Policy Brief

Institute of Child Health, Department of Mental Health and Social Welfare

Towards the establishment of an inter-sectoral epidemiological surveillance mechanism for child abuse and neglect incidents in European countries

challenges and lessons learned from the piloting of CAN-MDS System

Why an inter-sectoral epidemiological surveillance mechanism for child abuse and neglect incidents is needed?

Child abuse and neglect constitutes a complex public health problem caused by numerous factors related to individual, family and community characteristics (WHO 1999; NIH 2007) and occurs in every country across all social, cultural, religious and ethnic population-groups, resulting in immediate and long-term social, health and financial consequences (Pinheiro 2006; Runyan *et al.* 2009).

There is sufficient evidence in international literature suggesting that large numbers of abused and neglected children are not coming to the attention of child protective authorities while, from those eventually coming to authorities a large part is not registered appropriately. Thus, despite the importance of the problem, accurate estimates of its extent and characteristics in the general population –information which is necessary to inform planning and evaluation of prevention and intervention initiatives- are difficult to achieve because of two main interlinked problems: *under-reporting and under-recording of child abuse and neglect.*

Needs to be addressed

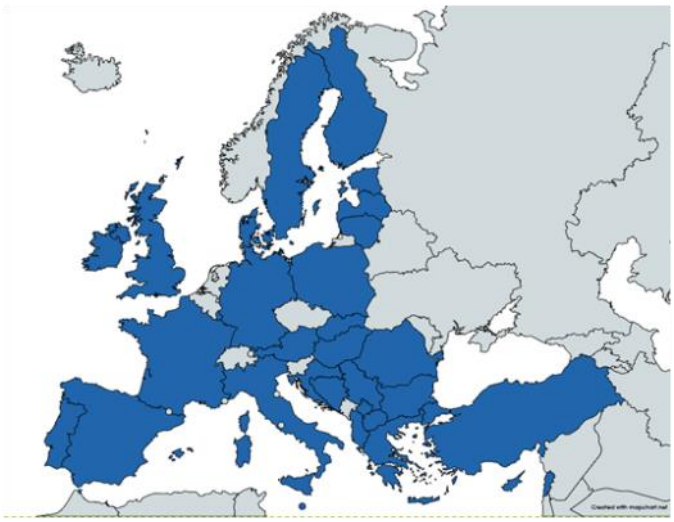
The necessity for data collection on child abuse and neglect (CAN) is a commonly accepted priority worldwide and in the European countries in particular. Therefore, the necessity for child maltreatment surveillance mechanisms that provide continuous and systematic data to monitor the magnitude and impact of CAN is undeniable. However, in most of the European countries it is a fact that CAN case-based data are often derived from a variety of inter-sectoral sources involved in the administration of cases and follow up of victims at local and national levels is not sufficiently coordinated among the involved services. In the General Comment 13 (2011) of the UN CRC it is noted that "*[…] The impact of measures taken is limited by* ***lack of knowledge, data and understanding of violence against children*** *and its root causes, by reactive efforts focusing on symptoms and consequences rather than causes, and by strategies which are fragmented rather than integrated.*"

Main barriers for effective administration of the CAN problem include: difficulties in recognition of CAN by professionals working with and for children; underreporting -even from mandated professionals; lack of common operational definitions; weak follow-up at a case level; lack of common registering practices and the use of a variety of methods and tools for collection and sharing information among involved parties within and between sectors. Due to insufficient registration of CAN reports follow up of cases at local and national levels is not sufficiently coordinated. At an international level, where monitoring systems exist, they vary considerably, so that comparisons are not feasible. Reliable data, however, are crucial to end the invisibility of violence, challenge its social acceptance, understand its causes and enhance protection for children at risk. Data are vital to support in each country government policy, planning and budgeting for universal and effective child protection services, and to inform the development of evidence-based legislation, policies and implementation processes.

This publication was funded by the European Union's Rights, Equality and Citizenship Programme (REC 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.

