Policy Brief

Ntinapogias, A. & Nikolaidis, G. (2019). Athens: Department of Mental Health & Social Welfare, Institute of Child Health

Joining forces to better protect children from abuse and neglect

Coordinated multi-sectoral response to child abuse and neglect cases

Child Abuse and Neglect is a major public health problem

1999 The World Health Organization recognized child abuse as a major public health problem (WHO 1999).

2008 Child maltreatment was recognized as a social problem that lends itself to a public health framework of study and subsequent prevention activities (O'Donnell et al. 2008).

2016 Child abuse and neglect has long been examined through a social service and child protection lens, but incidents of child abuse and neglect often come to the attention of multiple agencies and sectors (Fortson et al. 2016).

2018 Child maltreatment is a major public health problem, affecting at least 55 million children in the WHO European Region. The impact of abuse and/or neglect in childhood is detrimental to physical, psychological and reproductive health throughout the life-course, yet the high costs to society are avoidable (Sethi et al. 2018)

What is the true extent and the nature of the problem in our country?

The answer is "*we do not know*"; "*given the evolving nature of the identification, detection, and response to child maltreatment, no existing data collection system can represent all maltreated children*" (Fallon et al. 2010).

What is the number of child maltreatment cases reported during the last year in our country?

Although this is a totally different question and the response would be just as simple and known, the answer again is "*we do not know*"! This is because until now there is no mechanism in place for systematic reporting and/or recording of reported cases of child abuse and neglect.

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

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

CAN-MDS Policy Brief at a glance

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.

Session 1 describes available data at national level and professionals' assessments about data collection practices

Session 2 presents major data sources that can be used in improving surveillance of child maltreatment and administration at a case level.

Session 3 outlines the rationale of CAN-MDS system and presents CAN-MDS Toolkit and flowchart.

Session 4 summarizes the results of the CAN-MDS SWOT analysis and the main points of the brief.

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Session 1: What the available data show

BECAN Study: Greece

Main findings of the *Balkan epidemiological study on child abuse and neglect (BECAN E.S), which was conducted from 2011 to 2012 with representative sample of children aged 11, 13 and 16 year old and the results of the BECAN case-based surveillance study (BECAN CBSS), which was conducted in services covering the same geographic areas and the same age group of children).*

BECAN E.S: Self-reported incidence of adverse experiences (physical/ sexual/ psychological violence and feeling of neglect) (N=10451)	**BECAN CBSS:** Cases identified in services' files (same time period, population of reference & geographic areas)	**Ratio CBSS / E.S.** (cases known to services/ self-reported)
47.38% physical violence	0.18% physical abuse	0.38%
9.54% sexual violence	0.07% sexual abuse	0.73%
70.02% psychological violence	0.53% psychological abuse	0.76%
26.41% feeling of neglect	0.46% neglect	0.74%

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 presents the rates of known cases to services to self-reported rates of adverse experiences. Despite any methodological weaknesses of the CBSS, these rates underline the small number of cases that eventually reach at least one agency and being recorded, confirming for once more the iceberg phenomenon.

CAN-MDS Feasibility Study

To explore the situation in Greece, ICH conducted the CAN-MDS Feasibility study (2015) where professionals' assessments are included in regards to the level of awareness about CAN, currently applied practices and cooperation routes in place among and within sectors administrating CAN cases

Awareness on CAN situation : Greece

According to professionals' assessment, the extent of child maltreatment is not adequately known neither at a national nor at a local level; awareness about the extent of specific forms of CAN as well as changes over time are also not adequately known.

The above finding applies not only for the true extent and nature of the CAN problem in the country but also for CAN cases came to the attention of at least one relevant service.

Mean estimations of the extent to which the magnitude and nature of CAN is known (scale: 0-100) (N=30)

- **14.6** *changes on CAN magnitude OVER TIME*
- **21.7** *magnitude of CAN at a REGIONAL LEVEL*
- **27.2** *magnitude of SPECIFIC FORMS of CAN*
- **29.8** *magnitude of CAN at a NATIONAL LEVEL*

CAN reporting & recording: applied practices

Professionals replied that data collection is in place but it is neither systematic nor at a national level. Where data collection is made, various tools and methodologies are used. Therefore, available data are neither reliable nor comparable.

