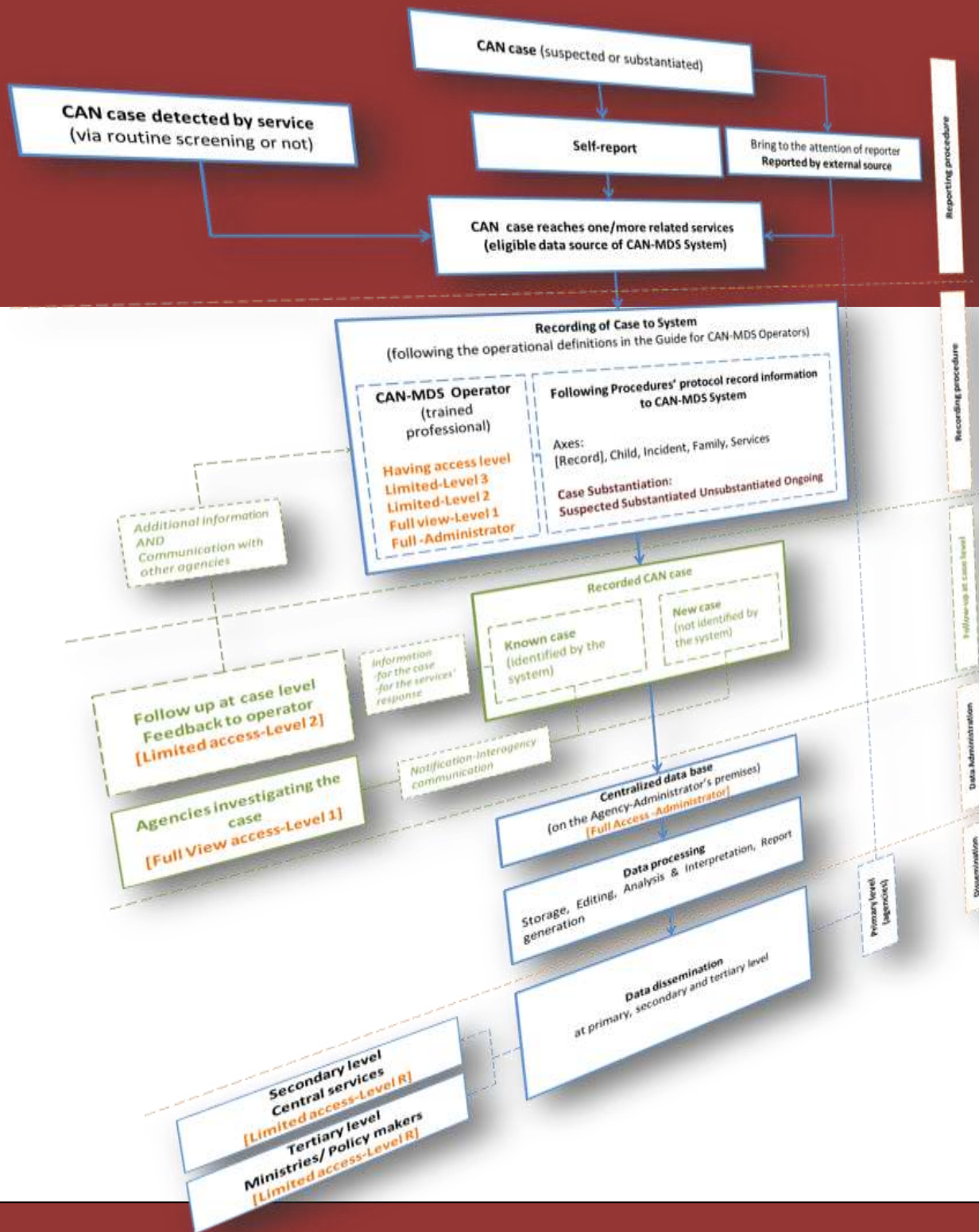
Co-funded by EU REC Programme 2014-2020

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

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

Deliverable's Information

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

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Project's Website: 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*"

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This publication was funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020). The content of this publication represents only the views of the authors and is their sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

Table of Contents

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, low 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)
- CAN-MDS – Administrator's Interface (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.

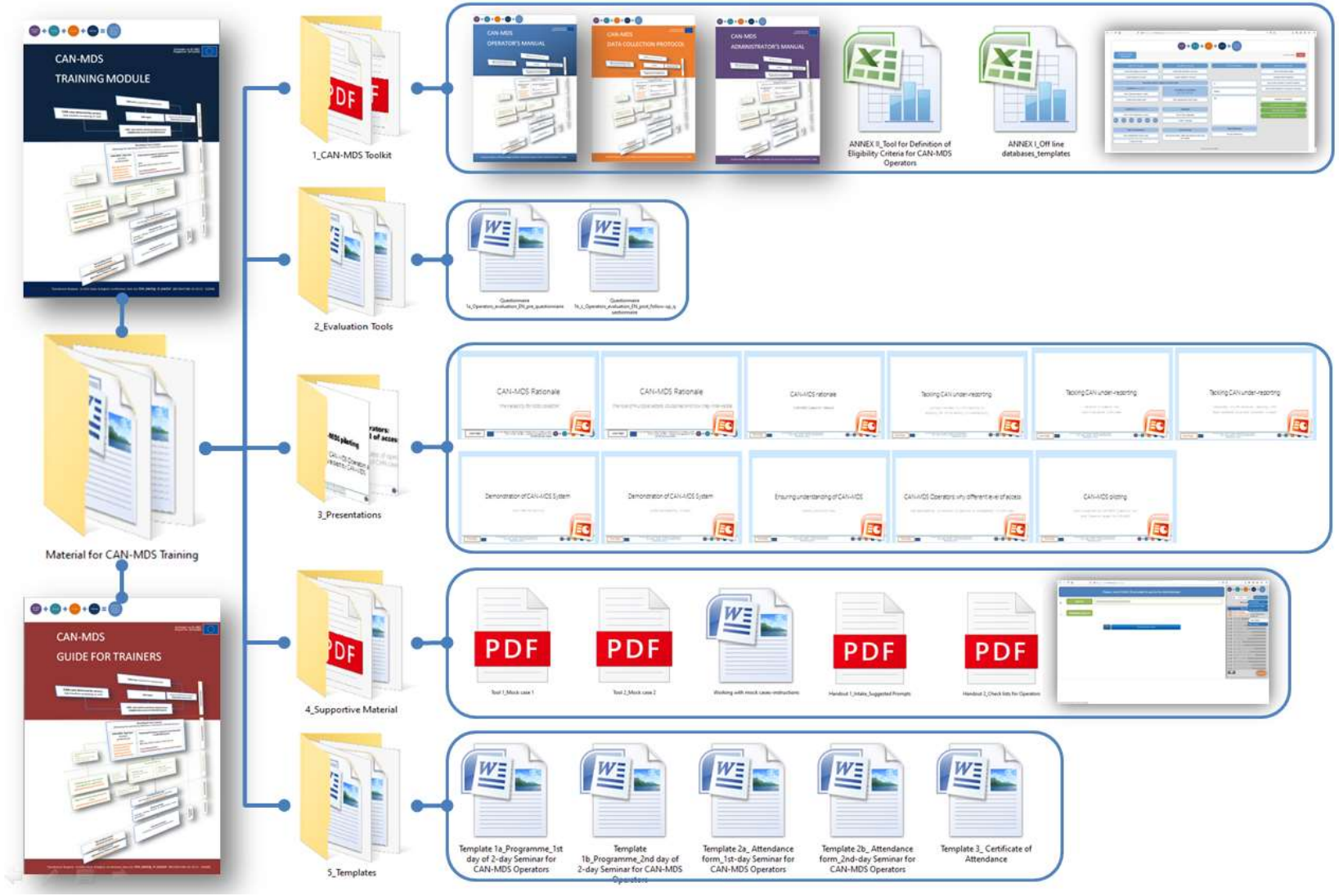
Sub-folder "5. Templates"

- 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[1]

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[2] - **use this information to create Agencies' IDs**
   b. Fill in DB3 Professionals-Operators[3]-**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)

[1] except for the case you have access in a room with adequate PCs
[2] ANNEX I_Off line databases_templates of the Step by Step Guide for CAN-MDS Administrators
[3] 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.

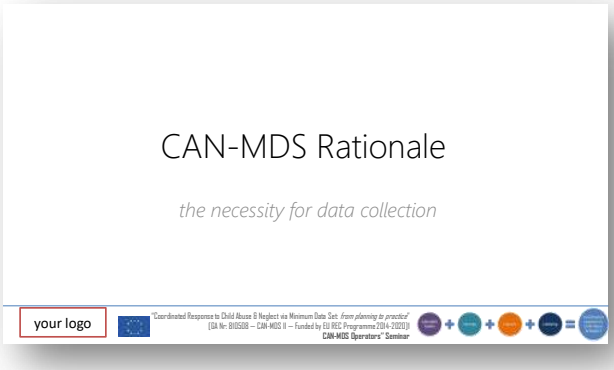
DOCUMENTATION of SEMINARS

- 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

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PART 2 - PREPARATION

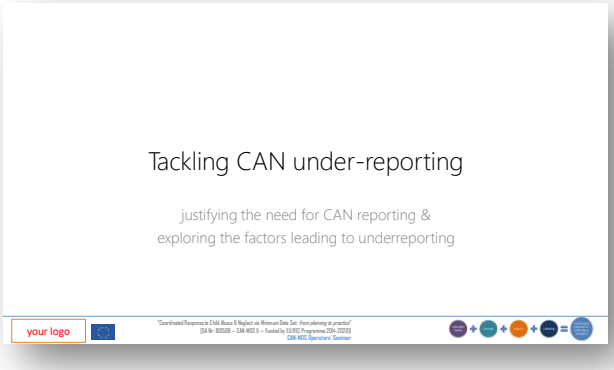
Total slides: 24
Slides to be translated: 15 (1-2 & 11-23)
Slides to be adapted according to country specifics: 9 (3-10 & 24) (see also notes)
Notes: If the situation in your country is similar to the Greek example, then you can keep and use slides 4-10 and 24; if you prepare your own slides, you can 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)

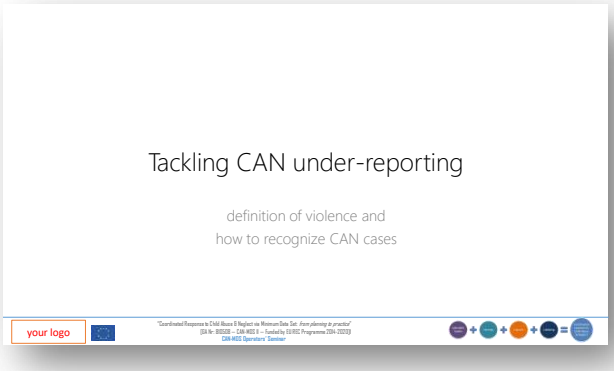
SESSION 2: Tackling Underreporting

PART 4 - PREPARATION



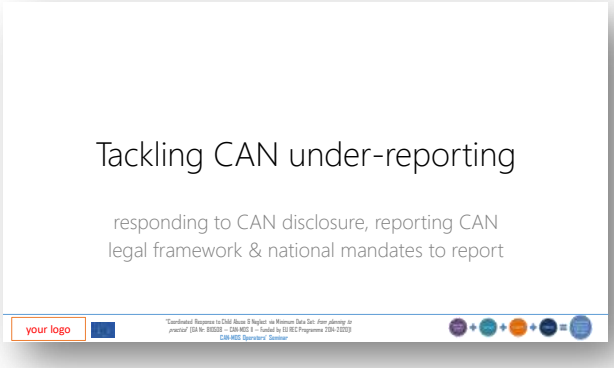
Total slides: 56
Slides to be translated: 31 (1-6, 8-11, 13-14, 29-47) +myths/facts
Slides to be adapted according to country specifics: 4 (2, 7, 12, 23); you may add slides, if needed
Notes: in this presentation there are slides that may be removed (currently hidden)
15-22 (myths & facts: you may keep 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)

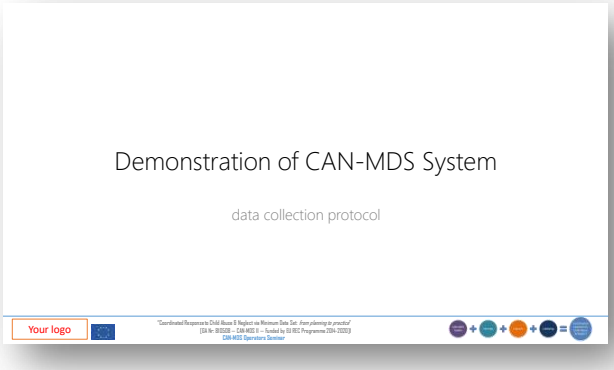
PART 6 - PREPARATION



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)

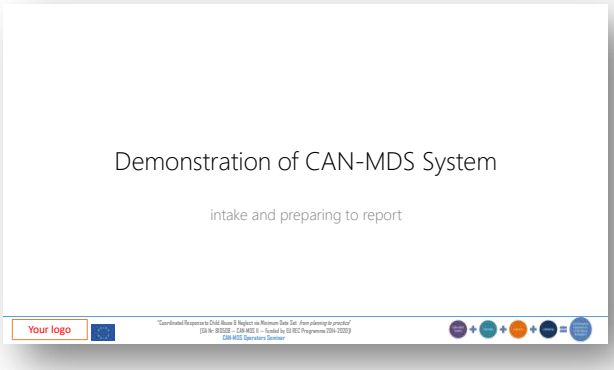
SESSION 3: Demonstration of CAN-MDS System

PART 7 - PREPARATION



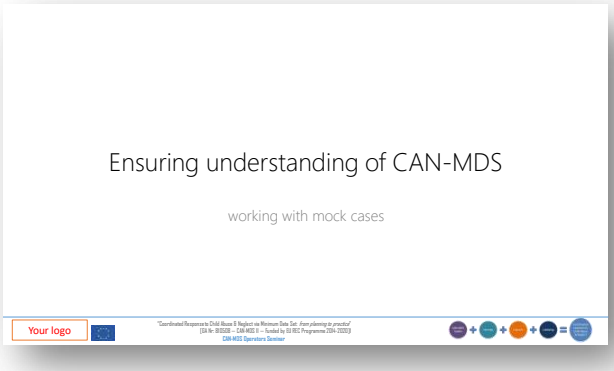
Total slides: 19
Slides to be translated: 19
Slides to be adapted according to country specifics: 0
Notes:
8, 15-19 (translation in your language is available in national Data Collection Protocol)

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)

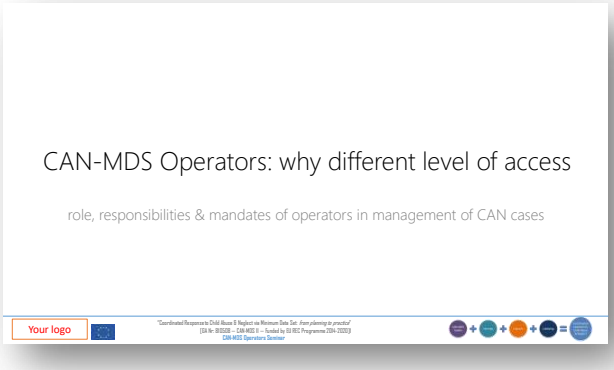
PART 9 - PREPARATION



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**

1b_c_Operators_evaluation_EN_**post_follow-up_questionnaire**

Total files: 2
Files to be translated: 2
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**
Tool 2 Mock (vignette) **case 2**
Handout 1
Handout 2
Instructions-Working with mock cases

Total files: 5
Files to be translated: 4
Files to be adapted: 2 (optionally you may adapt mock cases according to country specifics, if needed)
Notes:
Handout 1_ already translated (see national Data Collection Protocol; pp. 49-50 ANNEX I & II
Handout 2_already translated (see national Data Collection Protocol; pp. 46-48)
Instructions-Working with mock cases–addressed to trainers, no translation is necessary

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TEMPLATES

Template 1a
Template 1b
Template 2a
Template 2b
Template 3
DB2 (Agencies-Data Sources)
DB3 (Professionals-Operators)

Total files: 6
Files to be translated: 5
Files to be adapted: 5 (all but DBs)
Notes:
DB2 & DB3 are available in CAN-MDS Step by Step Guide for Administrators, ANNEX I_Off line databases_templates (no translation is necessary)

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

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E-APPLICATIONS

CAN-MDS – Operator's App (www.can-mds.infowood.gr)	Already translated
CAN-MDS –Administrator's Interface (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	**Welcome**
09:45–10:00	**Completion of pre-questionnaire**
10:00-10:30	**CAN-MDS Rationale** - 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	**Coffee-break**
11:30–13:30	- CAN-MDS Operator's Manual
13:30–14:00	**Light lunch**
14:00–14:30	**Tackling Underreporting** - exploring the reasons
14:30-15:30	- how to recognize CAN cases
15:30–16:00	**Coffee-break**
16:00–17:00	-national mandates to report per Operators group
17:00–17:30	**Discussion** - emphasis on Q&A
17:30	**End of Day 1**

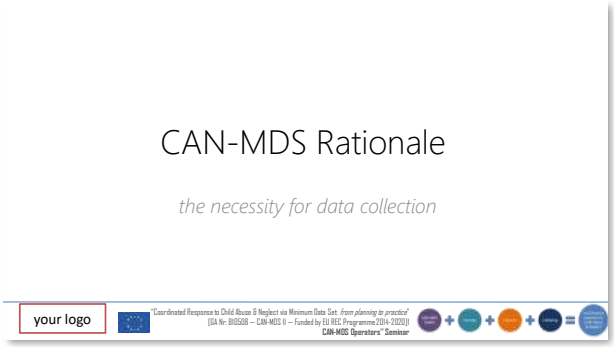
DAY 2: Demonstration of CAN-MDS: working with mock cases — DURATION: 8 HOURS

09:30–09:45	**Welcome**
09:45–10:45	**Demonstration of CAN-MDS System** - Data Collection Protocol & tools
10:45-11:00	- demonstration of operator's interface
11:00–11:30	**Coffee-break**
11:30–13:30	**Ensuring understanding of CAN-MDS** - working with mock cases: Case 1; reviewing mock case and clarifications - Q&A
13:30–14:00	**Light lunch**
14:00–15:30	- working with mock cases: Case 2; reviewing mock case and clarifications - Q&A
15:30–16:00	**Coffee-break**
16:00–17:15	**CAN-MDS piloting** - 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	**Post questionnaire & Certificates of Attendance**
17:30	**End of Seminar**

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 - *the necessity of data collection regarding child abuse and neglect incidents* - *the necessity of coordinated multi-sectoral and multidisciplinary approach for an effective response to child abuse and neglect* - *the rationale of CAN-MDS system based on a review of the Operator's Manual*
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

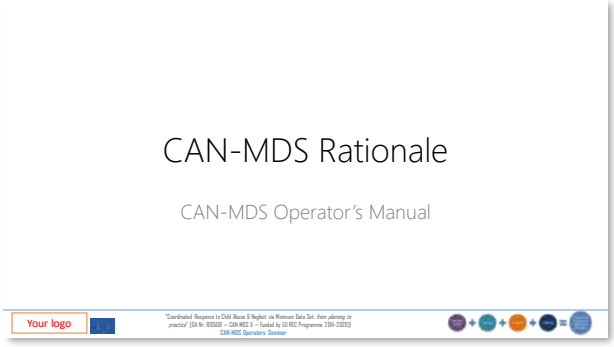
exploring the factors leading to underestimation

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

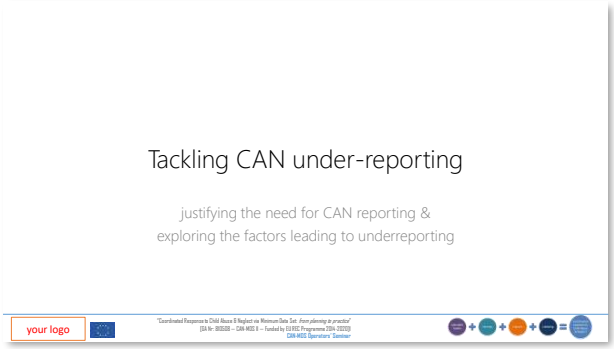


Outline

- 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	After the completion of Session 2 professionals-trainees - *are fully informed about what is CAN and its specific types* - *are familiar with the operational definitions of CAN on the basis of CRC, Art. 19 and GC 13 of UN CRC (2011)* - *are informed on how to recognize signs of child abuse and/or neglect* - *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)* - *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* - *are aware of what is provisioned by the law as well as for their own professional field's mandates for reporting* - *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*
Instructions to trainers	be familiarized with the presentations (see detailed information below)
Activities	NA
Training resources	Presentation Part 4 (translated & adapted) Presentation Part 5 (translated & adapted) Presentation Part 6 (translated)
Tips	Send the CAN-MDS Operator's Manual and Data Collection Protocol to trainees in advance, asking them to go through the documents

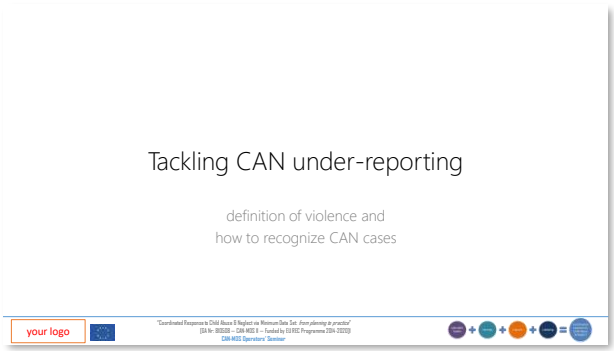
PART 4 - DURATION: 30 min



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

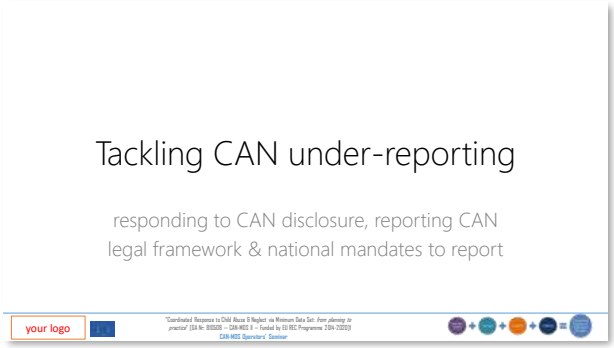
PART 5 - DURATION: 60 min



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

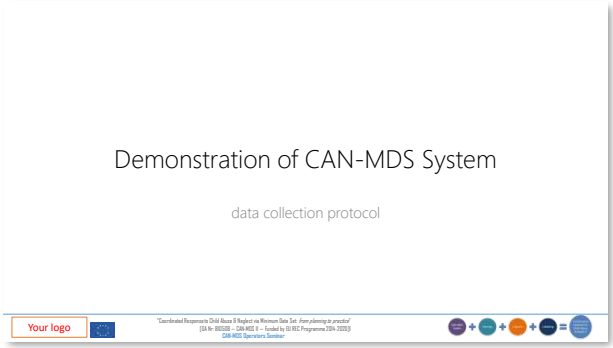


Outline

- 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 *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)*
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

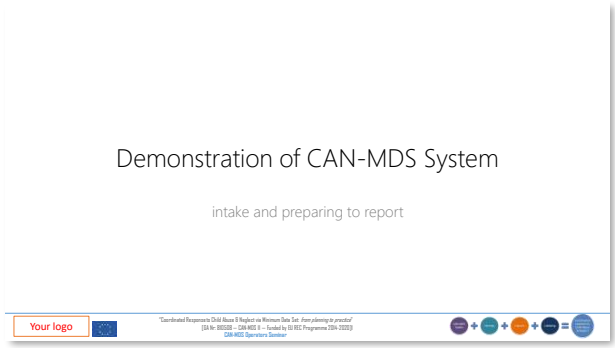
PART 7 - DURATION: 60 min



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*

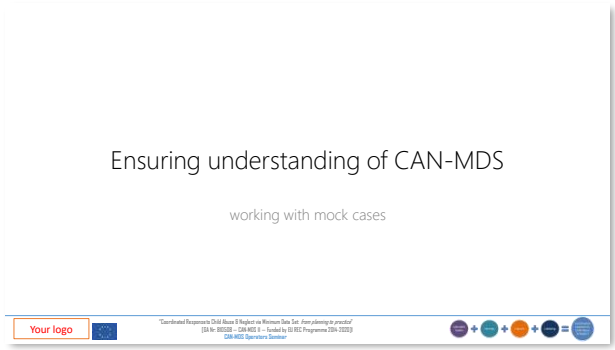
PART 8 - DURATION: 15 min



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

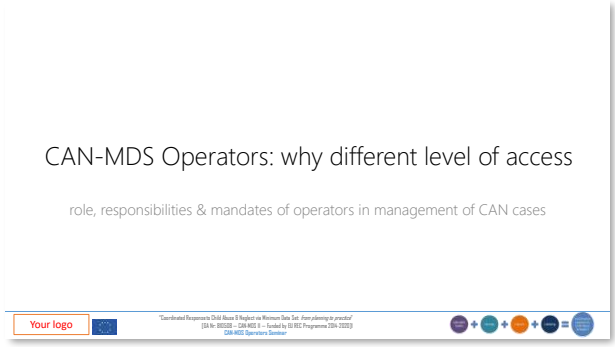


Outline

- 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

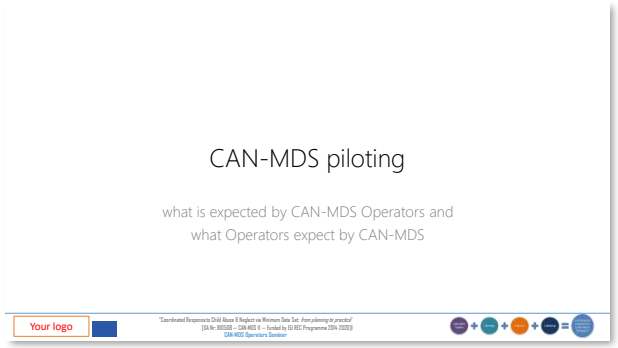
PART 10 - DURATION: 30 min



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



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

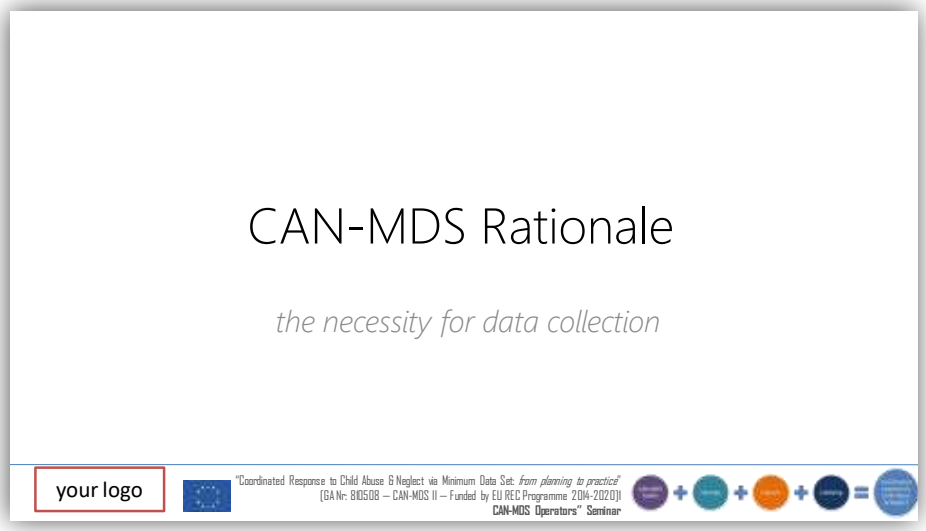
DO'S AND DON'TS OF TRAINING

- *prepare in advance*
- *use visual aids*
- *encourage questions*
- *recap at the end of each session*
- *use good time management*
- *check to see if your instructions are understood*

- *talk to the presentation*
- *block the visual aids*
- *stand in one spot*
- *ignore the participants' comments & feedback*
- *read from manual*
- *shout at participants*

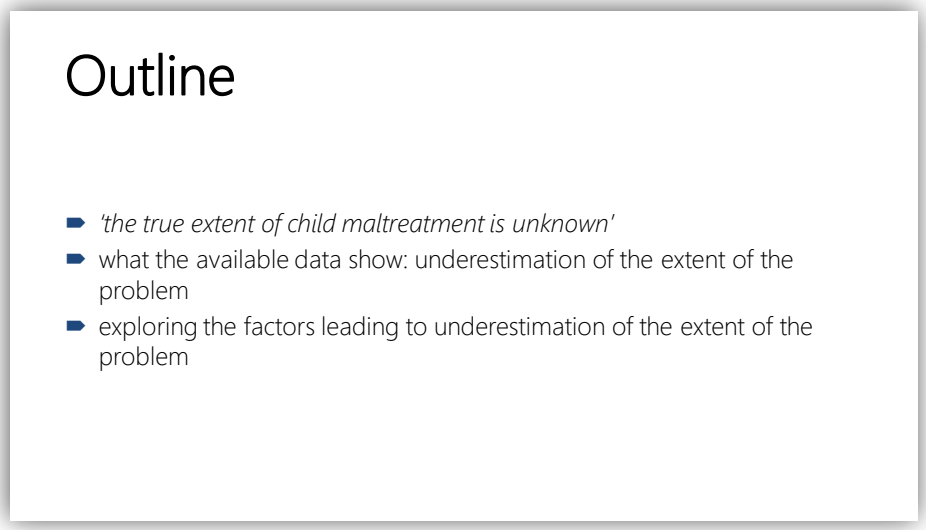
SESSION 1 – DURATION: 180 MIN (3h)
PART 1 – DURATION: 30 MIN

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

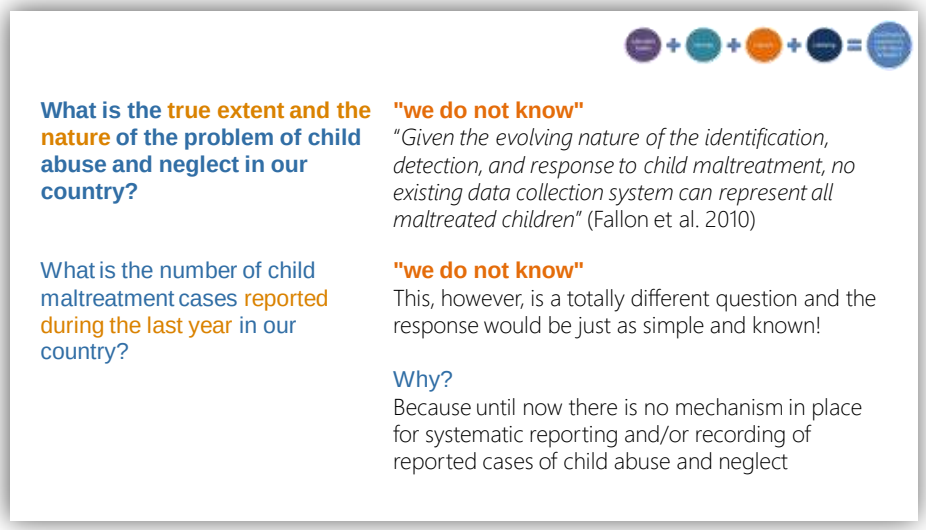


We will start with the commonly accepted opinion that *'the true extent of child maltreatment is unknown'* and how this is valid for our country too. We'll see what the available data show and what are the factors leading to underestimation of the magnitude of the problem of child maltreatment.

Slide 3

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



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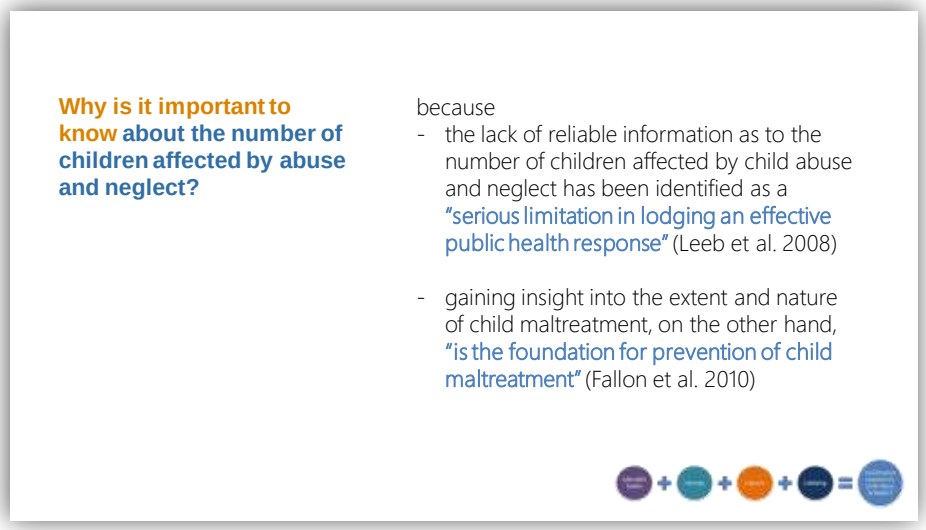
Slide 5



<see slide>

Slide 6

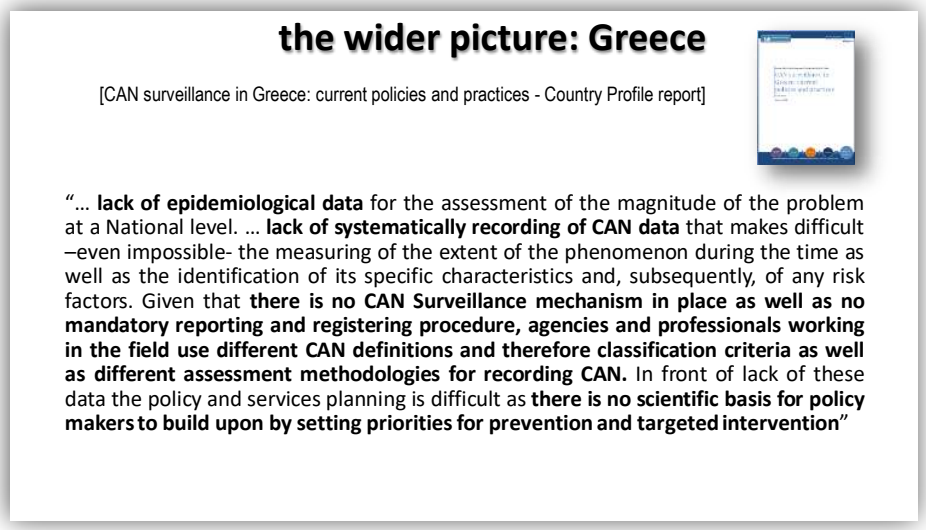
This is what the literature says:

- (1st box comment) the "*tip-of-the-iceberg analogy easily comes to mind when one thinks of the scope of child maltreatment*"
- (2nd box comment) This is what the comparison among *self-report* and based on *administrative data* surveys shows.
- (3rd 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

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

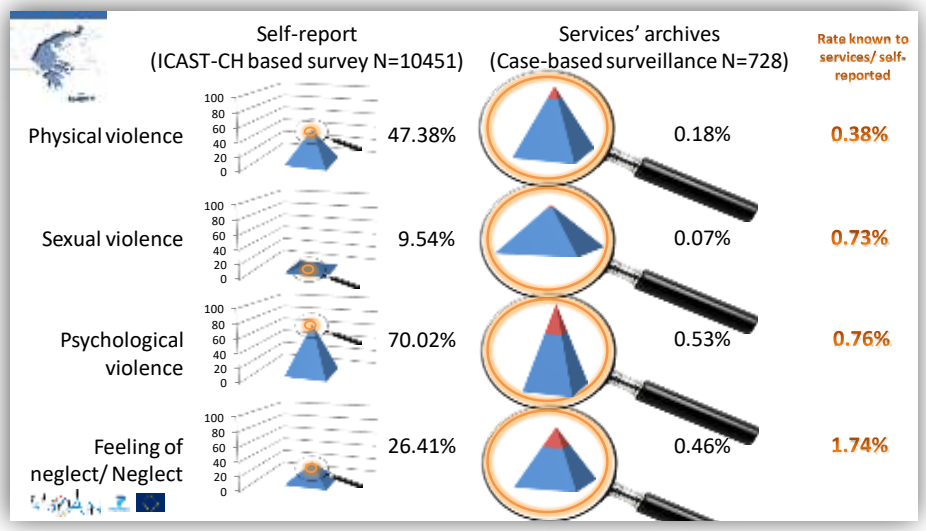
Slide 8 [hidden slide - example]



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

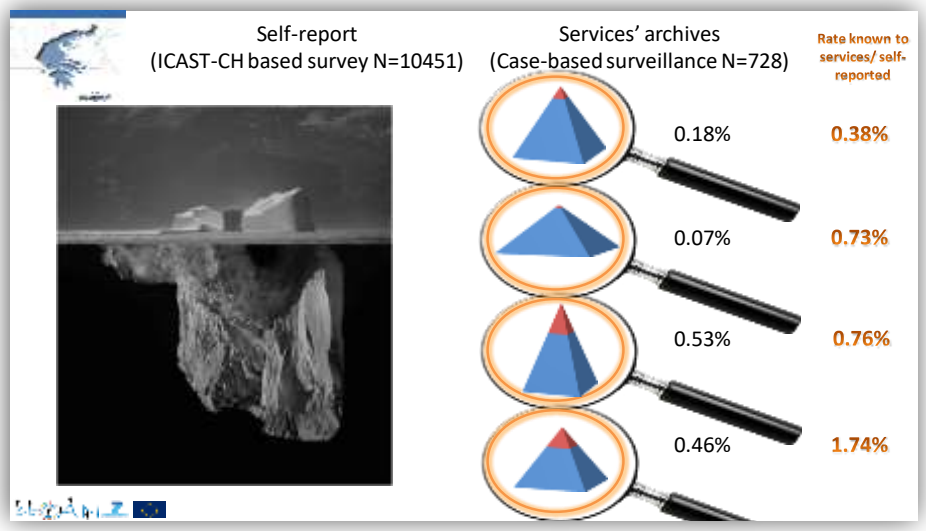
In Greece there is no fully coordinated child protection system (as such a system defined e.g. by UNICEF)
Apart from a few exceptions, there is a lack of epidemiological data on CAN, while no surveillance mechanism is currently in place.
Where data are collected, different definitions, methodologies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

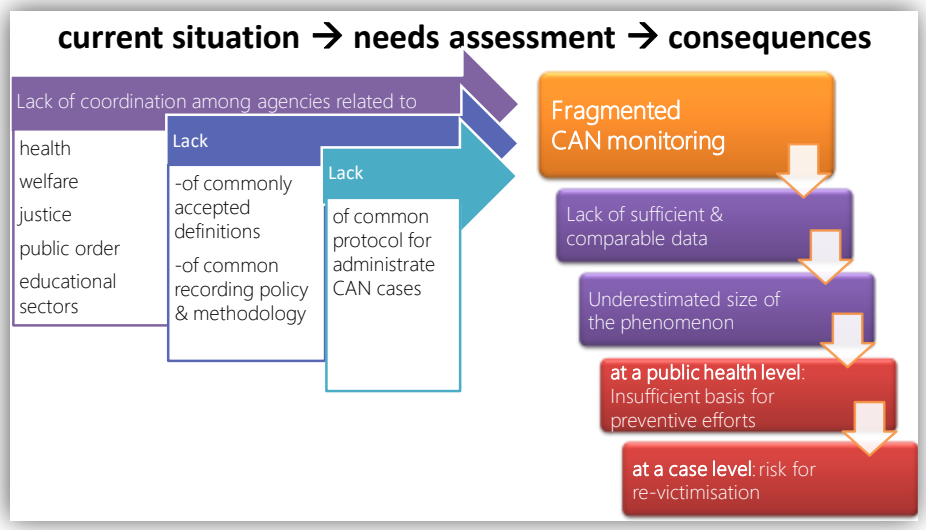
data interpretation-related limitations

- **"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>

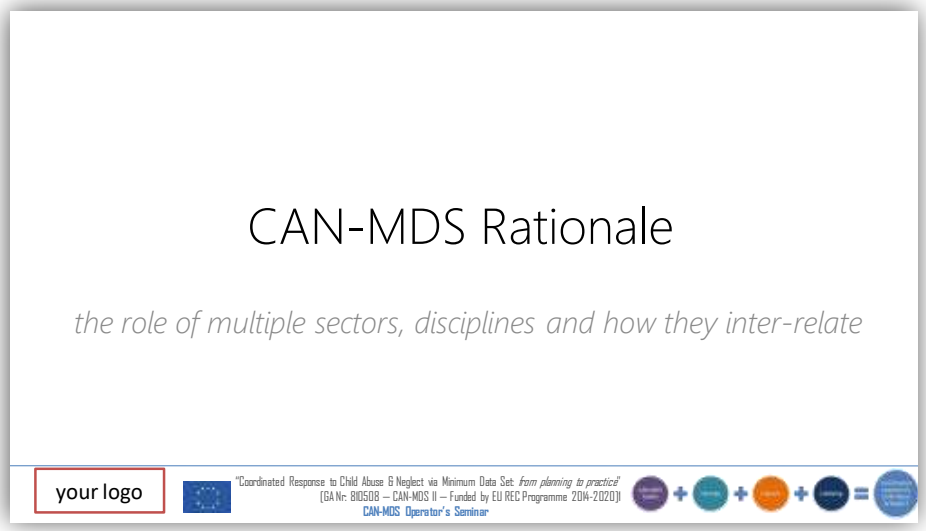
Slide 15



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.

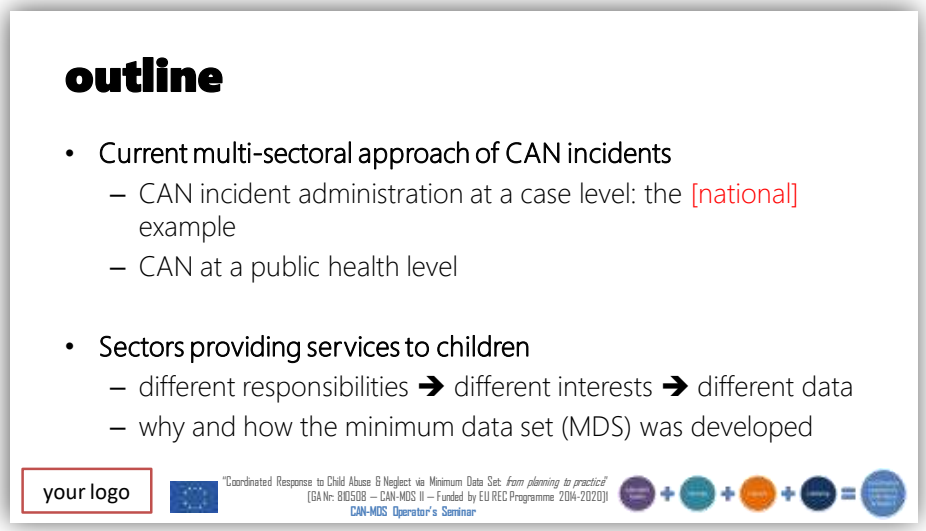
PART 2 – DURATION: 30 MIN

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.

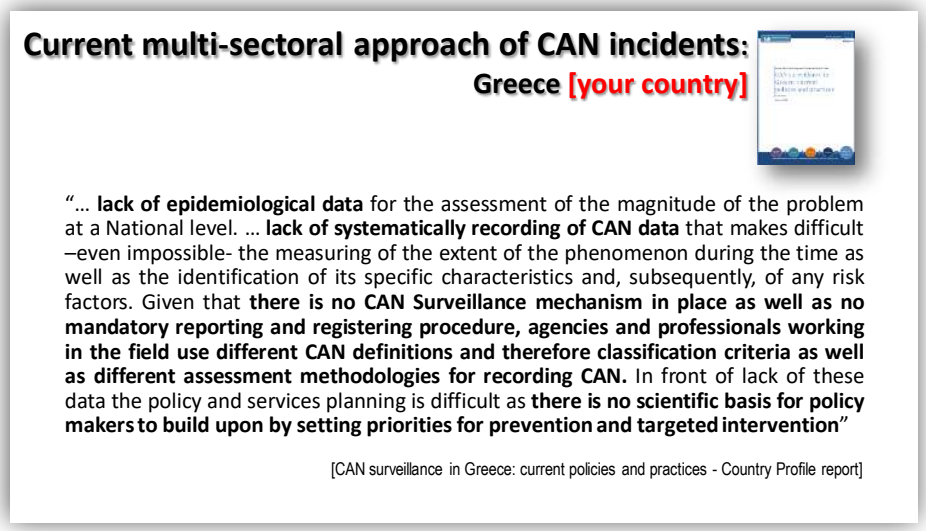
Slide 2



[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.

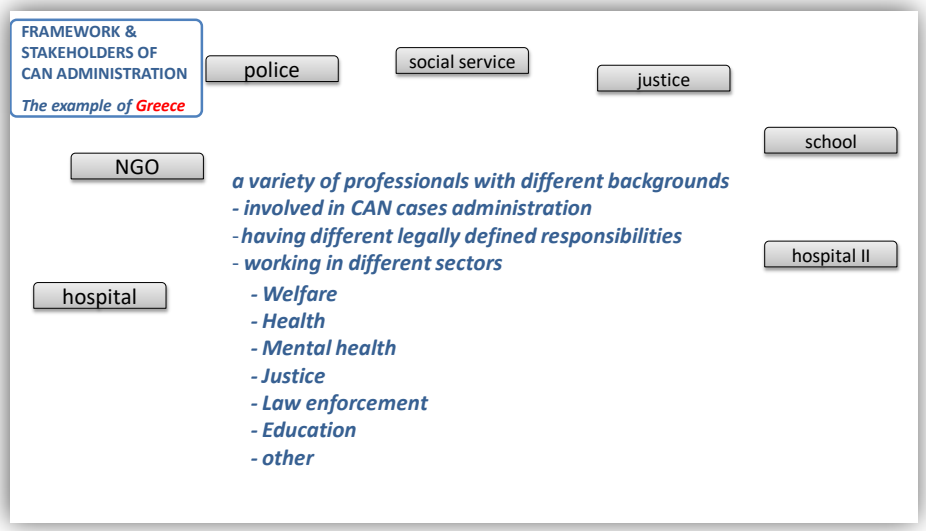
Slide 3 [hidden slide - example]



[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

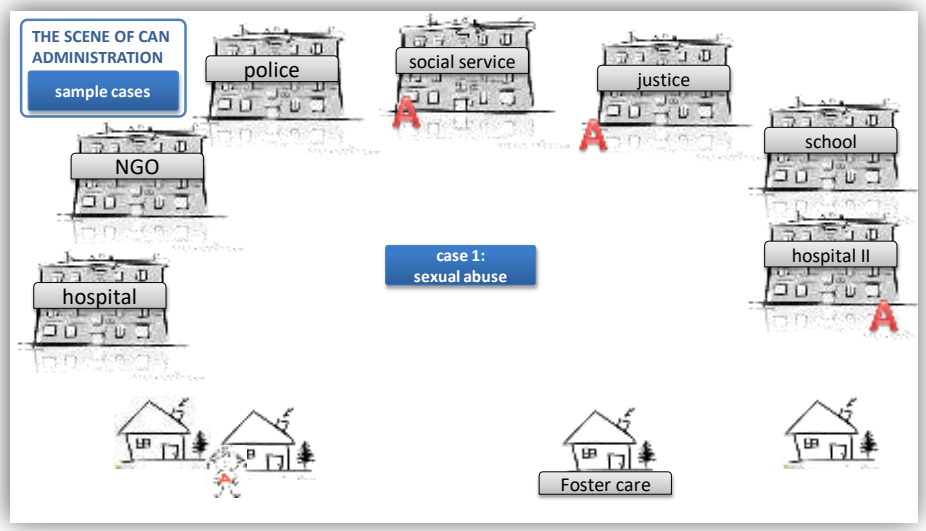
Slide 4 [example]



[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]

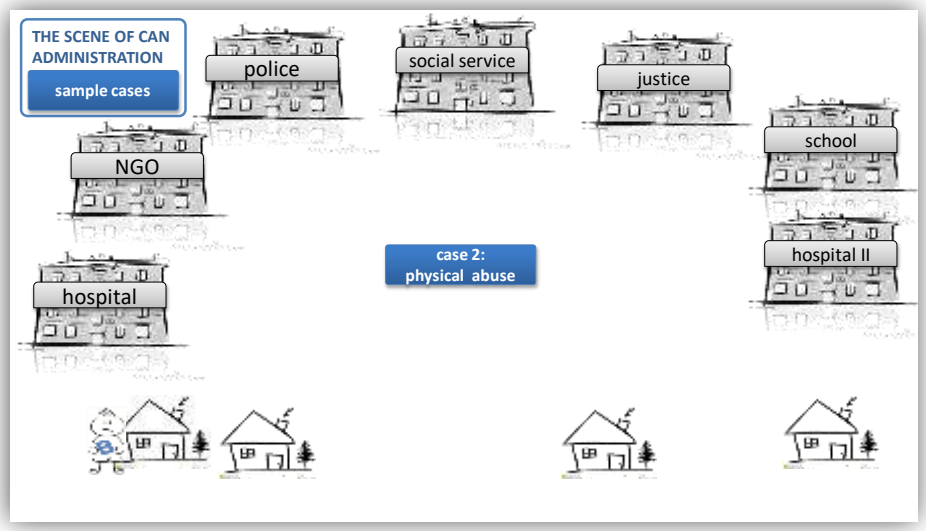
Let's see some more details on how a case of child maltreatment is administered in Greece.
A variety of professionals working in different sectors and agencies, with different legally defined responsibilities are involved in the route of a CAN case administration.

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

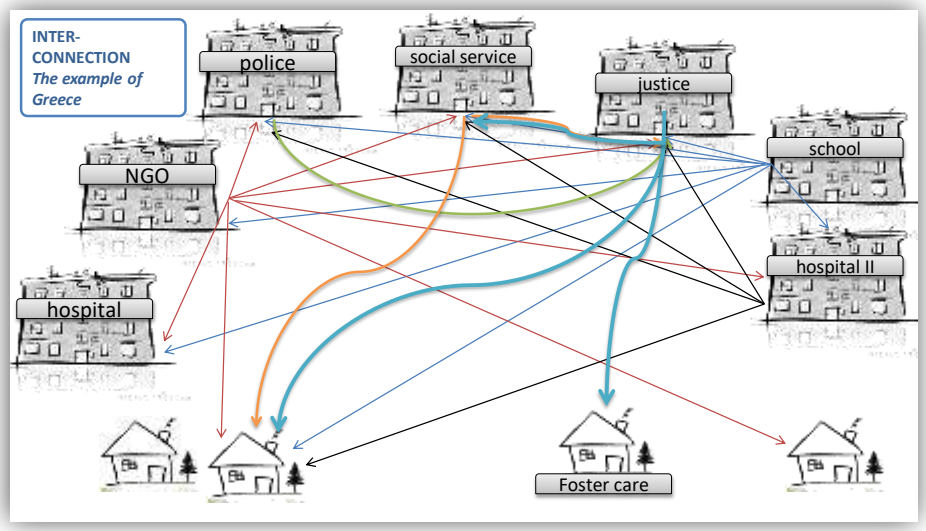


Let's suppose that a child is physically abused; after an incident the child ended up with an injury caregivers address a hospital seeking medical care; the hospital provides the care and the child goes back home; after a period the child suffers again some physical harm and care givers address another 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

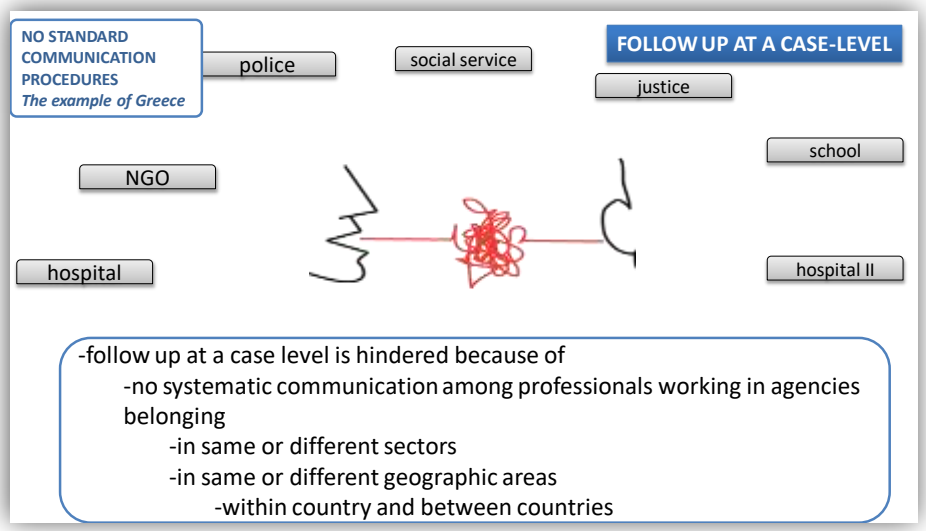
Last, in our example, a physically neglected child is identified by the teacher; s/he addresses a request for family support to an NGO and the NGO in turn refers the child to social services; they decide to intervene with the family, without however informing the prosecutor (because they consider that 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



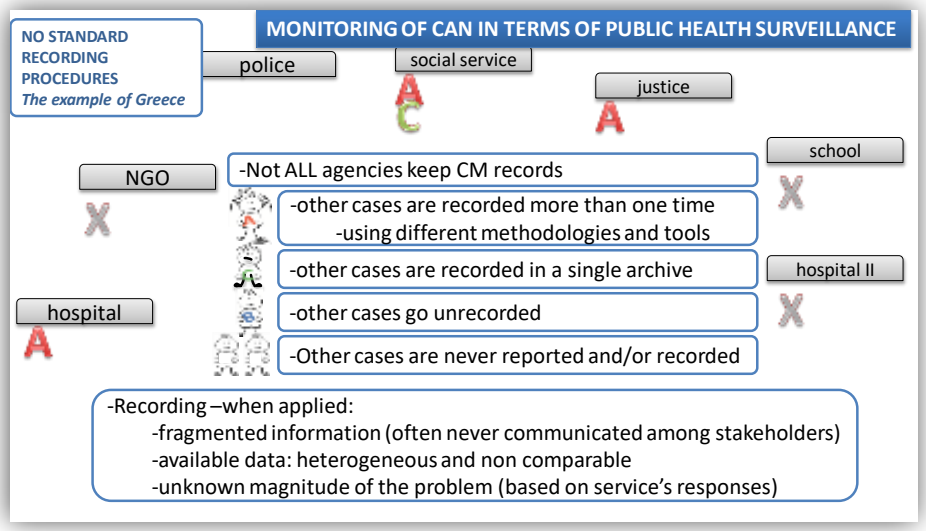
Actually, currently almost everyone can –hypothetically- communicate with everyone but without following standard procedures and only if they consider that it is needed

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.

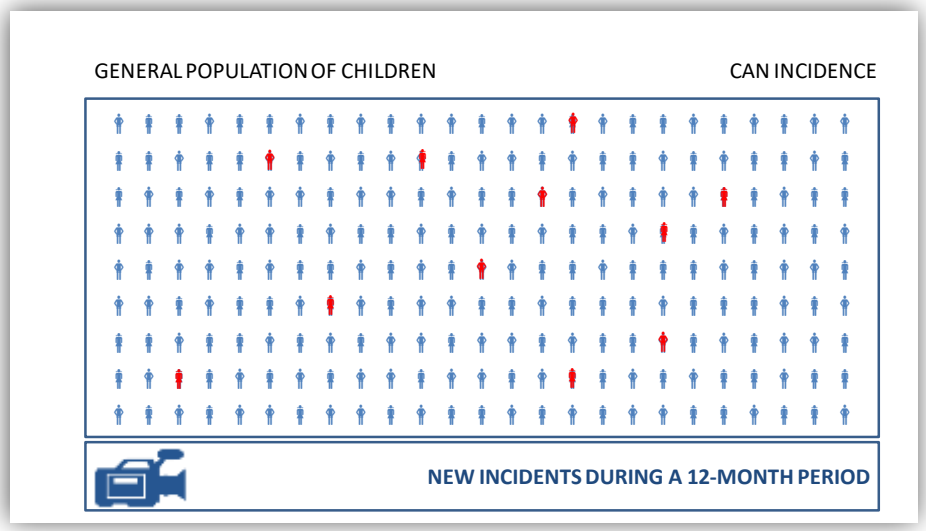
Slide 10



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.

