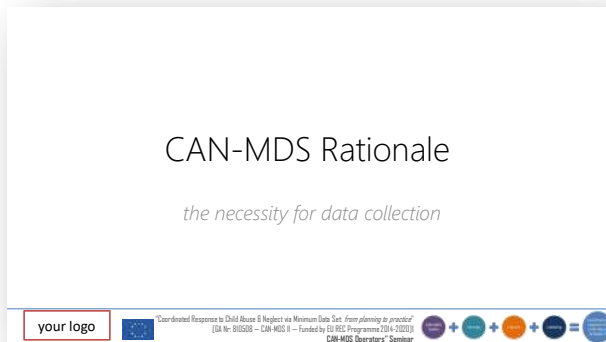


## OVERVIEW OF NECESSARY PREPARATION OF THE MATERIAL

## SESSION 1:

## CAN-MDS Rationale

### PART 1 - PREPARATION



Total slides: 15

Slides to be translated: 12 (1-7 & 11-15)

Slides to be adapted according to country specifics: 3 (8-10)

Note: During the adaptation you can add or remove slides, if needed

### PART 2 - PREPARATION



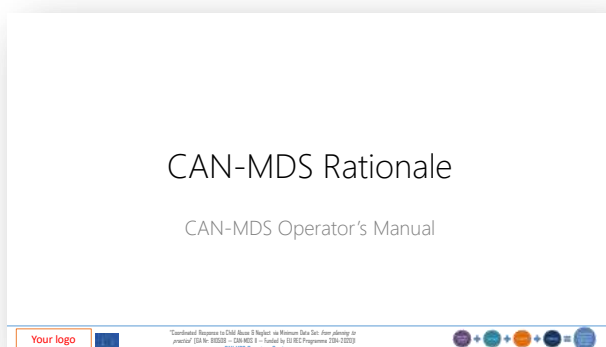
Total slides: 24

Slides to be translated: 15 (1-2 & 11-23)

Slides to be adapted according to country specifics: 9 (3-10 & 24) (see also notes)

Notes: If the situation in your country is similar to the Greek example, then you can keep and use slides 4-10 and 24; if you prepare your own slides, you can add or remove slides according to your needs.

### PART 3 - PREPARATION



Total slides: 27

Slides to be translated: 27

Slides to be adapted according to country specifics: 0  
Notes: Already available translations from your national toolkit

Slides 5, 6, 8, 12, 16 (from the Contents of Operator's Manual)

Slides 7, 11, 13 (from the first part of the manual)

Slides 14, 15, 17, 19, 20, 21 (you can use screen shots from the Operator's Manual)

Slides 26, 27 (objectives as described in the manual)

Slide 25 (screen shot from your national operators' application)

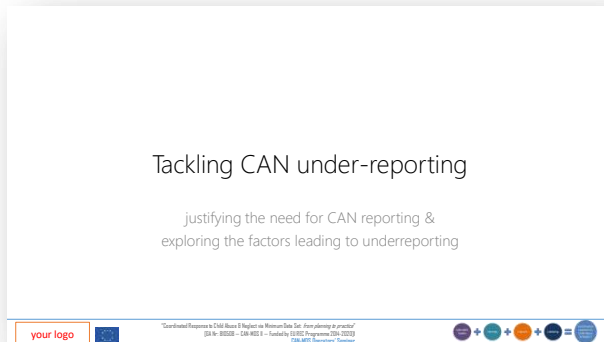
Slide 24, 10 (from the national data collection protocol, Content and Annex I & II respectively)



## SESSION 2:

## Tackling Underreporting

### PART 4 - PREPARATION



Total slides: 56

Slides to be translated: 31 (1-6, 8-11, 13-14, 29-47) + myths/facts

Slides to be adapted according to country specifics: 4 (2, 7, 12, 23); you may add slides, if needed

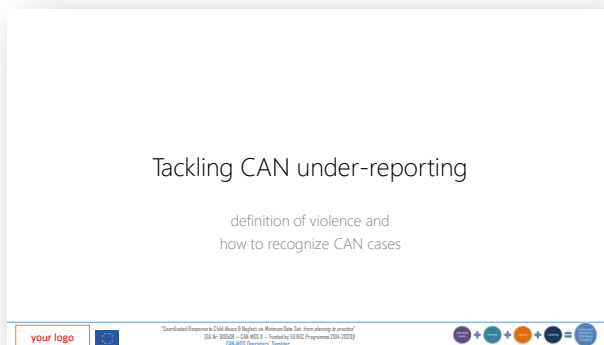
Notes: in this presentation there are slides that may be removed (currently hidden)

15-22 (myths & facts: you may keep all or as much as you like from these slides)

24-28 (you may keep the one related to your country, if any)

48-56 (for further reading, if needed)

### PART 5 - PREPARATION



Total slides: 79

Slides to be translated: 60-78 (all but 31; the variation from 60 to 78 depends on your decision on how many slides you will use including myths and case examples)

Slides to be adapted according to country specifics: 1 (31); you may add slides, if needed

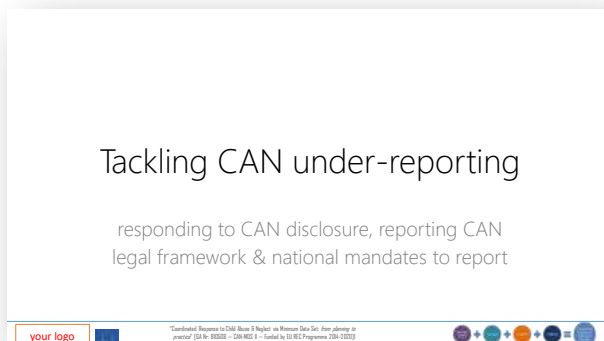
Notes:

5-15 (myths & facts: you may keep all or as much as you like from these slides)

42-48 (case examples: you may keep/adapt all or as much as you like from these slides)

79 (screen shot)

### PART 6 - PREPARATION



Total slides: 31

Slides to be translated: 23 (1-14, 18-20, 23, 27-31)

Slides to be adapted according to country specifics: 8 (15-17, 21-22, 24-26; also slides 2 and 14); you may add slides, if needed

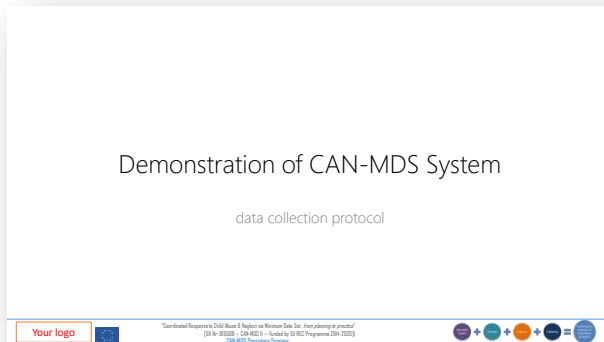
Notes:

27-31 (translation in your language is available in Operator's Manual)

## SESSION 3:

## Demonstration of CAN-MDS System

### PART 7 - PREPARATION



Total slides: 19

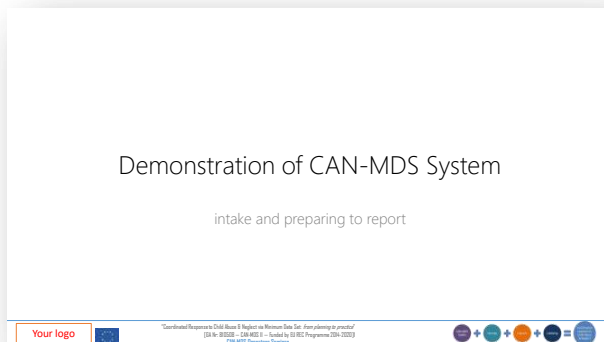
Slides to be translated: 19

Slides to be adapted according to country specifics: 0

Notes:

**8, 15-19** (translation in your language is available in national Data Collection Protocol)

### PART 8 - PREPARATION



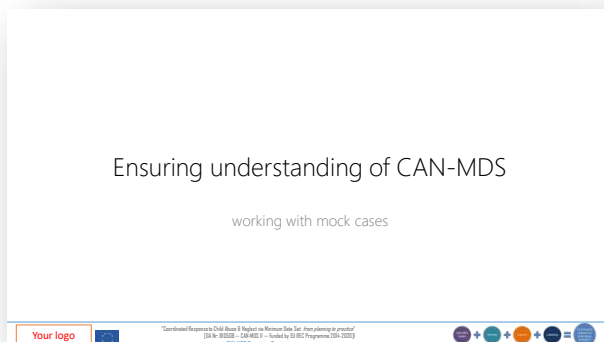
Total slides: 11

Slides to be translated: 11

Slides to be adapted according to country specifics: 1

(7) (if adaptation is needed)

### PART 9 - PREPARATION



Total slides: 7

Slides to be translated: 2 (1, 6)

Slides to be adapted according to country specifics: 0

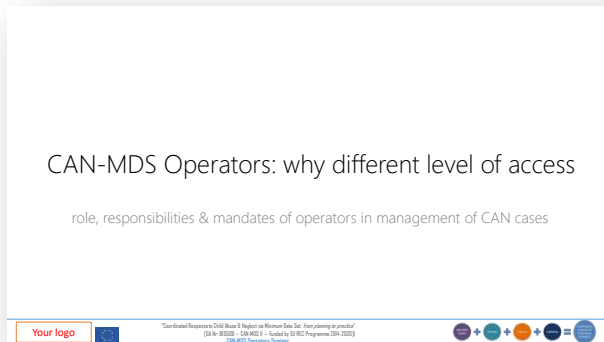
Notes:

**Slides 2-5 & 7** include information for the trainer (no need to be translated)

## SESSION 4:

## CAN-MDS Piloting

### PART 10 - PREPARATION



Total slides: 10

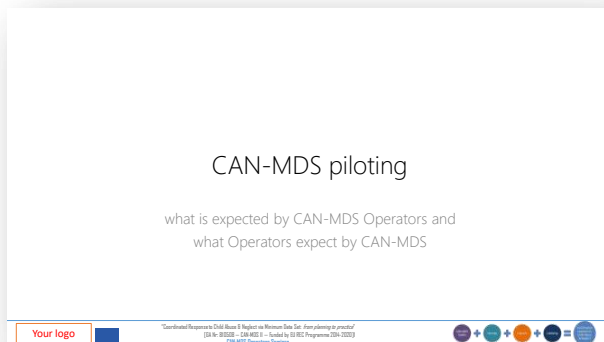
Slides to be translated: 9 (all but 6)

Slides to be adapted according to country specifics: 1 (6)

Notes:

3-5, 7-10 (translation is available in your national Operator's Manual)

### PART 11 - PREPARATION



Total slides: 6

Slides to be translated: 6

Slides to be adapted according to country specifics: 0

Notes:

3-6 (translation is available in your national Operator's Manual)

## PREPARATION OF MATERIAL OTHER THAN PRESENTATIONS

### QUESTIONNAIRES

1a\_Operators\_evaluation\_EN\_pre\_questionnaire

Total files: 2

Files to be translated: 2

1b\_c\_Operators\_evaluation\_EN\_post\_follow-up\_questionnaire

Notes:

- Please keep all questions included in the questionnaires
- You can add some questions you consider necessary
- Post and follow-up questionnaire are identical

### SUPPORTIVE MATERIAL

Tool 1 Mock (vignette) case 1

Total files: 5

Files to be translated: 4

Tool 2 Mock (vignette) case 2

Files to be adapted: 2 (optionally you may adapt mock cases according to country specifics, if needed)

Handout 1

Notes:

Handout 2

Handout 1\_ already translated (see national Data Collection Protocol; pp. 49-50 ANNEX I & II)

Instructions-Working with mock cases

Handout 2\_ already translated (see national Data Collection Protocol; pp. 46-48)

Instructions-Working with mock cases-addressed to trainers, no translation is necessary

### TEMPLATES

Template 1a

Total files: 6

Template 1b

Files to be translated: 5

Template 2a

Files to be adapted: 5 (all but DBs)

Template 2b

Notes:

Template 3

DB2 & DB3 are available in CAN-MDS Step by Step Guide for Administrators, ANNEX I\_Off line databases\_templates (no translation is necessary)

DB2 (Agencies-Data Sources)

DB3 (Professionals-Operators)

### MANUALS

CAN-MDS Training Module

To be translated

CAN-MDS Guide for Trainers

To be translated - Optionally

CAN-MDS Operator's Manual (National)

Already translated

CAN-MDS Data Collection Protocol (National)

Already translated

CAN-MDS Step by Step Guide for Administrators

Already translated - Optionally

### E-APPLICATIONS

CAN-MDS – Operator's App

([www.can-mds.infowood.gr](http://www.can-mds.infowood.gr))

Already translated

CAN-MDS –Administrator's Interface

([www.can-mds.infowood.gr/admin](http://www.can-mds.infowood.gr/admin))

Already translated



## ORGANIZATION OF CAN-MDS OPERATORS' SEMINARS



## DURATION

2 days; 16 hours

## TRAINERS & TRAINEES

### National CAN-MDS Operators' Seminars

**Trainers:** National CAN-MDS Administrators along with Local Coordinators and researchers, who have already participated in the *Training for National CAN-MDS Administrators*.

**Trainees:** Professionals working in relevant sectors that will be identified and recruited according to pre-defined eligibility criteria according to what is provisioned in the customized national pilot plans (see ANNEX I).

## ELIGIBLE PROFESSIONALS' GROUPS PER SECTOR

**Welfare related professions:** Social Workers, Health Visitors, Care providers in institutions, other personnel (e.g. working in anti-trafficking agencies, directorates for disability, Child Ombudsperson)

**Justice-related professions:** Judges (family courts, juvenile courts), Probation Officers, Public Prosecutors, Forensic surgeons' professionals, Lawyers, other justice related professions)

**Health related professions:** Medical Doctors (general doctors and specialized doctors such as gynecologists, pediatricians, orthopedists, and radiologists), Midwives, Nurses, and Dentists

**Mental health professions:** Child Psychiatrists, Psychiatrists, Psychologists, Licensed Counselors (Youth Counselors, Family Counselors, etc.)

**Law enforcement related professions:** Police Officers (in general and specialized police investigators e.g. in forensic interviews, for crimes against minors etc.)

**Education-related professions:** Teachers/Educators (pre-school, kindergarten, primary and secondary education, for children with special needs), School Principals

**Other professionals:** Researchers, Data administrators, other school personnel (e.g. school guardians), other Public officials (e.g. ministries' employees), other NGOs personnel (e.g. volunteers, priests, sisters)

**Note:** for more details see Report *Eligibility criteria for CAN-MDS Agencies & Operators' Groups*

## SUGGESTED PROGRAMME FOR THE CAN-MDS OPERATORS' SEMINARS

### DAY 1: CAN-MDS Rationale & Tackling Underreporting

DURATION: 8 HOURS

09:30–09:45	<b>Welcome</b>
09:45–10:00	<b>Completion of pre-questionnaire</b>
10:00–10:30	<b>CAN-MDS Rationale</b> - the necessity for CAN data collection
10:30–11:00	- the role of multiple sectors, disciplines and how they inter-relate
11:00–11:30	<b>Coffee-break</b>
11:30–13:30	- CAN-MDS Operator's Manual
13:30–14:00	<b>Light lunch</b>
14:00–14:30	<b>Tackling Underreporting</b> - exploring the reasons
14:30–15:30	- how to recognize CAN cases
15:30–16:00	<b>Coffee-break</b>
16:00–17:00	-national mandates to report per Operators group
17:00–17:30	<b>Discussion</b> - emphasis on Q&A
17:30	<b>End of Day 1</b>

### DAY 2: Demonstration of CAN-MDS: working with mock cases

DURATION: 8 HOURS

09:30–09:45	<b>Welcome</b>
09:45–10:45	<b>Demonstration of CAN-MDS System</b> - Data Collection Protocol & tools
10:45–11:00	- demonstration of operator's interface
11:00–11:30	<b>Coffee-break</b>
11:30–13:30	<b>Ensuring understanding of CAN-MDS</b> - working with mock cases: Case 1; reviewing mock case and clarifications - Q&A
13:30–14:00	<b>Light lunch</b>
14:00–15:30	- working with mock cases: Case 2; reviewing mock case and clarifications - Q&A
15:30–16:00	<b>Coffee-break</b>
16:00–17:15	<b>CAN-MDS piloting</b> - what is expected by CAN-MDS Operators and what Operators expect by CAN-MDS - explaining access levels according to operators' roles and mandates - Q&A
17:15–17:30	<b>Post questionnaire &amp; Certificates of Attendance</b>
17:30	<b>End of Seminar</b>

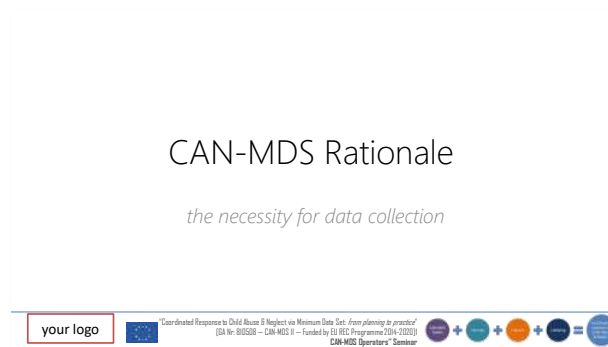




## OVERVIEW OF TRAINING SESSIONS

SESSION 1:	CAN-MDS Rationale
Duration	180 min
Learning objectives	After the completion of Session 1 professionals-trainees will be aware about <ul style="list-style-type: none"> <li>- the necessity of data collection regarding child abuse and neglect incidents</li> <li>- the necessity of coordinated multi-sectoral and multidisciplinary approach for an effective response to child abuse and neglect</li> <li>- the rationale of CAN-MDS system based on a review of the Operator's Manual</li> </ul>
Instructions to trainers	review learning objectives of the sessions & rehearse with slide presentation
Activities	NA
Training resources	Pre-questionnaire (translated & adapted) Presentation Part 1; Presentation Part 2 (translated & adapted) Presentation Part 3 (translated)
Tips	Send the CAN-MDS Operator's Manual and Data Collection Protocol to trainees in advance, asking them to go through the documents

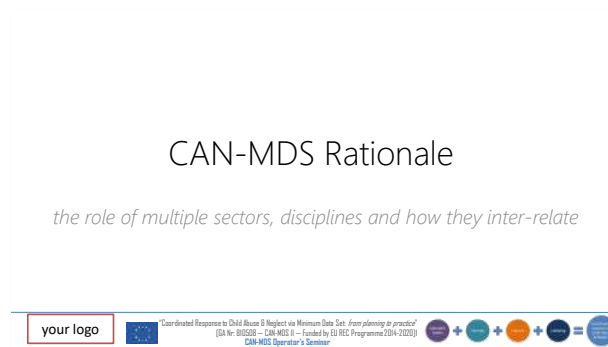
#### PART 1 - DURATION: 30 min



##### Outline

- 'the true extent of child maltreatment is unknown'
- what the available data show: underestimation of the extent of the problem
- exploring the factors leading to underestimation

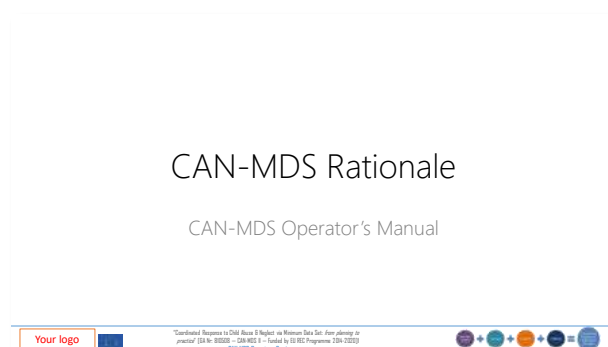
#### PART 2 - DURATION: 30 min



##### Outline

- Current multi-sectoral approach of CAN incidents
  - CAN incident administration at a case level: the [national] example
  - CAN at a public health level
- Sectors providing services to children
  - different responsibilities → different interests → different data
- why and how the minimum data set (MDS) was developed

#### PART 3 - DURATION: 120 min

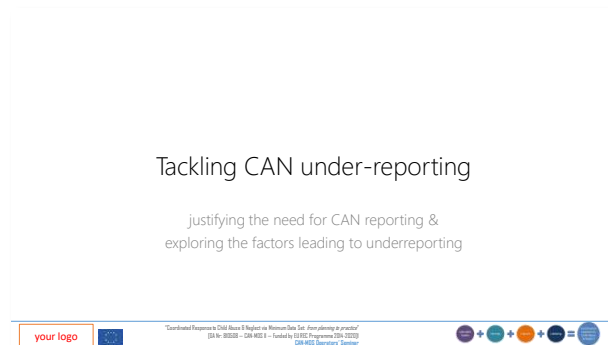


##### Outline

- Brief overview of the toolkit
- Operator's Manual: Content & Structure
  - PART 1 Introducing the CAN-MDS
  - PART 2 The Operator's Guide
  - PART 3 CAN-MDS Data-Dictionary
- Examples
- Other components of CAN-MDS Toolkit at a glance
- Possible uses of CAN-MDS Data

SESSION 2: Tackling Underreporting	
Duration	150 min
Learning objectives	<p>After the completion of Session 2 professionals-trainees</p> <ul style="list-style-type: none"> <li>- are fully informed about what is CAN and its specific types</li> <li>- are familiar with the operational definitions of CAN on the basis of CRC, Art. 19 and GC 13 of UN CRC (2011)</li> <li>- are informed on how to recognize signs of child abuse and/or neglect</li> <li>- are aware of the procedures to be followed upon the identification of a (suspected) CAN case (recognizing; reporting; registering; providing services; referring to other agencies; follow-up of cases)</li> <li>- are aware on their role and responsibilities in the course of administrating a CAN case and under which circumstances a case should be reported either to authorities in charge (depending on country) or by the professionals themselves directly via the system</li> <li>- are aware of what is provisioned by the law as well as for their own professional field's mandates for reporting</li> <li>- have a common understanding on what are the ethical principles governing CAN data collection, including the importance of data confidentiality, legislative provisions, and professionals' codes of ethics</li> </ul>
Instructions to trainers	be familiarized with the presentations (see detailed information below)
Activities	NA
Training resources	<p>Presentation Part 4 (translated &amp; adapted)</p> <p>Presentation Part 5 (translated &amp; adapted)</p> <p>Presentation Part 6 (translated)</p>
Tips	Send the CAN-MDS Operator's Manual and Data Collection Protocol to trainees in advance, asking them to go through the documents

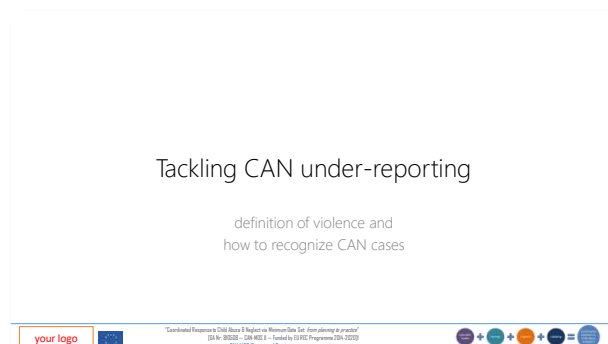
#### PART 4 - DURATION: 30 min



##### Outline

- What is a report of child abuse and/or neglect
  - Official definition in [country]
- What is CAN underreporting
  - Current situation in [country]
- Exploring the reasons of underreporting
- The need to tackle underreporting
- Connection of CAN under-reporting & CAN surveillance

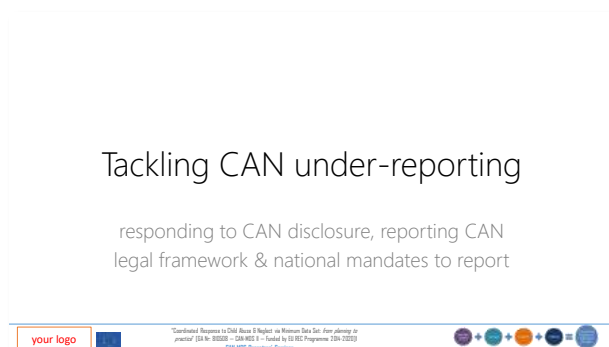
#### PART 5 - DURATION: 60 min



##### Outline

- Child abuse and neglect - *myths & facts*
- Definition of violence against children
  - legal analysis of CRC Art. 19 [UNCRC, GC 13 (2011)]
  - Explore forms of violence - *case examples*
- Recognizing child abuse and neglect
  - warning signs
- Short- and long term consequences of child abuse and neglect
  - at a glance

## PART 6 - DURATION: 60 min



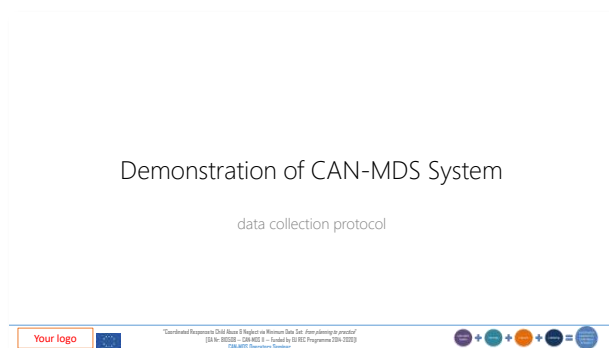
### Outline

- why children don't tell if they have been abused and/or neglected and why children reveal abuse
  - responding to a child who discloses being abused or neglected - *Do and Don't*
- the procedure of reporting child abuse
  - *Who must report* – national legislative context and the mandate to report CAN
  - *Why to report / When should report / Where to report / What to report / Non reporting*
- Connection of reporting to CAN-MDS and recording

## SESSION 3: Demonstration of CAN-MDS System

Duration	285 min
Learning objectives	After the completion of Session 3 professionals-trainees will be aware about <i>the CAN-MDS system and how it operates, namely</i> <ul style="list-style-type: none"> <li>- <i>which are the data elements comprising the minimum data set</i></li> <li>- <i>which cases are eligible to be recorded in the system</i></li> <li>- <i>what is the data entry procedure [record of (suspected) incident; information for child and family; services' response (institutional response and referrals made); how to communicate with and provide feedback to other professionals-operators (at case-level)]</i></li> <li>- <i>how to use the system (working in real time with mock-CAN cases)</i></li> </ul>
Instructions to trainers	be familiarized with the presentations (see detailed information below)
Activities	NA
Training resources	Presentation Part 7; Presentation Part 8); Presentation Part 9 (translated) Trainees-Operators' usernames and passwords Mock cases 1 & 2 e-app (online)
Tips	Send the CAN-MDS Operator's Manual and Data Collection Protocol to trainees in advance, asking them to go through the documents

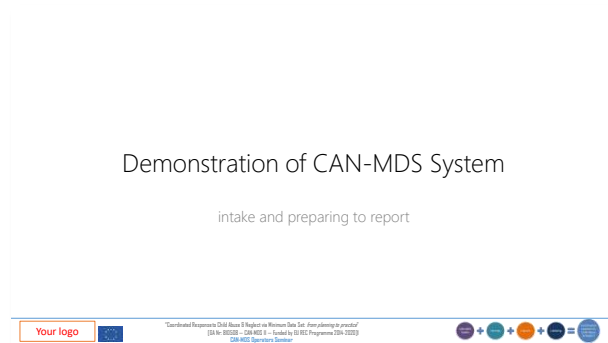
## PART 7 - DURATION: 60 min



### Outline

- CAN-MDS Data Collection Protocol
- who could be using CAN-MDS to report CAN ?
- where does information about CAN case come from?
- means of communication of information for a CAN case
- when a CAN case is suspected or identified
- step by step recording when a CAN case
  - *is identified or suspected by the Operator (or after disclosure)*
  - *is reported to an Agency by a source of information*

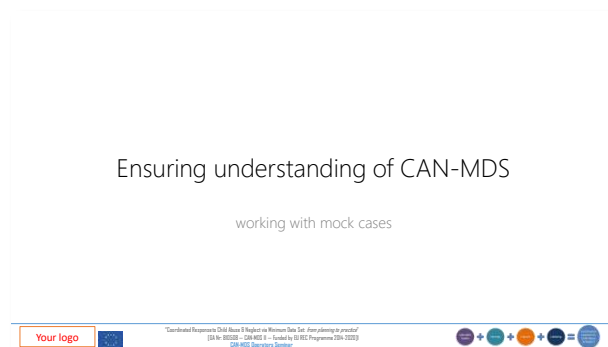
## PART 8 - DURATION: 15 min



### Outline

- ▀ starting the intake
- ▀ entering data sequentially in CAN-MDS
- ▀ practice exercise
  - ▀ *using TEMP ID*
  - ▀ *replacing TEMP ID with Child ID*

## PART 9 - DURATION: 210 min



### Outline

- ▀ Ensuring understanding of CAN-MDS via simulation
- ▀ [Preparation → for trainers]
- ▀ Instructions to trainees-operators
  - ▀ *before starting*
- ▀ [Instructions → for trainers]
  - ▀ *reviewing the records and clarifications*

## SESSION 4: CAN-MDS Piloting

**Duration** 75 min

**Learning objectives** After the completion of Session 4 professionals-trainees will be fully informed *on how levels of access to the system are granted and what is expected by them as system's Operators and how they will benefit by the system in their everyday practice depending to their roles and accountabilities*

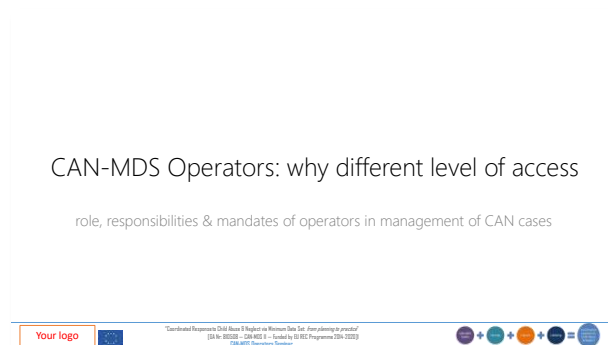
**Instructions to trainers** be familiarized with the presentations (see detailed information below)

**Activities** NA

**Training resources** Presentation Part 10 (translated)  
Presentation Part 11 (translated)  
Post questionnaire

**Tips** Send the CAN-MDS Operator's Manual

## PART 10 - DURATION: 30 min



### Outline

- ▀ who can become a CAN-MDS Operator?
- ▀ prerequisites for an eligible professional to become CAN-MDS Operator
- ▀ defining Level of Access to CAN-MDS according to responsibilities of stakeholders in managing CAN cases
  - ▀ *Examples*
  - ▀ attributes & "rights" per level of access

## PART 11 - DURATION: 45 min

CAN-MDS piloting

what is expected by CAN-MDS Operators and  
what Operators expect by CAN-MDS

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[REC-RDAP-GBV-AG-2017/ 810508] - CAN-MDS 1.0 - funded by [REC-Programme 2016-2020]  
CAN-MDS Operators Summary

### Outline

- ▀ objectives of CAN-MDS System – summing up
- ▀ what is expected by the Operator to contribute to CAN-MDS
  - ▀ what CAN-MDS can provide to Professionals-Operators

## DETAILED PRESENTATION OF TRAINING SESSIONS

Note: The information provided below aims to facilitate Trainers to use the suggested presentations. You can modify the wording and adapt it to your personal style. Moreover, you can add information you consider as missing or to skip information you think are not necessary taking into account the characteristics of the trainees

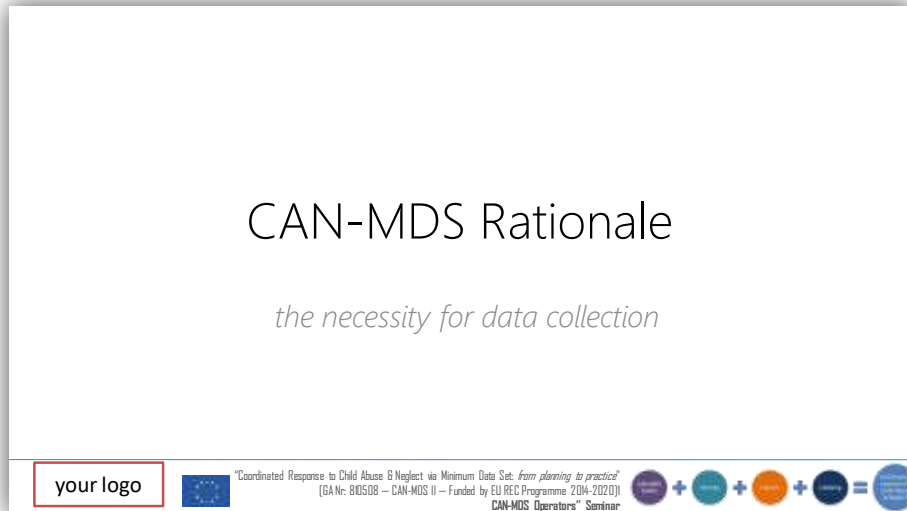
DO'S AND DON'TS OF TRAINING	
<ul style="list-style-type: none"> <li>▶ <i>prepare in advance</i></li> <li>▶ <i>use visual aids</i></li> <li>▶ <i>encourage questions</i></li> <li>▶ <i>recap at the end of each session</i></li> <li>▶ <i>use good time management</i></li> <li>▶ <i>check to see if your instructions are understood</i></li> </ul>	
	<ul style="list-style-type: none"> <li>▶ <i>talk to the presentation</i></li> <li>▶ <i>block the visual aids</i></li> <li>▶ <i>stand in one spot</i></li> <li>▶ <i>ignore the participants' comments &amp; feedback</i></li> <li>▶ <i>read from manual</i></li> <li>▶ <i>shout at participants</i></li> </ul>



SESSION 1 – DURATION: 180 MIN (3h)

PART 1 – DURATION: 30 MIN

Slide 1



[Instruction: start the presentation after the completion of the pre-questionnaire]

This training aims to provide professionals working with and/or for children with adequate information about the necessity of recognizing CAN incidents, reporting to authorities, recording and data collection and how the CAN-MDS system aims to contribute in tackling underreporting and child maltreatment in general.

First, an effort will be made to explain the rationale of the CAN-MDS system as a "coordinated response" of relevant sectors to CAN underreporting.

Slide 2

## Outline

- *'the true extent of child maltreatment is unknown'*
- what the available data show: underestimation of the extent of the problem
- exploring the factors leading to underestimation of the extent of the problem

We will start with the commonly accepted opinion that *'the true extent of child maltreatment is unknown'* and how this is valid for our country too. We'll see what the available data show and what are the factors leading to underestimation of the magnitude of the problem of child maltreatment.

Slide 3

[European report on preventing child maltreatment, 2013]








"child abuse and neglect are a product of social, cultural, economic and biological factors and occur in all societies"

 CAN-MDS Operators' Seminar     

When we are talking about child abuse and neglect we are actually discuss about a public health problem which occurs in all societies and as we already know this is true for the Europe too.

Slide 4

<b>What is the true extent and the nature of the problem of child abuse and neglect in our country?</b>	<b>"we do not know"</b> <i>"Given the evolving nature of the identification, detection, and response to child maltreatment, no existing data collection system can represent all maltreated children"</i> (Fallon et al. 2010)
<b>What is the number of child maltreatment cases reported during the last year in our country?</b>	<b>"we do not know"</b> This, however, is a totally different question and the response would be just as simple and known!
	<b>Why?</b> Because until now there is no mechanism in place for systematic reporting and/or recording of reported cases of child abuse and neglect

<see slide>

Slide 5

**Why is it important to know about the number of children affected by abuse and neglect?**


because

- the lack of reliable information as to the number of children affected by child abuse and neglect has been identified as a "serious limitation in lodging an effective public health response" (Leeb et al. 2008)
- gaining insight into the extent and nature of child maltreatment, on the other hand, "is the foundation for prevention of child maltreatment" (Fallon et al. 2010)



<see slide>

Slide 6



The image shows an iceberg floating in water. Only the very top tip of the iceberg is visible above the water line, while the vast majority of the iceberg's mass is submerged below the surface. This visualizes the concept that official cases are just the 'tip of the iceberg' and significantly underestimate the true extent of child maltreatment.

**'the number of official cases clearly underestimates the true extent of the problem'**

**'reporting rates of child abuse and neglect shall be improved'**

- *UN Committee on the Rights of the Child*  
"...strengthen mechanisms for data collection by establishing national central database ..."

CAW/MDS Tools + Steps + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

This is what the literature says:

- (1<sup>st</sup> box comment) the "tip-of-the-iceberg analogy easily comes to mind when one thinks of the scope of child maltreatment"
- (2<sup>nd</sup> box comment) This is what the comparison among *self-report* and based on *administrative data* surveys shows.
- (3<sup>rd</sup> box comment) Everybody –including professionals- has a duty to proceed with the reporting to authorities of concerns involving threats for children's safety.