Professionals estimated that CAN data collection is being applied at 42.8 in terms of geographic coverage (scale: 0=no data collection at all to 100=nationally) and at 43.7 in terms of methodological continuity (scale: 0=no systematic at all to 100=systematically)

Mean estimations of the extent to which common methodologies & tools are used, where data collection practices are applied (Scale: 0-100) (N=30)

- **7.6** *by ALL STAKEHOLDERS working in DIFFERENT SECTORS*
- **24.4** *among AGENCIES belonging in the SAME SECTOR*
- **35.5** *among PROFESSIONALS working in the SAME AGENCY*

Session 2: Data sources-Rationale & need for multi-sectoral approach

General population of children in their everyday life are in contact with various services and professionals either systematically or under specific conditions, according to their age, characteristics and needs. In each occasion, however, the same child undertakes different roles according to the context while each service and/or professional(s) is aware for specific aspects of child's life according to the agencies' interests, commitments, responsibilities and the nature of services provided.

SECTOR	EDUCATION	HEALTH	MENTAL HEALTH	WELFARE	JUSTICE	POLICE
child's ROLE potentially available information per sector: **different responsibilities > different interests > different data**	child > STUDENT -demographics -school performance -learning problems -school adjustment problems -… -CAN incident	child > PATIENT -demographics -medical history -illness -trauma -treatment -… -CAN incident	child > CLIENT -demographics -personal history -various issues e.g. emotional/behavioral -therapy/ cure -… -CAN incident	child > BENEFICIARY -demographics -family history -socio-economic situation -social support - … -CAN incident	child > OFFENDER/ VICTIM/ WITNESS -demographics -history -criminal record -custody issues -… -CAN incident	child > OFFENDER/ VICTIM/ WITNESS -demographics -victimization cases -infringements -arrestments -… -CAN incident

A systematic incident-based surveillance of incidence of identified and reported CAN should rely on information deriving from all sectors and all professionals working in the above settings where children of the general population addressed or are in contact. **Despite any differences related to sectors' mandates, in all these contexts children-victims are visible and, therefore, incidents of child abuse and/or neglect is possible to be identified. To this end, professionals working in the specific settings must be aware on *how* to identify a CAN incident while child protection policies of relevant services should provision clear reporting paths and apply appropriate recording practices for CAN incidents coming into their attention.**

Session 3: CAN-MDS Surveillance System at a glance

CAN-MDS aims

- to *continuously* provide comprehensive, reliable & comparable case-based information for children (alleged) victims of CAN who have used social, health, educational, judicial & public order services at national and international level

AND

- to serve as a ready-to-use tool in investigation and follow-up of children 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

OPERATION

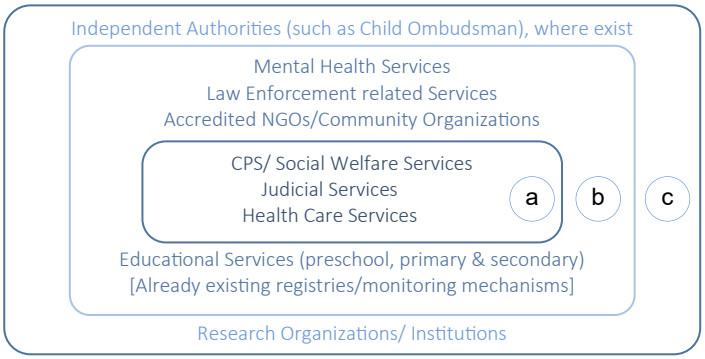
Continuous collection and dissemination of data via a central fully-anonymized registry on the basis of a commonly agreed upon minimum data set; data collection will be made by eligible professionals specially trained as "Operators", having different access level in the system. They will use common UN CRC definitions and methodology, via procedures taking into account all necessary measures for ensuring ethical aspects, privacy of personal sensitive data and confidentiality issues, operating at the same time as a communication channel among stakeholders and facilitating inter-sectoral collaboration and CAN follow-up at a case-level.