Current Situation in European Countries

In June 29-30, 2021 the CAN-MDS European Conference took place, where Experts across EU-27 were invited to present key issues related to child abuse and neglect data collection in their countries, focusing on challenges and currently applied good practices. Apart from European countries' representatives Experts from USA and UK also presented key issues related to data collection on child abuse and neglect. Lastly, in a distinct session CAN-MDS II Action Partners presented the main results of piloting of the CAN-MDS System in their countries. In the next pages information for CAN-data collection is presented on the basis of these presentations focusing on current situation, good practices and challenges.



Child Abuse & Neglect data collection in Austria

Chryssa Grylli, Dept of Pediatrics and Adolescent Medicine, Medical University of Vienna
FOKUS

(based on the presentation in the CAN-MDS Conference, June 30, 2021)

FOKUS (Forensische Kinder- und Jugenduntersuchungsstelle / forensic pediatric and adolescent examination center) is a task force of the department of Pediatrics and Adolescent Medicine of the Medical University of Vienna. As a multidisciplinary team, FOKUS offers timely support in real-time investigations and clarifications in cases where child maltreatment is suspected. FOKUS supports forensic, clinical/psychological examinations, diagnosis/reporting, suggested measures, etc. as well as further education/training/ information events; standardized documentation and checklists; and cooperation with child and youth social cervices, public prosecutors office and law enforcement.

Background: Since 2004 child protection teams (CPTs) are legally required in Austrian hospitals. These multidisciplinary teams (clinicians, psychologists, nursing staff, social workers and if available a forensics physician) are responsible for the management of abused and neglected children as well as their parents and families. Extramural child protection work is offered by child welfare services (CWS) and several non-public community services.

In Austria there is a mandatory reporting system for child maltreatment. Notification is required when during the exercise of the professional activity the well-founded suspicion arises that by a judicially criminal act children or young people are or have been mistreated, tortured, neglected or sexually abused; when death, grievous bodily harm or rape was caused and when adults who are unable to act or make decisions or who are defenseless because of frailty, illness or mental disability have been abused.

Reporting systems: Hospitals (system depends on hospital provider; FOKUS created the first database on CAN cases in Vienna); *Child and youth social services for the Vienna area* (provide yearly reports on their activities; these reports provide numbers for cases reported, types of abuse suspected and who reported the case; available at: www.wien.gv.at/kontakte/ma11/publikationen.html); *Police statistics* (are available via statistics Austria; provides information and distribution statistics on type of crimes; available at: www.statistik. at/web_de/statistiken/menschen_und_gesellschaft/soziales/kriminalitaet/index.html)

Problems-weaknesses: absence of clear case-definitions; incorrect ICD-code completion; absence of centralized data banks (states, institutions); and poor training, reluctance to notify the appropriate authorities, absence of clear guidelines and procedures, result in misdiagnosis, poor probe storage and analysis, and incorrect documentation. Often, the absence of multidisciplinary cooperation contributes to the reluctance to report suspected cases of child maltreatment.

Current Situation in European Countries

Child Abuse and Neglect data collection in Croatia

Miroslav Rajter, University of Zagreb

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Croatia: Basic Information

Population: 4.1 million | Cohort size: 37.000 | Report rate: 1.18% (16 y/o) |
No. of new CAN cases: 2.300 | CV prevalence: 26% (16 y/o)

The legal basis related to child abuse and neglect consists of:
- Criminal Act (is referred to the most severe forms of CAN)
- Family Act (all forms of violence are prohibited; everyone has to report)
- Act on Protection against Family Violence (repercussions for not-reporting for experts)

CAN Reporting System: Social Care sector is the core element of the system; other related sectors are Justice; Police; Health; Education and others. According to Family Act all cases should be reported to Social Care system. According to Act on Protection against Family Violence all cases should be reported to police or justice system.