Slide 7

## what the available data show in our country

[Preparation: Adapt slides 7-9 by providing data related to your country; e.g. from the policy brief or other sources]

Slide 8 [hidden slide - example]

### the wider picture: Greece

[CAN surveillance in Greece: current policies and practices - Country Profile report]



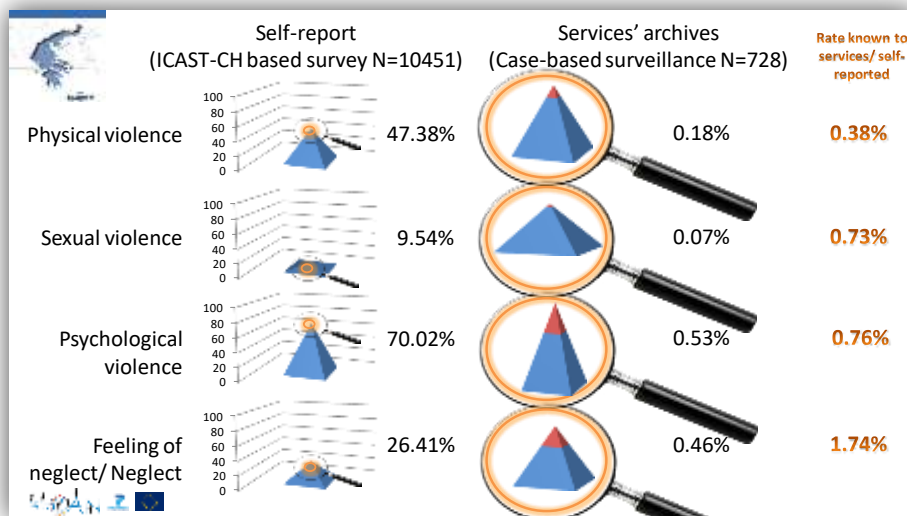
**"... lack of epidemiological data** for the assessment of the magnitude of the problem at a National level. ... **lack of systematically recording of CAN data** that makes difficult –even impossible– the measuring of the extent of the phenomenon during the time as well as the identification of its specific characteristics and, subsequently, of any risk factors. Given that **there is no CAN Surveillance mechanism in place as well as no mandatory reporting and registering procedure, agencies and professionals working in the field use different CAN definitions and therefore classification criteria as well as different assessment methodologies for recording CAN.** In front of lack of these data the policy and services planning is difficult as **there is no scientific basis for policy makers to build upon by setting priorities for prevention and targeted intervention"**

The Greek example [please provide the example of your country]

In Greece there is no fully coordinated child protection system (as such a system defined e.g. by UNICEF)  
Apart from a few exceptions, there is a lack of epidemiological data on CAN, while no surveillance mechanism is currently in place.

Where data are collected, different definitions, methodologies and tools are used

Slide 9 [hidden slide - example]

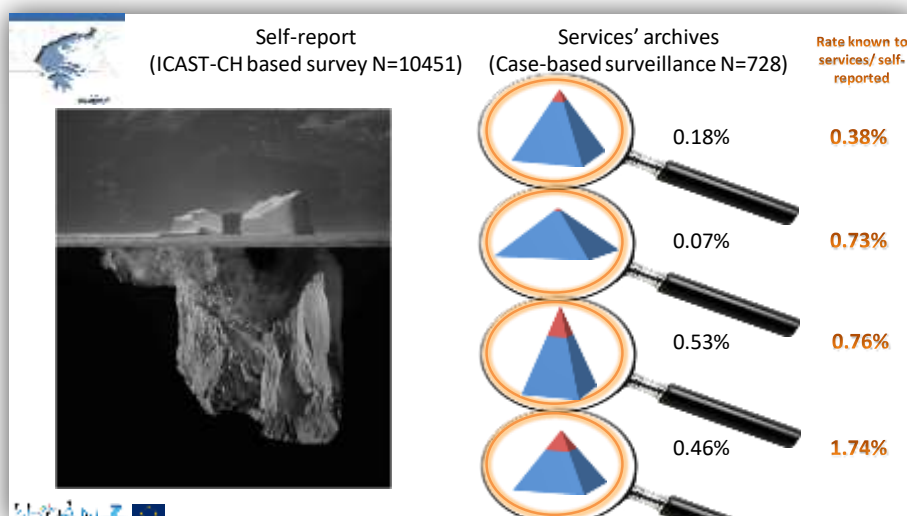


This is the case of Greece.

You will see the main findings of the of the Balkan epidemiological study on child abuse and neglect an FP7 project, which was conducted in nine Balkan countries from 2011 to 2012 with representative sample of children aged 11, 13 and 16 year old as well as the results of the case-based surveillance study which was conducted in the same geographic areas for the same ages in the nine countries.

The gap between the self-reported incidence rates and the rates related to CAN cases known to services per type of violence is explicitly illustrated. The last column gives the rates of known cases to services to self-reported rates of adverse experiences. Despite any methodological weaknesses of the CBSS, these rates underlie the small number of cases that eventually reach one at least agency –confirming, of course, the iceberg phenomenon!

Slide 10 [hidden slide - example]



We are talking about a well-known phenomenon in the field of child abuse and neglect

Slide 11

**which are the factors leading to this gap?**

**under-reporting due to**

- lack of legislation for mandatory reporting
- the reporting procedure
- resistance of professionals to proceed with reporting (because of no legal immunity etc)...

Therefore, the question that arises (for once more) is which are the factors that lead to this gap?  
More or less, we can include the limitations that are typically observed in any other health surveillance system related to data collection such as UNDER-REPORTING

<see slide>

Slide 12

**which are the factors leading to this gap?**

**data collection-related limitations**

- **under-recording** and/or **lack of timeliness in recording** due to under-reporting and/or because of
  - the recording procedure (time consuming because of unmanageable form or procedure)
  - lack of incentive for recording
- **distrust of the system and its necessity**
  - lack of feedback lead to perception that there is no action on the record
- **often services and, consequently professionals-responsible to collect CAN data are not aware of**
  - the responsibility to record (e.g. assume that someone else would record)
  - which cases must be recorded and of how to make the record
  - or have a negative attitude toward the recording process, e.g. concern that recording may result in a breach of confidentiality or that recording compromises the professional-(alleged) victim relationship

UNDER- RECORDING due to under-reporting or because of the reporting procedures and lack of legislation or mandatory reporting, lack of incentive for recording due to lack of feedback leading to the perception that there is no action on the record; often professionals are not aware of the responsibility or the process to make a record or even which cases must be recorded

<see slide>

Slide 13

**which are the factors leading to this gap?**

**data analysis-related limitations**

- data collection is based on services' responses to (self)-reported cases
- lack of representativeness (mostly cases deriving from specific sources, e.g. CPS or legal system)
- disagreement with the need to record specific cases after determining that the case is not that serious or recording mainly severe cases leading to an inflated estimate of severity

Other limitations related to data analysis (in CAN the information usually derives either from judicial services or from child protection services)

<see slide>

Slide 14

**which are the factors leading to this gap?**

**data interpretation-related limitations**

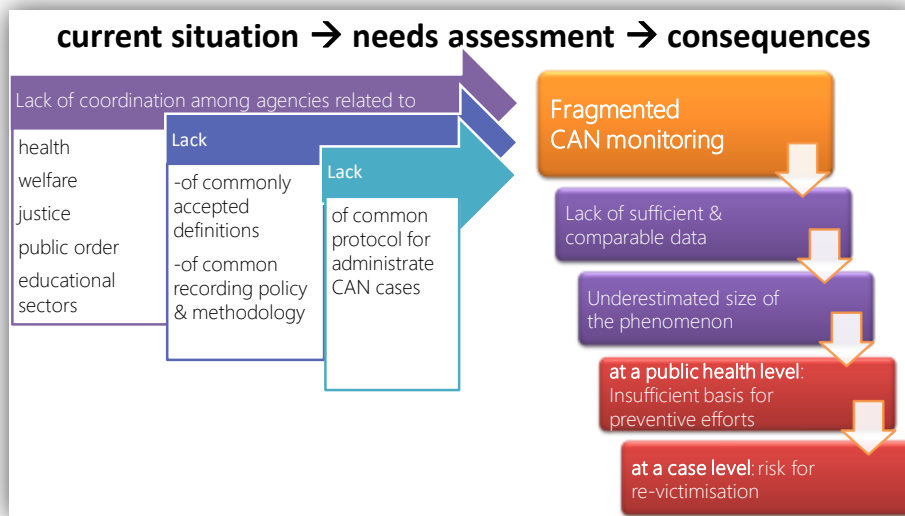
- "Case definitions" related difficulties: different definitions; inconsistency of case definitions
- usage of different data collection tools, procedures & methodologies (not harmonized data)

Additionally specific attributes of child maltreatment that are related, for example, to data interpretation (data are collected via different methodologies and tools while different definitions are used) add further limitations.

<see slide>



Slide 15

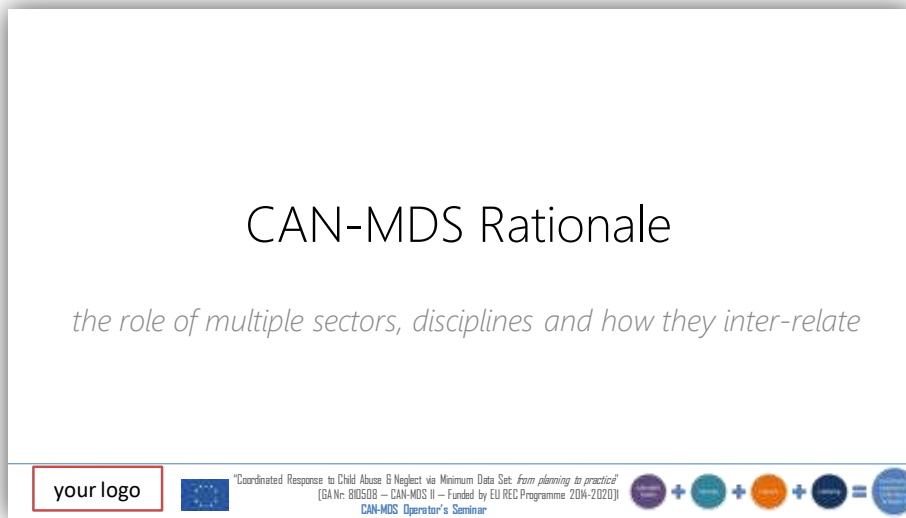


Summarizing:

Lack of coordination among sectors and lack of commonly accepted definitions and recording policies (namely a common protocol for administering CAN cases) lead to fragmented monitoring of child abuse and neglect; available data are neither adequate (in terms of quantity) nor comparable (in terms of quality) for providing a reliable picture of the magnitude of the problem, which is usually underestimated; without these crucial data, effectiveness evaluation of currently applied policies and practices is not feasible, and data-driven further preventive efforts could not be made.

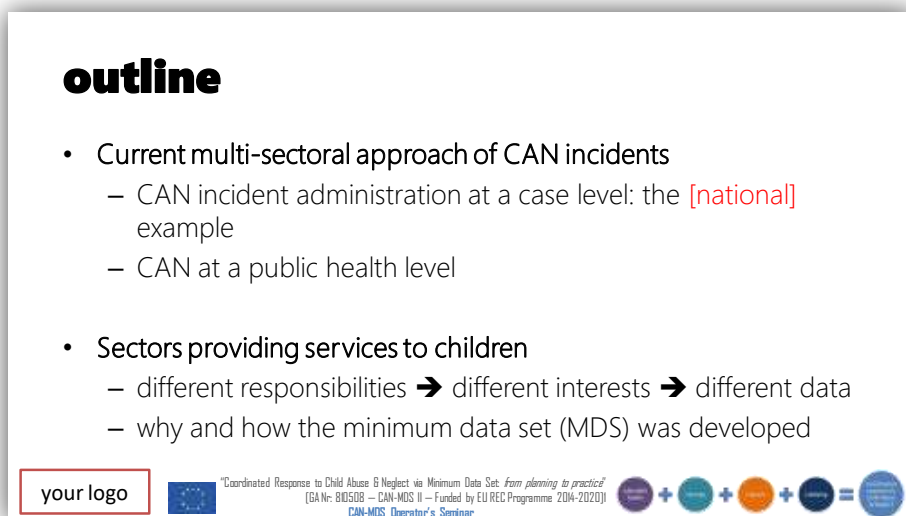
PART 2 – DURATION: 30 MIN

Slide 1



Now we are going to present the rationale of the CAN-MDS system as a “coordinated response” of relevant sectors and professionals to CAN underreporting.

Slide 2



- Current multi-sectoral approach of CAN incidents
  - CAN incident administration at a case level: the [national] example
  - CAN at a public health level
- Sectors providing services to children
  - different responsibilities → different interests → different data
  - why and how the minimum data set (MDS) was developed


[Instruction-insert the name of your country]

First the current multi-sectoral approach of CAN will be outlined along with the difficulties that usually arise in management of CAN incidents and the consequences at a case level and at a public level.

Next the necessity for coordinated multi-sectoral approach will be discussed as well as the reason led to the development of the CAN-MDS.

Slide 3 [hidden slide - example]

### Current multi-sectoral approach of CAN incidents: Greece [your country]



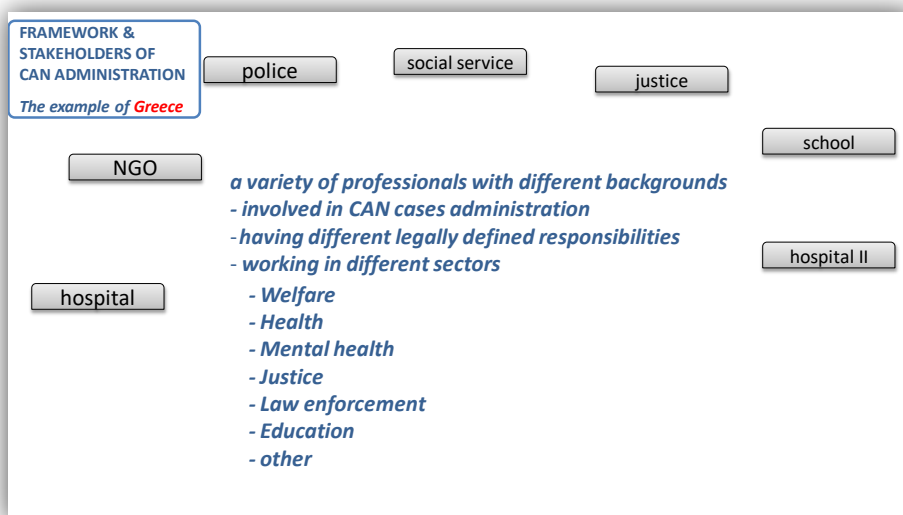
**"... lack of epidemiological data** for the assessment of the magnitude of the problem at a National level. ... **lack of systematically recording of CAN data** that makes difficult –even impossible- the measuring of the extent of the phenomenon during the time as well as the identification of its specific characteristics and, subsequently, of any risk factors. Given that **there is no CAN Surveillance mechanism in place as well as no mandatory reporting and registering procedure, agencies and professionals working in the field use different CAN definitions and therefore classification criteria as well as different assessment methodologies for recording CAN.** In front of lack of these data the policy and services planning is difficult as **there is no scientific basis for policy makers to build upon by setting priorities for prevention and targeted intervention"**

[CAN surveillance in Greece: current policies and practices - Country Profile report]

[Instruction-Replace this information with information describing the situation in your country]

In Greece actually there is no child protection system; with few exceptions, there is a lack of epidemiological data on CAN, while no surveillance mechanism is currently in place; where data are collected, different definitions, methodologies and tools are used

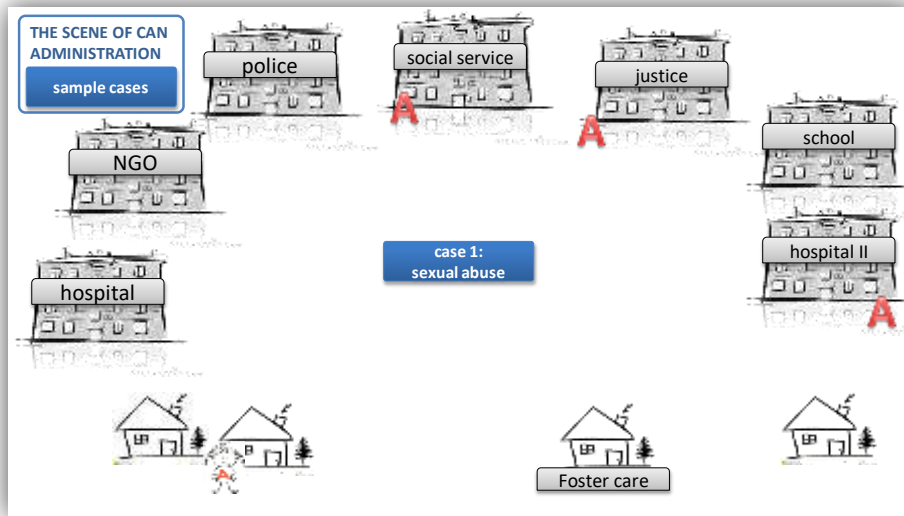
Slide 4 [example]



[Instruction: if the situation in your country is similar to Greece, please keep this example with necessary modifications (slides 4-10); otherwise replace these slides describing the situation in your country]

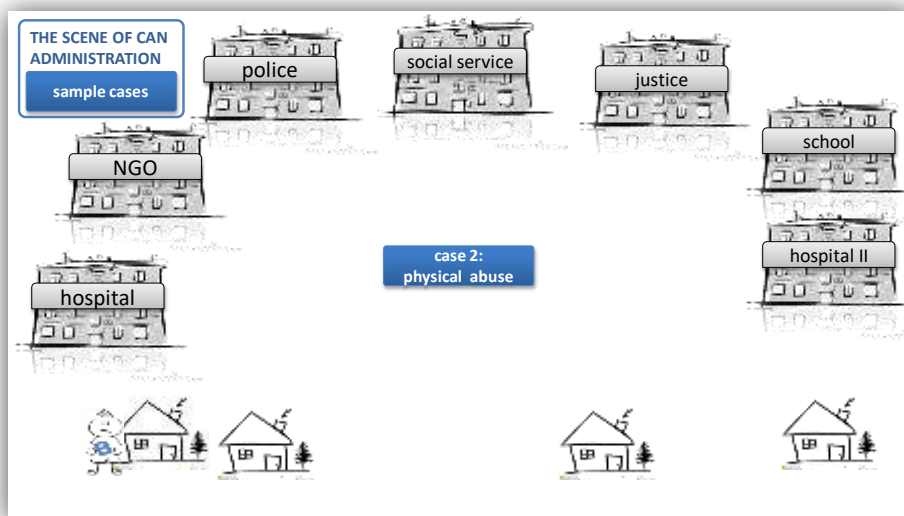
Let's see some more details on how a case of child maltreatment is administered in Greece. A variety of professionals working in different sectors and agencies, with different legally defined responsibilities are involved in the route of a CAN case administration.

Slide 5



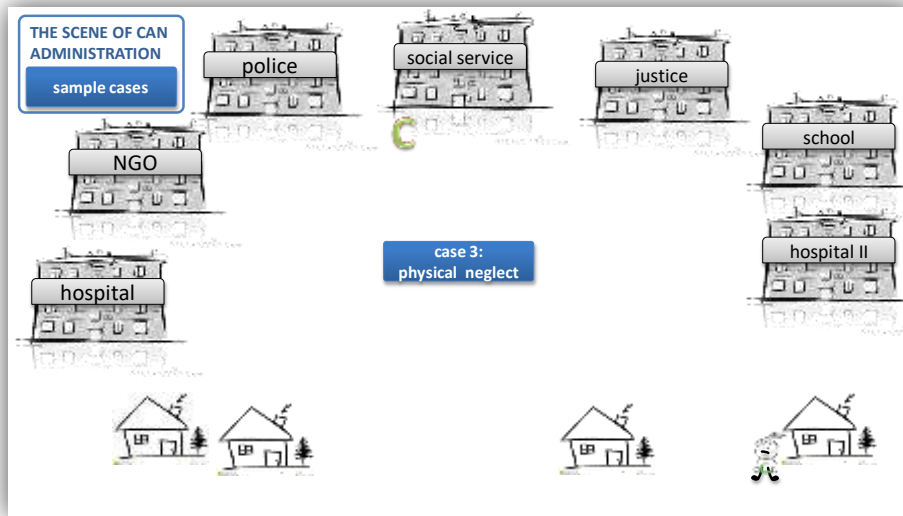
Let's suppose that we are talking about a case of sexual abuse; the teacher identify that something seems wrong and s/he reports the case to the social service of the municipality; they can keep a record and refer the child to a pediatric hospital (for physical exams, where another record is kept); the case is also referred to the prosecutor, who finally decides to place the child in alternative care (e.g. foster care) and also keeps a record on the case. This is a well-organized example that it is usually not the case.

Slide 6



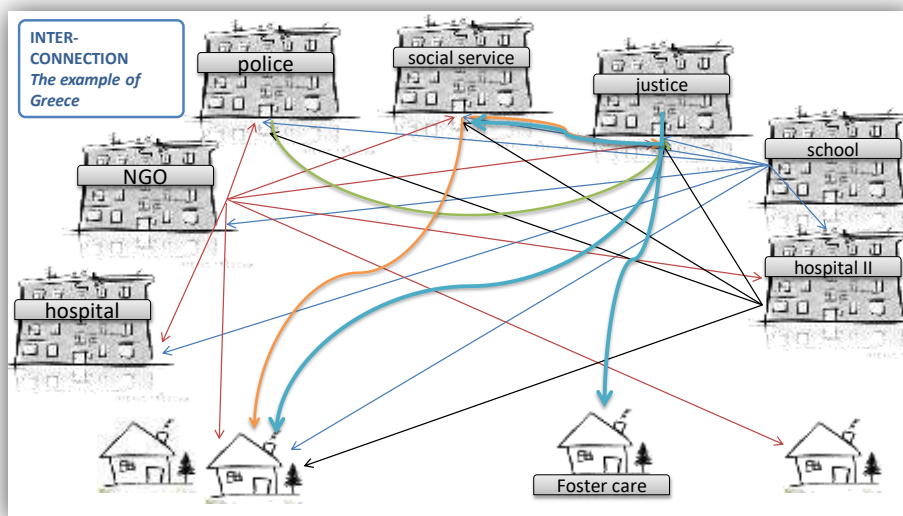
Let's suppose that a child is physically abused; after an incident the child ended up with an injury caregivers address a hospital seeking medical care; the hospital provides the care and the child goes back home; after a period the child suffers again some physical harm and care givers address another hospital seeking medical care; the other hospital provides the care and the child goes back home; no record is made and no referral is made to other authorities.

Slide 7



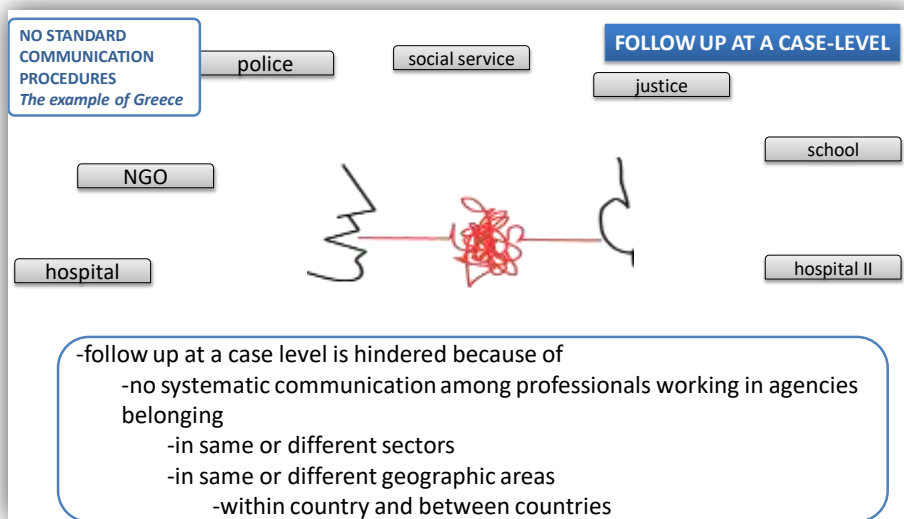
Last, in our example, a physically neglected child is identified by the teacher; s/he addresses a request for family support to an NGO and the NGO in turn refers the child to social services; they decide to intervene with the family, without however informing the prosecutor (because they consider that it's not necessary); a record of the case is available in the archives of the specific social service and the information is not communicated to any other authority.

Slide 8



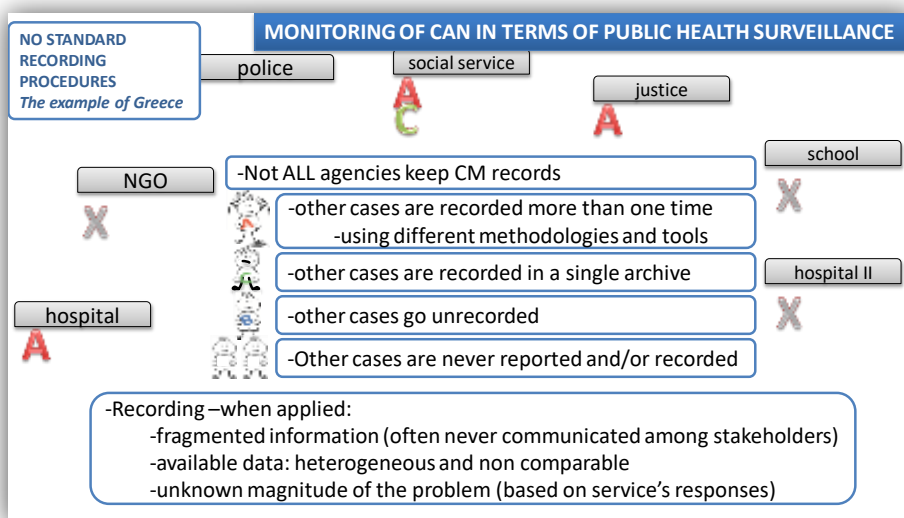
Actually, currently almost everyone can –hypothetically– communicate with everyone but without following standard procedures and only if they consider that it is needed

Slide 9



Monitoring of the child over time and follow up are not possible as no systematic communication is provisioned among professionals working in agencies belonging in the same sector (e.g. among social services) or in different sectors (e.g. welfare and health); as you understand, communication among professionals in charge for specific cases does not exist between different regions and of course at a national (and even worse) at an international level.

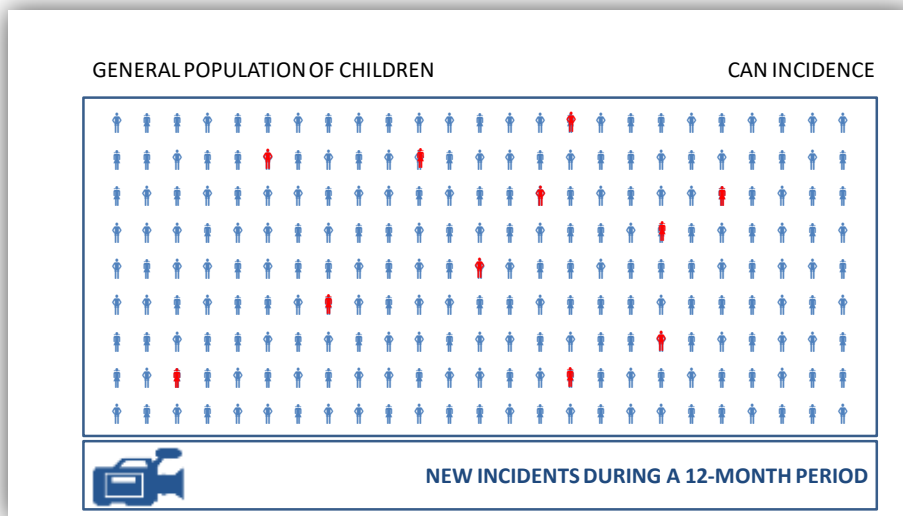
Slide 10



As for our records-based knowledge of the extent of the problem there are also a problem, as is presented in the slide: not all agencies keep records: some cases are recorded more than one time based on different definitions, methodologies and tools. Other cases are recorded in a single archive and the information is communicated nowhere while other cases go unrecorded despite they reached an agency. Lastly, many cases are never reported and/or recorded.

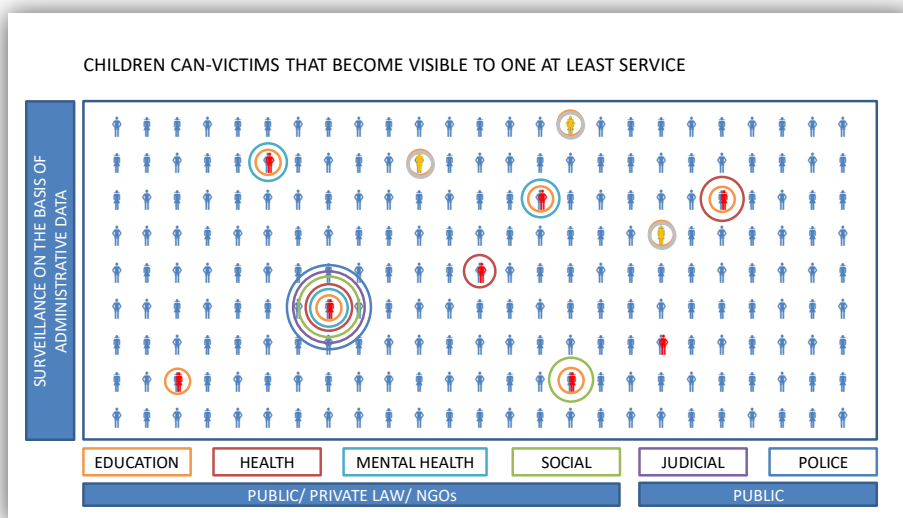
Moreover, recording –when applied is fragmented information (often never communicated among stakeholders). The available data are heterogeneous and non comparable and eventually the magnitude of the problem (based on service's responses) is unknown

Slide 11



Let's leave the cases and go back to the population. Child abuse and neglect is recognized as a major public health problem, the magnitude of which is often unknown because of various difficulties related to the characteristics of the problem (multiple types, secrecy, cultural issues), the population group (minors/ too young) and the public health surveillance (definitions, commitment of different stakeholders).

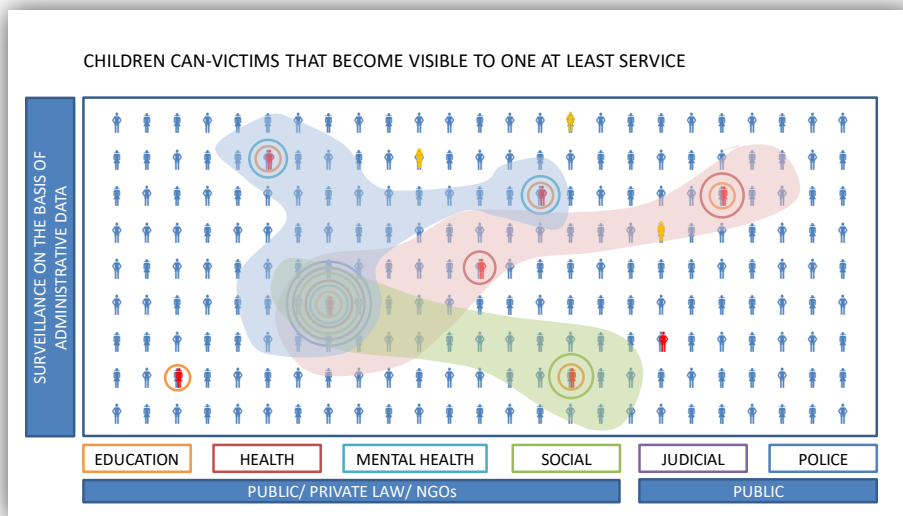
Slide 12



For measuring systematically incidence of CAN we should be starting with the response of services where children of the general population sought help or are in contact with (**according to their age and specific personal characteristics**) and therefore, these are the places where, most likely, children-victims first become visible.

Some cases can be identified in more than one different settings/ sectors (giving a false sense of more severe cases) while other cases may never identified and remain invisible.

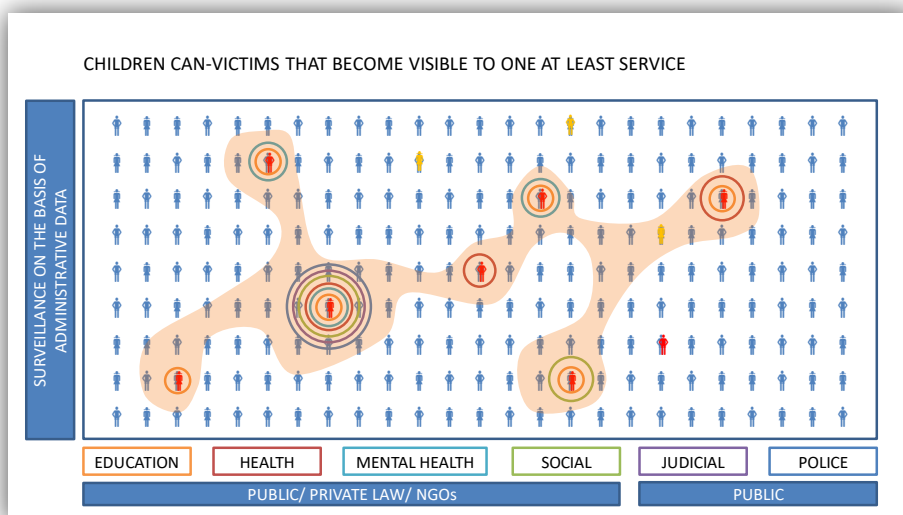
Slide 13



In the educational sector there is no provision for **keeping records** of CAN incidents, given that the teachers are often mandated only to report their concerns in other authorities. Many cases, however, are identified or disclosed by children exclusively in educational settings. If no reporting takes place, then only cases identified and recorded in other sectors (without including educational sector) are taken into account leading to the under-estimation of the problem.

On the other hand, if we try to put together all available records (child protection system, social welfare, NGOs, police etc.), then we will have potential duplication of cases and in any case available data are not expected to be comparable.

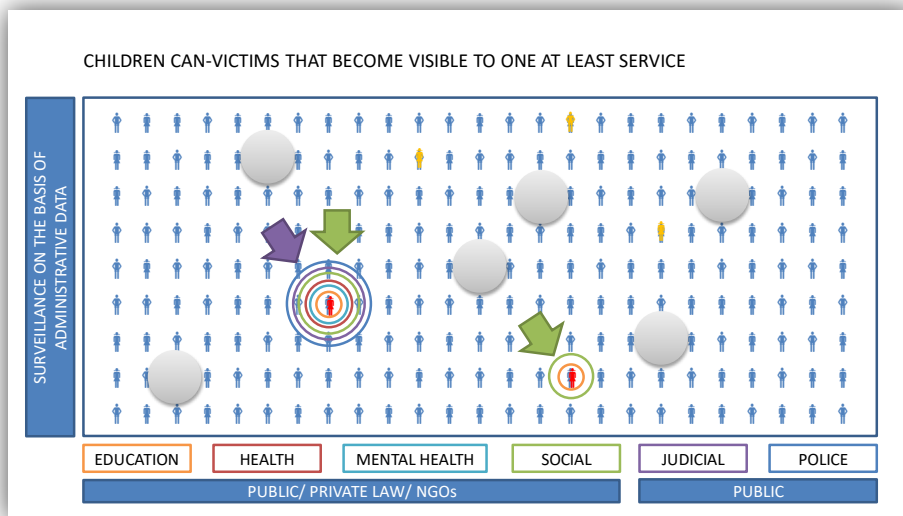
Slide 14



...While the real picture of CAN incidence in our example will be this one.

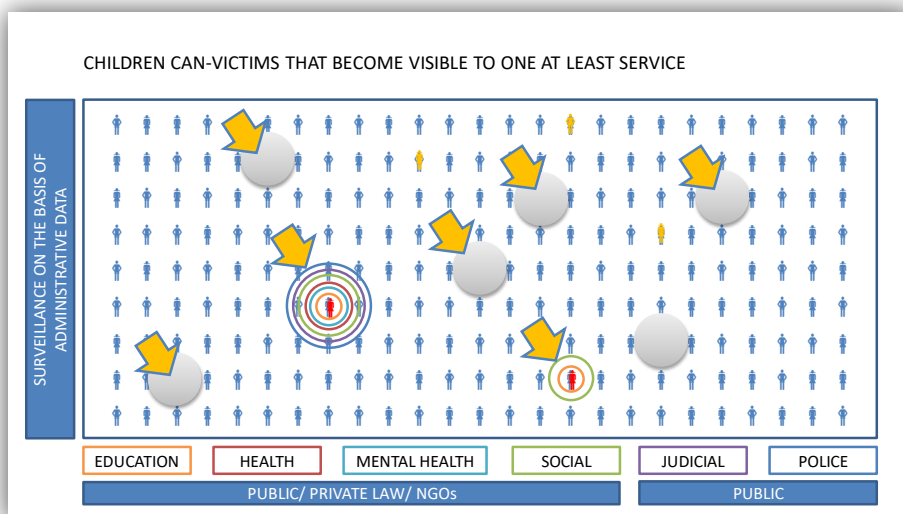


Slide 15



By examining records from various services, the ones including information about CAN were mainly social services and justice/police files. In our example, incidence of CAN would be restricted to only these cases while the remaining cases would not be visible.