STAKEHOLDERS & DATA SOURCES

Stakeholders are professionals who are involved in the route of CAN cases administration following legally defined responsibilities (such as mandatory reporting) in the context of their routine working tasks in agencies, services and organizations belonging in sectors relevant to CAN identification, reporting, administration, treatment, rehabilitation and handling in general.

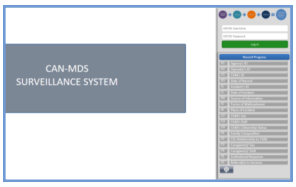
Relevant sectors include the social welfare system; primary, secondary and tertiary health system; mental health system; justice & law enforcement systems; educational system.

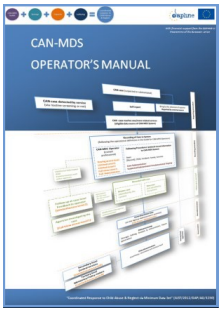
CAN-MDS *data sources**: (a) Core, (b) expanded & (c) under consideration data sources

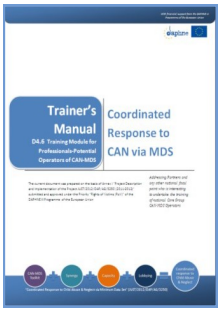


** The suggested sources of data and the operators for a potential CAN-MDS System resulted from a relevant study took place in 2015 in nine countries (BE-BG-CH-DE-ES-FR-GR-IT-RO)*

CAN-MDS Toolkit







CAN-MDS Toolkit The CAN-MDS Toolkit consists of three main elements: a. a Minimum Data Set comprising 18 data elements which resulted from a multiple-round quality and feasibility evaluation process, in which international stakeholders participated; an e-version of the CAN-MDS tool is available for use; b. a *step-by-step* data collection protocol on *how to* use the CAN-MDS system; this protocol could be used by any professional who has already been trained to become an operator; and c. the Operator's Manual where all the necessary background information is included. The main body of the Manual is dedicated to the detailed presentation of the data elements comprising the CAN-MDS, their technical specifications, definitions and the data dictionary; a special section on ethics, privacy and confidentiality issues related to CAN data collection is also included.

Target groups The CAN-MDS Toolkit addresses all professionals who are potential CAN-MDS users in agencies and services in the fields of welfare, health and mental health, justice, law enforcement and education that are involved in the administration of child maltreatment cases, professionals working in the field of CAN secondary and tertiary prevention, social & health scientists and epidemiologists.

Capacity building A large number of professionals -almost all of them mandated to report CAN- is provisioned to be trained on a wide range of CAN issues, starting from definitions, signs for recognizing CAN and reporting procedures, and concluding with the usage of the system for registering new cases, updating information for known cases, proceeding with referrals to other agencies, describing the services already provided and extracting available information (according to their level of access to available information according to their role and accountabilities). CAN-MDS training activities are in line with what it is recommended in Art. 26 "Cooperation & Coordination of Services" of Directive 2012/29/EU as well as in §63 (reporting) and §64 (commitment for better data collection).

Data Framework

Indicators targeted by the CAN-MDS are expected to be policy relevant, able to provide guidance for critical decisions on CAN prevention and administration, simple, sensitive and continuous, able to indicate trends in the problem over time

Exposure to child maltreatment	•CAN incidence •Children's vulnerability to each specific form of CAN •Incidence per type of substantiation
Child maltreatment outcomes	•Physical health outcomes •Mental health outcomes •Developmental outcomes
Surveillance of determinants for child maltreatment	•Risks related to perpetrator(s) characteristics •Child-related risks for CAN •Family and Household-related risks for CAN
Surveillance of services' response to child maltreatment	•Agencies involved during investigation and case administration •Institutional response/ services provided •Legal action taken

Ethics & Data protection To ensure the protection of sensitive personal data in the context of the CAN-MDS Surveillance system, the follow-ng provisions were adopted:

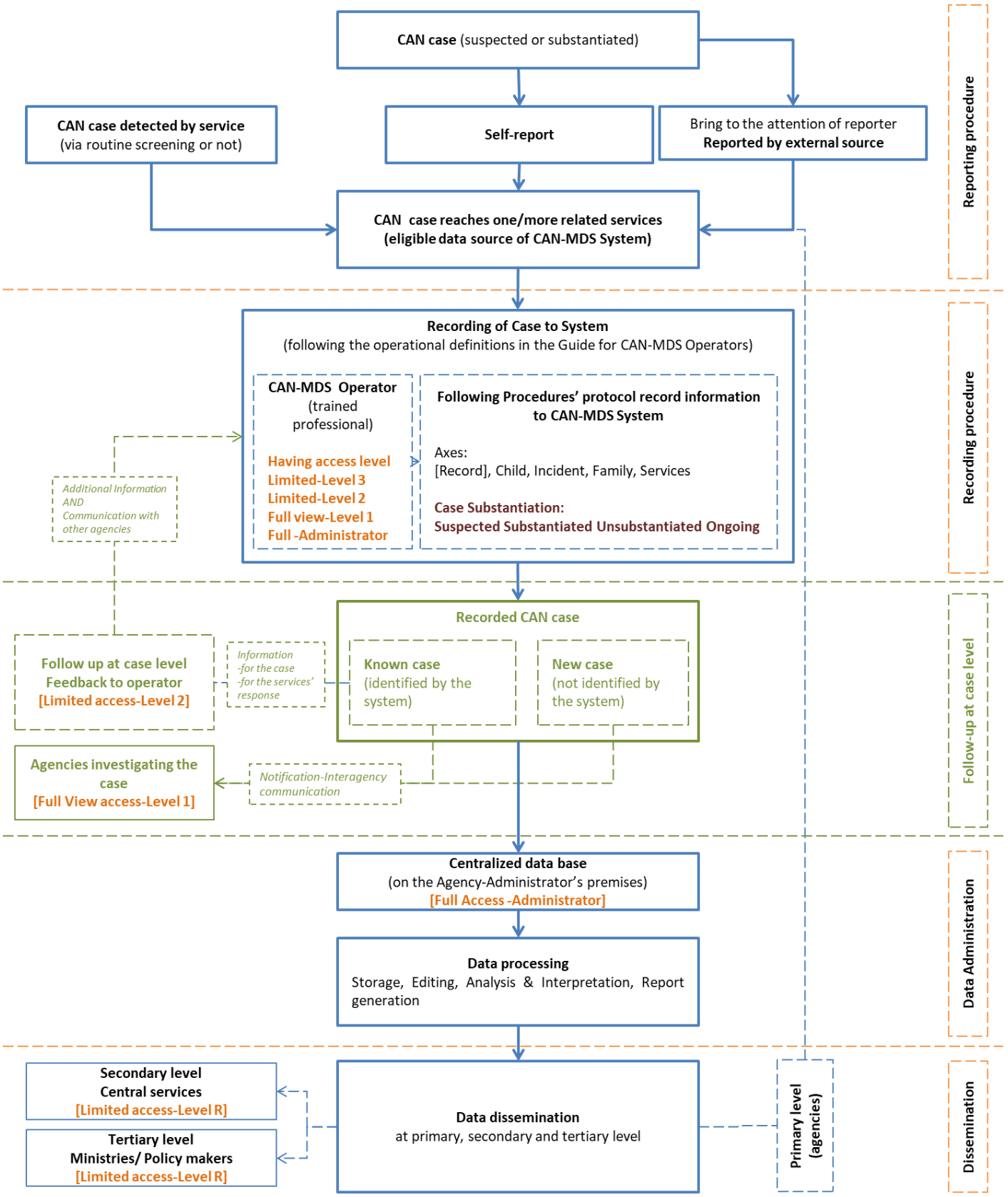
a. **use of the pseudoanonymisation** technique (following the rationale of ISO/TS25237:2008(en)-*Pseudoanymisation*): no personal identifier is recorded in the e-registry; instead, a pseudonym is used. The supplementary data linking the pseudonym with the subject of information (i.e. the child, a caregiver) is available ONLY to the Administrative Authority of the system (IOM, 2009);
b. **eligibility criterion for operators**: only professionals subject to a code of ethics or practice or an equivalent code can participate in the CAN-MDS as operators;
c. **password protected access**: each eligible operator is provided with a unique username and password that contains information on the operator's identity (secondary data related to the agency where s/he works, the geographic area where the agency is located, the professional's specialty and his/her ID within the agency); and
d. **graduated access**: operators are designated with different levels of access (4 levels) to the available information according to their responsibilities during the process of child abuse & neglect cases' administration.