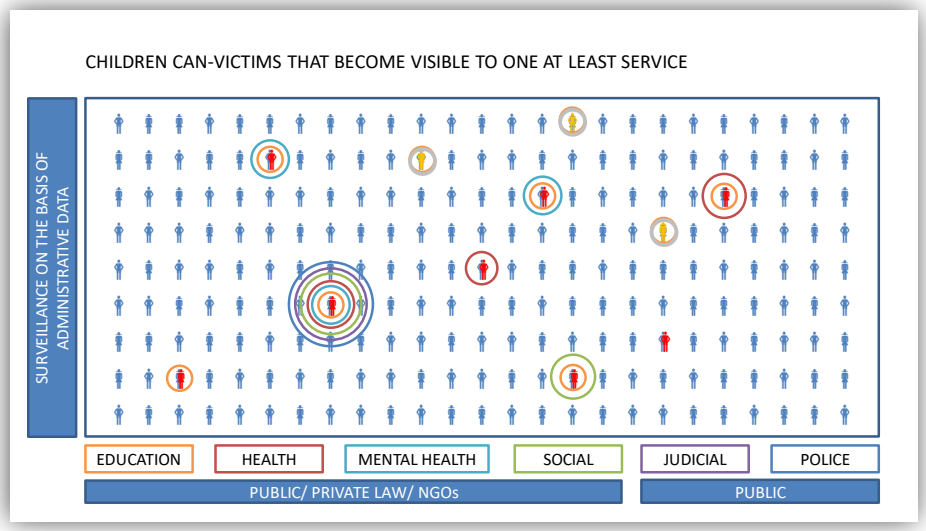
Moreover, recording –when applied is fragmented information (often never communicated among stakeholders). The available data are heterogeneous and non comparable and eventually the magnitude of the problem (based on service's responses) is unknown

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).

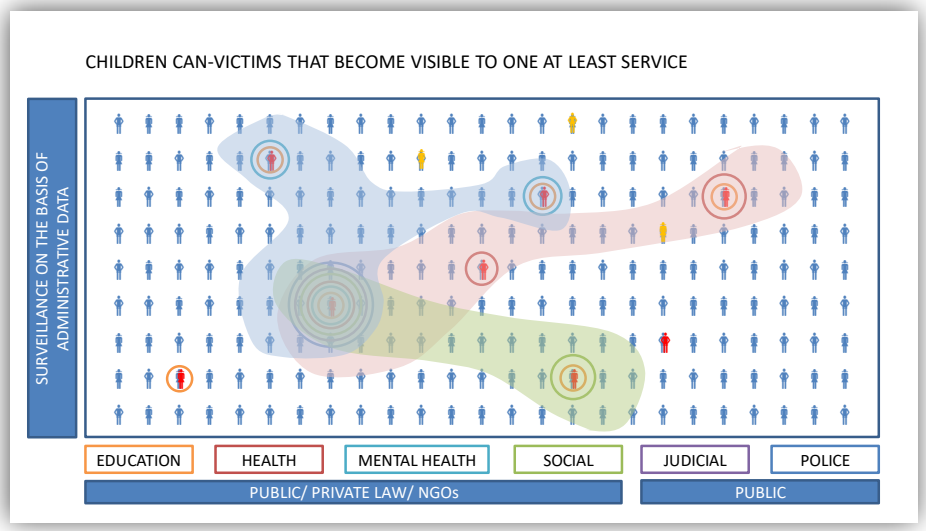
Slide 12



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.

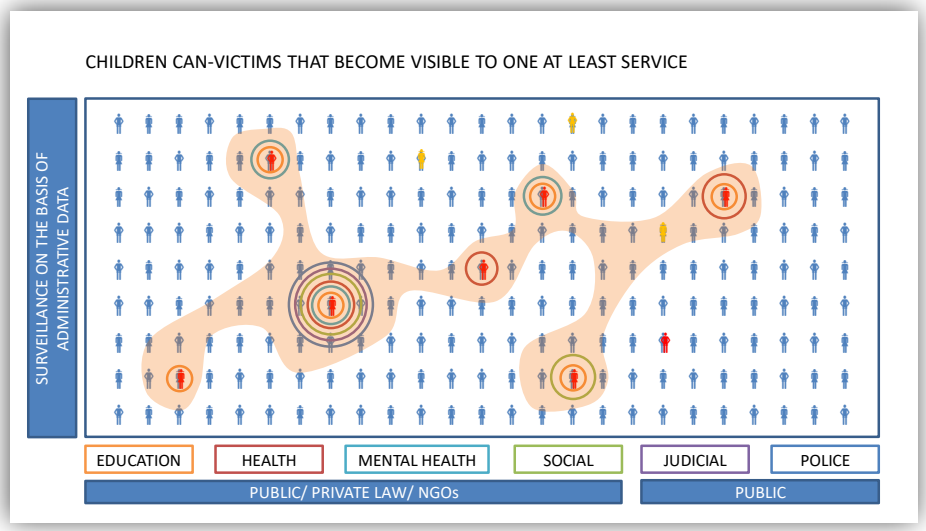
Slide 13



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.

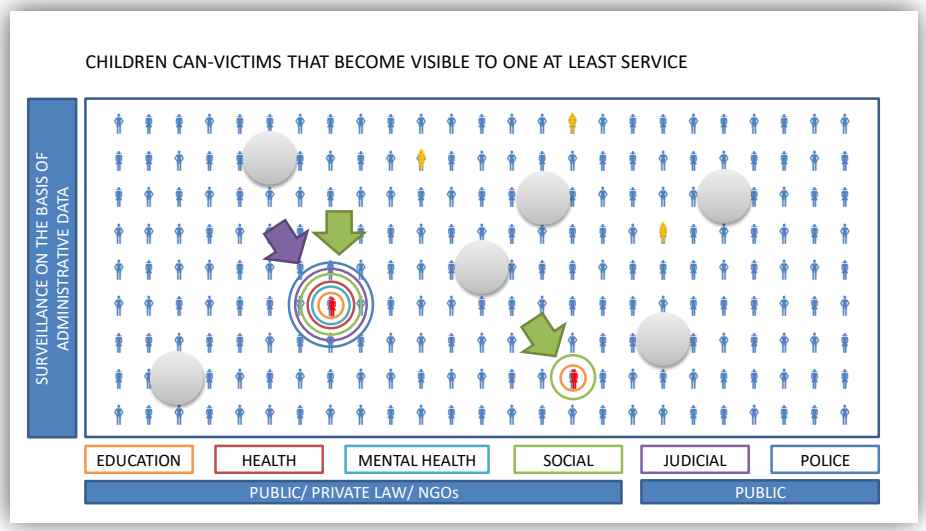
On the other hand, if we try to put together all available records (child protection system, social welfare, NGOs, police etc.), then we will have potential duplication of cases and in any case available data are not expected to be comparable.

Slide 14



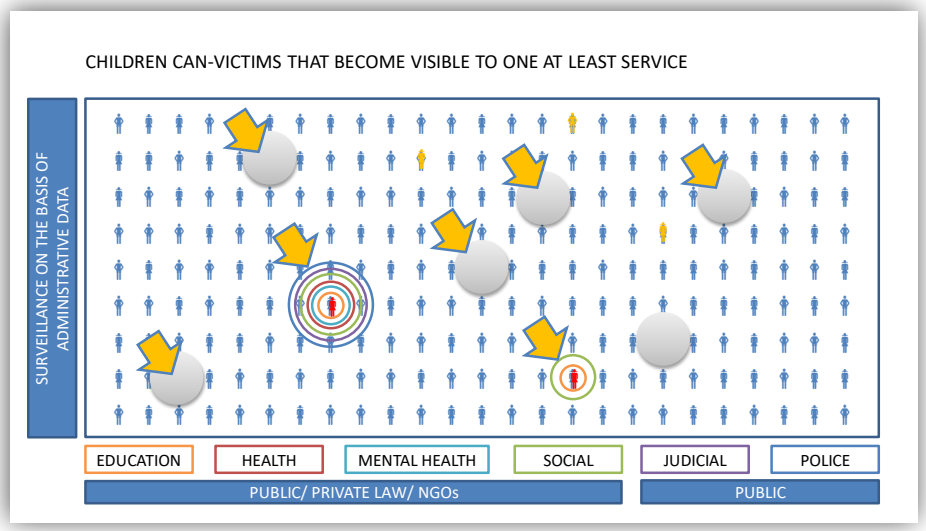
...While the real picture of CAN incidence in our example will be this one.

Slide 15



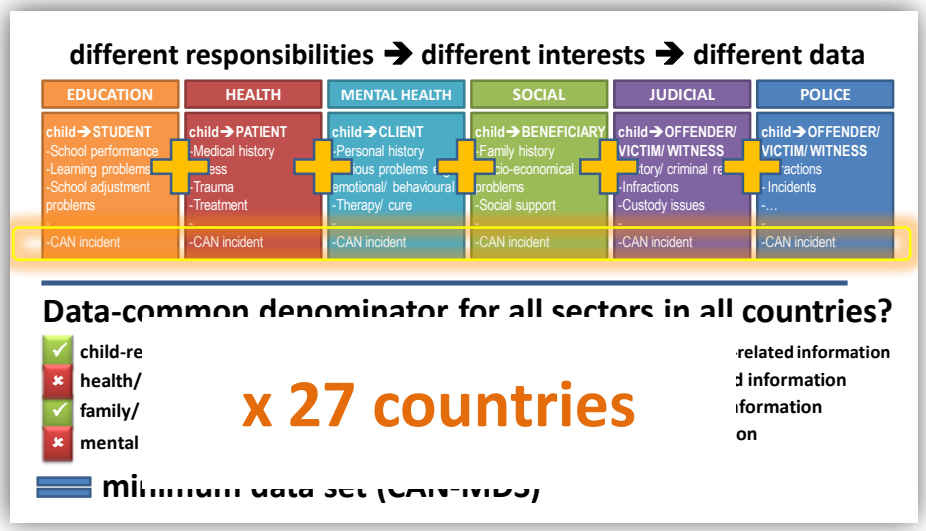
By examining records from various services, the ones including information about CAN were mainly social services and justice/police files. In our example, incidence of CAN would be restricted to only these cases while the remaining cases would not be visible.

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…).

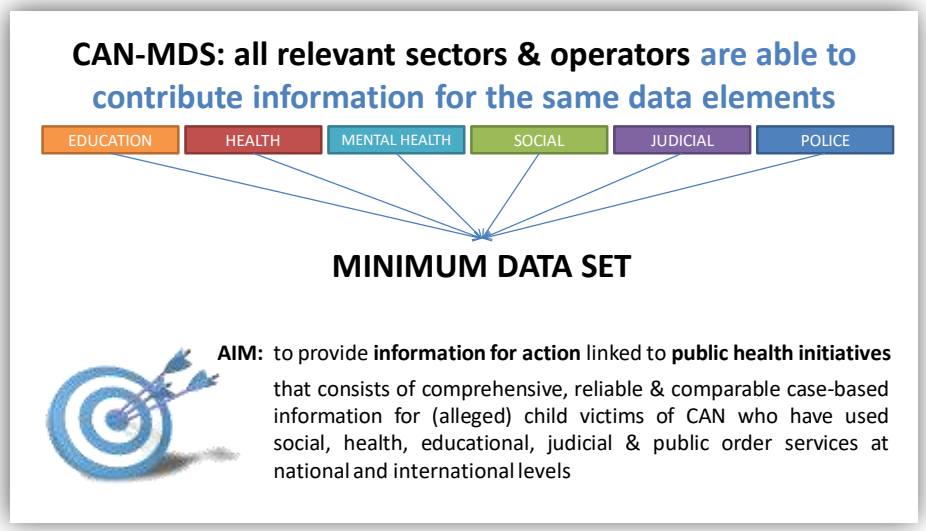
In all cases, however, a common condition is valid: the child-victim of CAN.

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?

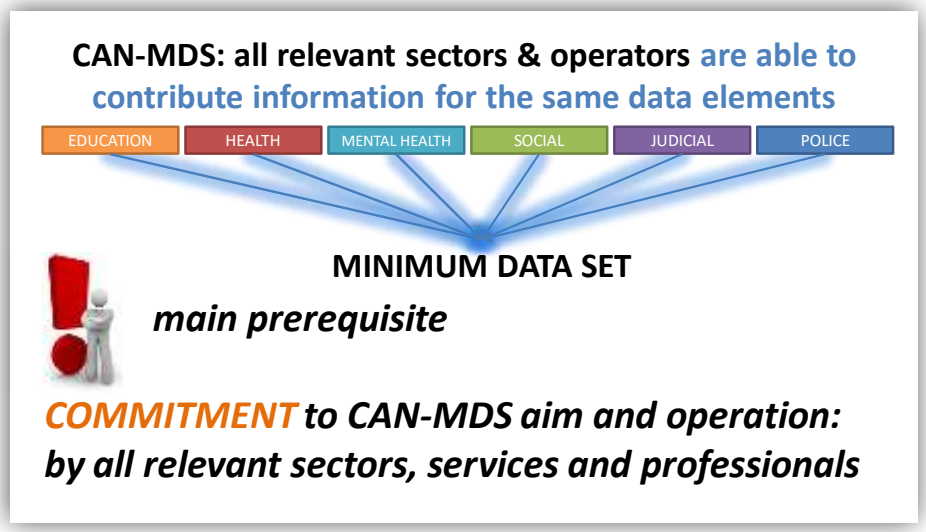
During the developing of the minimum data set, the COMMON DATA AMONG ALL SECTORS WERE IDENTIFIED while the remaining were excluded.

Slide 18



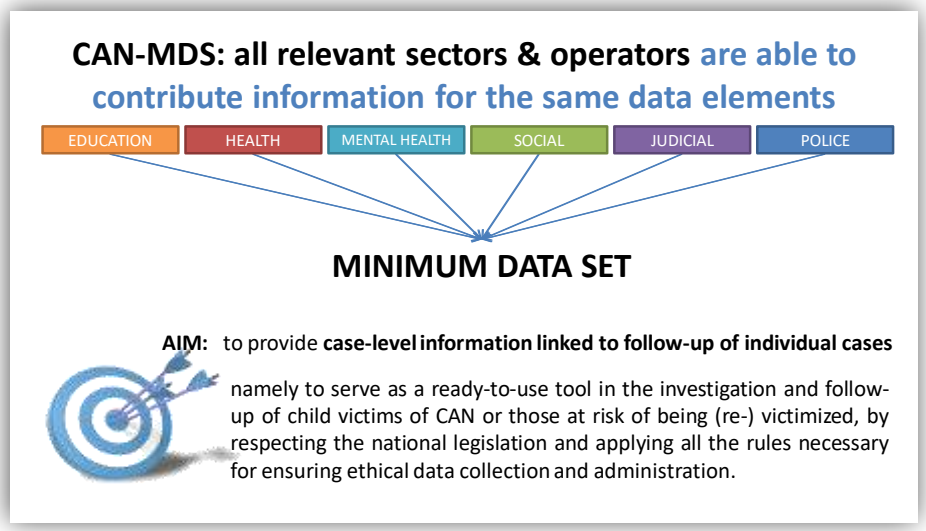
Therefore, the minimum data set for child abuse and neglect is a set of data elements where all relevant sectors, services and operators are able to contribute information (the common denominator rather than the minimum set of information).
This consists the first and main aim of the CAN-MDS, namely 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



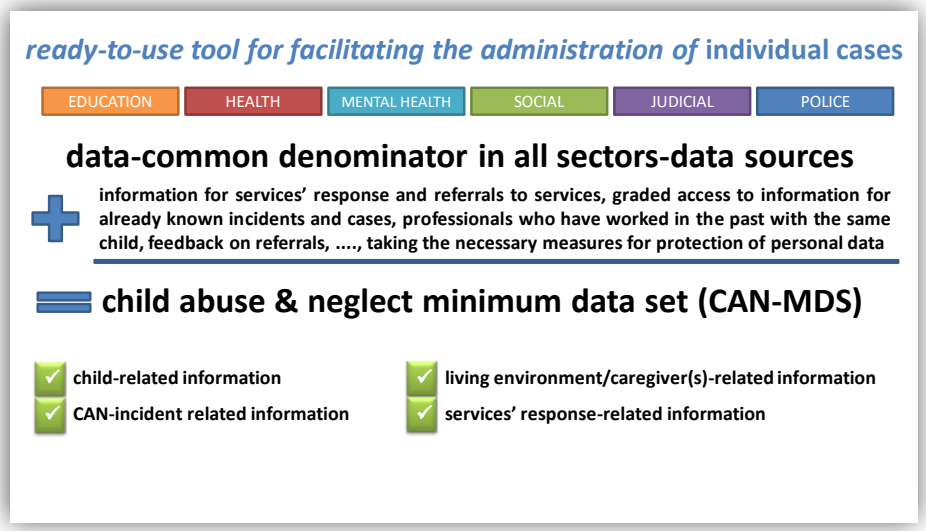
At this specific point the main weakness of such a methodology is arise: for effective data collection the acceptance and commitment of the aim and operation of the system by all stakeholders working in relevant sectors. Without continuous and consistent data input, data collection can not proceed.

Slide 20



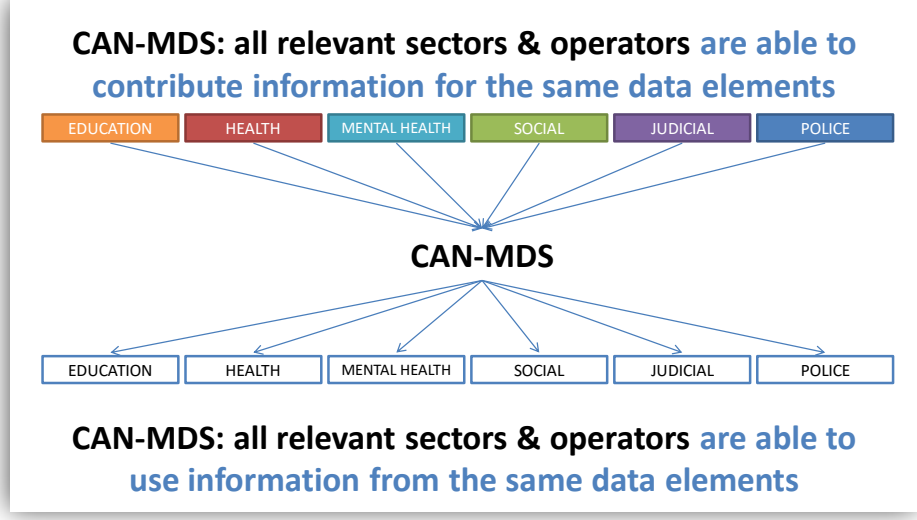
As a response to this weakness, namely the way adopted for strengthening the acceptance and the commitment to CAN-MDS, a second aim was added: a CAN-MDS system to be able to provide case-level information for use linked to follow-up of individual cases, namely to serve as a tool in the investigation 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



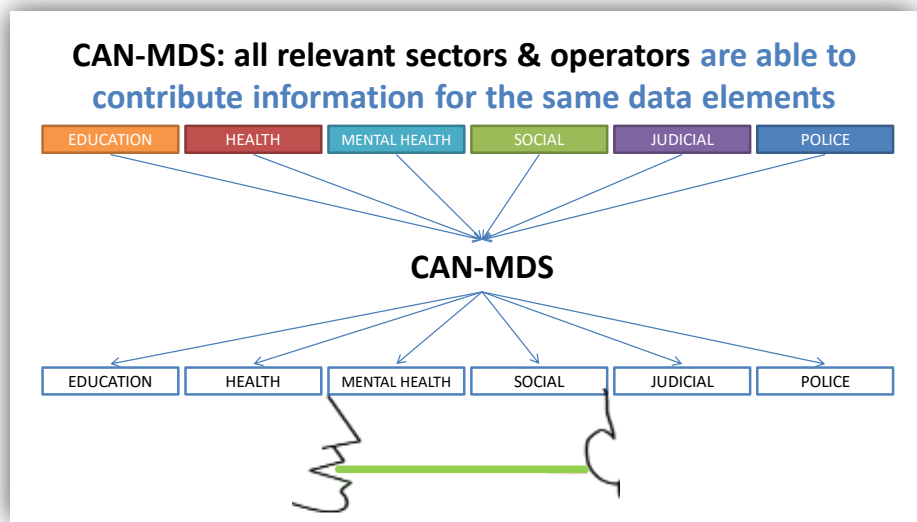
Therefore, in addition to the data elements identified before as common denominator among all involved services and sectors, a fourth (4th) axis is added including data elements related to services' response and referrals of cases. These specific data elements aim to make the system practical and able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

Slide 22



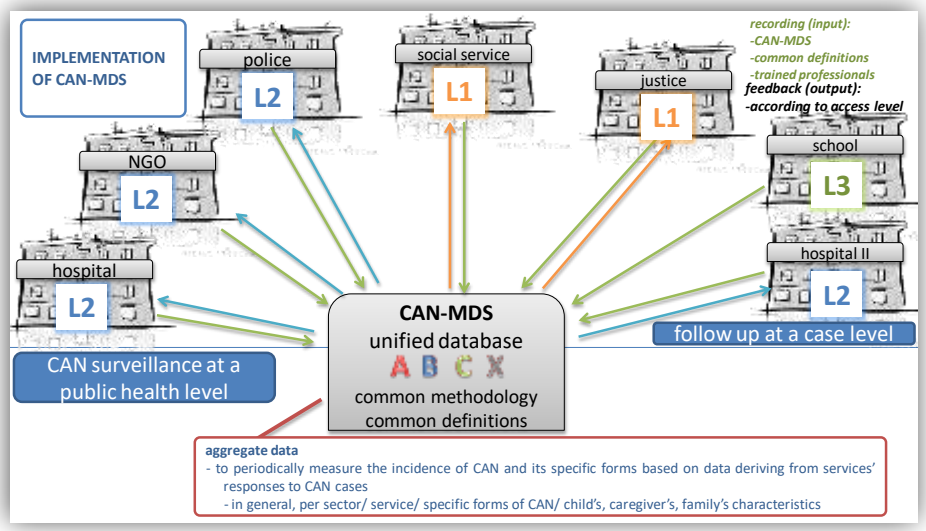
Based on the CAN-MDS operators working in all relevant sectors can contribute comparable and reliable data for the same data elements and, additionally, are also able to use the available information for the administration at a case level –providing that no rules are violated concerning the protection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

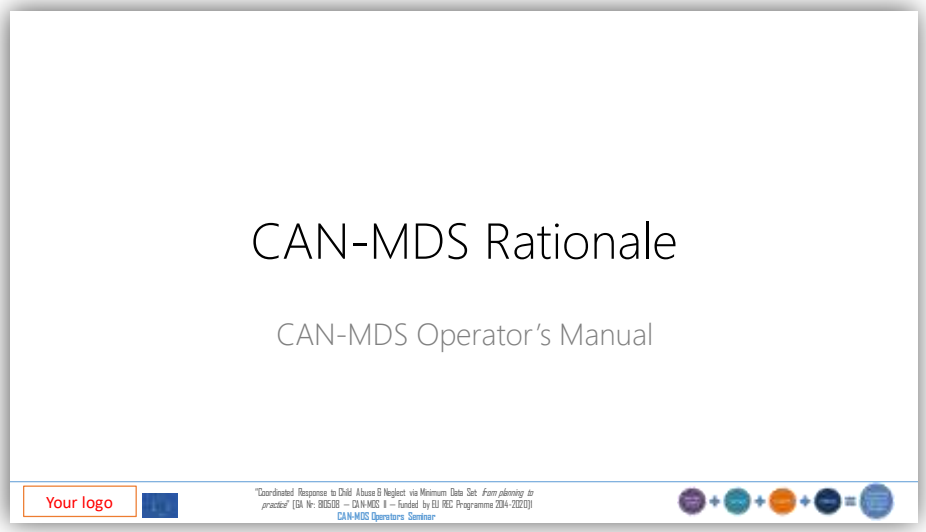
Slide 24



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)

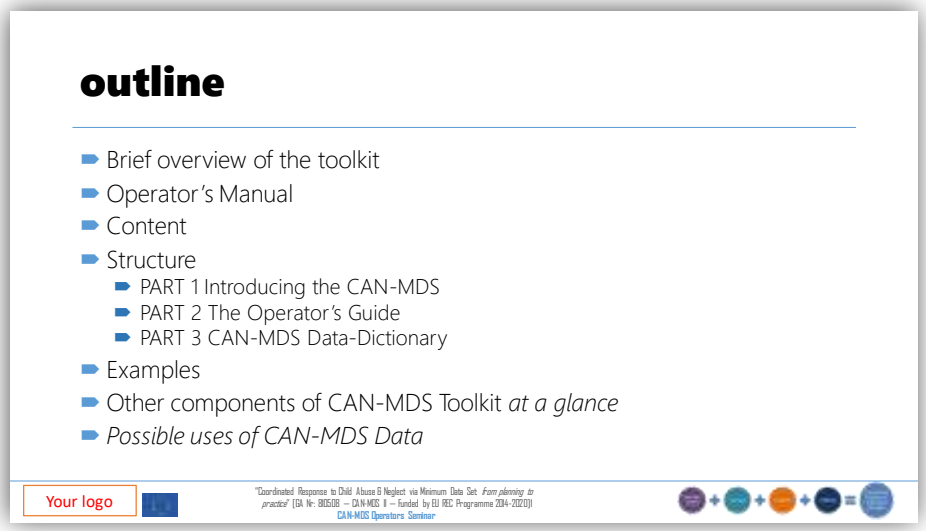
PART 3 – DURATION: 120 MIN

Slide 1



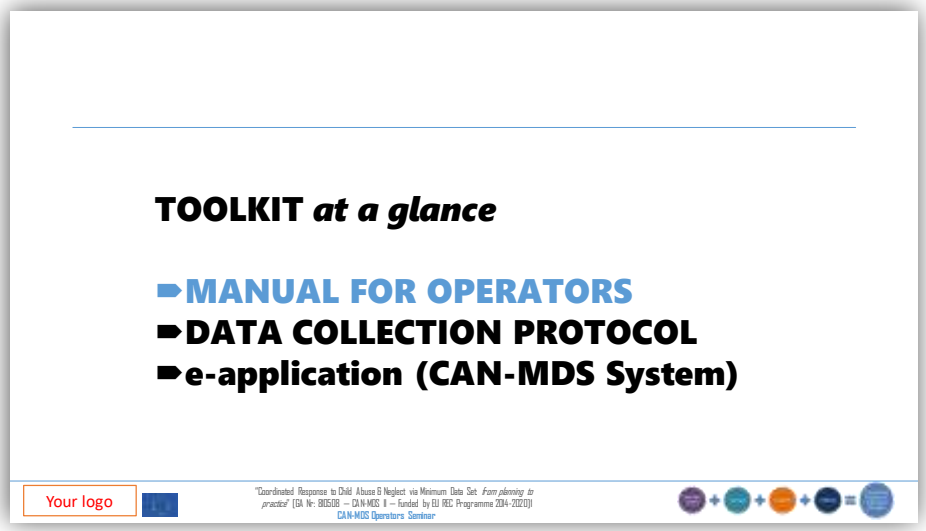
[INSTRUCTION – Ask trainees to open the national Operator's Manual.]

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.

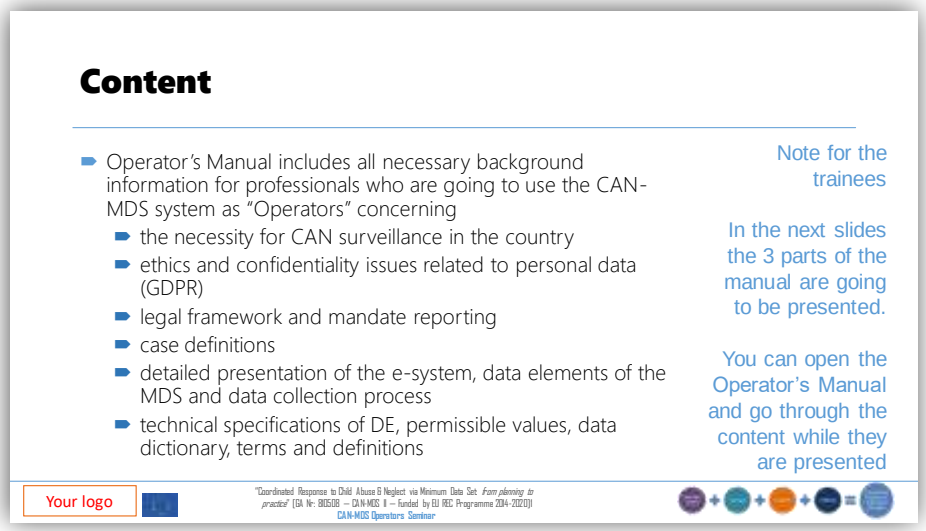
Slide 3



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]

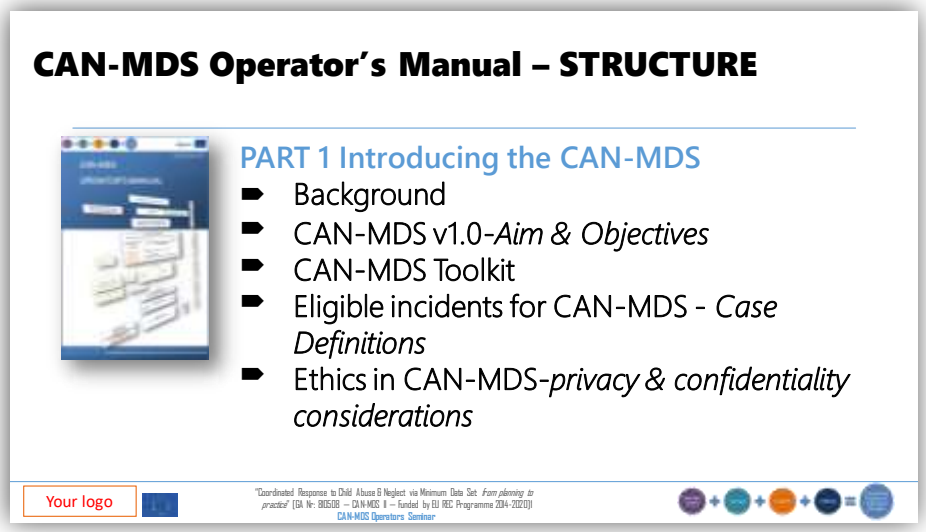
Slide 4



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



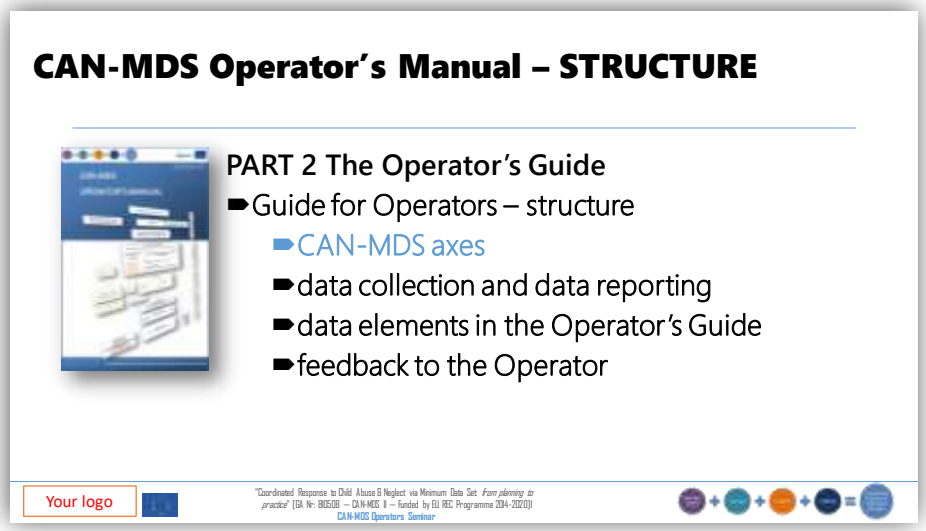
The structure of *PART 1 Introducing the CAN-MDS* includes

<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

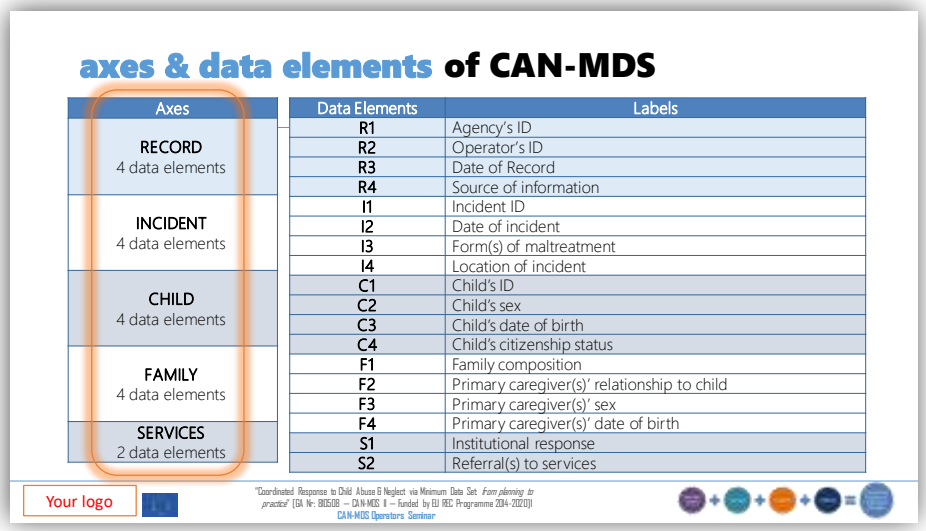


Here is the content of *PART 2 "The Operator's Guide"* <see slide>

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



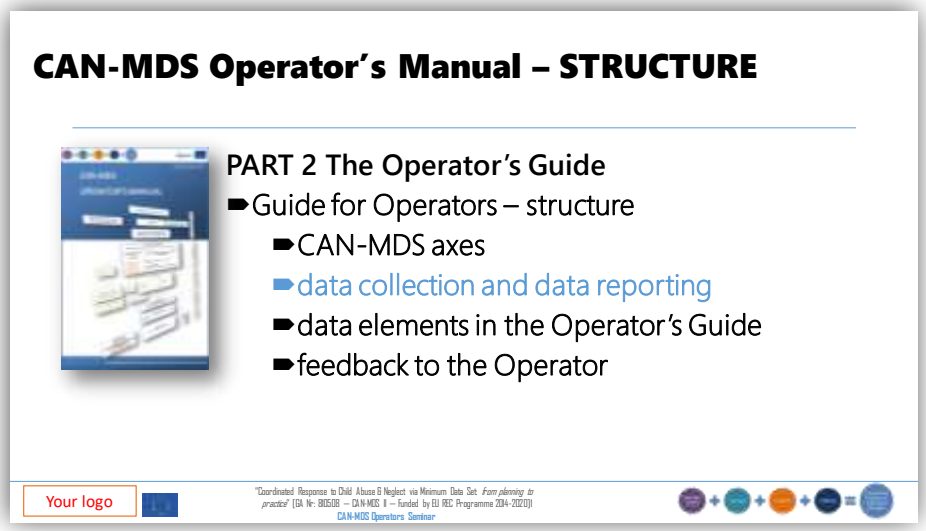
CAN-MDS Axes and data elements

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.

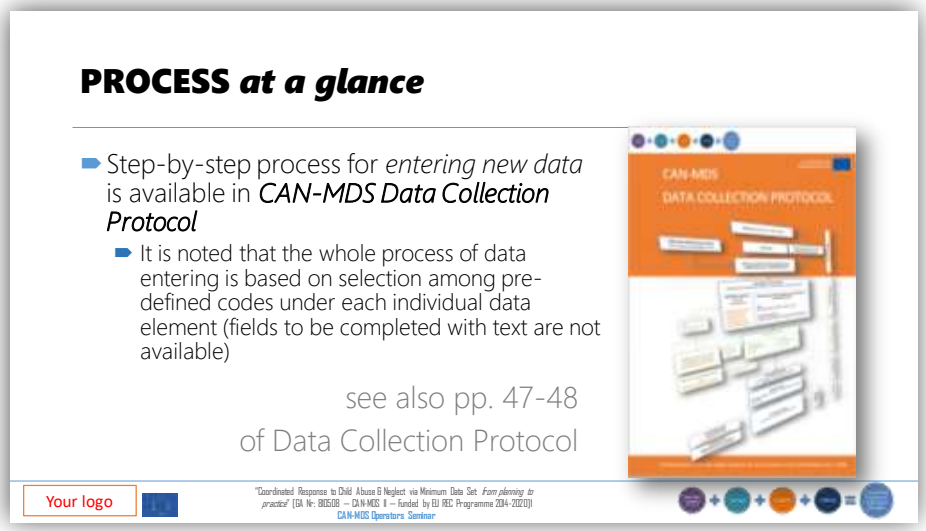
This information can be equally provided by all professionals working with children, regardless the sector where they are working

Slide 8



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

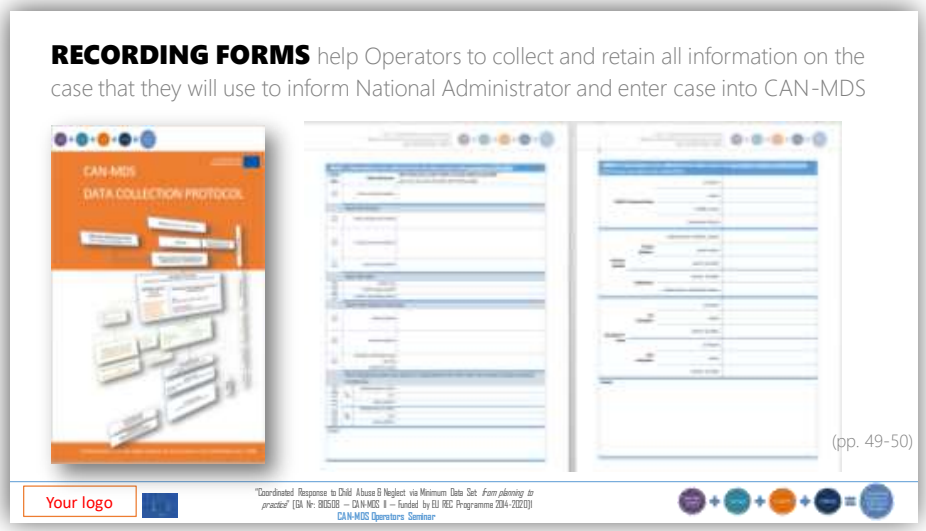
Slide 9



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

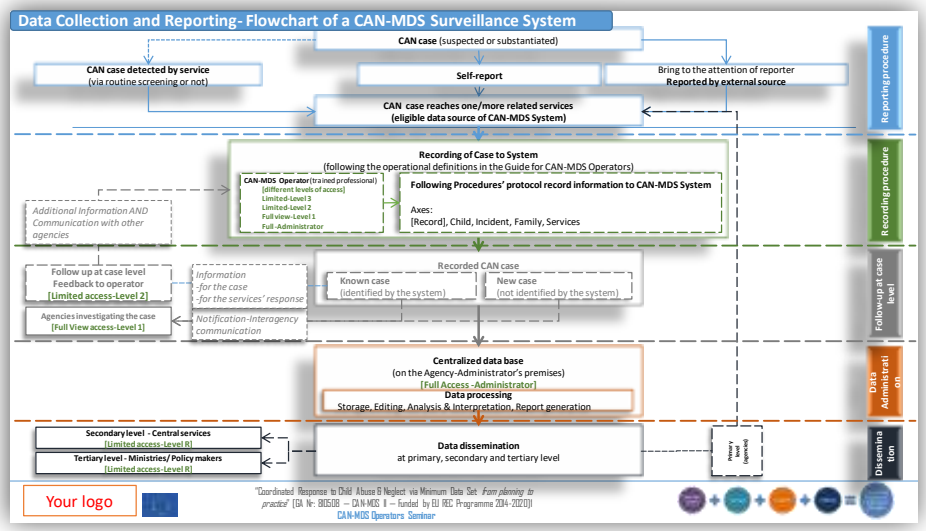
[Instruction - Please, before practicing print or select on your laptop/tablet page 49 and page 50 of the document. You will need those as you do the practice case intake. These are presented in the next slide]

Slide 10



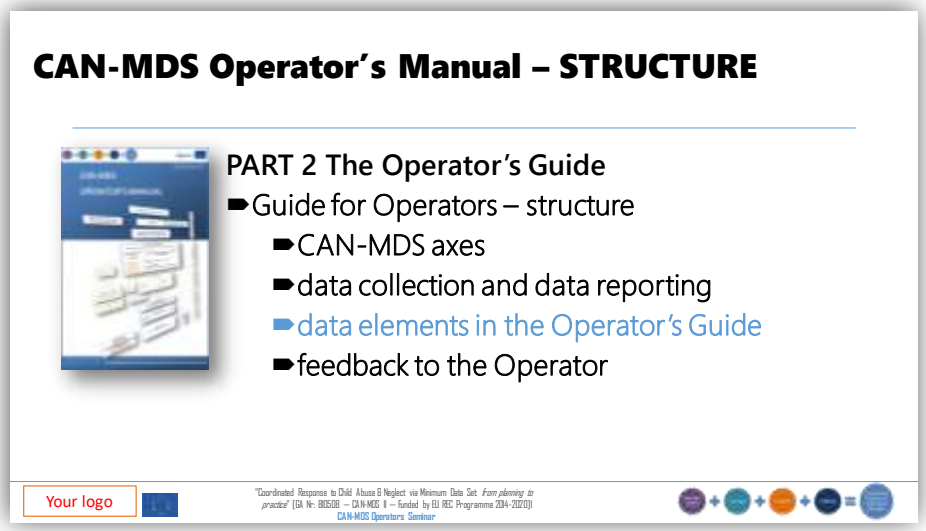
<see forms-check lists in the slide and describe their content>

Slide 11



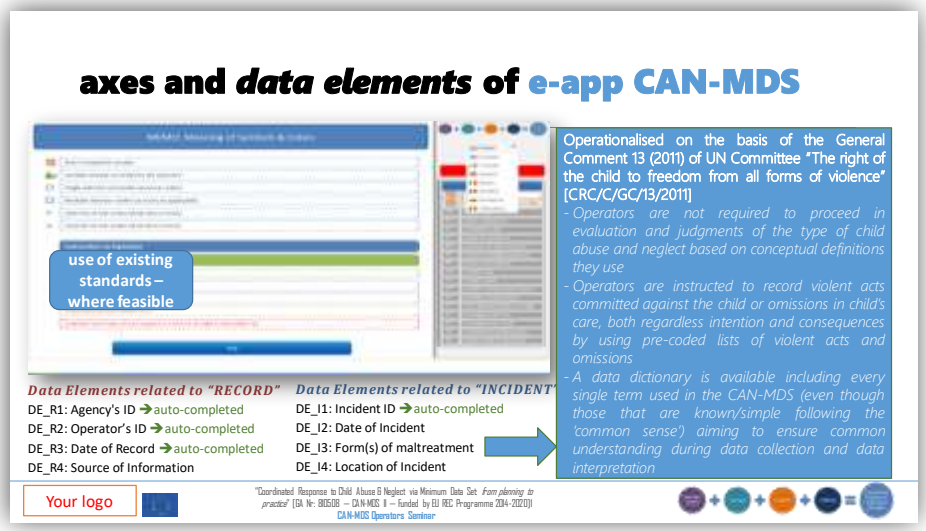
Here is a flowchart of the provisioned operation of a potential CAN-MDS system: starting from reporting procedures, the recording procedures, the monitoring at a case-level, the central data administration and the dissemination of appropriate information to different stakeholders;

Slide 12



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

Slide 13



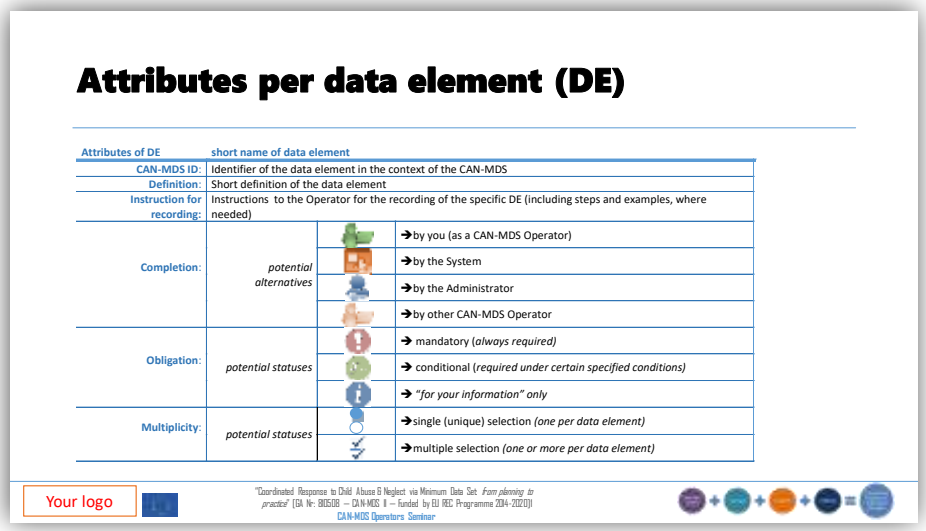
Here we can see the data elements that were presented before in the form they are included in the e-app CAN-MDS system.

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.

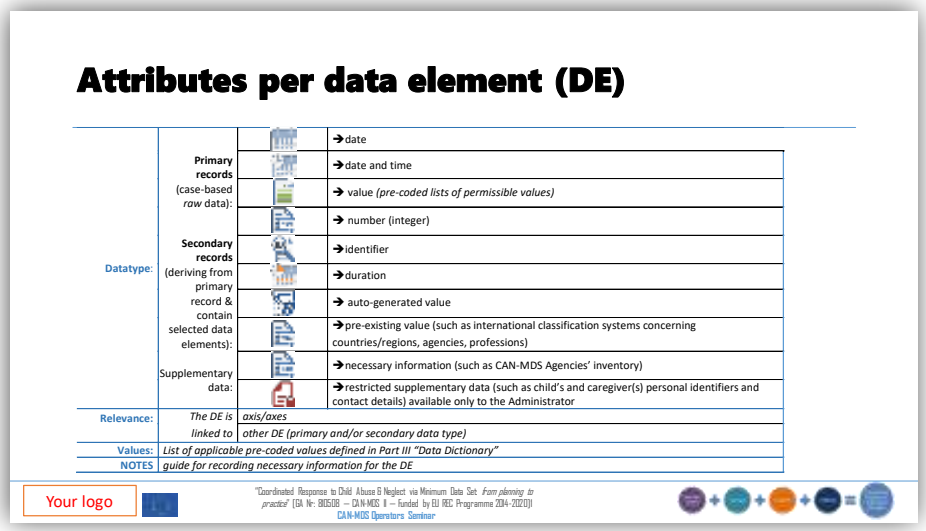
The element "form(s) of maltreatment" which is the core data element of the system is operationalized on the basis of … (see slide blue frame)

Slide 14



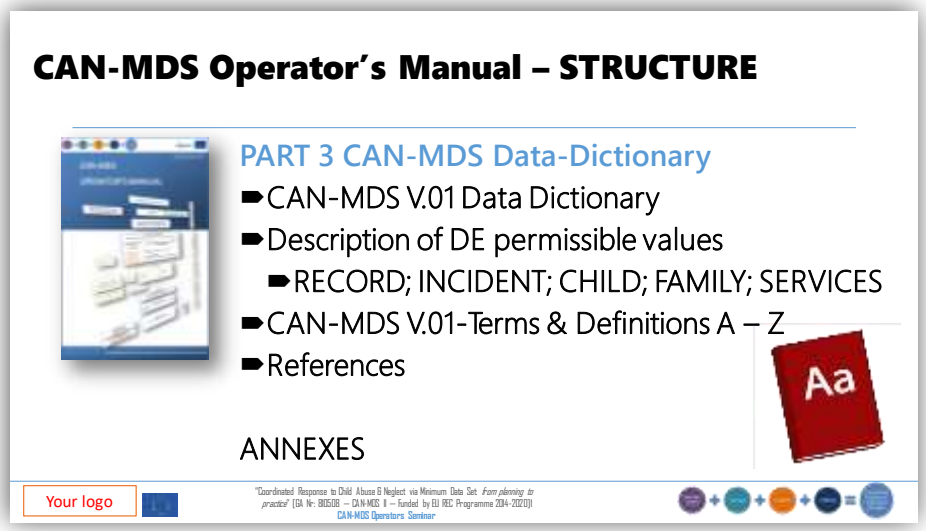
For each of the 18 data elements specific attributes are described such as: definition; Completion (by whom? The operator-the system-the administrator); Obligation (mandatory completion; condition –under certain conditions; only for Operator's information); Multiplicity (single/unique selection or multiple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

Slide 15



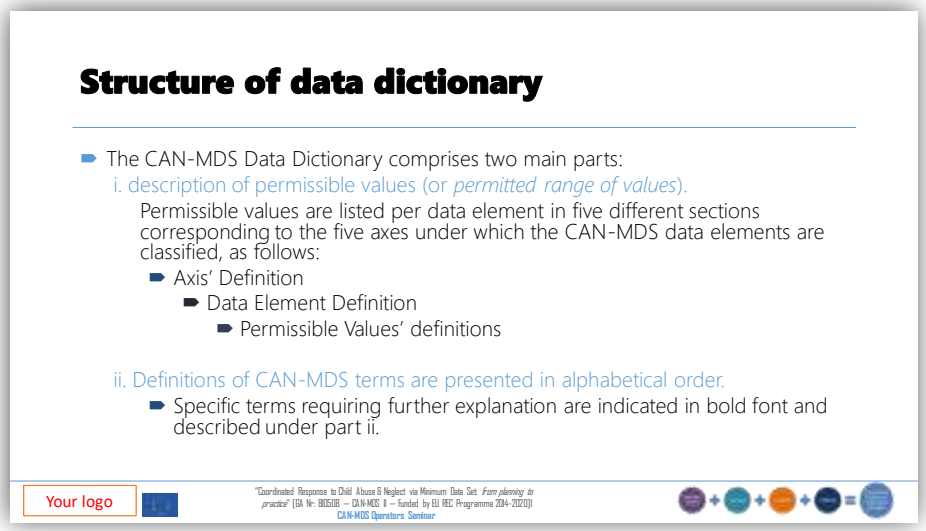
Also:
Data type (case-based data: date; time; value from a pre-coded list of values; number) or data deriving from other data (identifiers; duration; auto-generated value; pre-existing value; restricted supplementary data); relevance with other DE (to which axes the DE is related and to which specific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

Slide 16



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

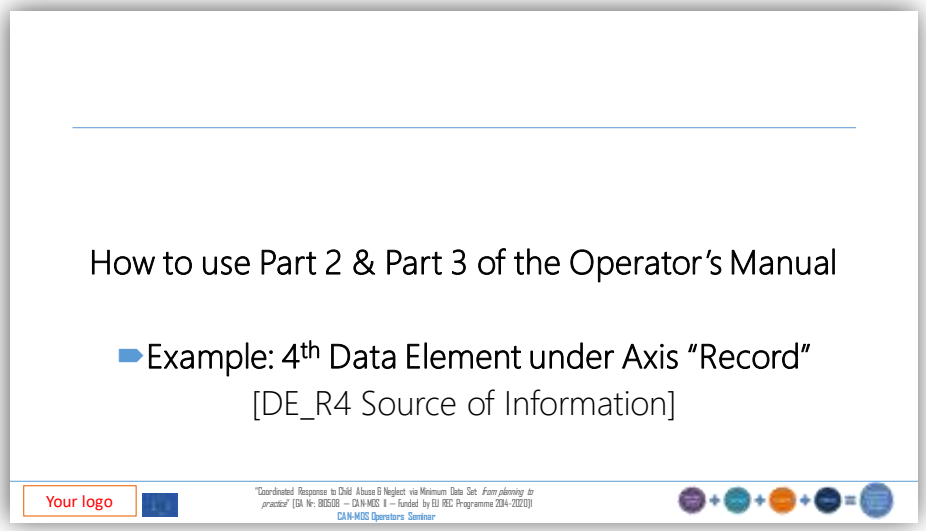
Slide 17



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

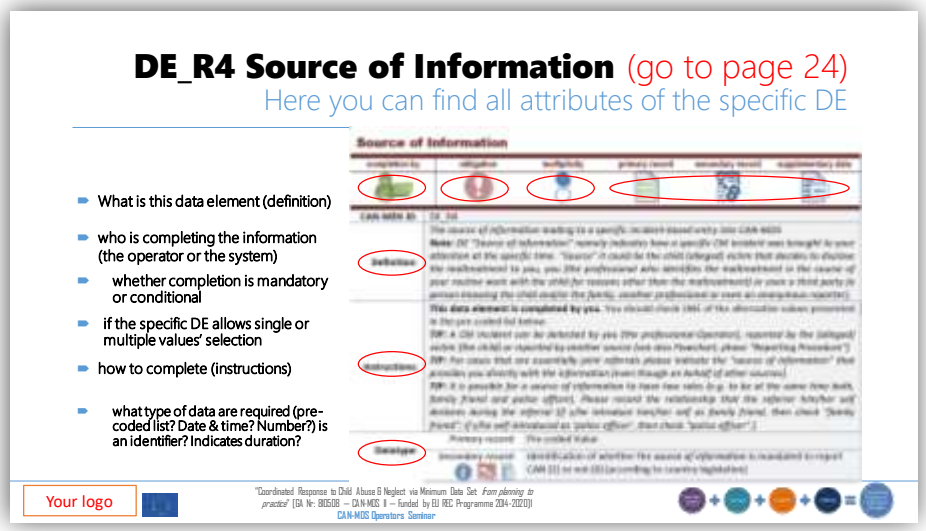
<see slide>

Slide 18



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

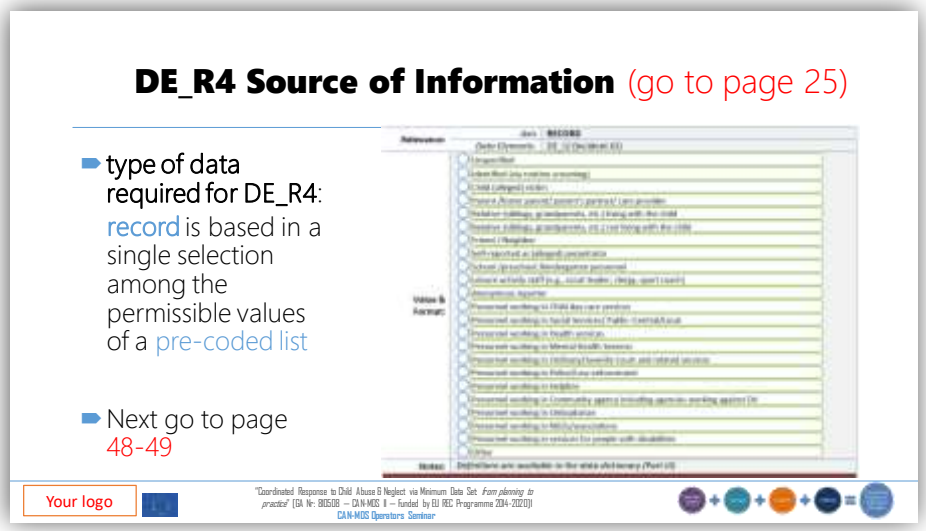
Slide 19



[Instruction: after the first picture-screen shot from the manual you can proceed with the presentation of the information included in the slide step by step]
Note: you can ask from trainees to go to p. 24 of the Operator's Manual

<see slide>

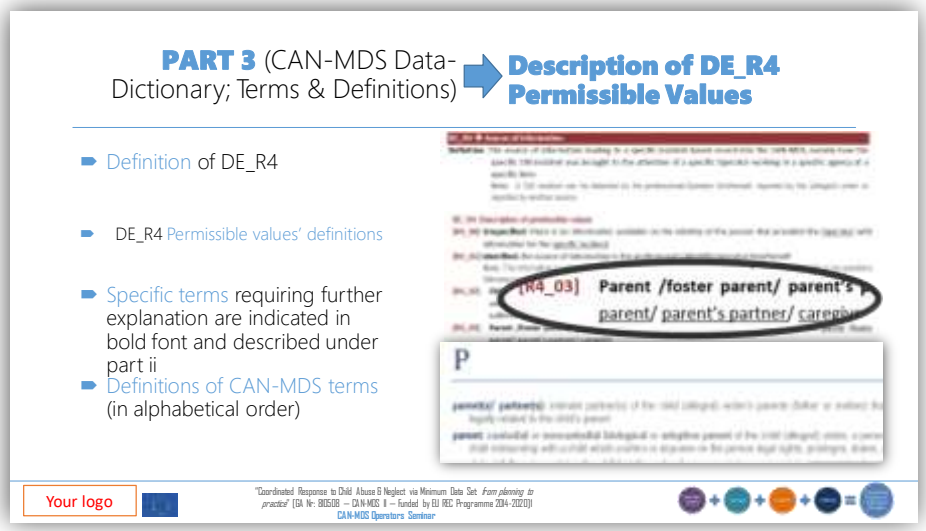
Slide 20



[Instruction: Proceed with the presentation of the slide step by step]
Note: you can ask from trainees to go to p. 24 of the Operator's Manual