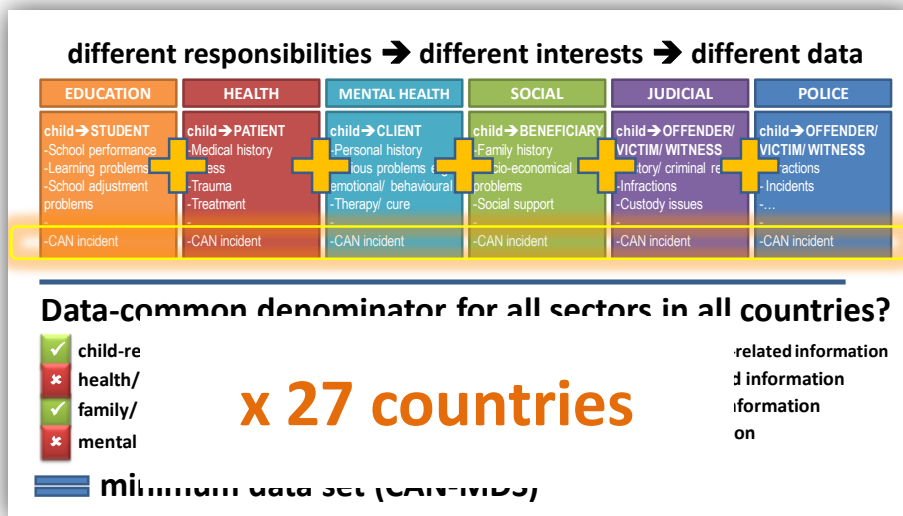
Slide 16



To undertake the necessary measures to deal with CAN at a public health level, however, we should know the real picture, to know all cases.

And, as you can see, even though all services responded sufficiently, again it is expected that some cases will remain invisible (considering that some children do not contact any of the services).

Slide 17



What is the difficulty?

Theoretically the same child can be in contact and receive services by many different services in different sectors. Records can be made in all sectors but with a different focus.

Specifically, in school, the child is student and the available information, apart from some information for the child and its family concerns school performance, etc. Respectively, for the health sector the child is patient and the records focusing in illness, injuries etc.

Think all these differences and the difficulties of communication of information within sectors at a national level and between countries at an EU level (due to different focus, different interests, different available data...).

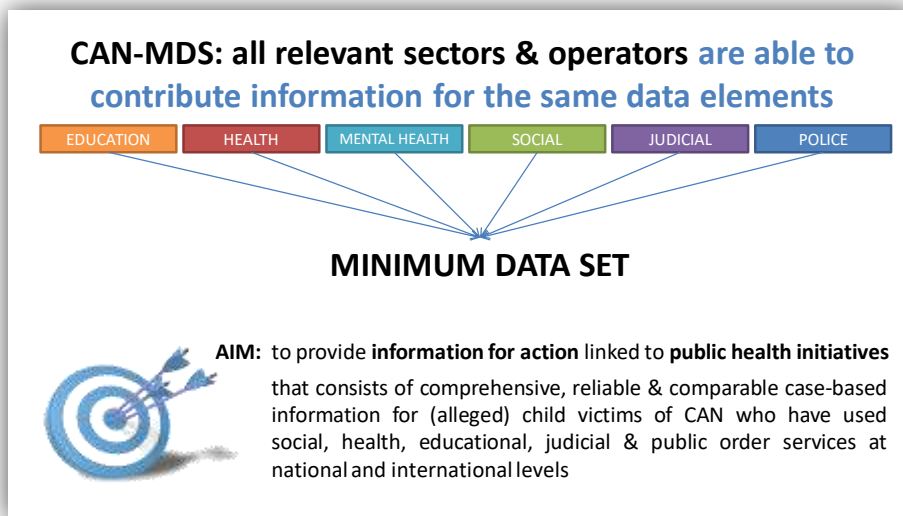
In all cases, however, a common condition is valid: the child-victim of CAN.

Supposedly, we would interesting for all recorded information. This, however, is not feasible as many of them are relevant only to special responsibilities of some services and totally irrelevant to others.

What are the data that consist **common denominator** among all services and sectors?

During the developing of the minimum data set, the **COMMON DATA AMONG ALL SECTORS WERE IDENTIFIED** while the remaining were excluded.

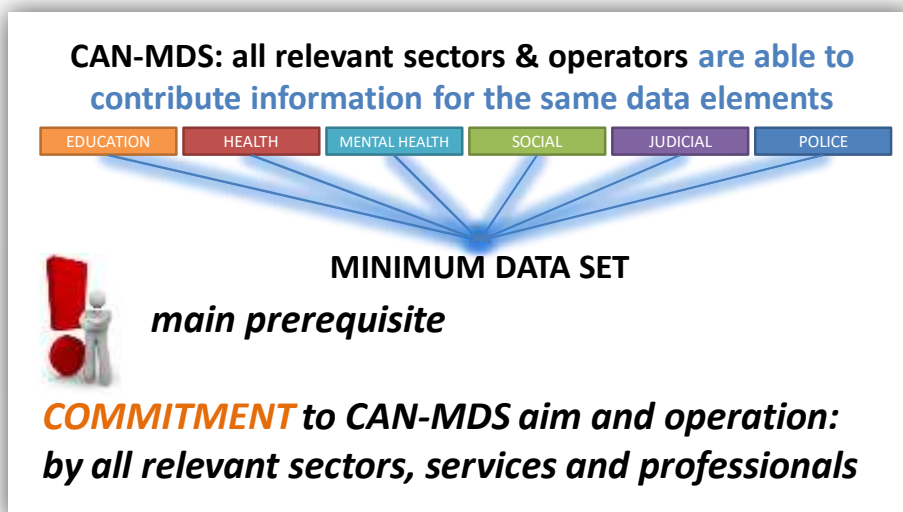
Slide 18



Therefore, the minimum data set for child abuse and neglect is a set of data elements where all relevant sectors, services and operators are able to contribute information (the common denominator rather than the minimum set of information).

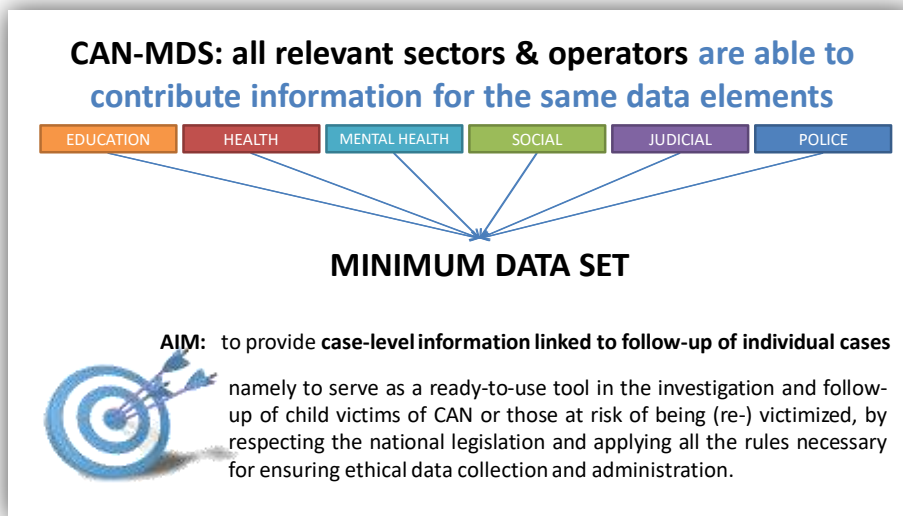
This consists the first and main aim of the CAN-MDS, namely to collect comprehensive reliable and comparable case-based epidemiological data for children (alleged) victims of CAN who have used services, according to services' response. These data can provide information for action, linked to public health initiatives.

Slide 19



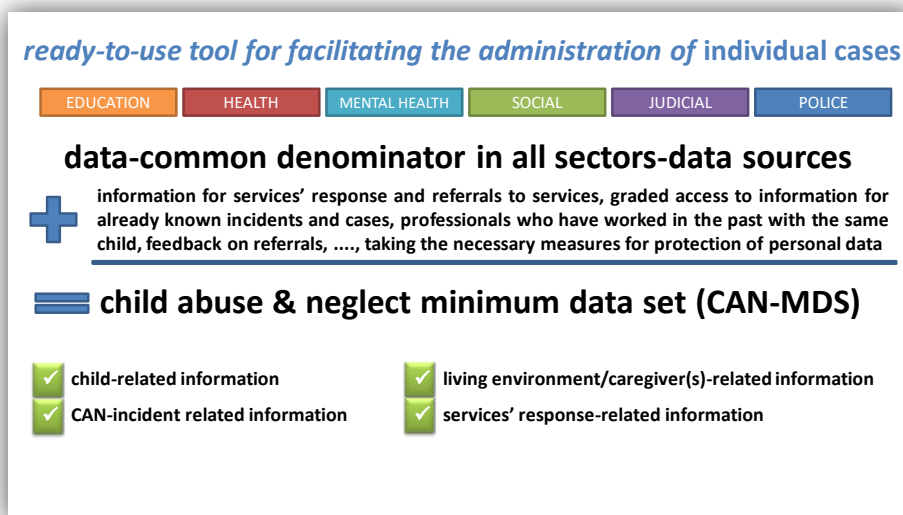
At this specific point the main weakness of such a methodology is arise: for effective data collection the acceptance and commitment of the aim and operation of the system by all stakeholders working in relevant sectors. Without continuous and consistent data input, data collection can not proceed.

Slide 20



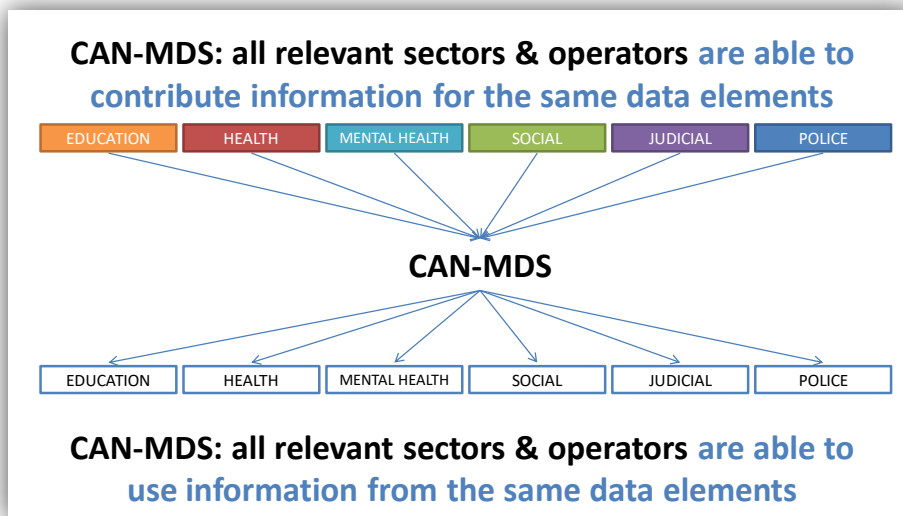
As a response to this weakness, namely the way adopted for strengthening the acceptance and the commitment to CAN-MDS, a second aim was added: a CAN-MDS system to be able to provide case-level information for use linked to follow-up of individual cases, namely to serve as a tool in the investigation and follow-up of child victims of CAN or those at risk of being (re-) victimized by respecting the national legislation and applying all the rules necessary for ensuring ethical data collection and administration. As far as I know this is not usual for epidemiological mechanisms and, therefore, it consists an innovative aspect of the CAN-MDS

Slide 21



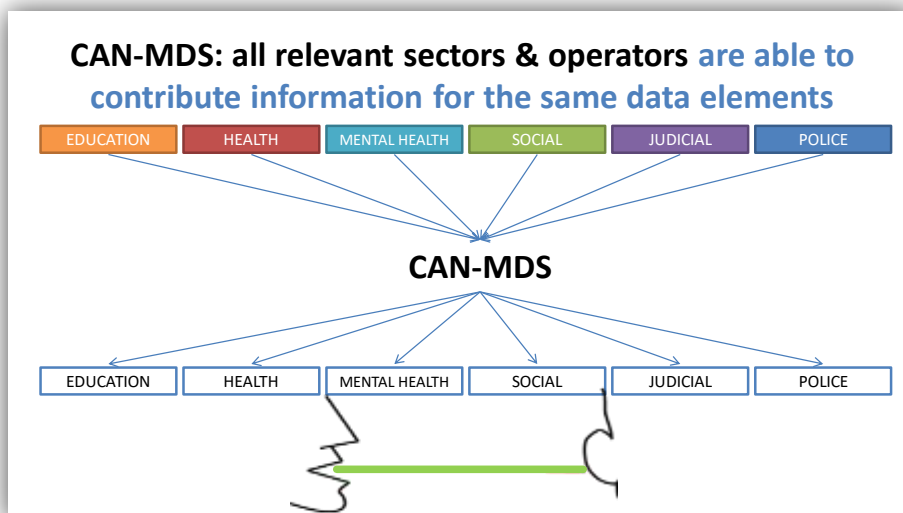
Therefore, in addition to the data elements identified before as common denominator among all involved services and sectors, a **fourth (4<sup>th</sup>)** axis is added including data elements **related to services' response and referrals of cases**. These specific data elements aim to make the system practical and able to provide feedback to operators, facilitating their communication when they work in the same cases.

Slide 22



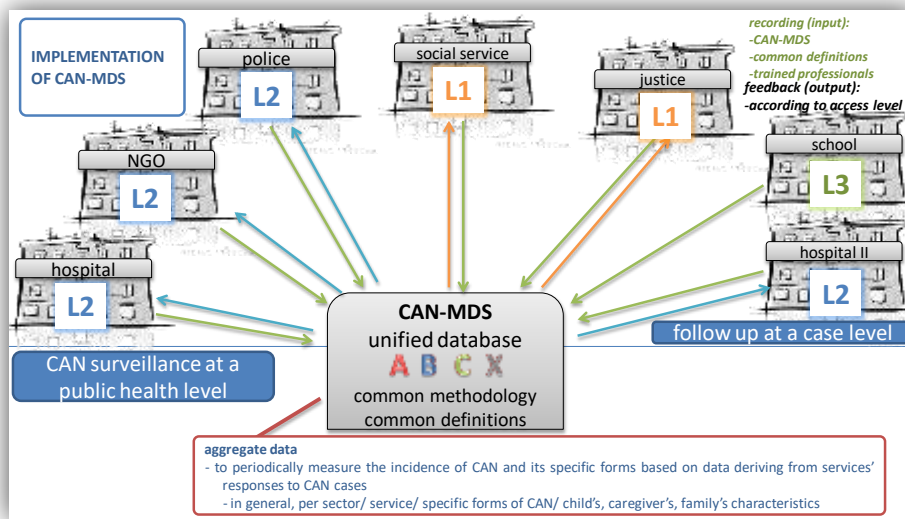
Based on the CAN-MDS operators working in all relevant sectors can contribute comparable and reliable data for the same data elements and, additionally, are also able to use the available information for the administration at a case level –providing that no rules are violated concerning the protection of personal sensitive data.

Slide 23



The use of a common set of data elements is expected to facilitate as a “common language” among sectors and to improve the communication among stakeholders (services, operators etc.) during the administration of CAN at a case-level and at the same time to improve completeness, validity and reliability of the necessary information.

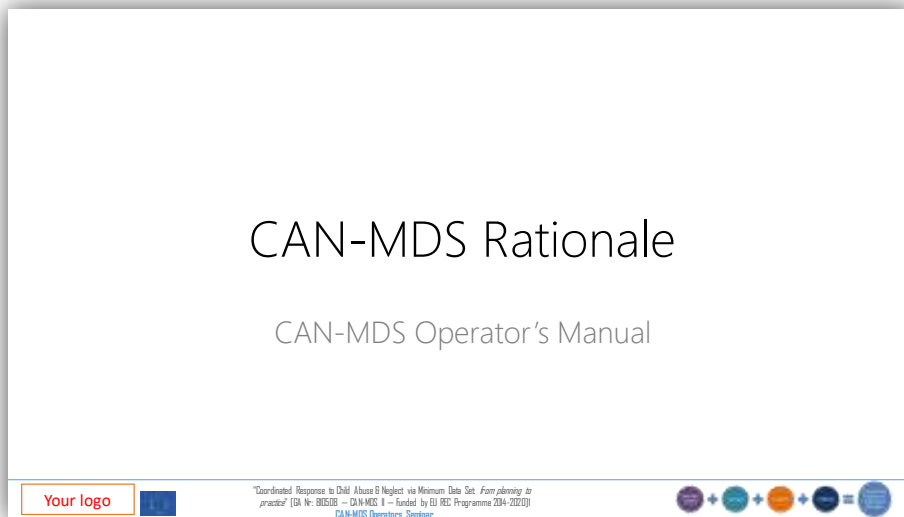
Slide 24



Going back to our [Greek] example: the role of a potential CAN-MDS system would have as follows: trained professionals working in relevant agencies belonging in a relevant sector would provide input (recording of incident-based information in real time) into a common database, based on common definitions (e.g. in the context of fulfilling their legally defined obligations for mandatory reporting); at a case level, each stakeholder would receive feedback in case that the child is "already known" in the system (according to their pre-defined level of access)

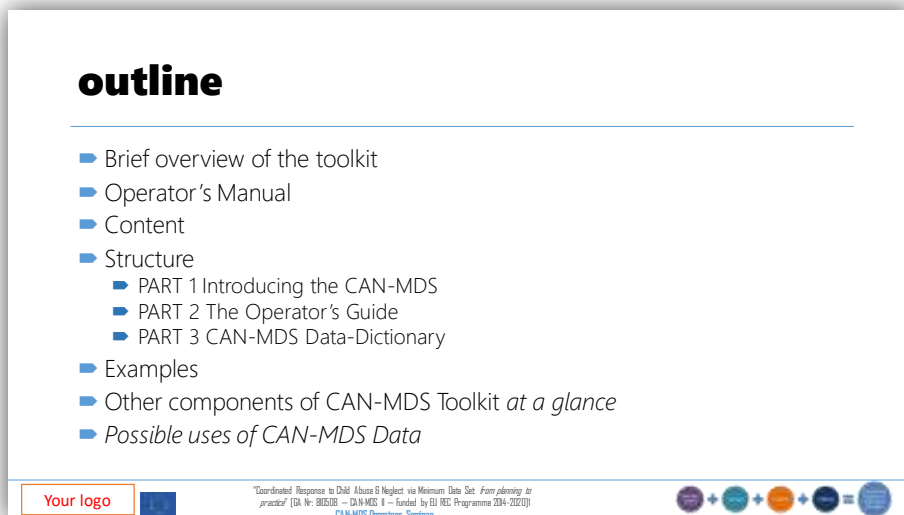
PART 3 – DURATION: 120 MIN

Slide 1



[INSTRUCTION – Ask trainees to open the national Operator's Manual.]

Slide 2



In this session a brief overview of the toolkit is presented. The focus will be in the Operator's Manual, the main tool for the professionals-operators of the CAN-MDS System, its content and structure. Examples will be presented in order to ensure common understanding on how the professional can use the Manual.

## Slide 3

**TOOLKIT at a glance**

- **MANUAL FOR OPERATORS**
- **DATA COLLECTION PROTOCOL**
- **e-application (CAN-MDS System)**

Your logo "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators Seminar

The Operator's Manual is a main part of the CAN-MDS Toolkit; other components of the toolkit are the data collection protocol and the electronic application.

[INSTRUCTION-Ask from trainees to open the pdf "operator's manual" and go through the content for the 3 parts]

## Slide 4

**Content**

- Operator's Manual includes all necessary background information for professionals who are going to use the CAN-MDS system as "Operators" concerning
  - the necessity for CAN surveillance in the country
  - ethics and confidentiality issues related to personal data (GDPR)
  - legal framework and mandate reporting
  - case definitions
  - detailed presentation of the e-system, data elements of the MDS and data collection process
  - technical specifications of DE, permissible values, data dictionary, terms and definitions

**Note for the trainees**

In the next slides the 3 parts of the manual are going to be presented.

You can open the Operator's Manual and go through the content while they are presented

Your logo "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators Seminar

As for its content, the Operator's Manual includes all necessary background and practical information for professionals who are going to use the CAN-MDS system as "Operators" concerning

<see slide>



Slide 5

## CAN-MDS Operator's Manual – STRUCTURE



### PART 1 Introducing the CAN-MDS

- Background
- CAN-MDS v1.0-Aim & Objectives
- CAN-MDS Toolkit
- Eligible incidents for CAN-MDS - *Case Definitions*
- Ethics in CAN-MDS-*privacy & confidentiality considerations*

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



The structure of *PART 1 Introducing the CAN-MDS* includes

<see slide>

#### CAN-MDS Toolkit

- What a CAN-MDS Operator can contribute to CAN-MDS
- What CAN-MDS can provide to a CAN-MDS Operator

#### Ethics in CAN-MDS - *privacy and confidentiality considerations*

- What is provisioned by the Law and GDPR
  - Professionals' Codes of Ethics
  - CAN-MDS Stakeholders, Operations, Tasks and Responsibilities

Slide 6

## CAN-MDS Operator's Manual – STRUCTURE



### PART 2 The Operator's Guide

- Guide for Operators – structure
  - CAN-MDS axes
    - data collection and data reporting
    - data elements in the Operator's Guide
    - feedback to the Operator

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



Here is the content of *PART 2 "The Operator's Guide"* <see slide>

**CAN-MDS v1 - data collection and data reporting including:** Entering new data in the CAN-MDS  
*CAN-MDS data entry; CAN-MDS data reporting; CAN-MDS data extraction; CAN-MDS Flowchart*

**Data elements in the Operator's Guide - outline of presentation:** Attributes per data element (DE) and Overview of DE attributes. Some more details are presented in the next slides

Slide 7

### axes & data elements of CAN-MDS

Axes	Data Elements	Labels
<b>RECORD</b> 4 data elements	R1	Agency's ID
	R2	Operator's ID
	R3	Date of Record
	R4	Source of information
<b>INCIDENT</b> 4 data elements	I1	Incident ID
	I2	Date of incident
	I3	Form(s) of maltreatment
	I4	Location of incident
<b>CHILD</b> 4 data elements	C1	Child's ID
	C2	Child's sex
	C3	Child's date of birth
	C4	Child's citizenship status
<b>FAMILY</b> 4 data elements	F1	Family composition
	F2	Primary caregiver(s)' relationship to child
	F3	Primary caregiver(s)' sex
	F4	Primary caregiver(s)' date of birth
<b>SERVICES</b> 2 data elements	S1	Institutional response
	S2	Referral(s) to services

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

### CAN-MDS Axes and data elements

CAN-MDS consists of 18 data elements that are classified under 5 main categories (record, incident, child, living environment/primary caregivers and services).

4 of the Data Elements are clearly administrative (IDs-identifiers); 2 data elements are relevant to the response of Operator for a specific incident; 4 data elements are relevant to the specific CAN incident, 4 to the child and the remaining 4 to child's family.

This information can be equally provided by all professionals working with children, regardless the sector where they are working

Slide 8

### CAN-MDS Operator's Manual – STRUCTURE



#### PART 2 The Operator's Guide

- Guide for Operators – structure
  - CAN-MDS axes
  - data collection and data reporting
  - data elements in the Operator's Guide
  - feedback to the Operator

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



Next, data collection and reporting through CAN-MDS is presented

Slide 9

## PROCESS *at a glance*

- Step-by-step process for *entering new data* is available in **CAN-MDS Data Collection Protocol**
  - It is noted that the whole process of data entering is based on selection among pre-defined codes under each individual data element (fields to be completed with text are not available)

see also pp. 47-48  
of Data Collection Protocol



Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

In addition to the Operator's manual, it is essential that you locate and save a copy of the Data Collection Protocol file.

[Instruction - Please, before practicing print or select on your laptop/tablet page 49 and page 50 of the document. You will need those as you do the practice case intake. These are presented in the next slide]

Slide 10

**RECORDING FORMS** help Operators to collect and retain all information on the case that they will use to inform National Administrator and enter case into CAN-MDS



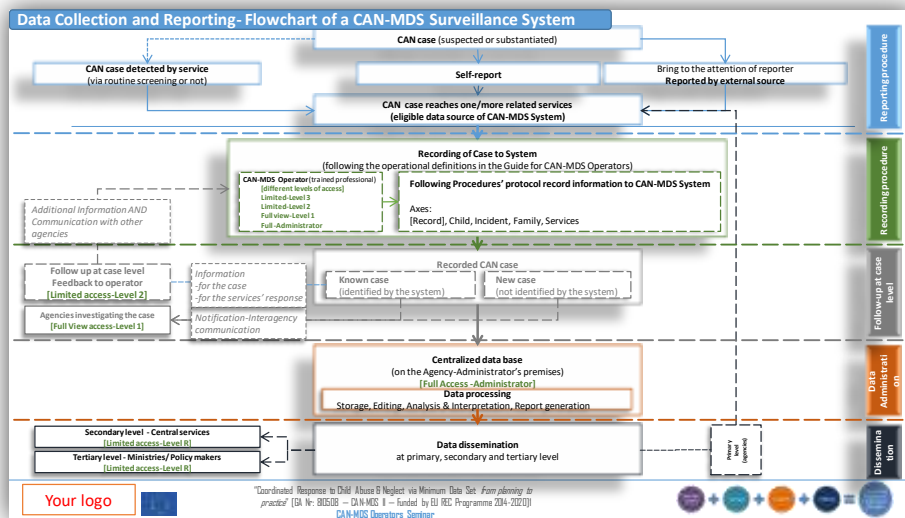
(pp. 49-50)

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

<see forms-check lists in the slide and describe their content>

Slide 11



Here is a flowchart of the provisioned operation of a potential CAN-MDS system: starting from reporting procedures, the recording procedures, the monitoring at a case-level, the central data administration and the dissemination of appropriate information to different stakeholders;

Slide 12

## CAN-MDS Operator's Manual – STRUCTURE



### PART 2 The Operator's Guide

- Guide for Operators – structure
  - CAN-MDS axes
  - data collection and data reporting
  - data elements in the Operator's Guide
  - feedback to the Operator

Your logo

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice' (CA No: 810508 - CAN-MDS II - Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



How data elements are described in the Operator's Manual?

Slide 13

### axes and data elements of e-app CAN-MDS

**use of existing standards – where feasible**

**Data Elements related to "RECORD"**

- DE\_R1: Agency's ID → auto-completed
- DE\_R2: Operator's ID → auto-completed
- DE\_R3: Date of Record → auto-completed
- DE\_R4: Source of Information

**Data Elements related to "INCIDENT"**

- DE\_I1: Incident ID → auto-completed
- DE\_I2: Date of Incident
- DE\_I3: Form(s) of maltreatment
- DE\_I4: Location of Incident

Operationalised on the basis of the General Comment 13 (2011) of UN Committee "The right of the child to freedom from all forms of violence" [CRC/C/GC/13/2011]

- Operators are not required to proceed in evaluation and judgments of the type of child abuse and neglect based on conceptual definitions they use
- Operators are instructed to record violent acts committed against the child or omissions in child's care, both regardless intention and consequences by using pre-coded lists of violent acts and omissions
- A data dictionary is available including every single term used in the CAN-MDS (even though those that are known/simple following the 'common sense') aiming to ensure common understanding during data collection and data interpretation

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Here we can see the data elements that were presented before in the form they are included in the e-app CAN-MDS system.

The whole toolkit is based on this 18-element MDS: as you will notice, no data are included for substantiation, perpetrators or severity of harm (given that not all stakeholders are able to provide this information and mainly because the aim is to create an all-inclusive database and not only substantiated cases by justice or CPS authorities);

For any individual data element an effort was made to be operationalized as much as possible.

The element "form(s) of maltreatment" which is the core data element of the system is operationalized on the basis of ... (see slide blue frame)

Slide 14

### Attributes per data element (DE)

Attributes of DE	short name of data element
CAN-MDS ID:	Identifier of the data element in the context of the CAN-MDS
Definition:	Short definition of the data element
Instruction for recording:	Instructions to the Operator for the recording of the specific DE (including steps and examples, where needed)
Completion:	<p><i>potential alternatives</i></p> <ul style="list-style-type: none"> <li>→ by you (as a CAN-MDS Operator)</li> <li>→ by the System</li> <li>→ by the Administrator</li> <li>→ by other CAN-MDS Operator</li> </ul>
Obligation:	<p><i>potential statuses</i></p> <ul style="list-style-type: none"> <li>→ mandatory (<i>always required</i>)</li> <li>→ conditional (<i>required under certain specified conditions</i>)</li> <li>→ "for your information" only</li> </ul>
Multiplicity:	<p><i>potential statuses</i></p> <ul style="list-style-type: none"> <li>→ single (unique) selection (<i>one per data element</i>)</li> <li>→ multiple selection (<i>one or more per data element</i>)</li> </ul>

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

For each of the 18 data elements specific attributes are described such as: definition; Completion (by whom? The operator-the system-the administrator); Obligation (mandatory completion; condition –under certain conditions; only for Operator's information); Multiplicity (single/unique selection or multiple selections – more than one values);

Slide 15

## Attributes per data element (DE)

Datatype:	Primary records (case-based row data):		→ date
			→ date and time
			→ value (pre-coded lists of permissible values)
			→ number (integer)
	Secondary records (deriving from primary record & contain selected data elements):		→ identifier
			→ duration
			→ auto-generated value
			→ pre-existing value (such as international classification systems concerning countries/regions, agencies, professions)
	Supplementary data:		→ necessary information (such as CAN-MDS Agencies' inventory)
			→ restricted supplementary data (such as child's and caregiver(s) personal identifiers and contact details) available only to the Administrator
Relevance:	The DE is linked to axis/axes other DE (primary and/or secondary data type)		
Values:	List of applicable pre-coded values defined in Part III "Data Dictionary"		
NOTES	guide for recording necessary information for the DE		

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Also:

Data type (case-based data: date; time; value from a pre-coded list of values; number) or data deriving from other data (identifiers; duration; auto-generated value; pre-existing value; restricted supplementary data); relevance with other DE (to which axes the DE is related and to which specific other Des-if any); values permitted (*List of applicable pre-coded values defined in Part III "Data Dictionary"*) and some notes

Slide 16

## CAN-MDS Operator's Manual – STRUCTURE



### PART 3 CAN-MDS Data-Dictionary

- CAN-MDS V.01 Data Dictionary
- Description of DE permissible values
  - RECORD; INCIDENT; CHILD; FAMILY; SERVICES
- CAN-MDS V.01-Terms & Definitions A – Z
- References



### ANNEXES

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

In regards to the content of *PART 3 "CAN-MDS Data-Dictionary Terms & Definitions"*

An introductory note is included along with information about the structure of the Data-Dictionary and its limitations.

Next, a *description of permissible values follows for any individual data element under each of the five axes* (RECORD; INCIDENT; CHILD; FAMILY and SERVICES).

Lastly, Part 3 includes a detailed index of *terms and definitions* of the CAN-MDS

Slide 17

## Structure of data dictionary

- The CAN-MDS Data Dictionary comprises two main parts:
  - i. *description of permissible values (or permitted range of values).*

Permissible values are listed per data element in five different sections corresponding to the five axes under which the CAN-MDS data elements are classified, as follows:

    - Axis' Definition
      - Data Element Definition
      - Permissible Values' definitions
  - ii. *Definitions of CAN-MDS terms are presented in alphabetical order.*
    - Specific terms requiring further explanation are indicated in bold font and described under part ii.

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



This is how the data dictionary is structured concerning *Permissible values* and *Definition of terms*

<see slide>

Slide 18

## How to use Part 2 & Part 3 of the Operator's Manual

- Example: 4<sup>th</sup> Data Element under Axis "Record"  
[DE\_R4 Source of Information]

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



In the next slides the data element SOURCE OF INFORMATION is presented as an example (4<sup>th</sup> Data Element under Axis "Record")







Slide 21

# PART 3 (CAN-MDS Data-Dictionary; Terms & Definitions) ➡ Description of DE\_R4 Permissible Values

---

- Definition of DE\_R4
  
- DE\_R4 Permissible values' definitions
  
- Specific terms requiring further explanation are indicated in bold font and described under part ii
  
- Definitions of CAN-MDS terms (in alphabetical order)

**[R4\_03] Parent /foster parent/ parent's partner/ parent's partner/ caregiver**

Your logo

[Instruction: Proceed with the presentation of the slide step by step]

<see slide>

Slide 22

► is it clear how to use the Operator's Manual?

[Note: Ask trainees if it is clear what the Operator's Manual is and how to use it; it is important to ensure that everybody understand the structure and description of the data elements]

## Slide 23

### Other components of CAN-MDS Toolkit at a glance

(these will be discussed in detail later)

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No: 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Next the remaining components of the CAN-MDS Toolkit for Operators is presented at a glance.

## Slide 24

### CAN-MDS Data Collection Protocol

- 1 RATIONALE
- 2 PURPOSE
- 3 APPLICABILITY
- 4 SOURCES
- 5 ELIGIBILITY CRITERIA for recording a CAN incident into CAN-MDS
- 6 SETTINGS

Suggested questions and prompts for collecting required information for CAN-MDS

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No: 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

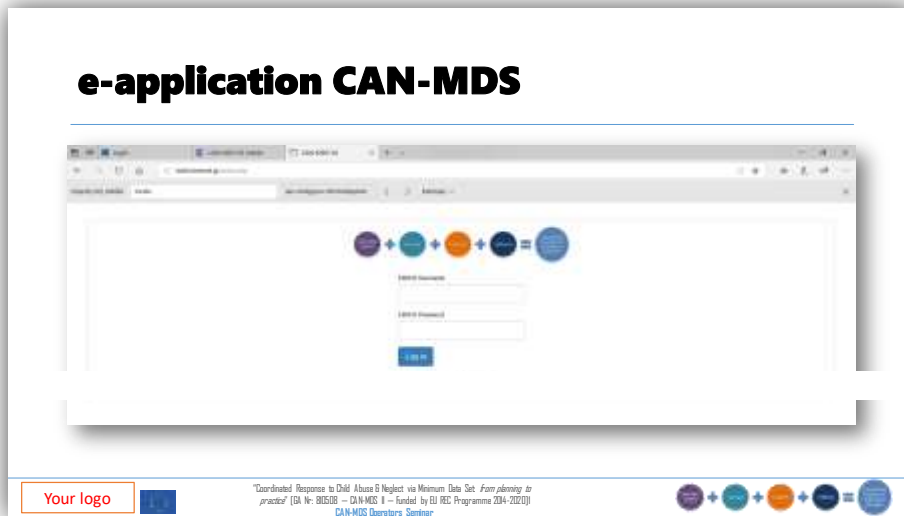
This is a brief description of the Data collection protocol; data collection protocol is a practical tool that connects the information included in the operator's manual with the online CAN-MDS application.

The main part of the protocol is dedicated to data recording. The process is presented step by step through screen-shots and the necessary information.

In addition, some practical tools are included as the suggested prompts for the intake and the forms-check lists to be used for ensuring the collection of all necessary information.

It is noted that the protocol is expected to be used during the first records; afterwards, when Operators will become familiar with the application, data collection protocol is expected to be used only for specific cases (e.g. addition of a new incident under the identity of an already known child).