Flowchart of the CAN-MDS Surveillance System

Ongoing and systematic data collection related to child maltreatment cases from a wide basis of data sources by trained professionals-operators with different levels of access to the system.

The CAN-MDS aims, among others, to promote standard description of data and common understanding, harmonization and standardization of data within and across organizations in the same and/or different sectors.

The data that comprise the CAN-MDS registry are derived from 18 data elements classified under 5 broader axes (data element concepts): RECORD, INCIDENT, CHILD, FAMILY and SERVICES



Session 4: SWOT Analysis results

Exploring the feasibility for a National CAN-MDS

SWOT analysis was used as a supportive tool in deciding whether it is appropriate to proceed with CAN-MDS in EU countries. The "internal environment" (system's "strengths" and "weaknesses") was taken into account as well as aspects of the "external environment" (i.e. "opportunities" or facilitating factors and "threats" that expected to hinder the initiative). A total of 136 replies were collected from 12 EU-MSs (BE, BG, DE, EL, ES, FR, HU, IE, IT, PL, RO, SI) on the basis of a tool requesting the respondents to assess both, current situation and potential for CAN-MDS implementation in their countries.

	positive aspects	negative aspects
INTERNAL ENVIRONMENT *related to CAN-MDS characteristics* (assessed during CAN-MDS development)	**STRENGTHS** -promotes uniform definitions of CAN according to General Comment 13 of the UN Committee (2011) -provides estimation of CAN incidence based on expanded sources of information -aims to capture all cases reaching services in various sectors at an early phase, regardless substantiation -promotes uniform data collection regardless of the particular characteristics of operators -requires minimum decision making by the operators -respects ethical rules applied in public health surveillance -is secure concerning the administration of sensitive personal data -is user-friendly and of practical value -continuous real-time data collection -low cost operation in terms of time required for its use (minimum data set) and necessary infrastructure -is easily transferrable in different contexts (within & between countries) -is easily revisable over time	**WEAKNESSES** -requires some short of political decision for its adoption -might require changes/ additions in legislation related to -professionals mandated for reporting CAN cases, -administration of /legislation on sensitive personal data, -professionals' legal immunity -works better the more stakeholders involved in CAN cases' administration are committed to using it -requires continuous presence of a National system's Administrator -requires short training of professionals to become operators -requires basic technical means such as server, telephone and internet lines in each agency -requires cultural adaptation in order to be transferred in the country -requires revision over time (as all MDSs in general) -requires pilot testing in real conditions
EXTERNAL ENVIRONMENT *related to general socio-economic & political conditions* (assessed via feasibility study)	**OPPORTUNITIES** -prioritization of CAN prevention among public health problems and in political-financial agendas of EU-MSs -conformity of CAN-MDS with the currently applicable national legislation & legislation following harmonization to international law e.g. UN CRC -availability of one national authority having the capacity to become national CAN-MDS Administrator & expected commitment of this authority to the role of the CAN-MDS Administrator -availability of technical means related to: procurement of a secure server; at least one telephone or fax line and one device with internet connection per agency -expected commitment of agencies involved in CAN cases administration to participate in a National CAN-MDS System -expected commitment of professionals involved in CAN cases' administration to act as operators of a CAN-MDS System	**THREATS** -prioritization of CAN prevention among public health problems and in political-financial agendas of EU-MSs -conformity of CAN-MDS with the currently applicable national legislation & legislation after harmonization to international law -availability of one national authority having the capacity to become national CAN-MDS Administrator & expected low commitment of this authority to the role of the CAN-MDS Administrator -availability of human resources on the part of relevant agencies and of financial resources for short-training of system Operators and for hosting & maintaining a server -availability of technical means related to procurement of a secure server; at least one telephone or fax line and one device with internet connection per agency -expected commitment of agencies involved in CAN cases administration to participate in a National CAN-MDS System -expected commitment of professionals involved in CAN cases' administration to act as operators of a CAN-MDS System -existence of other systems/ resistance to proceed with CAN-MDS

Main prerequisites for CAN-MDS

- *capacity building of professionals to identify CAN incidents*
- *establishment of clear referral pathways for identified CAN cases*
- *commitment to CAN-MDS aims & operation by relevant sectors, services & professionals*
- *political willingness to adopt & support CAN-MDS*

Main points

Child abuse and neglect affect individuals' physical and mental health during their childhood as well as into their adulthood.