<see slide>

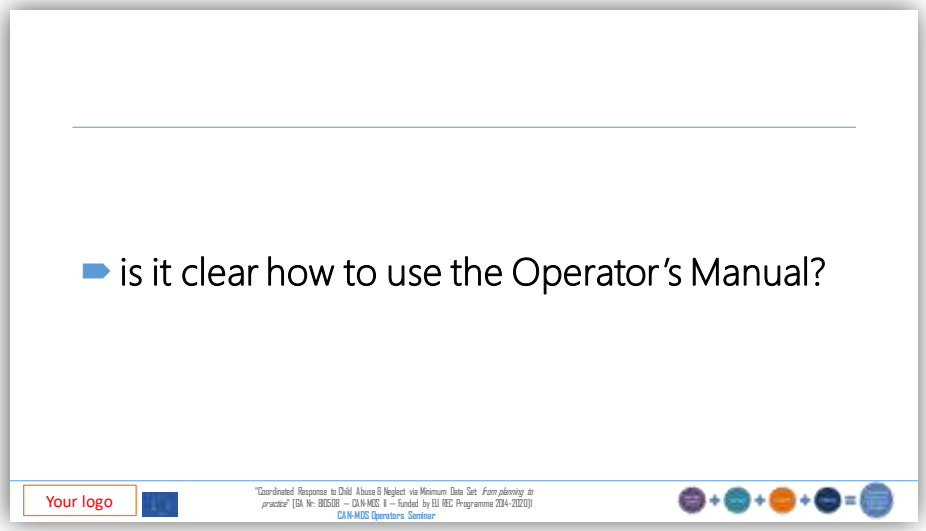
Slide 21



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

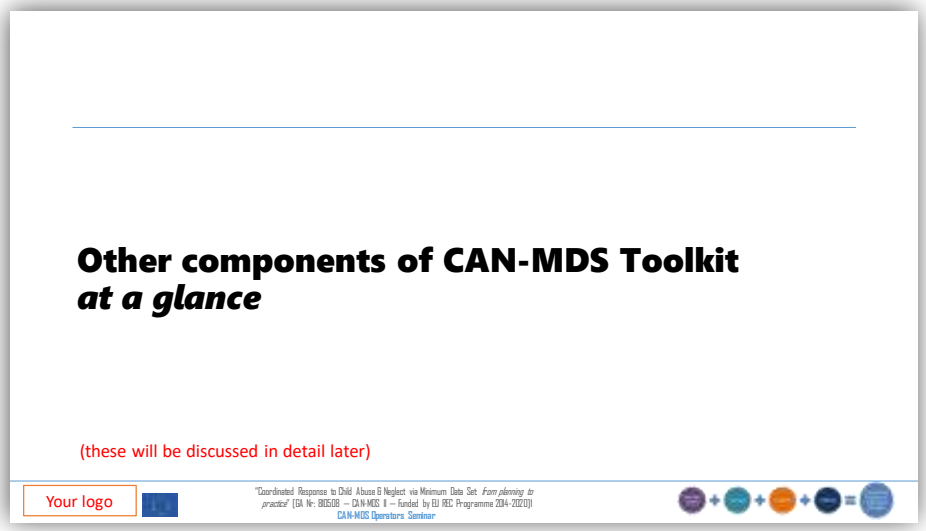
<see slide>

Slide 22



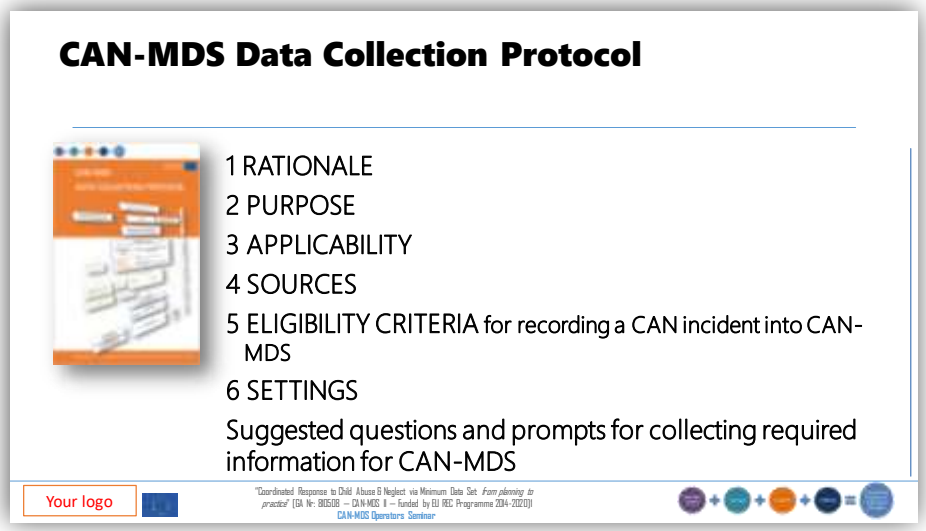
[Note: Ask trainees if it is clear what the Operator's Manual is and how to use it; it is important to ensure that everybody understand the structure and description of the data elements]

Slide 23



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

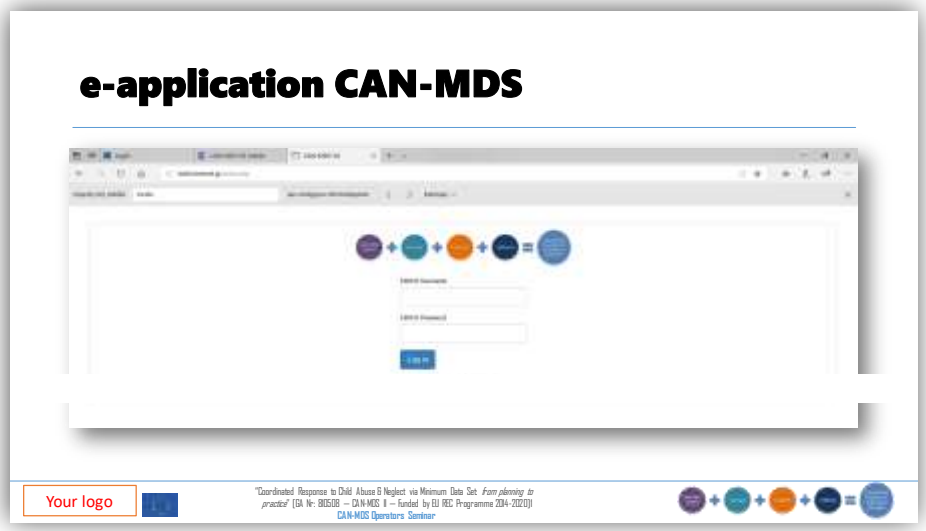
Slide 24



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.**

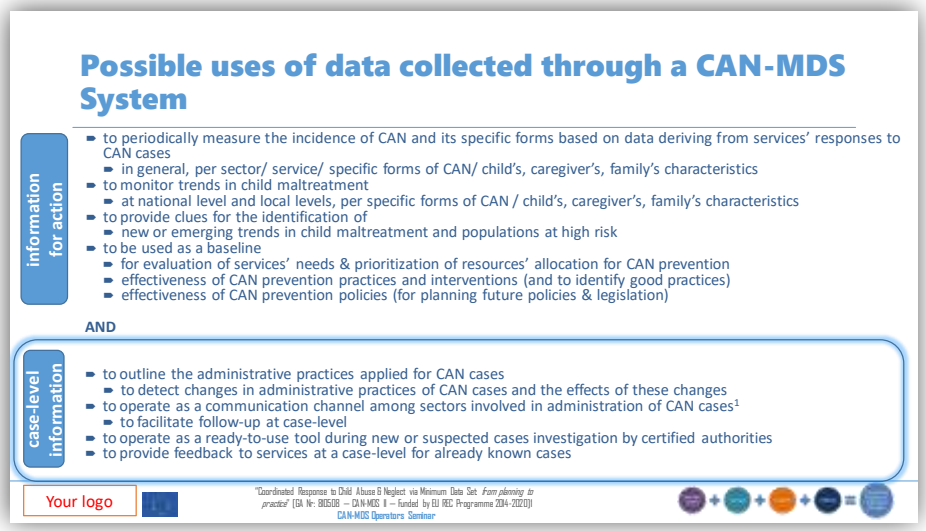
The main part of the protocol is dedicated to data recording. The process is presented step by step through screen-shots and the necessary information.
In addition, some practical tools are included as the suggested prompts for the intake and the forms-check lists to be used for ensuring the collection 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 *(Once the revised app is ready it will be moved under each partner server)*
SAMPLE OPERATORS' IDENTITIES *Usernames: 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]

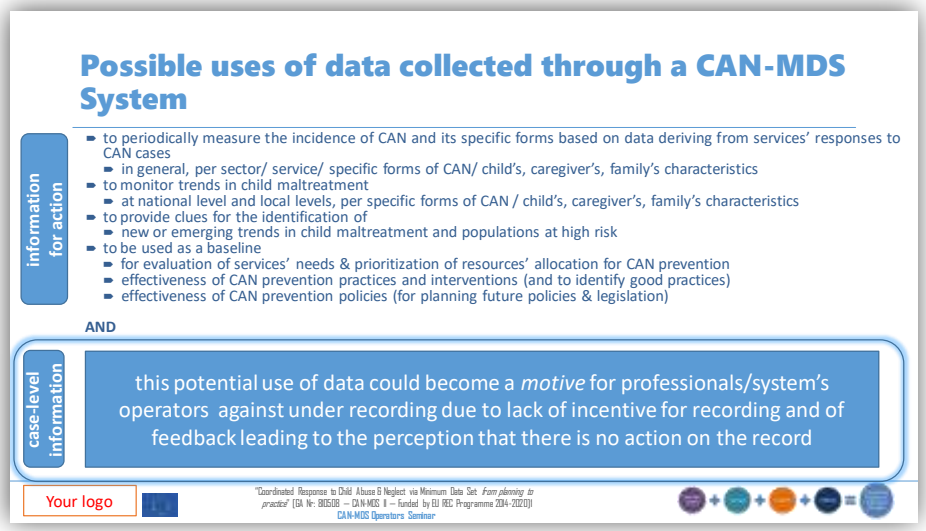
Slide 26



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[1]
- to provide feedback to services at a case-level for already known cases

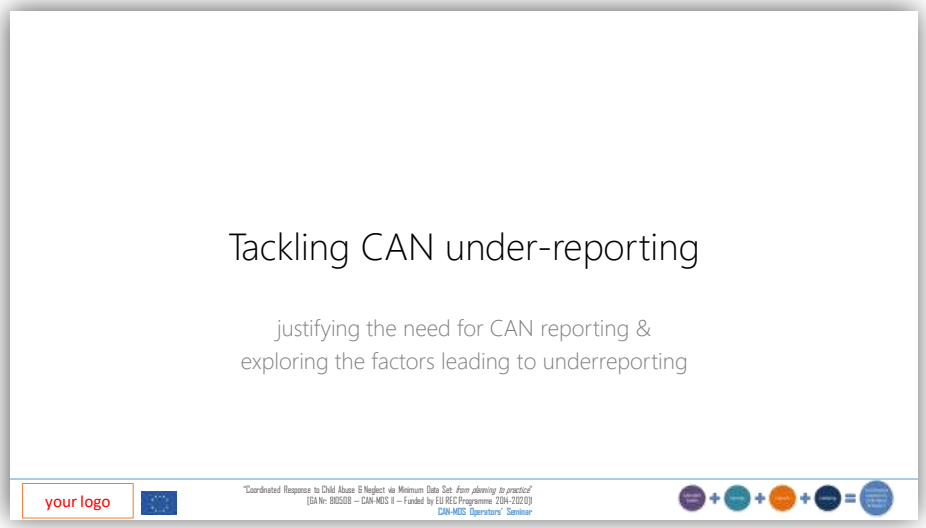
Slide 27



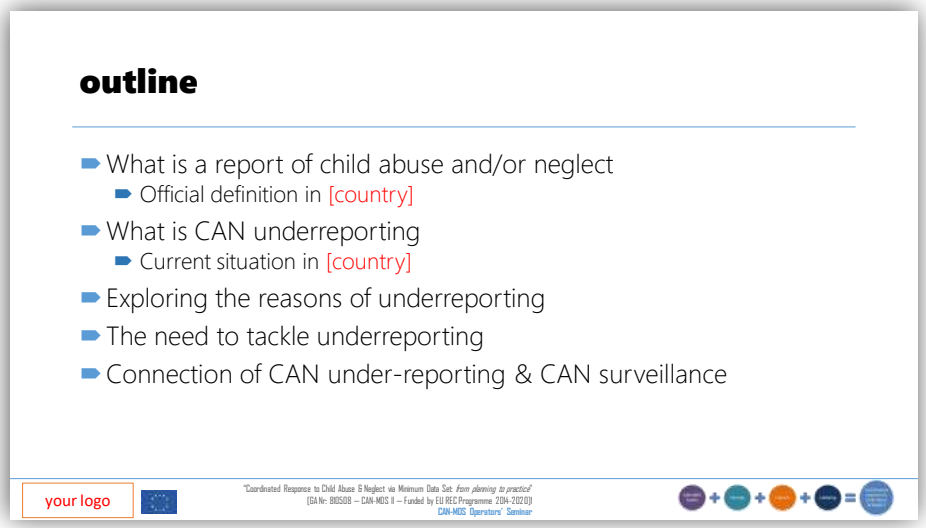
This potential use of data could become a *motive* for professionals/system's operators against under recording due to lack of incentive for recording and of feedback leading to the perception that there is no action on the record.

SESSION 2 – DURATION: 150 MIN
PART 4– DURATION: 30 MIN

Slide 1



Slide 2



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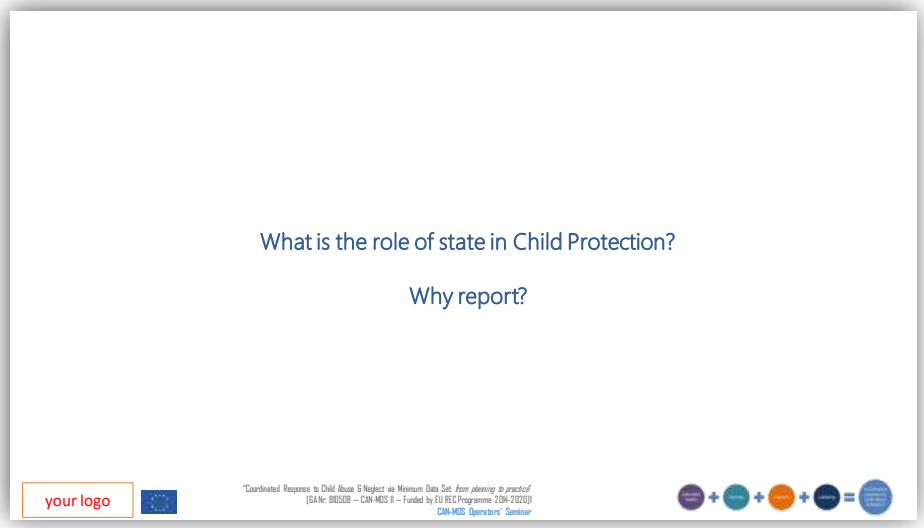


"The UN Convention on the Rights of the Child established that government is the main body responsible for preventing and responding to violence against children, considering children as rightful participants, with particular attention to ensuring that children are recipients of the safeguard mechanisms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

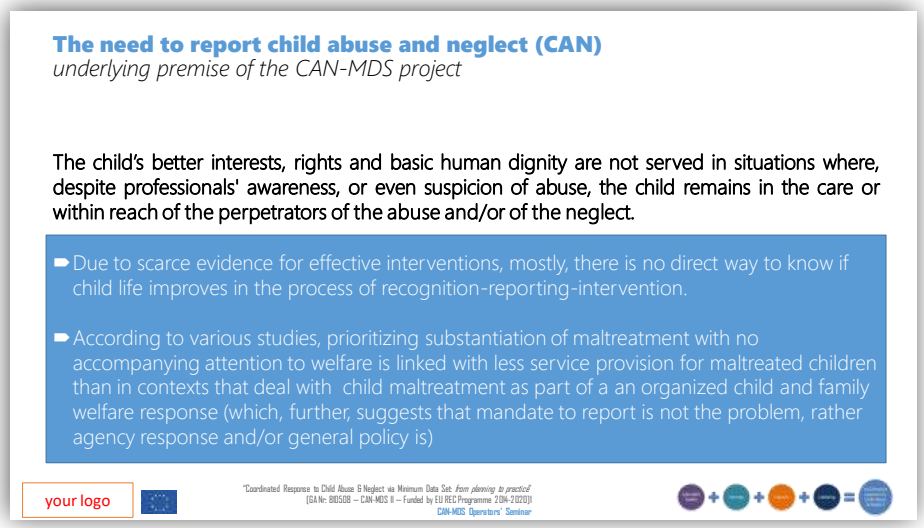
Mandatory reporting of suspected or confirmed CAN represents one common, key strategy to address violence against children. Legally requiring certain individuals to report child abuse is justified with the assumption that early detection of abuse helps prevent serious injuries and relieves the victims 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."

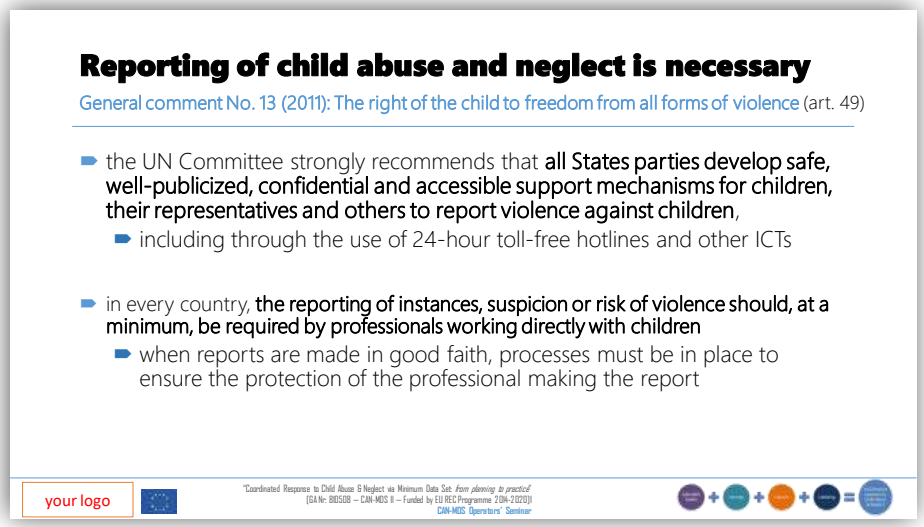
Suggested reading: https://www.macpeds.com/documents/LCCSession42ResidentFull.pdf

Slide 4



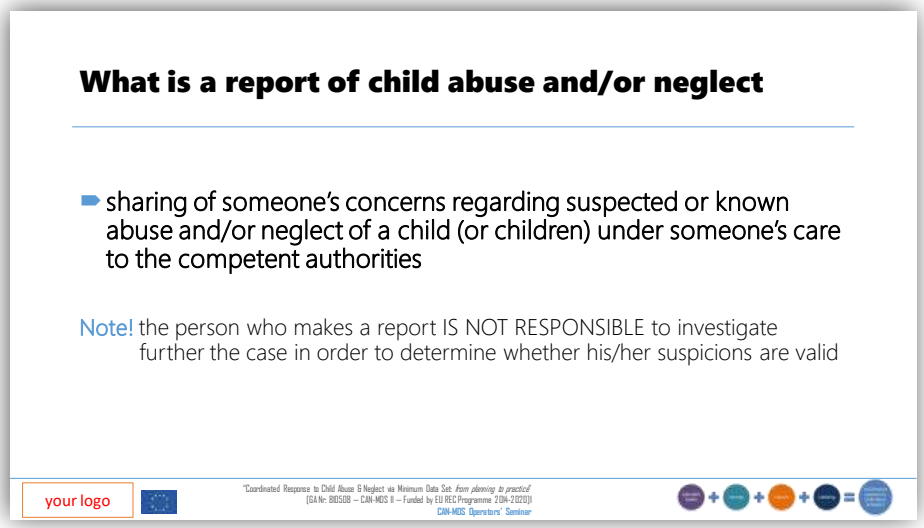
[Note: It is suggested to use this slide in a way that underscores your key argument on how necessary CAN-MDS is for the group you are training and for the recipients of their services (children!)]

Slide 5



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



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Slide 7

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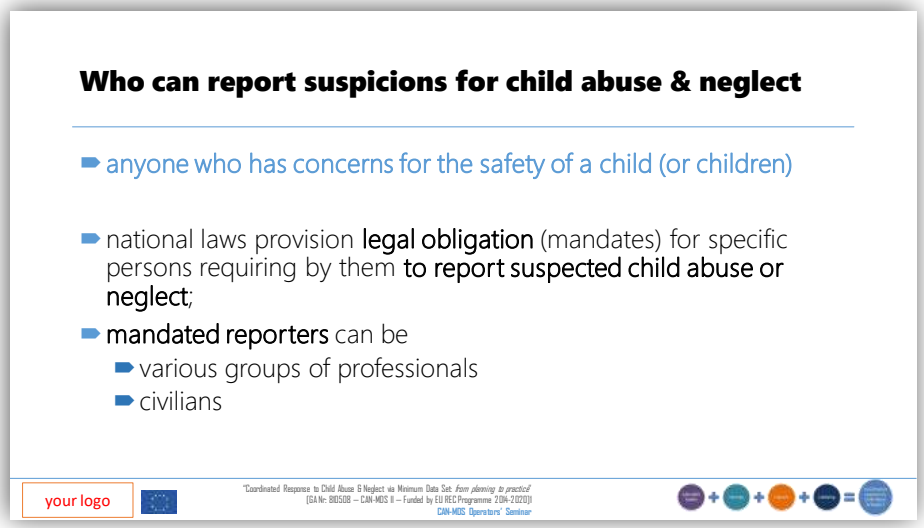
Slide 8



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Slide 9

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

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

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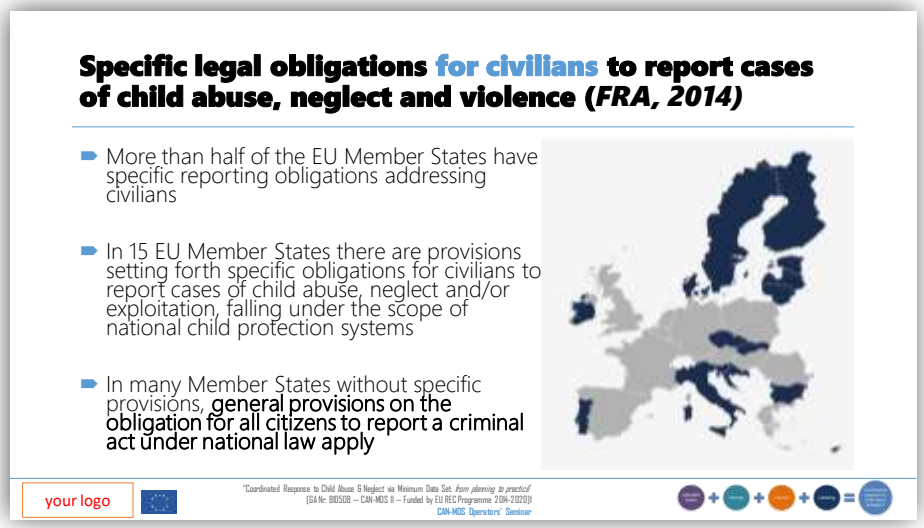
Slide 11

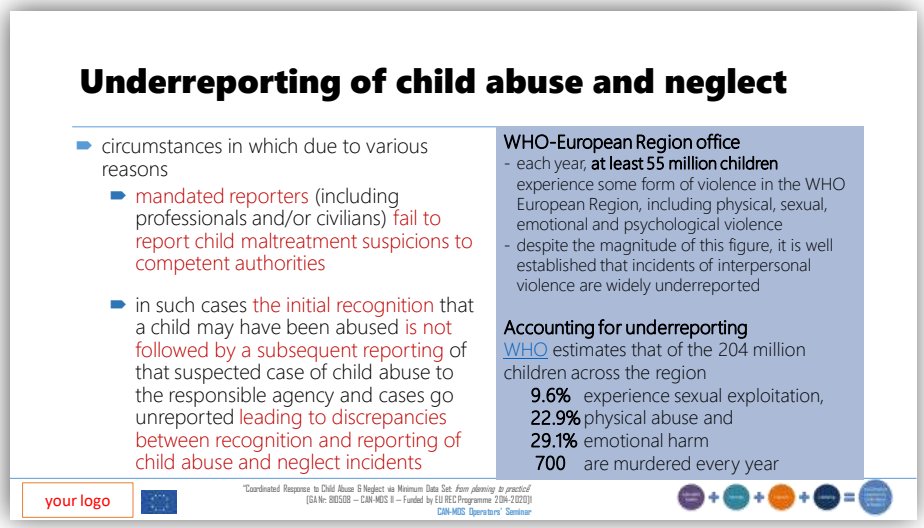


-More than half of the EU Member States have specific reporting obligations addressing civilians
-In 15 EU Member States (including **Bulgaria** and **Cyprus**), there are provisions setting forth specific obligations for civilians to report cases of child abuse, neglect and/or exploitation, falling 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

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

Slide 13



Source: http://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1

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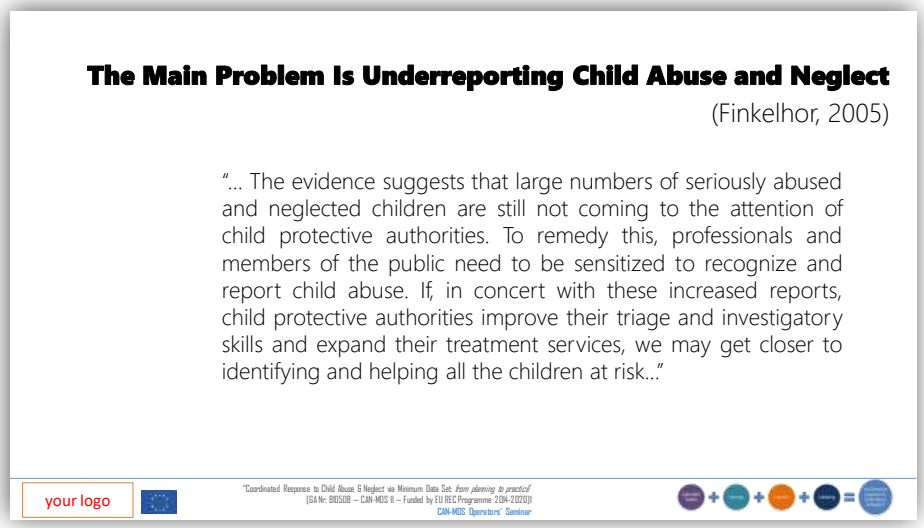
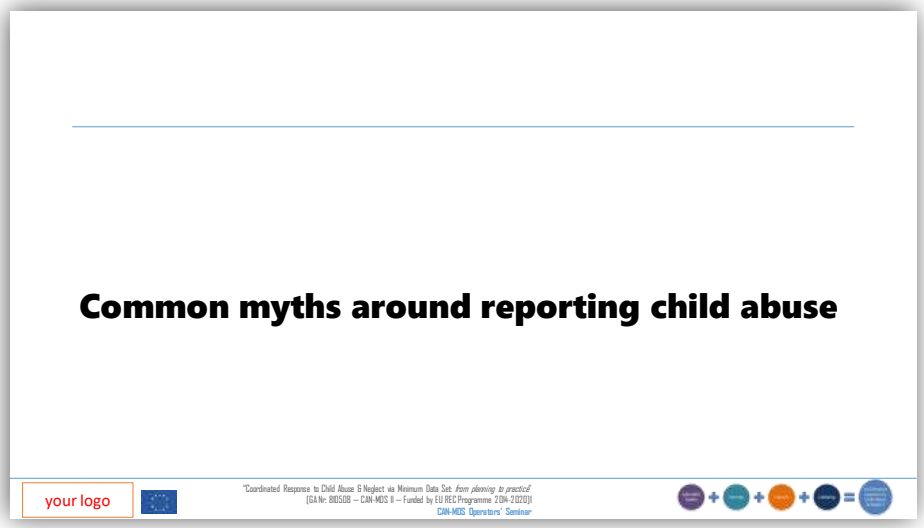
Slide 14



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

Slide 15



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

Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

<see slide>

Slide 17

Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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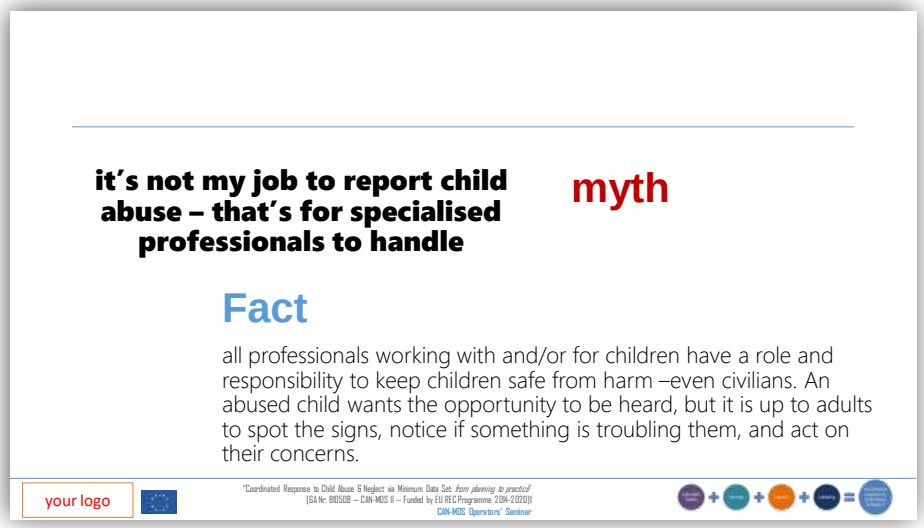
Slide 18



Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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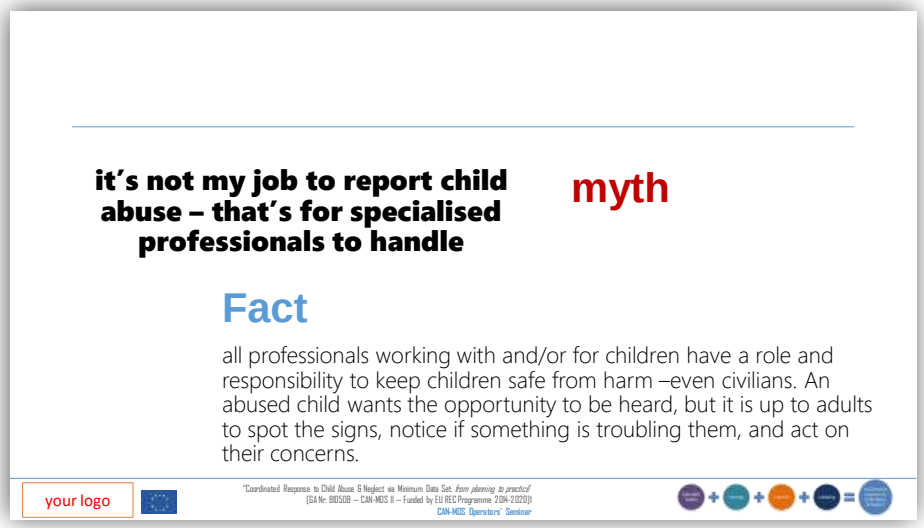
Slide 19



Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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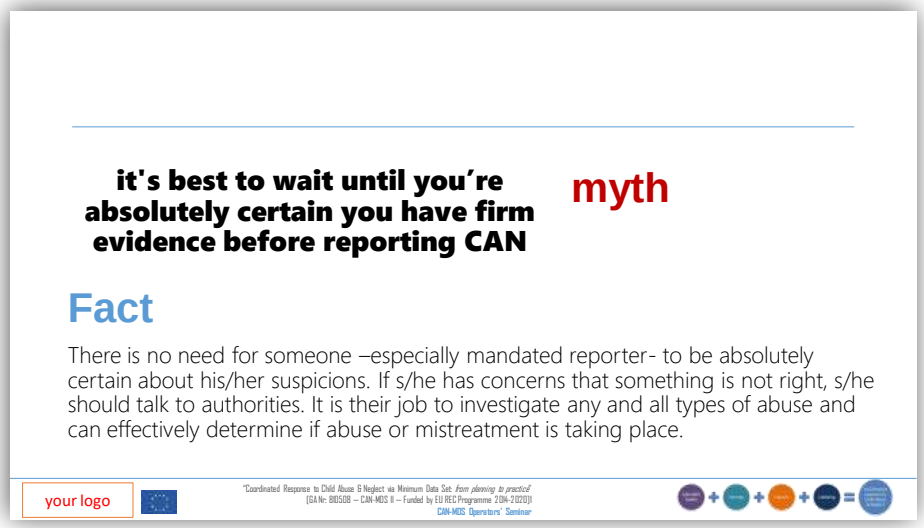
Slide 20



Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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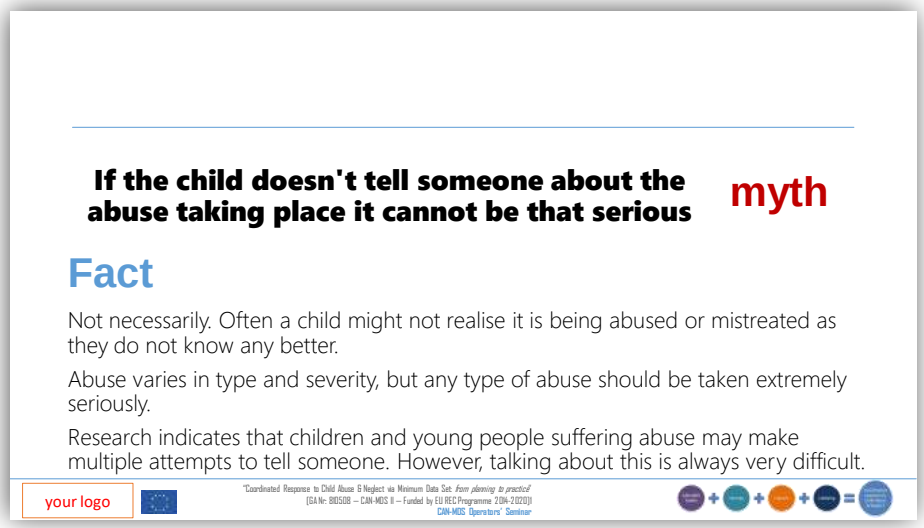
Slide 21



Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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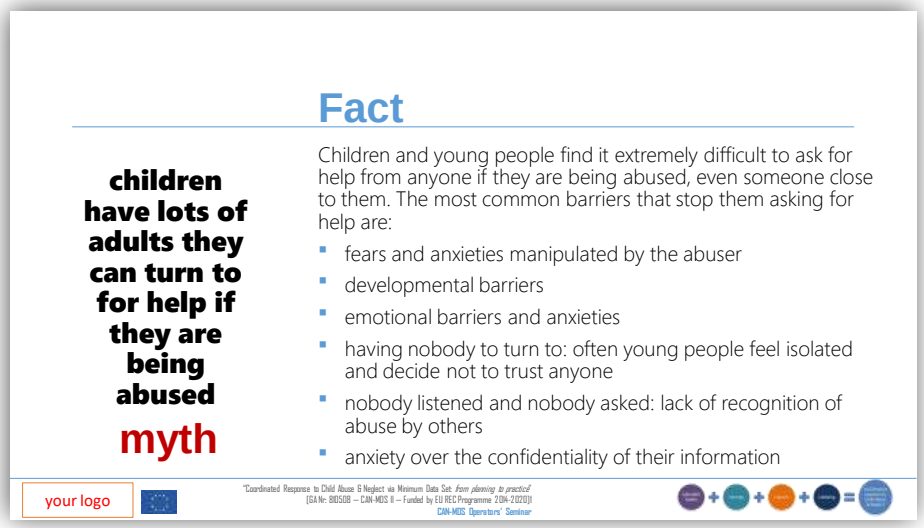
Slide 22



Source: https://www.bromley.gov.uk/info/200127/safeguarding_children/163/reporting_child_abuse/3

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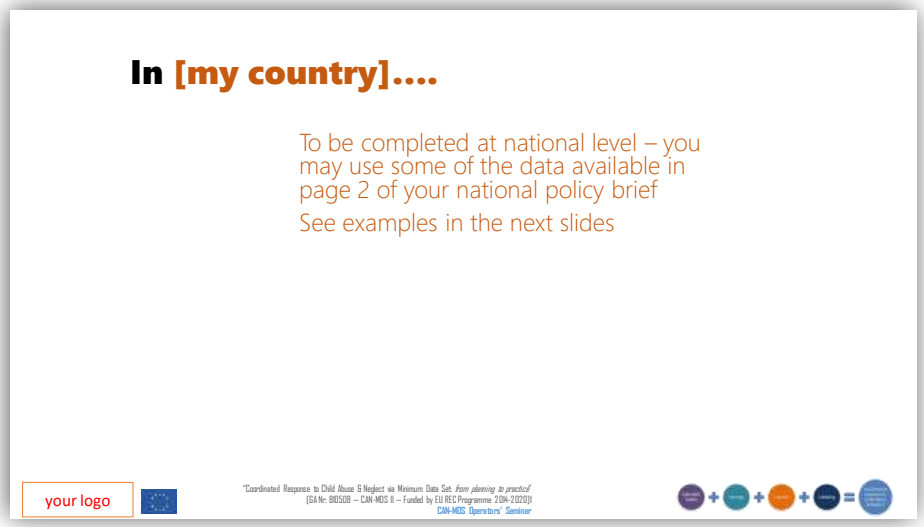
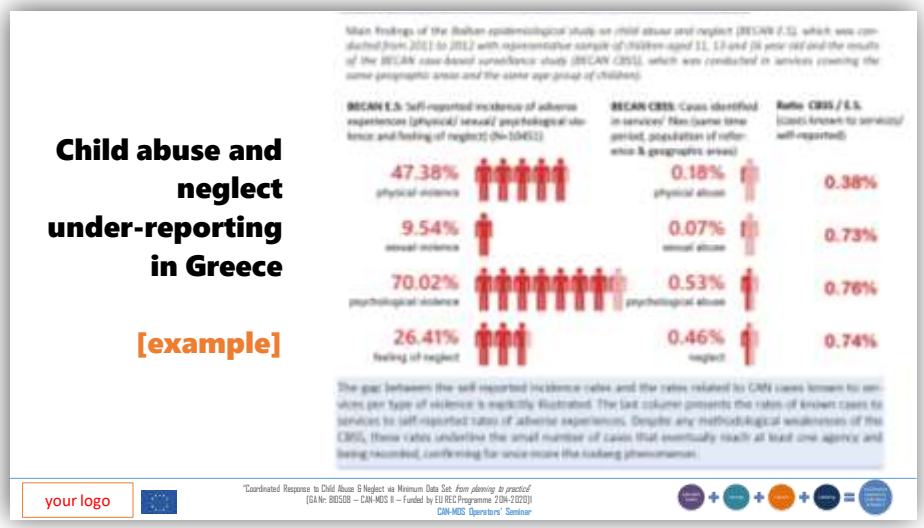
Slide 23



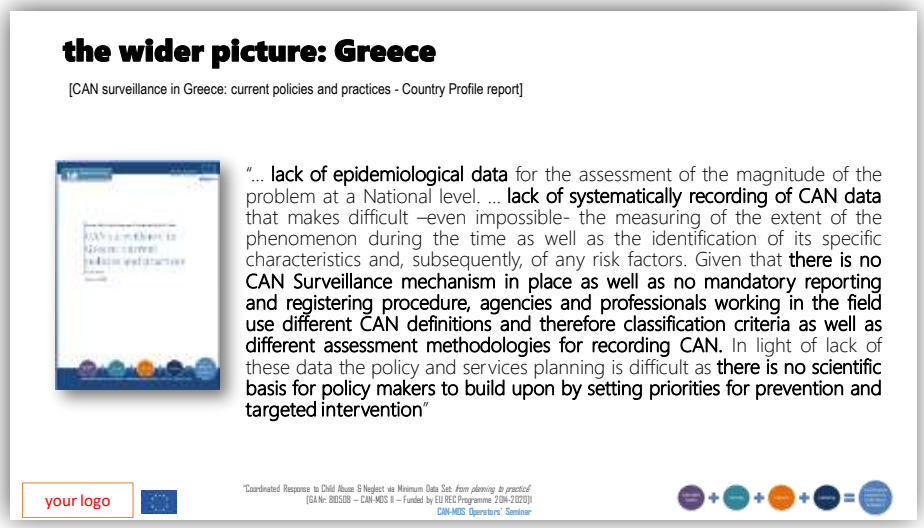
[Instruction: To be completed at national level – you may use some of the data available in page 2 of your national policy brief; See examples in the next slides]

Slide 24 [example – hidden slide]



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

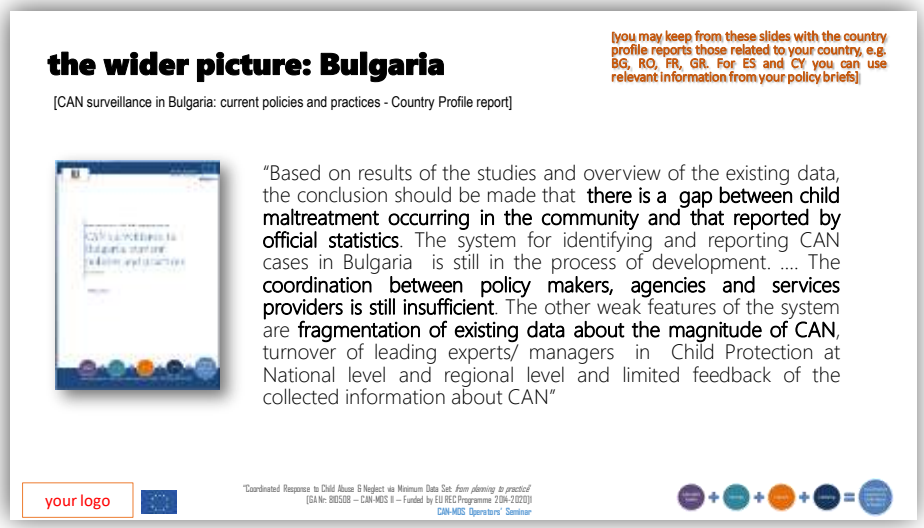
Slide 25 [example – hidden slide]



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

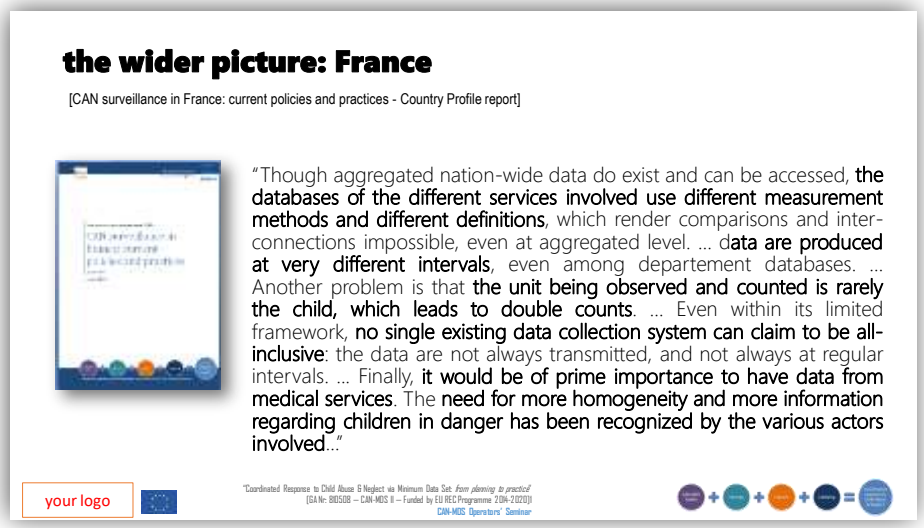
Slide 26 [example – hidden slide]



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.

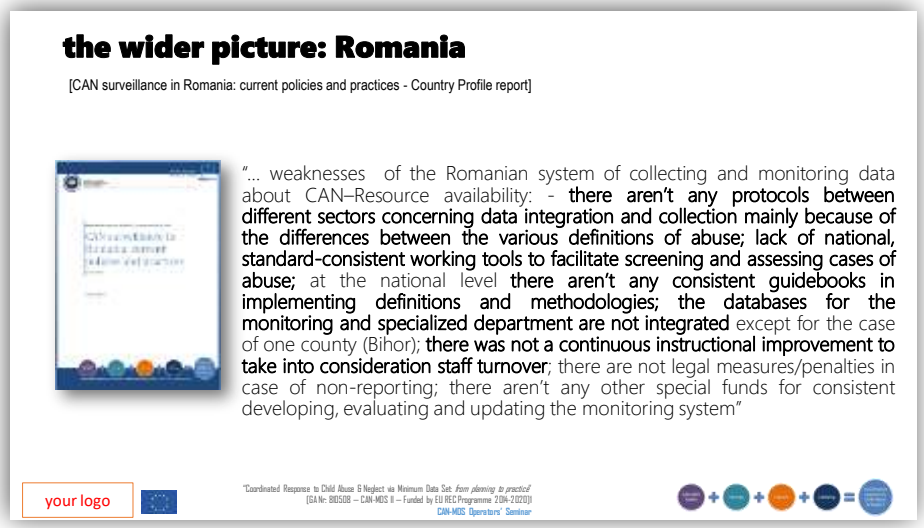
Slide 27 [example – hidden slide]



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.

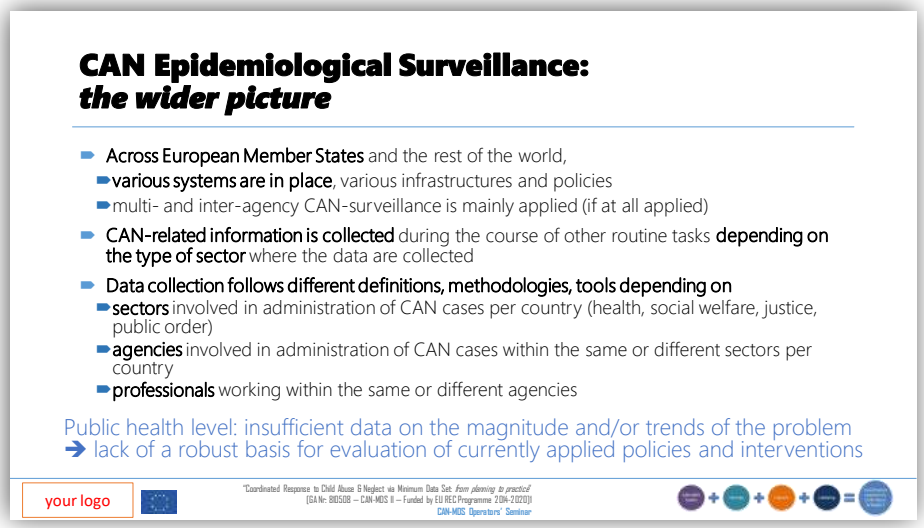
Slide 28 [example – hidden slide]



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



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"

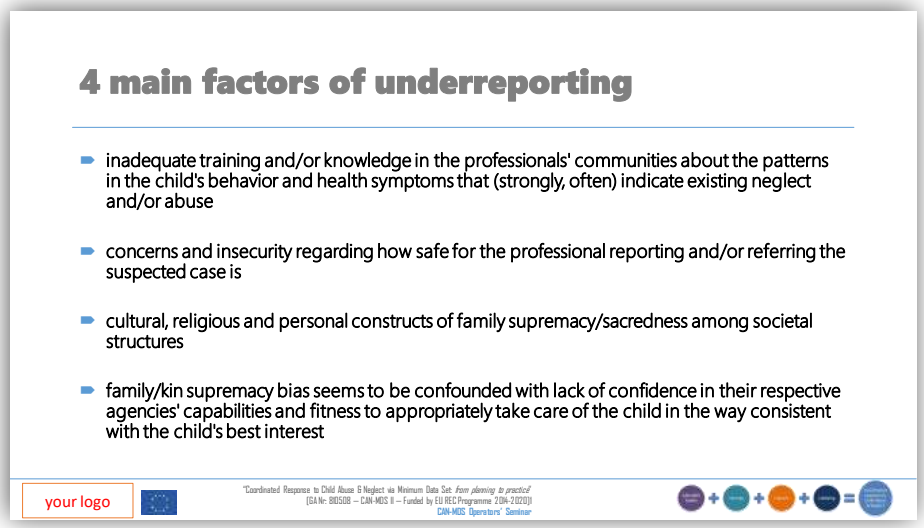
Twenty years later and despite the seriousness of the problem, accurate estimates of CAN extent and its characteristics in the general population are not available for various reasons: underreporting due to the silence that surrounds maltreatment cases because of shame, social stigma and the consequent 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

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

Slide 31



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

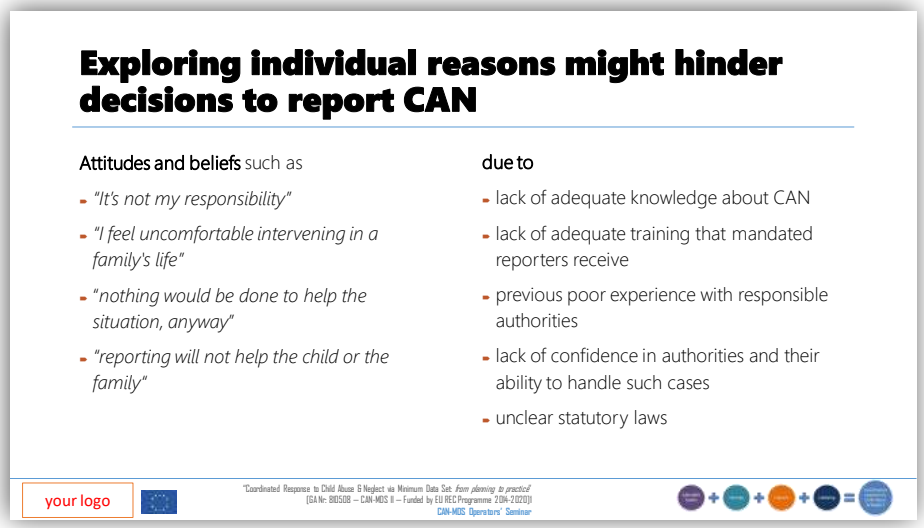
1. Inadequate training and/or knowledge in the professionals' communities about the patterns in the child's behavior and health symptoms that (strongly, often) indicate existing neglect and/or abuse. Ambiguity surrounding maltreatment definitions, along with what is grounds for "reasonable suspicion"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



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Sources:

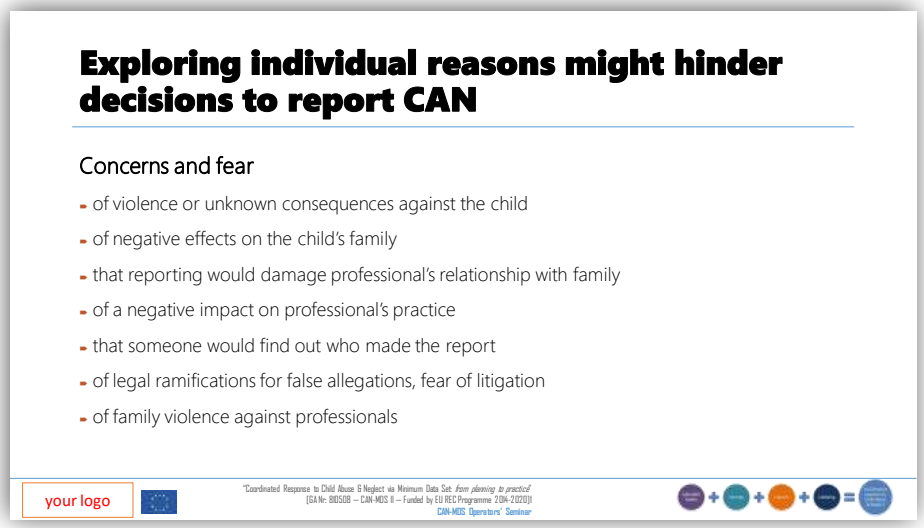
Walsh, W., & Jones, L. (2015). Factors that influence child abuse reporting: A survey of child-serving professionals. *Durham, NH: Crimes against Children Research Center*.

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



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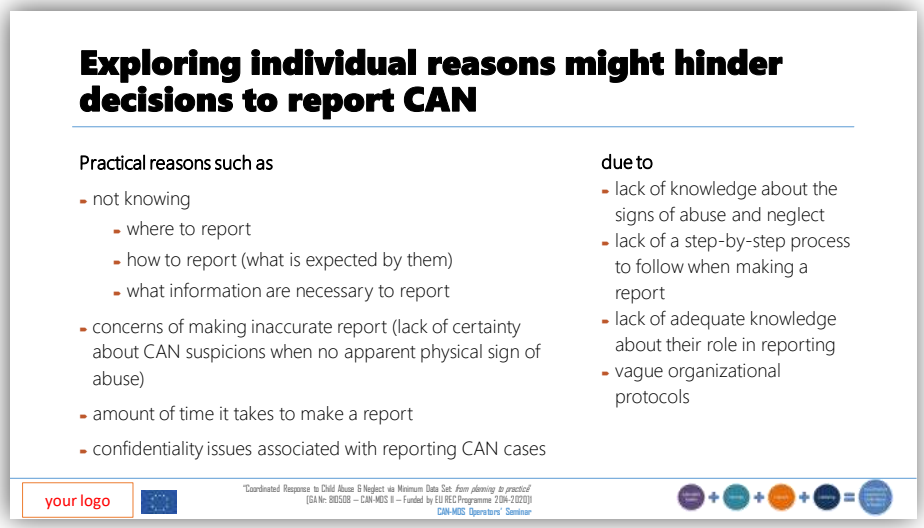
Sources: As above

Slide 34



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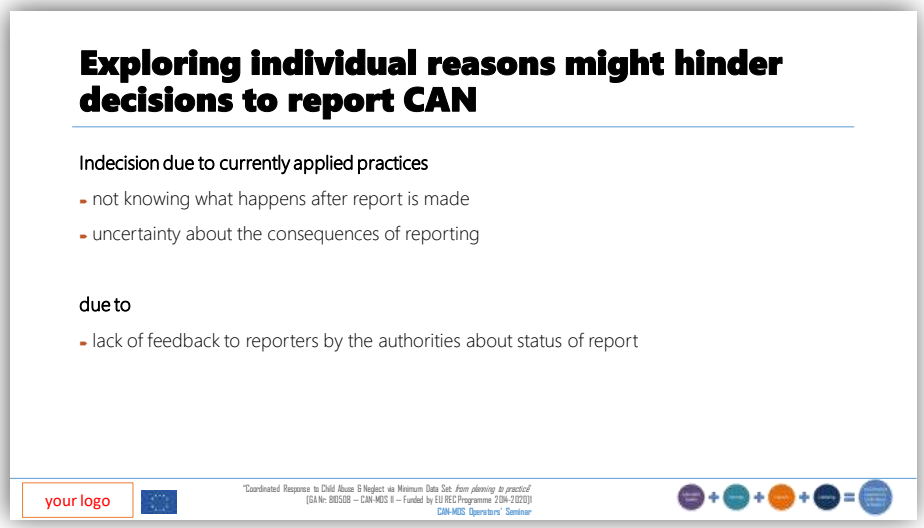
Sources: as above

Slide 35



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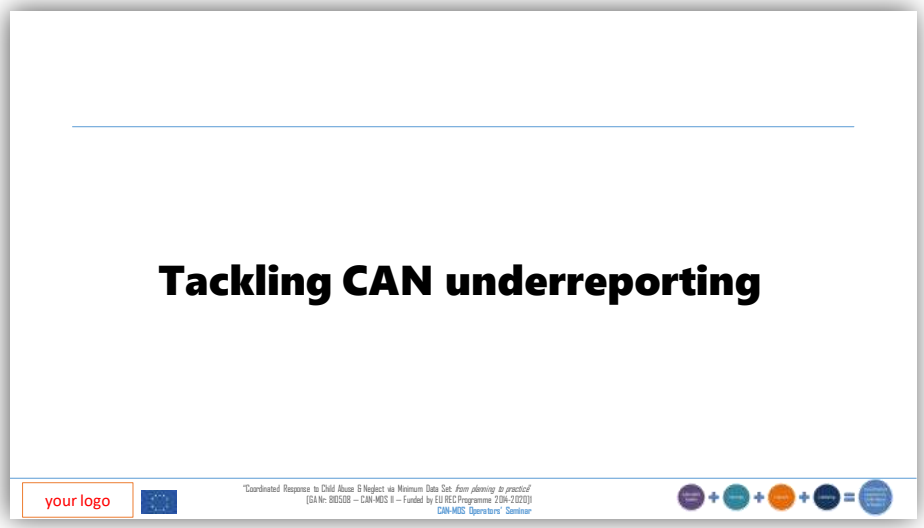
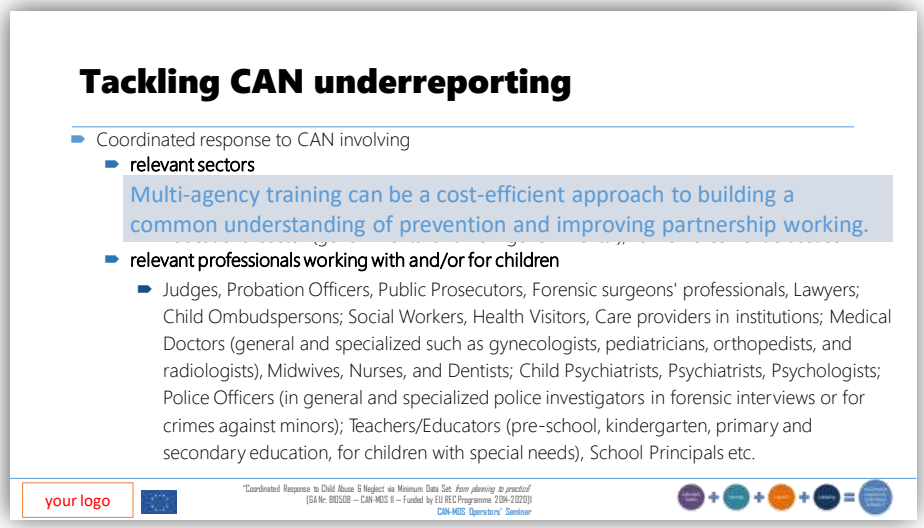
Sources: as above

Slide 36



Slide 37



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

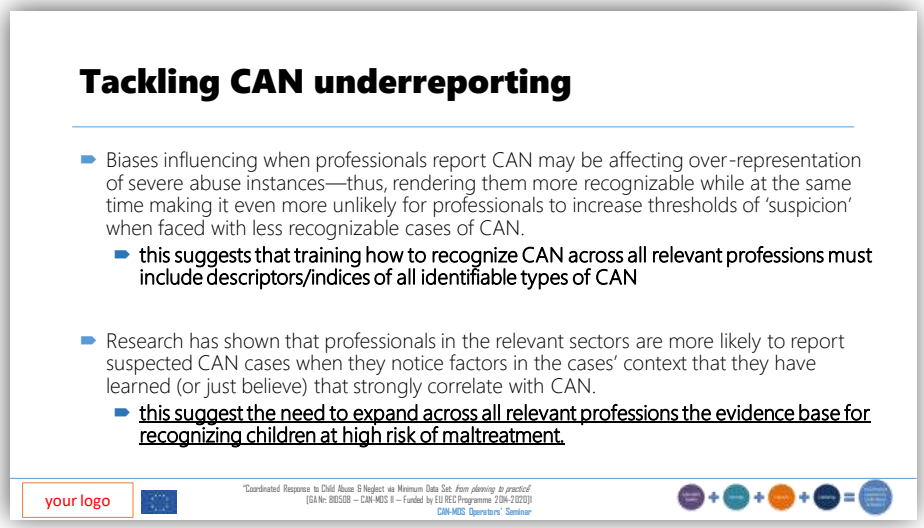
Mental health professions: Child Psychiatrists, Psychiatrists, Psychologists, Licensed Counselors (Youth Counselors, Family Counselors, etc.)