Slide 25



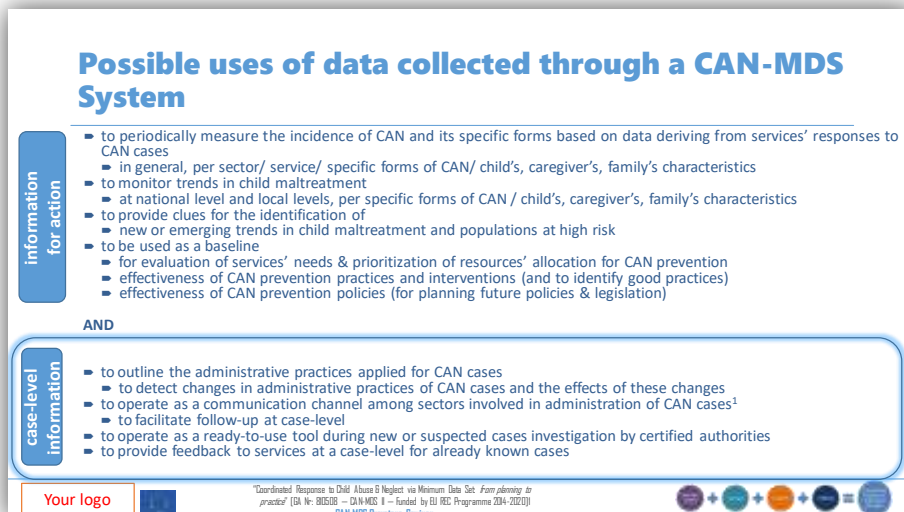
This is the introductory screen of the OPERATOR'S CAN-MDS System (e-app):

Currently the app is available at [www.can-mds.infowood.gr](http://www.can-mds.infowood.gr) (Once the revised app is ready it will be moved under each partner server)

SAMPLE OPERATORS' IDENTITIES *Username: Operator 0; Operator 1; Operator 2; Operator 3. Password: 12345* **Note:** You can add new incidents for children unknown or already known to system (Sample known children: Child ID: 55555, 66666, 77777, 88888)

[PLEASE USE YOUROWN USERNAMES AND PASSWORDS in order the app to open in your language]

Slide 26



In this slide are presented possible uses of data collected through a CAN-MDS Surveillance System, such as:

- to periodically measure the incidence of CAN and its specific forms
- to be used as a baseline for evaluation of services' needs & prioritization of resources' allocation for CAN prevention AND
- to outline the administrative practices applied for CAN cases
- to operate as a communication channel among sectors involved in administration of CAN cases<sup>1</sup>
- to provide feedback to services at a case-level for already known cases

Slide 27

## Possible uses of data collected through a CAN-MDS System

information for action

- to periodically measure the incidence of CAN and its specific forms based on data deriving from services' responses to CAN cases
  - in general, per sector/ service/ specific forms of CAN/ child's, caregiver's, family's characteristics
- to monitor trends in child maltreatment
  - at national level and local levels, per specific forms of CAN / child's, caregiver's, family's characteristics
- to provide clues for the identification of
  - new or emerging trends in child maltreatment and populations at high risk
- to be used as a baseline
  - for evaluation of services' needs & prioritization of resources' allocation for CAN prevention
  - effectiveness of CAN prevention practices and interventions (and to identify good practices)
  - effectiveness of CAN prevention policies (for planning future policies & legislation)

AND

case-level information

this potential use of data could become a *motive* for professionals/system's operators against under recording due to lack of incentive for recording and of feedback leading to the perception that there is no action on the record

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operations Seminar

This potential use of data could become a *motive* for professionals/system's operators against under recording due to lack of incentive for recording and of feedback leading to the perception that there is no action on the record.

SESSION 2 – DURATION: 150 MIN

PART 4– DURATION: 30 MIN

Slide 1

## Tackling CAN under-reporting

justifying the need for CAN reporting &  
exploring the factors leading to underreporting

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Slide 2

## outline

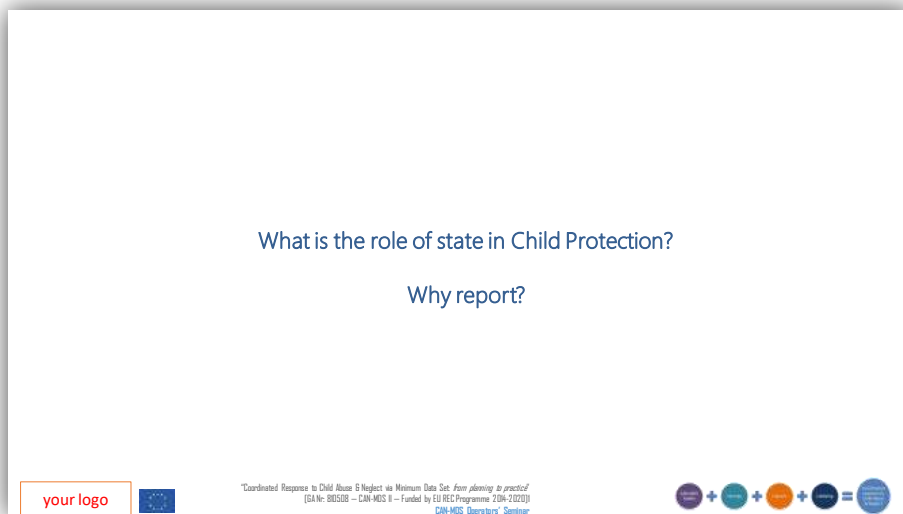
- What is a report of child abuse and/or neglect
  - Official definition in [country]
- What is CAN underreporting
  - Current situation in [country]
- Exploring the reasons of underreporting
- The need to tackle underreporting
- Connection of CAN under-reporting & CAN surveillance

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

<see slide>

Slide 3



"The UN Convention on the Rights of the Child established that government is the main body responsible for preventing and responding to violence against children, considering children as rightful participants, with particular attention to ensuring that children are recipients of the safeguard mechanisms supporting human rights (Pinheiro, 2006).

The Convention on the Rights of the Child requires all signatory nations to establish integrated child protection systems to ensure a coordinated response to child abuse and neglect (Svevo-Cianci, Hart, & Robinson, 2010).

These integrated systems are commonly divided into three main areas: (1) mandates (laws, regulations, and policies); (2) mechanisms/interventions (education, service programs, and data management); and (3) child outcomes (performance measures of the child's health, development, and well-being) (Svevo-Cianci et al., 2010). An additional consideration is the resource provision to support recovery following exposure to violence, where mandatory reporting is conceptualized as a key element in the resilience-in-the-context-of-maltreatment process (Wekerle, 2013).

Mandatory reporting of suspected or confirmed CAN represents one common, key strategy to address violence against children. Legally requiring certain individuals to report child abuse is justified with the assumption that early detection of abuse helps prevent serious injuries and relieves the victims of the responsibility to seek help for themselves, thus enhancing coordination between legal, medical, and service responses (Krug et al., 2002).

Legislation mandating health professionals to report concerns for CAN is available in many countries across the world (US, Canada, Australia, Argentina, Israel, Poland, Sri Lanka, etc.). However, a number of countries (United Kingdom, New Zealand, etc.) have not always mandated health professionals to report concerns for CAN (Krug et al., 2002).

Additionally, mandatory reporting of CAN varies between jurisdictions. Differences exist regarding the type of maltreatment that is required to be reported and in some cases the source of the maltreatment."



Suggested reading: <https://www.macpedis.com/documents/LCCSession42ResidentFull.pdf>

## Slide 4

**The need to report child abuse and neglect (CAN)**  
*underlying premise of the CAN-MDS project*

The child's better interests, rights and basic human dignity are not served in situations where, despite professionals' awareness, or even suspicion of abuse, the child remains in the care or within reach of the perpetrators of the abuse and/or of the neglect.

- Due to scarce evidence for effective interventions, mostly, there is no direct way to know if child life improves in the process of recognition-reporting-intervention.
- According to various studies, prioritizing substantiation of maltreatment with no accompanying attention to welfare is linked with less service provision for maltreated children than in contexts that deal with child maltreatment as part of a an organized child and family welfare response (which, further, suggests that mandate to report is not the problem, rather agency response and/or general policy is)



your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (EU No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

[Note: It is suggested to use this slide in a way that underscores your key argument on how necessary CAN-MDS is for the group you are training and for the recipients of their services (children!)]

## Slide 5

**Reporting of child abuse and neglect is necessary**  
*General comment No. 13 (2011): The right of the child to freedom from all forms of violence (art. 49)*

- the UN Committee strongly recommends that **all States parties develop safe, well-publicized, confidential and accessible support mechanisms for children, their representatives and others to report violence against children**,
  - including through the use of 24-hour toll-free hotlines and other ICTs
- in every country, **the reporting of instances, suspicion or risk of violence should, at a minimum, be required by professionals working directly with children**
  - when reports are made in good faith, processes must be in place to ensure the protection of the professional making the report

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (EU No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

It is also noted that children's right to be heard and to have their views taken seriously must be respected.

- Reporting mechanisms must be coupled with, and should present themselves as help-oriented services offering public health and social support, rather than as triggering responses which are primarily punitive.
- The establishment of reporting mechanisms includes: (a) providing appropriate information to facilitate the making of complaints; (b) participation in investigations and court proceedings; (c) developing protocols which are appropriate for different circumstances and made widely known to children and the general public; (d) establishing related support services for children and families; and (e) training and providing ongoing support for personnel to receive and advance the information received through reporting systems.

Source: <https://www.refworld.org/docid/4e6da4922.html>

Slide 6

## What is a report of child abuse and/or neglect

- sharing of someone's concerns regarding suspected or known abuse and/or neglect of a child (or children) under someone's care to the competent authorities

**Note!** the person who makes a report IS NOT RESPONSIBLE to investigate further the case in order to determine whether his/her suspicions are valid

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4-Nr. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Slide 7

## Official definition of report in **[your country]**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4-Nr. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



[Please complete the slide]



Slide 8

### Who can report suspicions for child abuse & neglect

- anyone who has concerns for the safety of a child (or children)
- national laws provision **legal obligation** (mandates) for specific persons requiring by them to report suspected child abuse or neglect;
- **mandated reporters** can be
  - various groups of professionals
  - civilians

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAW-MDS II – Funded by EU REC Programme 2014-2020)  
CAW-MDS Operators' Seminar



<see slide>

Slide 9

### Provisions on **professionals' legal obligation to report cases of child abuse, neglect and violence (FRA, 2014)**

- In 15 Member States reporting obligations are in place for all professionals.
- In 10 Member States existing obligations only address certain professional groups such as social workers or teachers.
- In many Member States, the anonymity of reporting professionals is not always guaranteed



your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAW-MDS II – Funded by EU REC Programme 2014-2020)  
CAW-MDS Operators' Seminar



In the majority of EU Member States, reporting obligations exist for professionals who are in contact with children.

They do not, however, always apply to all professionals groups.

Specifically

-In 15 Member States (including **Bulgaria, France, Romania** and **Spain**) reporting obligations are in place for all professionals.

-In 10 Member States (including **Cyprus** and **Greece**), existing obligations only address certain professional groups such as social workers or teachers.

--In many Member States, the anonymity of reporting professionals is not always guaranteed (as in **Greece**)

--This lack of anonymity may sometimes discourage professionals from reporting a case of a presumed victim

Source: <https://fra.europa.eu/en/publication/2015/mapping-child-protection-systems-eu/reporting-1>

Slide 10

### Provisions on **professionals' legal obligation to report cases of child abuse, neglect and violence (FRA, 2014)**

- In some Member States there is a comprehensive referral mechanism.
  - in many countries, however, the lack of clear reporting procedures and protocols creates further delays or leads to the under-reporting of cases
- The lack of a comprehensive document outlining the referral mechanism in place as well as the responsibilities of each of the actors involved has resulted in ineffective cooperation among professionals
- An important challenge identified in tackling under-reporting is the failure of professionals to recognise abuse and to understand and fulfil their professional responsibilities and obligations once concerns are noticed
  - There is thus a great need of training on the signs of abuse and the identification of child victims for all professionals who come into contact with children.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 505508 – CAW-MDS II – Funded by EU REC Programme 2014-2020)  
CAW-MDS Operators' Seminar



Source: <https://fra.europa.eu/en/publication/2015/mapping-child-protection-systems-eu/reporting-1>

<see slide>

Slide 11

### Specific legal obligations **for civilians to report cases of child abuse, neglect and violence (FRA, 2014)**

- More than half of the EU Member States have specific reporting obligations addressing civilians
- In 15 EU Member States there are provisions setting forth specific obligations for civilians to report cases of child abuse, neglect and/or exploitation, falling under the scope of national child protection systems
- In many Member States without specific provisions, **general provisions on the obligation for all citizens to report a criminal act under national law** apply



your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 505508 – CAW-MDS II – Funded by EU REC Programme 2014-2020)  
CAW-MDS Operators' Seminar



- More than half of the EU Member States have specific reporting obligations addressing civilians
- In 15 EU Member States (including **Bulgaria** and **Cyprus**), there are provisions setting forth specific obligations for civilians to report cases of child abuse, neglect and/or exploitation, falling under the scope of national child protection systems
- In many Member States without specific provisions, **general provisions on the obligation for all citizens to report a criminal act under national law** apply

-- in such cases there is no particular obligation to report a child at risk or presumed cases of abuse

Source: <https://fra.europa.eu/en/publication/2015/mapping-child-protection-systems-eu/reporting2>

## Slide 12

### Legal obligations for professionals & civilians to report cases of child abuse, neglect and violence in [your country]

- Please provide here only main points; detailed presentation of national legal framework will follow

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice" (SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

[Instruction: Please provide here only main points; detailed presentations of the national legal framework will follow]

## Slide 13

### Underreporting of child abuse and neglect

- circumstances in which due to various reasons
  - mandated reporters (including professionals and/or civilians) fail to report child maltreatment suspicions to competent authorities
  - in such cases the initial recognition that a child may have been abused is not followed by a subsequent reporting of that suspected case of child abuse to the responsible agency and cases go unreported leading to discrepancies between recognition and reporting of child abuse and neglect incidents

**WHO-European Region office**

- each year, at least 55 million children experience some form of violence in the WHO European Region, including physical, sexual, emotional and psychological violence
- despite the magnitude of this figure, it is well established that incidents of interpersonal violence are widely underreported

**Accounting for underreporting**  
WHO estimates that of the 204 million children across the region

- 9.6% experience sexual exploitation,
- 22.9% physical abuse and
- 29.1% emotional harm
- 700 are murdered every year

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice" (SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

Source: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1)

<see slide>

Slide 14

## The Main Problem Is Underreporting Child Abuse and Neglect

(Finkelhor, 2005)

"... The evidence suggests that large numbers of seriously abused and neglected children are still not coming to the attention of child protective authorities. To remedy this, professionals and members of the public need to be sensitized to recognize and report child abuse. If, in concert with these increased reports, child protective authorities improve their triage and investigatory skills and expand their treatment services, we may get closer to identifying and helping all the children at risk..."

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



Source: Finkelhor, D. (2005). The main problem is underreporting child abuse and neglect. *Current controversies on family violence*, 2, 299-310.

Slide 15

## Common myths around reporting child abuse

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



[https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

[Instruction: Next 7 slides contain common myths around reporting of child abuse and neglect incidents. You can use all of some of these myths –according to available time- to involve trainees in brief discussion]

Slide 16

**if child abuse is reported to authorities, the child will be removed from their family by social workers**

myth

Fact

sometimes parents need help to care for their child. If there are worries about a child's safety at home, help should be provided to parents to get support to keep their child safe and well. Social workers protect vulnerable children and provide support to families in need of assistance.

The decision to 'remove' children from families ultimately rests with the courts, so this not likely to happen, especially after just one phone call. Sharing of concerns with authorities means they spot a problem sooner, and can take action to help the child and the family concerned

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 17

**people will know it's me that reported something**

myth

Fact

In most countries people who report suspected child abuse and neglect have the option to keep their details private when they are asked for them

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 18

**it's not my job to report child abuse – that's for specialised professionals to handle**

**myth**


**Fact**

all professionals working with and/or for children have a role and responsibility to keep children safe from harm –even civilians. An abused child wants the opportunity to be heard, but it is up to adults to spot the signs, notice if something is troubling them, and act on their concerns.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 19


**it's not my job to report child abuse – that's for specialised professionals to handle**

**myth**


**Fact**

all professionals working with and/or for children have a role and responsibility to keep children safe from harm –even civilians. An abused child wants the opportunity to be heard, but it is up to adults to spot the signs, notice if something is troubling them, and act on their concerns.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 20

**it's best to wait until you're absolutely certain you have firm evidence before reporting CAN**

myth

**Fact**

There is no need for someone –especially mandated reporter– to be absolutely certain about his/her suspicions. If s/he has concerns that something is not right, s/he should talk to authorities. It is their job to investigate any and all types of abuse and can effectively determine if abuse or mistreatment is taking place.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No. 985558 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

+ + + =

Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 21

**If the child doesn't tell someone about the abuse taking place it cannot be that serious**

myth

**Fact**

Not necessarily. Often a child might not realise it is being abused or mistreated as they do not know any better.

Abuse varies in type and severity, but any type of abuse should be taken extremely seriously.

Research indicates that children and young people suffering abuse may make multiple attempts to tell someone. However, talking about this is always very difficult.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No. 985558 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

+ + + =

Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 22

**children have lots of adults they can turn to for help if they are being abused myth**

### Fact

Children and young people find it extremely difficult to ask for help from anyone if they are being abused, even someone close to them. The most common barriers that stop them asking for help are:

- fears and anxieties manipulated by the abuser
- developmental barriers
- emotional barriers and anxieties
- having nobody to turn to: often young people feel isolated and decide not to trust anyone
- nobody listened and nobody asked: lack of recognition of abuse by others
- anxiety over the confidentiality of their information

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[CA No: 585508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar

Source: [https://www.bromley.gov.uk/info/200127/safeguarding\\_children/163/reporting\\_child\\_abuse/3](https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3)

<see slide>

Slide 23

## In [my country]....

To be completed at national level – you may use some of the data available in page 2 of your national policy brief  
See examples in the next slides

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[CA No: 585508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar

[Instruction: To be completed at national level – you may use some of the data available in page 2 of your national policy brief; See examples in the next slides]



Slide 24 [example – hidden slide]



Example from Greek Policy Brief [please replace with example of your country]

Slide 25 [example – hidden slide]

### the wider picture: Greece

[CAN surveillance in Greece: current policies and practices - Country Profile report]

"... lack of epidemiological data for the assessment of the magnitude of the problem at a National level. ... lack of systematically recording of CAN data that makes difficult –even impossible– the measuring of the extent of the phenomenon during the time as well as the identification of its specific characteristics and, subsequently, of any risk factors. Given that there is no CAN Surveillance mechanism in place as well as no mandatory reporting and registering procedure, agencies and professionals working in the field use different CAN definitions and therefore classification criteria as well as different assessment methodologies for recording CAN. In light of lack of these data the policy and services planning is difficult as there is no scientific basis for policy makers to build upon by setting priorities for prevention and targeted intervention"

your logo

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*  
[G4-NC-2015/2016 - CAN-MDS II - Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar


Example of Greece

In Greece actually there is no child protection system; with few exceptions, there is a lack of epidemiological data on CAN, while no surveillance mechanism is currently in place; where data are collected, different definitions, methodologies and tools are used

Slide 26 [example – hidden slide]



## the wider picture: Bulgaria

[CAN surveillance in Bulgaria: current policies and practices - Country Profile report]




"Based on results of the studies and overview of the existing data, the conclusion should be made that **there is a gap between child maltreatment occurring in the community and that reported by official statistics**. The system for identifying and reporting CAN cases in Bulgaria is still in the process of development. .... The **coordination between policy makers, agencies and services providers is still insufficient**. The other weak features of the system are **fragmentation of existing data about the magnitude of CAN**, turnover of leading experts/ managers in Child Protection at National level and regional level and limited feedback of the collected information about CAN"

[you may keep from these slides with the country profile reports those related to your country, e.g. BG, RO, FR, GR. For ES and CY you can use relevant information from your policy briefs]

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar




Example of Bulgaria

In Bulgaria it is noted that there is a gap between child maltreatment occurring in the community and that reported by official statistics, as -more or less- happens everywhere. The coordination among policy makers, agencies and services providers is insufficient while the available data are fragmented and do not represent the magnitude of CAN.



Slide 27 [example – hidden slide]

## the wider picture: France


[CAN surveillance in France: current policies and practices - Country Profile report]



"Though aggregated nation-wide data do exist and can be accessed, the **databases of the different services involved use different measurement methods and different definitions**, which render comparisons and inter-connections impossible, even at aggregated level. ... **data are produced at very different intervals**, even among departement databases. ... Another problem is that **the unit being observed and counted is rarely the child, which leads to double counts**. ... Even within its limited framework, **no single existing data collection system can claim to be all-inclusive**: the data are not always transmitted, and not always at regular intervals. ... Finally, **it would be of prime importance to have data from medical services**. The need for more homogeneity and more information regarding children in danger has been recognized by the various actors involved..."

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Example of France

As for France, different services collecting data on children in danger use different measurement methodologies, including various definitions; data are produced at various time intervals while the unit being observed and measured is rarely at the child (often leading to double counts). No single existing data collection system can claim to be all-inclusive and, in conclusion, there is a need for more homogeneity and more information regarding children in danger.

Slide 28 [example – hidden slide]

### the wider picture: Romania

[CAN surveillance in Romania: current policies and practices - Country Profile report]

"... weaknesses of the Romanian system of collecting and monitoring data about CAN-Resource availability: - **there aren't any protocols between different sectors concerning data integration and collection** mainly because of the differences between the various definitions of abuse; lack of national, standard-consistent working tools to facilitate screening and assessing cases of abuse; at the national level **there aren't any consistent guidebooks in implementing definitions and methodologies**; the databases for the monitoring and specialized department are not integrated except for the case of one county (Bihor); **there was not a continuous instructional improvement to take into consideration staff turnover**; there are not legal measures/penalties in case of non-reporting; there aren't any other special funds for consistent developing, evaluating and updating the monitoring system"

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No: 505508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Toolkit + Synergy + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

Example of Romania

In Romania no protocols are available for data integration and collection among different sectors while various definitions of abuse are used; there are no legal measures/penalties in cases of non-reporting – which is actually similar to Greece

Slide 29

### CAN Epidemiological Surveillance: the wider picture

- Across European Member States and the rest of the world,
  - various systems are in place, various infrastructures and policies
  - multi- and inter-agency CAN-surveillance is mainly applied (if at all applied)
- CAN-related information is collected during the course of other routine tasks depending on the type of sector where the data are collected
- Data collection follows different definitions, methodologies, tools depending on
  - sectors involved in administration of CAN cases per country (health, social welfare, justice, public order)
  - agencies involved in administration of CAN cases within the same or different sectors per country
  - professionals working within the same or different agencies

Public health level: insufficient data on the magnitude and/or trends of the problem  
→ lack of a robust basis for evaluation of currently applied policies and interventions

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No: 505508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Toolkit + Synergy + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

In 1999, the World Health Organization issued a press release announcing that: "RECOGNIZES CHILD ABUSE AS A MAJOR PUBLIC HEALTH PROBLEM"; it is stated among others that "abused children suffer from multiple physical, emotional and developmental problems, which can hamper their ability to live healthy and productive lives"; First among the main recommendations to the international community was "the development of worldwide data collection on child abuse and neglect, the estimation of the impact on public health and also the associated economic cost"

Twenty years later and despite the seriousness of the problem, accurate estimates of CAN extent and its characteristics in the general population are not available for various reasons: underreporting due to the silence that surrounds maltreatment cases because of shame, social stigma and the consequent criminal liability but also under-recording due to the lack of coordinated national CAN monitoring mechanisms. All leading to underestimation of the magnitude of the problem

Slide 30

## Underreporting

- professionals in primary care and pediatrics, mental health services, schools, social services and law enforcement play an important role in detecting and reporting child maltreatment, as they encounter children in their daily work
- having professional groups reporting suspected child maltreatment can help to develop understanding of the scope of the problem and potentially lead to earlier instigation of safeguarding measures
- HOWEVER**, for a variety of reasons

child maltreatment is being globally underreported according to the existing data across studies in the US, UK, Canada, New Zealand, Australia, Northern Europe, and low-to-middle income countries mainly in Africa

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



**HOWEVER**, for a variety of reasons such as inadequate training and lack of understanding of the signs, symptoms, and outcomes of child maltreatment, fears of damaging professional–client relationships, and perception that reporting may do more harm than good lead to under-reporting

Source: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1)

Slide 31

## 4 main factors of underreporting

- inadequate training and/or knowledge in the professionals' communities about the patterns in the child's behavior and health symptoms that (strongly, often) indicate existing neglect and/or abuse
- concerns and insecurity regarding how safe for the professional reporting and/or referring the suspected case is
- cultural, religious and personal constructs of family supremacy/sacredness among societal structures
- family/kin supremacy bias seems to be confounded with lack of confidence in their respective agencies' capabilities and fitness to appropriately take care of the child in the way consistent with the child's best interest

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



A cluster of four main factors seems to summarize the findings:

1. Inadequate training and/or knowledge in the professionals' communities about the patterns in the child's behavior and health symptoms that (strongly, often) indicate existing neglect and/or abuse. Ambiguity surrounding maltreatment definitions, along with what is grounds for "reasonable suspicion" have also been found to be barriers.

2. Concerns and insecurity regarding how safe for the professional reporting and/or referring the suspected case is. Specifically, professionals seem to worry about losing clientele, parents' retaliation and loss of their standing in the local communities if they are identified as the ones reporting the suspected abuse.



3. **Cultural, religious and personal constructs of family supremacy/sacredness among societal structures:** this seems to be a strong, not always fully articulated barrier in attitude change towards systematic and informed reporting even in the case of slightest suspicion. Professionals in the sectors that traditionally are more likely to be able to identify signs of child maltreatment are globally and overwhelmingly prone to want to protect the caregivers'/perpetrators' feelings and sensibilities, hesitate to initiate procedures that might result in the child being removed from the family's home and -still, even in the face of severe abuse- implicitly seem to believe the child's best fate seems to be with the (abusive) caregiver.

4. **Family/kin supremacy bias seems to be confounded with lack of confidence in their respective agencies' capabilities and fitness to appropriately take care of the child in the way consistent with the child's best interest.** This attitude is particularly pronounced in low to middle income countries, countries with recent histories of political instability and/or violent wars, and countries with huge income discrepancies, where minorities, marginalized ethnical groups and indigenous populations have historically been abused within the system structures that were originally supposed to support them.

Slide 32

### Exploring individual reasons might hinder decisions to report CAN

Attitudes and beliefs such as	due to
<ul style="list-style-type: none"> <li>• "It's not my responsibility"</li> <li>• "I feel uncomfortable intervening in a family's life"</li> <li>• "nothing would be done to help the situation, anyway"</li> <li>• "reporting will not help the child or the family"</li> </ul>	<ul style="list-style-type: none"> <li>• lack of adequate knowledge about CAN</li> <li>• lack of adequate training that mandated reporters receive</li> <li>• previous poor experience with responsible authorities</li> <li>• lack of confidence in authorities and their ability to handle such cases</li> <li>• unclear statutory laws</li> </ul>

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA No: 80508 - CAN-MDS II - Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

<see slide>

Sources:

- Walsh, W., & Jones, L. (2015). Factors that influence child abuse reporting: A survey of child-serving professionals. *Durham, NH: Crimes against Children Research Center.*
- Alrimawi, I., Rajeh Saifan, A., & Abu Ruz, M. (2014). Barriers to child abuse identification and reporting. *Journal of Applied Sciences*, 14: 2793-2803.
- Lynne, E. G., Gifford, E. J., Evans, K. E., & Rosch, J. B. (2015). Barriers to Reporting Child Maltreatment Do Emergency Medical Services Professionals Fully Understand Their Role as Mandatory Reporters?. *North Carolina medical journal*, 76(1), 13-18.
- Azizi, M., & Shahhosseini, Z. (2017). Challenges of reporting child abuse by healthcare professionals: A narrative review. *Journal of Nursing and Midwifery Sciences*, 4(3), 110.

Slide 33

## Exploring individual reasons might hinder decisions to report CAN

### Concerns and fear

- of violence or unknown consequences against the child
- of negative effects on the child's family
- that reporting would damage professional's relationship with family
- of a negative impact on professional's practice
- that someone would find out who made the report
- of legal ramifications for false allegations, fear of litigation
- of family violence against professionals

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[G4 No: 585508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Sources: As above

Slide 34

## Exploring individual reasons might hinder decisions to report CAN

### Practical reasons such as

- not knowing
  - where to report
  - how to report (what is expected by them)
  - what information are necessary to report
- concerns of making inaccurate report (lack of certainty about CAN suspicions when no apparent physical sign of abuse)
- amount of time it takes to make a report
- confidentiality issues associated with reporting CAN cases

### due to

- lack of knowledge about the signs of abuse and neglect
- lack of a step-by-step process to follow when making a report
- lack of adequate knowledge about their role in reporting
- vague organizational protocols

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[G4 No: 585508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Sources: as above

Slide 35

## Exploring individual reasons might hinder decisions to report CAN

### Indecision due to currently applied practices

- not knowing what happens after report is made
- uncertainty about the consequences of reporting

### due to

- lack of feedback to reporters by the authorities about status of report

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GAP-805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Sources: as above

Slide 36

## Tackling CAN underreporting

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GAP-805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Slide 37

## Tackling CAN underreporting

- Coordinated response to CAN involving

- relevant sectors

Multi-agency training can be a cost-efficient approach to building a common understanding of prevention and improving partnership working.

- relevant professionals working with and/or for children

- Judges, Probation Officers, Public Prosecutors, Forensic surgeons' professionals, Lawyers; Child Ombudspersons; Social Workers, Health Visitors, Care providers in institutions; Medical Doctors (general and specialized such as gynecologists, pediatricians, orthopedists, and radiologists), Midwives, Nurses, and Dentists; Child Psychiatrists, Psychiatrists, Psychologists; Police Officers (in general and specialized police investigators in forensic interviews or for crimes against minors); Teachers/Educators (pre-school, kindergarten, primary and secondary education, for children with special needs), School Principals etc.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
[G4 No. 585558] – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



Examples of professional backgrounds per sector

**Welfare related professions:** Social Workers, Health Visitors, Care providers in institutions, other personnel (e.g. working in anti-trafficking agencies, directorates for disability, Child Ombudsperson)

**Justice-related professions:** Judges (family courts, juvenile courts), Probation Officers, Public Prosecutors, Forensic surgeons' professionals, Lawyers, other justice related professions)

**Health related professions:** Medical Doctors (general doctors and specialized doctors such as gynecologists, pediatricians, orthopedists, and radiologists), Midwives, Nurses, and Dentists

**Mental health professions:** Child Psychiatrists, Psychiatrists, Psychologists, Licensed Counselors (Youth Counselors, Family Counselors, etc.)

**Law enforcement related professions:** Police Officers (in general and specialized police investigators e.g. in forensic interviews, for crimes against minors etc.)

**Education-related professions:** Teachers/Educators (pre-school, kindergarten, primary and secondary education, for children with special needs), School Principals

**Other professionals:** Researchers, Data administrators, other school personnel (e.g. school guardians), other Public officials (e.g. ministries' employees), other NGOs personnel (e.g. volunteers, priests, sisters)



Slide 38

## Tackling CAN underreporting

- Biases influencing when professionals report CAN may be affecting over-representation of severe abuse instances—thus, rendering them more recognizable while at the same time making it even more unlikely for professionals to increase thresholds of 'suspicion' when faced with less recognizable cases of CAN.
  - **this suggests that training how to recognize CAN across all relevant professions must include descriptors/indices of all identifiable types of CAN**
- Research has shown that professionals in the relevant sectors are more likely to report suspected CAN cases when they notice factors in the cases' context that they have learned (or just believe) that strongly correlate with CAN.
  - this suggest the need to expand across all relevant professions the evidence base for recognizing children at high risk of maltreatment.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No: 985508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Slide 39

## Capacity-building in the context of CAN-MDS

- Capacity building of multidisciplinary professionals working with children on
  - raising awareness of child maltreatment and its prevalence and impacts
  - how to recognize signs of child abuse and neglect
  - what are the national mandates for reporting CAN and the legal framework
  - why and how to report (highlighting the procedure for reporting and referring cases to appropriate services)
  - facilitating early intervention or support for parents and caregivers

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No: 985508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Source: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1)

Slide 40

## Tackling CAN underreporting

- Tools and common methodology addressing all stakeholders
  - CAN-MDS Toolkit (e-application; Operator's Manual; data collection protocol)
- Case definitions
  - based on the based on the United Nations' Committee on the Rights of the Child's General comment No. 13 (2011), "The right of the child to freedom from all forms of violence" [CRC/C/GC/13 (2011)]
  - In addition, a further review was made including
    - UNCRC Article 19
    - the World Report on VAC (2006)
    - WHO and ISPCANs definitions (2006) and
    - CDCs (2008) definitions

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(EU No. 585558) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



One major challenge of the CAN-MDS is to overcome variations in the definitions of child maltreatment used by professionals, researchers and officials with different professional backgrounds, working in different jurisdictions within and between countries (see "CAN-MDS Operators").

Deciding on whether their suspicion is 'reasonable' before reporting seems to be a major factor in systematic omissions to report, generally. The decision is influenced by biases related to cultural biases about who can do what for a child and under what circumstances, what is, then, 'normal', and what options are there for children in certain context to have reasonably good lives if a report is made. Other, less honorable variables, such as limited notions of accountability, responsibility and a desire to skip some work duties, very often get grouped under the same explanation.

### INCIDENT *for CAN-MDS* is:

*an incident documented by the child protection system, law enforcement, the medical system, or other reporting source (e.g., school) in which child maltreatment is alleged or confirmed*

*Notes: In the context of the CAN-MDS "documented" means "eligible to be entered into the CAN-MDS following a report"*

### CHILD MALTREATMENT INCIDENT REPORTING is:

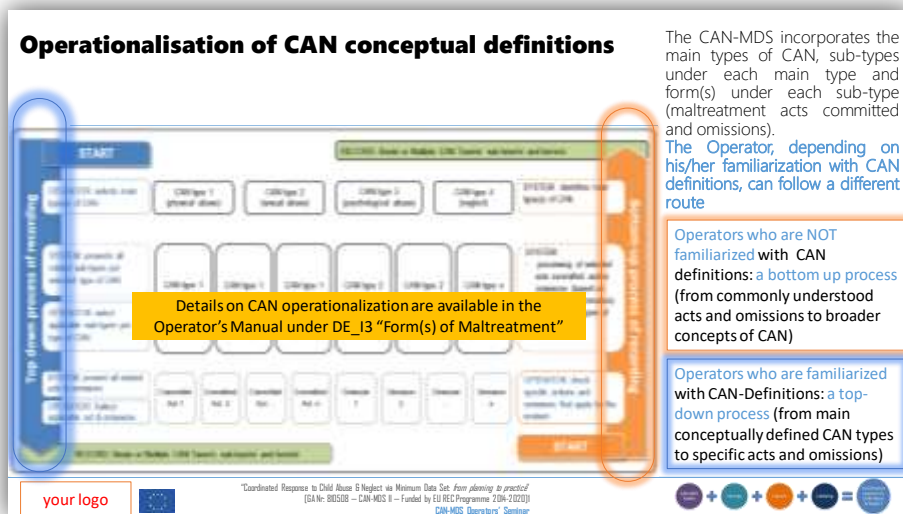
*reporting of a child maltreatment incident by a source of information that involves at least one act of maltreatment or at least one omission in a child's care. A report can refer to a single distinct abuse and/or neglect event/episode or to continuous maltreatment including one or more distinct abuse and/or neglect events/episodes or to continuous maltreatment where no distinct abuse and/or neglect event/episode took place*

*Note: Acts of maltreatment against a child and omissions in a child's care are defined on the basis of CRC/C/GC/13 (2011)*

Cases excluded (i.e. not eligible) from CAN-MDS are the ones where:

- The child's name is not available
- There are no acts of maltreatment or no omissions in the child's care to be recorded---IN OTHER WORDS: FOR CAN-MDS WE HAVE "NO CASE" WHEN WE EITHER HAVE NO WAY OF KNOWING WHO THE CHILD IS, OR THERE IS NO FORM OF CAN SUSPECTED TO BE RECORDED

Slide 41



The use of a commonly understood language and technical specifications is required for making it feasible for a wide range of professionals to contribute to the system by entering CAN incident-based data and to benefit from the system by accessing CAN incident-based data. In order to ensure to the greatest possible extent a common understanding by any potential operator and subsequently, the recording and collection of reliable and comparable information, it is suggested that a **bottom-up process** be adopted for operationalizing CAN case definitions for the needs of the CAN-MDS.

It is as follows: instead of using a broad classification of the main types and subtypes of CAN, pre-coded exhaustive [check]lists of clearly defined *maltreatment acts committed* and *omissions in a child's care* have been developed which can be identified via observation, interview, available information or other means, AND indicate (automatically based on an algorithm) specific subtypes and consequently main types of CAN, allowing at the same time the recording of multiple forms of maltreatment (see slide).

Slide 42

## Important reminders about the CAN-MDS Operators' tasks

Cases of child maltreatment are entered/reported regardless of any plans for future action on the case that the Operator or their work supervisor, or anyone else, may have or may not have → this means that the Operator when recording the CAN case in the system does not need to already know or have decided or even have an opinion on the type of intervention they may need to follow

Cases of child maltreatment are entered/reported regardless of substantiation → this also means that the Operator does not need to first establish the truth of their suspicion before recording the case. They simply record as they come across the incident/case.