Apart from physical, psychological and behavioral consequences for victims, child abuse and neglect result in costs including, among others, *medical costs (childhood and adult health care), productivity losses, child welfare costs, criminal justice costs, and special education costs;* **economic burden of both, fatal and non-fatal child maltreatment for society is also significant** (Fang et al 2012).

Research suggests the **benefits of effective prevention likely outweigh the costs of child abuse and neglect** (CDC 2018). Effective prevention is to stop child maltreatment from happening in the first place (primary prevention); to identify maltreatment already in place and avoid re-victimization (secondary prevention); and to support victims already suffered abuse (tertiary prevention). Due to complex nature of the problem, primary and secondary prevention require adequate knowledge of the problem, its extent and special characteristics.

'the true extent of child maltreatment is unknown' "*Between half to four fifths of all victims of maltreatment are not known to child protection services*"; the "*tip-of-the-iceberg analogy easily comes to mind when one thinks of the scope of child maltreatment*" (Trocmé et al 2005; Bolen & Scannapieco 1999; Sedlak & Broadhurst 1996)

'the number of official cases clearly underestimates the true extent of the problem' This is what the comparison among *self-report* and based on *administrative data* surveys shows.

'child abuse and neglect has long been examined through a social service and child protection lens' (Fortson et al. 2016); incidents of child abuse and neglect, however, often come to the attention of multiple agencies and sectors stressing the need for a multi-sectoral and multi-disciplinary response to child abuse and neglect

'the responsibility for promoting children's wellbeing and protecting children from abuse and neglect belongs to everyone'; tackling under-reporting and promoting multi-disciplinary cooperation among relevant professionals is required in order to effectively protect and support victims of violence against children

'reporting rates of child abuse and neglect shall be improved; everybody –including professionals- has a duty to proceed with the reporting to authorities of concerns involving threats for children's safety.

'information sharing between agencies and professionals can lead to appropriate decision making at a case-level'; effective information sharing, however, should not harm at any way involved children and, therefore, shall be subjected to legislation relevant to sensitive personal data and professional codes of ethics protecting confidentiality of information

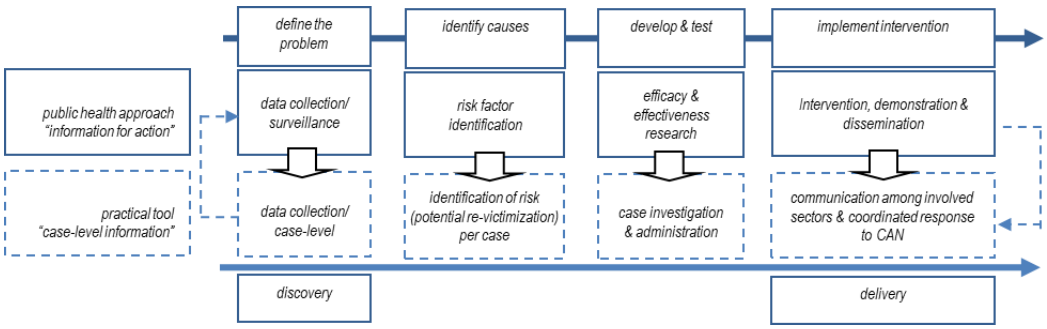
'capacity building of relevant professionals in recognizing and reporting child abuse and neglect is required'. Children are most likely to disclose abuse to adults they trust; professionals working with and/or for children have a special responsibility. For some professionals' groups reporting of CAN is mandatory (although in some cases there is no legal provision neither for professional immunity in case of reporting nor for penalties in case of non-reporting)

UN Committee on the Rights of the Child (2012) Concluding Recommendations: Greece

... (to) strengthen its mechanisms for data collection by establishing a national central database on children and developing indicators consistent with the Convention, in order to ensure that data is collected on all areas covered by the Convention, particularly on violence, trafficking and sexual exploitation of children...