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



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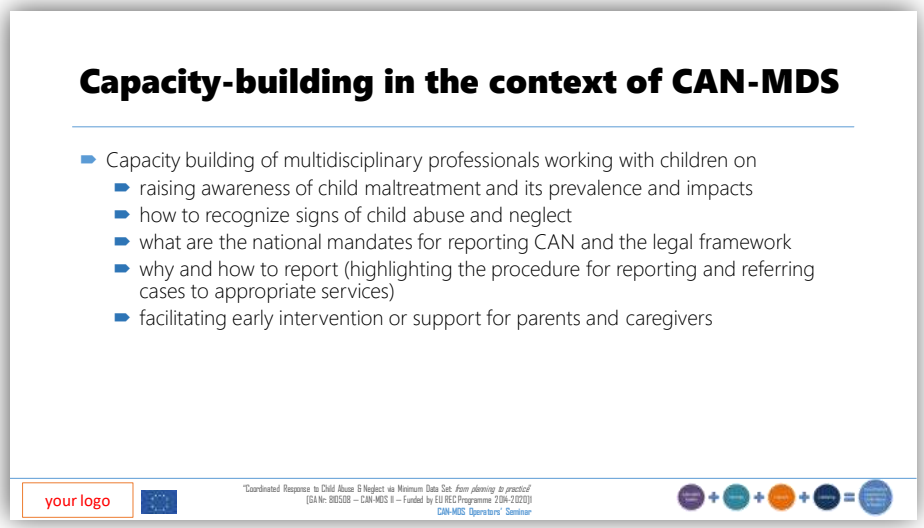
Slide 39



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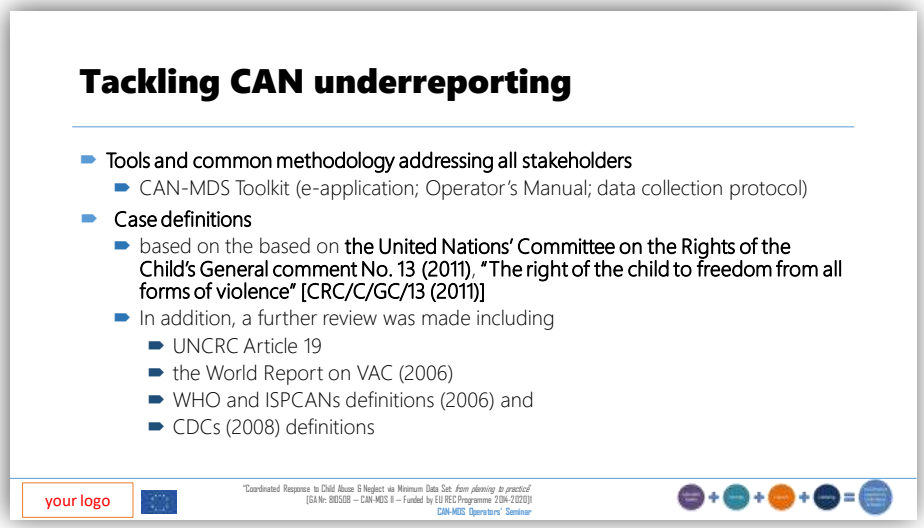
Source: http://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf?ua=1

Slide 40



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"

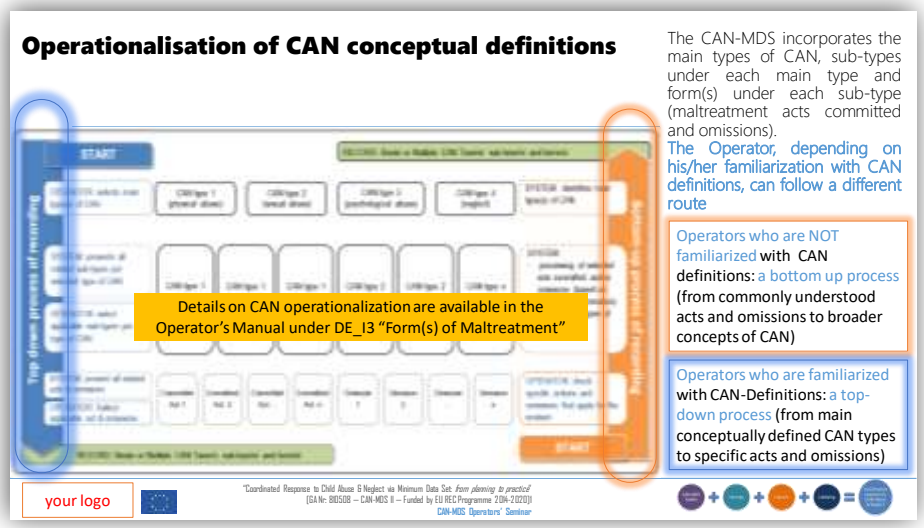
CHILD MALTREATMENT INCIDENT REPORTING is:
reporting of a child maltreatment incident by a source of information that involves at least one act of maltreatment or at least one omission in a child's care. A report can refer to a single distinct abuse and/or neglect event/episode or to continuous maltreatment 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

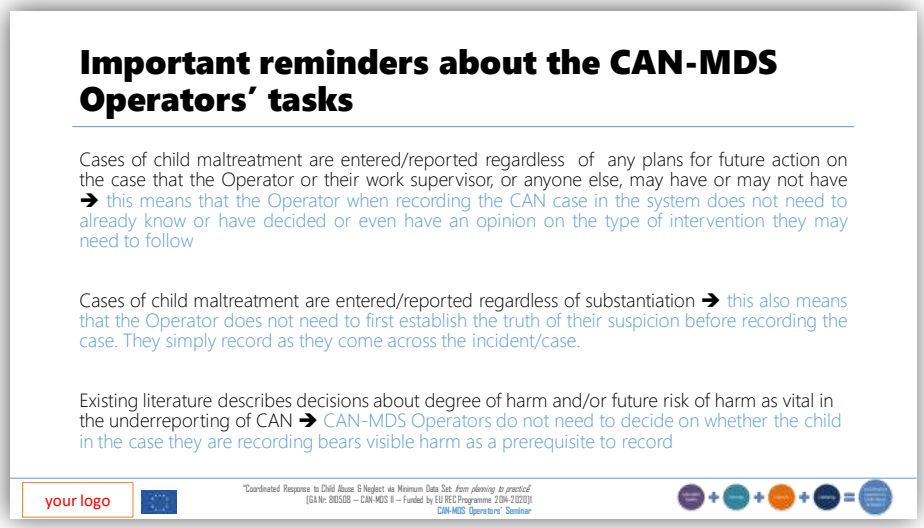
Slide 41



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



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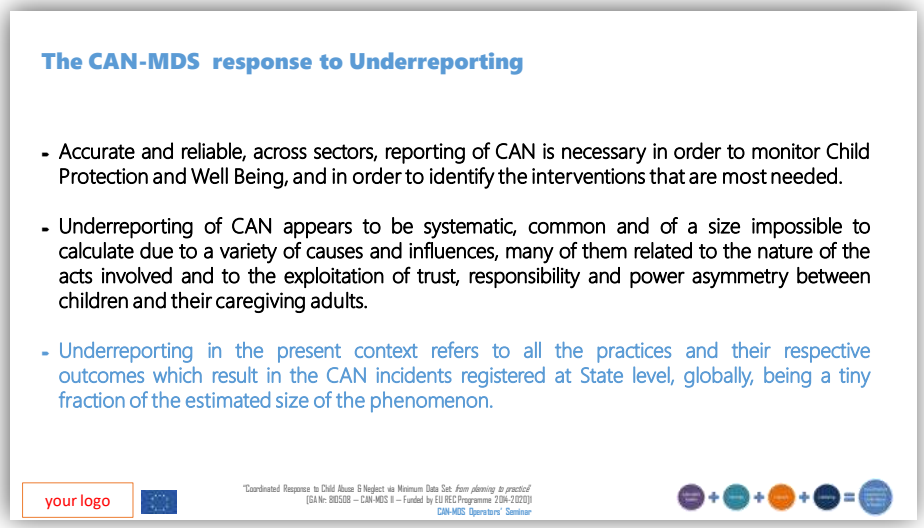
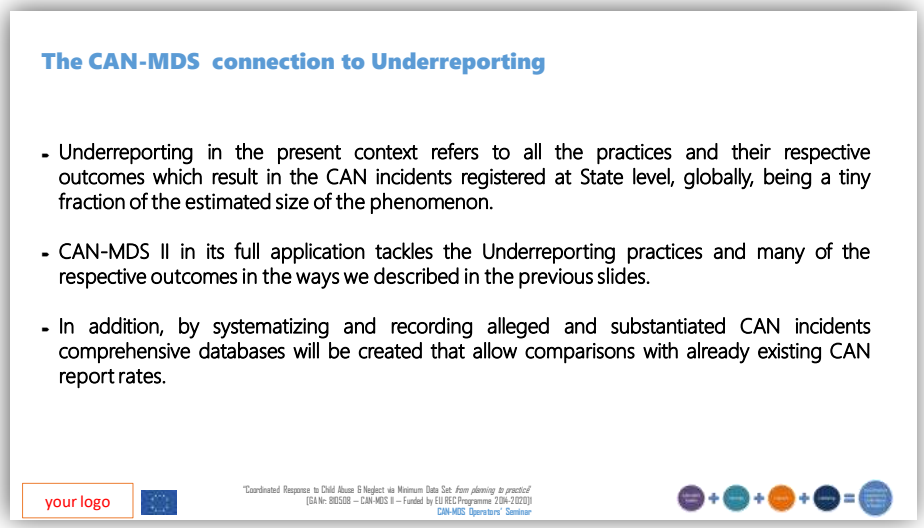
Slide 43



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

Slide 44



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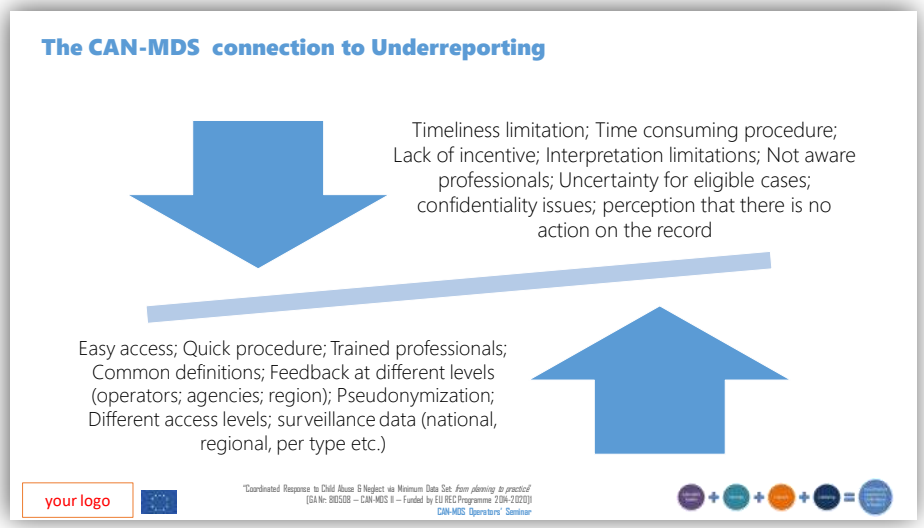
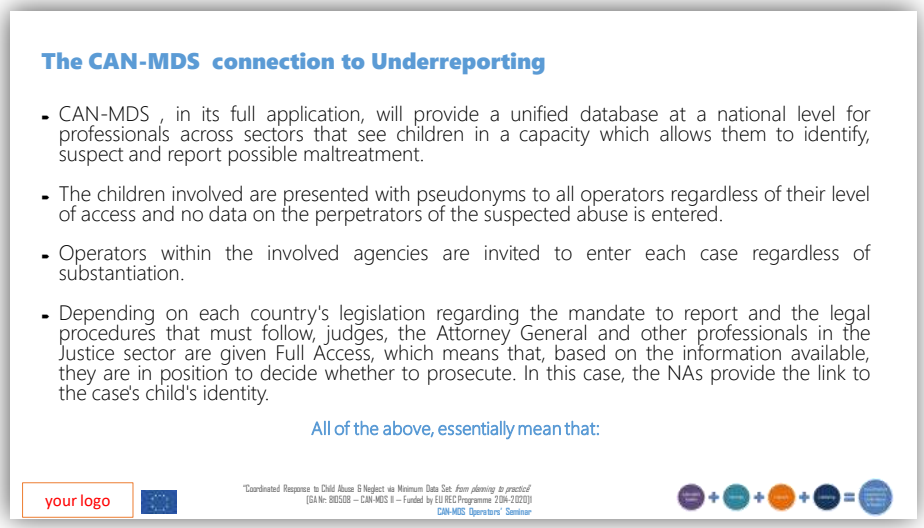


[it is suggested to use as is to show again how using CAN-MDS reverses the identified problem]

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

<see slide>

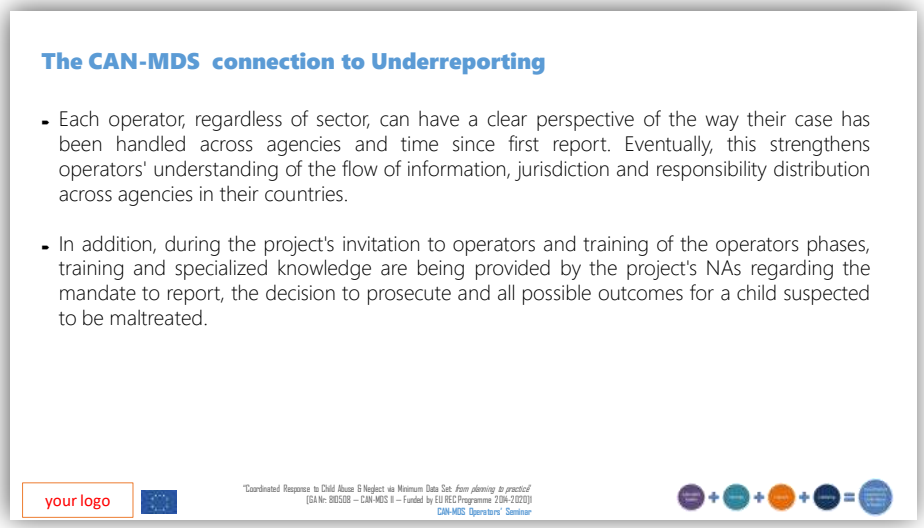
Slide 46



[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]

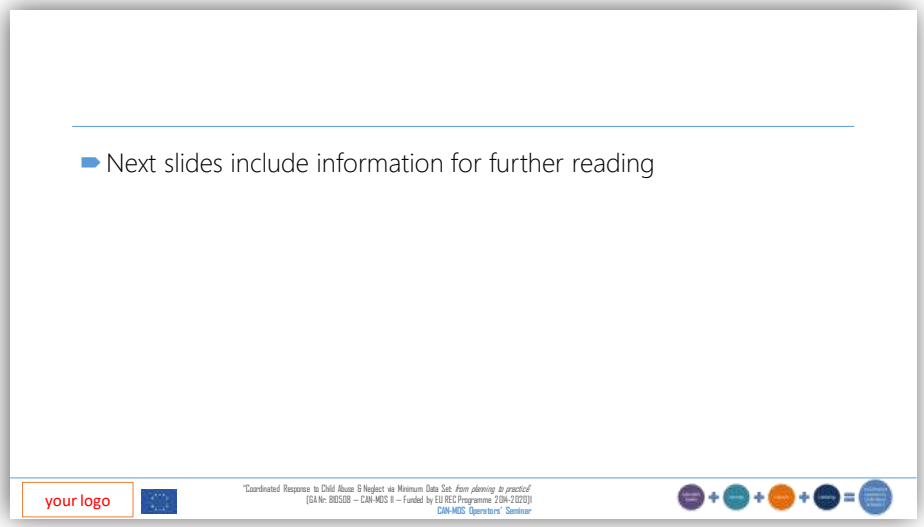
<see slide>

Slide 47



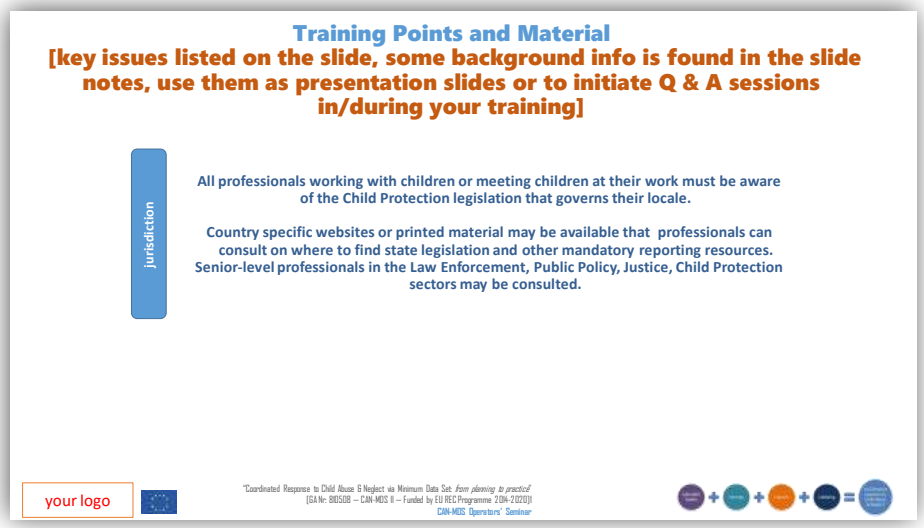
[Note: as above]

Slide 48 [hidden slide]



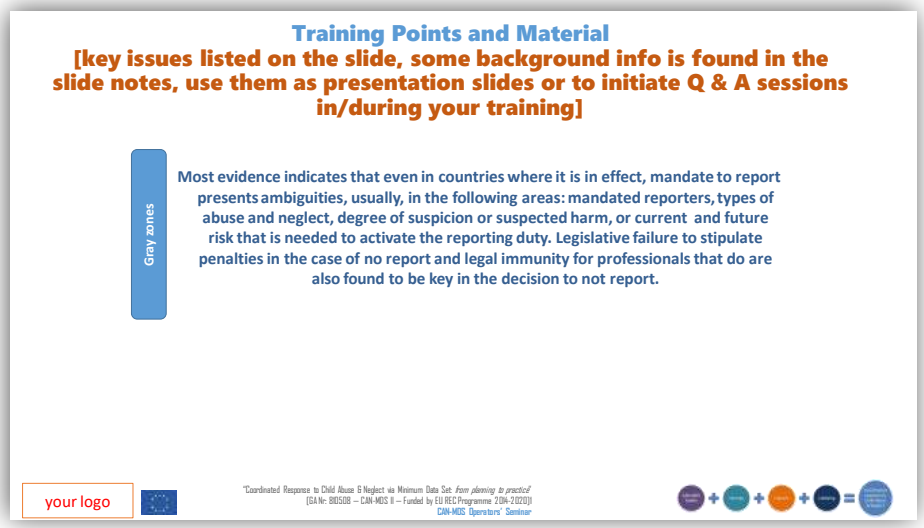
[Note: Next slides are hidden; here trainers can find further information about CAN underreporting]

Slide 49 [hidden slide]

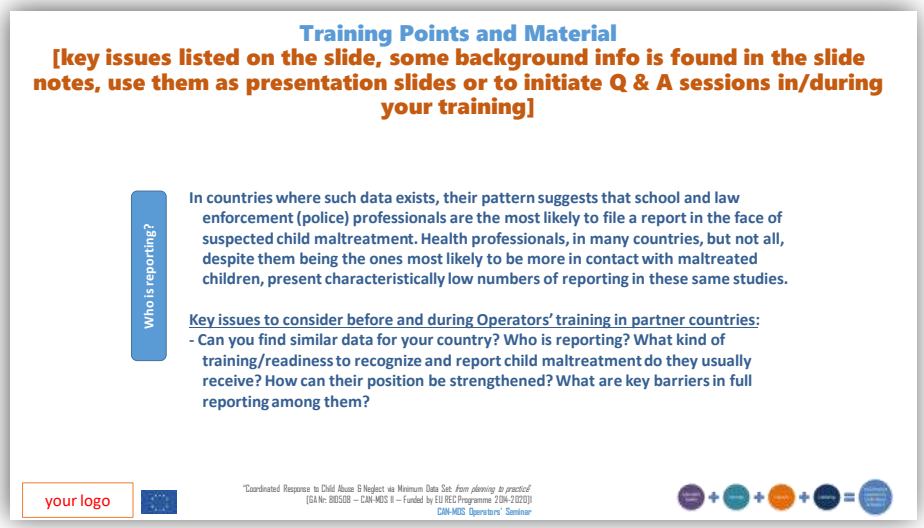


www.childwelfare.gov
www.cwrp.ca
http://www.aihw.gov.au/child-protection

Slide 50 [hidden slide]



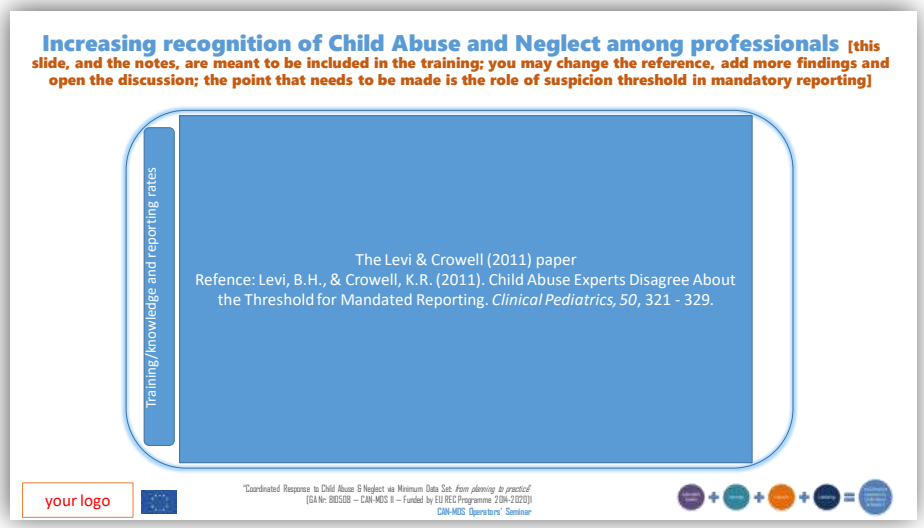
Slide 51 [hidden slide]



Slide 52 [hidden slide]

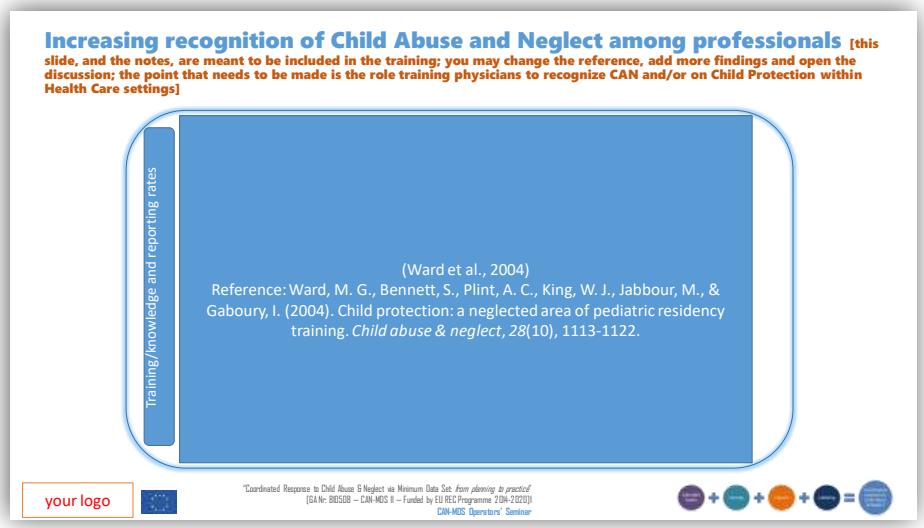
A qualitative study of home visiting nurses involved with high-risk families identified variability in knowledge, attitudes, and opinions about what constitutes maltreatment, as well as when to report children exposed to intimate partner violence

Slide 53 [hidden slide]



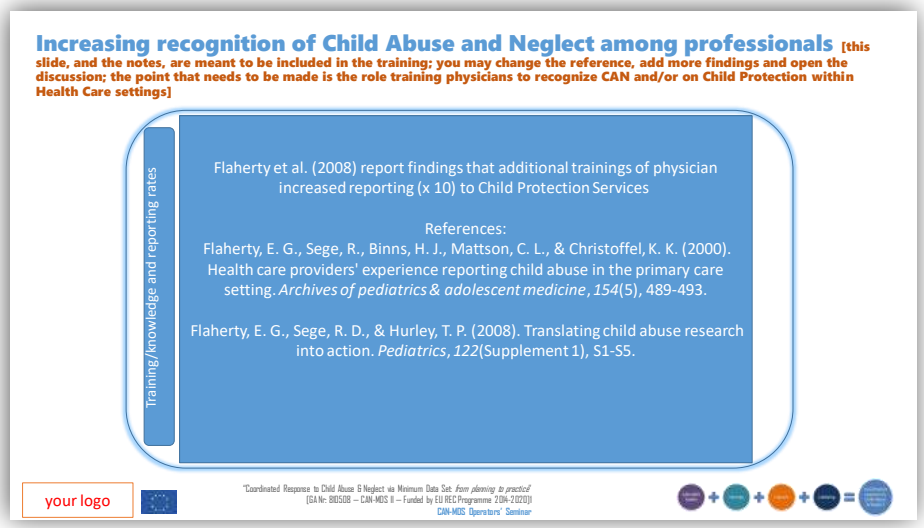
Additionally, ambiguity in the mandatory reporting statutes that reference "suspicion" of maltreatment and "reasonable suspicion" of maltreatment may negatively contribute to physicians' confidence in identifying CAN

Slide 54 [hidden slide]



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]



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/dcfsnvgov/content/Tips/Reports/SB258%20Report.pdf

Slide 56 [hidden slide]

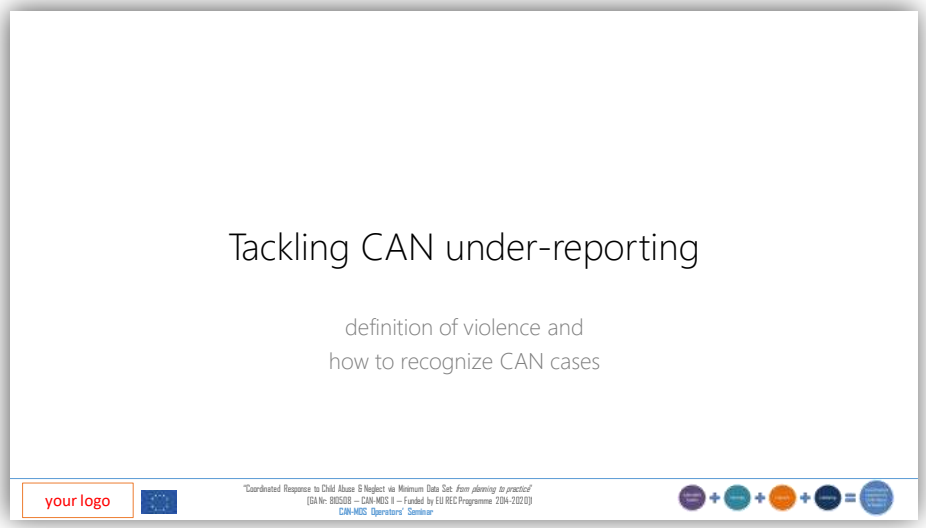
References:

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.

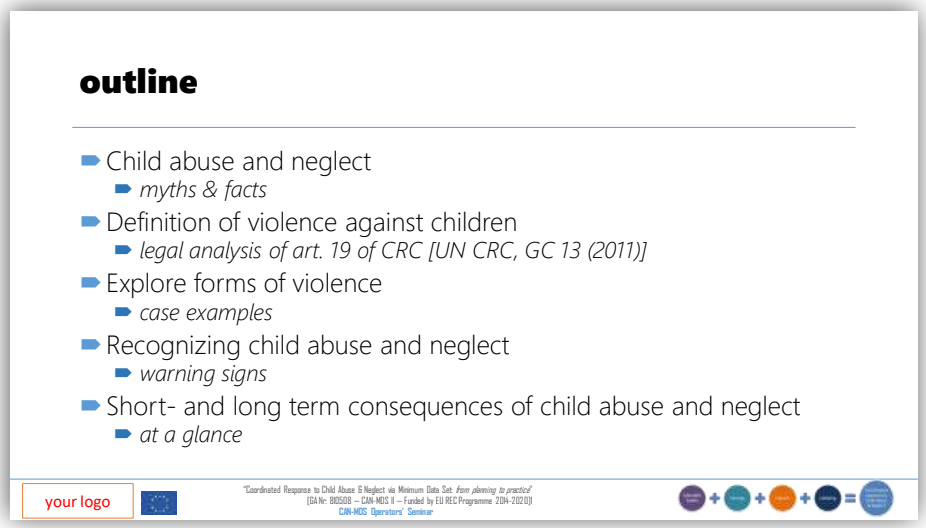
Runyan, D., May-Chahal, C., Ikeda, R., Hassan, F., & Ramiro, L. (2002). Child Maltreatment. In E.G. Krug, L.L. Dahlberg, J.A., Mercy, A.B. Zwi, R. Lozano, & WHO (Eds.). In *World report on violence and health* (pp.58-85)

PART 5 – DURATION: 60 MIN

Slide 1

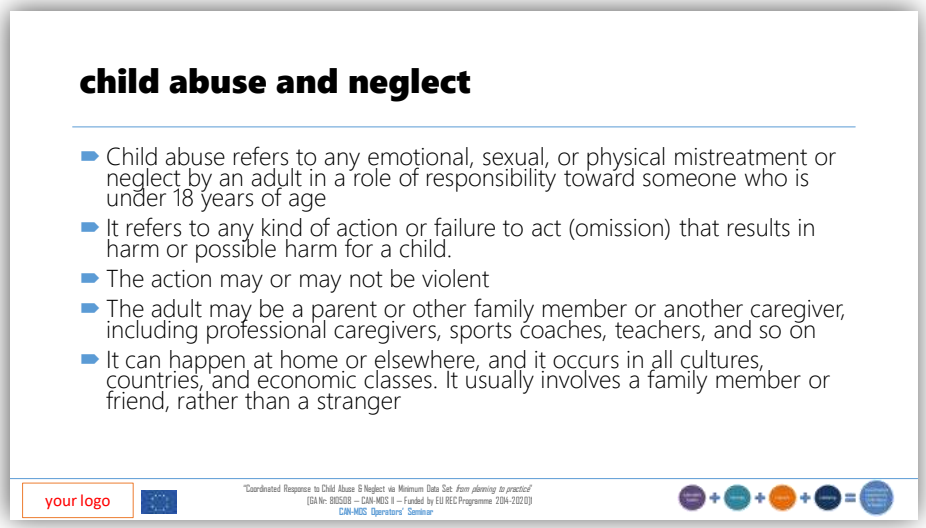


Slide 2



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

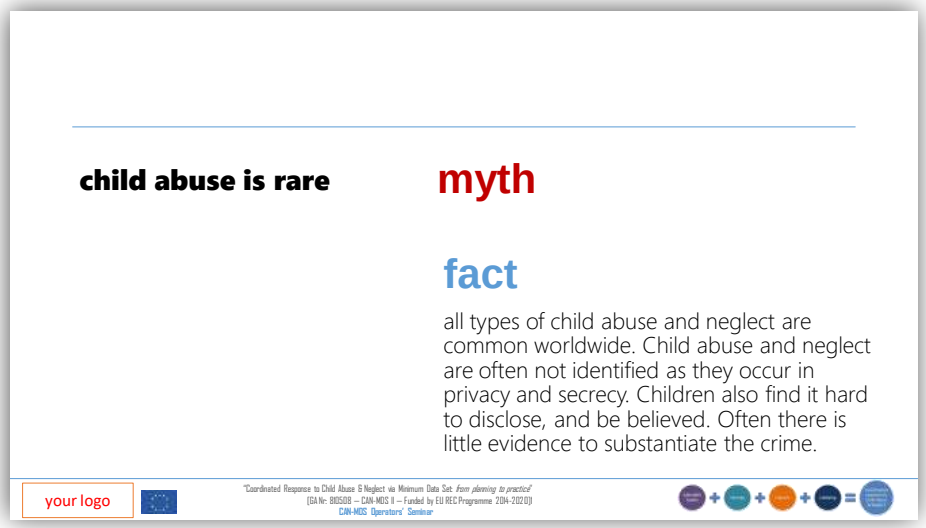


In this slides some general characteristics of child abuse and neglect are listed. Specifically:
<see slide>

Slide 4

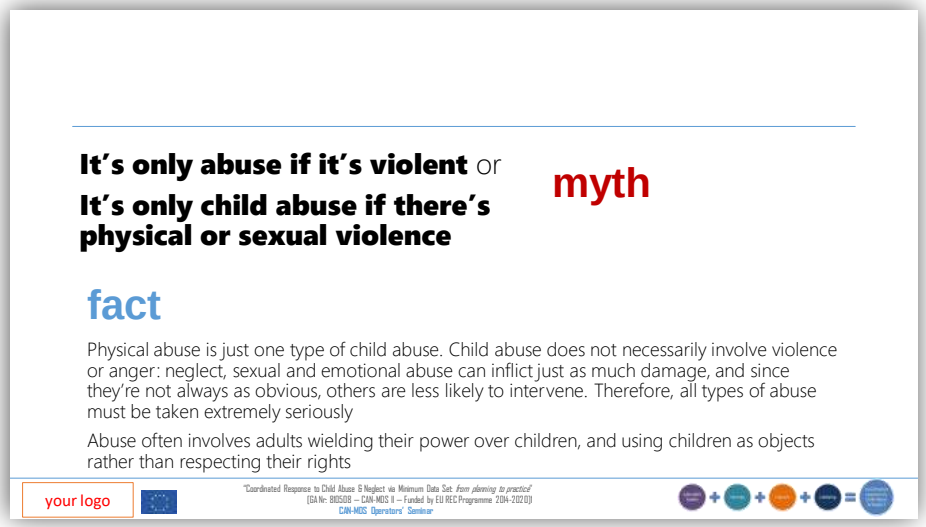
Even today there are a lot of false beliefs around child abuse and neglect that often prevent people from reporting CAN incidents.
<see slide>

Slide 5



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

Slide 6



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

Slide 7

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

Slide 8

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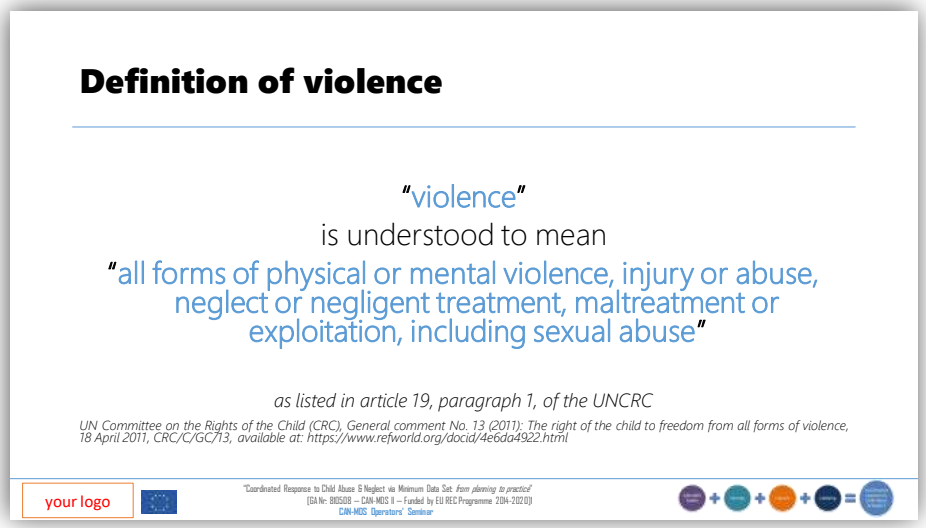
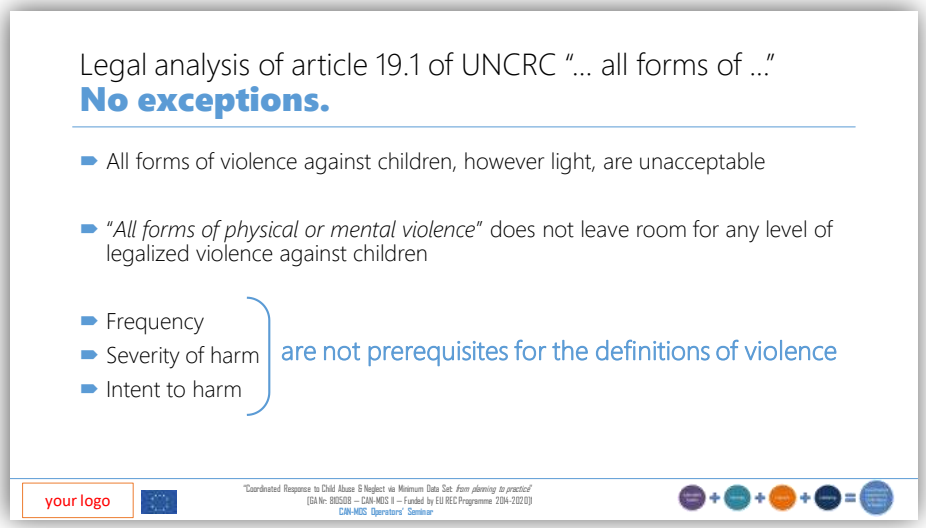
Slide 16



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

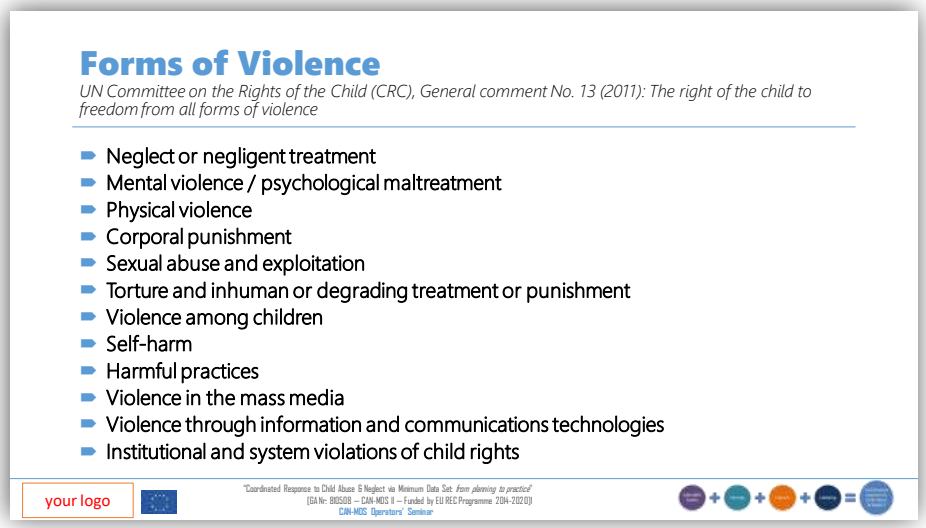


Comment about frequency, severity of harm and intent of harm:
State parties may refer to such factors in intervention strategies in order to allow proportional responses in the best interests of the child, but definitions must in no way erode the child's absolute right to human dignity and physical and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

Slide 18

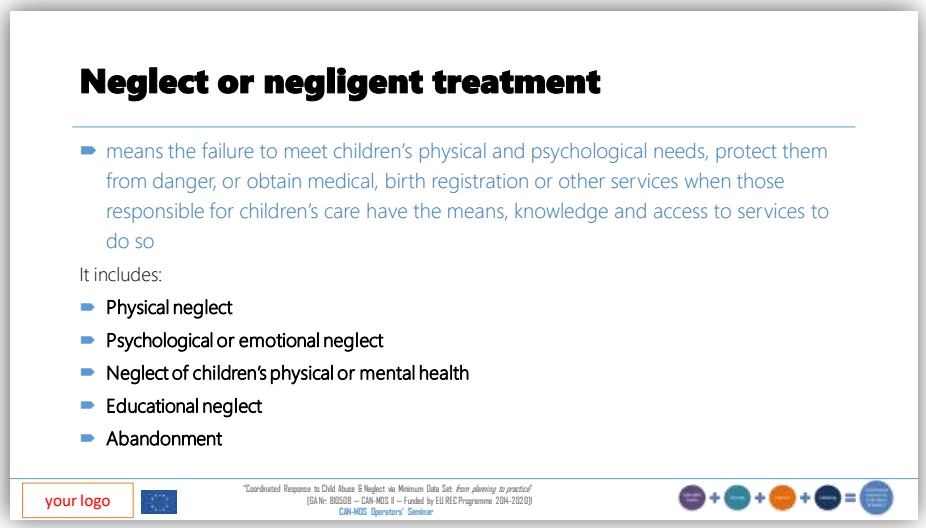
In addition, state parties need to establish national standards for child well-being, health and development as securing these conditions is the ultimate goal of child caregiving and protection.

Slide 19



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



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;

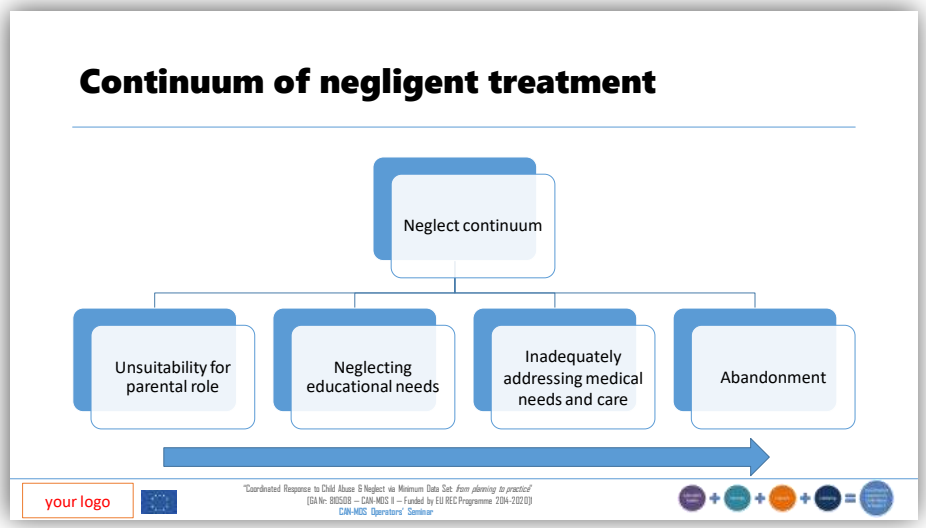
Psychological or emotional neglect: including lack of any emotional support and love, chronic inattention to the child, caregivers being "psychologically unavailable" by overlooking young children's cues and signals, and exposure to intimate partner violence, drug or alcohol abuse;

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

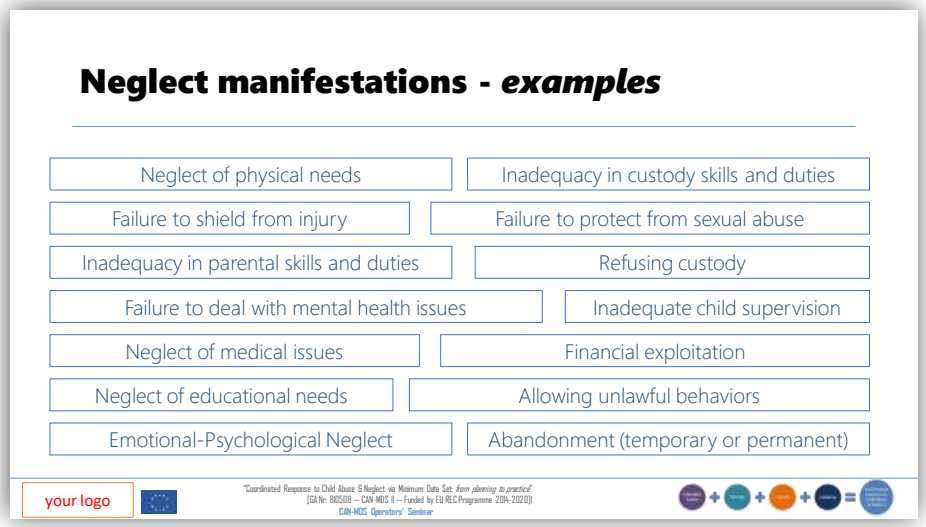
Abandonment: a practice which is of great concern and which can disproportionately affect, inter alia, children out of wedlock and children with disabilities in some societies.

Slide 21



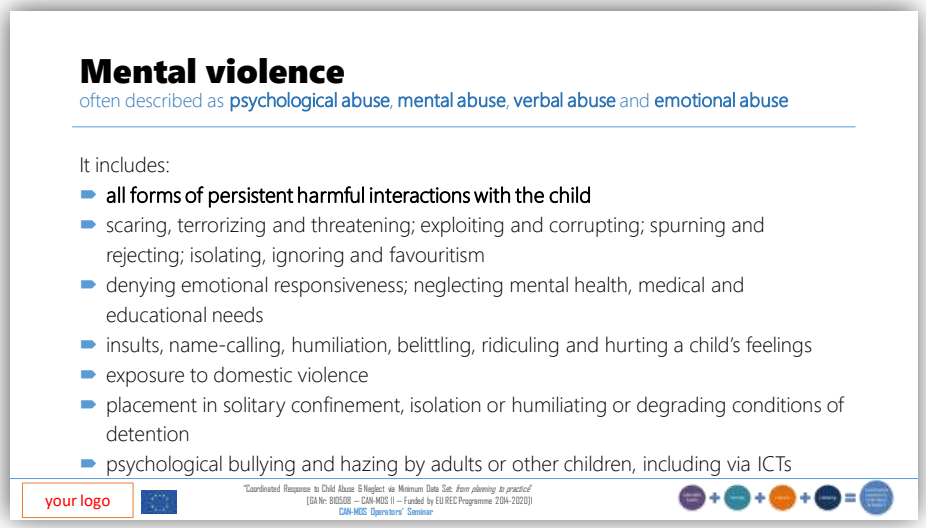
Negligent treatment, similarly to the remaining forms of child maltreatment, consists of a continuum of omissions that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed. For example:
<see slide>

Slide 22



Other neglect manifestations are listed in the slide

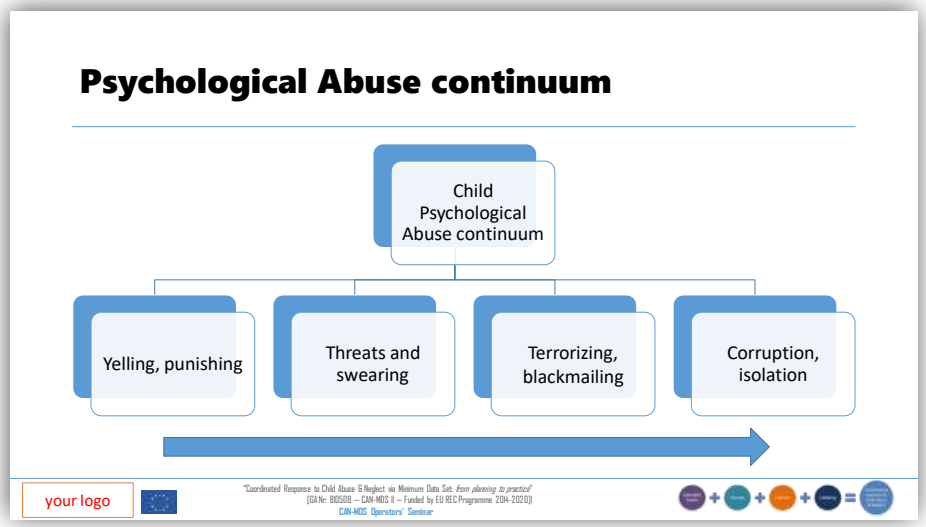
Slide 23



Mental violence 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:

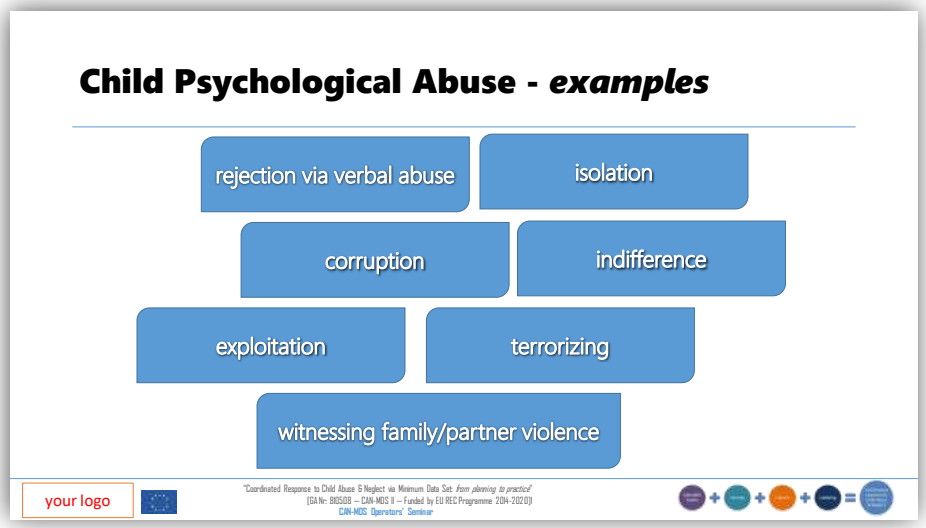
- All forms of persistent harmful interactions with the child, for example, conveying to children that they are worthless, unloved, unwanted, endangered or only of value in meeting another's needs
- Scaring, terrorizing and threatening; exploiting and corrupting; spurning and rejecting; isolating etc
- 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



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



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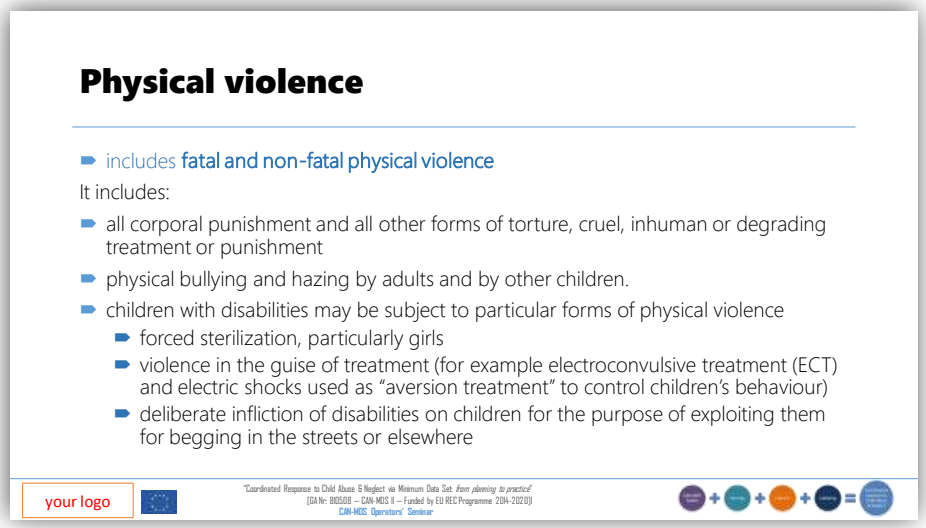
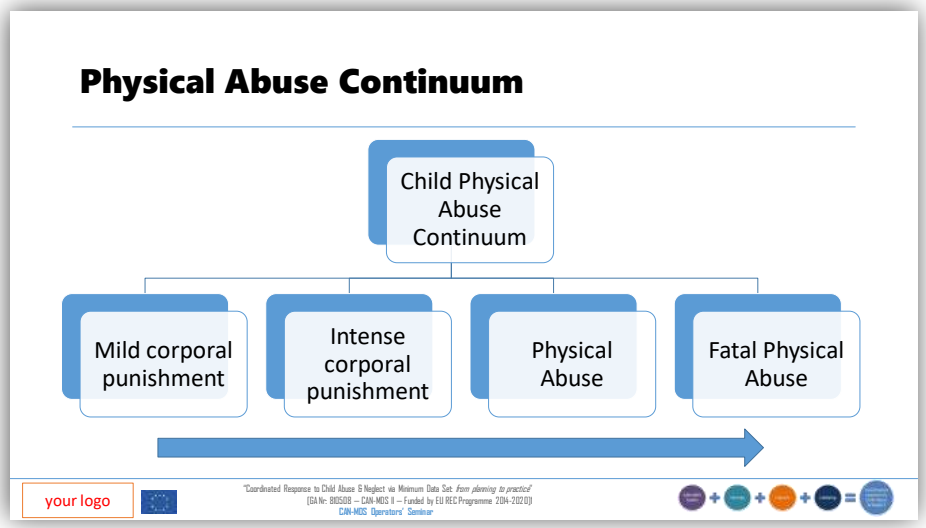


Physical violence is defined as the intentional use of violence against a child's body, which causes or may cause harm affecting the child's health, survival, growth or their dignity. Violence on the body includes all types of blows, beatings, kicking, shaking, biting, struggling, burning, poisoning 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.

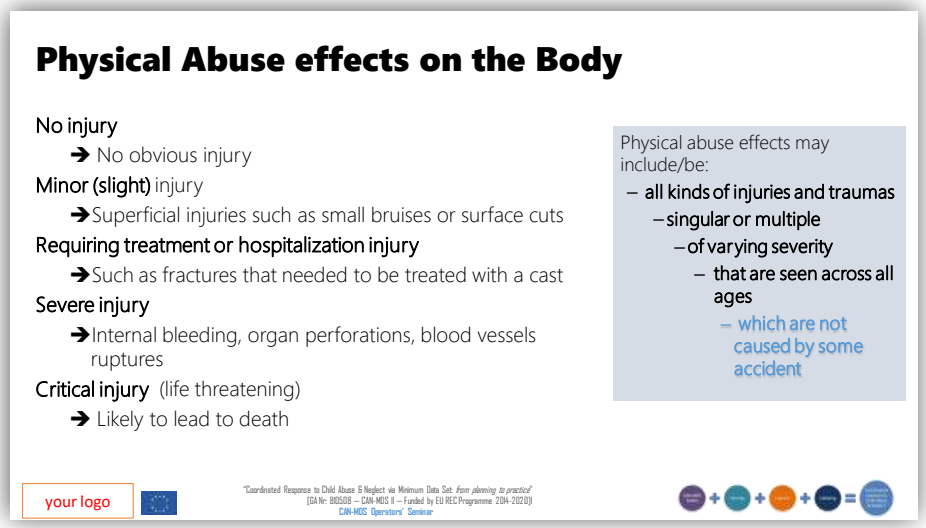
<see also slide>

Slide 27



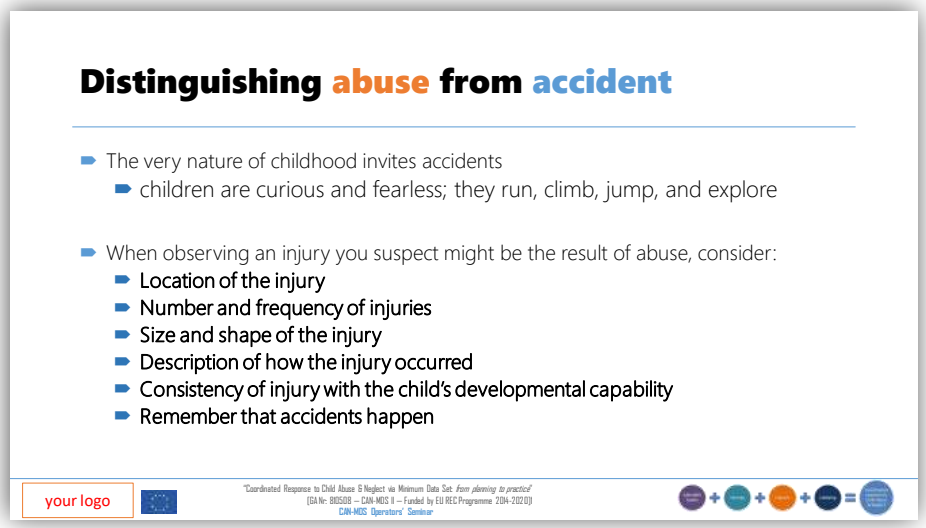
It consists of a continuum of acts that may differ in regards to severity of potential harm, the intention on the part of caregivers and/or the frequency they are observed.
For example: <see slide>

Slide 28



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



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.