Existing literature describes decisions about degree of harm and/or future risk of harm as vital in the underreporting of CAN → CAN-MDS Operators do not need to decide on whether the child in the case they are recording bears visible harm as a prerequisite to record

your logo

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*  
(G4-Ne-985508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

<see slide>



## Slide 43

### The CAN-MDS response to Underreporting

- Accurate and reliable, across sectors, reporting of CAN is necessary in order to monitor Child Protection and Well Being, and in order to identify the interventions that are most needed.
- Underreporting of CAN appears to be systematic, common and of a size impossible to calculate due to a variety of causes and influences, many of them related to the nature of the acts involved and to the exploitation of trust, responsibility and power asymmetry between children and their caregiving adults.
- Underreporting in the present context refers to all the practices and their respective outcomes which result in the CAN incidents registered at State level, globally, being a tiny fraction of the estimated size of the phenomenon.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



[Note: it is suggested to use as is and/or enhance with additional, country-specific content and/or arguments]

## Slide 44

### The CAN-MDS connection to Underreporting

- Underreporting in the present context refers to all the practices and their respective outcomes which result in the CAN incidents registered at State level, globally, being a tiny fraction of the estimated size of the phenomenon.
- CAN-MDS II in its full application tackles the Underreporting practices and many of the respective outcomes in the ways we described in the previous slides.
- In addition, by systematizing and recording alleged and substantiated CAN incidents comprehensive databases will be created that allow comparisons with already existing CAN report rates.

your logo

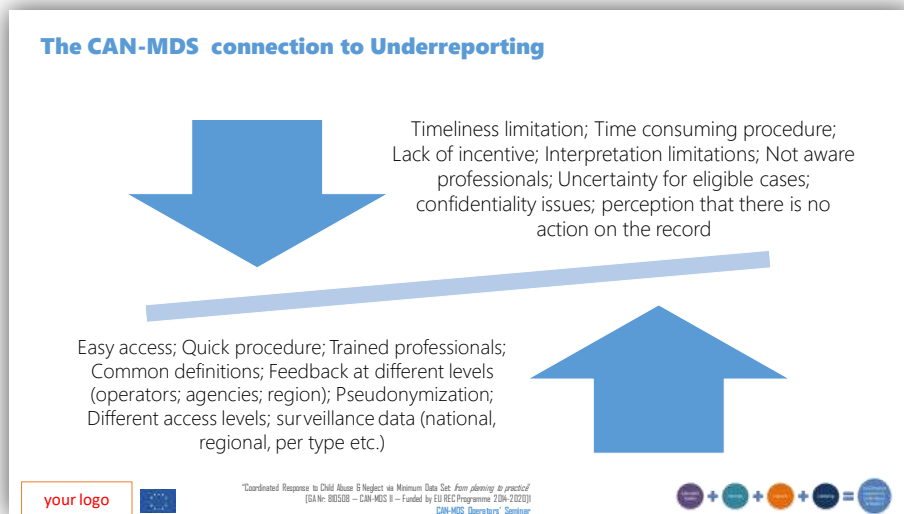


"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Slide 45



[it is suggested to use as is to show again how using CAN-MDS reverses the identified problem]

Easy access into the system etc. are expected to operate as a counterbalance for data collection and interpretation-related limitations

<see slide>

Slide 46

### The CAN-MDS connection to Underreporting

- CAN-MDS , in its full application, will provide a unified database at a national level for professionals across sectors that see children in a capacity which allows them to identify, suspect and report possible maltreatment.
- The children involved are presented with pseudonyms to all operators regardless of their level of access and no data on the perpetrators of the suspected abuse is entered.
- Operators within the involved agencies are invited to enter each case regardless of substantiation.
- Depending on each country's legislation regarding the mandate to report and the legal procedures that must follow, judges, the Attorney General and other professionals in the Justice sector are given Full Access, which means that, based on the information available, they are in position to decide whether to prosecute. In this case, the NAs provide the link to the case's child's identity.

All of the above, essentially mean that:

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[G4 No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar


[Note: it is suggested to use this slide for ideas on how to formulate a concrete, convincing description of how CAN-MDS will enhance the professionals work without adding burden or liability. Emphasize the ultimate effects on children, the specific ways CAN-MDS helps everyone and how risk-free and hassle-free it is for the professionals]

<see slide>


Slide 47

### The CAN-MDS connection to Underreporting

- Each operator, regardless of sector, can have a clear perspective of the way their case has been handled across agencies and time since first report. Eventually, this strengthens operators' understanding of the flow of information, jurisdiction and responsibility distribution across agencies in their countries.
- In addition, during the project's invitation to operators and training of the operators phases, training and specialized knowledge are being provided by the project's NAs regarding the mandate to report, the decision to prosecute and all possible outcomes for a child suspected to be maltreated.

your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[CAN-MDS-GBV-AG-2017/ 810508] – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar




[Note: as above]


Slide 48 [hidden slide]

---

Next slides include information for further reading

your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[CAN-MDS-GBV-AG-2017/ 810508] – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



[Note: Next slides are hidden; here trainers can find further information about CAN underreporting]

Slide 49 [hidden slide]

### Training Points and Material

**[key issues listed on the slide, some background info is found in the slide notes, use them as presentation slides or to initiate Q & A sessions in/during your training]**

jurisdiction

All professionals working with children or meeting children at their work must be aware of the Child Protection legislation that governs their locale.

Country specific websites or printed material may be available that professionals can consult on where to find state legislation and other mandatory reporting resources. Senior-level professionals in the Law Enforcement, Public Policy, Justice, Child Protection sectors may be consulted.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4N-805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

[www.childwelfare.gov](http://www.childwelfare.gov)

[www.cwrp.ca](http://www.cwrp.ca)

<http://www.aihw.gov.au/child-protection>

Slide 50 [hidden slide]

### Training Points and Material

**[key issues listed on the slide, some background info is found in the slide notes, use them as presentation slides or to initiate Q & A sessions in/during your training]**

Gray zones

Most evidence indicates that even in countries where it is in effect, mandate to report presents ambiguities, usually, in the following areas: mandated reporters, types of abuse and neglect, degree of suspicion or suspected harm, or current and future risk that is needed to activate the reporting duty. Legislative failure to stipulate penalties in the case of no report and legal immunity for professionals that do are also found to be key in the decision to not report.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(G4N-805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Slide 51 [hidden slide]

### Training Points and Material

**[key issues listed on the slide, some background info is found in the slide notes, use them as presentation slides or to initiate Q & A sessions in/during your training]**

Who is reporting?

In countries where such data exists, their pattern suggests that school and law enforcement (police) professionals are the most likely to file a report in the face of suspected child maltreatment. Health professionals, in many countries, but not all, despite them being the ones most likely to be more in contact with maltreated children, present characteristically low numbers of reporting in these same studies.

**Key issues to consider before and during Operators' training in partner countries:**

- Can you find similar data for your country? Who is reporting? What kind of training/readiness to recognize and report child maltreatment do they usually receive? How can their position be strengthened? What are key barriers in full reporting among them?

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA-Nr. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Slide 52 [hidden slide]

### Increasing recognition of Child Abuse and Neglect among professionals [this slide, and the notes, are meant to be included in the training; you may change the reference, add more findings and open the discussion; the point that needs to be made is the importance of training professionals to increase recognizing CAN]

Training/knowledge and reporting rates

The Davidov, Jack, Frost, & Coben (2012) study

Reference: Davidov, D.M., Nadorff, M.R., Jack, S.M., & Coben, J.H. (2012). Nurse home visitors' perceptions of mandatory reporting of intimate partner violence to law enforcement agencies. *Journal of interpersonal violence*, 27 12, 2484-502 .

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA-Nr. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

A qualitative study of home visiting nurses involved with high-risk families identified variability in knowledge, attitudes, and opinions about what constitutes maltreatment, as well as when to report children exposed to intimate partner violence



Slide 53 [hidden slide]

**Increasing recognition of Child Abuse and Neglect among professionals** [this slide, and the notes, are meant to be included in the training; you may change the reference, add more findings and open the discussion; the point that needs to be made is the role of suspicion threshold in mandatory reporting]

Training/knowledge and reporting rates

The Levi & Crowell (2011) paper  
Reference: Levi, B.H., & Crowell, K.R. (2011). Child Abuse Experts Disagree About the Threshold for Mandated Reporting. *Clinical Pediatrics*, 50, 321 - 329.

your logo

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*  
[CAN-MDS-GBV-AG-2017/ 810508] – CAN-MDS II – Funded by EU REC Programme 2014-2020  
CAN-MDS Operators' Seminar

Additionally, ambiguity in the mandatory reporting statutes that reference "suspicion" of maltreatment and "reasonable suspicion" of maltreatment may negatively contribute to physicians' confidence in identifying CAN

Slide 54 [hidden slide]

**Increasing recognition of Child Abuse and Neglect among professionals** [this slide, and the notes, are meant to be included in the training; you may change the reference, add more findings and open the discussion; the point that needs to be made is the role training physicians to recognize CAN and/or on Child Protection within Health Care settings]

Training/knowledge and reporting rates

(Ward et al., 2004)  
Reference: Ward, M. G., Bennett, S., Plint, A. C., King, W. J., Jabbour, M., & Gaboury, I. (2004). Child protection: a neglected area of pediatric residency training. *Child abuse & neglect*, 28(10), 1113-1122.

your logo

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*  
[CAN-MDS-GBV-AG-2017/ 810508] – CAN-MDS II – Funded by EU REC Programme 2014-2020  
CAN-MDS Operators' Seminar

A Canadian study of pediatric residents arrived at similar conclusions, with 92% of residents reporting a desire for a more extensive educational program in child protection

Slide 55 [hidden slide]

**Increasing recognition of Child Abuse and Neglect among professionals** [this slide, and the notes, are meant to be included in the training; you may change the reference, add more findings and open the discussion; the point that needs to be made is the role training physicians to recognize CAN and/or on Child Protection within Health Care settings]

Training/knowledge and reporting rates

Flaherty et al. (2008) report findings that additional trainings of physician increased reporting (x 10) to Child Protection Services

References:  
Flaherty, E. G., Sege, R., Binns, H. J., Mattson, C. L., & Christoffel, K. K. (2000). Health care providers' experience reporting child abuse in the primary care setting. *Archives of pediatrics & adolescent medicine*, 154(5), 489-493.  
Flaherty, E. G., Sege, R. D., & Hurley, T. P. (2008). Translating child abuse research into action. *Pediatrics*, 122(Supplement 1), S1-S5.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

These selected studies suggest that additional training for professionals may be valuable.

According to these reports, receiving formal education in child maltreatment following physicians' residency program, makes it 10 times more likely to report concerns to CPS compared to those who did not.

Useful resource: <http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Tips/Reports/SB258%20Report.pdf>

Slide 56 [hidden slide]

**Increasing recognition of Child Abuse and Neglect among professionals** [this slide, and the notes, are meant to be included in the training; you may change the reference, add more findings and open the discussion; the point that needs to be made is that even after increased reporting following training, concerns about other aspects (i.e. litigation) remain]

Training/knowledge and reporting rates

Gilbert, Kemp, Thoburn, Sidebotham, Radford, Glaser, & MacMillan (2009) report, however, that findings on increased reporting following training are not uniform.  
Besides, concerns regarding litigation following reporting are considered significant factor in underreporting

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

References:

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. L. (2009). Recognising and responding to child maltreatment. *The lancet*, 373(9658), 167-180.  
Runyan, D., May-Chahal, C., Ikeda, R., Hassan, F., & Ramiro, L. (2002). Child Maltreatment. In E.G. Krug, L.L. Dahlberg, J.A., Mercy, A.B. Zwi, R. Lozano, & WHO (Eds.). In *World report on violence and health* (pp.58-85)

PART 5 – DURATION: 60 MIN


Slide 1

## Tackling CAN under-reporting

definition of violence and  
how to recognize CAN cases

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar




Slide 2

## outline

- Child abuse and neglect
  - *myths & facts*
- Definition of violence against children
  - *legal analysis of art. 19 of CRC [UN CRC, GC 13 (2011)]*
- Explore forms of violence
  - *case examples*
- Recognizing child abuse and neglect
  - *warning signs*
- Short- and long term consequences of child abuse and neglect
  - *at a glance*

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



We will start this session by mentioning some common myths around child abuse and neglect; next we will proceed in the operational definition of violence against children according to General Comment 13 (2011) of the UN Committee on the basis of which the CAN-MDS was built. A short discussion based on case examples will follow. Next warning signs for each individual form of child maltreatment (physical, sexual, psychological abuse and neglect) will be presented; on the basis of such signs may be recognized by professionals. Lastly short and long term consequences of child abuse and neglect will be mentioned.

Slide 3

## child abuse and neglect

- Child abuse refers to any emotional, sexual, or physical mistreatment or neglect by an adult in a role of responsibility toward someone who is under 18 years of age
- It refers to any kind of action or failure to act (omission) that results in harm or possible harm for a child.
- The action may or may not be violent
- The adult may be a parent or other family member or another caregiver, including professional caregivers, sports coaches, teachers, and so on
- It can happen at home or elsewhere, and it occurs in all cultures, countries, and economic classes. It usually involves a family member or friend, rather than a stranger

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GRN: 085508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



In this slides some general characteristics of child abuse and neglect are listed. Specifically:  
<see slide>

Slide 4

## Myths about child abuse and neglect

- People, including professionals, often have reservations when it comes to reporting child abuse: perhaps they think
  - they are overreacting
  - it is none of their business, or
  - they might not know what 'abuse' really means→ As a result many people who suspect child abuse **DO NOTHING**
- In the following slides some common myths around reporting child abuse and neglect are presented as well as the corresponding facts.

**If the barriers to reporting child abuse and neglect are removed, underreporting and, therefore, child abuse and neglect will be tackled.**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GRN: 085508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Even today there are a lot of false beliefs around child abuse and neglect that often prevent people from reporting CAN incidents.

<see slide>

Slide 5

**child abuse is rare**

**myth**

**fact**

all types of child abuse and neglect are common worldwide. Child abuse and neglect are often not identified as they occur in privacy and secrecy. Children also find it hard to disclose, and be believed. Often there is little evidence to substantiate the crime.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GR No. 885508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 6

**It's only abuse if it's violent or  
It's only child abuse if there's  
physical or sexual violence**


**myth**

**fact**


Physical abuse is just one type of child abuse. Child abuse does not necessarily involve violence or anger: neglect, sexual and emotional abuse can inflict just as much damage, and since they're not always as obvious, others are less likely to intervene. Therefore, all types of abuse must be taken extremely seriously

Abuse often involves adults wielding their power over children, and using children as objects rather than respecting their rights

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GR No. 885508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 7

**children make up stories about abuse**

or

**children are just attention seeking when they act up**

**myth**

**Fact**

a child rarely lies about abuse. A child may change what they've said if they've been pressured or threatened to deny what's happened, or they're afraid of being removed from their family after they've told someone about it.

Moreover, changes in behaviour are one of the key signs that a child may be suffering from abuse or neglect

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[SA No: 810508] – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 8

**sometimes children are to blame for their abuse**

**myth**

**Fact**

a child is never to blame for abuse. Adults are responsible for their own behaviour and no matter how a child behaves, adults have no right to harm a child.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[SA No: 810508] – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 9

**only young children are abused**

**myth**

**Fact**

child abuse can happen to babies, children or teenagers. It may seem that teenagers should be able to fight back, but it's hard to stand up to an adult who is causing the abuse, especially a parent. Child abuse is often an abuse of power and trust. Cruel words or sexual or physical abuse hurts teenagers as much as it hurts a child.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GK No. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 10

**abuse doesn't happen in "good" families or neighborhoods**

**myth**

**fact**

abuse and neglect happen cross all racial, economic, and cultural lines. It can happen in any family regardless of their wealth or education.  
People who harm children can come from any background, culture or religion, and have any kind of job.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GK No. 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>




Slide 11

**children aren't affected by domestic violence if they don't see it happen**

**myth**

**Fact**

a child doesn't need to see domestic violence to know it's happening and be affected by it. A child sees how violence affects the person close to them.

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GR No. 180508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>


Slide 12

**physical discipline is not child abuse**

**myth**

**Fact**

children can be disciplined to behave in a more acceptable way. Physical discipline will become physical abuse if it causes harm or injury to a child. There are many ways to discipline children without using force.

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GR No. 180508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>



Slide 13

**most child abusers are strangers**


**myth**

**fact**

while abuse by strangers does happen, most abusers are family members or others close to the family

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GK-Nr. 810508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

Slide 14

**abused children always grow up to be abusers**

**myth**


**fact**

It is possible that abused children are likely to repeat the cycle as adults, unconsciously repeating what they experienced as children.

On the other hand, many adult survivors of child abuse have a strong motivation to protect their children against what they went through and become excellent parents

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GK-Nr. 810508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

## Slide 15

**children usually tell someone about their abuse**

**myth**

**Fact**

most children do not tell anyone. They are often silenced through threats or fear of not being believed. Some children don't have the words to speak about what is happening to them.

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(CAN-MDS II – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

## Slide 16

### Definition of violence

**"violence"**

is understood to mean

**"all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse"**

*as listed in article 19, paragraph 1, of the UNCRC*

UN Committee on the Rights of the Child (CRC), General comment No. 13 (2011): The right of the child to freedom from all forms of violence, 18 April 2011, CRC/C/GC/13, available at: <https://www.refworld.org/docid/4e6da4922.html>

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(CAN-MDS II – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

The term violence has been chosen in the General Comment 13 (2011) of the UN Committee to represent all forms of harm to children as listed in article 19, paragraph 1, in conformity with the terminology used in the 2006 United Nations study on violence against children, although the other terms used to describe types of harm (injury, abuse, neglect or negligent treatment, maltreatment and exploitation) carry equal weight. In common parlance the term violence is often understood to mean only physical harm and/or intentional harm. However, the Committee emphasizes most strongly that the choice of the term violence in the present general comment must not be interpreted in any way to minimize the impact of, and need to address, non-physical and/or non-intentional forms of harm (such as, inter alia, neglect and psychological maltreatment).

Source: CRC/C/GC13-2011

## Slide 17

### Legal analysis of article 19.1 of UNCRC "... all forms of ..." **No exceptions.**

- All forms of violence against children, however light, are unacceptable
- "All forms of physical or mental violence" does not leave room for any level of legalized violence against children
- Frequency
- Severity of harm
- Intent to harm

are not prerequisites for the definitions of violence

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 985508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Comment about frequency, severity of harm and intent of harm:

State parties may refer to such factors in intervention strategies in order to allow proportional responses in the best interests of the child, but definitions must in no way erode the child's absolute right to human dignity and physical and psychological integrity by describing some forms of violence as legally and/or socially acceptable.

## Slide 18

### **The need for child rights-based definitions**

- **clear operational legal definitions** are required of the different forms of violence outlined in article 19 of CRC in order to ban all forms of violence in all settings
- definitions must be sufficiently **clear** to be **usable** and should be **applicable** in different societies and cultures.
- **efforts to standardize definitions internationally in order to facilitate data collection and cross-country exchange of experiences should be encouraged**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 985508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



In addition, state parties need to establish national standards for child well-being, health and development as securing these conditions is the ultimate goal of child caregiving and protection.

Slide 19

## Forms of Violence

UN Committee on the Rights of the Child (CRC), General comment No. 13 (2011): *The right of the child to freedom from all forms of violence*

- Neglect or negligent treatment
- Mental violence / psychological maltreatment
- Physical violence
- Corporal punishment
- Sexual abuse and exploitation
- Torture and inhuman or degrading treatment or punishment
- Violence among children
- Self-harm
- Harmful practices
- Violence in the mass media
- Violence through information and communications technologies
- Institutional and system violations of child rights



These are the forms of violence against children as they are described in the previously mentioned general comment. In the next slides more details per form of violence are presented. Given that operational definitions of CAN-MDS are based on this specific comment, it is considered as necessary for system's operators to be informed on these details.

Slide 20

## Neglect or negligent treatment

- means the failure to meet children's physical and psychological needs, protect them from danger, or obtain medical, birth registration or other services when those responsible for children's care have the means, knowledge and access to services to do so

It includes:

- Physical neglect
- Psychological or emotional neglect
- Neglect of children's physical or mental health
- Educational neglect
- Abandonment



Every instance when the caregiver systematically endangers the child or fails to fulfill the child's basic needs, resulting in health and/ or developmental problems for the child.

Is seen in various forms, such as in cases when nutrition, medical care, clothing, housing, education, or child monitoring afforded to the child are so intensely inadequate or inappropriate that the child's health and development are either being overlooked and/or jeopardized. It includes:

**Physical neglect:** failure to protect a child from harm, including through lack of supervision, or failure to provide the child with basic necessities including adequate food, shelter, clothing and basic medical care;

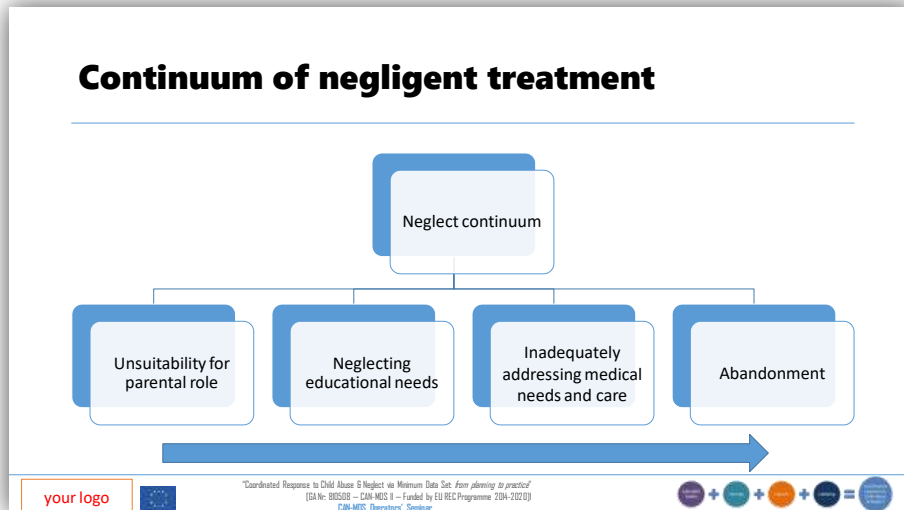
**Psychological or emotional neglect:** including lack of any emotional support and love, chronic inattention to the child, caregivers being "psychologically unavailable" by overlooking young children's cues and signals, and exposure to intimate partner violence, drug or alcohol abuse;

**Neglect of children's physical or mental health:** withholding essential medical care;

**Educational neglect:** failure to comply with laws requiring caregivers to secure their children's education through attendance at school or otherwise; and

**Abandonment:** a practice which is of great concern and which can disproportionately affect, inter alia, children out of wedlock and children with disabilities in some societies.

Slide 21



Negligent treatment, similarly to the remaining forms of child maltreatment, consists of a continuum of omissions that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed. For example:

<see slide>

Slide 22



Other neglect manifestations are listed in the slide

Slide 23

## Mental violence

often described as **psychological abuse**, **mental abuse**, **verbal abuse** and **emotional abuse**

It includes:

- all forms of persistent harmful interactions with the child
- scaring, terrorizing and threatening; exploiting and corrupting; spurning and rejecting; isolating, ignoring and favouritism
- denying emotional responsiveness; neglecting mental health, medical and educational needs
- insults, name-calling, humiliation, belittling, ridiculing and hurting a child's feelings
- exposure to domestic violence
- placement in solitary confinement, isolation or humiliating or degrading conditions of detention
- psychological bullying and hazing by adults or other children, including via ICTs

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar

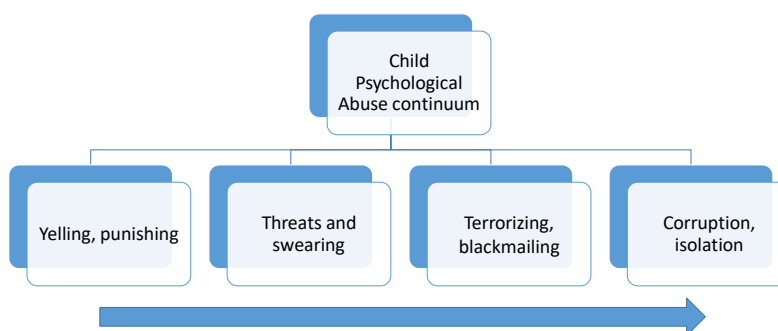


Mental violence or emotional or psychological abuse includes separate instances and a pattern of continued failure on the part of the caregivers to provide a child with the conditions they need to grow and thrive. This type of abuse includes limiting the child's movement, their humiliation, the use of threats and blame, discrimination against the child's person, their ridiculing and other forms of rejection and/or hostile treatment. It includes:

- All forms of persistent harmful interactions with the child, for example, conveying to children that they are worthless, unloved, unwanted, endangered or only of value in meeting another's needs
- Scaring, terrorizing and threatening; exploiting and corrupting; spurning and rejecting; isolating etc
- Denying emotional responsiveness; neglecting mental health, medical and educational needs
- Insults, name-calling, humiliation, belittling, ridiculing and hurting a child's feelings
- Exposure to domestic violence
- Placement in solitary confinement, isolation or humiliating or degrading conditions of detention and
- Psychological bullying and hazing by adults or other children, including via information and communication technologies (ICTs) such as mobile phones and the Internet (known as "cyberbullying")

Slide 24

## Psychological Abuse continuum



your logo

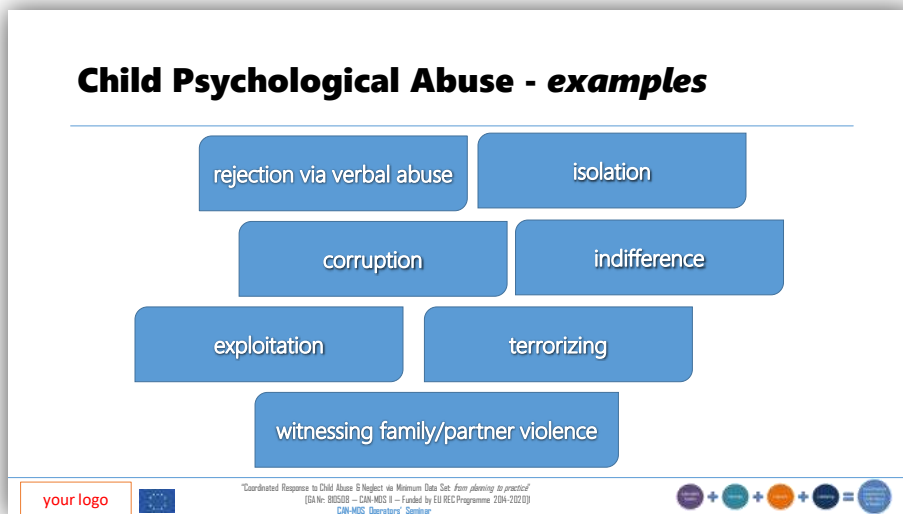


"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar



It consists of a continuum of acts that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed. For example: <see slide>

Slide 25



<see slide>

Slide 26

### Physical violence

- includes **fatal and non-fatal physical violence**

It includes:

- all corporal punishment and all other forms of torture, cruel, inhuman or degrading treatment or punishment
- physical bullying and hazing by adults and by other children.
- children with disabilities may be subject to particular forms of physical violence
  - forced sterilization, particularly girls
  - violence in the guise of treatment (for example electroconvulsive treatment (ECT) and electric shocks used as "aversion treatment" to control children's behaviour)
  - deliberate infliction of disabilities on children for the purpose of exploiting them for begging in the streets or elsewhere

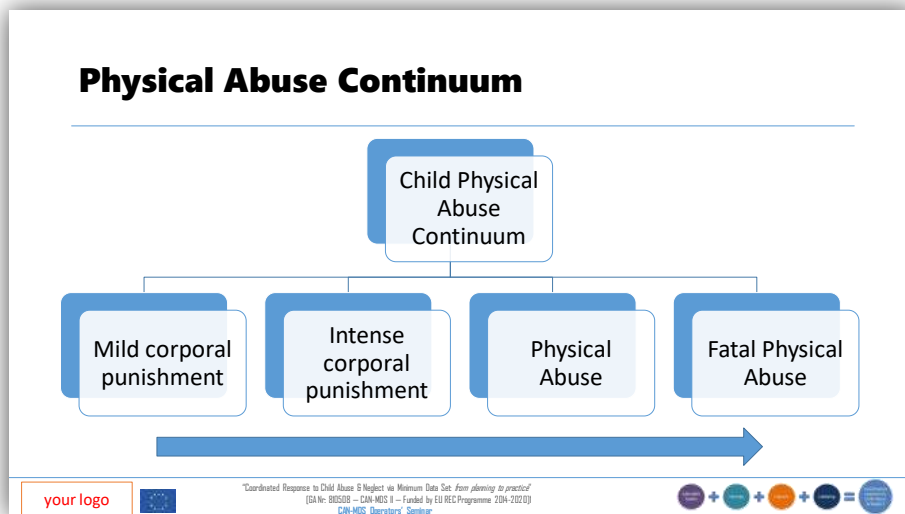
your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(CA No. 985508) – CAH-MDS II – Funded by EU REC Programme 2014-2020)  
CAH-MDS Operators' Seminar

Physical violence is defined as the intentional use of violence against a child's body, which causes or may cause harm affecting the child's health, survival, growth or their dignity. Violence on the body includes all types of blows, beatings, kicking, shaking, biting, struggling, burning, poisoning and asphyxiation. It is often the case that the violence against the child's body takes place in the context of corporal punishment. Is every instance/case when a child sustains bodily injury as a result of an adult's actions, who is supposed to have the child under their care.

<see also slide>

Slide 27



It consists of a continuum of acts that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed.  
For example: <see slide>

Slide 28

### Physical Abuse effects on the Body

- No injury
  - No obvious injury
- Minor (slight) injury
  - Superficial injuries such as small bruises or surface cuts
- Requiring treatment or hospitalization injury
  - Such as fractures that needed to be treated with a cast
- Severe injury
  - Internal bleeding, organ perforations, blood vessels ruptures
- Critical injury (life threatening)
  - Likely to lead to death

Physical abuse effects may include/be:

- all kinds of injuries and traumas
- singular or multiple
- of varying severity
- that are seen across all ages
- which are not caused by some accident

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No: 805508 – CAH-MDS II – Funded by EU REC Programme 2014-2020)  
CAH-MDS Operators' Seminar

Actual effects of physical abuse on the child's body can vary from no injury or no obvious injury to life threatening injuries. Apart from their severity, when there are injuries, they can be of various types, singular or multiple, and seen across all ages.  
It is noted that even in cases of physical abuse without obvious injuries the acts should still considered as abuse because they could potentially result in injury.



Slide 29

## Distinguishing **abuse** from **accident**

- The very nature of childhood invites accidents
  - children are curious and fearless; they run, climb, jump, and explore
- When observing an injury you suspect might be the result of abuse, consider:
  - Location of the injury
  - Number and frequency of injuries
  - Size and shape of the injury
  - Description of how the injury occurred
  - Consistency of injury with the child's developmental capability
  - Remember that accidents happen

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GRN: 08550) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



It is important, however, to make the distinction between injury due to physical abuse and due to accident.  
<see slide>

In more detail,

**Location of the injury:** Certain locations on the body are more likely to sustain accidental injury. They include the knees, elbows, shins, or forehead. Protected body parts and soft tissue areas, such as the back, thighs, genital area, buttocks, back of the legs, or face, are less likely to accidentally come into contact with objects that could cause injury.

**Number and frequency of injuries:** The greater the number of injuries, the greater the cause for concern. Unless the child is involved in a serious accident, he/she is not likely to sustain a number of different injuries accidentally. Multiple injuries in different stages of healing may indicate abuse.

**Size and shape of the injury:** Many non-accidental injuries are inflicted with familiar objects: a stick, a board, a belt, or a hair brush. The injury could also be a handprint. These marks bear strong resemblance to the object that was used. Accidental marks resulting from bumps and falls usually have no defined shape.

**Description of how the injury occurred:** If an injury is accidental, there should be a reasonable explanation of how it happened that is consistent with the appearance of the injury. When the description of how the injury occurred and the injury are inconsistent, there is cause for concern. For example, it is not likely that a fall off a chair onto a rug would produce bruises all over the body.

**Consistency of injury with the child's developmental capability:** As a child grows and gains new skills, their ability to engage in activities which can cause injury increases. A toddler trying to run is likely to suffer bruised knees and a bump on the head and is less likely to suffer a broken arm than is an eight-year-old who has discovered the joy of climbing trees. A two-week-old infant does not have the movement capability to self-inflict a bruise.

**Remember that accidents happen:** When assessing an injury, consider whether the child is developmentally capable of causing his or her own injuries. Also consider the child's size and whether he/she is able to generate sufficient force to create injury. Parents are not perfect. Injuries occur that might have been avoided. Nevertheless, there is cause for concern when injuries recur and/or the explanation is inconsistent with the injury or the child's developmental abilities.

Source: A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [https://www.dss.virginia.gov/files/division/dfs/mandated\\_reporters/cps/resources\\_guidance/032-02-0280-03-eng-07-19.pdf](https://www.dss.virginia.gov/files/division/dfs/mandated_reporters/cps/resources_guidance/032-02-0280-03-eng-07-19.pdf)

Slide 30

## Corporal punishment

- Corporal punishment involves the deliberate infliction of pain to discipline children, and is an important risk factor for child maltreatment
- The legality of corporal punishment in some countries represents a violation of children's rights of equal protection under the UNCRC
- Corporal punishment not only has physical implications, but also adversely affects mental health and well-being
- Legislation banning corporal punishment effectively reduces violence against children

As for the corporal punishment, in the General Comment No. 8 (para. 11), the Committee defined "corporal" or "physical" punishment as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting ("smacking", "slapping", "spanking") children, with the hand or with an implement - a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, caning, forcing children to stay in uncomfortable positions, burning, scalding, or forced ingestion. In the view of the Committee, corporal punishment is invariably degrading.

Source: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1)

A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. At:

[www.dss.virginia.gov/files/division/dfs/mandated\\_reporters/cps/resources\\_guidance/032-02-0280-03-eng-07-19.pdf](http://www.dss.virginia.gov/files/division/dfs/mandated_reporters/cps/resources_guidance/032-02-0280-03-eng-07-19.pdf)

<https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864>

Slide 31

## Corporal punishment in [your country]

- the use of corporal punishment on children by parents is [illegal/not illegal in your country]
- corporal punishment is [permitted/not permitted] in schools, foster homes and other child caring settings
- there is people still use corporal punishment as a way to discipline their children; corporal punishment, however,
  - teaches children to resolve conflicts violently and to use physical power rather than reason to obtain results or express anger
  - can easily result in unintended injury to a child due to the difference in size between an adult and a child, the presence of anger, and the use of force

the line between corporal punishment and physical abuse is subjective, unclear and varies from case to case

[Please complete the slide with country specific information (see also Step by step Guide for Administrators)]

Any corporal punishment may leave emotional scars. Parental behaviors that cause pain, physical injury or emotional trauma — even when done in the name of discipline — could be child abuse to avoid harm corporal punishment should be avoided

Slide 32

## Sexual abuse and exploitation

includes:

- the inducement or coercion of a child to engage in any unlawful or psychologically harmful sexual activity
- the use of children in commercial sexual exploitation
- the use of children in audio or visual images of child sexual abuse
- child prostitution, sexual slavery, sexual exploitation in travel and tourism, trafficking (within and between countries) and sale of children for sexual purposes and forced marriage.
  - many children experience sexual victimization which is not accompanied by physical force or restraint but which is nonetheless psychologically intrusive, exploitive and traumatic.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar

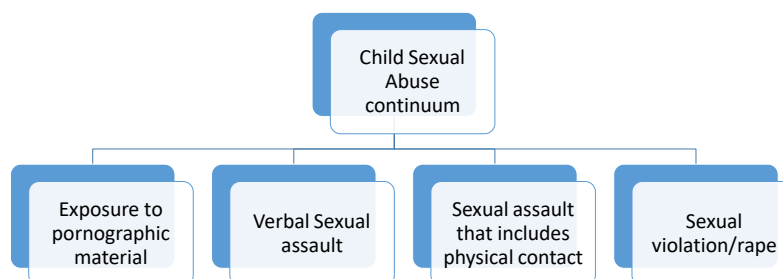


Sexual abuse is defined as the child's participation in any sexual activity that they don't fully understand, about which they are by default unable to provide consent, or they are developmentally immature to be in , or violates the laws and taboos of the specific and global culture. Child sexual abuse may be perpetrated by adults or by other children, who, due to age or developmental stage are in a position of responsibility, trust or power in relation to the child victim.