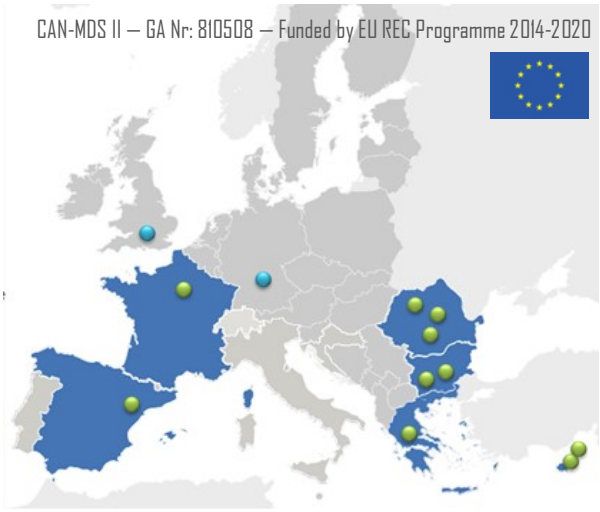
Coordinated response to child abuse and neglect via a Minimum Data Set

CAN-MDS suggests that ongoing systematic multi-sectoral, based on common definitions and tools data collection for identified and/or reported child abuse and neglect cases, regardless status of substantiation, by trained multi-disciplinary professionals working with and/or for children in various settings can be the first step for effective primary and secondary prevention of violence against children: better understanding of its magnitude, trends, nature, and services' response can guide policies and strategies to prevent violence before it starts (public health approach) and to timely stop it –if already started (case-level information).



Action "CAN-MDS II"

Identity of the Action "Coordinated Response to Child Abuse and Neglect via a Minimum Data Set: *from planning to practice*"



Action number: **810508** Action acronym: **CAN-MDS II**
Starting date: **01/11/2018** Duration: **24 Months**
Call identifier: **REC-RDAP-GBV-AG-2017**
Topic: **Prevent & combat gender-based violence & violence against children**

Consortium

INSTITUTE OF CHILD HEALTH (COORDINATING ORGANIZATION)	Greece
GIP ENFANCE EN DANGER	France
FUNDACIO PRIVADA AROA	Spain
FEDERATIA ORGANIZATIILOR NEGUVERNAMENTALE PENTRU COPIL	Romania
DARZHAVNA AGENTSIA ZA ZAKRILA NA DETETO	Bulgaria
UNIVERSITATEA BABES BOLYAI	Romania
SOUTH-WEST UNIVERSITY NEOFIT RILSKI	Bulgaria
HFC HOPE FOR CHILDREN CRC POLICY CENTER	Cyprus
DIRECTIA DE ASISTENTA SOCIALA SI MEDICALA	Romania
MINISTRY OF LABOUR AND SOCIAL INSURANCE	Cyprus

AIMS

CAN-MDS II Action has a dual aim:

- to contribute to the protection of maltreated children and children at risk by building the capacity of professionals working with or for children in recognizing CAN cases and by facilitating reporting of identified or suspected cases and follow-up at a case level;
- to create the scientific basis, necessary tools and synergies for establishing national child abuse and neglect monitoring mechanisms using a minimum data set, common methodology and definitions throughout all relevant sectors.

OBJECTIVES

CAN-MDS II Action targets to:

- ensure the availability of necessary resources, training modules & toolkits for building the capacity of professionals working with/for children in reporting & registering CAN cases;
- pilot the CAN-MDS system in real conditions at different levels in 6 MSs for testing the extent the system is able to improve cooperation of professionals within & among child well-being-sectors, increase reporting & facilitate the administration of CAN cases;
- provide -at a case level- comprehensive & reliable data essential to inform prevention, identification, reporting, referral, investigation, treatment, judicial involvement & follow-upl
- provide -at a population level- aggregated data essential to identify trends, measure responses & feed into policy development .

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