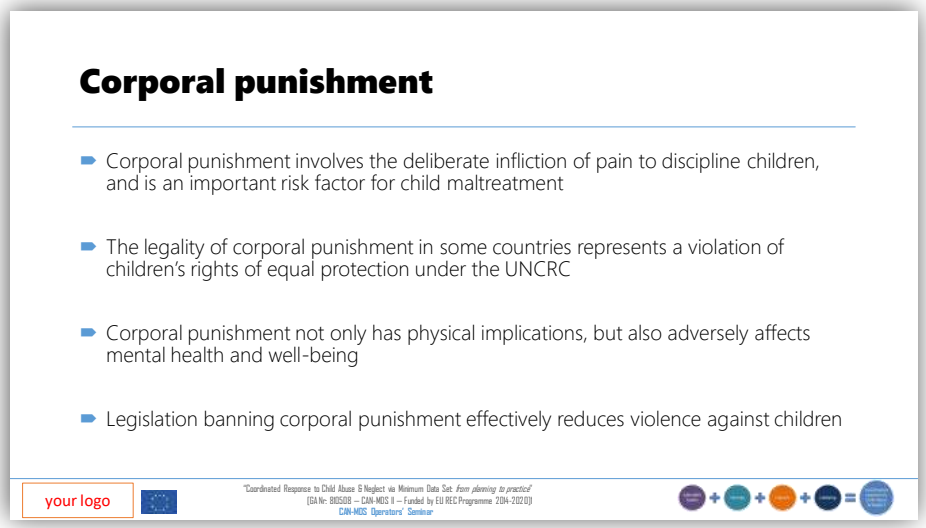
Description of how the injury occurred: If an injury is accidental, there should be a reasonable explanation of how it happened that is consistent with the appearance of the injury. When the description of how the injury occurred and the injury are inconsistent, there is cause for concern. For example, 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

Slide 30



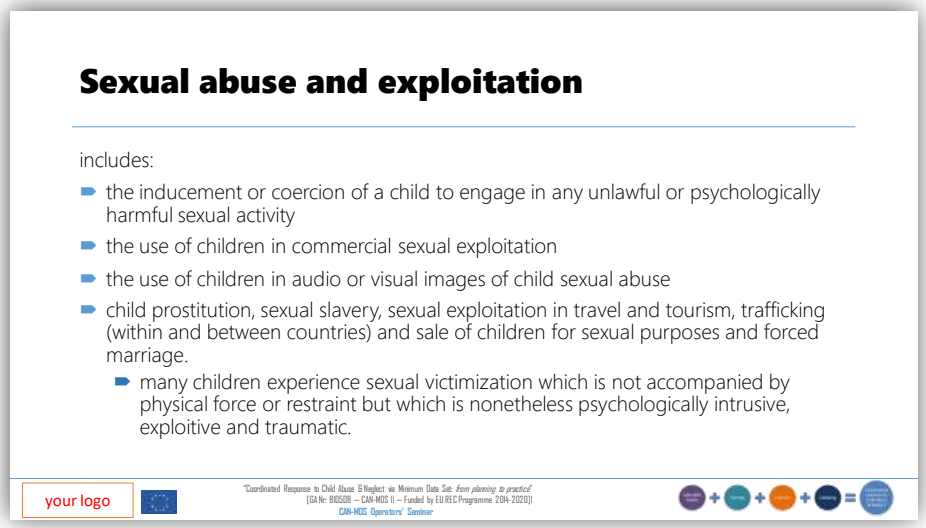
As for the corporal punishment, in the General Comment No. 8 (para. 11), the Committee defined "corporal" or "physical" punishment as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting ("smacking", "slapping", "spanking") 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
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
https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864

Slide 31

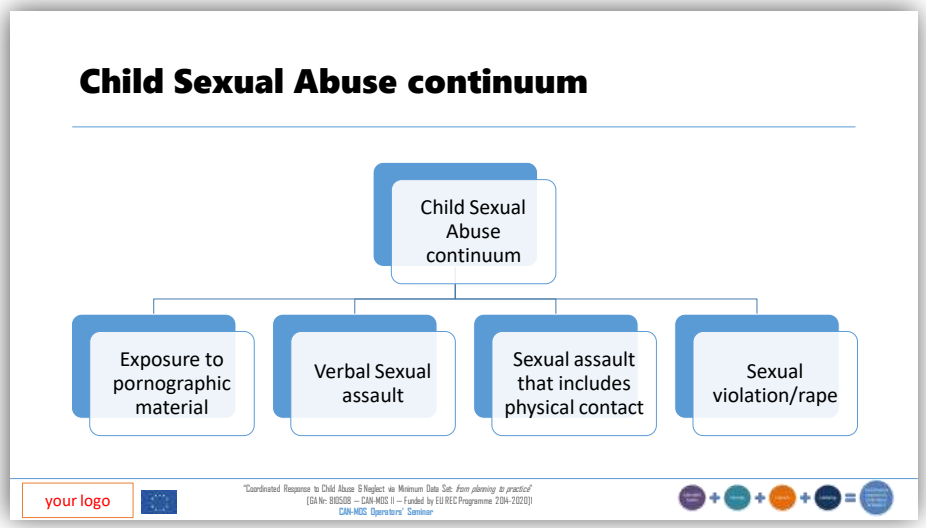
[Please complete the slide with country specific information (see also Step by step Guide for Administrators)]
Any corporal punishment may leave emotional scars. Parental behaviors that cause pain, physical injury or emotional trauma — even when done in the name of discipline — could be child abuse to avoid harm corporal punishment should be avoided

Slide 32



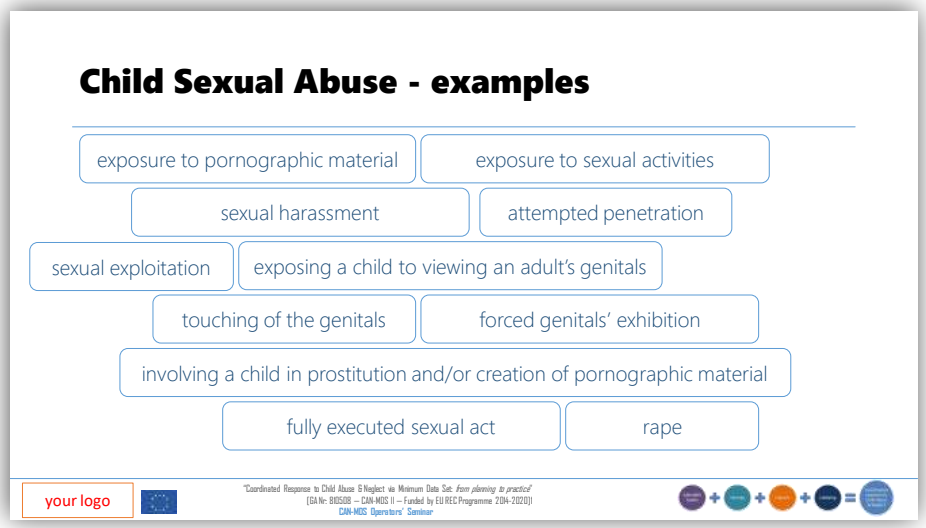
Sexual abuse is defined as the child's participation in any sexual activity that they don't fully understand, about which they are by default unable to provide consent, or they are developmentally immature to be in , or violates the laws and taboos of the specific and global culture. Child sexual abuse 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



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



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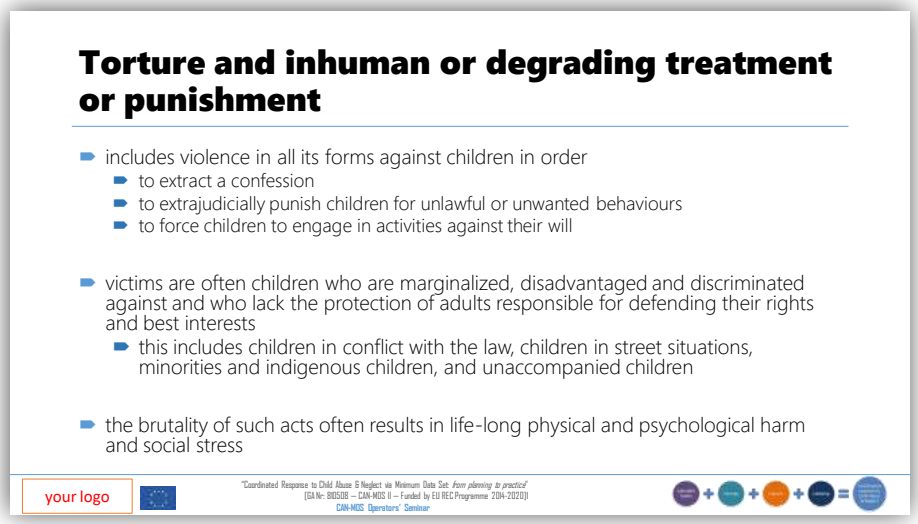
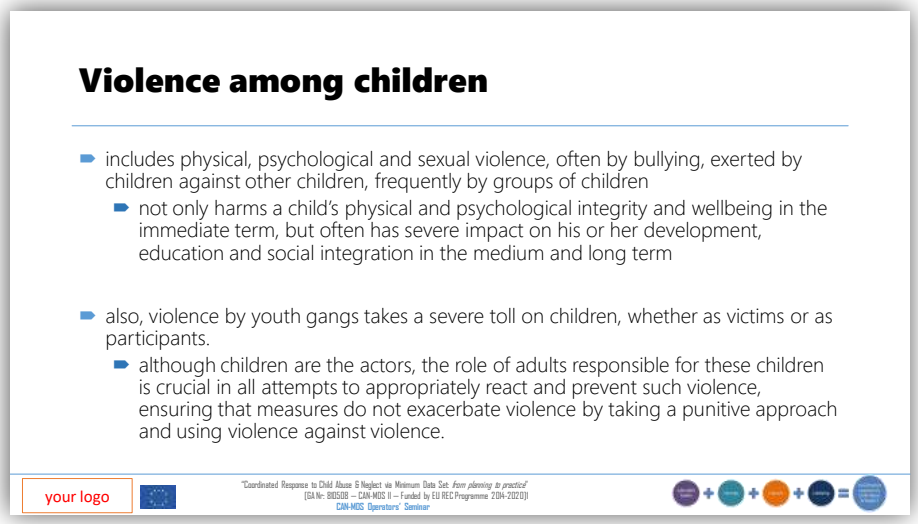


Such type of acts are often applied by police and law-enforcement officers, staff of residential and other institutions and persons who have power over children, including non-State armed actors.

Slide 36



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

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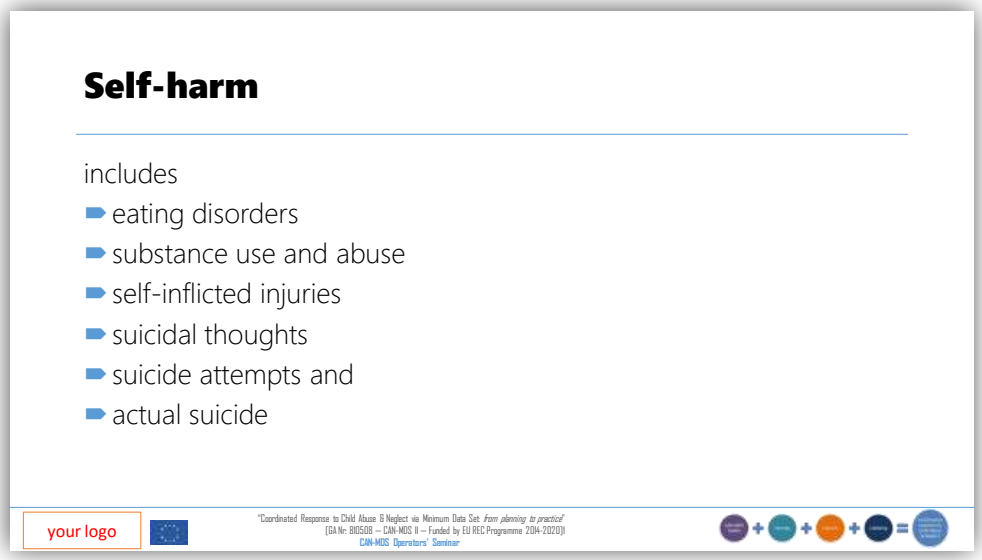
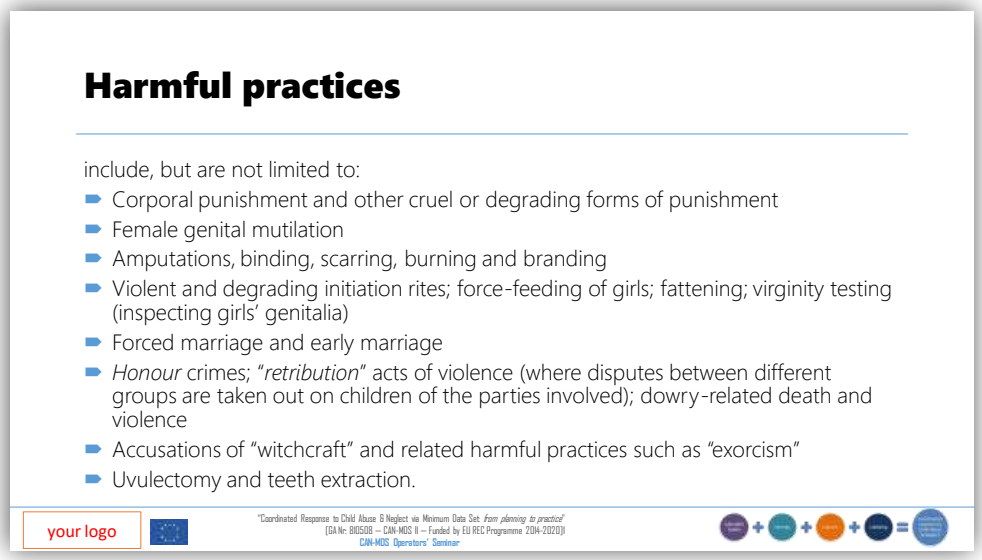


Suicide among adolescents is of particular concern to the Committee.
For more information trainees can read the CRC/C/GC13(2011).

Slide 38



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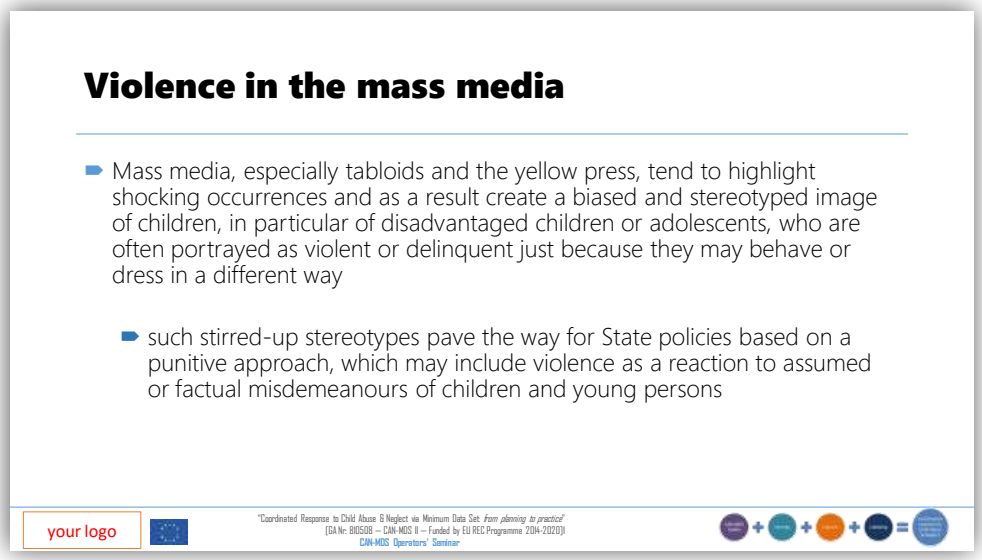

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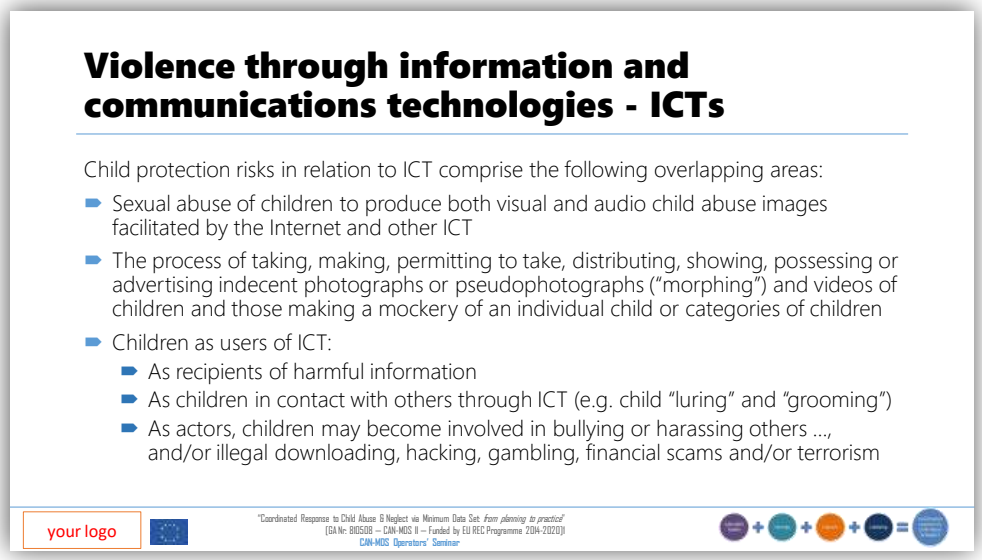
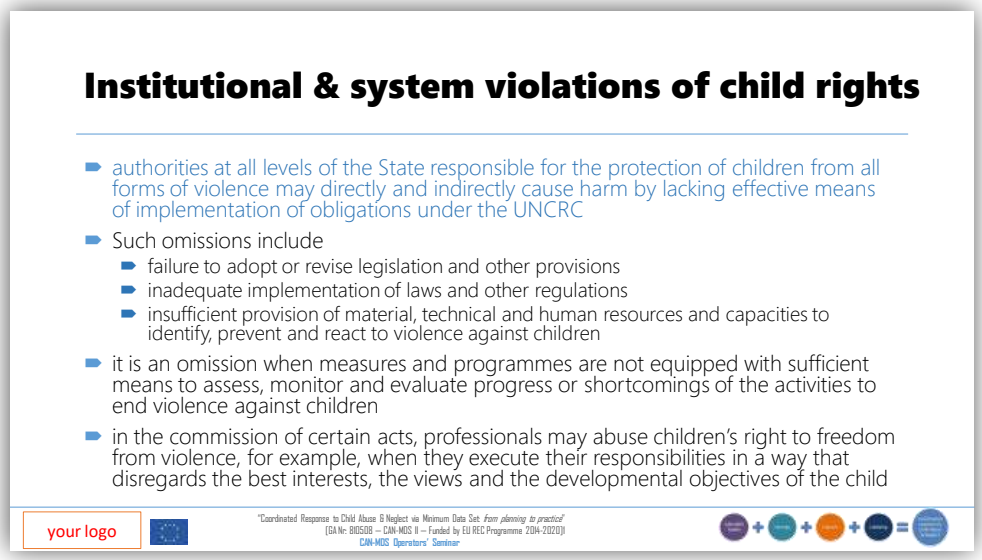


Children as users of ICT:

- 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, pornographic11, 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



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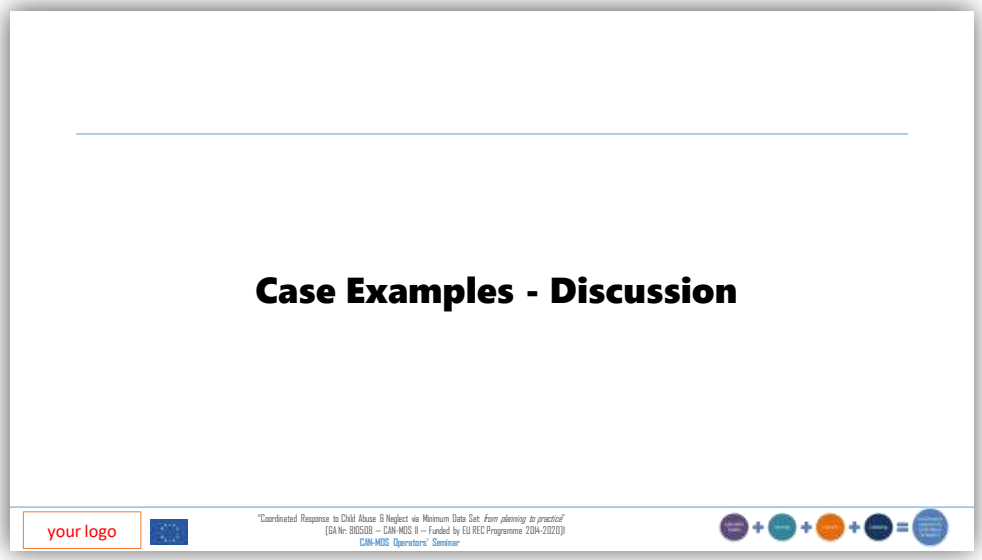
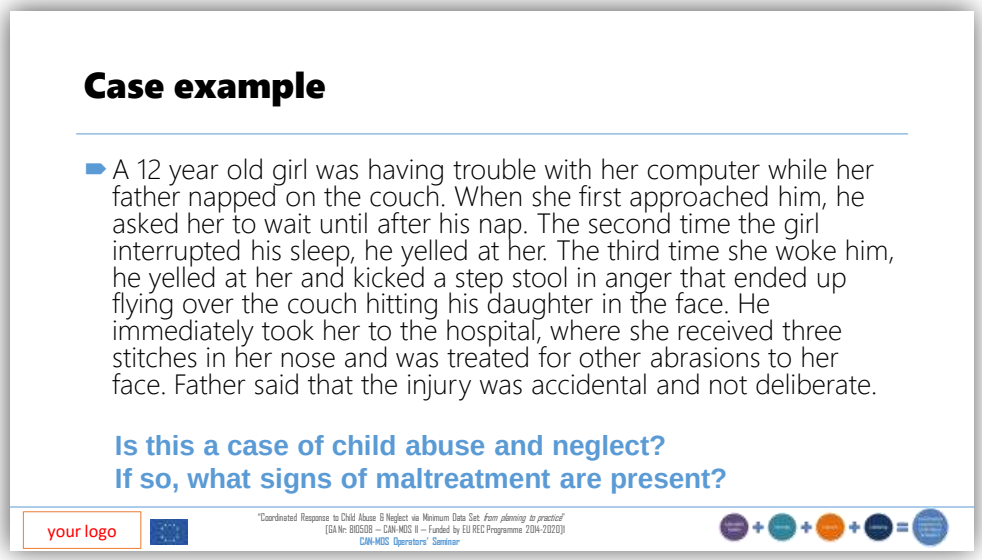


[Instruction: You may use one or more of the following case examples for discussion; alternatively you can move some or all of the case examples after the presentation of the warning signs of child abuse and neglect, namely after current slide 74]

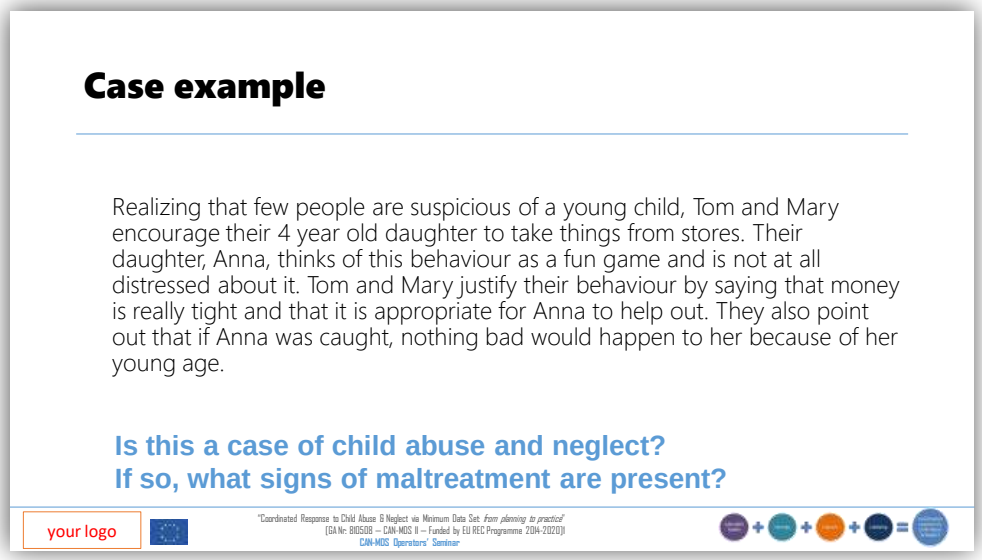
Slide 43



[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)

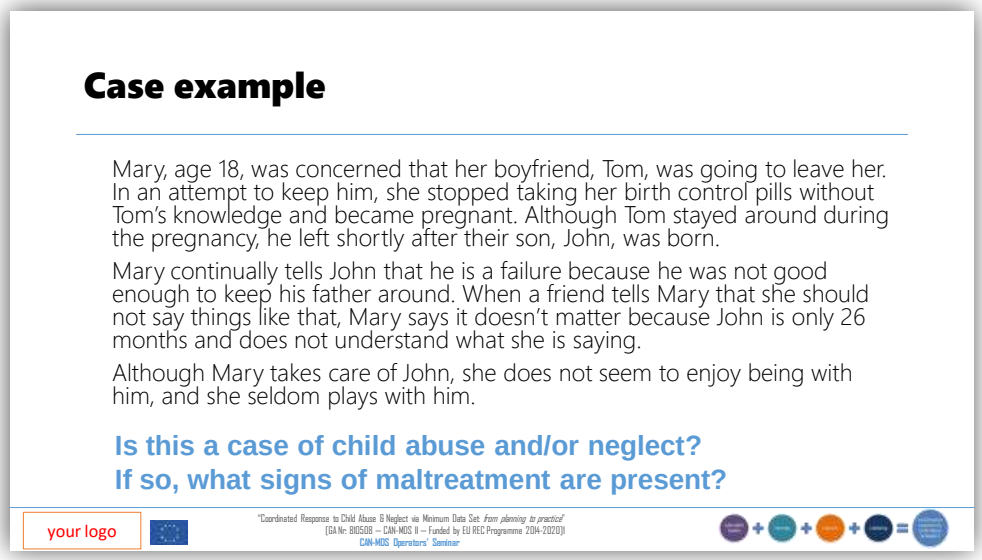
Slide 44



[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)

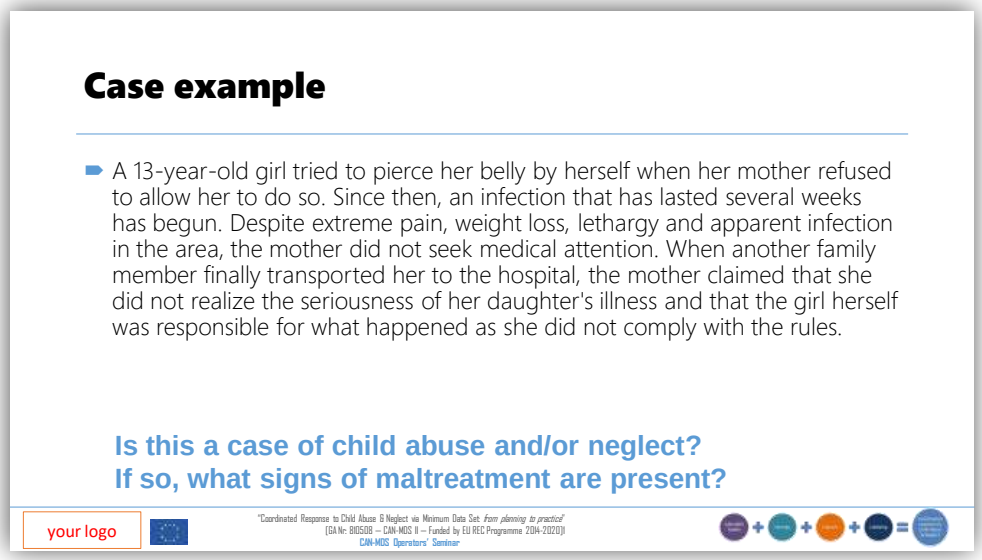
Slide 45



[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)

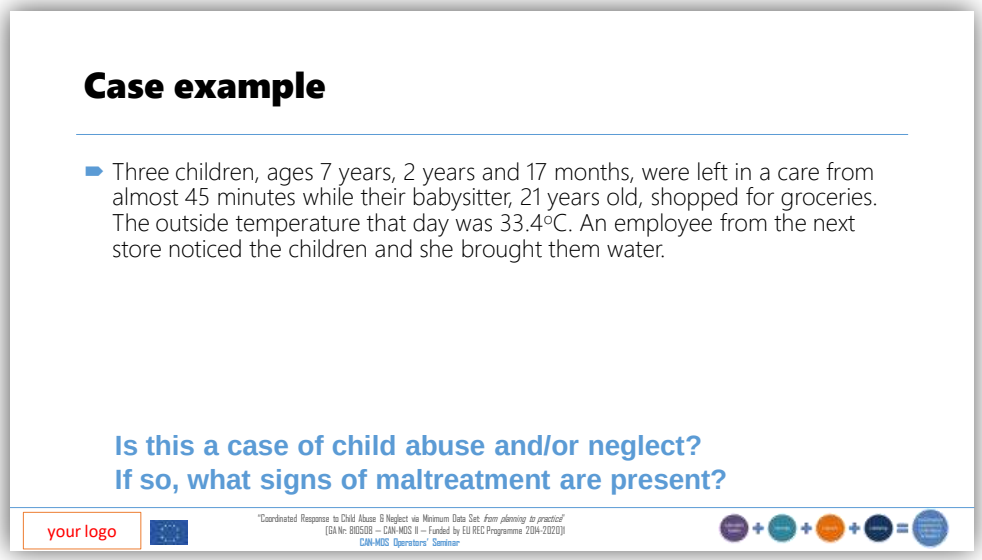
Slide 46



[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)

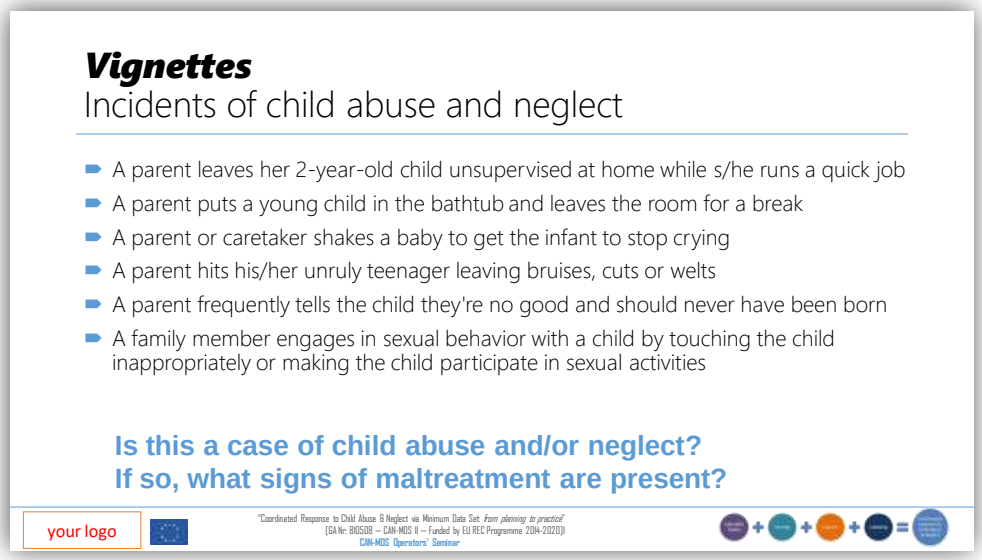
Slide 47



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

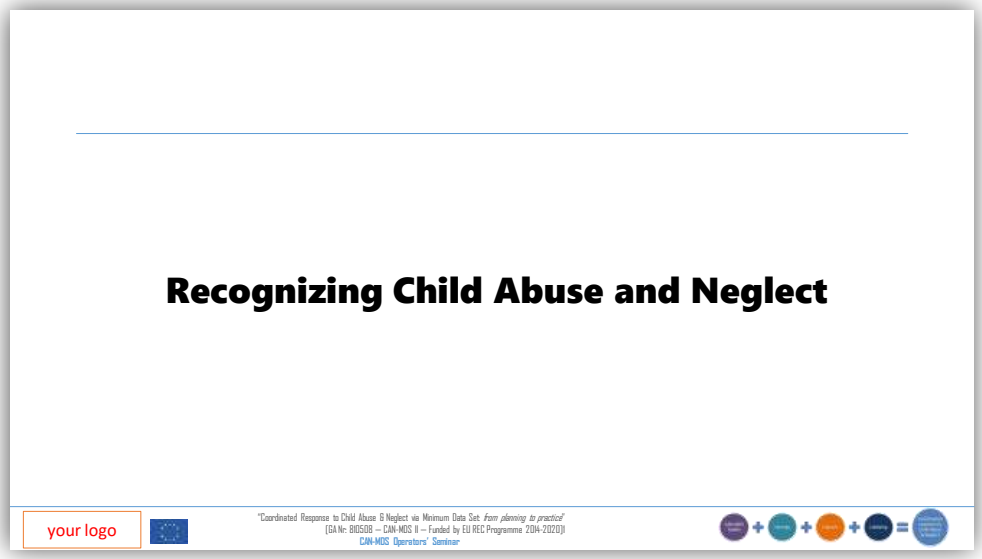
Source: McCoy, M. L., & Keen, S. M. (2013). Child abuse and neglect. Psychology Press. (link)

Slide 48



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

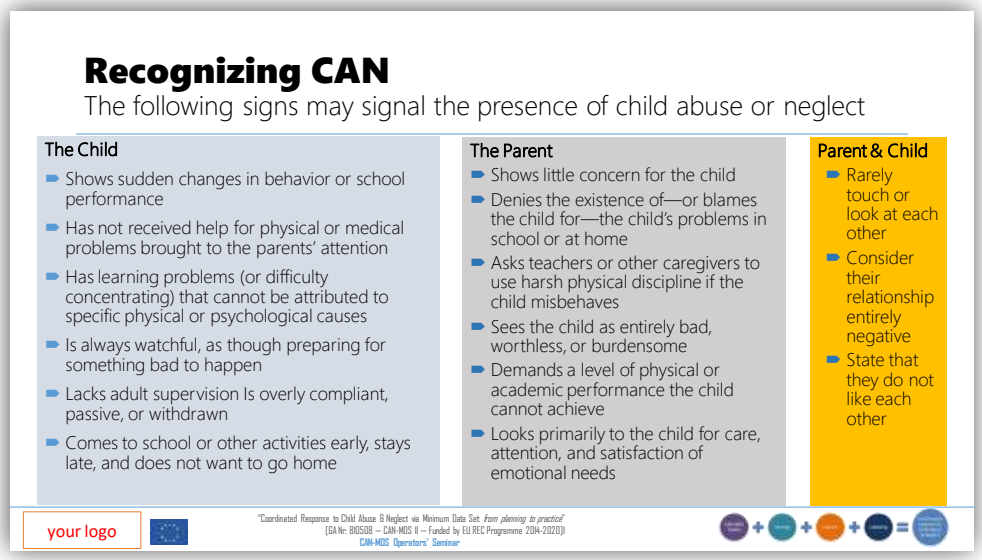
Slide 49



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



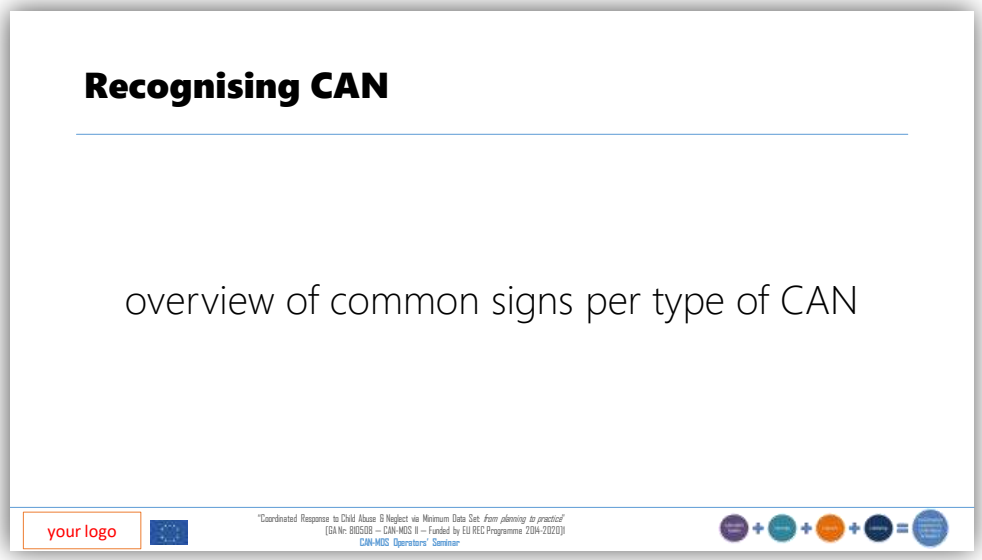
The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination.

<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



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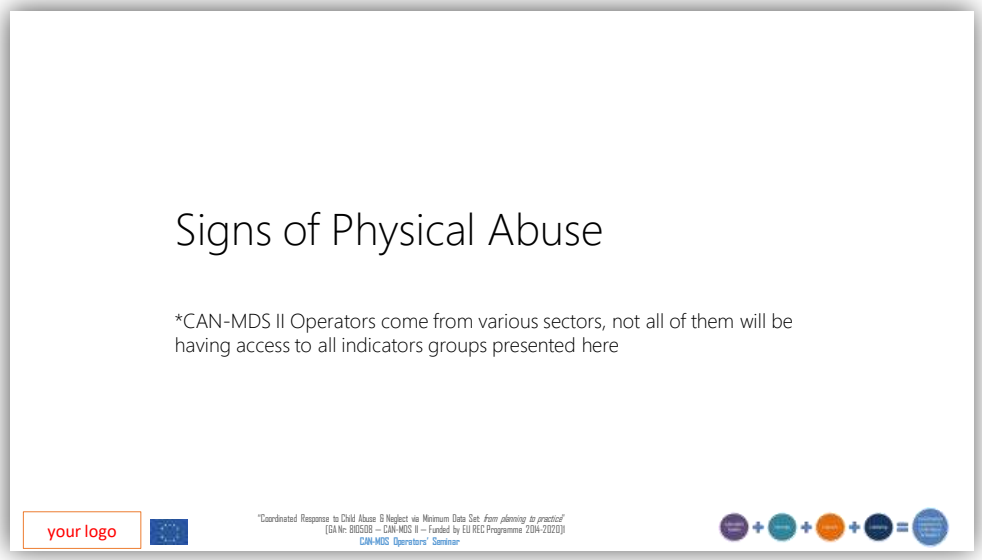

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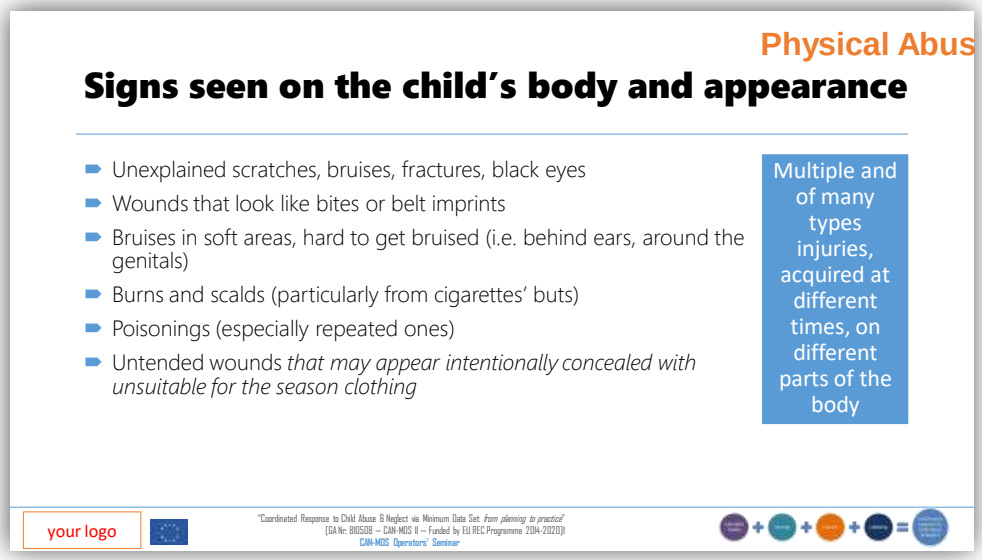

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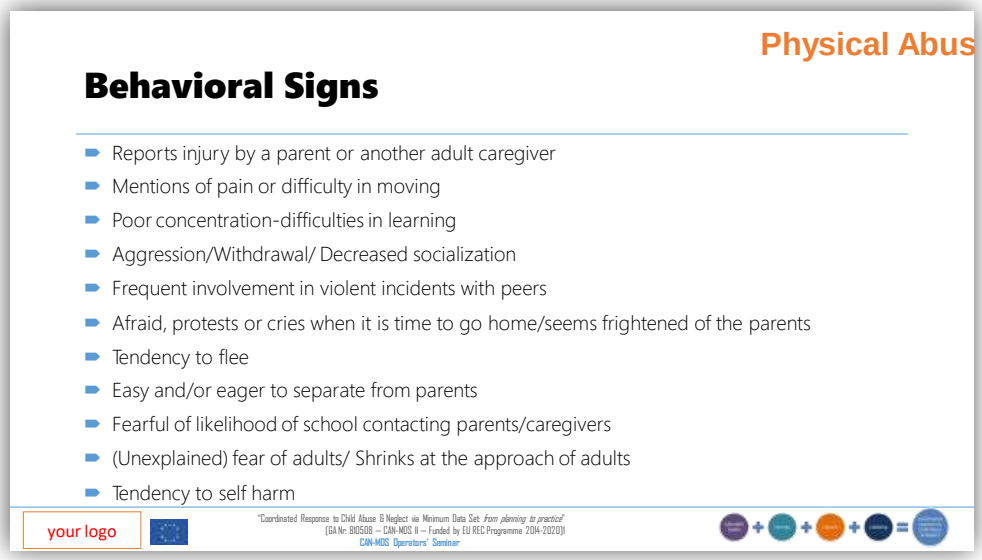

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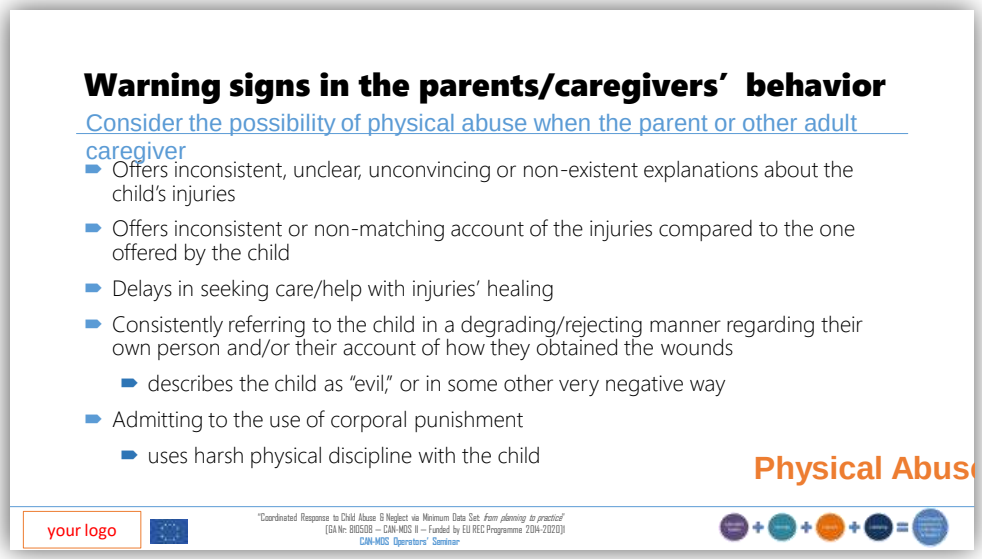

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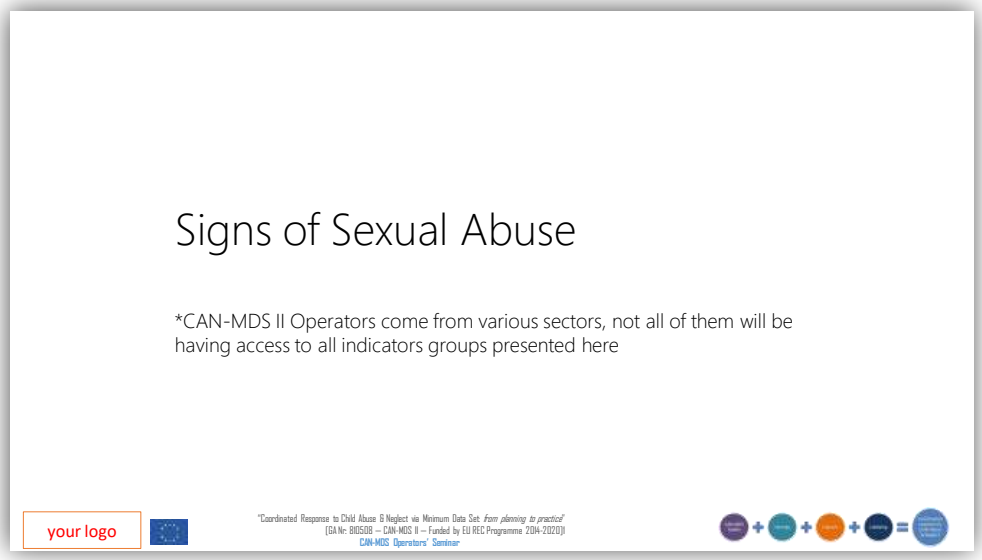
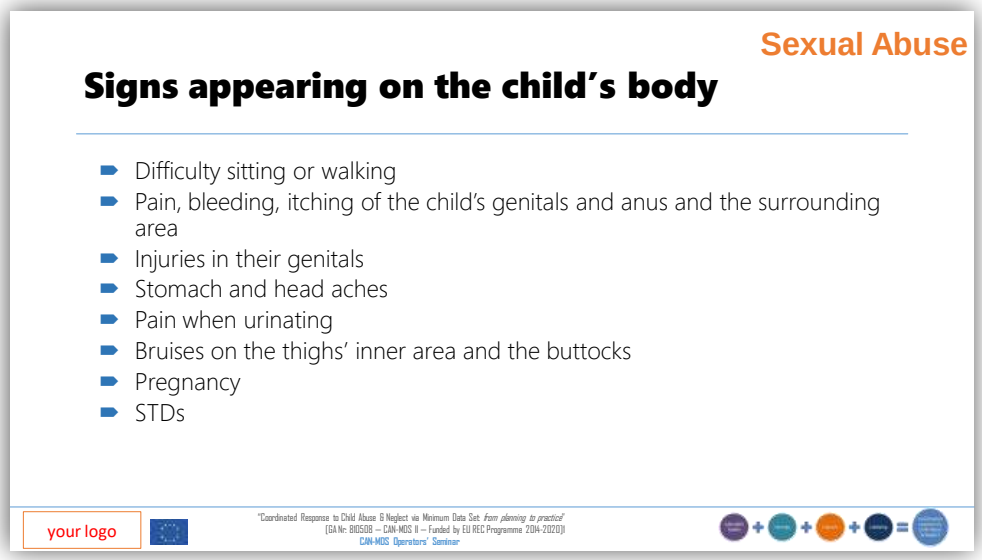


Sexual abuse usually involves someone the child knows. Often, the child will be told to keep the relationship a secret. They may be threatened with something bad happening if they tell anyone.
An adult who carries out sexual abuse with a child may have received the same treatment in the past. Breaking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

Slide 57



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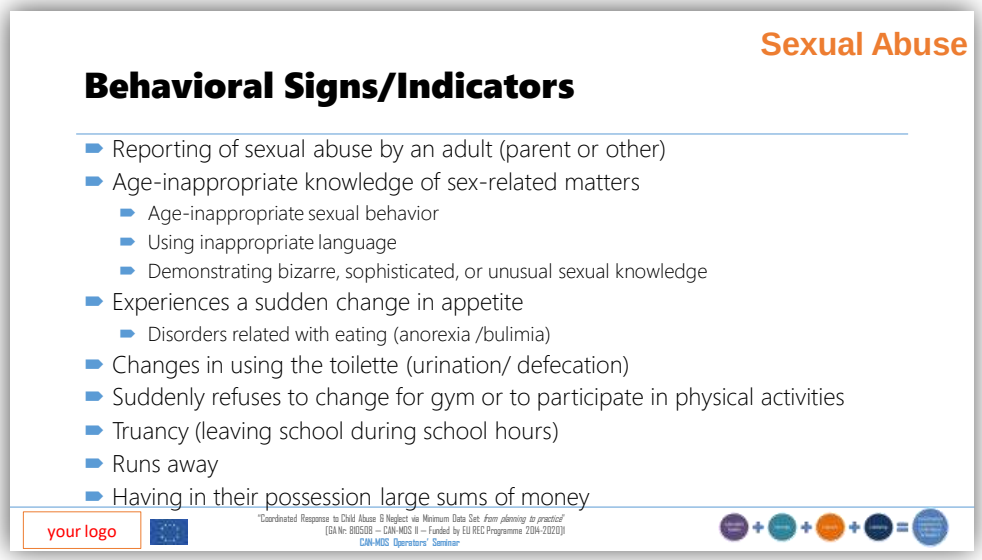

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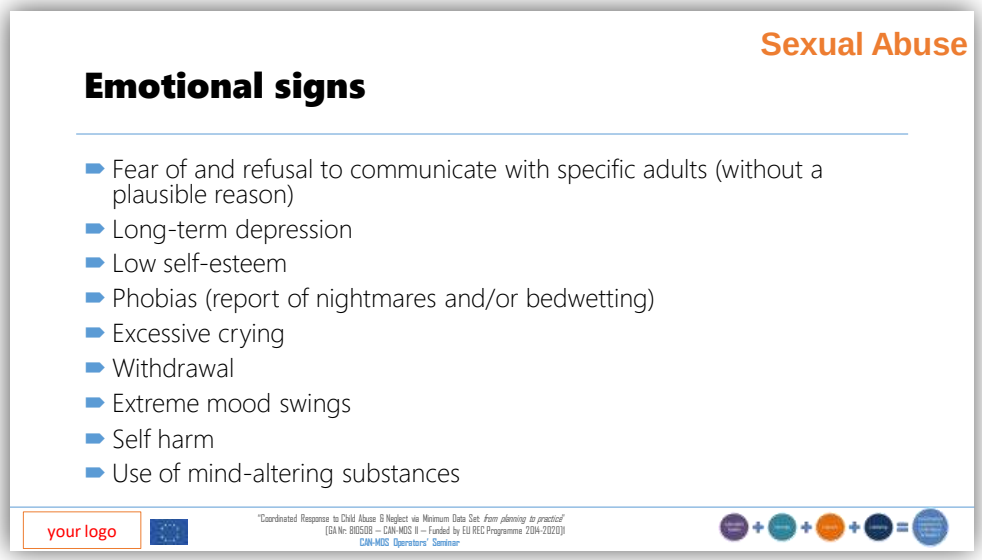

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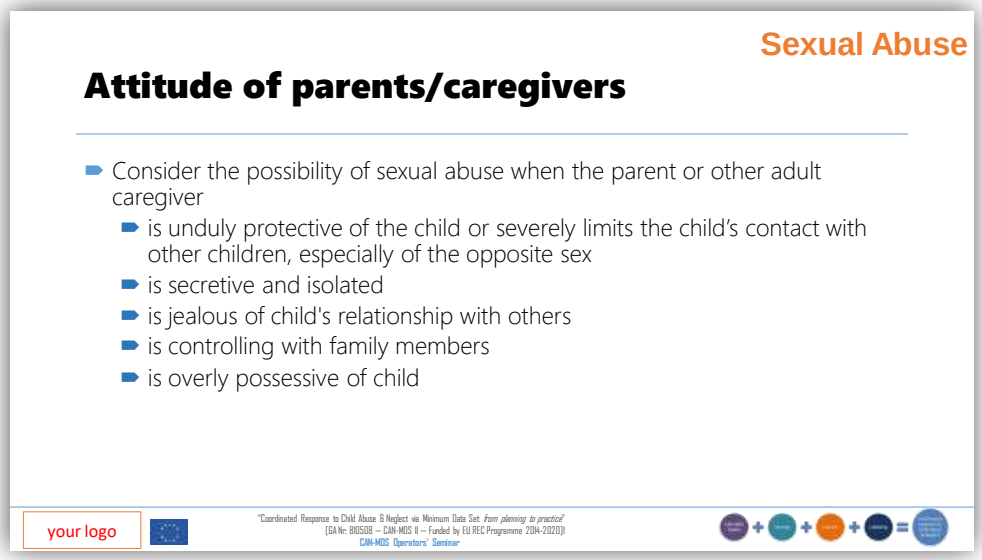

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Source: https://www.childwelfare.gov/pubPDFs/signs.pdf

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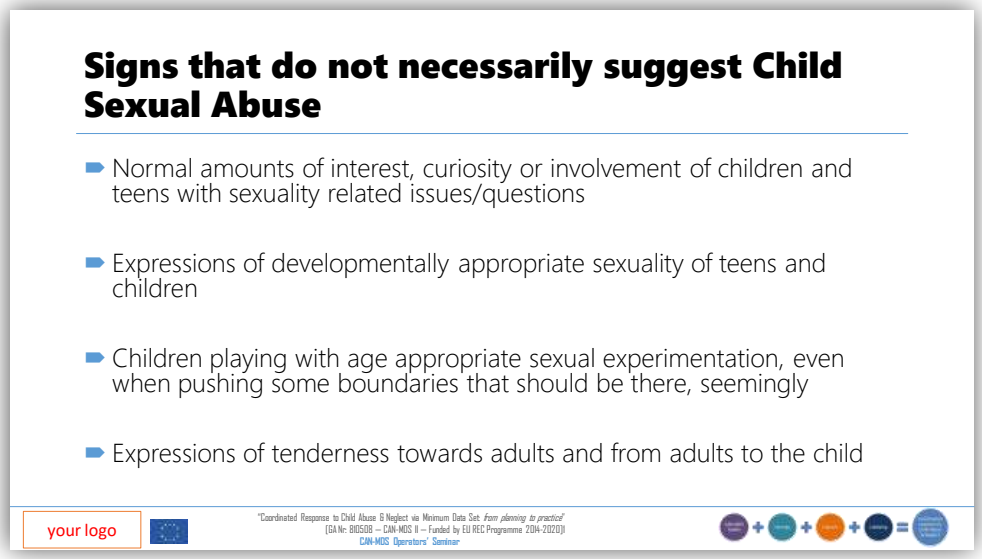

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Further notes for the trainer:

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

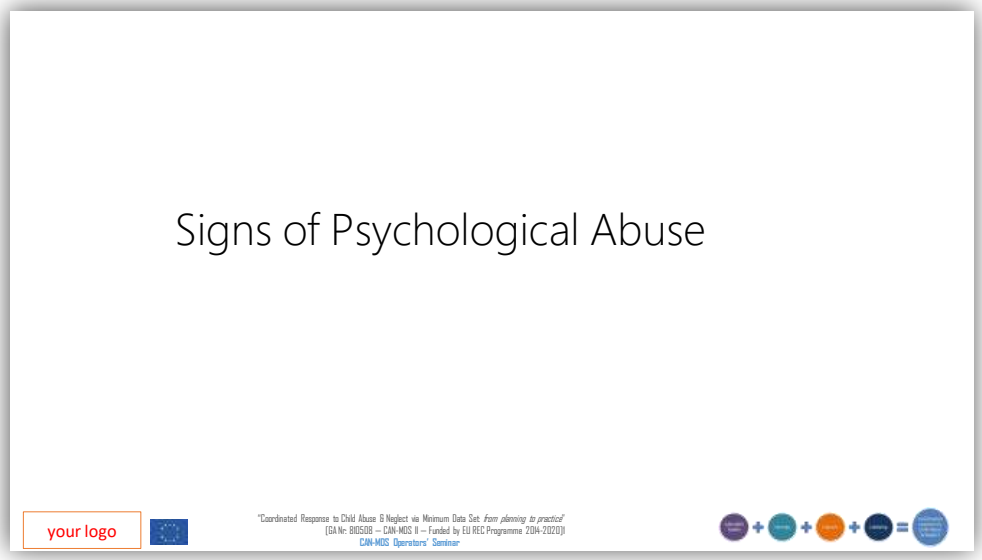
Sexual behavior problems include any act that: is clearly beyond the child's developmental stage (for example, a three-year-old attempting to kiss an adult's genitals); involves threats, force, or aggression; involves children of widely different ages or abilities (such as a 12-year-old "playing doctor"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

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

Slide 62



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.