Data collection issues

- 30% of school personnel does not know their legal obligations in regards CAN cases reporting
- The need for continuous monitoring is not present (although it is proscribed)
- Data collection is purposeful (but not for research)
- Different units of analysis are used within sectors (child, family, perpetrator, patient, case, etc.)
- There are no systematic prevalence studies
- There is no single system dedicated to CAN
- Digitalization in CAN data collection is not fully implemented yet

Beware of the under-representation

Child abuse and neglect data collection practices in Denmark

Troels Græsholt-Knudsen, Department of Public Health, Aarhus University

Presented in the CAN-MDS EU Conference, June 29-30, 2021

In Denmark, all forms of physical abuse are forbidden since 1997. The Law of Service mandates all citizens to file reports on suspicion of maltreatment of any form to their municipality. A survey from 2016 estimates that 17% of Danish youth have been exposed to violence within the last year; 8% were exposed to psychological violence and 12% to sexual violence.

Data sources: In Denmark all records by public institutions is linked through a personal identifier. This information can be anonymized and made available for research purposes.

Health: Information on maltreatment is available from national in-patient data - before 1994 ICD 8-codes are used, but with varying local practices at different institutions. The author can be contacted for diagnoses and references. After 1994 ICD 10-codes are used - for diagnoses currently recommended see: https://bit.ly/3A2erdj. Maltreatment with lethal consequences is recorded in cause of death-registers. Police and courts: Court decisions are available since 1980, reports to the police since 1990 and registry linking of victims and perpetrators is available since 2001. Perpetrators under the age of 18 are registered since 2005. An informal assessment by the author found 151 unique codes related to maltreatment, but the number of codes in actual use may be much lower. Social services: Reports to municipalities of possible maltreatment is nationally available with a limited number of variables - but only since 2015. A lot of local data exist. Surveys link -able to national registries: Only one major survey exists, see https://bit.ly/3rq8jaz (in Danish). Other sources: A number of surveys have been conducted, but are not link-able to national registries - contact author for further information.

Challenges: There is no standardized procedure, for example an interdisciplinary review, of diagnoses assigned in the health sector. Many variables across the systems are composites of different sub-types of abuse. Unsubstantiated reports are only recently available on a national scale. There is no automatic sharing of information across branches of the public sector. Among health workers there is a wish for better education on maltreatment.

Current Situation in European Countries

Child abuse and neglect data collection practices in Estonia

Kärmen Toros, School of Governance, Law and Society, Tallinn University

Presented in the CAN-MDS EU Conference, June 29-30, 2021

Based on statistics from Ministry of Social Affairs (2019), the number of children identified in need of assistance has increased in recent years in Estonia. According to the Child Protection Act (2014, §26), the child in need of assistance in Estonia is defined as "a child whose well-being is threatened or in the case of whom doubt has arisen concerning his or her abuse, neglect or any other situation violating the rights of the child and a child whose behaviour threatens his or her well-being or the well-being of other persons". In 2007, 2,396 children in need were registered (0.9% of the total population of children in that year), whereas in 2017, the number of children registered as in need of assistance was 8,366, representing 3.3% of the total population of children. The increasing number of children in need indicates a greater number of assistance and support required by children. Nevertheless, there is no systematic data collection on national level, including data collection protocol. Some data is collected annually by the Ministry of Social Affairs from child protective workers (e.g., number of active cases of children in need, new cases of children in need, children removed from their biological families, children's placement in substitute care) based on children's age groups, not by specific form of abuse/neglect. This general data (up to 2015) was publicly available in the database of Statistics Estonia until 2021. Since 2021, the data is partly accessible on the webpage of Ministry of Social Affairs. Ministry of Justice, Criminal Policy Department, is collecting data from various institutions, including police, Children's House (data on sexually abused children receiving services), victim support service. The data is provided in the form of reports, whereas latest statistics is not available (data in reports dates back 2-3 years). Self-reported incidences of abuse and neglect is additionally collected by the hotlines (e.g., national Child Help hotline, Victim Support Crisis hotline).