It includes: physical contact & non physical contact (i.e. picture taking)

Slide 33

## Child Sexual Abuse continuum



your logo



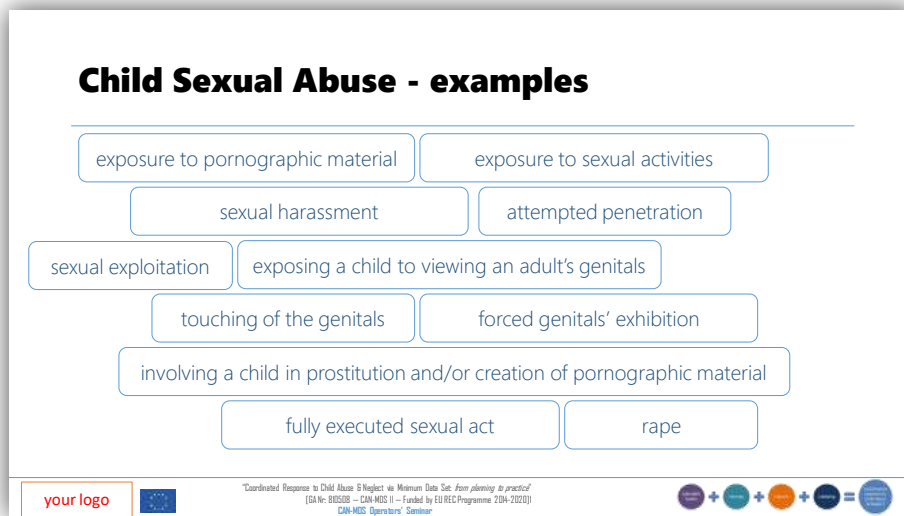
"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar



It consists from a continuum of acts that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed.

For example: <see slide>

Slide 34



<see slide>

Slide 35

### Torture and inhuman or degrading treatment or punishment

- includes violence in all its forms against children in order
  - to extract a confession
  - to extrajudicially punish children for unlawful or unwanted behaviours
  - to force children to engage in activities against their will
- victims are often children who are marginalized, disadvantaged and discriminated against and who lack the protection of adults responsible for defending their rights and best interests
  - this includes children in conflict with the law, children in street situations, minorities and indigenous children, and unaccompanied children
- the brutality of such acts often results in life-long physical and psychological harm and social stress

your logo   "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA No. 88508) – CAH-MDS II – Funded by EU REC Programme 2014-2020) CAH-MDS Operators' Seminar

Such type of acts are often applied by police and law-enforcement officers, staff of residential and other institutions and persons who have power over children, including non-State armed actors.

Slide 36

## Violence among children

- includes physical, psychological and sexual violence, often by bullying, exerted by children against other children, frequently by groups of children
  - not only harms a child's physical and psychological integrity and wellbeing in the immediate term, but often has severe impact on his or her development, education and social integration in the medium and long term
- also, violence by youth gangs takes a severe toll on children, whether as victims or as participants.
  - although children are the actors, the role of adults responsible for these children is crucial in all attempts to appropriately react and prevent such violence, ensuring that measures do not exacerbate violence by taking a punitive approach and using violence against violence.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



To be noted at this point that the most prominent feature of CAN is the asymmetry of the relationship of the involved parties, namely the relationship of "responsibility, trust and power" between the perpetrator and the victim. That is what distinguishes CAN from other forms of interpersonal violence (WHO, 1999).

Bullying, though involving other minor persons in the role of the victim, but who are generally superior to the victim, is generally regarded as a form of abuse.

On the other hand, phenomena like quarrels, beatings or other aggressive behaviors among more or less same-age children do not fall under the definition of abuse; voluntary consensual sexual intercourse between adolescents and/or children does not fall under the definition of child sexual abuse.

In the context of CAN-MDS violence among children is also considered as negligent treatment mainly on the part of caregivers of children-perpetrators

<see slide>

Slide 37

## Self-harm

includes

- eating disorders
- substance use and abuse
- self-inflicted injuries
- suicidal thoughts
- suicide attempts and
- actual suicide

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



Suicide among adolescents is of particular concern to the Committee.  
For more information trainees can read the CRC/C/GC13(2011).

Slide 38

## Harmful practices

include, but are not limited to:

- Corporal punishment and other cruel or degrading forms of punishment
- Female genital mutilation
- Amputations, binding, scarring, burning and branding
- Violent and degrading initiation rites; force-feeding of girls; fattening; virginity testing (inspecting girls' genitalia)
- Forced marriage and early marriage
- Honour crimes; "retribution" acts of violence (where disputes between different groups are taken out on children of the parties involved); dowry-related death and violence
- Accusations of "witchcraft" and related harmful practices such as "exorcism"
- Uvulectomy and teeth extraction.

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Slide 39

## Violence in the mass media

- Mass media, especially tabloids and the yellow press, tend to highlight shocking occurrences and as a result create a biased and stereotyped image of children, in particular of disadvantaged children or adolescents, who are often portrayed as violent or delinquent just because they may behave or dress in a different way
- such stirred-up stereotypes pave the way for State policies based on a punitive approach, which may include violence as a reaction to assumed or factual misdemeanours of children and young persons

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Slide 40

## Violence through information and communications technologies - ICTs

Child protection risks in relation to ICT comprise the following overlapping areas:

- Sexual abuse of children to produce both visual and audio child abuse images facilitated by the Internet and other ICT
- The process of taking, making, permitting to take, distributing, showing, possessing or advertising indecent photographs or pseudophotographs ("morphing") and videos of children and those making a mockery of an individual child or categories of children
- Children as users of ICT:
  - As recipients of harmful information
  - As children in contact with others through ICT (e.g. child "luring" and "grooming")
  - As actors, children may become involved in bullying or harassing others ..., and/or illegal downloading, hacking, gambling, financial scams and/or terrorism

Children as users of ICT:

- As recipients of information, children may be exposed to actually or potentially harmful advertisements, spam, sponsorship, personal information and content which is aggressive, violent, hateful, biased, racist, pornographic<sup>11</sup>, unwelcome and/or misleading
- As children in contact with others through ICT, children may be bullied, harassed or stalked (child "luring") and/or coerced, tricked or persuaded into meeting strangers off-line, being "groomed" for involvement in sexual activities and/or providing personal information
- As actors, children may become involved in bullying or harassing others, playing games that negatively influence their psychological development, creating and uploading inappropriate sexual material, providing misleading information or advice, and/or illegal downloading, hacking, gambling, financial scams and/or terrorism

Slide 41

## Institutional & system violations of child rights

- authorities at all levels of the State responsible for the protection of children from all forms of violence may directly and indirectly cause harm by lacking effective means of implementation of obligations under the UNCRC
- Such omissions include
  - failure to adopt or revise legislation and other provisions
  - inadequate implementation of laws and other regulations
  - insufficient provision of material, technical and human resources and capacities to identify, prevent and react to violence against children
- it is an omission when measures and programmes are not equipped with sufficient means to assess, monitor and evaluate progress or shortcomings of the activities to end violence against children
- in the commission of certain acts, professionals may abuse children's right to freedom from violence, for example, when they execute their responsibilities in a way that disregards the best interests, the views and the developmental objectives of the child

<see slide>

Slide 42

**Case Examples - Discussion**

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Steps + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

[Instruction: You may use one or more of the following case examples for discussion; alternatively you can move some or all of the case examples after the presentation of the warning signs of child abuse and neglect, namely after current slide 74]

Slide 43

**Case example**

► A 12 year old girl was having trouble with her computer while her father napped on the couch. When she first approached him, he asked her to wait until after his nap. The second time the girl interrupted his sleep, he yelled at her. The third time she woke him, he yelled at her and kicked a step stool in anger that ended up flying over the couch hitting his daughter in the face. He immediately took her to the hospital, where she received three stitches in her nose and was treated for other abrasions to her face. Father said that the injury was accidental and not deliberate.

**Is this a case of child abuse and neglect?**  
**If so, what signs of maltreatment are present?**

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Steps + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

[Physical abuse case - discussion on whether this can be accidental injury]

Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. ([link](#))



Slide 44

## Case example

Realizing that few people are suspicious of a young child, Tom and Mary encourage their 4 year old daughter to take things from stores. Their daughter, Anna, thinks of this behaviour as a fun game and is not at all distressed about it. Tom and Mary justify their behaviour by saying that money is really tight and that it is appropriate for Anna to help out. They also point out that if Anna was caught, nothing bad would happen to her because of her young age.

**Is this a case of child abuse and neglect?  
If so, what signs of maltreatment are present?**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



[Psychological abuse - discussion on whether this is a case of exploitation and corruption]

Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. ([link](#))

Slide 45

## Case example

Mary, age 18, was concerned that her boyfriend, Tom, was going to leave her. In an attempt to keep him, she stopped taking her birth control pills without Tom's knowledge and became pregnant. Although Tom stayed around during the pregnancy, he left shortly after their son, John, was born.

Mary continually tells John that he is a failure because he was not good enough to keep his father around. When a friend tells Mary that she should not say things like that, Mary says it doesn't matter because John is only 26 months and does not understand what she is saying.

Although Mary takes care of John, she does not seem to enjoy being with him, and she seldom plays with him.

**Is this a case of child abuse and/or neglect?  
If so, what signs of maltreatment are present?**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



[Emotional neglect; rejection; psychological abuse - discussion on whether this is a case of CAN]

Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. ([link](#))

Slide 46

## Case example

- ▶ A 13-year-old girl tried to pierce her belly by herself when her mother refused to allow her to do so. Since then, an infection that has lasted several weeks has begun. Despite extreme pain, weight loss, lethargy and apparent infection in the area, the mother did not seek medical attention. When another family member finally transported her to the hospital, the mother claimed that she did not realize the seriousness of her daughter's illness and that the girl herself was responsible for what happened as she did not comply with the rules.

**Is this a case of child abuse and/or neglect?  
If so, what signs of maltreatment are present?**



[Medical neglect; Psychological abuse/ blame - discussion on whether this is a case of CAN]

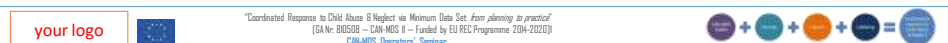
Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. ([link](#))

Slide 47

## Case example

- ▶ Three children, ages 7 years, 2 years and 17 months, were left in a care from almost 45 minutes while their babysitter, 21 years old, shopped for groceries. The outside temperature that day was 33.4°C. An employee from the next store noticed the children and she brought them water.

**Is this a case of child abuse and/or neglect?  
If so, what signs of maltreatment are present?**



[Physical neglect: failure to protect a child from harm, including through lack of supervision - discussion on whether this is a case of CAN]

Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. ([link](#))

Slide 48

## Vignettes

### Incidents of child abuse and neglect

- ▶ A parent leaves her 2-year-old child unsupervised at home while s/he runs a quick job
- ▶ A parent puts a young child in the bathtub and leaves the room for a break
- ▶ A parent or caretaker shakes a baby to get the infant to stop crying
- ▶ A parent hits his/her unruly teenager leaving bruises, cuts or welts
- ▶ A parent frequently tells the child they're no good and should never have been born
- ▶ A family member engages in sexual behavior with a child by touching the child inappropriately or making the child participate in sexual activities

**Is this a case of child abuse and/or neglect?  
If so, what signs of maltreatment are present?**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



[Instruction - Other examples you can use to start a discussion]

Slide 49

## Recognizing Child Abuse and Neglect

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



In the following slides warning signs of various types of child maltreatment are presented. These signs can appear in the child's body, emotion and behavior, as well as in caregivers behavior and in the relationship between child and caregivers.

It is reminded that more information and definitions of the signs mentioned below are included in the CAN-MDS Operator's Manual, Part 3 "Data Dictionary"

Slide 50

## Recognizing CAN

The following signs may signal the presence of child abuse or neglect

### The Child

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home

### The Parent

- Shows little concern for the child
- Denies the existence of—or blames the child for—the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of emotional needs

### Parent & Child

- Rarely touch or look at each other
- Consider their relationship entirely negative
- State that they do not like each other

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination.

<see slide>

Source: <https://www.childwelfare.gov/pubPDFs/signs.pdf>

**Suggested further reading:** Sistovaris, M., Fallon, B., Miller, S., Birken, C., Denburg, A., Jenkins, J., Levine, J., Mishna, F., Sokolowski, M. and Stewart, S. (2020). *Child Welfare and Pandemics*. Toronto, Ontario: Policy Bench, Fraser Mustard Institute of Human Development, University of Toronto. At: ([Link](#))

Slide 51

## Recognising CAN

overview of common signs per type of CAN

your logo




"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar




Slide 52

## Signs of Physical Abuse

\*CAN-MDS II Operators come from various sectors, not all of them will be having access to all indicators groups presented here

your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[SA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar




Slide 53

## Signs seen on the child's body and appearance


**Physical Abuse**

- Unexplained scratches, bruises, fractures, black eyes
- Wounds that look like bites or belt imprints
- Bruises in soft areas, hard to get bruised (i.e. behind ears, around the genitals)
- Burns and scalds (particularly from cigarettes' butts)
- Poisonings (especially repeated ones)
- Untended wounds *that may appear intentionally concealed with unsuitable for the season clothing*

Multiple and of many types injuries, acquired at different times, on different parts of the body

your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[SA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Slide 54

## Behavioral Signs

- Reports injury by a parent or another adult caregiver
- Mentions of pain or difficulty in moving
- Poor concentration-difficulties in learning
- Aggression/Withdrawal/ Decreased socialization
- Frequent involvement in violent incidents with peers
- Afraid, protests or cries when it is time to go home/seems frightened of the parents
- Tendency to flee
- Easy and/or eager to separate from parents
- Fearful of likelihood of school contacting parents/caregivers
- (Unexplained) fear of adults/ Shrinks at the approach of adults
- Tendency to self harm

Physical Abuse

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Toolset + Synergy + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

<see slide>

Slide 55

## Warning signs in the parents/caregivers' behavior

Consider the possibility of physical abuse when the parent or other adult caregiver

- Offers inconsistent, unclear, unconvincing or non-existent explanations about the child's injuries
- Offers inconsistent or non-matching account of the injuries compared to the one offered by the child
- Delays in seeking care/help with injuries' healing
- Consistently referring to the child in a degrading/rejecting manner regarding their own person and/or their account of how they obtained the wounds
  - describes the child as "evil," or in some other very negative way
- Admitting to the use of corporal punishment
  - uses harsh physical discipline with the child

Physical Abuse

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



CAN-MDS Toolset + Synergy + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

<see slide>

Slide 56

## Signs of Sexual Abuse

\*CAN-MDS II Operators come from various sectors, not all of them will be having access to all indicators groups presented here

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



Sexual abuse usually involves someone the child knows. Often, the child will be told to keep the relationship a secret. They may be threatened with something bad happening if they tell anyone. An adult who carries out sexual abuse with a child may have received the same treatment in the past. Breaking the cycle may help prevent it passing down to the next generation.

Slide 57

## Signs appearing on the child's body

### Sexual Abuse

- Difficulty sitting or walking
- Pain, bleeding, itching of the child's genitals and anus and the surrounding area
- Injuries in their genitals
- Stomach and head aches
- Pain when urinating
- Bruises on the thighs' inner area and the buttocks
- Pregnancy
- STDs

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 

<see slide>

Slide 58

**Sexual Abuse**

**Behavioral Signs/Indicators**

- ▶ Reporting of sexual abuse by an adult (parent or other)
- ▶ Age-inappropriate knowledge of sex-related matters
  - ▶ Age-inappropriate sexual behavior
  - ▶ Using inappropriate language
  - ▶ Demonstrating bizarre, sophisticated, or unusual sexual knowledge
- ▶ Experiences a sudden change in appetite
  - ▶ Disorders related with eating (anorexia /bulimia)
- ▶ Changes in using the toilette (urination/ defecation)
- ▶ Suddenly refuses to change for gym or to participate in physical activities
- ▶ Truancy (leaving school during school hours)
- ▶ Runs away
- ▶ Having in their possession large sums of money

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

<see slide>

Slide 59

**Sexual Abuse**

**Emotional signs**

- ▶ Fear of and refusal to communicate with specific adults (without a plausible reason)
- ▶ Long-term depression
- ▶ Low self-esteem
- ▶ Phobias (report of nightmares and/or bedwetting)
- ▶ Excessive crying
- ▶ Withdrawal
- ▶ Extreme mood swings
- ▶ Self harm
- ▶ Use of mind-altering substances

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

<see slide>





Slide 60

## Sexual Abuse

### Attitude of parents/caregivers

- Consider the possibility of sexual abuse when the parent or other adult caregiver
  - is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
  - is secretive and isolated
  - is jealous of child's relationship with others
  - is controlling with family members
  - is overly possessive of child

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 



<see slide>

Source: <https://www.childwelfare.gov/pubPDFs/signs.pdf>

Slide 61

### Signs that do not necessarily suggest Child Sexual Abuse

- Normal amounts of interest, curiosity or involvement of children and teens with sexuality related issues/questions
- Expressions of developmentally appropriate sexuality of teens and children
- Children playing with age appropriate sexual experimentation, even when pushing some boundaries that should be there, seemingly
- Expressions of tenderness towards adults and from adults to the child

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

<see slide>

Further notes for the trainer:

Understanding healthy childhood sexual development plays a key role in child sexual abuse prevention. Many adults are never taught what to expect as children develop sexually, which can make it hard to tell the difference between healthy and unhealthy behaviors. When adults understand the difference between healthy and unhealthy behaviors, they are better able to support healthy attitudes and behaviors and react to teachable moments. Rather than interpret a child's actions with an adult perspective of sex and sexuality, adults can promote healthy development when they understand what behaviors are developmentally expected at different stages of childhood. They are also better equipped to intervene when there are concerns related to behavior or abuse.

Like all forms of human development, sexual development begins at birth. Sexual development includes not only the physical changes that occur as children grow, but also the sexual knowledge and beliefs they come to learn and the behaviors they show. Any given child's sexual knowledge and behavior is strongly influenced by: the child's age; what the child observes (including the sexual behaviors of family and friends); and what the child is taught (including cultural and religious beliefs concerning sexuality and physical boundaries).

What is considered as "typical" childhood sexual play and exploration? Each society shapes its own content of what it considers to be "normal" that is acceptable sexuality. Something that is considered "normal" in one generation can be considered "not normal" in the next. "Normal" sexuality depends on the relative expectations and representations of society and on the gender of the child. Therefore children learn the rules that govern sexuality following their surroundings' suggestions of what is permissible and what is not.

The relevant legislative framework (to be nationally adapted)

Most sexual play is an expression of children's natural curiosity and should not be a cause for concern or alarm. In general, "typical" childhood sexual play and exploration: occurs between children who play together regularly and know each other well; occurs between children of the same general age and physical size; is spontaneous and unplanned; is infrequent; is voluntary (the children agreed to the behavior, none of the involved children seem uncomfortable or upset); is easily diverted when parents tell children to stop and explain privacy rules.

#### Common Sexual Behaviors in Childhood

*Preschool children (less than 4 years):* exploring and touching private parts, in public and in private; rubbing private parts (with hand or against objects); showing private parts to others; trying to touch mother's or other women's breasts; removing clothes and wanting to be naked; attempting to see other people when they are naked or undressing (such as in the bathroom); asking questions about their own—and others'—bodies and bodily functions; talking to children their own age about bodily functions

*Young Children (approximately 4-6 years):* purposefully touching private parts (masturbation), occasionally in the presence of others; attempting to see other people when they are naked or undressing; mimicking dating behavior (such as kissing, or holding hands); talking about private parts and using "naughty" words, even when they don't understand the meaning; exploring private parts with children their own age (such as "playing doctor", "I'll show you mine if you show me yours," etc.)

*School-Aged Children (approximately 7-12 years):* purposefully touching private parts (masturbation), usually in private; playing games with children their own age that involve sexual behavior (such as "truth or dare", "playing family," or "boyfriend/girlfriend"); attempting to see other people naked or undressing; looking at pictures of naked or partially naked people; viewing/listening to sexual content in media (television, movies, games, the Internet, music, etc.); wanting more privacy (for example, not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues; beginnings of sexual attraction to/interest in peers

Sexual behavior problems include any act that: is clearly beyond the child's developmental stage (for example, a three-year-old attempting to kiss an adult's genitals); involves threats, force, or aggression; involves children of widely different ages or abilities (such as a 12-year-old "playing doctor" with a four-year-old); provokes strong emotional reactions in the child—such as anger or anxiety.

Sources:

NSVRC: An overview of healthy childhood sexual development. Available at: [www.nationalcac.org/wp-content/uploads/2016/08/HealthySexualDevelopmentOverview.pdf](http://www.nationalcac.org/wp-content/uploads/2016/08/HealthySexualDevelopmentOverview.pdf)


NCTSN & NCSBY. Sexual Development and Behavior in Children. Available at: [https://www.nctsn.org/sites/default/files/resources/sexual\\_development\\_and\\_behavior\\_in\\_children.pdf](https://www.nctsn.org/sites/default/files/resources/sexual_development_and_behavior_in_children.pdf)

Slide 62

## Signs of Psychological Abuse

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



Psychological or emotional abuse happens when people consistently say things and behave in a way that conveys to the child that they are inadequate, unloved, worthless, or only valued as far as the other person's needs are concerned.

Slide 63

## Behavioral Signs/Indicators


- Reports a lack of attachment to the parent
- The child doesn't seem close to a parent or caregiver
- Self soothing movements such as rocking back and forth and thumb-sucking
- Fear of change
- Chronic tendency to flee
- Superficial relationships/loneliness
- Showing little interest in friends and activities
- Attention-seeking
- Doing poorly in school
- Truancy
- Deviancy
- Extreme behavior, such as overly compliant, too demanding, extreme passivity, or aggression

...the list includes many of the signs listed under the rest of the types of CAN

Psychological Abuse

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar



<see slide>

Slide 64

## Behavioral Signs/Indicators

- Constant worry about doing something wrong
- Delays in physical or emotional development
- Speech problems or delays in learning and emotional development
- Sudden appearance of speech difficulties (i.e. stuttering)
- Urination and Defecation outside normative patterns
- Mood swings, including depressive episodes and inability to communicate
- Headaches and stomachaches with no clear cause
- Anorexia/Bulimia/Frequent Vomiting
- Depression and low self-esteem
- Self harm incidents/ attempted suicide

...the list includes many of the signs listed under the rest of the types of CAN

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Signs + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

<see slide>

Slide 65

## Attitude of parents/caregivers

- Consider the possibility of psychological abuse when the parent or other adult caregiver
  - constantly blames, belittles, or berates the child
  - is unconcerned about the child and refuses to consider offers of help for the child's problems
  - overtly rejects the child

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Signs + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

<see slide>

Source: <https://www.childwelfare.gov/pubPDFs/signs.pdf>

Slide 66



Child neglect is when a parent or caregiver persistently fails to meet the basic physical and psychological needs of a child, resulting in impairment of the child's health or development

Slide 67

## General Appearance

### Neglect – Negligent treatment

- ▶ Inadequate body hygiene
- ▶ Age- and season-inappropriate appearance, clothes and style
- ▶ Untended to injuries and wounds
- ▶ Bad eating habits/ unremittent hunger
- ▶ Frequent infections
- ▶ Stunted growth
- ▶ Unfulfilled basic needs
- ▶ Frequent illnesses
- ▶ Lack of needed medical or dental care, immunizations, or glasses

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Toolset + Systems + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

<see slide>



Note: A discussion may be take place on immunizations – see also the respective Working File in the Step by Step Guide for Administrators

Slide 68

## Neglect – Negligent treatment

### Signs/Indicators appearing on the body

- ▶ Constant self reports of being tired, feeling sleepy
- ▶ Lack of energy
- ▶ Low/excess weight
- ▶ Bad dental hygiene
- ▶ Body odor, bad smell
- ▶ Untended wounds

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



<see slide>

Slide 69

## Neglect – Negligent treatment

### Emotional signs

- ▶ Lack of energy and liveliness
- ▶ Decreased skills in playing
- ▶ Lack of excitement
- ▶ Over-dependence on, extreme seeking of adult approval
- ▶ Low self-esteem, feeling unworthy

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



<see slide>

Slide 70

## Neglect – Negligent treatment

### Signs/Indicators found in cognitive activity

- ▶ Lack of school progress
- ▶ Developmental delays in language and speech
- ▶ Deficits in attention and concentration
- ▶ Decreased basic skills of problem solving
- ▶ General developmental delays
- ▶ Poor kinetic skills
- ▶ Poor coordination
- ▶ Learning Difficulties

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



<see slide>

Slide 71

## Neglect – Negligent treatment

### Behavioral Signs/Indicators

- ▶ The child refers to or reports lack of (parental/caregivers') care
- ▶ Frequent absences from school or unpredictable schedule
- ▶ Constant hunger, beg or stealing food or money from classmates
- ▶ High-risk behaviors, substance use
- ▶ Prone to accidents
- ▶ Inadequate self-care
- ▶ Parentified child taking care of younger siblings
- ▶ Low self-esteem
- ▶ Deviant behavior

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



<see slide>

Slide 72

## Neglect – Negligent treatment

### Attitude of parents/ caregivers

- Consider the possibility of neglect when the parent or other adult caregiver
  - appears to be indifferent to the child
  - seems apathetic or depressed
  - behaves irrationally or in a bizarre manner Is abusing alcohol or other drugs

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 

<see slide>



Slide 73

## Parental behavior's signs

sometimes a parent's demeanor or behavior sends red flags about child abuse

Warning signs include a parent who:

- shows little concern for the child
- appears unable to recognize physical or emotional distress in the child
- blames the child for the problems
- consistently belittles or berates the child, and describes the child with negative terms, such as "worthless" or "evil"
- expects the child to provide him or her with attention and care and seems jealous of other family members getting attention from the child
- uses harsh physical discipline
- demanding an inappropriate level of physical or academic performance
- severely limits the child's contact with others
- offers conflicting or unconvincing explanations for a child's injuries or no explanation at all

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 

<see slide>

Source: <https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864>



Slide 74

## CAN risk determinants

- Lack of social support for the family
- Low social standing and lack of educational capital of the parents
- Large family (>4 children)
- Single parent family
- Early parenthood
- 'Difficult' child
- Child's age: infant or teen
- One or both parents/caregivers
  - present with a major mental health issue
  - are addicted to alcohol and/or other substances
  - have a record of deviant and/or unlawful behavior
  - have a record of severe disability
  - have a history of abuse in their childhoods

→ usually many of these factors appear together

→ they correlate with other known determinants of dysfunctional family contexts

**! Presence of one or more of these conditions doesn't necessarily mean CAN**

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Slide 75

## PLEASE KEEP IN MIND!

- warning signs depend on the type of abuse and can vary

HOWEVER

- **warning signs are just that-warning signs**; they are only suggestive and may signal a suspicion of child abuse or neglect

the presence of warning signs doesn't necessarily mean that a child is being abused as similar indicators can also exist in situations where a child is NOT abused or neglected and may have an entirely appropriate or unrelated explanation

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Source: <https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864>

Slide 76

## summarizing

- child abuse and neglect is not always obvious
  - it can be physical but also sexual, or emotional. The child may be neglected, meaning his/her caregivers don't provide for basic needs, like food or safety
- many children are too young or too frightened to tell anyone what is happening to them
- children, especially younger, are often unaware that what is happening to them is abuse
- what makes it even harder to stop is that most of the time, the abuser is someone the child knows and because of this s/he may be reluctant to say something because s/he may want to protect that person or is afraid of what they will do if she speaks up
- therefore, identifying CAN is not always a straightforward task; sometimes, it takes a caring adult to recognize that something is not right in the child's life
- it is important especially for individuals who work with children to be able to recognize child abuse and neglect

## the signs aren't always so clear

raise red flags

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

<see slide>

Sources:

- Recognizing child abuse available at: <https://www.pa-fsa.org/Mandated-Reporters/Recognizing-Child-Abuse-Neglect/Recognizing-Child-Abuse>
- Sakher AlQahtani, BDS, MClintDent, PhD Amber D. Riley, MS, RDH Identifying and responding to child abuse and neglect - For the dental professional, identifying child abuse and neglect is not always a straightforward task. Knowing the relevant laws and research findings is important to lead to informed assessments and decisions. Available at: <https://www.rdhmag.com/patient-care/article/14167560/recognizing-and-responding-to-child-abuse-and-neglect-a-guide-for-dental-professionals>
- <https://www.webmd.com/children/child-abuse-signs#1>

Slide 77

## Short & Long Term Effects of CAN *at a glance*

- In most cases, children who are abused or neglected suffer greater emotional than physical damage
- Not all abused or neglected children will experience long-term consequences
  - The outcomes of individual cases are influenced by a variety of factors that include:
    - Age and development status when the abuse took place
    - The type of abuse (physical, emotional, sexual, etc.)
    - Regularity and duration of the abuse
    - The child's relationship with the abuser

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Slide 78

## Short & Long Term Effects of CAN

### PHYSICAL EFFECTS

- Can be minor (bruises or cuts) or severe (broken bones, hemorrhage)
- Important regions of the brain fail to form or grow properly
- Lifelong physical health problems
- Shaken Baby Syndrome (blindness, learning disabilities, mental retardation, cerebral palsy)

### PSYCHOLOGICAL EFFECTS

#### Immediate Effects:

- Isolation
- Fear
- Inability to trust

#### Lifelong

#### Consequences:

- Low self-esteem
- Depression
- Relationship difficulties

### BEHAVIORAL EFFECTS

Studies have found abused or neglected children to be at least 25% more likely to experience problems in adolescence, including:

- Delinquency
- Teen pregnancy
- Low Academic Achievement
- Drug Use
- Mental Health Problems

### SOCIETAL EFFECTS

#### Direct Costs:

- Maintaining a child welfare system
- Expenditures by the judicial, law enforcement, health, and mental health systems

#### Indirect Costs:

- Costs associated with juvenile and adult criminal activity
- Mental illness
- Substance Abuse
- Domestic Violence
- Loss of productivity due to unemployment and underemployment

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Source: <http://www.butterflybridgecac.org/resourcesabuseeffects.php>

Slide 79

## Long-term Consequences of CAN (increased risk)

Table 1 Long-Term Consequences of Child Maltreatment: (Increased Risk)

Injury, Illness, Disability	Risky Health Behaviors	Social, Emotional Cognitive Impairment
Chronic obstructive pulmonary disease (COPD)	Alcoholism and alcohol abuse	Depression
Ischemic heart disease (IHD)	Illicit drug use	Risk for intimate partner violence
Liver disease	Promiscuity	Suicide attempts
Adolescent pregnancy	Smoking	unemployment
Health-related quality of life	Early initiation of sexual activity	Less likely to own place of residence, bank account, stock
Fetal death	Sexually transmitted diseases (STDs)	Criminality/incarceration
Skeletal Fractures	Early initiation of smoking	Lower educational attainment

Sources: 1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (January 18, 2013)

2. Child Maltreat. 2010 May; 15(2): 111–120. Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being  
Janet Currie and Cathy Spatz Widom

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

PART 6 – DURATION: 60 MIN

Slide 1

# Tackling CAN under-reporting

responding to CAN disclosure, reporting CAN  
legal framework & national mandates to report

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

Slide 2

## Outline

- why children don't tell if they have been abused and/or neglected and why children eventually reveal abuse
- responding to a child who discloses being abused or neglected
  - Do and Don't
- the procedure of reporting child abuse
  - Who must report
    - Legislative Context and the mandate to report CAN in [your country]
  - Why to report
  - When should report
  - Where to report
  - What to report
- Non reporting
- Connection of reporting to CAN-MDS and recording

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

In this session we are going to explore why children don't tell if they have been abused and/or neglected and why children eventually reveal abuse.

We will discuss also about the appropriate responding to a child who discloses being abused or neglected and the procedure of reporting (Who must report, Why to report, When to report, Where to report and What to report).

At the end the connection of reporting to CAN-MDS and recording will be outlined

Slide 3

## Why don't children tell if they have been abused and/or neglected?

- They may be afraid of the consequences
  - they are afraid to speak up because of the existing balance of power
  - the abuser may have bribed the child or threatened that something terrible will happen if s/he tells
  - they may fear that the person who is abusing them is too important or powerful
  - they may worry that they won't be believed
  - if they do know, they may be too ashamed to tell, embarrassed, or worry that they are to blame
  - they may feel guilty
  - they may not wish to admit that their families are different

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (DA Nr. 80508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Partner



Despite there being a range of people for children to talk to, it's evident that many child victims choose to keep their experiences of abuse hidden. This could be for a variety of reasons and isn't simply because keeping secrets is something that children and teenagers 'just do'. Children may keep quiet about abuse for various reasons:

<see slide>

Notes for the trainer

### They may be afraid of the consequences

Children often hold back from telling someone about the abuse they're suffering because they're scared of what might happen next. They may worry that they'll get in trouble (with the person they've told or with the abuser) or that they'll get the abuser in trouble for 'telling on them'. The child may also be concerned about the adult's reaction – that they'll be angry, frightened or shocked, that they may go to the police or that they'll have the child put into care.

### They may worry that they won't be believed

It can take a lot of courage for a child to approach an adult and disclose information about abuse, so it's understandable that the child may choose not to say anything just in case the adult doesn't believe what they are being told. The child may prefer to keep quiet rather than risk being humiliated, ignored or dismissed.

### They may feel guilty or to blame

Children may blame themselves for what's going on and may feel too guilty or ashamed to tell someone. They may think that the abuse is their fault because they've done something to deserve it. As a result, the details of what's happening may feel too embarrassing for them to talk about, making it easier for them to simply say nothing.

Source: <https://www.hightspeedtraining.co.uk/hub/disclosure-child-abuse/>

Slide 4

## Why don't children tell if they have been abused and/or neglected?

### Other conditions

- they may not have the ability to speak out
  - they are too young to put what has happened into words
  - they do not speak the language
  - they may not know they are being abused; they may think this happens in all families or that abuse is punishment for being "bad"
- In many cases, the abuser is known and trusted
  - they may love the abuser and think the abuse is normal
  - the abuse is ongoing so it becomes harder to tell
    - they may be hoping that the abuse will stop
- People around them may make it difficult to talk
  - they may have told in other ways
  - they may think that adults know about the abuse already
  - they have never been asked

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (DA Nr. 86528 – CAN-MDS II – funded by EU REC-Programme 2014-2020)  
CAN-MDS Operations' *Continues*



Notes for the trainer

### They may not have the ability to speak out

Younger children, or those who have a disability, may not have the words to describe what is happening to them, let alone the ability to understand what is going on. Children are vulnerable at any age but particularly so if they don't have the skills to recognize the abuse. This can easily lead to cases of abuse going undetected.

### They may love the abuser and think the abuse is normal

If the child is being abused by someone that they know, trust and love – a friend or family member – then they may believe that the abuse is normal and not recognize that anything is wrong. They may believe that they're in control of the situation because they have a positive relationship with the person in question.

### They may be hoping that the abuse will stop

A child may refrain from speaking out about the abuse they are suffering because they believe that the situation is only temporary and that it will soon stop. The child may think they are being punished for something, or that the abuse is just a part of normal life, and may be waiting for the moment to pass.

### They have never been asked

In some cases it may be that the child is simply waiting for someone to notice that something isn't right. The child may not have the courage or opportunity to speak out and they may be hoping that a trusting adult will approach them and ask what's wrong. This makes it essential for adults to stay alert to the possible signs of abuse and discuss the behaviours with the child when appropriate.

Source: <https://www.hightspeedtraining.co.uk/hub/disclosure-child-abuse/>

Slide 5

## Why a child do not disclose sexual abuse

- *Keep it a secret!*
- Fear and Threats
- *I don't know how or who to tell*
- The Blame Game
- Grooming
- *No one will believe you!*
- Dissociation
- Punishment
- Shame
- Love



Source: [childsafehouse.org/info/faqs/why-do-children-not-tell/](https://childsafehouse.org/info/faqs/why-do-children-not-tell/)

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA-N-MOS II – funded by EU REC Programme 2014-2020)  
CA-N-MOS Operations' Seminar



[Note: This slide is referred exclusively to sexual abuse – you can skip it if you think that necessary information covered in the previous slides addressing all types of abuse]

It may be difficult to comprehend that a child would **NOT** immediately run to tell someone — mom, dad, a teacher, sibling, grandparent — after experiencing sexual abuse. Unfortunately, silence or delayed disclosure is actually the norm, rather than the exception.

1) **"Keep it a secret!"** Perpetrators instruct children to keep the abuse a "secret," that it's something special that just the two of them are doing. This tactic is used frequently, especially with younger children.

2) **Fear and Threats.** Another common tactic used by sexual perpetrators is to instill fear in child victims and/or threaten them. Threats can take a variety of forms including physical harm to the child, the child's parents, siblings, friends or even a child's pets. Threats can also include withholding items or privileges that are special to a child or even the basic necessities of life such as food and water. Sometimes, kids are just plain scared of or intimidated by their abusers. A child might also be fearful of how the person they want to disclosure to will react, or of negative repercussions, both explicit and implied, for telling.

3) **"I don't know how or who to tell."** It is difficult for a young child or even a teenager trying to find the words to describe their experience of sexual abuse. For younger children, this is can often be difficult if they do not know the proper names of their body parts or understand basic body safety principles. For older kids, even if they can describe the abuse, it's often embarrassing for them to talk about even with someone they trust. In fact, most children who disclose sexual abuse DO NOT tell their parents — rather, they seek out someone else in their circle of trust, if they choose to disclose at all.