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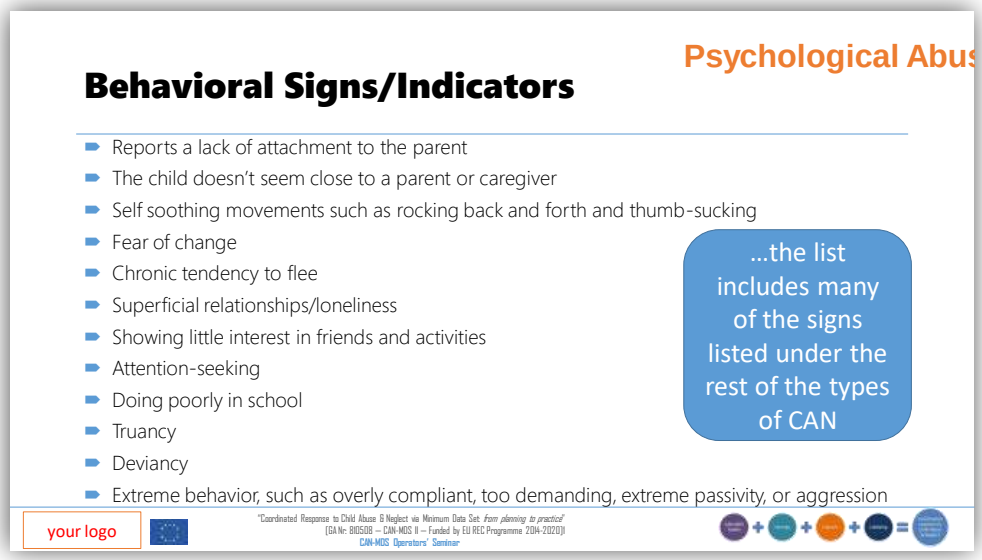

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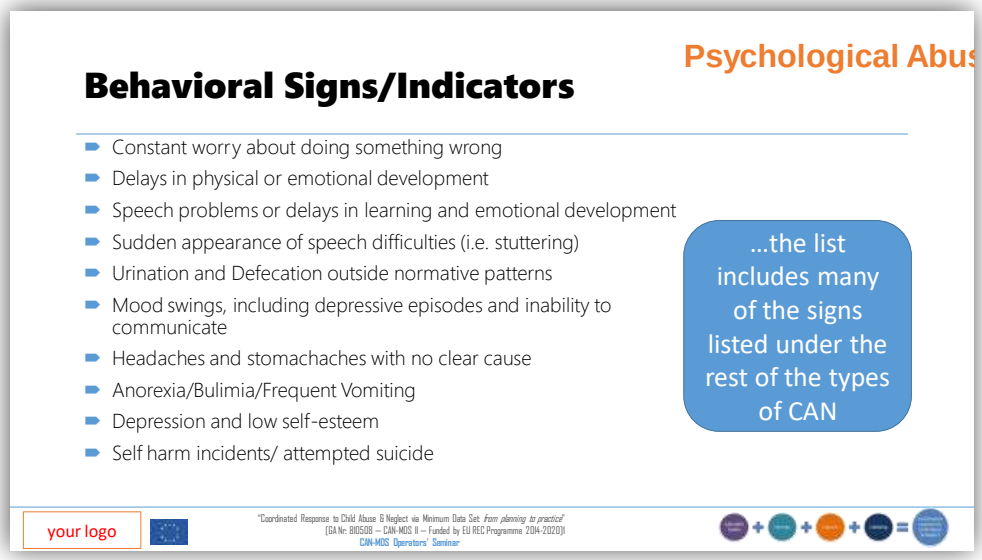

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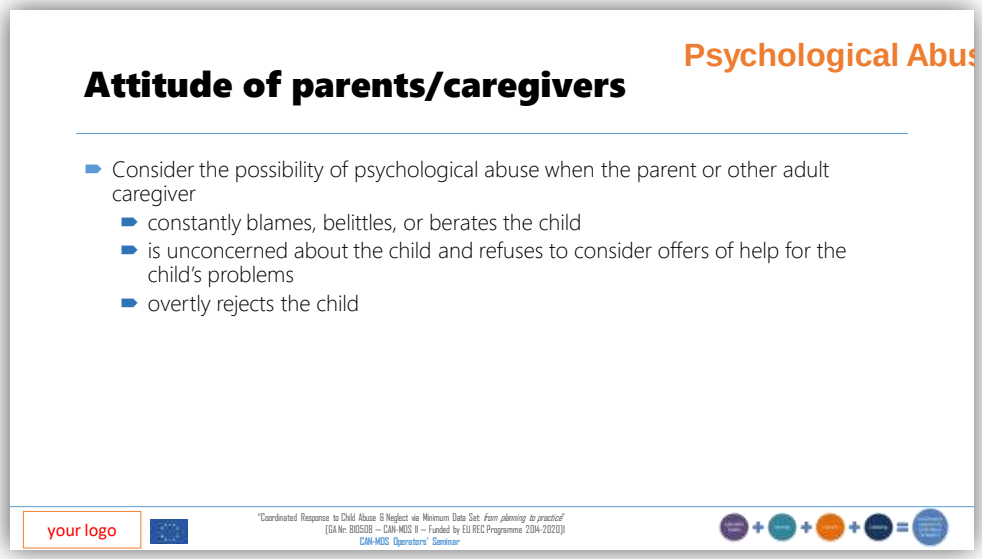

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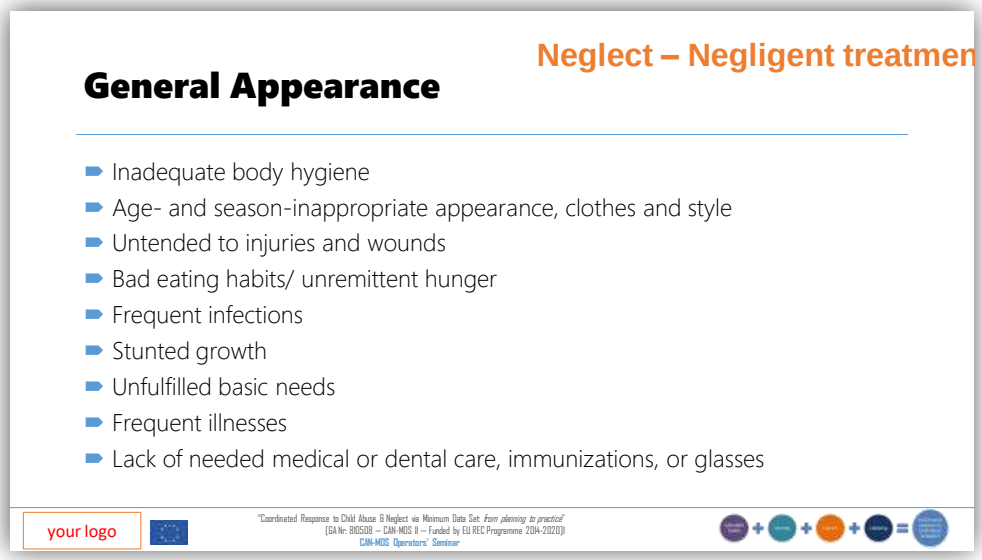
Source: https://www.childwelfare.gov/pubPDFs/signs.pdf

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



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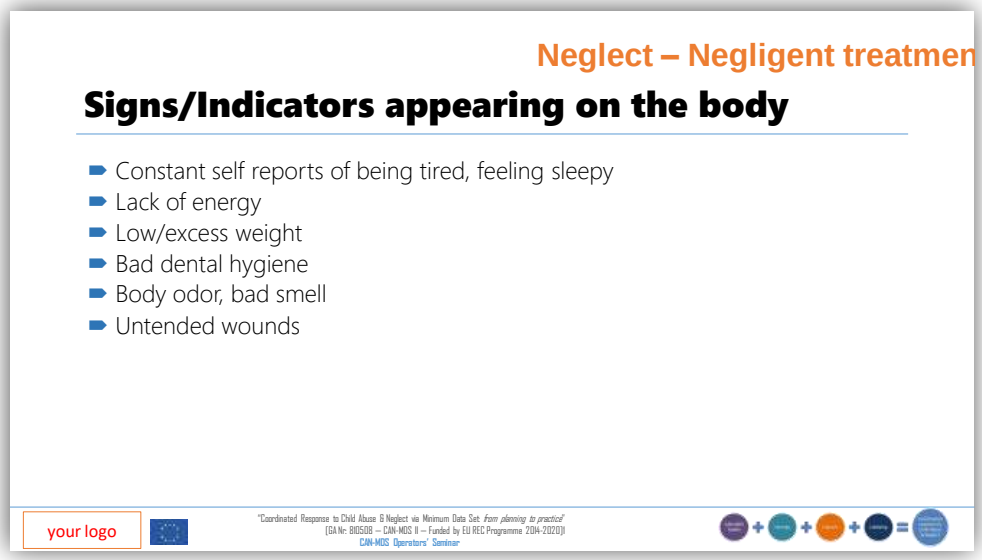
Note: A discussion may be take place on immunizations – see also the respective Working File in the Step by Step Guide for Administrators

Slide 68



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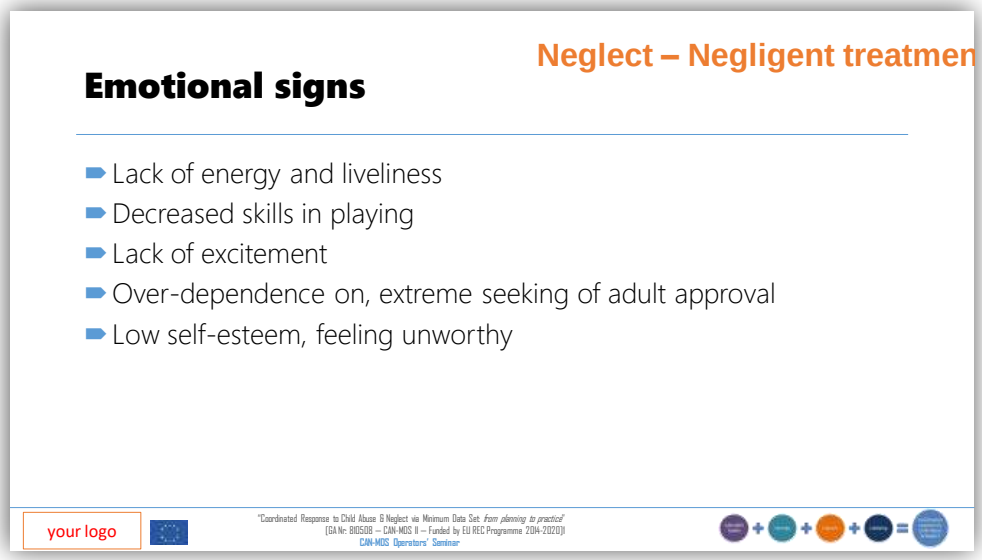

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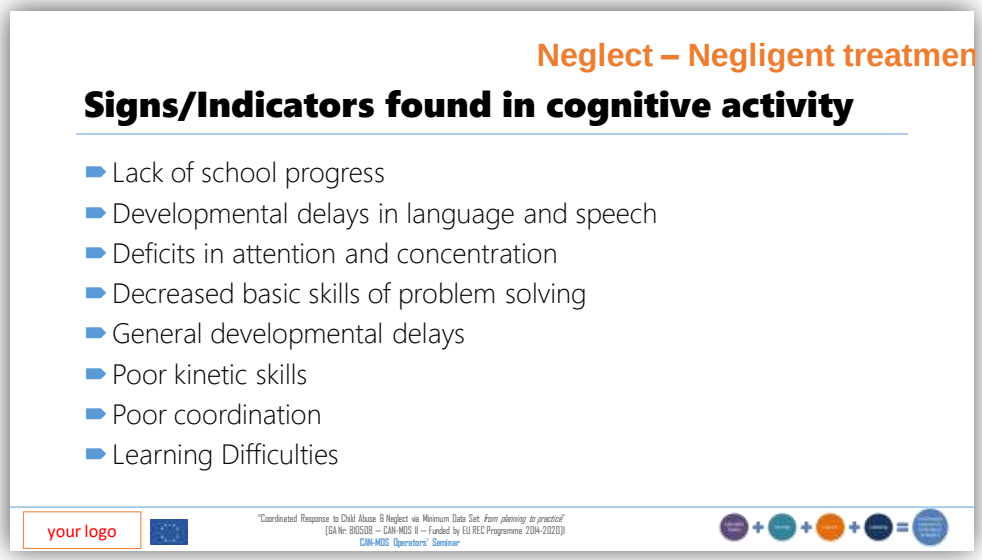

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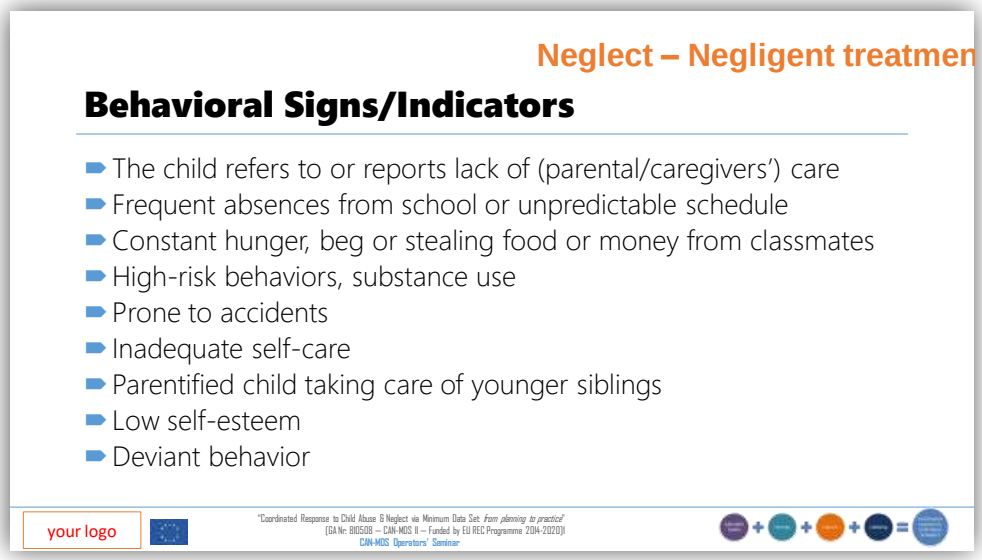

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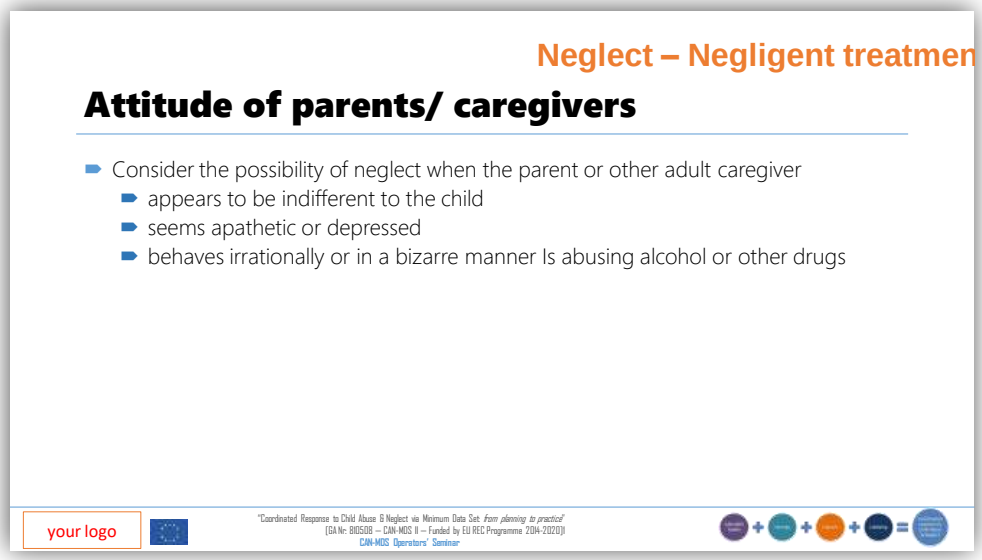

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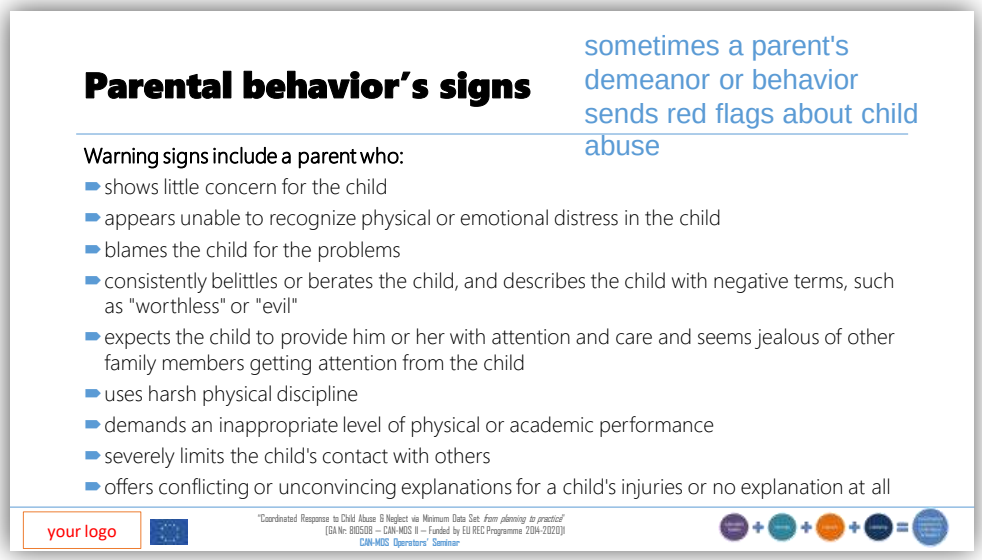

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Source: https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864

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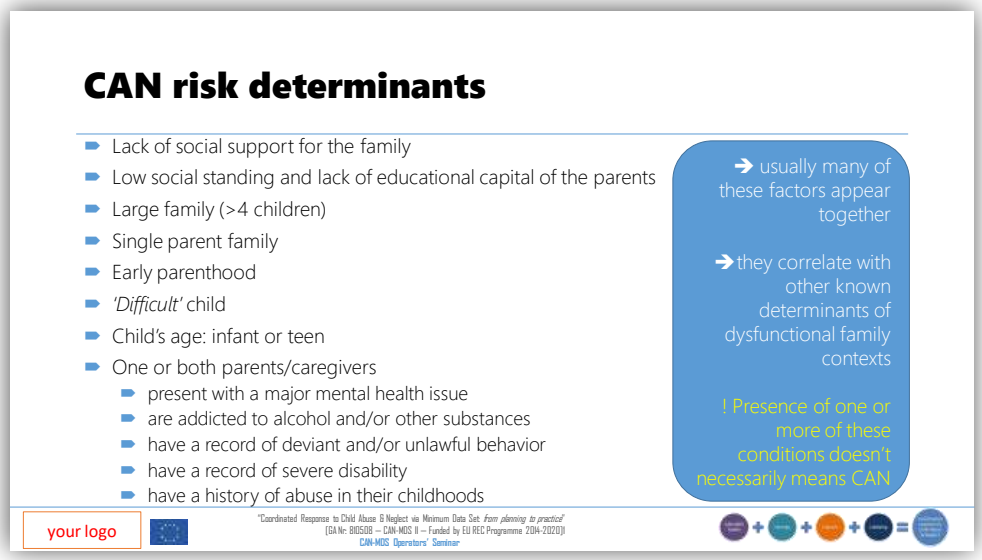

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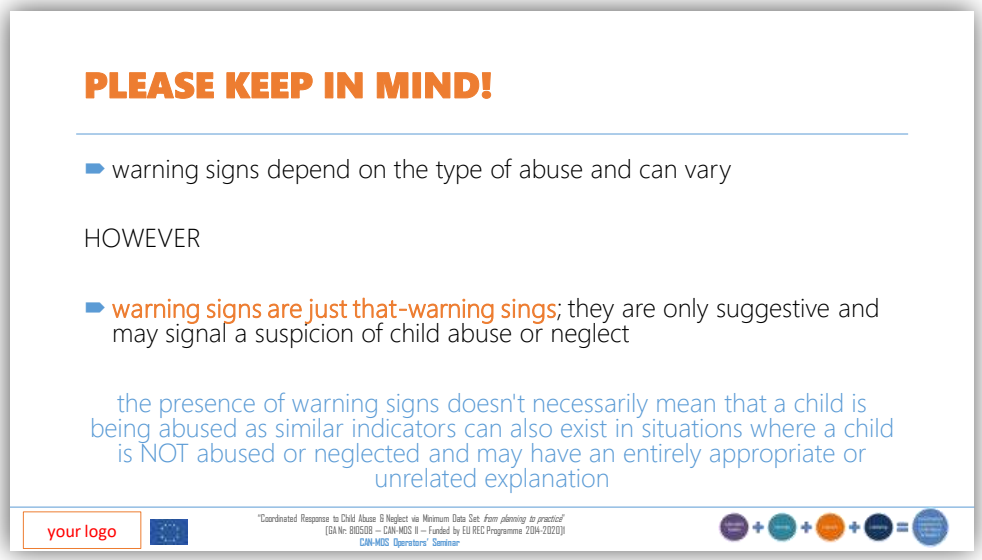

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Source: https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864

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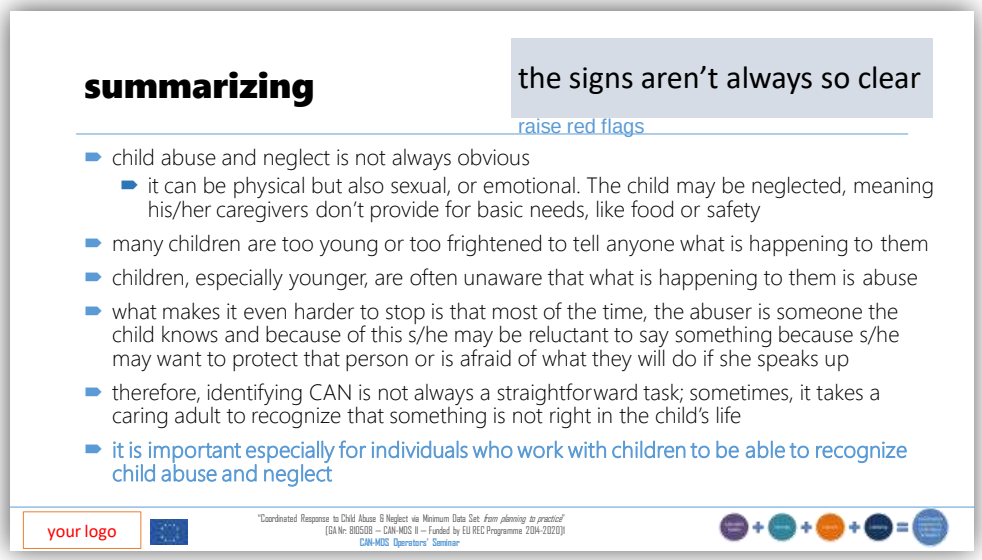

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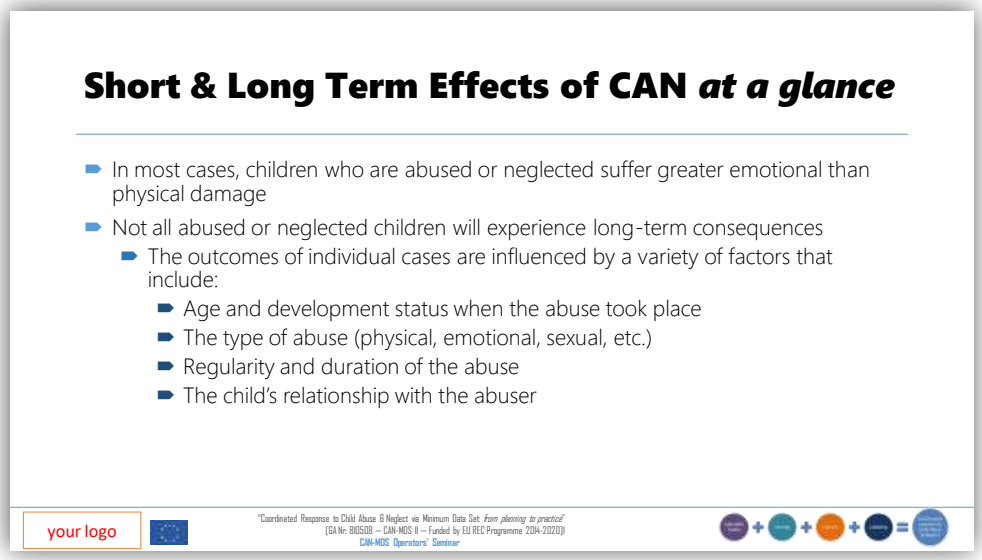
Sources:

- Recognizing child abuse available at: https://www.pa-fsa.org/Mandated-Reporters/Recognizing-Child-Abuse-Neglect/Recognizing-Child-Abuse
- Sakher AlQahtani, BDS, MClinDent, PhDAmber 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



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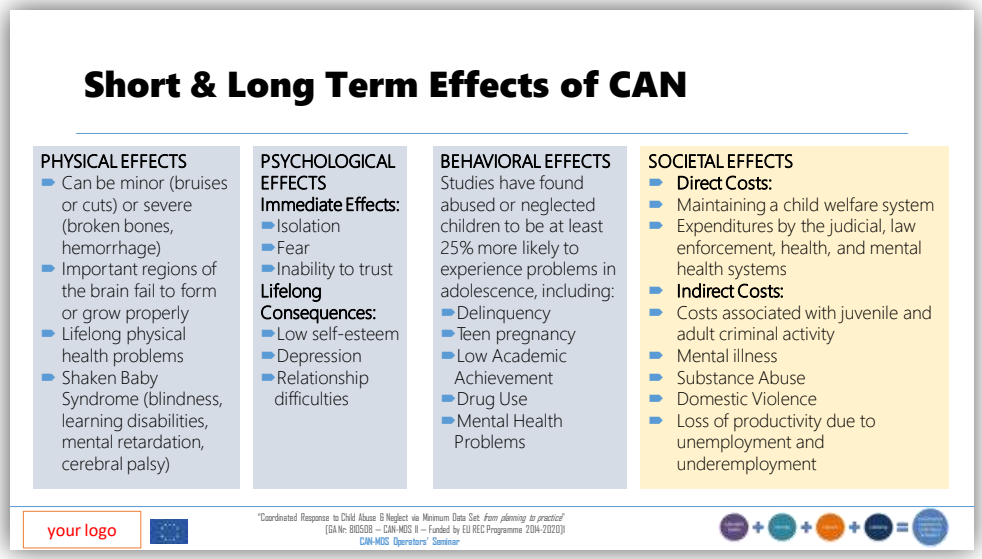

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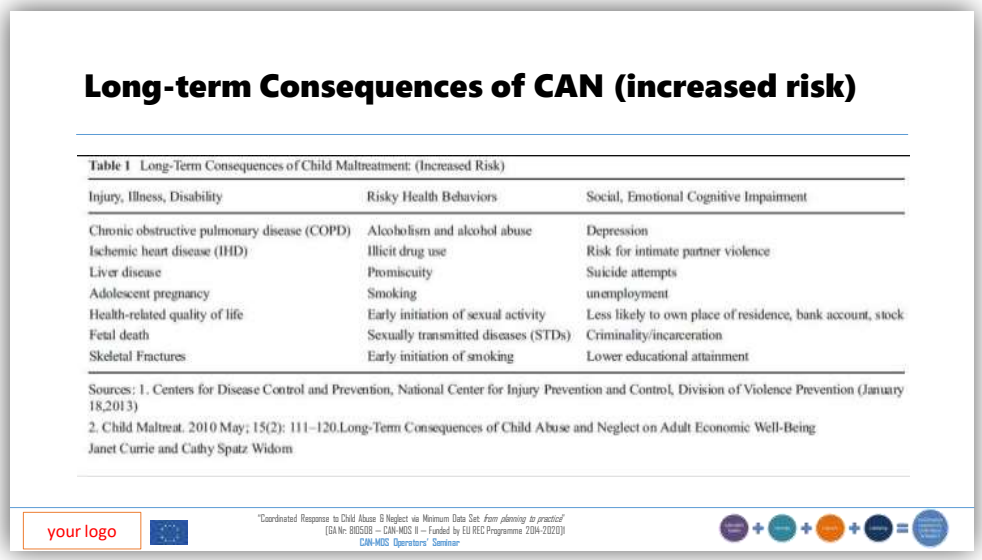
Source: http://www.butterflybridgecac.org/resourcesabuseeffects.php

Slide 79



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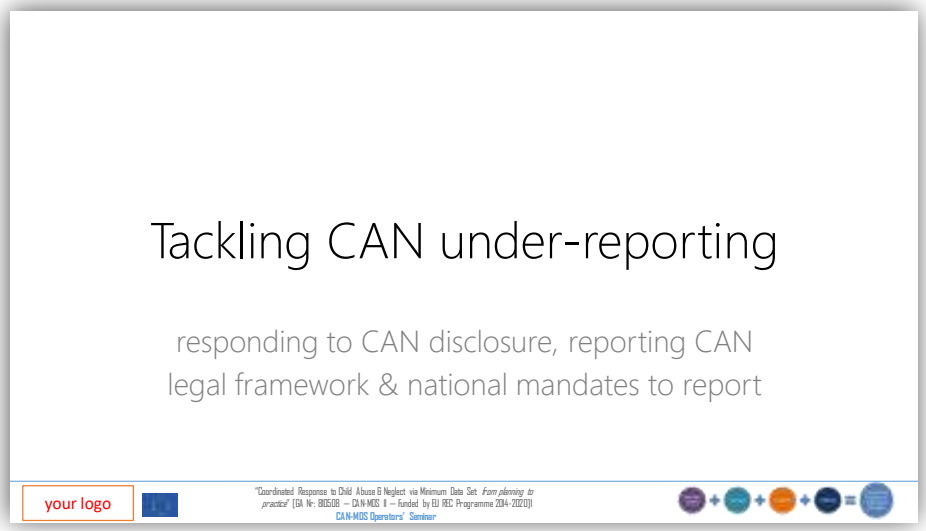
PART 6 – DURATION: 60 MIN

Slide 1



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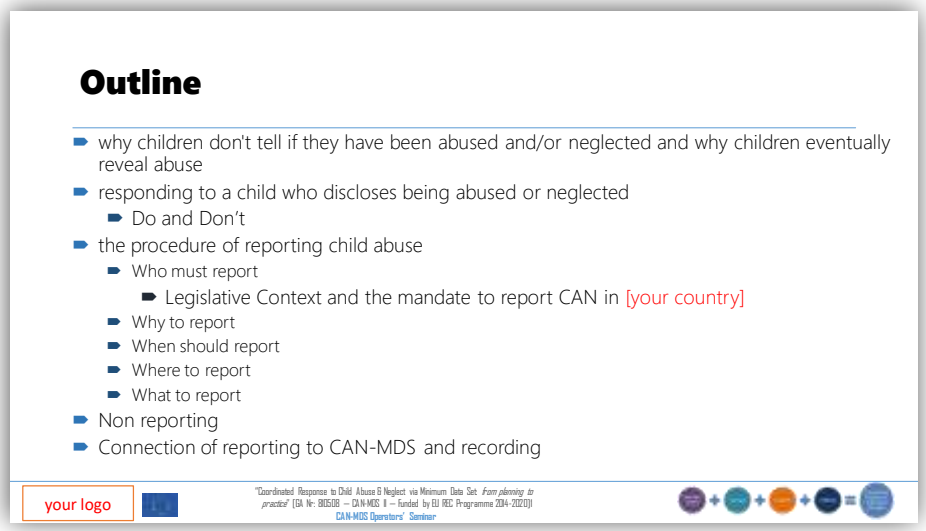
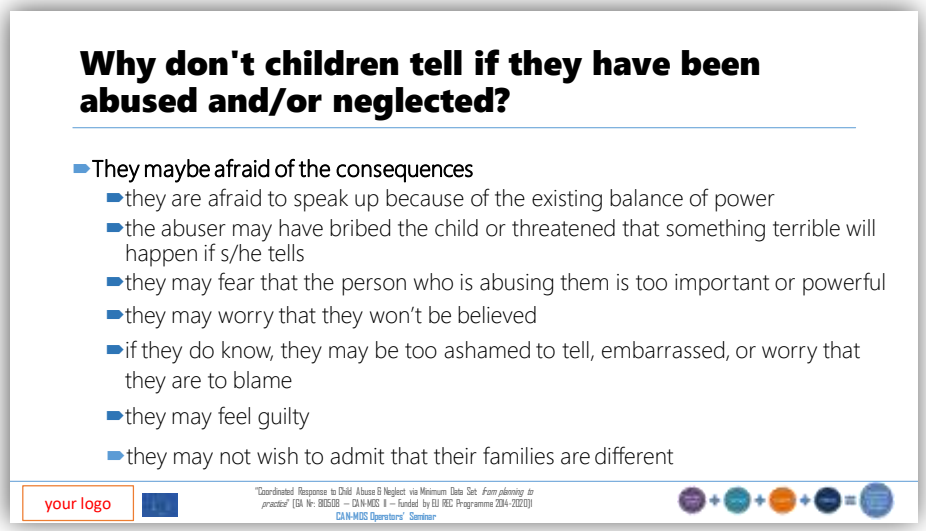


In this session we are going to explore why children don't tell if they have been abused and/or neglected and why children eventually reveal abuse.
We will discuss also about the appropriate responding to a child who discloses being abused or neglected and the procedure of reporting (Who must report, 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



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

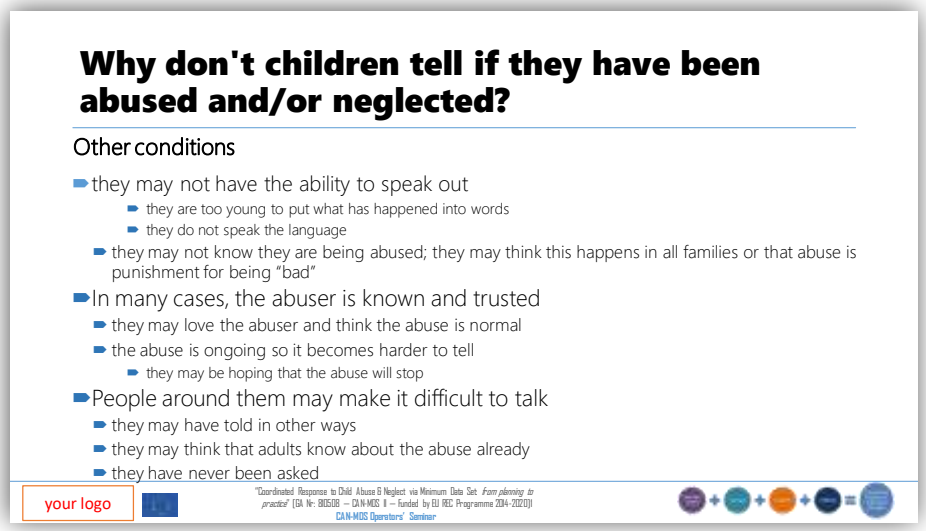
It can take a lot of courage for a child to approach an adult and disclose information about abuse, so it's understandable that the child may choose not to say anything just in case the adult doesn't believe what they are being told. The child may prefer to keep quiet rather than risk being humiliated, 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.highspeedtraining.co.uk/hub/disclosure-child-abuse/

Slide 4



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

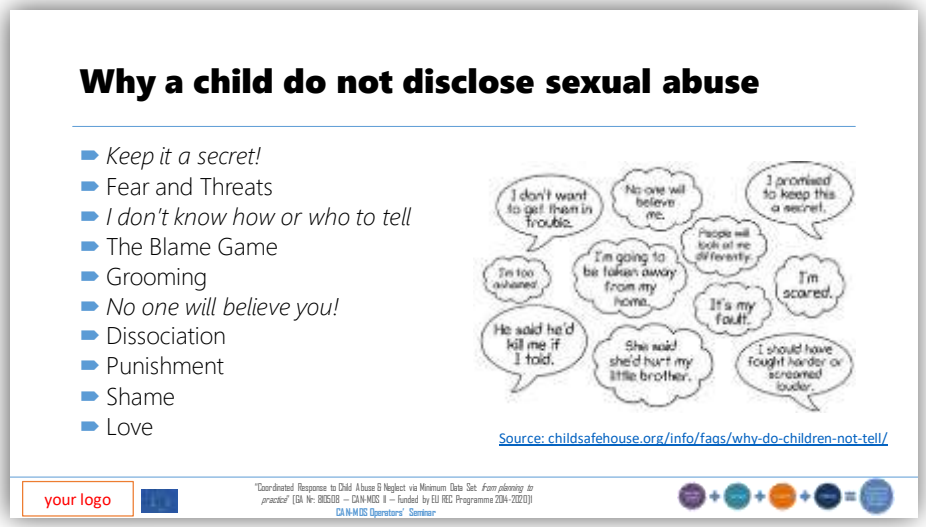
A child may refrain from speaking out about the abuse they are suffering because they believe that the situation is only temporary and that it will soon stop. The child may think they are being punished for something, or that the abuse is just a part of normal life, and may be waiting for the moment 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.highspeedtraining.co.uk/hub/disclosure-child-abuse/

Slide 5



[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

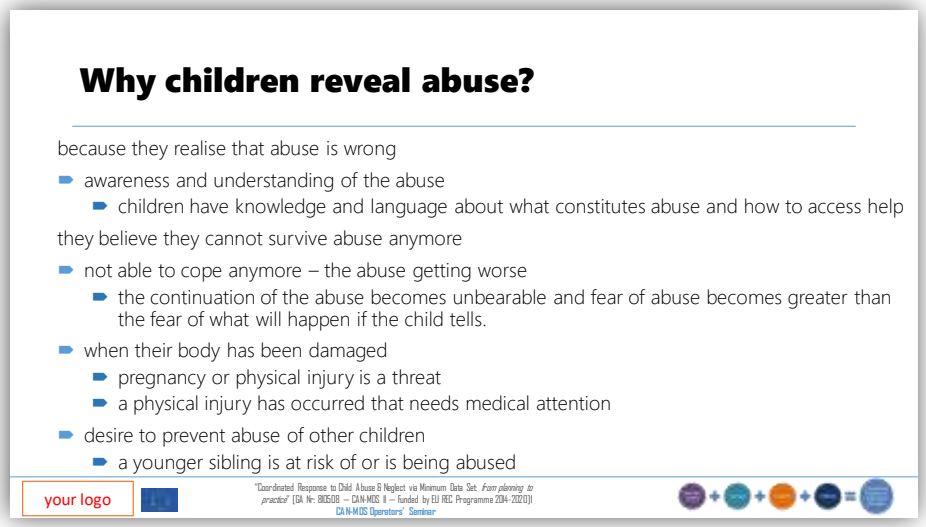
A Romeo-Juliet scenario exists where the child thinks s/he is in love with an older perpetrator

Sources:

Townsend, C. (2016). Child sexual abuse disclosure: What practitioners need to know. Charleston, S.C., Darkness to Light. Retrieved from www.D2L.org.

https://www.traversebaycac.org/2018/07/13/10-reasons-children-dont-disclose-sexual-abuse/

Slide 6



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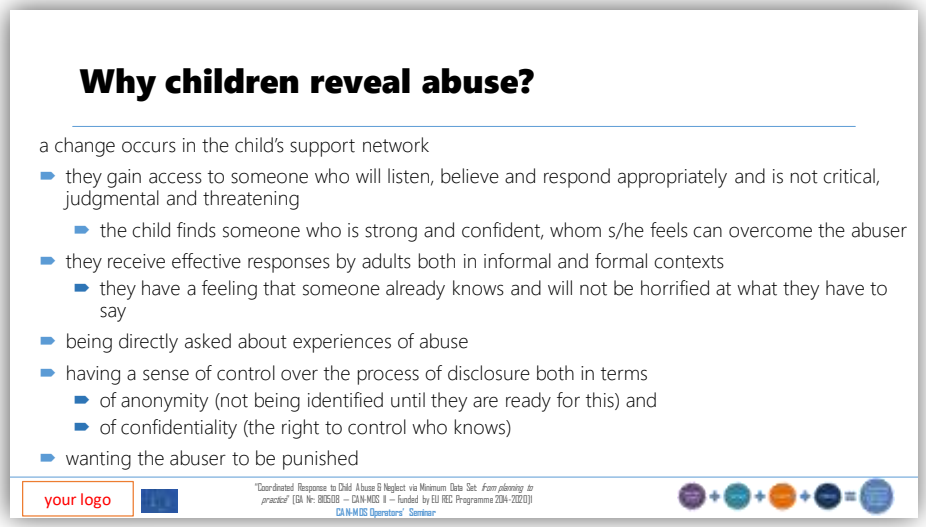

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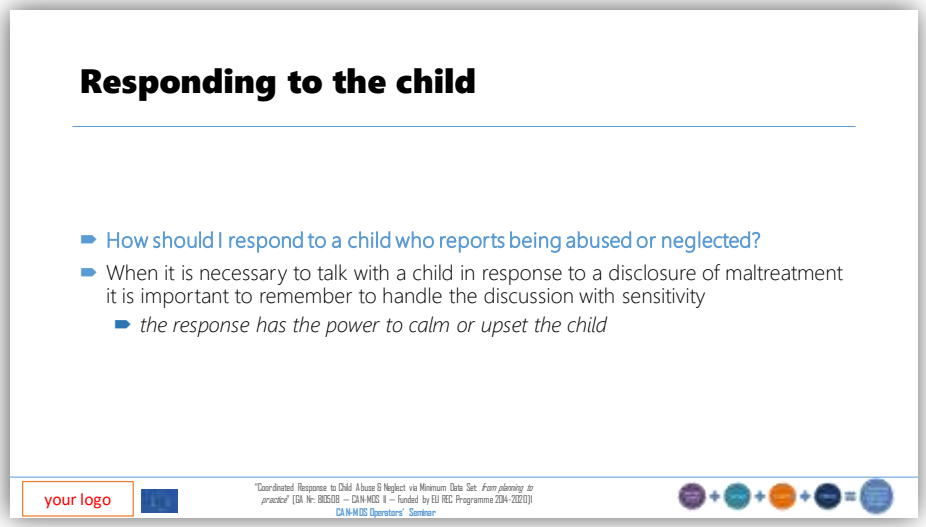

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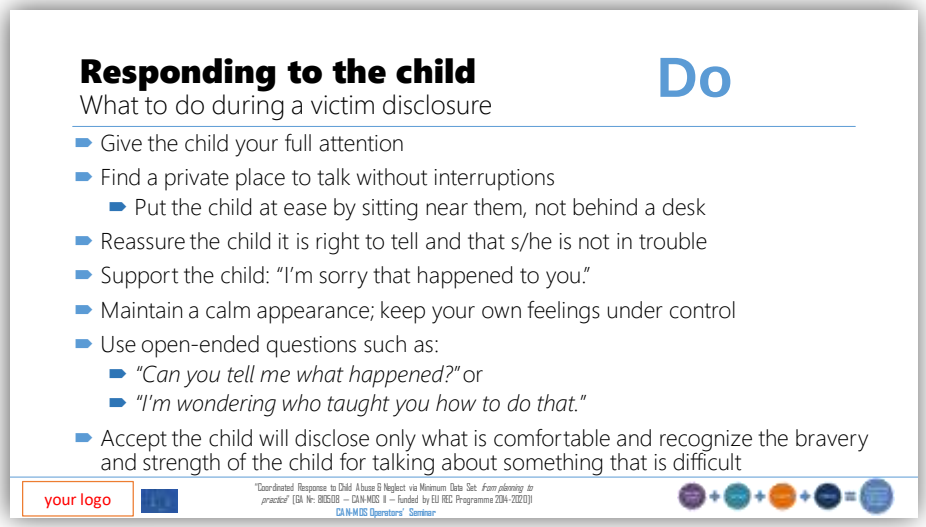
Source:
A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: Link

Slide 9



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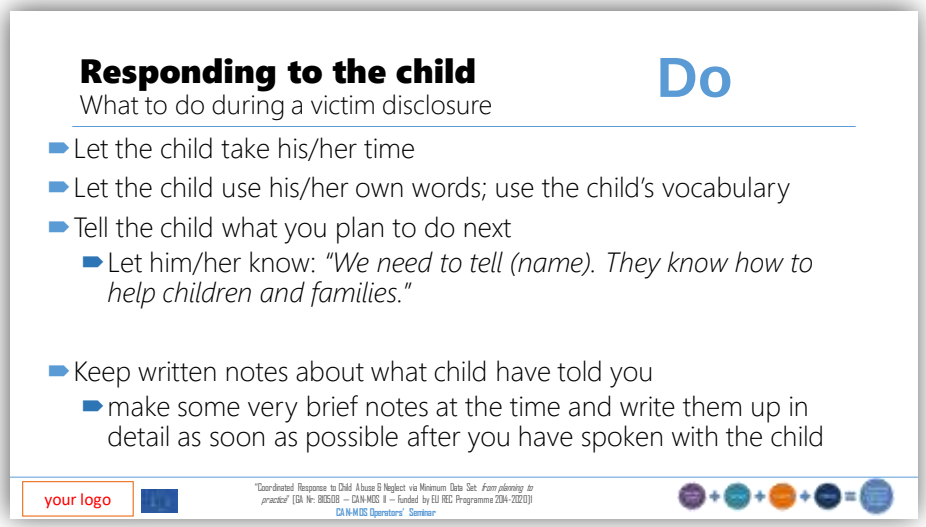
Sources:

- 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



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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.

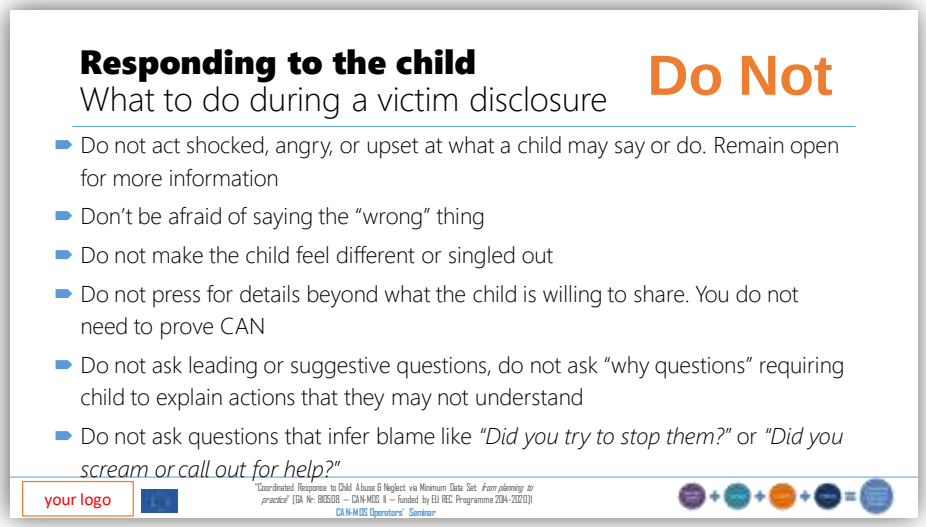
Record the date, time, place, words used by the child and how the child appeared to you – be specific.

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

Slide 11



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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

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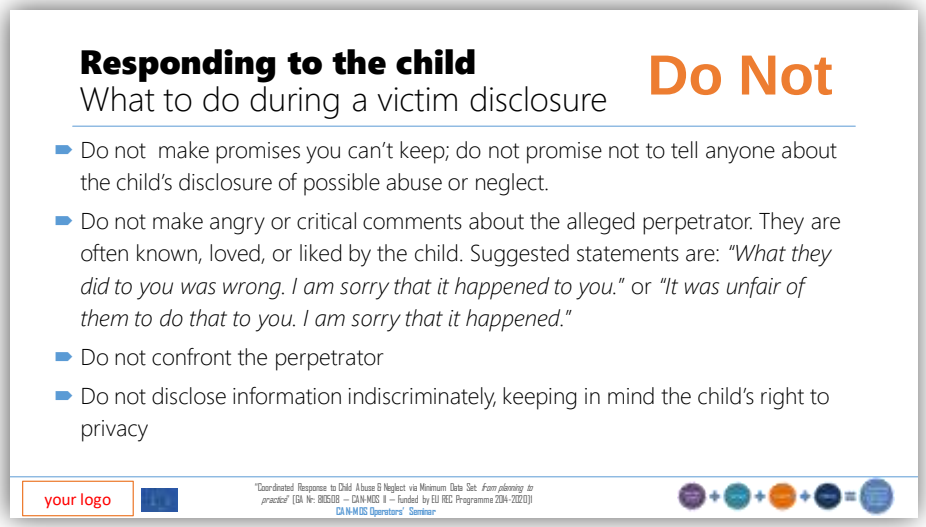

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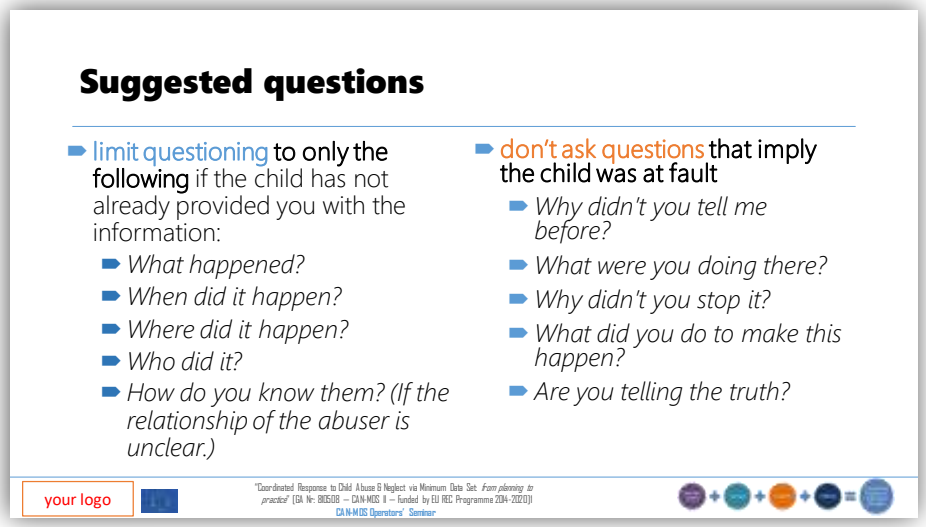
Sources:

- 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



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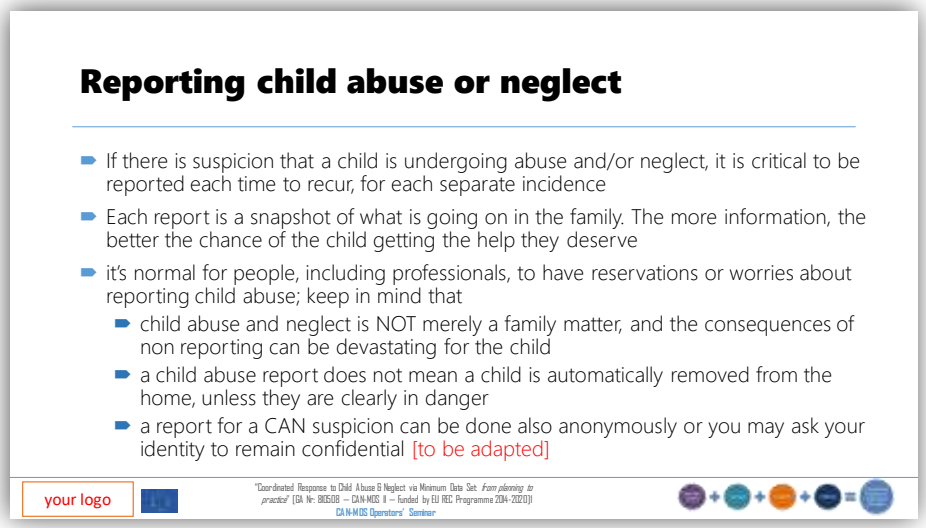
Also:
- listen to the child, letting them explain what happened in his or her own words; don't stop child in the middle of the story to go get someone or do something else
- reassure the child that he/she is not at fault and have done nothing wrong

Slide 14



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

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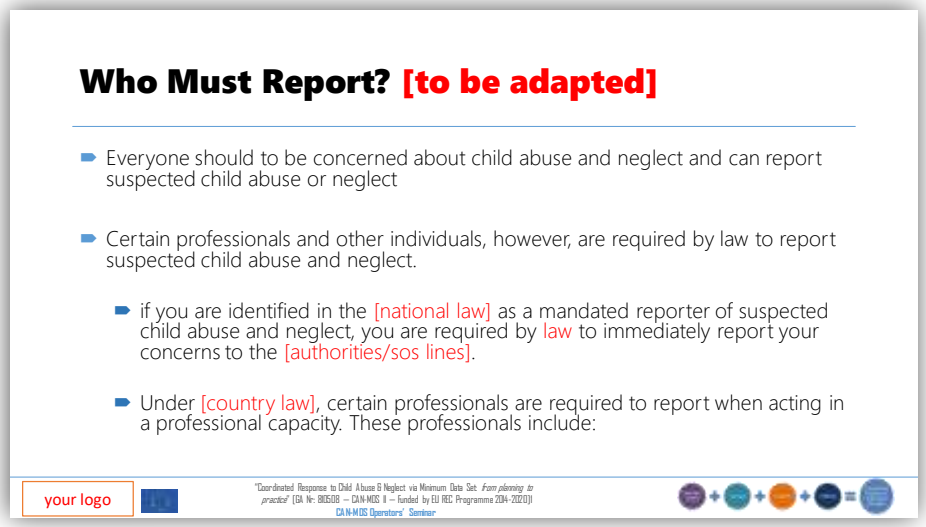
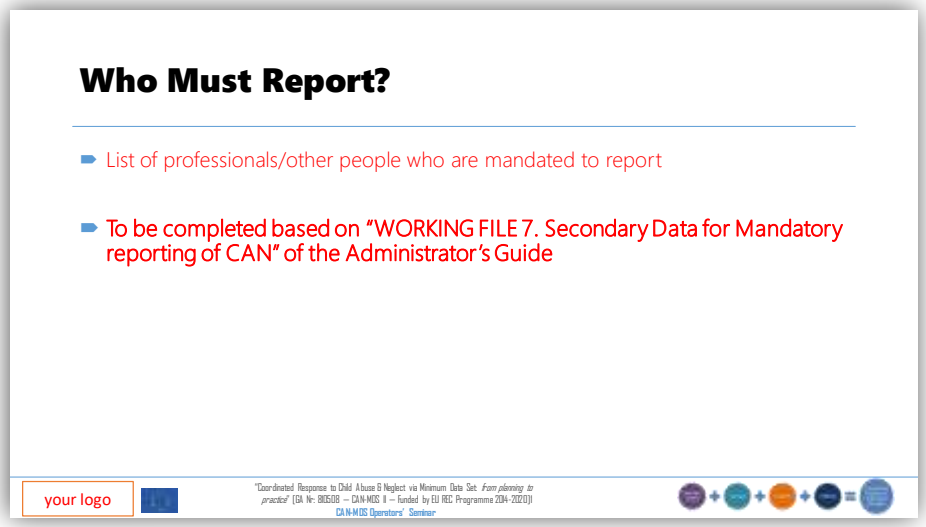


[Instruction – to be adapted according to country specifics]

Slide 16

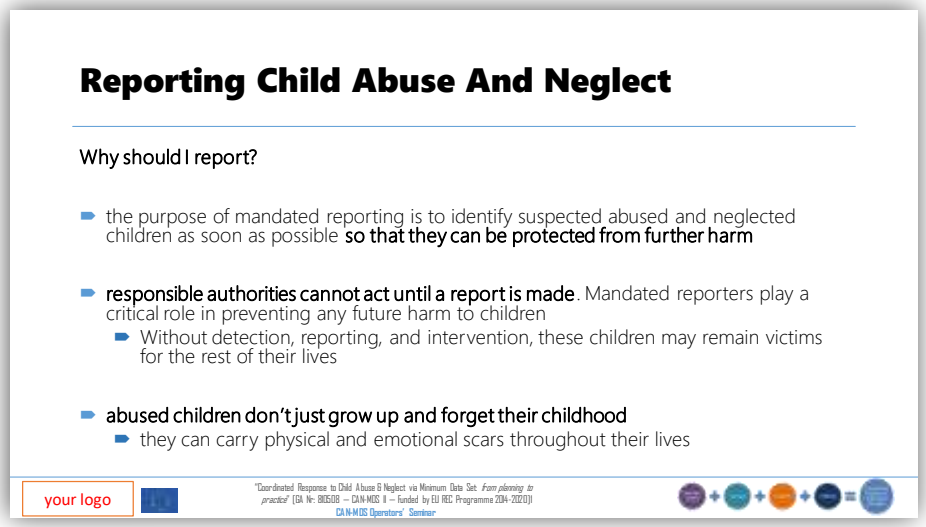


[Instruction - To be completed based on "WORKING FILE 7. Secondary Data for Mandatory reporting of CAN" of the Administrator's Guide]