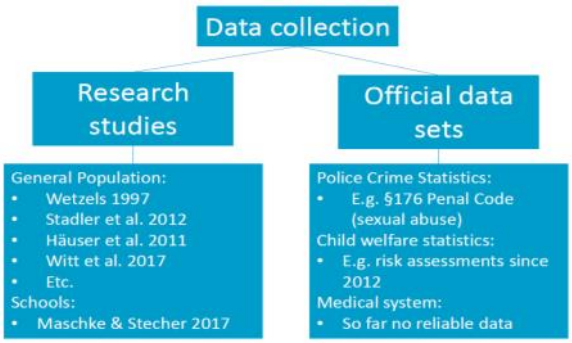
Developments on child maltreatment data collection practices in Germany

Andreas Witt, Department of Child and Adolescent Psychiatry & Psychotherapy University Hospital Ulm

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Main issues on CAN data collection in Germany

- There is no mandatory reporting
- Child protection agencies can/should be informed based on reasonable suspicion
- There is no registry/ central data collection
- Data are collected in different systems, based on different definitions and for different aims
- There is a focus on sexual abuse
- There is no linking of data



Developments

- Ban of corporal punishment in 2000
- "Sexual Abuse Scandal" in Germany 2010
- Round Table, Installation of an Independent Commissioner for Child Sexual Abuse Issues
- Legal changes (e.g. data collection on risk assessments since 2012)
- Establishment of a National Council against sexual violence against children (2019)

National Council against sexual violence against children (2019)

AIM: 1. Better protection of children and adolescents and
2. Establishment of a valid and continuous monitoring through a strategic research approach

- Working groups on Protection, Support, Child-oriented justice system, protection against exploitation and international cooperation, Research and Science
- Guidelines for a strategy for data collection: High ethical standards; Inclusion, participation of victims; Combination of research and support; Incorporate studies into chains of measures; Conduct studies with children and adolescents; Also collect data on other types of maltreatment; Conduct household studies as well as school studies; and Relate agency data with study data
- Establishment of a national competence center to monitor violence against children

2022 step-wise introduction of the ICD-11 that contains a new section to code child maltreatment; Potential to collect data in the medical system

Data collection on child abuse and neglect in Hungary

Gábor Juhász & Andrea Rácz, Eötvös Loránd University, Budapest

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

The Hungarian child protection system is determined by Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship and it is aimed at facilitating that, children shall be raised in families, at preventing and terminating their vulnerability and at ensuring the substitute protection of the child without parental care or care provided by other relatives.
Overview on data collection in the child protection system by the Hungarian Central Statistical Office: Legal framework, protocols, the methods, actors and main data of data collection.
Hungarian child protection system is determined by Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship and it is aimed at facilitating that children shall be raised in families, at preventing and terminating their vulnerability and at ensuring the substitute protection of the child without parental care or care provided by other relatives. Which child protection measures are needed, is based on the scale of children needs.