4) **The Blame Game.** Perpetrators often lead a child to believe that the sexual abuse is all the child's fault! A child is told that s/he is the reason behind the abuse and that the child "made" the perpetrator do it — the perpetrator places all the blame for the abuse on the child.

5) **Grooming.** Grooming is the process of earning a child victim's trust and compliance. Perpetrators groom victims for two reasons: 1. "Test the waters" to see how a child victim will react or respond to advances; 2. Train the child victim for continued inappropriate and more advanced sexual contact. Grooming enables predators to earn a victim's trust and can also reduce the likelihood that a victim will disclose the abuse. Grooming can take place in a very short period of time, or through numerous interactions with a child over a longer period of time.

6) **"No one will believe you!"** By diminishing a child's self-esteem and convincing a child that no one will believe them, perpetrators often manipulate children into silence. This tactic is commonly used by people in positions of power or authority. If a child thinks his/her story of abuse will not be believed, then why bother telling anyone?

**7) Dissociation.** Dissociation is defined as disruptions in aspects of consciousness, identity, memory, physical actions and/or the environment. This state of being can often help children live through abuse by psychologically separating the child from the trauma as the abusive event is occurring. Sometimes, children who dissociate from abusive events do not recall the abuse until sometime in the future.

**8) Punishment.** Many times, children are led to believe they will get in trouble for disclosing. Punishment can take on many forms including physical abuse, harm to other family members including beloved pets, or elimination of items that are special to a child (toys, special privileges, etc.). Kids are sometimes told they will be taken away from a parent or home they love if they tell anyone about the abuse.

**9) Shame.** Sexual assault victims of any age can experience shame, embarrassment or humiliation. Those feelings can be so strong that they override the choice to tell anyone about the abuse.

**10) Love.** Love is a powerful motivator to stay silent about abuse. The vast majority of all sexually abused children knows, love, or trust their abusers. So, it's pretty common for children to have strong feelings for those perpetrating crimes against them. Because of those strong feelings, children often keep sexual abuse a secret. Love can take on many forms in child sexual abuse cases; some examples include:

The child loves a parent or another family member who is abusing him/her

The child wants to protect mom, dad, grandma, etc. if that person's partner is sexually molesting him/her

A Romeo-Juliet scenario exists where the child thinks s/he is in love with an older perpetrator

Sources:

Townsend, C. (2016). Child sexual abuse disclosure: What practitioners need to know. Charleston, S.C., Darkness to Light. Retrieved from [www.D2L.org](http://www.D2L.org).

<https://www.traversebaycac.org/2018/07/13/10-reasons-children-dont-disclose-sexual-abuse/>

Slide 6

## Why children reveal abuse?

because they realise that abuse is wrong

- awareness and understanding of the abuse
  - children have knowledge and language about what constitutes abuse and how to access help

they believe they cannot survive abuse anymore

- not able to cope anymore – the abuse getting worse
  - the continuation of the abuse becomes unbearable and fear of abuse becomes greater than the fear of what will happen if the child tells.

■ when their body has been damaged

- pregnancy or physical injury is a threat
- a physical injury has occurred that needs medical attention

■ desire to prevent abuse of other children

- a younger sibling is at risk of or is being abused

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>



Slide 7

## Why children reveal abuse?

a change occurs in the child's support network

- ▶ they gain access to someone who will listen, believe and respond appropriately and is not critical, judgmental and threatening
  - ▶ the child finds someone who is strong and confident, whom s/he feels can overcome the abuser
- ▶ they receive effective responses by adults both in informal and formal contexts
  - ▶ they have a feeling that someone already knows and will not be horrified at what they have to say
- ▶ being directly asked about experiences of abuse
- ▶ having a sense of control over the process of disclosure both in terms
  - ▶ of anonymity (not being identified until they are ready for this) and
  - ▶ of confidentiality (the right to control who knows)
- ▶ wanting the abuser to be punished

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operations Seminar



<see slide>

Slide 8

## Responding to the child

- ▶ How should I respond to a child who reports being abused or neglected?
- ▶ When it is necessary to talk with a child in response to a disclosure of maltreatment it is important to remember to handle the discussion with sensitivity
  - ▶ *the response has the power to calm or upset the child*

your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operations Seminar



<see slide>

Source:

A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)

Slide 9

## Responding to the child

### Do

What to do during a victim disclosure

- Give the child your full attention
- Find a private place to talk without interruptions
  - Put the child at ease by sitting near them, not behind a desk
- Reassure the child it is right to tell and that s/he is not in trouble
- Support the child: "I'm sorry that happened to you."
- Maintain a calm appearance; keep your own feelings under control
- Use open-ended questions such as:
  - "Can you tell me what happened?" or
  - "I'm wondering who taught you how to do that."
- Accept the child will disclose only what is comfortable and recognize the bravery and strength of the child for talking about something that is difficult

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA N° 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"

CAN-MDS Operators' Seminar

<see slide>

Sources:

- Pollack, D., & Kornblum, L. S. (2019). When a child discloses abuse. Available at: [Link](#)
- A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)
- Sakher AlQahtani, BDS, MCLinDent, PhDamber D. Riley, MS, RDH Identifying and responding to child abuse and neglect. Available at: [Link](#)

Slide 10

## Responding to the child

### Do

What to do during a victim disclosure

- Let the child take his/her time
- Let the child use his/her own words; use the child's vocabulary
- Tell the child what you plan to do next
  - Let him/her know: *"We need to tell (name). They know how to help children and families."*
- Keep written notes about what child have told you
  - make some very brief notes at the time and write them up in detail as soon as possible after you have spoken with the child

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA N° 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"

CAN-MDS Operators' Seminar

<see slide>

Also: **Write some notes about what they have told you**

Make some very brief notes at the time and write them up in detail as soon as possible.

Do not destroy your original notes in case they are required by Court.

Record the date, time, place, words used by the child and how the child appeared to you – be specific.

Record the actual words used; including any swear words or slang.

Record statements and observable things, not your interpretations or assumptions – keep it factual.

Source: [https://www.britishcouncil.org/sites/default/files/handling\\_disclosure\\_from\\_a\\_child\\_0.pdf](https://www.britishcouncil.org/sites/default/files/handling_disclosure_from_a_child_0.pdf)

Slide 11

## Responding to the child


### What to do during a victim disclosure

## Do Not

- Do not act shocked, angry, or upset at what a child may say or do. Remain open for more information
- Don't be afraid of saying the "wrong" thing
- Do not make the child feel different or singled out
- Do not press for details beyond what the child is willing to share. You do not need to prove CAN
- Do not ask leading or suggestive questions, do not ask "why questions" requiring child to explain actions that they may not understand
- Do not ask questions that infer blame like *"Did you try to stop them?"* or *"Did you scream or call out for help?"*

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"  
CAN-MDS Operations Seminar



<see slide>

Sources:

- A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)
- [Sakher AlQahtani, BDS, MCLinDent, PhDAmber D. Riley, MS, RDH](#) Identifying and responding to child abuse and neglect. Available at: [Link](#)

Slide 12

## Responding to the child


### What to do during a victim disclosure

## Do Not

- Do not make promises you can't keep; do not promise not to tell anyone about the child's disclosure of possible abuse or neglect.
- Do not make angry or critical comments about the alleged perpetrator. They are often known, loved, or liked by the child. Suggested statements are: *"What they did to you was wrong. I am sorry that it happened to you."* or *"It was unfair of them to do that to you. I am sorry that it happened."*
- Do not confront the perpetrator
- Do not disclose information indiscriminately, keeping in mind the child's right to privacy

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"  
CAN-MDS Operations Seminar



<see slide>

Sources:

- A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)
- [Sakher AlQahtani, BDS, MCLinDent, PhDAmber D. Riley, MS, RDH](#) Identifying and responding to child abuse and neglect. Available at: [Link](#)

Slide 13

## Suggested questions

- ▶ **limit questioning** to only the following if the child has not already provided you with the information:
  - ▶ *What happened?*
  - ▶ *When did it happen?*
  - ▶ *Where did it happen?*
  - ▶ *Who did it?*
  - ▶ *How do you know them? (If the relationship of the abuser is unclear.)*
- ▶ **don't ask questions** that imply the child was at fault
  - ▶ *Why didn't you tell me before?*
  - ▶ *What were you doing there?*
  - ▶ *Why didn't you stop it?*
  - ▶ *What did you do to make this happen?*
  - ▶ *Are you telling the truth?*

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA Nr. 810508 – CAN-MOS II – funded by EU REC-Programme 2014-2020)  
CAN-MOS Operations Seminar



<see slide>

Also:

- listen to the child, letting them explain what happened in his or her own words; don't stop child in the middle of the story to go get someone or do something else
- reassure the child that he/she is not at fault and have done nothing wrong

Slide 14

## Reporting child abuse or neglect

- ▶ If there is suspicion that a child is undergoing abuse and/or neglect, it is critical to be reported each time to recur, for each separate incidence
- ▶ Each report is a snapshot of what is going on in the family. The more information, the better the chance of the child getting the help they deserve
- ▶ it's normal for people, including professionals, to have reservations or worries about reporting child abuse; keep in mind that
  - ▶ child abuse and neglect is NOT merely a family matter, and the consequences of non reporting can be devastating for the child
  - ▶ a child abuse report does not mean a child is automatically removed from the home, unless they are clearly in danger
  - ▶ a report for a CAN suspicion can be done also anonymously or you may ask your identity to remain confidential [to be adapted]

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA Nr. 810508 – CAN-MOS II – funded by EU REC-Programme 2014-2020)  
CAN-MOS Operations Seminar



Source: <https://www.helpguide.org/articles/abuse/child-abuse-and-neglect.htm>

<see slide>

Slide 15

## Who Must Report? [to be adapted]

- Everyone should to be concerned about child abuse and neglect and can report suspected child abuse or neglect
- Certain professionals and other individuals, however, are required by law to report suspected child abuse and neglect.
  - if you are identified in the [national law] as a mandated reporter of suspected child abuse and neglect, you are required by law to immediately report your concerns to the [authorities/sos lines].
  - Under [country law], certain professionals are required to report when acting in a professional capacity. These professionals include:

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar



[Instruction – to be adapted according to country specifics]

Slide 16

## Who Must Report?

- List of professionals/other people who are mandated to report
- To be completed based on "WORKING FILE 7. Secondary Data for Mandatory reporting of CAN" of the Administrator's Guide

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operations' Seminar



[Instruction - To be completed based on "WORKING FILE 7. Secondary Data for Mandatory reporting of CAN" of the Administrator's Guide]

Slide 17

## What if I do not report?

- Liability of the Reporter
  - Adapt according to country specific
- Penalty for failure to report
  - Adapt according to country specific



[Instruction – to be adapted according to country specifics]

Slide 18

## Reporting Child Abuse And Neglect

### Why should I report?

- the purpose of mandated reporting is to identify suspected abused and neglected children as soon as possible **so that they can be protected from further harm**
- responsible authorities cannot act until a report is made.** Mandated reporters play a critical role in preventing any future harm to children
  - Without detection, reporting, and intervention, these children may remain victims for the rest of their lives
- abused children don't just grow up and forget their childhood**
  - they can carry physical and emotional scars throughout their lives



<see slide>

Source:

A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)

Slide 19

## What if I am not sure?

- If a child has told you about abuse or neglect, this is enough for you to proceed with the report
  - it is better to make your concerns known than to remain silent and possibly allow a child to remain unprotected
- Reports of suspected maltreatment should be made immediately, any time you have concerns about the safety of a child
  - in case you may want to collect additional information before reporting, waiting for proof may place the child in danger

a report of suspected child abuse or neglect is not an accusation. It is a request for the helping process to begin and can be described as "making a referral to request help and services for the child and family"



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

Source:

A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: [Link](#)

Slide 20

## When Should I Report?

Apart from cases where children disclose they are abused/neglected

- any time you suspect that a child is being abused or neglected, you should immediately report your concerns



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



[Instruction - If different in your country, please adapt according to country specifics]

Slide 21

## Where to Report?

- list of authorities/ services receiving reports (including sos lines etc)



[Instruction – to be adapted according to country specifics]

Slide 22

## What information should I report?

- When making a report, it is helpful to provide as much information as possible
- (adapt according to country specifics)
  - Name and address of the child and his/her parents or other person(s) responsible for his/her care
  - Child's birth date or age and sex
  - Information for other children or other persons who live with the child and their relationship to the child
  - Nature and extent of the abuse/neglect, including any knowledge of prior maltreatment of the child or siblings;
  - Any other pertinent information
- You may report anonymously/ to provide your contact details and ask authorities to keep them confidential
  - name, address and phone number



[Instruction – to be adapted according to country specifics]



Slide 23

## Non reporting

- ▶ while reporting does not guarantee that the situation will improve, not reporting guarantees that if abuse or neglect exists, the child will continue to be at risk

### Notes for the trainer

The reporting process may not always go smoothly. Difficulties may be encountered which can act as a barrier to reporting or can discourage continued involvement in situations of child abuse and neglect.

-Professionals who have had an unsatisfactory experience when reporting suspected child abuse or neglect may be reluctant to report a second time. These professionals may have been discouraged from reporting, or may have developed a distrust of Authorities, feeling that a previous referral was not handled to their satisfaction.

-The Belief That Nothing Will Be Done: while reporting does not guarantee that the situation will improve, not reporting guarantees that if abuse or neglect exists, the child will continue to be at risk. Sometimes potential reporters are convinced that nothing will be done if they report, so they don't report. Aside from the legal considerations, such reasoning is faulty. If an incident of suspected child abuse or neglect is reported, some action will occur. At the very least, reporting ensures that responsible authorities are made aware of your concerns and your legal obligation will be fulfilled. On the other hand, if the incident is not reported, nothing will occur. Abused and neglected children cannot be protected unless they are first identified. The key to identification is reporting.

Slide 24

## Legislative Context and the mandate to report CAN in [your country]

[Instruction – to be adapted based on information included in the Operator's Manual, *What is provisioned by the National Law* and Step by step Guide for Administrators, *Working File 7*]

Slide 25

## Legal framework

- Law provisions ....

[Please use information from the respective chapter of national Operator's Manual]

Slide 26

## Mandatory reporting

- provisions ....

[Please use information from the respective chapter of national Operator's Manual]

## Slide 27

the CAN-MDS contribution to tackling the issues of  
under-reporting, under-recording,  
under-responding, under-analyzing

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

[We suggest presenting the meaning of each component of the project's (CAN-MDS) acronym, as we have, here, as they relate directly to the issues under discussion, here, in this part of the training. You are welcome to add comments that make more sense for your country's situation, or change the emphasis during the presentation to more accurately reflect your audience's areas of interest and/or concern]

## Slide 28

**Coordinated Response to CAN via a MDS**

**Coordinated**

- promoting uniform data collection from all sectors involved in administration of CAN cases
- using a common user-friendly registry tool
- creating a communication channel among involved sectors
- involving all eligible (following pre-defined criteria) professionals working in the related sectors
- building their capacity through short training & necessary material

your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA No 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar







<see slide>

Slide 29

**Coordinated Response to CAN via a MDS**

**Response**

- **at a population level:** public health surveillance
  - allowing comparisons within and between countries
  - providing continuously updated information as a basis for evaluation of existing practices & policies
- **at a case-level:** follow-up of individual cases
  - facilitating case-investigation & further administration
  - providing feedback to authorized professionals/services at a case-level for already known cases







your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"  
CAN-MDS Operators' Seminar     

Slide 30

**Coordinated Response to CAN via a MDS**

**to CAN**

- **defined** on the basis of the **UN CRC/C/GC/13 (2011)**
  - operationalized in a way ensuring a common understanding among (non homogeneous) involved parties
- **targeting to collect all cases identified by services**
  - regardless of substantiation







your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"  
CAN-MDS Operators' Seminar     

Slide 31

**Coordinated Response to CAN via a MDS**

**via MDS**

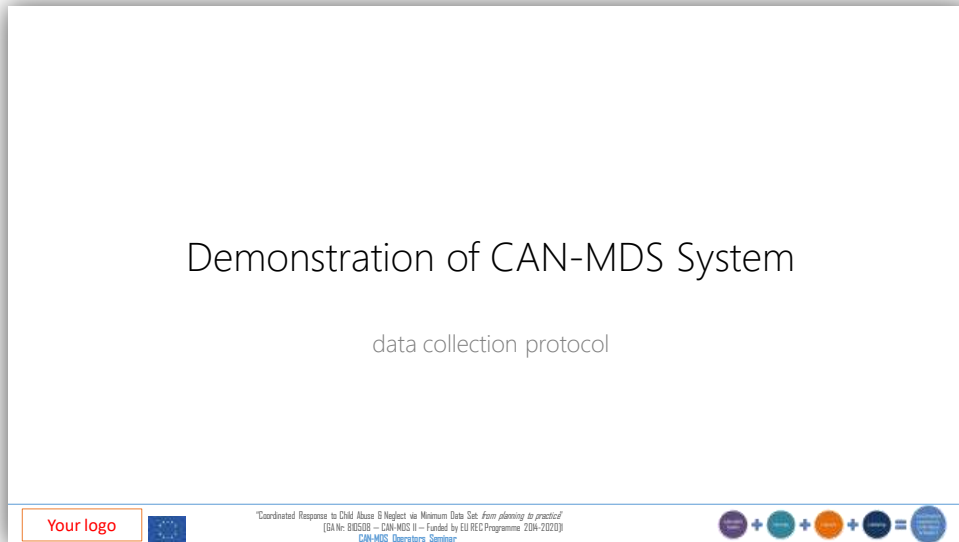
- **using a standard set of variables** (endorsed by all stakeholders)
  - evaluated in terms of ethics, quality (relevance, usefulness, understandability, accessibility) and feasibility (data availability, reliability, validity, timeliness, confidentiality and associated cost)
- operationalized using or following international standards (where feasible) & matched to avail. coding systems

your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (CA Nr. 810508 – CAN-MDS II – funded by EU REC Programme 2014-2020)"  
CAN-MDS Operators' Seminar     

SESSION 3 – DURATION: 285 MIN (4h 45 min)

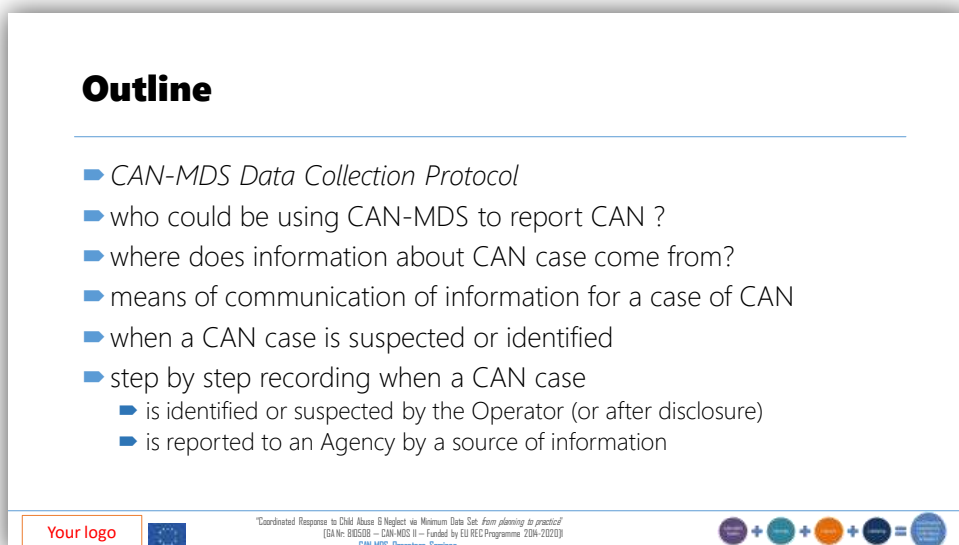
PART 7 – DURATION: 30 MIN

## Slide 1



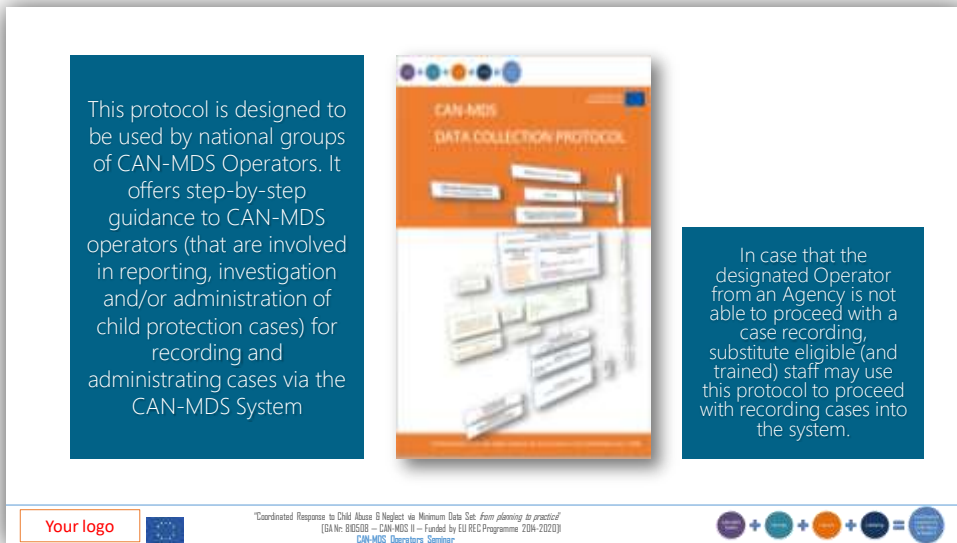
[Note: The document most useful for this phase of practice is the CAN-MDS Data Collection Protocol]

## Slide 2



During this session the demonstration of CAN-MDS System will take place. First the data collection protocol will be presented; next a demonstration of using the system will take place and lastly a simulation of CAN incident recording will be conducted on the bases of some vignettes with the participation of all trainees. The first part will start with a presentation of CAN-MDS Data collection protocol as well as of the following issues:  
<see slide>


### Slide 3




This protocol is designed to be used by national groups of CAN-MDS Operators. It offers step-by-step guidance to CAN-MDS operators (that are involved in reporting, investigation and/or administration of child protection cases) for recording and administrating cases via the CAN-MDS System

CAN-MDS  
DATA COLLECTION PROTOCOL

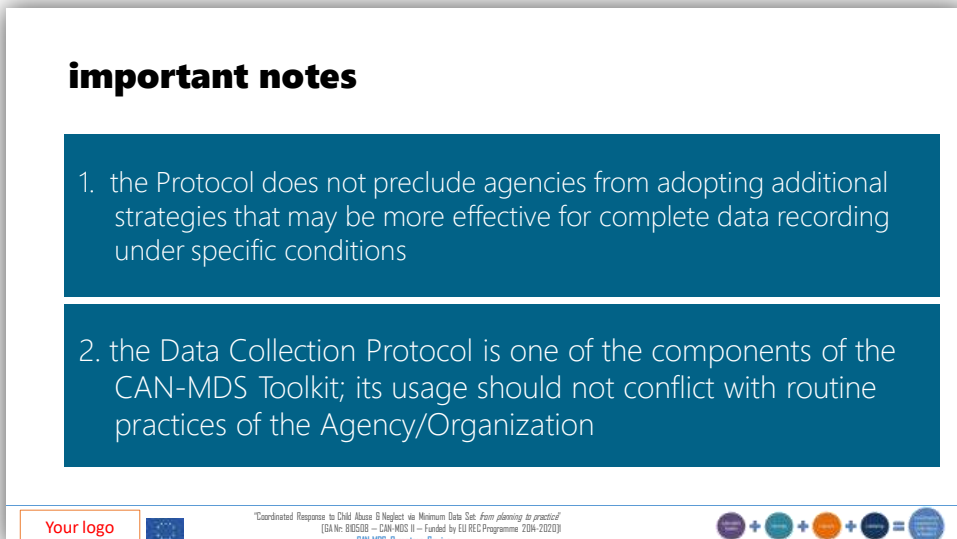
In case that the designated Operator from an Agency is not able to proceed with a case recording, substitute eligible (and trained) staff may use this protocol to proceed with recording cases into the system.

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar




Here is the main aim of the data collection protocol:  
<see slide>


### Slide 4



## important notes

1. the Protocol does not preclude agencies from adopting additional strategies that may be more effective for complete data recording under specific conditions
2. the Data Collection Protocol is one of the components of the CAN-MDS Toolkit; its usage should not conflict with routine practices of the Agency/Organization

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No: 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



At least for the piloting phase and possibly afterwards please bear in mind that:

<see slide>

Slide 5

## Who could be using CAN-MDS to report CAN ?

- Trained professionals working in agencies/organizations where child maltreatment cases are addressed.
- Agencies/organizations could be active in the following fields: education, health and mental health, social welfare/child protection, law enforcement and justice.
- Professionals could be, respectively: School principals, Teachers, Pediatricians and other Medical Doctors of various specialties, Nurses, Child-Psychiatrists, Child-Psychologists, Psychiatrists, Psychologists and other licensed eligible Counselors, Social Workers, Health Visitors, Police Officers (Minors' Departments or in general), and Prosecutors (for minors or general)

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



Here is a reminder about who could be using the CAN-MDS System; you have been invited to this training because you are belong in at least one of the above categories (you are namely an eligible professional to become CAN-MDS Operator).

<see slide>

Slide 6

## where does information about CAN case come from?

- a case could be identified or suspected by the Operator (for example via routine screening or during their contact with the child in other settings, such as at school or in a hospital); in such cases, there is no external source of information.
- other sources of information could be the child-victim itself (self-reporting), a relative of the child, a friend or neighbor, professionals who are mandated to report child maltreatment cases (see national legislation) or any other citizen.

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA Nr. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



A CAN incident can be identified by each one of you through three different routes:

- after the disclosure of abuse by a child-victim
- by a third person ("source of information") that can be a child's relative, neighbor, friend, another professional, a citizen or even through anonymous information
- you may recognize a suspected case of CAN through warning signs during your everyday work with children OR as a result of routine screening process (where applied)

<see slide>

Slide 7

## Means of Communication of information for a case of CAN

- ▶ initial information about the case can be reported during a face-to-face interaction with the Professional/Operator, via telephone or in writing (by email or other means).
- ▶ the face-to-face interaction category includes cases where the Professional/Operator witnesses the suspected CAN case

The information about a CAN incident may reach the CAN-MDS Operator

- face to face (disclosure by the child or provision of information by other third person)
- via telephone, SOS line, e-mail or other e-communication mean (disclosure by the child or provision of information by other third person)
- real time witnessing of warning signs by the Operator him/herself (the information is not provided by other person) OR as a result of routine screening process (where applied) <see slide>

Slide 8

## Important notes!

- ▶ Minimum required information for recording in CAN-MDS
  - i. Child's name
  - ii. At least one reported act of maltreatment or omission in child's care
- ▶ Exclusion criteria for recording in CAN-MDS
  - i. the Child's name is not available
  - ii. no act of maltreatment nor omission to be reported

If there is no available identifier of child's identity, then the incident cannot be recorded in the CAN-MDS. If, for example, a civilian inform the Operator that s/he saw an adult slapping and yelling against a child five days ago in a bus and has no further information about the identity of the involved persons, then the incident is not eligible to be recorded in the system. On the other hand, if a third person provide the Operator with information on the identity of a child but s/he has absolutely no information for a suspected violence act against the child or an omission in child's care, then the incident is not eligible to be recorded in the CAN-MDS. If you are not sure about some violent acts and omissions in child's care, you can find relevant information in the Operator's Manual.



Slide 9

## when a CAN case is suspected or identified

- the Operator proceeds with keeping information about the case (according to his/her usual practice)
- Please, note that implementation of routine screening policy must take place according to the existing regulations within the specific setting

### Next two actions to remember:

- A checklist including CAN-MDS data elements (Annex I) helps with checking the completeness of required information, during intake
- The Operator communicates with CAN-MDS Administrator to ask for a pseudonym for the child.

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



When a CAN incident –suspected or identified- is eligible to be recorded in the CAN-MDS system, then the Operator will proceed by keeping the necessary information (intake). Each operator can follow his/her usual practice for the intake; however, in order to be sure that you have collected all necessary pieces of information for the CAN-MDS it is strongly recommended to use the short checklists (annexed in Data Collection Protocol). When you communicate with the National CAN-MDS Administrator to acquire the Child's ID (given that no identifiers are recorded in the system) this information will be necessary.

<see slide>

Slide 10

## entering data into CAN-MDS

- instructions can be found in the Manual for Operators, in the application prompts, and in the step-by-step description of the Data Collection Protocol, as outlined in the rest of the presentation

### Next two actions to remember:

- A checklist including CAN-MDS data elements (Annex I) helps with checking the completeness of required information, during intake
- The Operator communicates with CAN-MDS Administrator to ask for a pseudonym for the child.

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



The process of data entering will be presented below; the description, however, of this process is included in the Data Collection Protocol in full detail. In the phase of recording you can check terms and other information (e.g. legal issues) in the Operator's Manual.

<see slide>

## Slide 11

do you have any questions?

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No. 806508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

[Instruction – ask trainees whether everything is clear - if there are questions be sure that you provide replies before proceeding in the following parts.

## Slide 12

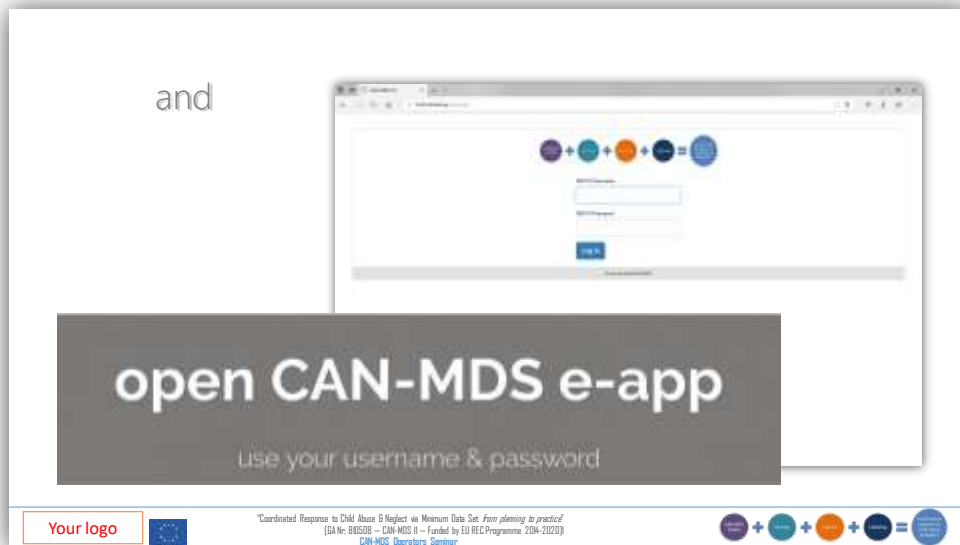
Please, go to p. 6 of the Data Collection Protocol, now:)

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No. 806508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

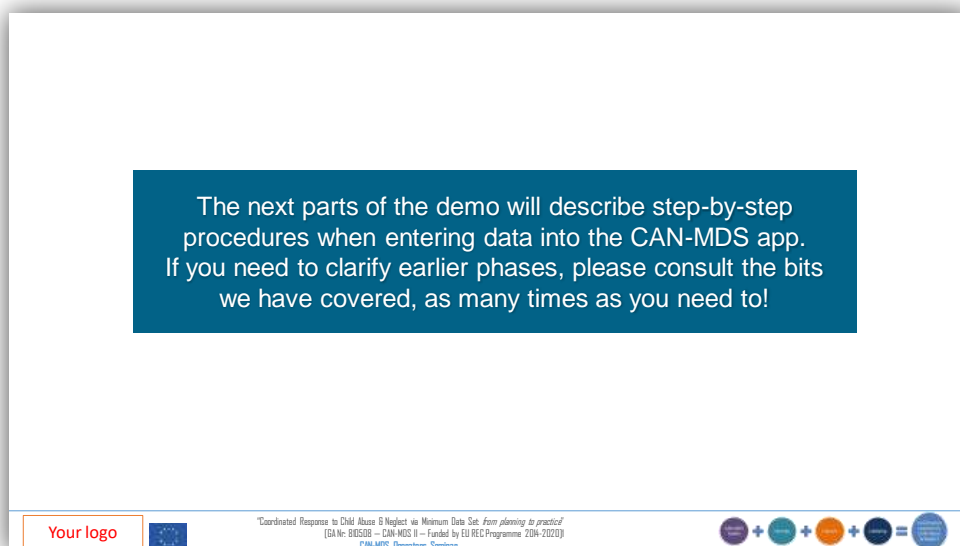
[Instruction – Ask trainees to go to page 6 of the national version of the Data Collection Protocol; use this slide as an example of what information is included in this document –namely screen shots and explanations]

Slide 13



[Instruction – Open the CAN-MDS application for showing the inter-relation between the CAN-MDS operators' interface and the respective description in the Data Collection Protocol. Please use your own username and password in order for the application to open in your national language]

Slide 14



<see slide>

Slide 15


**e-CAN-MDS - introductory screen**

**Notes**

In the right side of the screen, system's operational tools are available (including language selection drop-down menu, Operator's Panel, Print and Log out buttons).


TIP: The column in the right side of the screen is actually a list of the MDS data elements that serves **in multiple ways**:

- ▶ indicates the sequence of data elements to be recorded
- ▶ indicates who records the necessary information, namely you (green boxes) or the system (orange boxes)
- ▶ provides you with an overview of the information already recorded and with notifications for potential duplications
- ▶ operates as a navigation menu among the different data elements



take some time to study the color scheme and the indicators, all found on the introductory screen


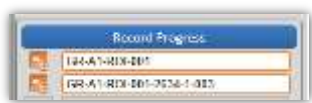
Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No. 810508 - CAN-MDS II - Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar


<please describe by following the animation in the slide>


Slide 16

**Operator's Panel → new incident → Agency's ID and Operator's ID**

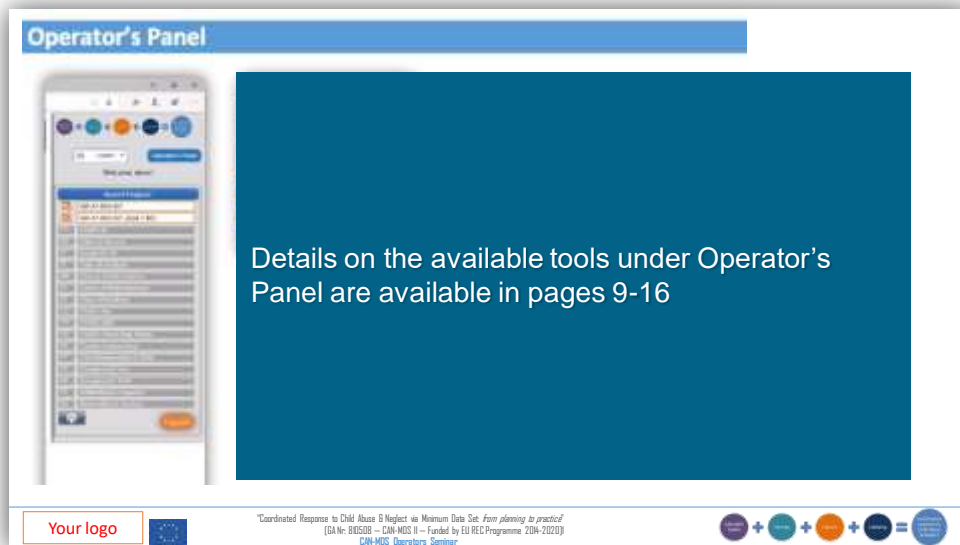
note: your agency's and your professional code are auto-completed by the app (in orange) (p.7)

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
(SA No. 810508 - CAN-MDS II - Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar


<please describe by following the animation in the slide>

Slide 17



<please describe by following the animation in the slide>

Slide 18

**a CAN case is identified or suspected by the Operator**  
(implementation of routine screening policy: depending on settings' specifics)

Pages 17-45: Recording process step by step

Page 18: use of Child's ID (pseudonym) or Temporary Child's ID

Page 19: record of a new incident for a KNOWN or UNKNOWN child

Pages 20-37: step-by-step record of a new incident for an UNKNOWN child

Pages 38-45: step-by-step record of a new incident for an UNKNOWN child

[Instruction - Ask from trainees to open CAN-MDS Data collection protocol and go through the pages. Please mention the conditions covered in the data collection protocol; at this point there is no need to go through the whole manual in detail]

Slide 19

## a CAN case is reported to an Agency by a source of information

- Page 46: what is expected by the operator  
*use of the checklists in Annexes I and II for checking about the completeness of required information*
- Page 47-48: Suggested questions and prompts for collecting required information for CAN-MDS

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(GA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



[Instruction - Ask from trainees to open CAN-MDS Data collection protocol and go through the pages. Please mention the conditions covered in the data collection protocol; at this point there is no need to go through the whole manual in detail]

[Next you are going to proceed with the demonstration of the system through making a record]

PART 8 – DURATION: 15 MIN

Slide 1

# Demonstration of CAN-MDS System

intake and preparing to report

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Sympa + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

Slide 2

## outline

- starting the intake
- entering data sequentially in CAN-MDS
- practice exercise
  - using TEMP ID
  - replacing TEMP ID with Child ID

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar

CAN-MDS Tool + Sympa + Capacity + Lobbying = Coordinated Response to Child Abuse & Neglect

During this part of the presentation the sequence of data entering is demonstrated; first an incident will be recorded by using the Temporary ID and then the TEMP ID will be replaced with the Child's ID.