Slide 17

[Instruction – to be adapted according to country specifics]

Slide 18



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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

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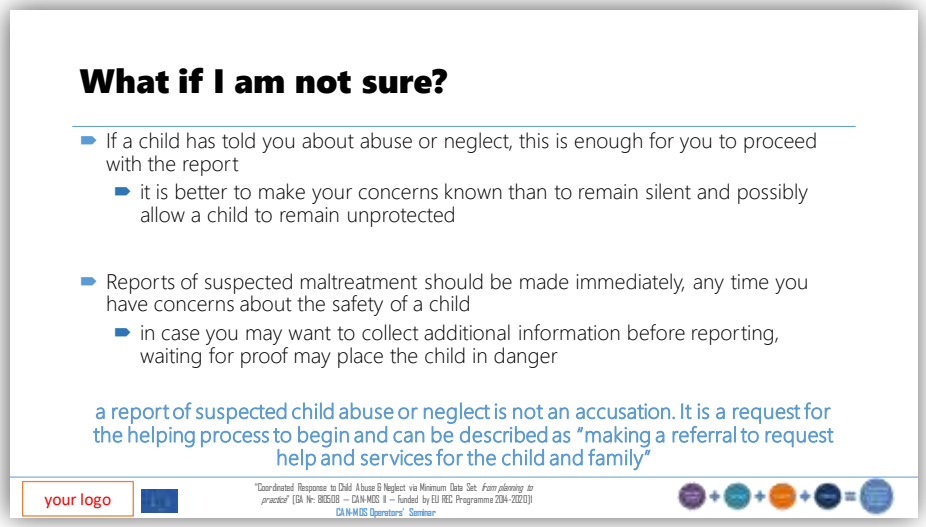

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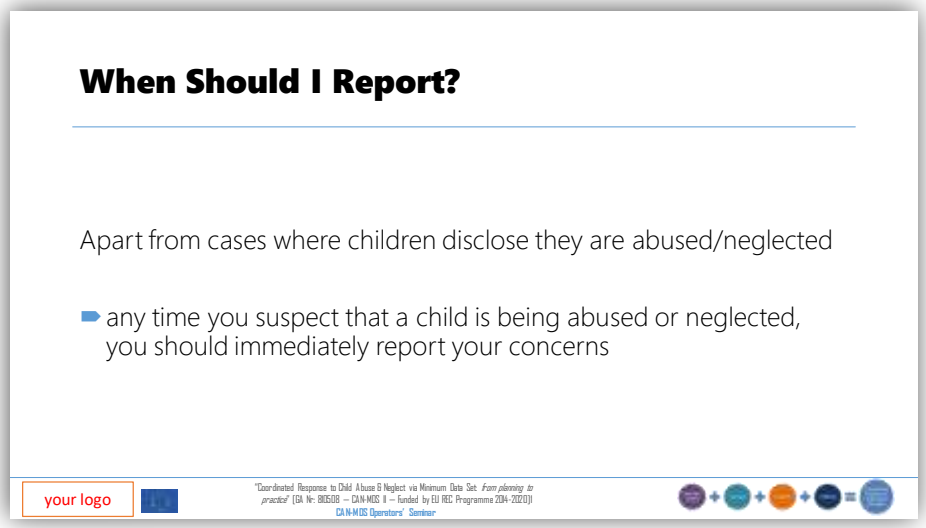
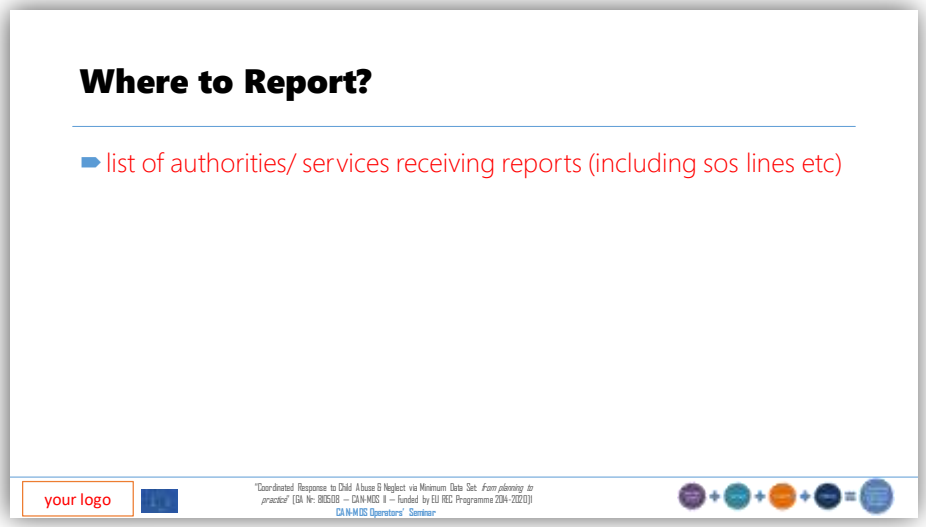
Source:
A Guide For Mandated Reporters In Recognizing And Reporting Child Abuse And Neglect. Commonwealth of Virginia Department of Social Services Child Protective Services. Available at: Link

Slide 20



[Instruction - If different in your country, please adapt according to country specifics]

Slide 21



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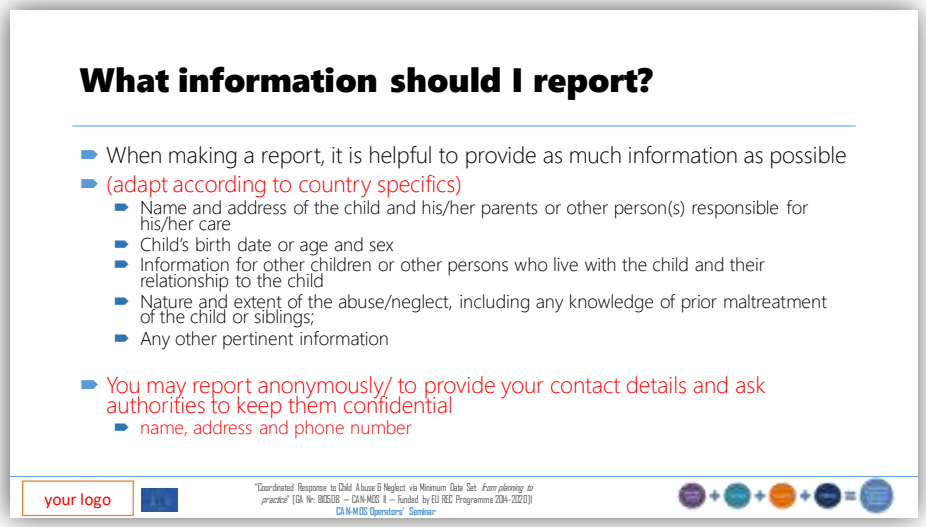
Slide 22



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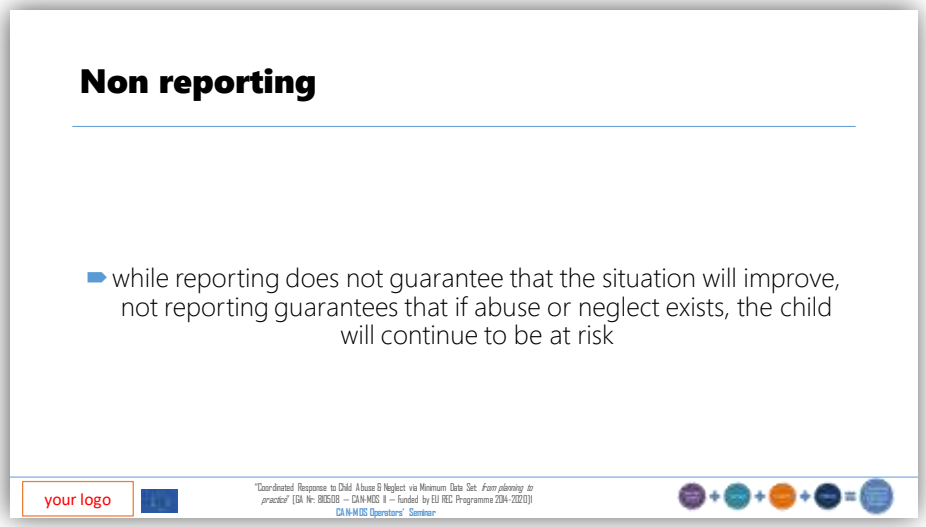
Slide 23



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.

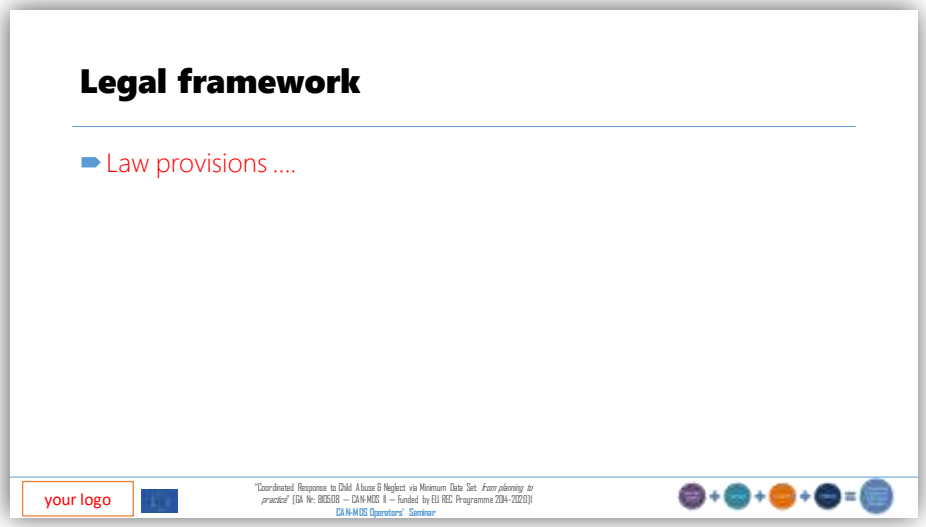
-Professionals who have had an unsatisfactory experience when reporting suspected child abuse or neglect may be reluctant to report a second time. These professionals may have been discouraged from reporting, or may have developed a distrust of Authorities, feeling that a previous referral was not handled 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

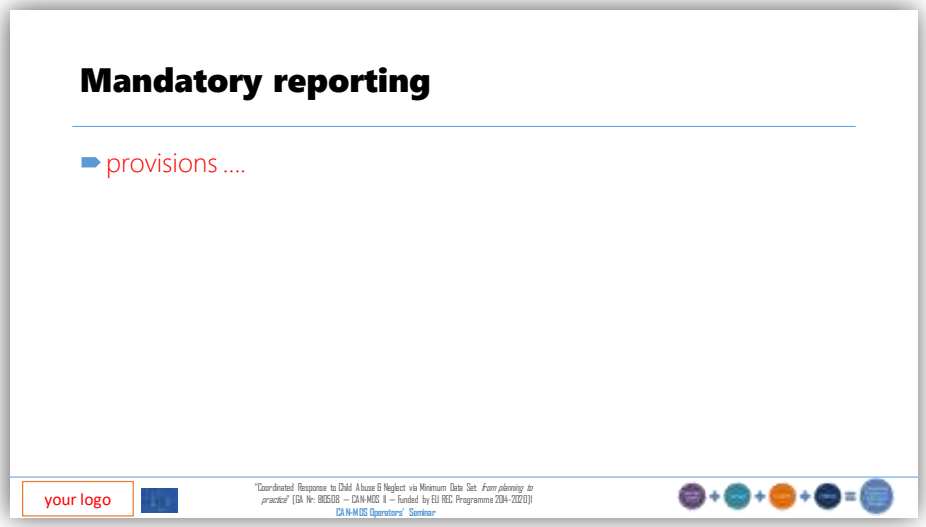
[Instruction – to be adapted based on information included in the Operator's Manual, ***What is provisioned by the National Law*** and Step by step Guide for Administrators, **Working File 7**]

Slide 25



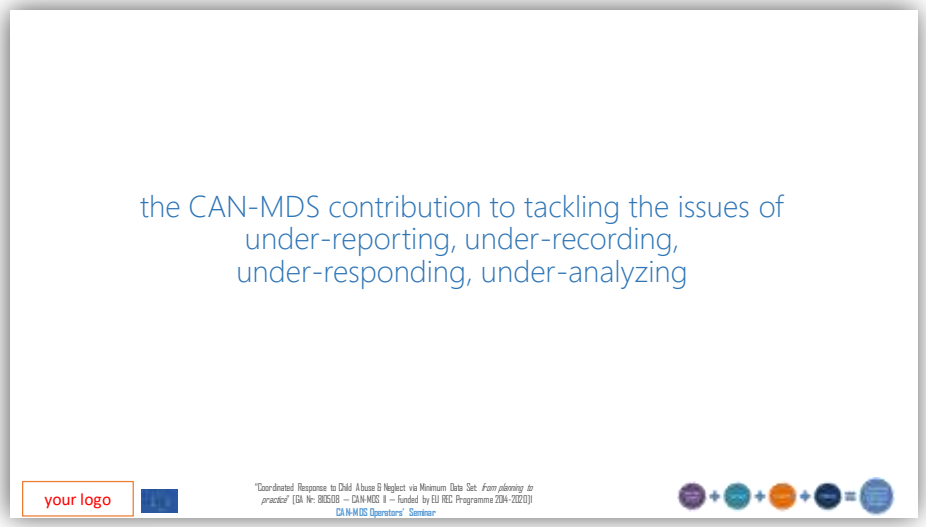
[Please use information from the respective chapter of national Operator's Manual]

Slide 26



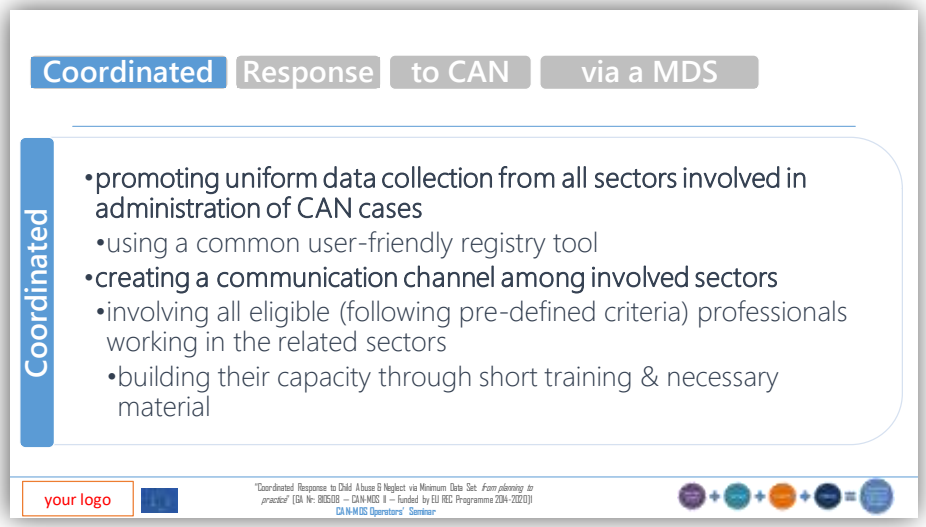
[Please use information from the respective chapter of national Operator's Manual]

Slide 27



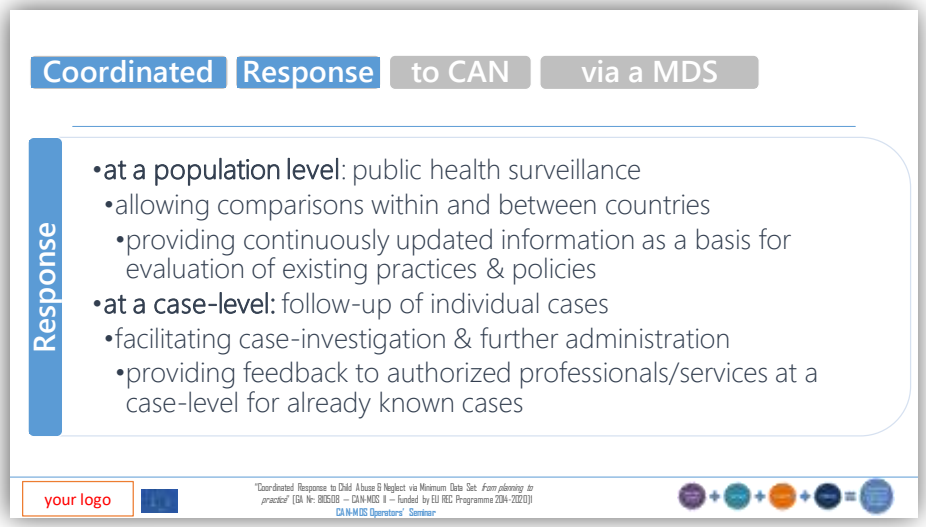
[We suggest presenting the meaning of each component of the project's (CAN-MDS) acronym, as we have, here, as they relate directly to the issues under discussion, here, in this part of the training. You are welcome to add comments that make more sense for your country's situation, or change the emphasis during the presentation to more accurately reflect your audience's areas of interest and/or concern]

Slide 28

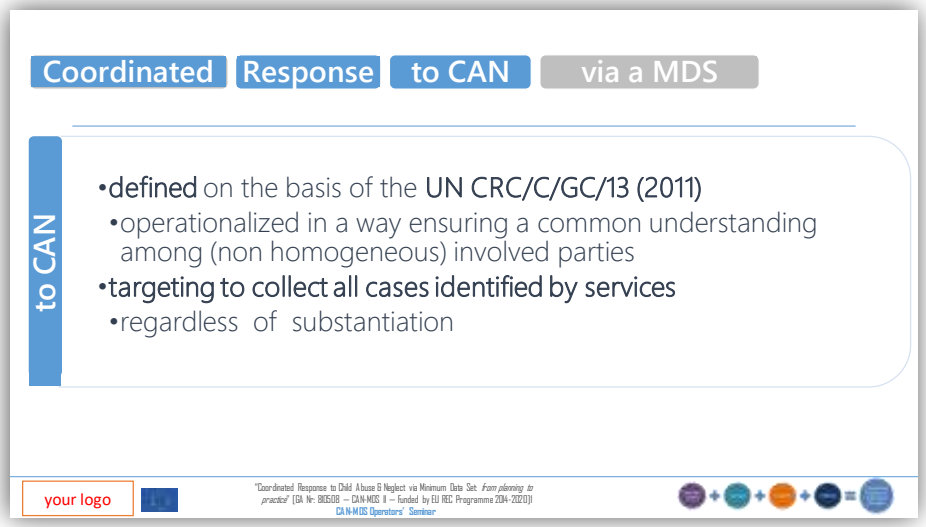


<see slide>

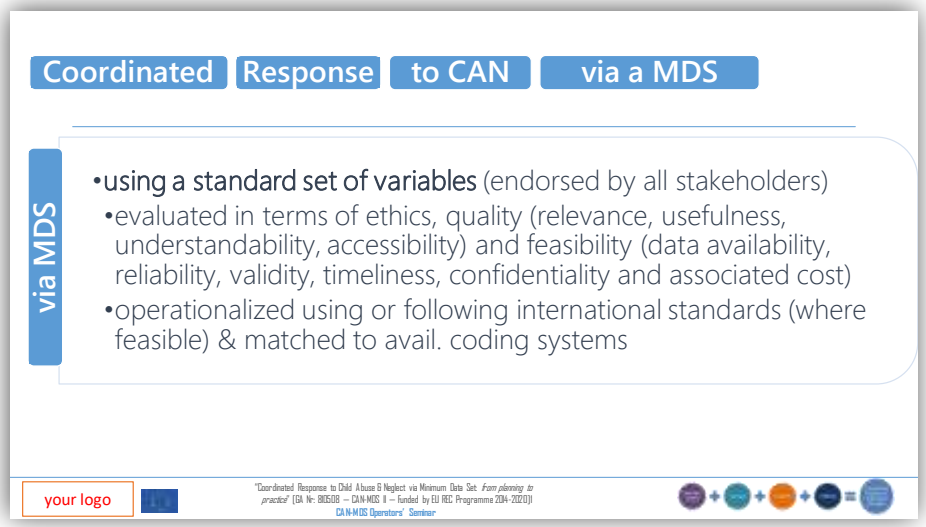
Slide 29



Slide 30

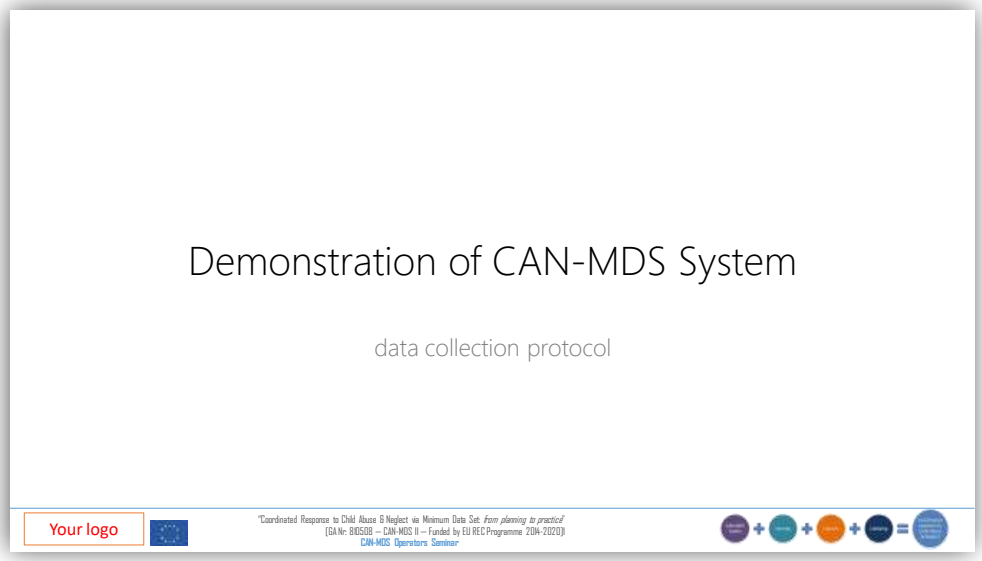


Slide 31



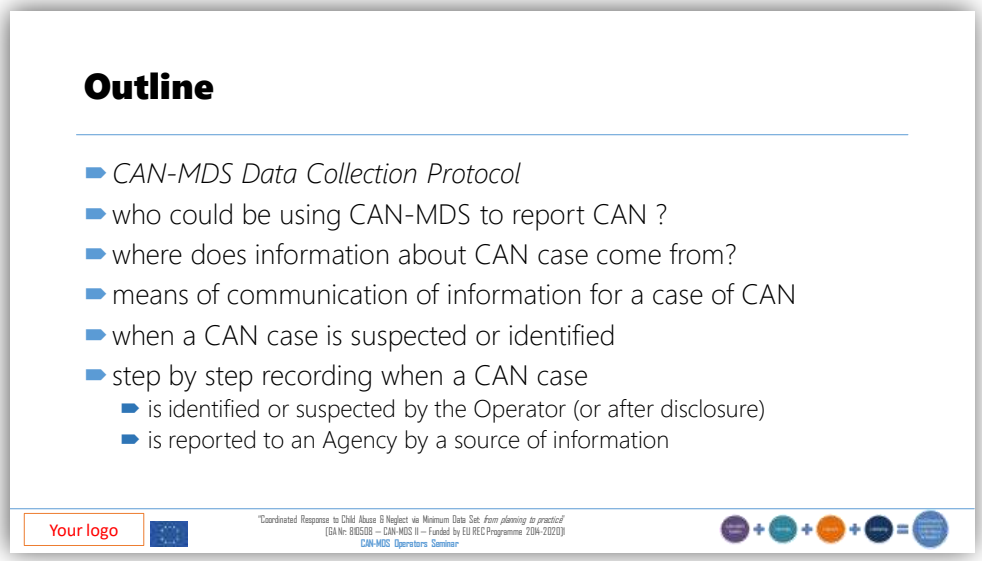
SESSION 3 – DURATION: 285 MIN (4h 45 min)
PART 7 – DURATION: 30 MIN

Slide 1



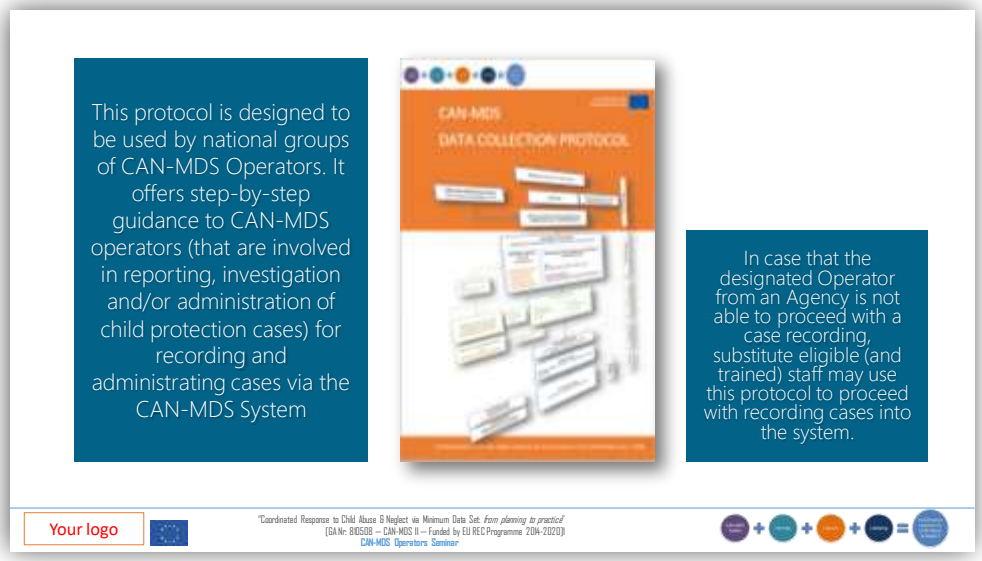
[Note: The document most useful for this phase of practice is the CAN-MDS Data Collection Protocol]

Slide 2



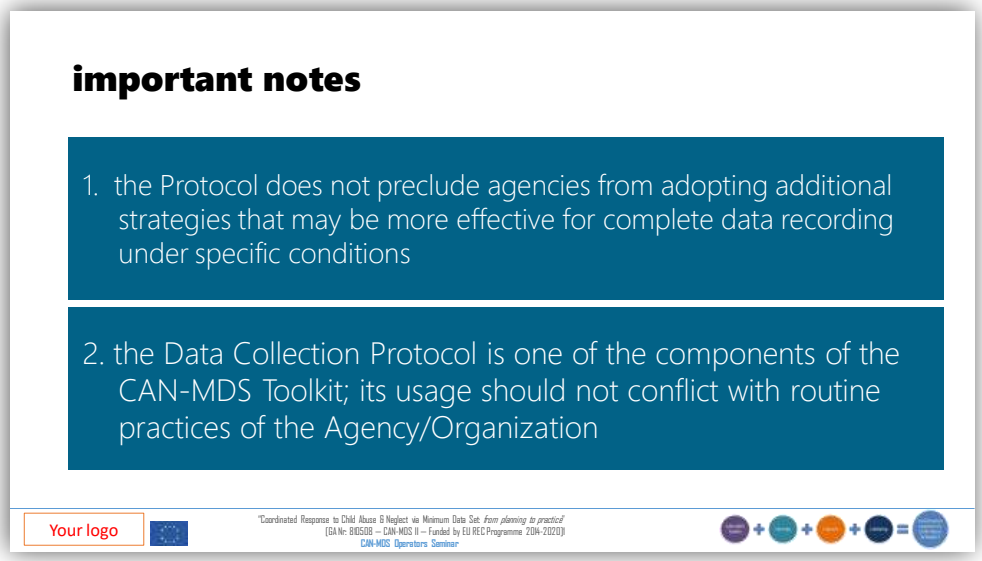
During this session the demonstration of CAN-MDS System will take place. First the data collection protocol will be presented; next a demonstration of using the system will take place and lastly a simulation of CAN incident recording will be conducted on the bases of some vignettes with the participation 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



Here is the main aim of the data collection protocol:
<see slide>

Slide 4



At least for the piloting phase and possibly afterwards please bear in mind that:

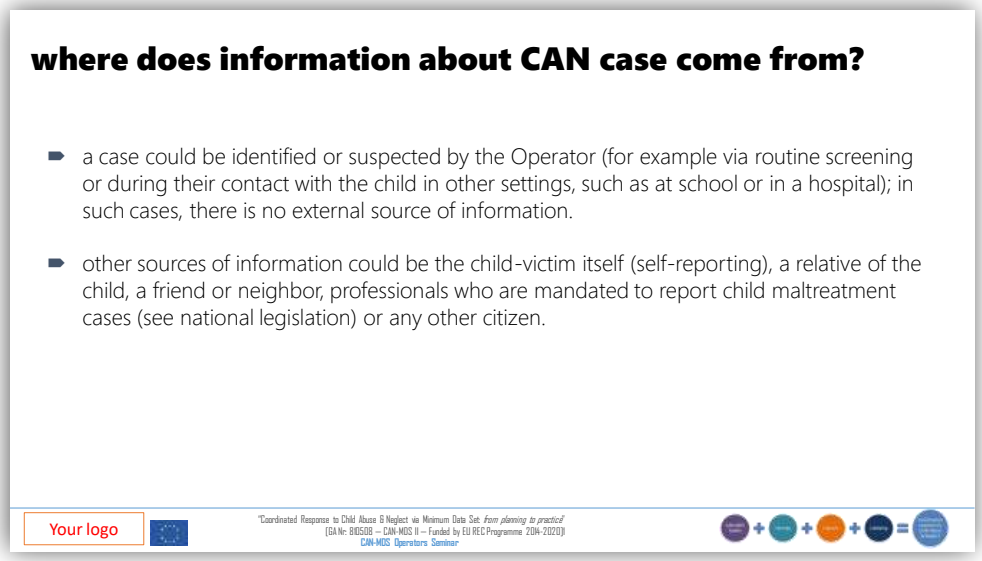
<see slide>

Slide 5

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

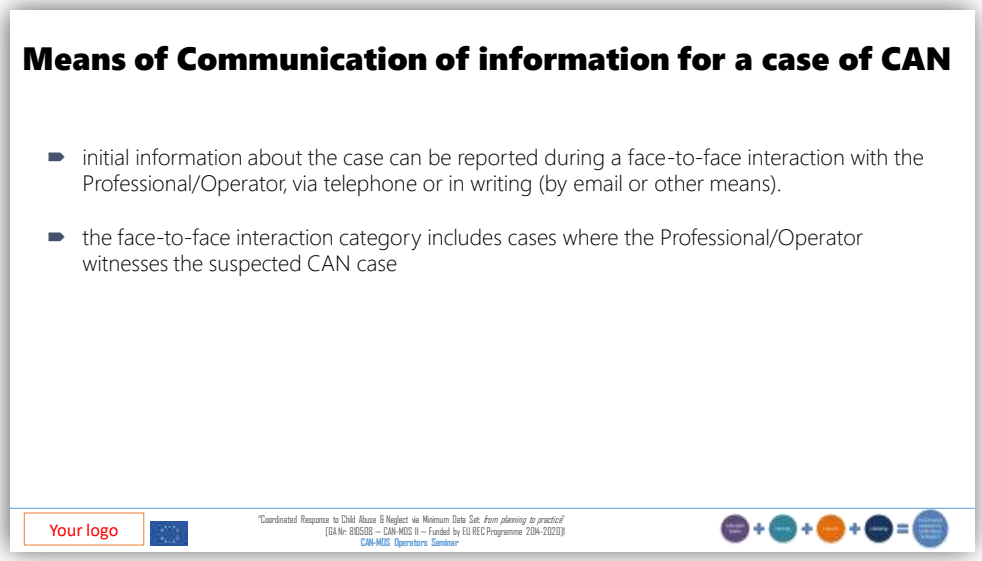


A CAN incident can be identified by each one of you through three different routes:

- after the disclosure of abuse by a child-victim
- by a third person ("source of information") that can be a child's relative, neighbor, fried, 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>

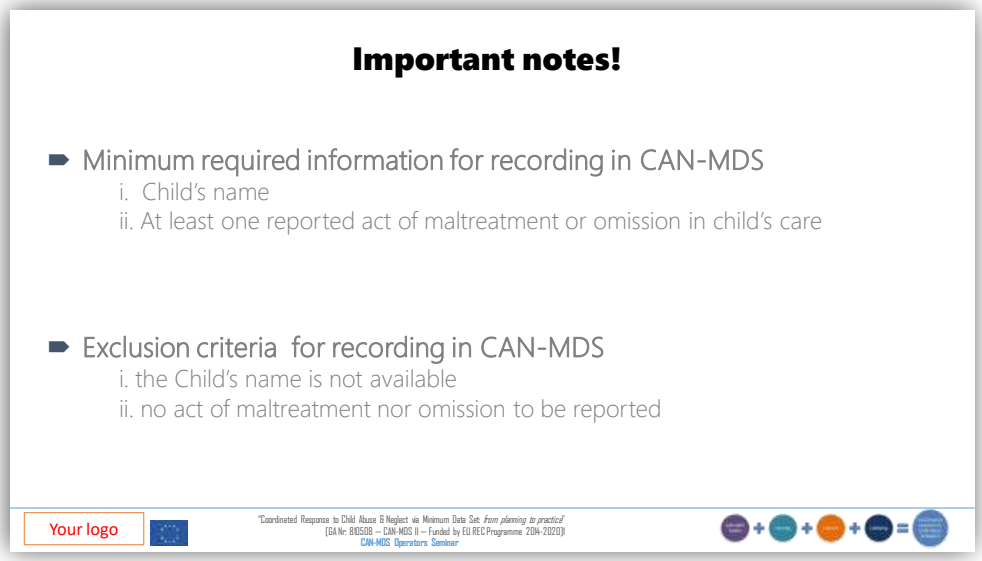
Slide 7



The information about a CAN incident may reach the CAN-MDS Operator

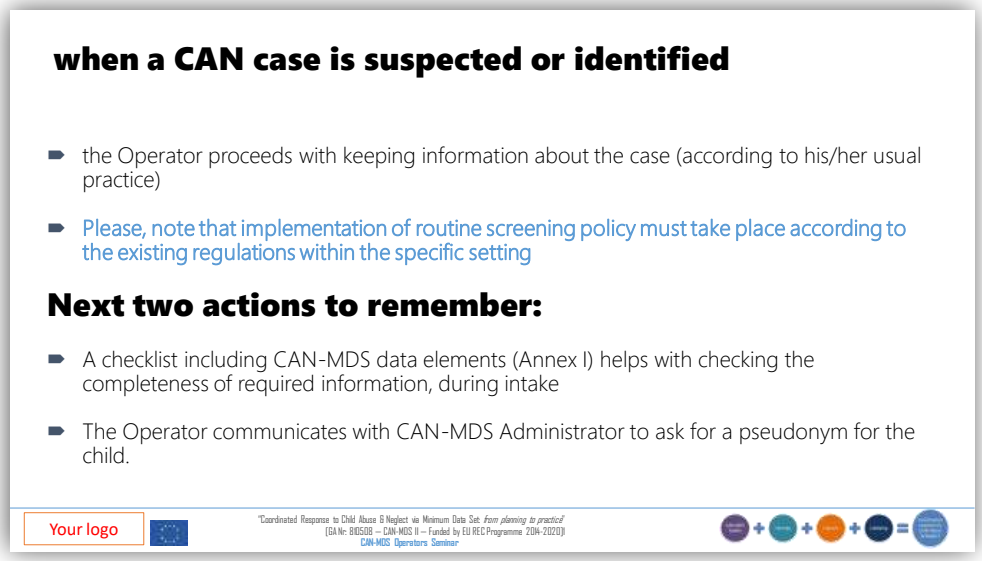
- face to face (disclosure by the child or provision of information by other third person)
- via telephone, SOS line, e-mail or other e-communication mean (disclosure by the child or provision of information by other third person)
- real time witnessing of warning signs by the Operator him/herself (the information is not provided by other person) OR as a result of routine screening process (where applied) <see slide>

Slide 8



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.

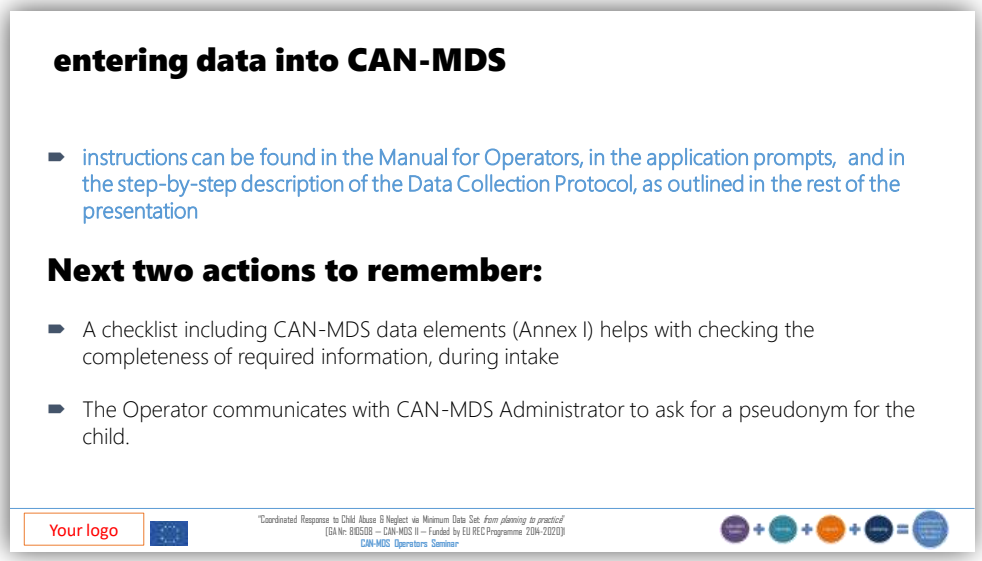
Slide 9



When a CAN 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 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) these information will be necessary.

<see slide>

Slide 10

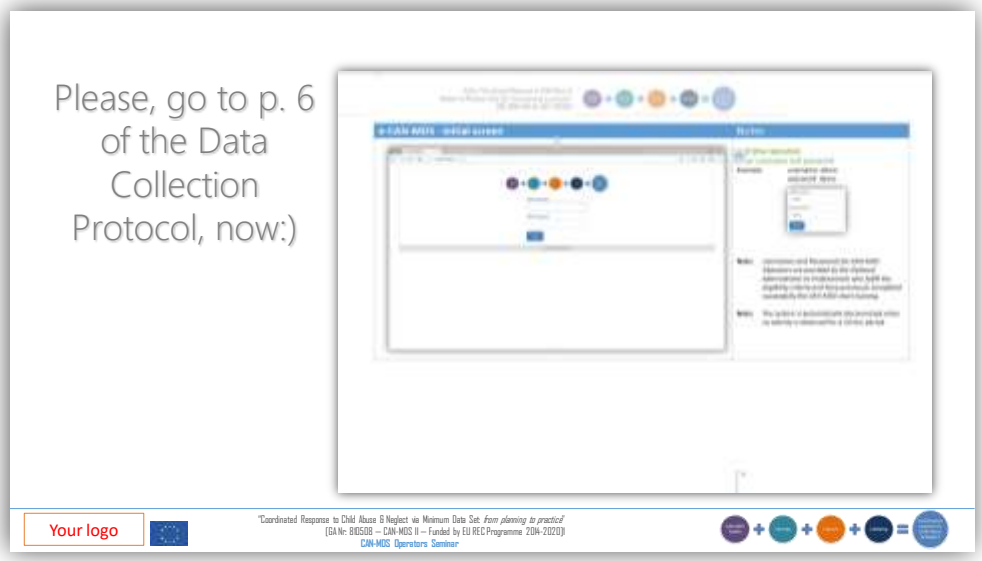


The process of data entering will be presented below; the description, however, of this process is included in the Data Collection Protocol in full detail. In the phase of recording you can check terms and other information (e.g. legal issues) in the Operator's Manual.
<see slide>

Slide 11

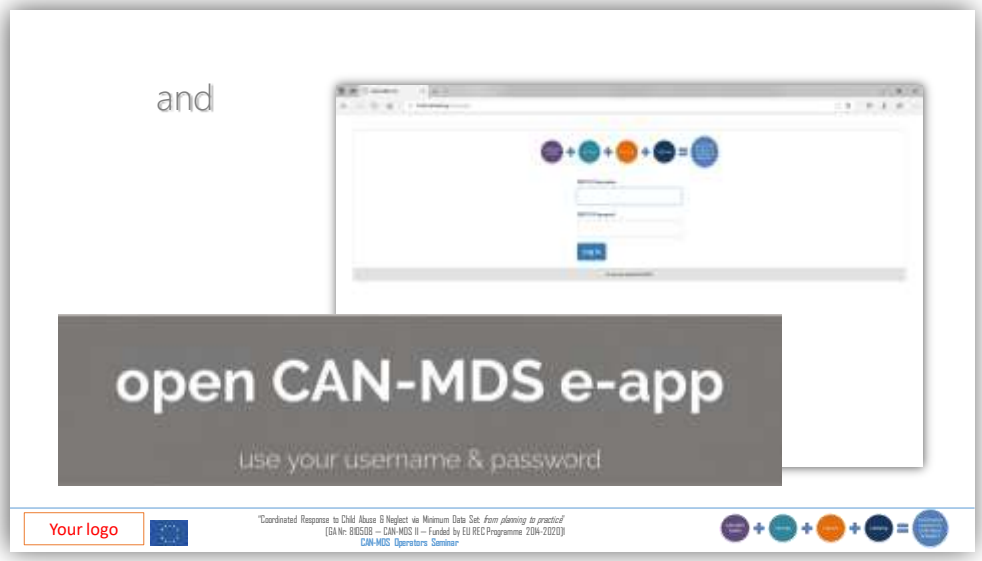
[Instruction – ask trainees whether everything is clear - if there are questions be sure that you provide replies before proceeding in the following parts.

Slide 12



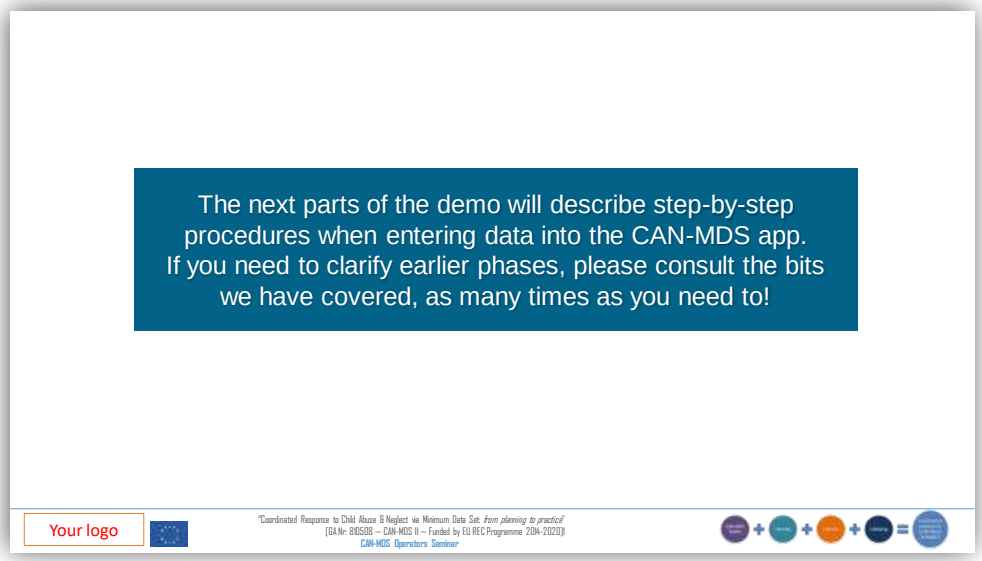
[Instruction – Ask trainees to go to page 6 of the national version of the Data Collection Protocol; use this slide as an example of what information is included in this document –namely screen shots and explanations]

Slide 13



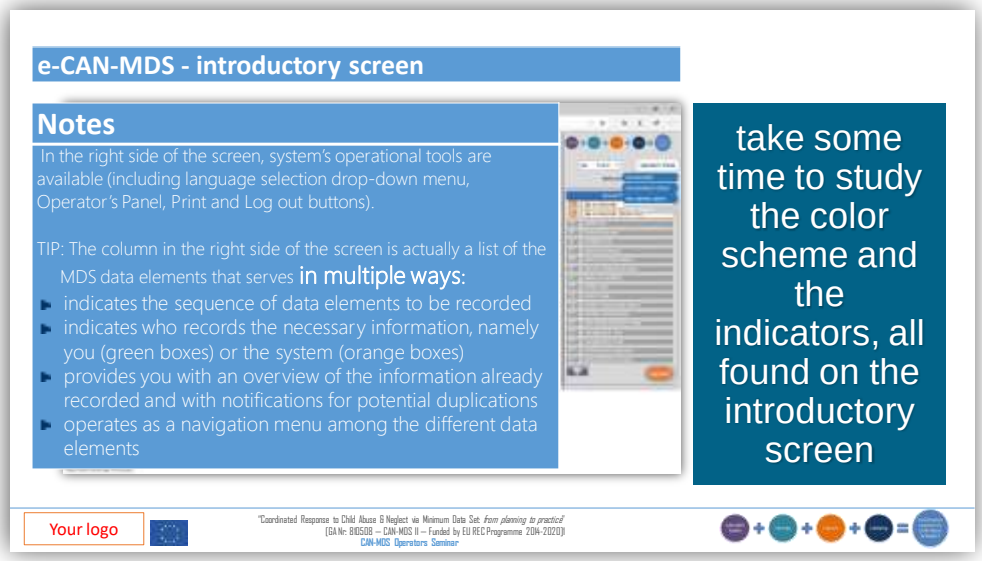
[Instruction – Open the CAN-MDS application for showing the inter-relation between the CAN-MDS operators' interface and the respective description in the Data Collection Protocol. Please use your own username and password in order for the application to open in your national language]

Slide 14



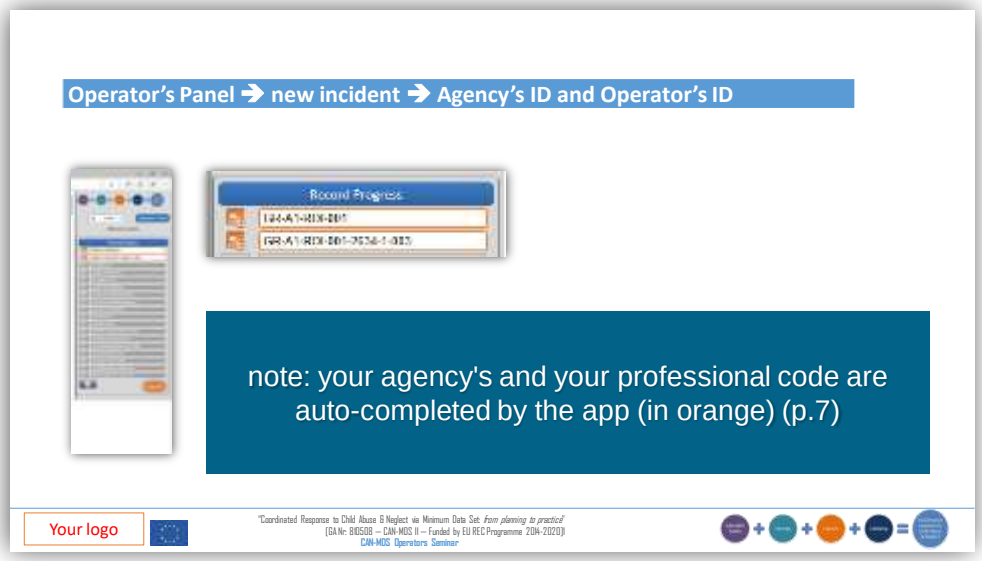
<see slide>

Slide 15



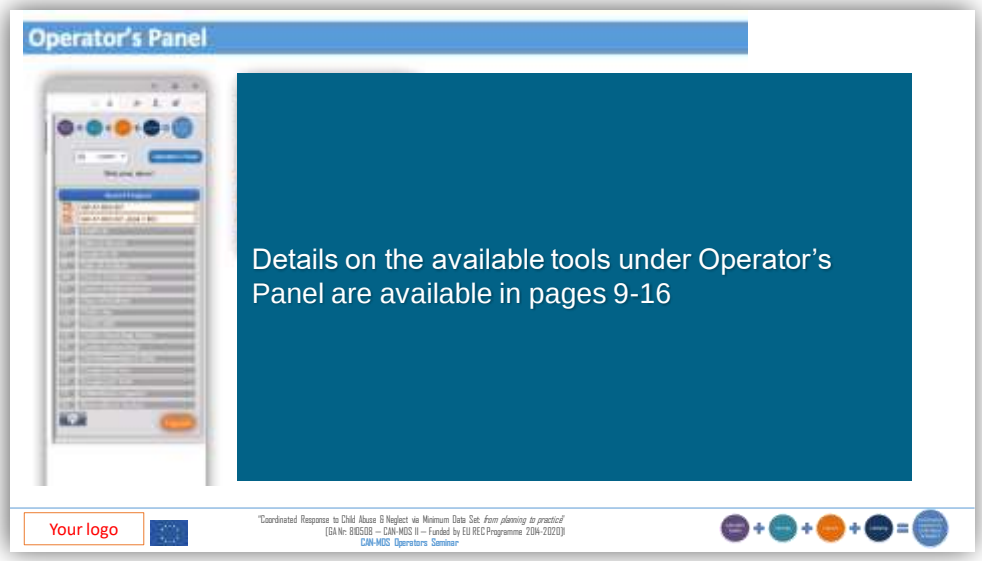
<please describe by following the animation in the slide>

Slide 16



<please describe by following the animation in the slide>

Slide 17



<please describe by following the animation in the slide>

Slide 18

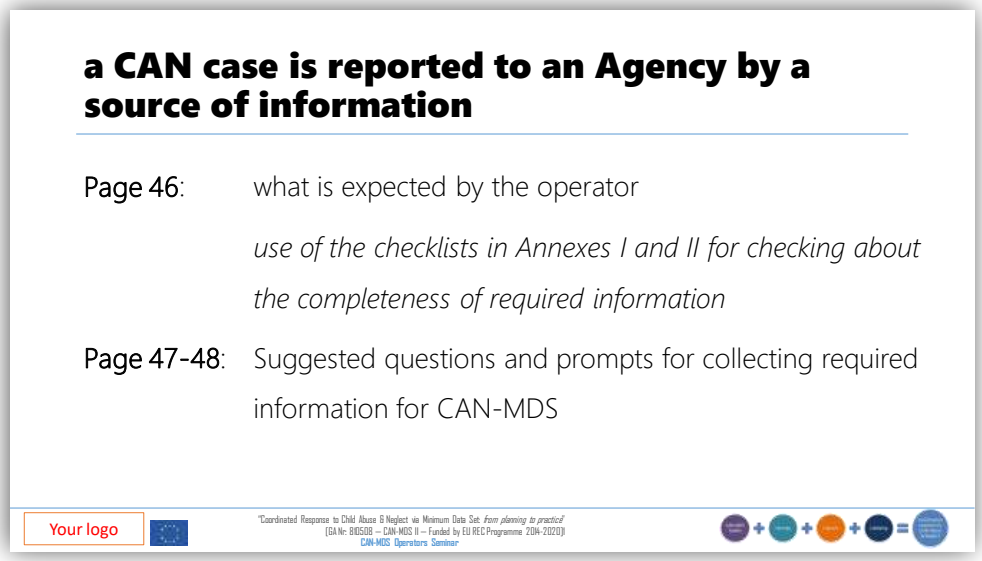
a CAN case is identified or suspected by the Operator
(implementation of routine screening policy: depending on settings' specifics)

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

Your logo

[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

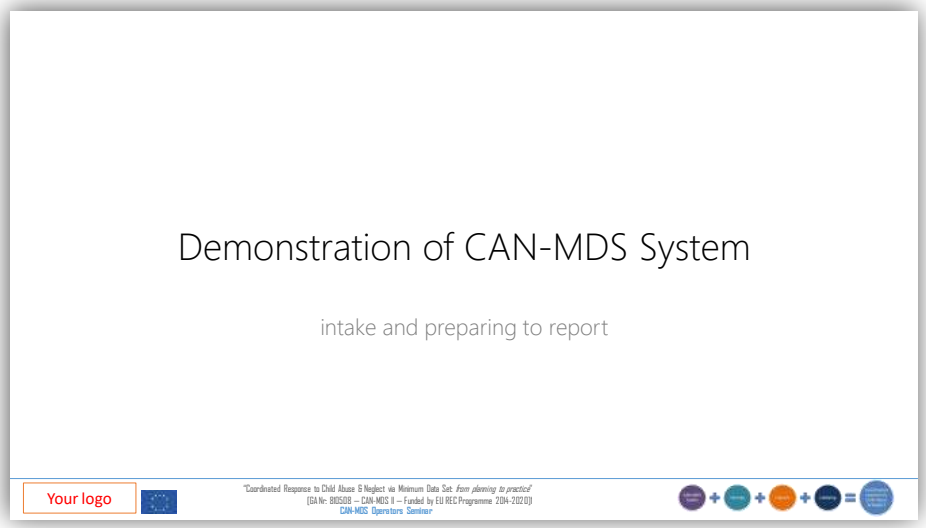


[Instruction - Ask from trainees to open CAN-MDS Data collection protocol and go through the pages. Please mention the conditions covered in the data collection protocol; at this point there is no need to go through the whole manual in detail]

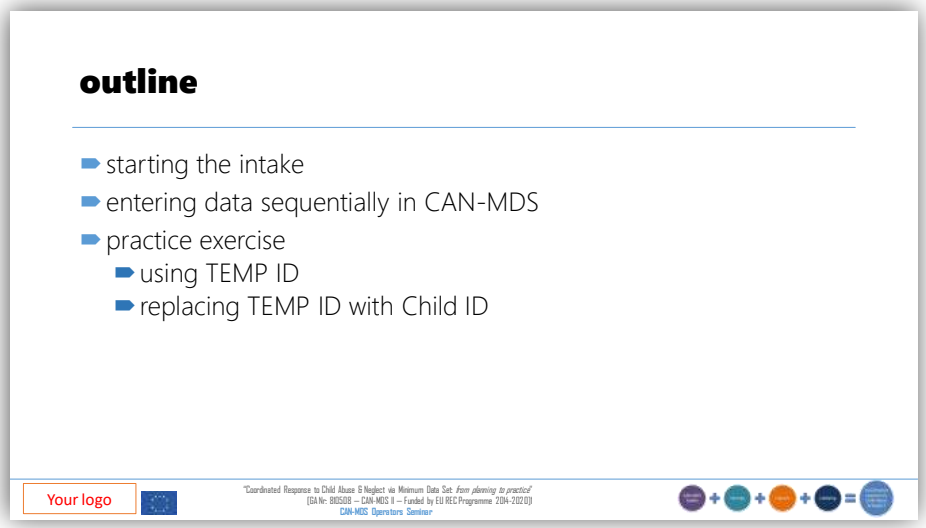
[Next you are going to proceed with the demonstration of the system through making a record]

PART 8 – DURATION: 15 MIN

Slide 1

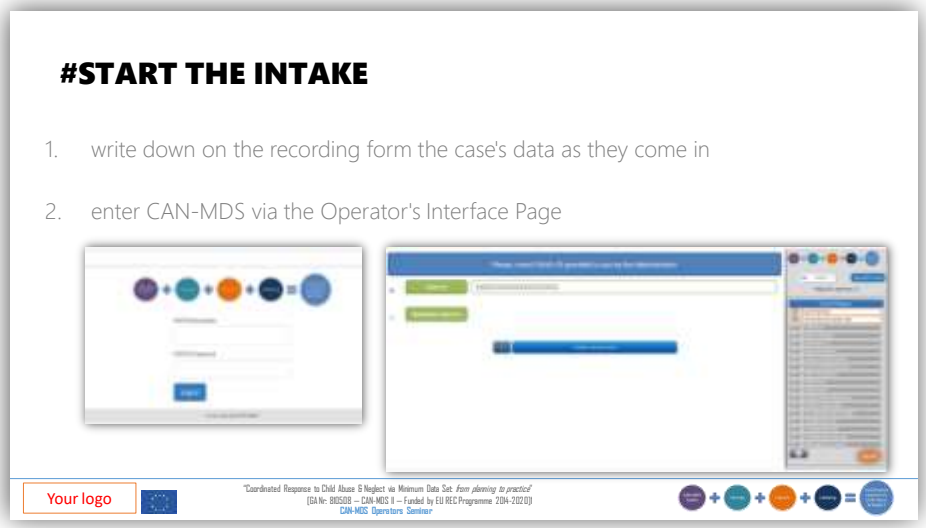


Slide 2



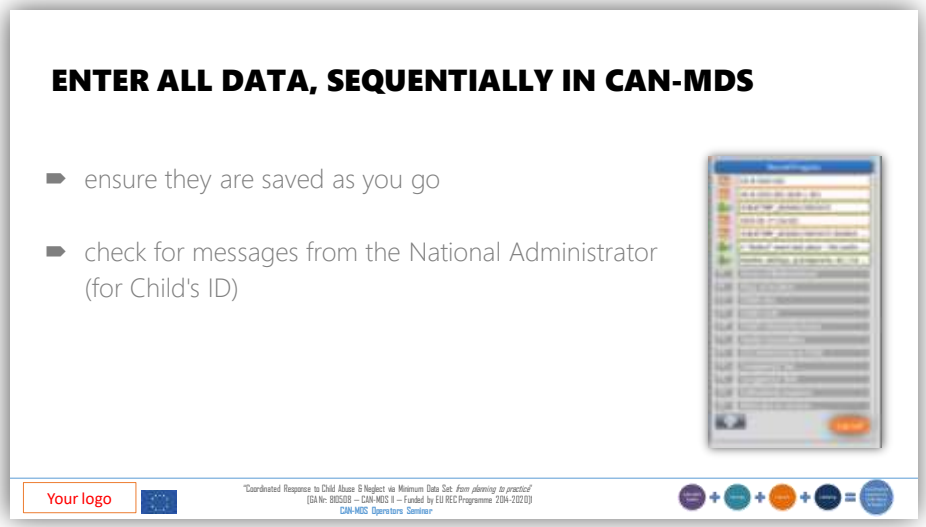
During this part of the presentation the sequence of data entering is demonstrated; first an incident will be recorded by using the Temporary ID and then the TEMP ID will be replaced with the Child's ID.