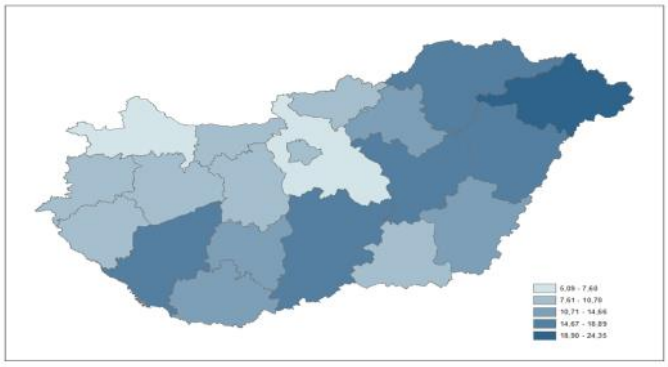
Legal Framework

- Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship: 2016 – 2 levels in the child welfare service system to reflect risk in the family: 1) child welfare services based on family social work – municipal level; 2) child welfare centres based on case management after legal procedure – micro-region level , 2018 – kindergarten and school social work, 1 professional / 1000 children and youth
- Protocol on recognition and elimination of child abuse related to the signal system (unified and sector neutral principles and methods, Ministry of Human Resources, 2017, 3rd edition) – in accordance with the health system's protocol on child abuse (Health professional principles, Ministry of Human Resources, 2016)
- Protocol on recognition and elimination of child abuse in the child protection system (institutional care, foster care, custody for young criminals, Ministry of Human Resources, 2018)
- GYVR system (Protect our children registration system) – from July 1st, 2021, it's a new digitalized system from basic care services to child protection, based on social insurance number for new and current clients, reports can download, Hungarian Central Statistical Office will get data from this system – it's not connected with the health and education system.

Data collection – Hungarian Central Statistical Office (HCSO)

Data collection takes place at all levels of the Child Protection System at an annual basis. Currently no thematic or systematic analysis on annual data is applied. The problem is that these data are aggregated on county/regional level. The new GYVR system will give a chance to follow the child's way in the system and get reports about neglect and child abuse in different aspects.
Actors – within Child Protection System: Child welfare services; Child welfare centres; Temporary homes for children; Temporary homes for families; Regional child protection agencies; Guardianship offices;

In the year 2017, 20 948 children were under professional child care provision, which means an increase of 400 children to the previous year. Around 12% of the children taken into professional child protection were under the age of 3 years. About half of the children were between 11 and 17 years old, making them the largest group of children under provision. Besides them, 2 417 young adults (between 18 and 25) were placed in after-care provision. Analysis of the regional dimensions of professional child care provision showed that 24/1000 children were under professional child care provision in the county Szabolcs-Szatmár-Bereg in the north-eastern region of Hungary; this is quintuplicate of the data of the county Győr-Moson-Sopron, which is an economically well-developed county at the Austrian border.



Minors under professional child care (per 1000 inhabitants of corresponding age), HCSO, 2017

Effects of COVID-19 in the child welfare system

When analyzing the Hungarian child protection system, we can conclude that both regarding the accessibility and extent of services, and the basic and special services, there are significant regional and internal structural inequalities with regard to the possibilities to respond to needs. High numbers of cared children are rather typical for regions where deep and complex social problems prevail. This situation became harder under the COVID-19.

- 87% of the Child Welfare Sevices had lack of IT tools
- Legal and psychological support for 6000 people in 15000 cases
- Signal system became „blind" (signals came from the police and doctors)
- Total number of all support: 8700 clients in 26000 cases (donation, support digital education)
- Family care was reduced, because of support the elderly
- Family abuse: in 700 cases!
- Ethical dilemmas under the pandemic situation in family care work: „dangerous helper, dangerous client"
- Structural problems became more visible in the child protection system, but NGOs had important complementary roles in help.

Child Maltreatment Data Collection in Ireland, Good Practices and Challenges

Sadhbh Whelan, Department of Children, Equality, Disability, Integration and Youth, Dublin
Ciara Murray, Tusla, Child and Family Agency, Dublin,