## Slide 3

### #START THE INTAKE

1. write down on the recording form the case's data as they come in
2. enter CAN-MDS via the Operator's Interface Page



Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No. 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



[Instruction - Trainer goes to the app and present quickly the structure and the Operator's Panel button]

## Slide 4

### ENTER ALL DATA, SEQUENTIALLY IN CAN-MDS

- ensure they are saved as you go
- check for messages from the National Administrator (for Child's ID)



Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No. 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



[Instruction -Trainer explain the role of the right column (see also Step by step Guide for Administrator, p. 8)]

On the right side of the screen, system's operational tools are available (including language selection drop-down menu, Operator's Panel, Print and Log out buttons).

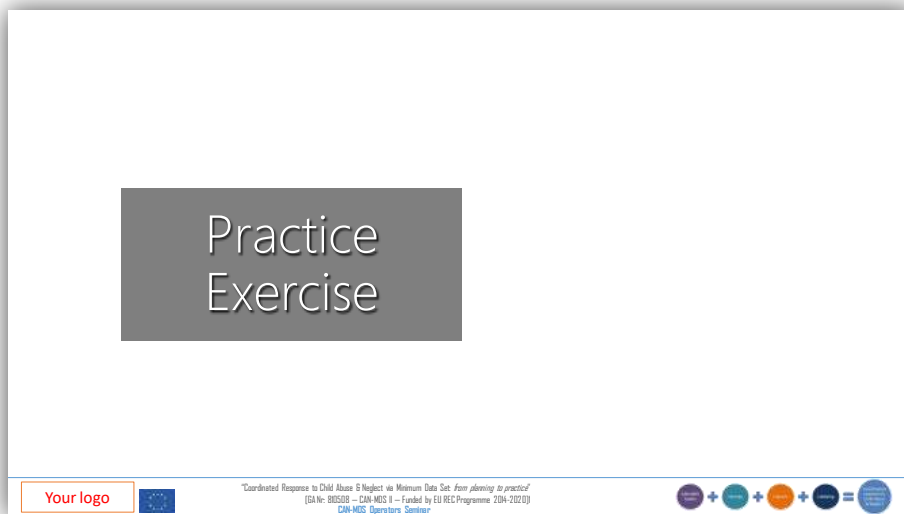
The right column of the screen is actually a list of the MDS data elements that serves in multiple ways:

- indicates the sequence of data elements to be recorded
- indicates who records the necessary information, namely you (green boxes) or the system (orange boxes)
- provides you with an overview of the information already recorded and with notifications for potential duplications
- operates as a navigation menu among the different data elements

**Note:** A memo explaining the meaning of symbols and colors used in the application is presented. This may be useful especially for new users. To proceed with the recording, a familiarized Operator can skip this screen by pressing the "skip" button.



## Slide 5

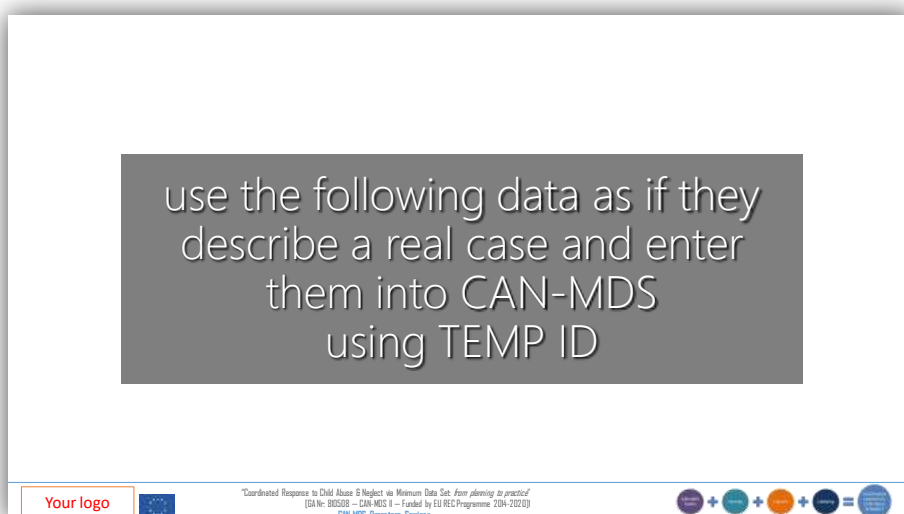


Trainer proceeds with a demonstration of data recording based on the case "ANDREAS" in the next slide, while trainees observe the process and the description while they are instructed to keep notes for questions/ clarifications.

Note: Alternatively, you can ask from one of the trainees to report a case of which s/he is aware or had worked with (without mention any information of the identity of the involved persons).

Use the checklists to keep information in order to be sure that you have all necessary data and proceed with recording in the CAN-MDS.

## Slide 6



<see slide>

Slide 7

**case: ANDREAS**

- 8-year old boy
- lives with mother, mother has a live-in boyfriend
- neighbor is calling your agency/organization
- neighbor heard mother crying and yelling, the boyfriend swearing and a lot of crashing and thumping noises the night before
- the mother is your country's national, looks around 30-35, she works at a local farmer's market, setting up stalls
- they live in your hometown
- there is no phone, ID, date of birth available
- the child's name is Andreas Ioannou

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 90508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar



8-year old boy lives with mother, mother has a live-in boyfriend neighbor is calling your agency/organization neighbor heard mother crying and yelling, the boyfriend swearing and a lot of crashing and thumping noises the night before the mother is your country's national, looks around 30-35, she works at a local farmer's market, setting up stalls they live in your home town there is no phone, ID, date of birth available the child's name is Andreas Ioannou

Slide 8

write down  
your  
questions,  
bring  
them to the  
training group

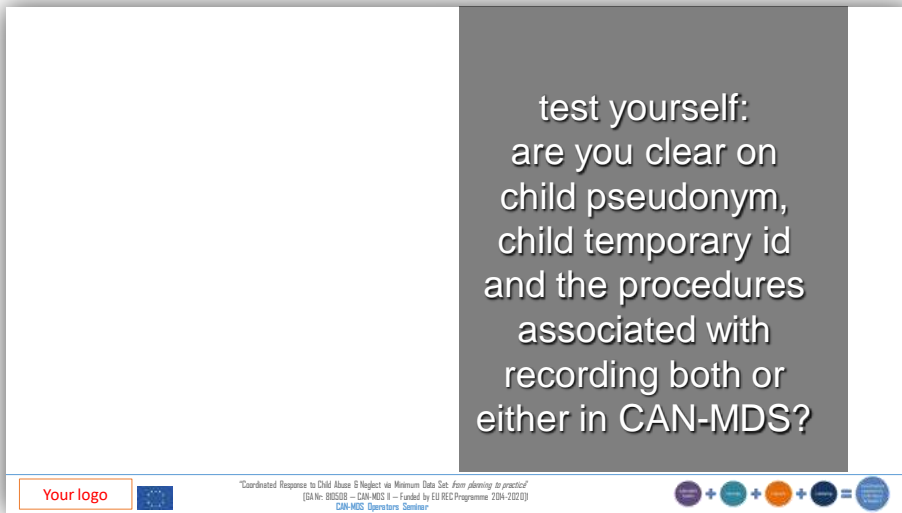
Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 90508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar





Please make notes on any glitches, queries, ambiguities you come across when trying to practice the tasks outlined in this demo.

Slide 9



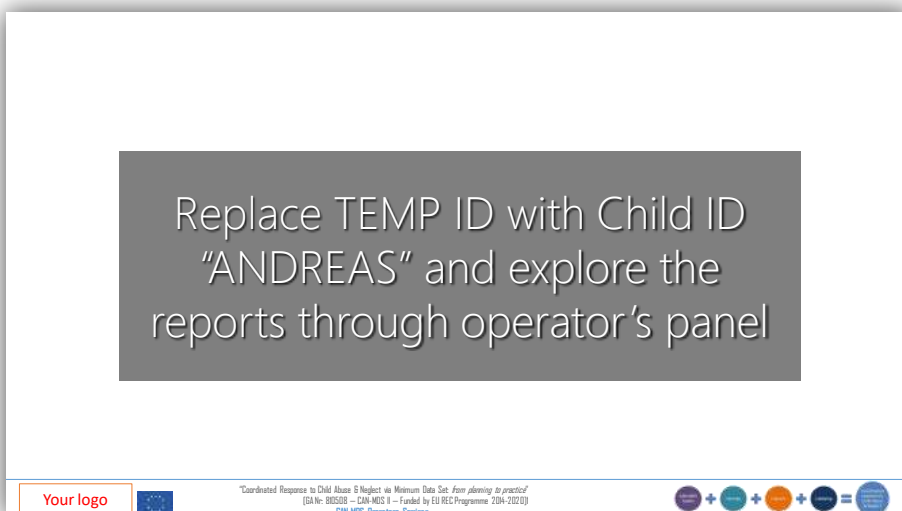
test yourself:  
are you clear on  
child pseudonym,  
child temporary id  
and the procedures  
associated with  
recording both or  
either in CAN-MDS?

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 



Necessary documents:

- p.8 of Data Collection Protocol
- p. 20 of Data Collection Protocol
- p. 21-22-23 of Data Collection Protocol
- p.41 of Data Collection Protocol
- p.49 of Data Collection Protocol
- p.36 of Master Toolkit Guide for Operators
- p. 23 of Master Toolkit Guide for Administrators

Slide 10





Replace TEMP ID with Child ID  
"ANDREAS" and explore the  
reports through operator's panel

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar 

Slide 11

proceed with a new record using  
Child ID "ANDREAS" to  
demonstrate the case of  
"known child"

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No. 810508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



The process if the child is already known described in data collection protocol p. 19 and pp. 38-45

PART 9 – DURATION: 210 MIN (3h 30 min)

Slide 1

# Ensuring understanding of CAN-MDS

working with mock cases

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Simulation phase

Slide 2 [hidden slide]

## Outline

- Preparation
  - *for trainers*
- Instructions to trainees-operators
  - *before starting*
- Instructions
  - *for trainers: reviewing the records and clarifications*

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Slide 3 [hidden slide]

## Preparation-for Trainers

- Individual accounts for EVERY trainee-operator should be prepared from before (the information will be recorded in the system will be part of the evaluation process)
  - Use the off-line DB2 Agencies-data sources & DB3 Professionals-Operators to keep the information (slides 3, 4)
    - Names and passwords will be distributed to trainees before the starting of the simulation with mock cases
  - Every trainee-operator should have a PC/Laptop with internet connection
  - Printed copies of Annexes I & II should be available for any trainee-operator as well as copies of pages 47-49
- Also
- One (or more) persons/"actors" (other than the trainees) will undertake the role of "source of information" (e.g. child's teacher; neighbor etc.)
    - "actors" are provided with copies of mock case
    - they should read the case from before in order to be familiarized with the details
  - Ideally one actor per trainee (face to face or even via phone)
    - if no feasible split the trainees' group in smaller groups respectively according to the number of actors
- NOTE: at least one actor is required; in this case one trainee will undertake the role of asking questions

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
[CA No. 810508] - CAN-MDS II - funded by ERDF Programme 2014-2020  
CAN-MDS Operators' Seminar

CAN-MDS Toolset + Sympy + Capcity + Lobbying = Coordinated Response to Child Abuse & Neglect

### Notes for the Trainer

#### WORKING WITH MOCK CASES

#### Preparation

- One (or more) persons/"actor(s)" will undertake the role of "source of information" (e.g. child's teacher; neighbor etc.)
  - "actors" are provided with copies of mock cases
  - actors should study the mock cases in advance so that they become familiar with the details

TIP: Ideally, simulation would include one actor per trainee (face to face, or even via phone)

- if this is no feasible, split the trainees' group in smaller groups, respectively, according to the number of actors available
- at least one actor is required; in this case the actor will provide the information to the whole group while one of the trainees will undertake the role of asking questions/ clarifications; the rest of the trainees will be able to ask for additional information at the end of the process

Slide 4 [hidden slide]

### Record information of agencies agreed to participate in the CAN-MDS in DB2-Agencies-Data Sources

- At a later phase using this information you can create Agencies' IDs

#### Data to be collected for the DB2 "Agencies-Data Sources"

Identity	Agency's Name
	Legal status
	Field/ Sector
Contact details	Street name
	Street number
	Postal code
	Town
	Telephone number
	E-mail address
Bilateral agreement	sent (Yes/No) [template is needed]
	(if yes) date
Notes	

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice"  
[CA No. 810508] - CAN-MDS II - funded by ERDF Programme 2014-2020  
CAN-MDS Operators' Seminar

CAN-MDS Toolset + Sympy + Capcity + Lobbying = Coordinated Response to Child Abuse & Neglect

Slide 5 [hidden slide]

Record information of professionals agreed to participate in the CAN-MDS in DB3  
**Professionals-Operators**  
- USE this information to organize the seminars for the operators and to create Operators' IDs

Data to be collected for the "DB 3. Secondary Data for CAN-MDS Trained Professionals" database

Identity	Surname
	Name
	ISCO-08
Professional background	Available license (yes/no)
	Subject in Code of Ethics (yes/no)
	Mandated to report CAN (yes/no)
Contact details	Direct/personal phone
	Personal e-mail
Agency where s/he works	Agency ID
	Operator (yes/no)
	(if yes) since (date)
	ID number within agency
CAN-MDS training	Yes/No
Informed consent	(if yes) date
	signed (yes/no) <b>[template is needed]</b>
e-CAN-MDS	username
	level of access
Notes	

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Slide 6

## Instructions to trainees-operators before starting

Now we are going to proceed with the simulation of the process.

- a pediatrician (or school director or other) call you or visit your agency to report some concerns s/he has for the safety of a child
- after you hear what s/he has to say, you can ask her/him for further information (as you probably do in your everyday work) and taking into account what information is needed for the CAN-MDS
  - you can use the pages with the suggested prompts, if you think that it would be of help for you

**IMPORTANT:** during the whole process please keep the information in the 2 short checklists in order to be sure that you collected all the necessary information

- after the end of the process please go to CAN-MDS System, enter your username and password and proceed with recording the incident using a TEMPORARY ID. When you'll complete the process submit the record

Your logo

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508) – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators Seminar

Instruction – Please provide the following instructions to trainees in order to go on with the simulation.

**Key sentences-Instructions from trainer(s) to trainees-operators before starting:**

- We are, now, going to proceed with the simulation of the process
- A pediatrician (or school director or other) calls you or visits your agency to report his/her worries concerning the safety of a child
- After you hear what s/he has to say, you can ask her/him for further information (as you probably do in your everyday work) and taking into account what information is needed for the CAN-MDS
- You may use the pages with the suggested prompts, if you think that it will be of help

**IMPORTANT:** during the whole process please record the information you receive into the 2 short checklists (i.e. printed Annex I and II of the Data Collection Protocol), in order to be sure that you have collected all the necessary information

**After the end of the process**

- log into the CAN-MDS System
- enter your username and password and
- proceed with recording the incident
  - using a TEMPORARY ID
- when you believe you have completed the process, submit the record

Slide 7 [hidden slide]

## Instructions for trainers Reviewing the records and clarifications

- when all trainees-operators submit their records, ask them to open the relevant report
  - You (the trainer) should have the complete record (that you prepared from before) and go line by line through report
  - When differences are noted (by one or more trainees) you may discuss what happened, explore whether there were misunderstandings or trainees faced any other problems (technical or other)
- If there is available time, please repeat the process with the second mock case

### Reviewing the records and clarifications

- when all trainees-operators submit their records, ask them to open the relevant report
- Note: You (the trainee) should have the complete record (one that you have prepared from before)*
- work through each line of the record/entry in the process of incident reporting and check with trainees the information they each entered
  - when differences are noted (by one or more trainees), discuss what happened, explore whether there were misunderstandings or trainees faced any other problems (technical or other)


Repeat the process with the second mock case




Slide 1

## CAN-MDS Operators: why different level of access

role, responsibilities & mandates of operators in management of CAN cases


Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 80508 – CAN-MDS II – Funded by EU REC-Programme 2014-2020)  
CAN-MDS Operators' Seminar




Slide 2

## outline

- who can become a CAN-MDS Operator?
- prerequisites for an eligible professional to become CAN-MDS Operator
- defining Level of Access to CAN-MDS according to responsibilities of stakeholders in managing CAN cases
  - Examples
- attributes & "rights" per level of access

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA Nr. 80508 – CAN-MDS II – Funded by EU REC-Programme 2014-2020)  
CAN-MDS Operators' Seminar



The aim of this part is to make clear why CAN-MDS Operators are granted with different level of access in the information included in the system.

Slide 3

## Who can become a CAN-MDS Operator and How?

### Eligible professional backgrounds

- **Welfare related professions:** Social Workers, Health Visitors, Care providers in institutions, other personnel (e.g. working in antitrafficking agencies, directorates for disability, Child Ombudspersons etc.)
- **Justice-related professions:** Judges (family courts, juvenile courts), Probation Officers, Public Prosecutors, Forensic surgeons' professionals, Lawyers, other justice related professionals)
- **Health related professions:** Medical Doctors (general doctors and specialized doctors such as gynecologists, pediatricians, orthopedists, and radiologists), Midwives, Nurses, and Dentists
- **Mental health professions:** Child-Psychiatrists, Psychiatrists, Psychologists, Licensed Counselors (Youth Counselors, Family Counselors, etc.)
- **Law enforcement related professions:** Police Officers (in general and specialized police investigators e.g. in forensic interviews, for crimes against minors etc.)
- **Education-related professions:** Teachers/Educators (pre-school, kindergarten, primary and secondary education, for children with special needs), School Principals
- **Other professionals:** Researchers, Data administrators, other school personnel (e.g. school guards), other Public officials (e.g. ministries' employees), other NGOs personnel (e.g. volunteers, priests, nuns)

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[Call No: 885508 - CAN-MDS II - Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar"



Any professional who belongs to one of the following groups, has a valid professional license or is legally certified and is subjected to a professional code of ethics or a similar condition, depending on the profession

Slide 4

## Prerequisites for an eligible professional to become CAN-MDS Operator

- *to be active (not a student, not a pensioner)*
- *to work in an organization/agency and participating as a representative on behalf of his/her agency*
- *to successfully complete the short training (and be certified)*

Your logo



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
[Call No: 885508 - CAN-MDS II - Funded by EU REC Programme 2014-2020]  
CAN-MDS Operators' Seminar"



[Suggestion: You can ask trainees to inform their own colleagues who are eligible and belong to the above categories to participate in the system]

Slide 5

Defining Level of Access to CAN-MDS according to responsibilities of stakeholders in managing CAN cases	Responsibilities in managing CAN cases	
	System Administrator	Full Access (level 0)
	Making decisions on legal action such as	Full View access (level 1)
	<ul style="list-style-type: none"> <li>- to remove the child from the family</li> <li>- to remove parental rights</li> <li>- to decide whether sufficient evidence exists to prosecute (alleged) offenders</li> </ul>	
	Involvement in administration of reported/detected cases & follow-up	Limited access (level 2)
	<ul style="list-style-type: none"> <li>- Conducting initial assessments for suspected CAN cases</li> <li>- Providing services to CAN victims (diagnostic/ treatment/ consultation/care)</li> <li>- Providing services to CAN victims' families (supporting)</li> <li>- Following-up of CAN cases</li> </ul>	
	Non actual involvement in administration of reported/detected cases	Limited access (level 3)
	<ul style="list-style-type: none"> <li>- Notifying (optionally) authorities of (suspected) CAN cases</li> <li>- Reporting mandatorily (suspected) CAN cases</li> <li>- Applying screening in the general child population for CAN</li> <li>- Providing emergency protective measures to CAN victims</li> <li>- Providing legal advice/ consultation/ advocacy for CAN cases</li> </ul>	

Four different levels of access are provisioned for a CAN-MDS. Assignment of access level to an Operator depends on his/her professional responsibilities concerning CAN incidents (if any), namely if his/her role focuses exclusively on reporting CAN incidents (without further involvement in cases' administration) or includes responsibilities related to administration of cases (such as assessment, care, and support) or making decisions on legal consequences (e.g. for (alleged) offenders). Specifically:

Slide 6

EXAMPLES FOR ASSIGNING LEVEL OF ACCESS TO OPERATORS ACCORDING TO THEIR PROFESSION, ROLE AND RESPONSIBILITIES (to be adapted per country)		
Full View Access (Level 1)	Limited Access (Level 2)	Limited Access (Level 3)
<ul style="list-style-type: none"> <li>Public Prosecutors working in Judicial Services</li> <li>Social Workers working in the Child Protection System (where applicable)</li> </ul>	<ul style="list-style-type: none"> <li>Social Workers working in Social Welfare Services</li> <li>Social Workers working in Accredited NGOs/ Community Organizations</li> <li>Mental Health Professionals (psychologists, psychiatrists) working in Mental Health services</li> <li>Child Psychiatrists working in Health Care Services</li> <li>Psychiatrists working in Mental Health Services</li> <li>Psychologists working in Child Protection/Social Welfare Services</li> <li>Psychologists working in Health Care Services</li> <li>Paediatricians working in Health Care Services</li> <li>Medical Doctors (different specialties, e.g. orthopaedists, radiologists) working in Health Care Services</li> <li>Police Officers working in Law Enforcement-related Services</li> <li>Mental Health Professionals (psychologists, psychiatrists) working in Law Enforcement related services</li> <li>Licensed Counsellors working in CPS/Social Welfare Services</li> <li>Licensed Counsellors working in Mental Health Services</li> <li>Judges working in Judicial Services</li> <li>Gynaecologists working in Health Care Services</li> <li>Nurses working in CPS/Social Welfare Services</li> <li>Midwives working in CPS/Social Welfare Services</li> <li>Data administrators working in existing related registries</li> <li>Legitimate researchers working on human subject protection</li> </ul>	<ul style="list-style-type: none"> <li>Social Workers working in Health Care Services</li> <li>Mental Health Professionals (psychologists, psychiatrists, licensed counsellors) working in Accredited NGOs/Community Organizations</li> <li>Social Workers working in Education Services</li> <li>Social Workers working in Mental Health Services</li> <li>Care Providers in Institutions working in the Child Protection System/ Social Welfare Services</li> <li>Psychologists working in Educational Services</li> <li>Licensed Counsellors working in Education</li> <li>Probation Officers working in Judicial Services</li> <li>Other Justice-related professions working in Judicial Services</li> <li>Nurses working in Accredited NGOs/Community Organizations</li> <li>Teachers/educators (pre-school, kindergarten, primary &amp; secondary education, special education, school principals) working in Educational services</li> <li>Other personnel working in antitrafficking, directorate for disability, Child Ombudsman, etc.) working in Independent Authorities</li> </ul>

[This is the result of a relevant study where data from 8 countries are included; it probably needs adaptation according to country specifics]

## Slide 7

Responsibilities	Level of access	Attributes & "rights" of the level of access
System Administrator	Full Access	<ul style="list-style-type: none"> <li>Has access to view full reports of all existing incidents for any children's IDs recorded by him/her self or any other operator;</li> <li>Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID;</li> <li>Has access to edit/update all existing incidents (both, information related to incident and information related to child and family) that have been recorded by him/her self or other operator</li> <li>Has access to administrative environment (agencies and users accounts, full aggregated and disaggregated data, send notifications)</li> <li>Has the access to view and edit contact details and accounts of any Operator</li> </ul>

<see slide>



## Slide 8

Responsibilities	Level of access	Attributes & "rights" of the level of access
<ul style="list-style-type: none"> <li>Making decision on whether sufficient evidence exists to prosecute (alleged) offenders</li> </ul>	Full View access (level 1)	<ul style="list-style-type: none"> <li>Has access to view full reports of existing incidents recorded by him/her self or any other operator but only for children's IDs recorded by him/her self;</li> <li>Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID;</li> <li>In case of known child, s/he has access to view full reports of all previous incidents and edit/update existing incidents (only information related to incident) that have been recorded by him/her self</li> <li>In case of known child, s/he has access to view contact details of Operator's who have worked with the specific child's ID in the past</li> <li>Has access to update his/her own contact details &amp; password</li> </ul>

<see slide>

Slide 9

Responsibilities	Level of access	Attributes & "rights" of the level of access
<ul style="list-style-type: none"> <li>- Conducting initial assessments for suspected CAN cases</li> <li>- Providing services to CAN victims (diagnostic/ treatment/ consultation/ care)</li> <li>- Providing services to CAN victims' families (supporting)</li> <li>- Following-up of CAN cases</li> </ul>	Limited access (level 2)	<ul style="list-style-type: none"> <li>• Has access to view full reports of existing incidents recorded by him/her self or by any other operator but only for children's IDs recorded by him/her self;</li> <li>• Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID;</li> <li>• In case of known child, s/he has access to view full reports of all previous incidents (but not edit/update any existing incidents)</li> <li>• In cases of known child, s/he has access to view contact details of Operator's who have worked with the specific child's ID in the past</li> <li>• Has access to update his/her own contact details &amp; password</li> </ul>

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (Call No: 810508 - CAN-MDS II - Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 

<see slide>

Slide 10

Responsibilities	Level of access	Attributes & "rights" of the level of access
<ul style="list-style-type: none"> <li>- Notifying (optionally) authorities of (suspected) CAN cases</li> <li>- Reporting mandatorily (suspected) CAN cases</li> <li>- Applying screening in the general child population for CAN</li> <li>- Providing emergency protective measures to CAN victims</li> <li>- Providing legal advice/ consultation/ advocacy for CAN cases</li> </ul>	Limited access (level 3)	<ul style="list-style-type: none"> <li>• Has access to view full reports of existing incidents recorded by him/her self and brief description of incidents recorded by any other operator but only for children's IDs recorded by him/her self;</li> <li>• Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID;</li> <li>• In case of known child, s/he has access to view brief description of existing incidents that have been recorded by him/her self or by any other operators (but not edit/update any existing incidents)</li> <li>• In cases of known child, s/he has access to view contact details of Operator's who have worked with the specific child in the past</li> <li>• Has access to update his/her own contact details &amp; password</li> </ul>


<see slide>


PART 11 – DURATION: 45 MIN

Slide 1

## CAN-MDS piloting

what is expected by CAN-MDS Operators and  
what Operators expect by CAN-MDS


Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar




Slide 2

## Outline

- objectives of CAN-MDS System – summing up
- what is expected by the Operator to contribute to CAN-MDS
- what CAN-MDS can provide to Professionals-Operators

Your logo  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar





In this last part we are going to sum up the objectives of the CAN-MDS System. Moreover to make clear what is expected by the professionals who trained as Operators to contribute in the system during the pilot phase and, hopefully, afterwards as well as what CAN-MDS can provide to professionals-operators.

## Slide 3

### Objectives of CAN-MDS System – *summing up*

Data collected via a potential CAN-MDS Surveillance System can be used:

<p>to periodically measure the incidence of CAN and its specific forms based on data deriving from services' responses to CAN cases</p> <ul style="list-style-type: none"> <li>per specific form of abuse and neglect, and child, caregiver and family characteristics / per sector and service / in general</li> </ul>	<p>to monitor trends in child maltreatment (benchmarking)</p> <ul style="list-style-type: none"> <li>per specific form of abuse and neglect, and child, caregiver and family characteristics / at international, national and local levels</li> </ul>	<p>to provide clues for the identification of</p> <ul style="list-style-type: none"> <li>new or emerging trends in child maltreatment / populations at high risk</li> </ul>	<p>to be used as a baseline for the assessment of</p> <ul style="list-style-type: none"> <li>services' needs (needs assessment related to CAN cases administration) for prioritizing the allocation of resources for CAN primary, secondary and tertiary prevention</li> <li>effectiveness of CAN prevention practices and interventions (and to identify good practices)</li> <li>effectiveness of CAN prevention policies (for planning future policies &amp; legislation)</li> </ul>
---	---	---	---

**Your logo**  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 



<present the objectives following the animation in the slide>

## Slide 4

### Summarizing Objectives of CAN-MDS System

Additionally, data that will be collected via the CAN-MDS System can be used:

- to outline the administrative practices applied for CAN cases
- to detect changes in administrative practices of CAN cases and the effects of these changes
- to operate as a communication channel among sectors involved in administration of CAN cases<sup>1</sup>
  - to facilitate follow-up at case-level
- to operate as a ready-to-use tool during new or suspected case investigation by certified authorities
- to provide feedback to services at a case-level for already known cases

**Your logo**  "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*" (SA No: 805508 – CAN-MDS II – Funded by EU REC Programme 2014-2020) CAN-MDS Operators' Seminar 


<present the objectives following the animation in the slide>

Slide 5


### During the piloting and -hopefully- afterwards...

#### What a CAN-MDS Operator can contribute

- to record new CAN incidents for new cases (children) identified or following a report
- to add data for new incidents under already known cases
- to update data for already recorded incidents for known cases (follow-up)

Your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar




<see slide>

Slide 6


### During the piloting and -hopefully- afterwards...

#### What CAN-MDS can provide to a CAN-MDS Operator

- a **user-friendly tool** for
  - reporting CAN incidents (especially when the professional is mandated to report)
  - keeping basic information for all new incidents of CAN brought to his/her attention
  - checking demographic and other data for already known children (via auto-produced reports)
- a **communication channel** with other professionals working in the same or different sectors on the same case
- basic information on previous incidents** for already known cases (children) (according to his/her level of access)
- a **ready-to-use tool** for
  - informing other agencies on his/her agency's response (e.g. what services have already been provided)
  - notifying other agencies of new cases (for example, via referrals)

Your logo 

"Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"  
(SA No: 80508 – CAN-MDS II – Funded by EU REC Programme 2014-2020)  
CAN-MDS Operators' Seminar



<see slide>

After the end of this presentation please proceed with the completion of the post-questionnaire; take care to remind trainees to fill-in the code in the right up corner of the document.





## FURTHER READING

The CAN-MDS Training Module is based on a series of work done in the context of the Action CAN-MDS II "*Coordinated Response to Child Abuse and Neglect via a Minimum Data Set: from planning to practice*" co-funded by EU REC Programme 2014-2020. All information related to the training of professionals who are interested to participate in the CAN-MDS Surveillance System is available to any interested party.

Apart from the CAN-MDS Toolkit, it is strongly recommended that future trainers in the context of their preparatory work read the documents related to CAN-MDS trainings (namely the Guide for Trainers) as well as the documents related to their country specifics (such as the Policy Briefs that are available in [www.can-via-mds.eu](http://www.can-via-mds.eu)).

Moreover, future trainers can read the reports under the title "*How the CAN-MDS was developed*", especially for issues they may consider as not clear enough (such as the definition of the eligibility criteria for formatting core and expanded groups of operators or how the content of the MDS was decided).

Optionally, further Informative reading material suggested for CAN-MDS trainers is the *CAN-MDS Policy and Procedures Manual*, *informational leaflets*, and the *website of the Action "coordinated response to child abuse and neglect via a minimum data set"*.

*For a more comprehensive understanding:* the United Nations' Committee on the Rights of the Child's General comment No. 13 (2011), "The right of the child to freedom from all forms of violence" [CRC/C/GC/13 (2011) §19-33]<sup>1</sup>, UNCRC Article 19,<sup>2</sup> the World Report on VAC (2006),<sup>3</sup> the *World Health Organization and International Society for Prevention of Child Abuse and Neglect*. (2006). *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva: WHO Press and the Leeb R, Paulozzi L, Melanson C, Simon T, Arias I. (2008). *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements*. Centers for Disease Control and Prevention, National Center for Injury Control and Prevention: Atlanta, GA.

<sup>1</sup>Available at: [http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13\\_en.pdf](http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf)

<sup>2</sup>Available at: [http://www.unicef.org.uk/Documents/Publication-pdfs/betterlifeleaflet2012\\_press.pdf](http://www.unicef.org.uk/Documents/Publication-pdfs/betterlifeleaflet2012_press.pdf)

<sup>3</sup>Available at: <http://www.unicef.org/violencestudy/reports.html>

## CAN-MDS Toolkit

- Content:
  - o *CAN-MDS Operator's Manual*
  - o *CAN-MDS Data Collection Protocol*
  - o *e-CAN-MDS registry (online application)*
- To whom the Guide for Trainers is addressed: Partners of Action "CAN-MDS II" and all relevant stakeholders and who are interested in training professionals either as CAN-MDS Operators
- *Trainees: All potential CAN-MDS Toolkit Users in partners' and other EU countries: Professionals working in the field of CAN secondary and tertiary prevention, Professionals working in the field of CAN primary prevention, Social and Health Scientists. Also, Epidemiologists and Policy Makers.*
- Available at: [www.can-via-mds.eu](http://www.can-via-mds.eu)

## Country specific information

- ***National Policy Briefs (Bulgaria, Cyprus, France, Greece, Romania, Spain)***
  - o *Joining forces to better protect children from abuse and neglect: coordinated multi-sectoral response to child abuse and neglect cases*
  - o *Content: This policy brief provides an overview of what is known about the extent and characteristics of child abuse and neglect problem at national level and how this situation is related to the currently applied data collection practices. Coordinated response to child maltreatment cases, focusing on incidents' reporting and recording by multi-sectoral data*

*sources relevant to child wellbeing is suggested; the aim is to stimulate the discussion on the installation and operation of a robust national surveillance system in this area. Better illustration through data can help decision-makers and agency administrators to better understand the problem and, therefore, to effectively respond to and prevent child maltreatment*

- Target groups: *Policy Makers, Administrations and Professionals in child protection, social welfare, health and mental health-, justice-, low enforcement-, education sectors*
- Available at: [www.can-via-mds.eu](http://www.can-via-mds.eu)

## Information for training

### - **Training Module**

- Content: *Training module for professionals-potential operators of CAN-MDS on the basis of CAN-MDS Toolkit including a special session on CAN monitoring ethical aspects*
- Target groups: *Project Partners and any other national "focal point" who is interesting to undertake the training of national core group of CAN-MDS operators*
- Available at: [www.can-via-mds.eu](http://www.can-via-mds.eu)

## How the CAN-MDS was developed (Available at: [www.can-via-mds.eu](http://www.can-via-mds.eu))

- Developing of evaluation methodology and tools for CAN-MDS Toolkit
- Evaluation of Toolkit in terms of Feasibility & Experts' evaluation results
- Developing of eligibility criteria for the creation of national CAN-MDS Core and Expanded Groups of Operators
- Designing of methodology and tools for effectiveness evaluation of training
- Evaluation Results from the *train-of-trainers* seminar

## Other Informational material

### **Developed in the content of project**

- Policy and Procedures' Manual
- CAN-MDS Surveillance System (Informational leaflet)
- CAN-MDS Flyer
- Website [www.can-via-mds.eu](http://www.can-via-mds.eu)

## Literature

- United Nations' Committee on the Rights of the Child's General comment No. 13 (2011), "The right of the child to freedom from all forms of violence" [CRC/C/GC/13 (2011)] (instead of WHO & ISPCAN (2006) definitions).
  - Available at: [http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13\\_en.pdf](http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf)



### Resources for protecting children within the context of the COVID epidemic.

- Sistovaris, M., Fallon, B., Miller, S., Birken, C., Denburg, A., Jenkins, J., Levine, J., Mishna, F., Sokolowski, M. and Stewart, S. (2020). *Child Welfare and Pandemics*. Toronto, Ontario: Policy Bench, Fraser Mustard Institute of Human Development, University of Toronto. At: [https://fncaringociety.com/sites/default/files/child\\_welfare\\_and\\_pandemics\\_literature\\_scan.pdf](https://fncaringociety.com/sites/default/files/child_welfare_and_pandemics_literature_scan.pdf)
- <https://www.ispcan.org/covid19resourcepage/>
- <https://www.coe.int/en/web/children/-/coronavirus-and-children>
- <https://www.coe.int/en/web/genderequality/-/for-many-women-and-children-the-home-is-not-a-safe-place>
- <https://www.unicef.org/coronavirus/how-talk-your-child-about-coronavirus-covid-19>
- <https://www.childhelplineinternational.org/child-helplines/tools/coronavirus/>
- <https://www.savethechildren.org/us/what-we-do/emergency-response/coronavirus-outbreak/coronavirus-outbreak-facts-tips-how-to-help-protect-children#talk>
- <https://www.eurochild.org/news/covid-19/>
- <https://young.scot/campaigns/national/coronavirus>
- <https://www.mindheart.co/>
- Please add (national and/or international related literature)



+