Slide 3



[Instruction - Trainer goes to the app and present quickly the structure and the Operator's Panel button]

Slide 4



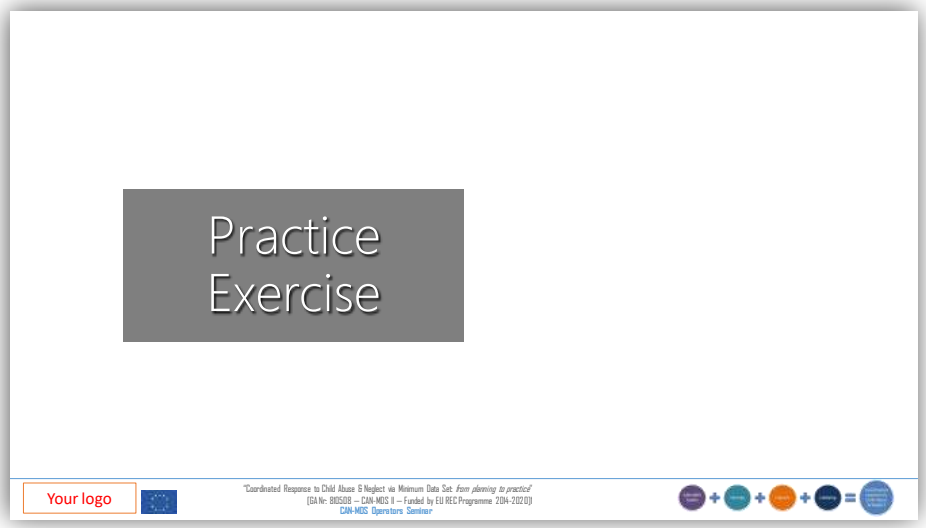
[Instruction -Trainer explain the role of the right column (see also Step by step Guide for Administrator, p. 8]

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.

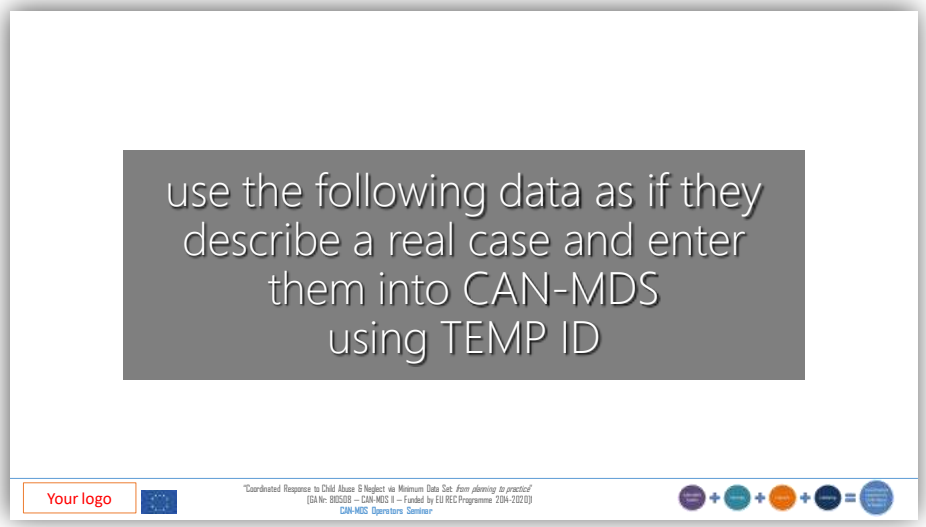
Slide 5



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.

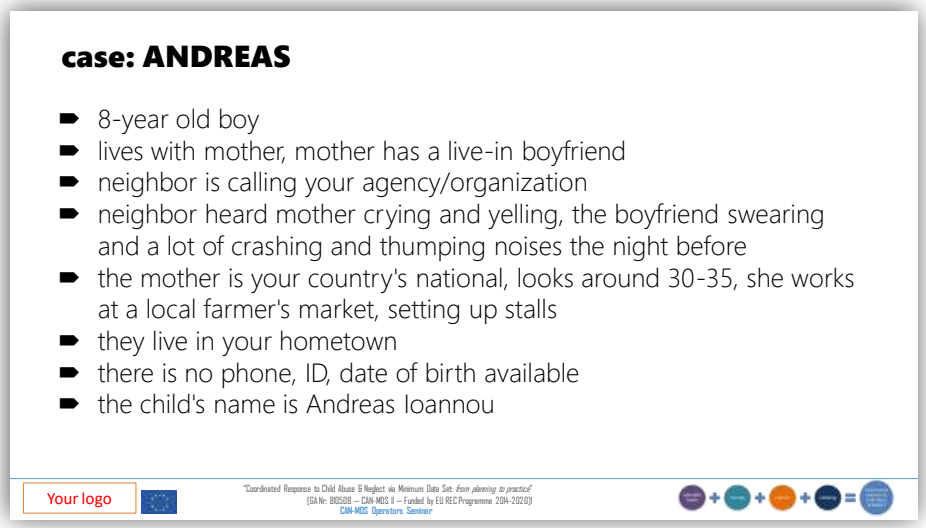
Note: Alternatively, you can ask from one of the trainees to report a case of which s/he is aware or had worked with (without mention any information of the identity of the involved persons).
Use the checklists to keep information in order to be sure that you have all necessary data and proceed with recording in the CAN-MDS.

Slide 6



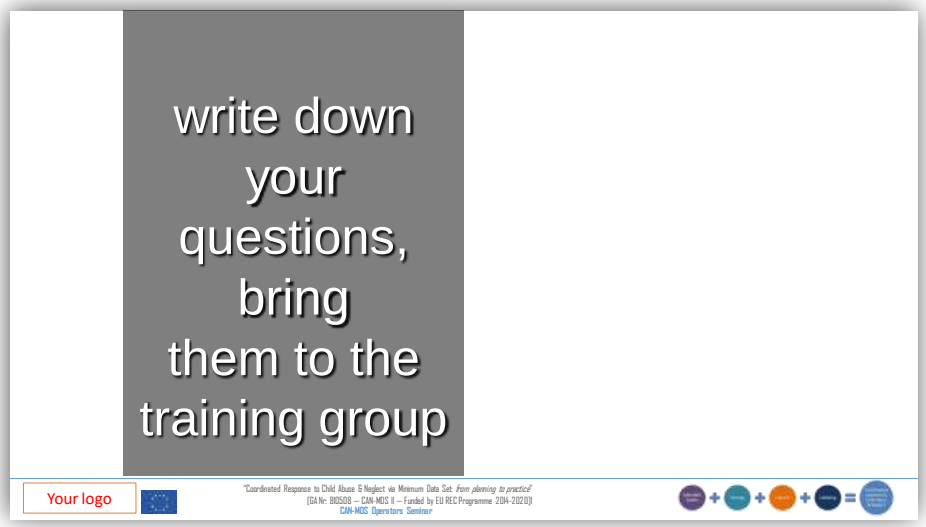
<see slide>

Slide 7



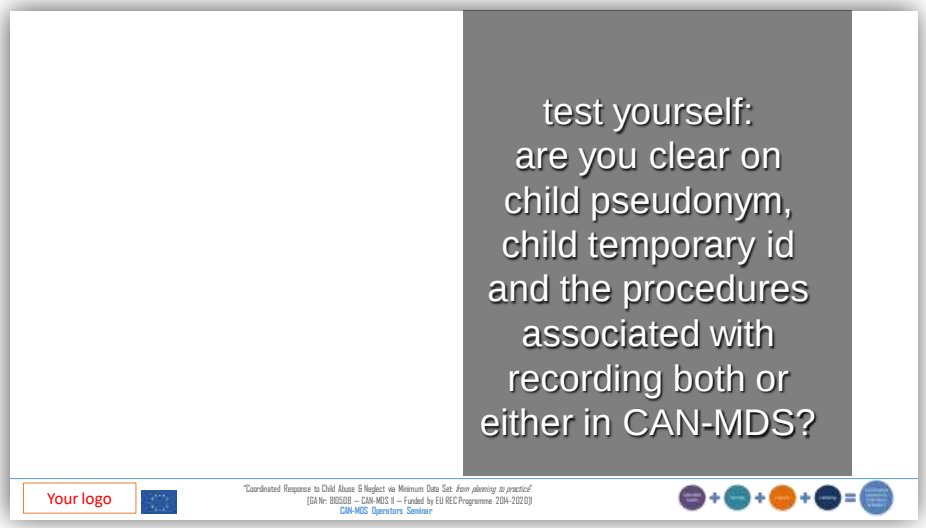
8-year old boy lives with mother, mother has a live-in boyfriend neighbor is calling your agency/organization neighbor heard mother crying and yelling, the boyfriend swearing and a lot of crashing and thumping noises the night before the mother is your country's national, looks around 30-35, she works 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



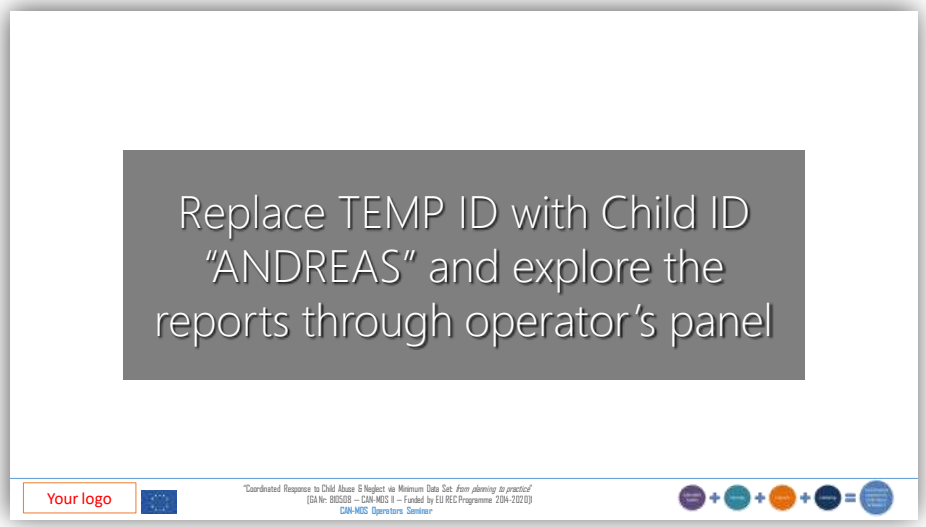
Please make notes on any glitches, queries, ambiguities you come across when trying to practice the tasks outlined in this demo.

Slide 9

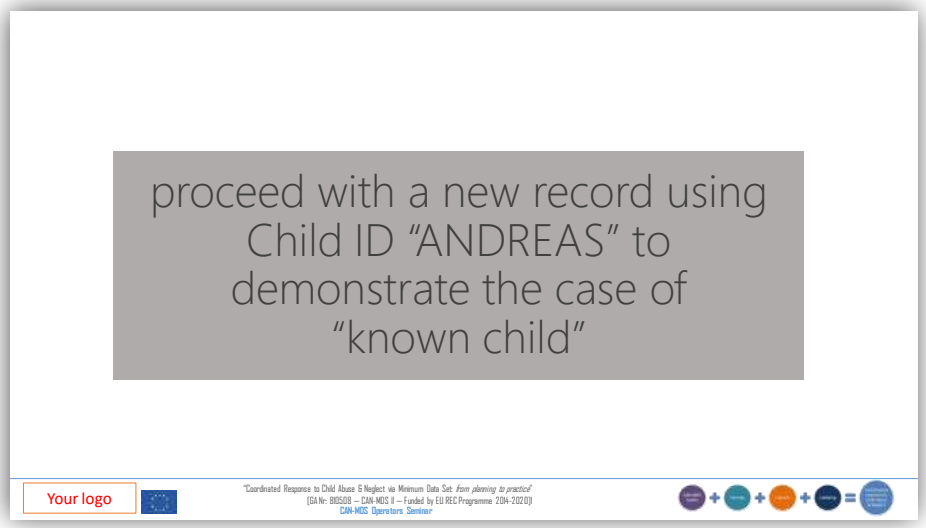


Necessary documents:
p.8 of Data Collection Protocol
p. 20 of Data Collection Protocol
p. 21-22-23 of Data Collection Protocol
p.41 of Data Collection Protocol
p.49 of Data Collection Protocol
p.36 of Master Toolkit Guide for Operators
p. 23 of Master Toolkit Guide for Administrators

Slide 10



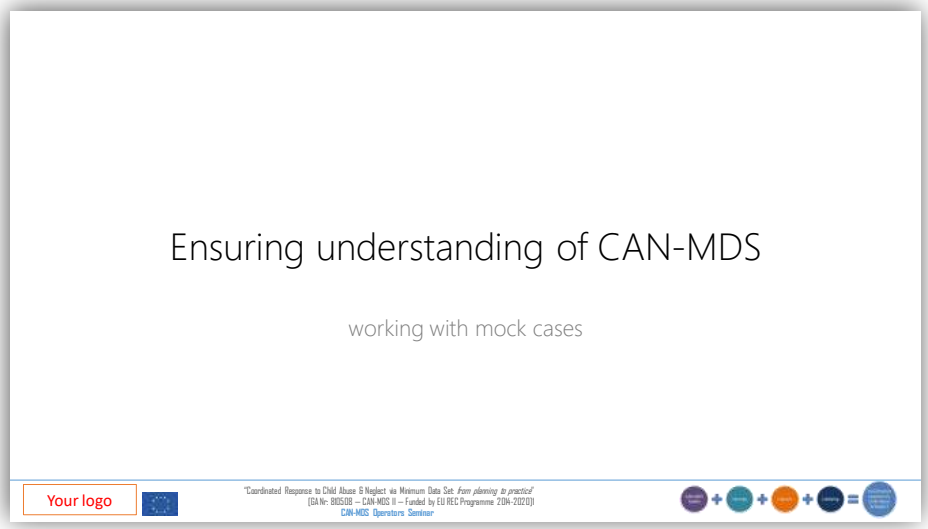
Slide 11



The process if the child is already known described in data collection protocol p. 19 and pp. 38-45

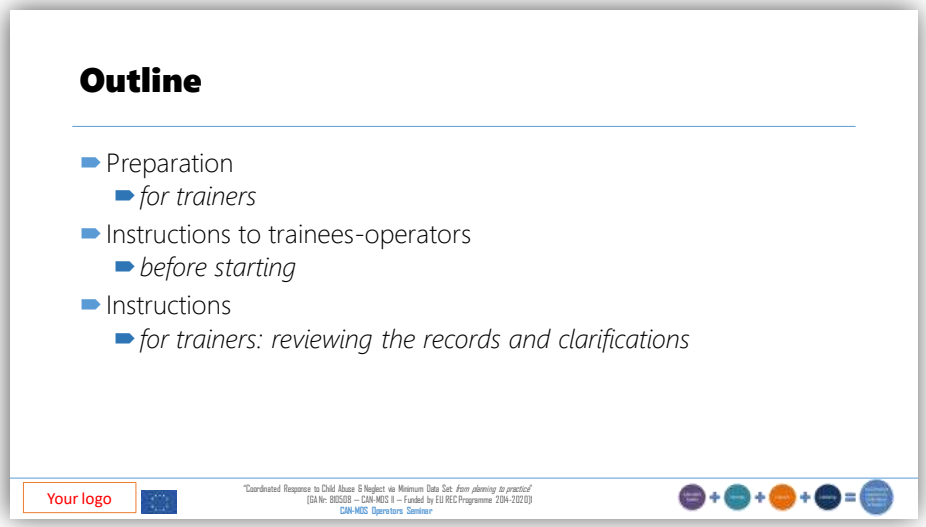
PART 9 – DURATION: 210 MIN (3h 30 min)

Slide 1

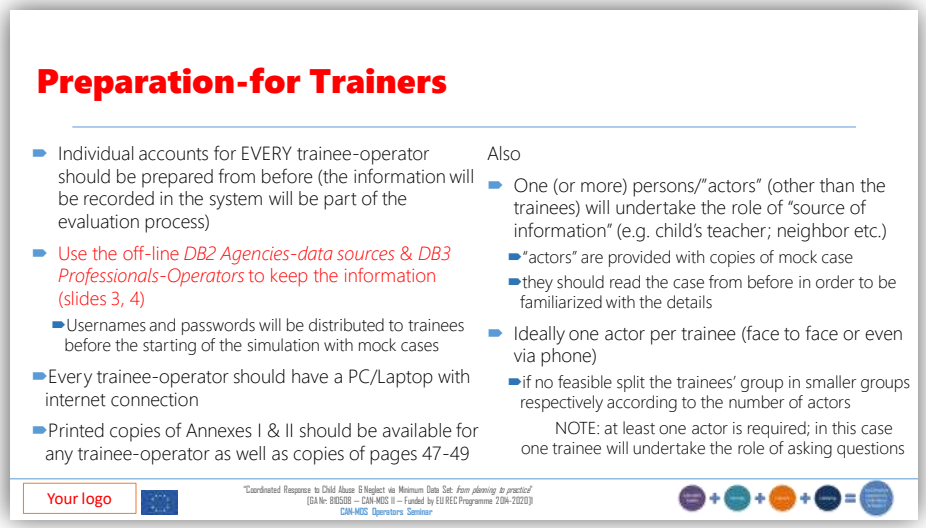


Simulation phase

Slide 2 [hidden slide]



Slide 3 [hidden slide]



Notes for the Trainer

WORKING WITH MOCK CASES

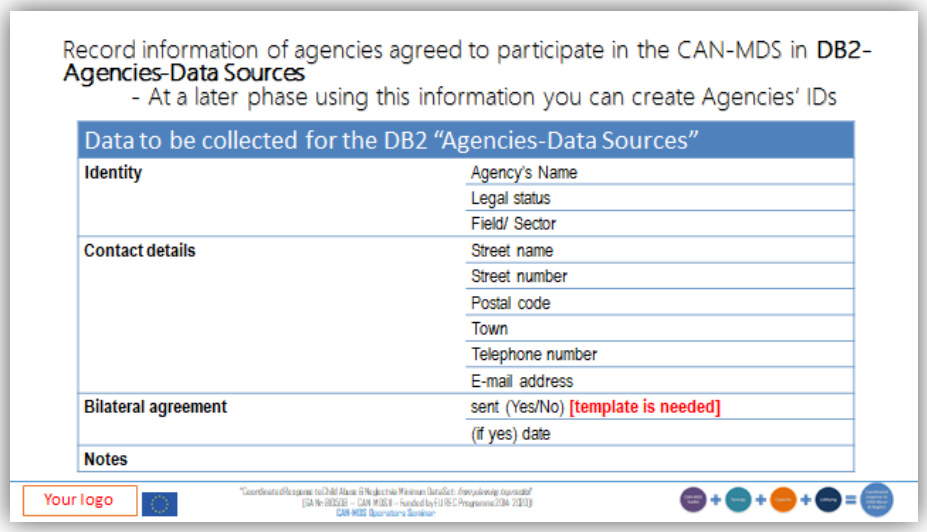
Preparation

- 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

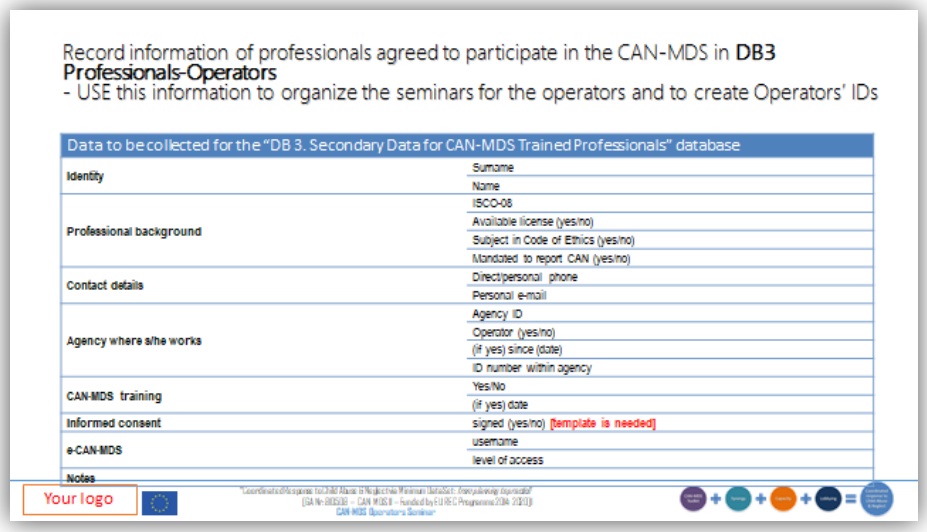
TIP: Ideally, simulation would include one actor per trainee (face to face, or even via phone)

- 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

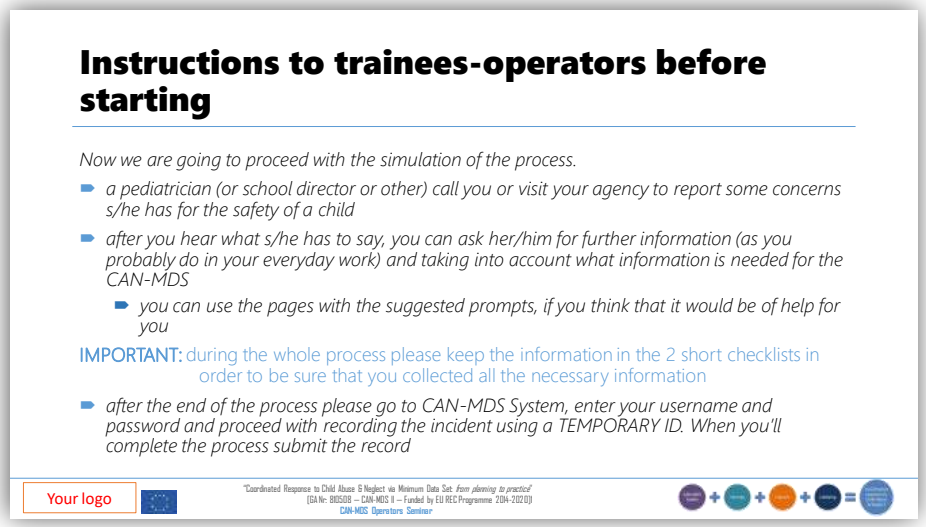
Slide 4 [hidden slide]



Slide 5 [hidden slide]



Slide 6



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:

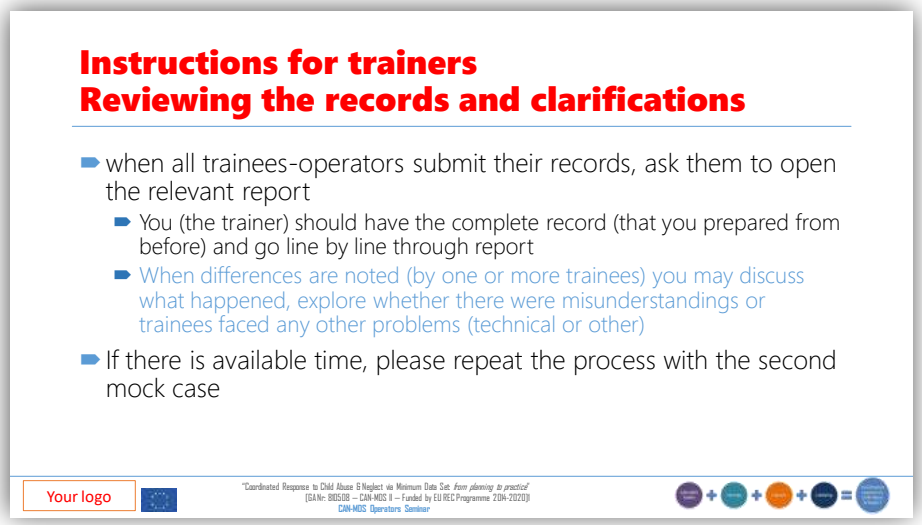
- *We are, now, going to proceed with the simulation of the process*
- *A pediatrician (or school director or other) calls you or visits your agency to report his/her worries concerning the safety of a child*
- *After you hear what s/he has to say, you can ask her/him for further information (as you 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]



Reviewing the records and clarifications

- *when all trainees-operators submit their records, ask them to open the relevant report*

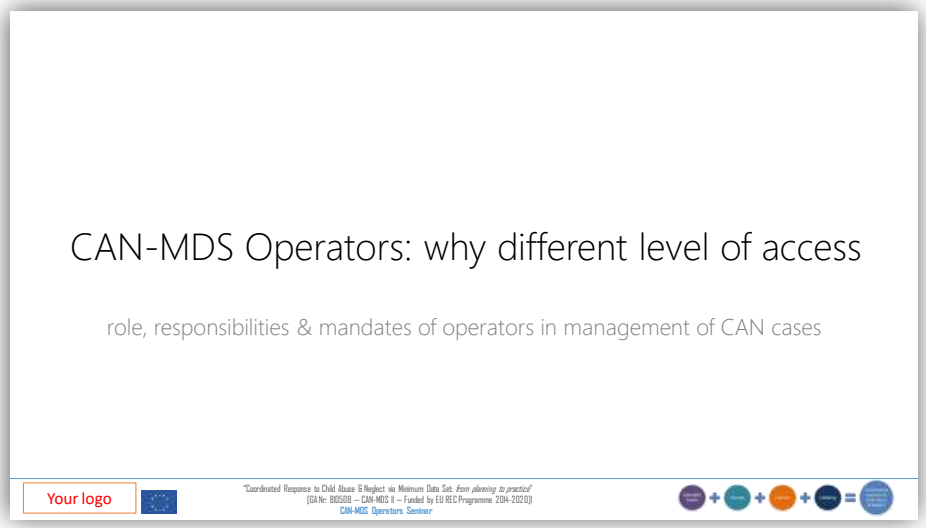
Note: You (the trainee) should have the complete record (one that you have prepared from before)

- *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

SESSION 4 – DURATION: 75 MIN
PART 10 – DURATION: 30 MIN

Slide 1



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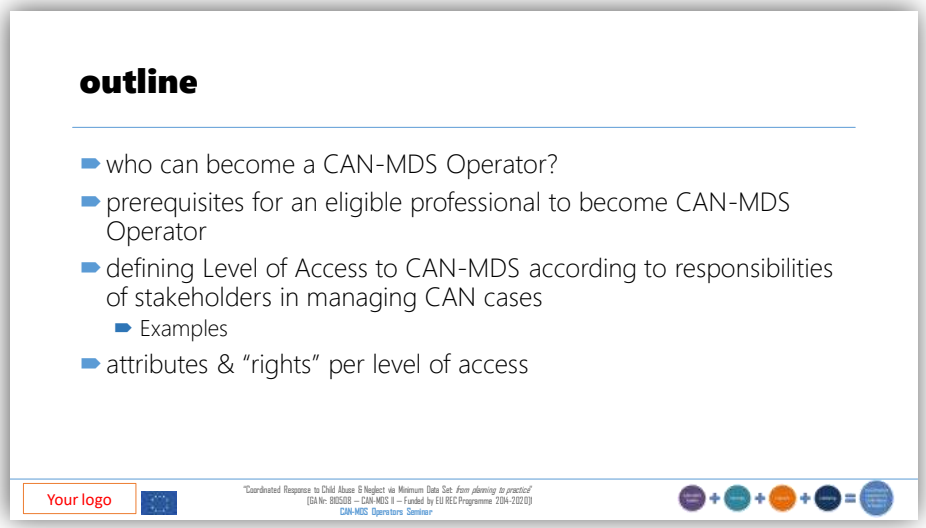
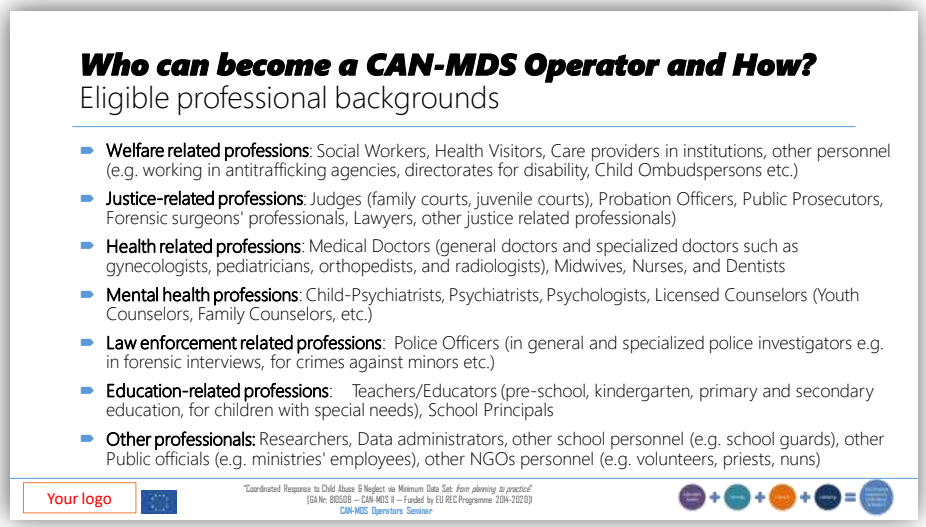


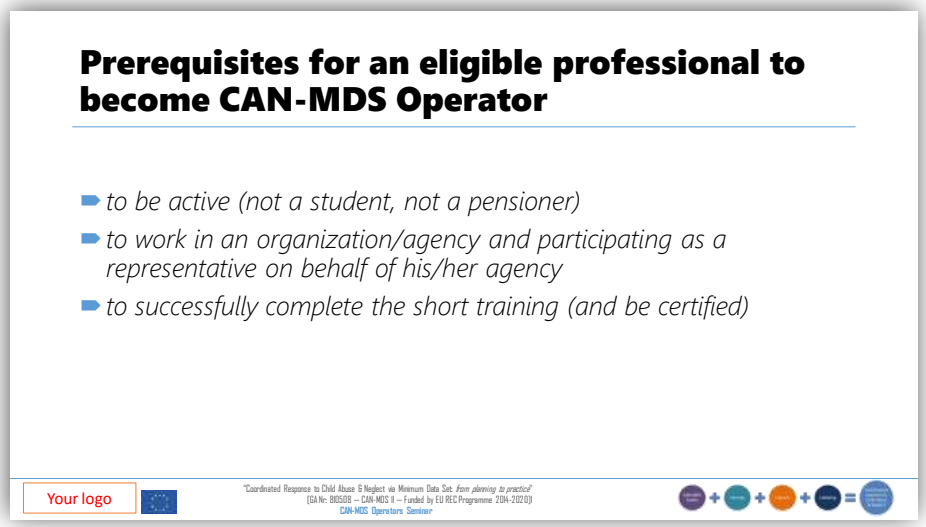
The aim of this part is to make clear why CAN-MDS Operators are granted with different level of access in the information included in the system.

Slide 3



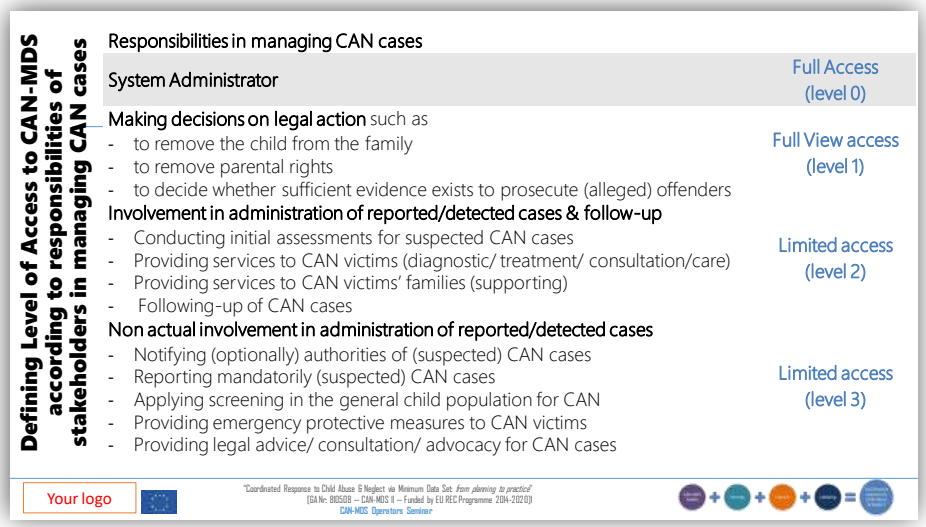
Any professional who belongs to one of the following groups, has a valid professional license or is legally certified and is subjected to a professional code of ethics or a similar condition, depending on the profession

Slide 4



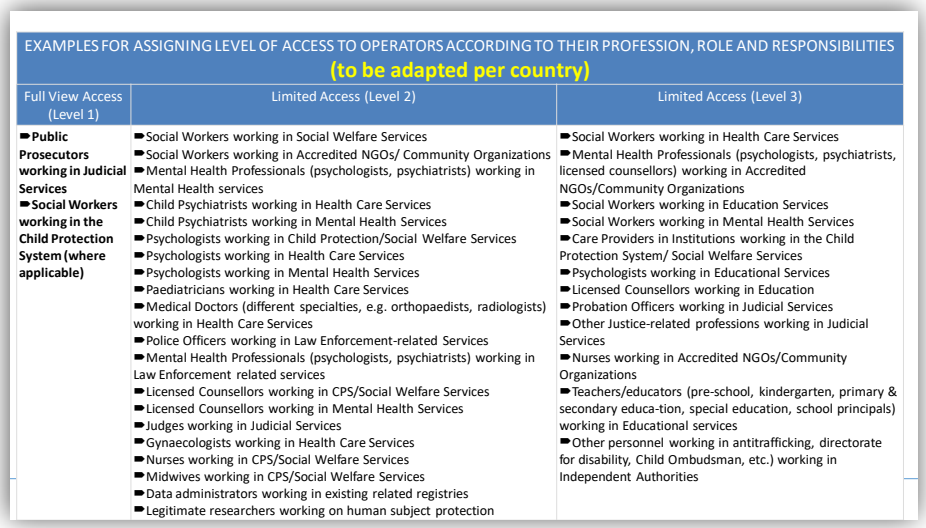
[Suggestion: You can ask trainees to inform their own colleagues who are eligible and belong to the above categories to participate in the system]

Slide 5



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

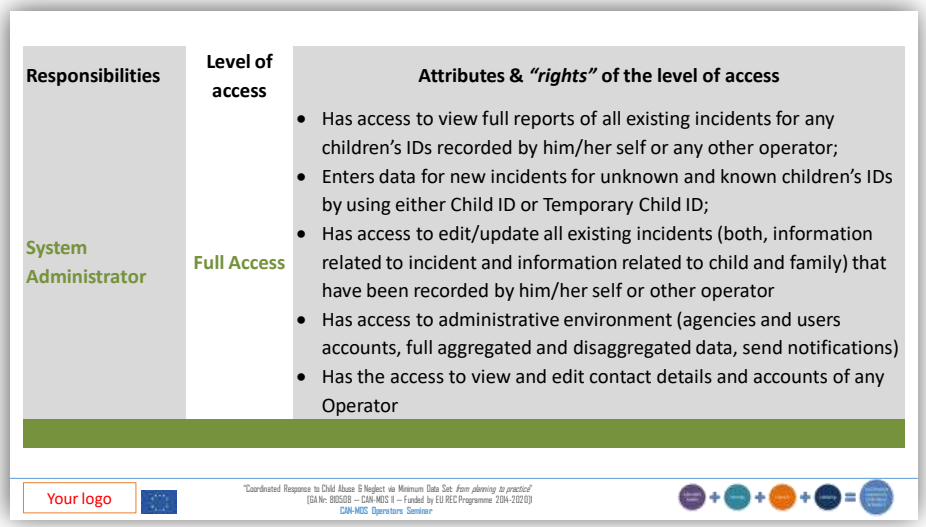


EXAMPLES FOR ASSIGNING LEVEL OF ACCESS TO OPERATORS ACCORDING TO THEIR PROFESSION, ROLE AND RESPONSIBILITIES
(to be adapted per country)

Full View Access (Level 1)	Limited Access (Level 2)	Limited Access (Level 3)
➨**Public Prosecutors working in Judicial Services** ➨**Social Workers working in the Child Protection System (where applicable)**	➨Social Workers working in Social Welfare Services ➨Social Workers working in Accredited NGOs/ Community Organizations ➨Mental Health Professionals (psychologists, psychiatrists) working in Mental Health services ➨Child Psychiatrists working in Health Care Services ➨Child Psychiatrists working in Mental Health Services ➨Psychologists working in Child Protection/Social Welfare Services ➨Psychologists working in Health Care Services ➨Psychologists working in Mental Health Services ➨Paediatricians working in Health Care Services ➨Medical Doctors (different specialties, e.g. orthopaedists, radiologists) working in Health Care Services ➨Police Officers working in Law Enforcement-related Services ➨Mental Health Professionals (psychologists, psychiatrists) working in Law Enforcement related services ➨Licensed Counsellors working in CPS/Social Welfare Services ➨Licensed Counsellors working in Mental Health Services ➨Judges working in Judicial Services ➨Gynaecologists working in Health Care Services ➨Nurses working in CPS/Social Welfare Services ➨Midwives working in CPS/Social Welfare Services ➨Data administrators working in existing related registries ➨Legitimate researchers working on human subject protection	➨Social Workers working in Health Care Services ➨Mental Health Professionals (psychologists, psychiatrists, licensed counsellors) working in Accredited NGOs/Community Organizations ➨Social Workers working in Education Services ➨Social Workers working in Mental Health Services ➨Care Providers in Institutions working in the Child Protection System/ Social Welfare Services ➨Psychologists working in Educational Services ➨Licensed Counsellors working in Education ➨Probation Officers working in Judicial Services ➨Other Justice-related professions working in Judicial Services ➨Nurses working in Accredited NGOs/Community Organizations ➨Teachers/educators (pre-school, kindergarten, primary & secondary educa-tion, special education, school principals) working in Educational services ➨Other personnel working in antitrafficking, directorate for disability, Child Ombudsman, etc.) working in Independent Authorities

[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	• Has access to view full reports of all existing incidents for any children's IDs recorded by him/her self or any other operator; • Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID; • 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 • Has access to administrative environment (agencies and users accounts, full aggregated and disaggregated data, send notifications) • Has the access to view and edit contact details and accounts of any Operator

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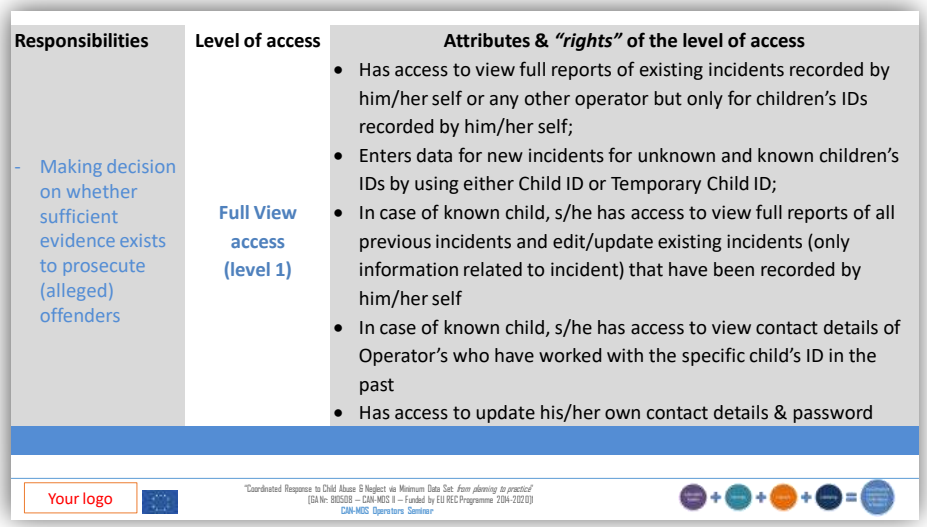
Slide 8



Responsibilities	Level of access	Attributes & *"rights"* of the level of access
- Making decision on whether sufficient evidence exists to prosecute (alleged) offenders	Full View access (level 1)	• 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; • Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID; • 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 • 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 • Has access to update his/her own contact details & password

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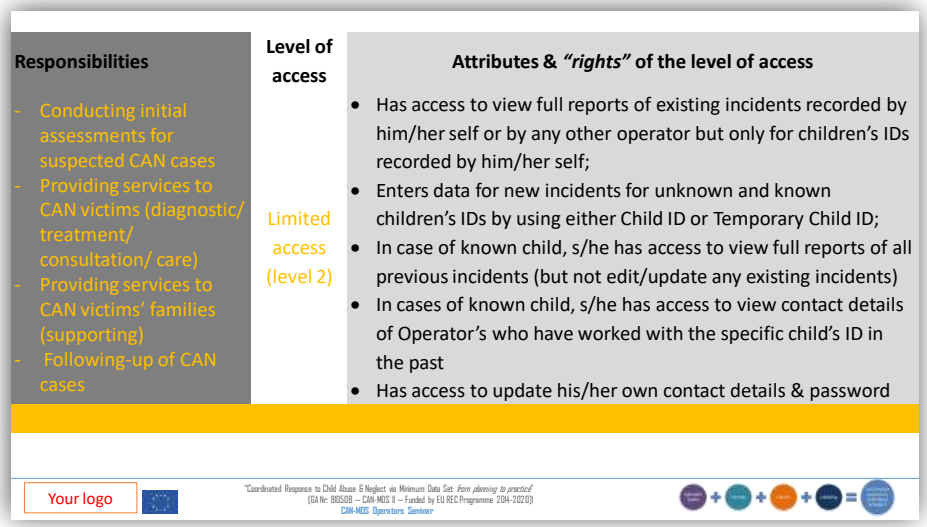
Slide 9



Responsibilities	Level of access	Attributes & *"rights"* of the level of access
- Conducting initial assessments for suspected CAN cases - Providing services to CAN victims (diagnostic/ treatment/ consultation/ care) - Providing services to CAN victims' families (supporting) - Following-up of CAN cases	Limited access (level 2)	• 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; • Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID; • In case of known child, s/he has access to view full reports of all previous incidents (but not edit/update any existing incidents) • 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 • Has access to update his/her own contact details & password

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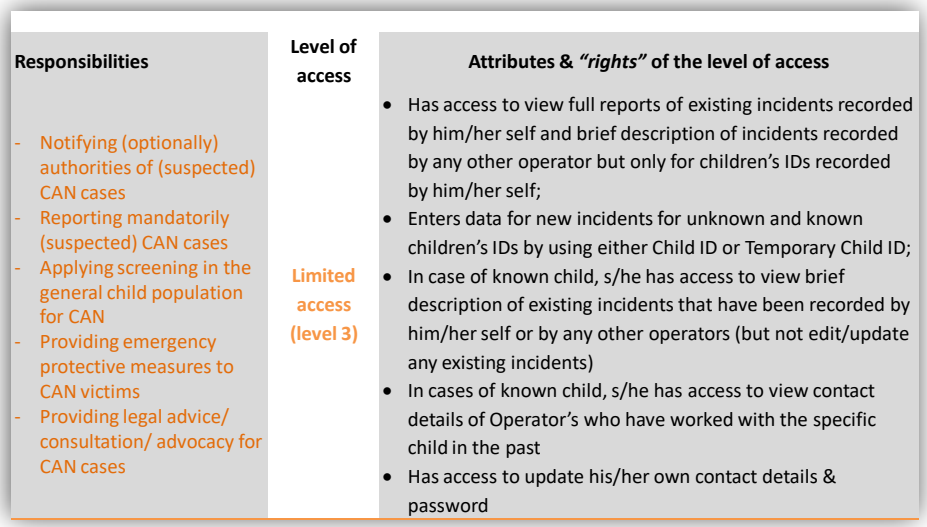
Slide 10



Responsibilities	Level of access	Attributes & *"rights"* of the level of access
- Notifying (optionally) authorities of (suspected) CAN cases - Reporting mandatorily (suspected) CAN cases - Applying screening in the general child population for CAN - Providing emergency protective measures to CAN victims - Providing legal advice/ consultation/ advocacy for CAN cases	Limited access (level 3)	• 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; • Enters data for new incidents for unknown and known children's IDs by using either Child ID or Temporary Child ID; • 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) • 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 • Has access to update his/her own contact details & password

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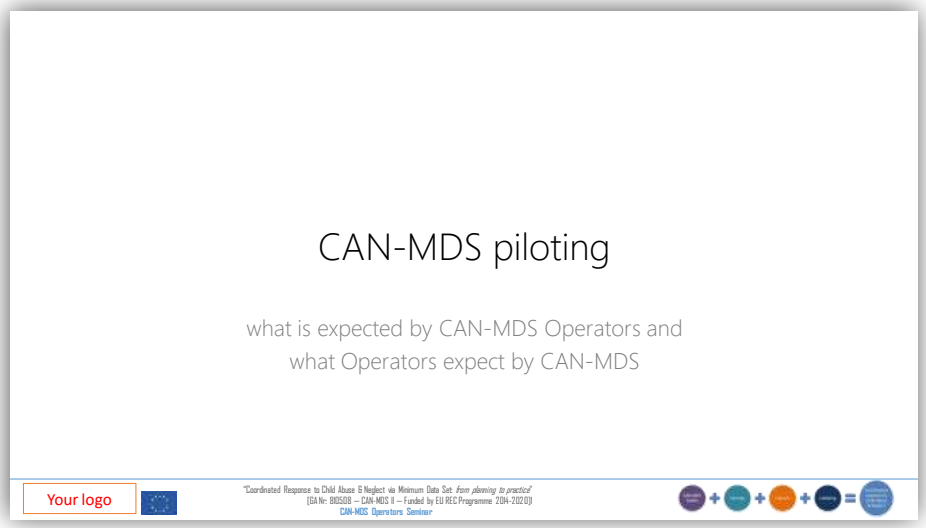
PART 11 – DURATION: 45 MIN

Slide 1



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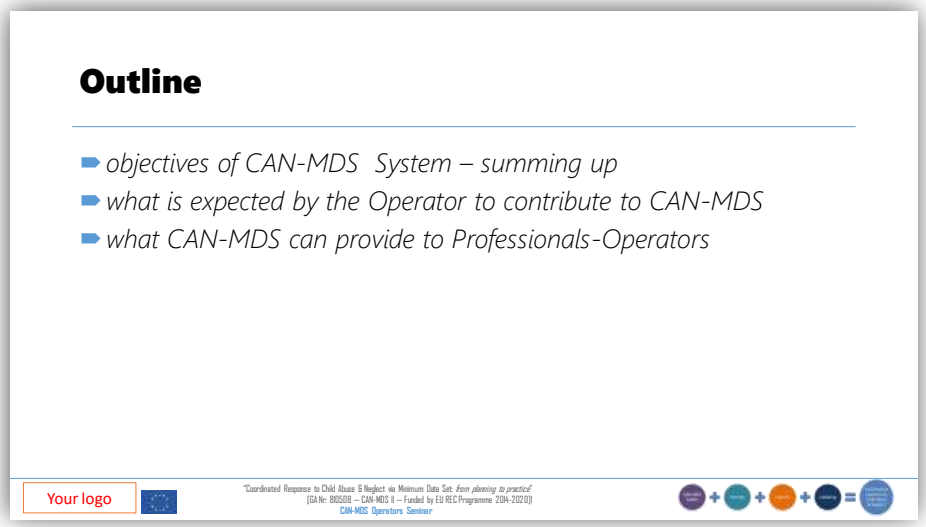
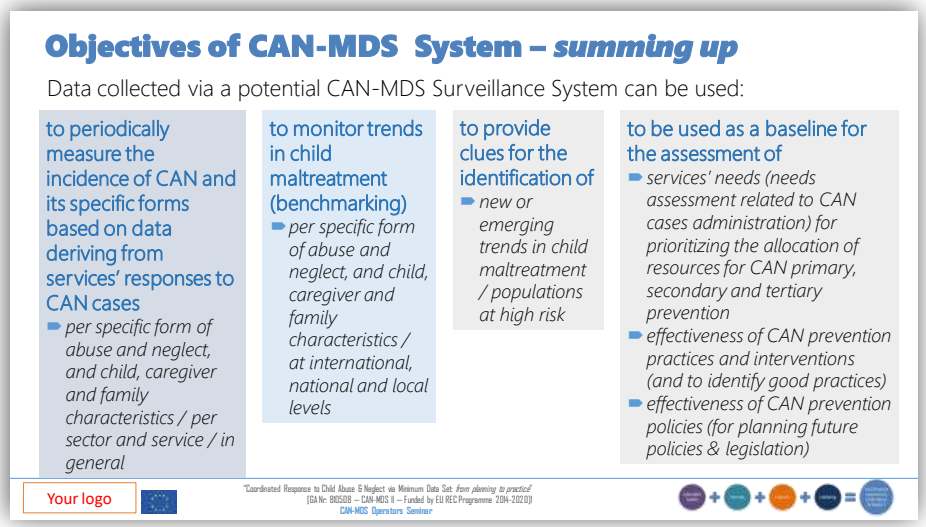


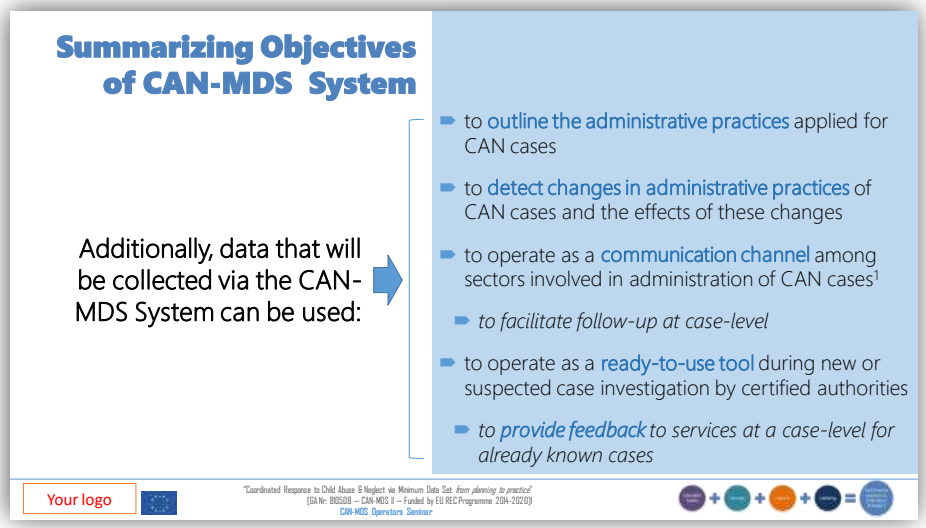
In this last part we are going to sum up the objectives of the CAN-MDS System. Moreover to make clear what is expected by the professionals who trained as Operators to contribute in the system during the pilot phase and, hopefully, afterwards as well as what CAN-MDS can provide to professionals-operators.

Slide 3



<present the objectives following the animation in the slide>

Slide 4



<present the objectives following the animation in the slide>

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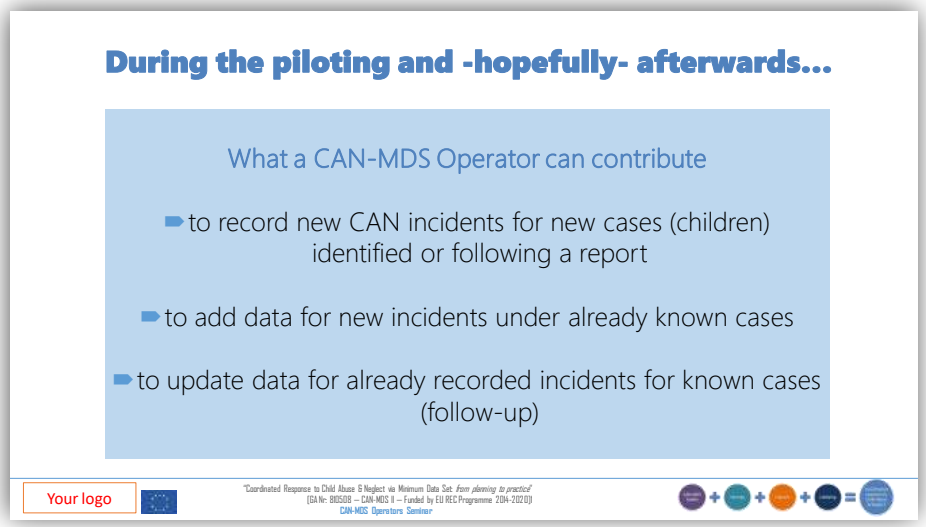

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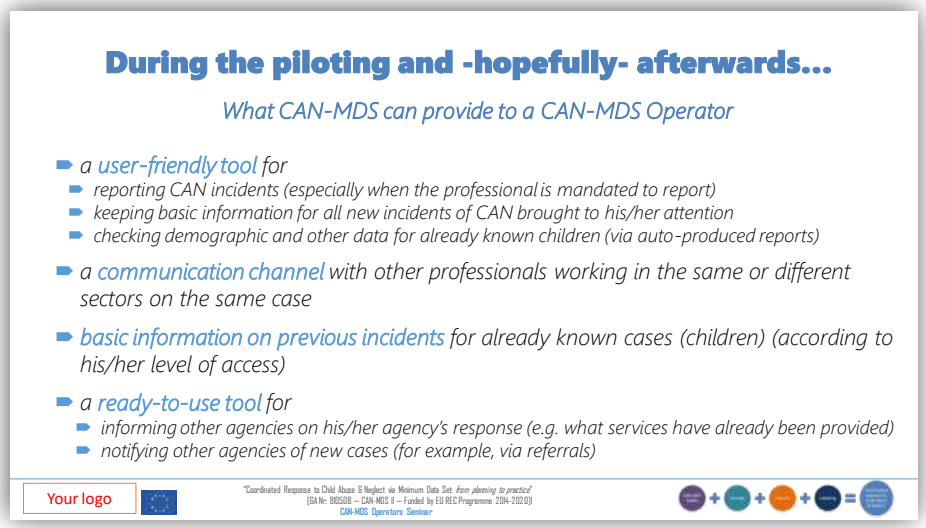

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After the end of this presentation please proceed with the completion of the post-questionnaire; take care to remind trainees to fill-in the code in the right up corner of the document.

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 fia 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).
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][1], UNCRC Article 19,[2] the World Report on VAC (2006),[3] 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*.

[1]Available at: http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf
[2]Available at: http://www.unicef.org.uk/Documents/Publication-pdfs/betterlifeleaflet2012_press.pdf
[3]Available at: http://www.unicef.org/violencestudy/reports.html

CAN-MDS Toolkit

- Content:
    - *CAN-MDS Operator's Manual*
    - *CAN-MDS Data Collection Protocol*
    - *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*

Country specific information

- *National Policy Briefs (Bulgaria, Cyprus, France, Greece, Romania, Spain)*
    - Joining forces to better protect children from abuse and neglect: *coordinated multi-sectoral response to child abuse and neglect cases*
    - 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*

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*

How the CAN-MDS was developed (Available at: 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

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

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://fncaringsociety.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)

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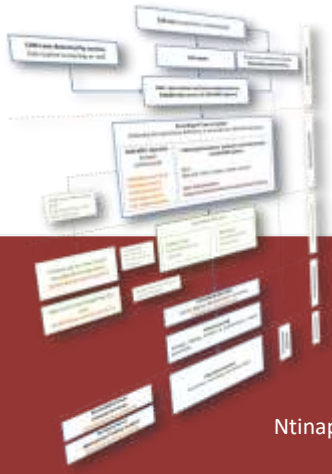

CAN-MDS Guide for Trainer

Ntinapogias, A., Chouchourelou, A., Gray, J., Jud, A., Nikolaidis, G. & CAN-MDS II Action's Partners and IT Experts