Presented in the CAN-MDS EU Conference, June 29-30, 2021

CAN-data collection in EU Countries

Austria

Croatia

Denmark

Estonia

Germany

Hungary

Ireland

Italy

Latvia

Lithuania

Malta

Poland

Portugal

Slovakia

Sweden

CAN-data collection Outside EU countries

USA

UK

CAN-MDS Piloting

Greece

Cyprus

Spain

Bulgaria

Romania

External Evaluator

Next steps

France-EuroCAN Action

Policy and legislative context

Government responsibility for improving outcomes for children and young people in Ireland is with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) (https://www.gov.ie/en/organisation/department-of-children-equality-disability-integration-and-youth/).
As part of its work, the DCEDIY has oversight of the governance and performance of Tusla, Child and Family Agency (https://www.tusla.ie/).
Tusla was established in 2014 and is Ireland's dedicated State agency responsible for improving wellbeing and outcomes for children. Services provided by Tusla include child protection and welfare services, alternative (State) care and adoption services, family support and early years school age services, education support services and domestic, sexual and gender based violence services (DSGBV). Tusla is a national organisation, with 17 area based child protection teams and children in alternative (State) care teams, and a national team that looks after the needs of children seeking international protection.
The Child Care Act 1991[1] is the primary piece of legislation regulating child care and child protection policy in Ireland. It is a wide ranging piece of legislation which, at its core, seeks to promote the welfare of children who may not be receiving adequate care and protection. The Children First Act 2015 was commenced in full on 11th December 2017. This act places a number of statutory obligations on specific professionals (mandated persons) and on particular organisations providing services to children. Under this Act mandated persons are required to report any concerns or information, above a defined threshold, that indicate a child has been harmed, is being harmed or is at risk of being harmed. Mandated persons include police officers, teachers, social workers, and other health professionals who may not have contact with children but may come across harm, for example adult psychiatrists and addiction counsellors. This Act also states that all services and organisations, that have contact with or access to children, must have a Child Safeguarding Statement. This is a written statement that sets out how organisations assess potential risks to children and what they will do to keep them safe.
The policy intent is that the Children First Act 2015 will operate side-by-side with the existing non-statutory obligations provided for in *Children First: National Guidance for the Protection and Welfare of Children* (2017) (https://www.tusla.ie/children-first/report-a-concern/). Non-statutory obligations for all persons coming into contact with children are detailed in this guidance. The Tusla website also provides definitions of abuse and all processes to be followed, including an on-line portal for professionals and others to submit referrals concerning child abuse and neglect. In practice, this means that all concerns regarding the welfare and protection of children, above a defined threshold, should be received by Tusla. While other organisations and bodies in Ireland provide services to children and families, if they are concerned about the safety or welfare of a child they are obliged to report their concern to Tusla.

Snapshot of Statistics (2020)

The child population of Ireland is approximately 1.2 million of an overall population of 4.9 million. Almost 70,000 child protection and welfare referrals were received by Tusla in 2020,[2] equivalent to about 59 referrals per 1,000 children living in Ireland. Generally, a larger proportion relate to child welfare concerns (45% in 2020)[3] than child protection (child abuse) concerns (32% in 2020). The majority of referrals don't reach the threshold for child protection services and only about a quarter receive an initial assessment.

[1] The Department of Children, Equality, Disability, Integration and Youth has commenced a review to update the Child Care Act 1991.

[2] Referrals increased significantly in 2020 as Tusla now counts all referrals or concerns about the welfare and protection of children and not just those requiring a social work response.

[3] The primary report type was not available for the remaining 24% of referrals.

Principal referrers to child protection and welfare services include An Garda Siochana (AGS) (the Irish police force), teachers and health professionals.
There are approximately 6,000 children in State care, the vast majority of whom (92%) are in foster care placements (including relative care). The remainder are placed in residential care.
At the end of each year there are approximately 1,000 children listed as active on Ireland's child protection register, termed the Child Protection Notification System (CPNS).
Some increases have been noted in the number of referrals to Tusla from adults concerning abuse in their childhoods, which may be related to the introduction of mandatory reporting.

Data collection on child abuse and neglect in Ireland

In 2018 Tusla implemented the roll out of the National Child Care Information System (NCCIS), an integrated case management system, which manages child abuse and neglect and alternative care data.

Tusla publish a wide range of monthly, quarterly and annual data on the number of referrals received and the services provided (https://www.tusla.ie/data-figures/2021-performance-data/). Tusla also has an interactive data hub, which allows users to visualise performance and activity open data as interactive charts (https://data.tusla.ie/).

The NCCIS has improved the integrity of the data collected, brought more consistency to the interpretation of data metrics, provided scope for additional data to be gathered and improved the management and oversight of cases. The remainder of Tusla services record and collate data on a range of bespoke electronic and paper based systems.
Consultation is underway to plan for the next stage of the NCCIS. It is proposed to move all Tusla's services on to one case management system. This is a welcome and positive development. It will mean that links (connections) can easily be made across all services, enabling frontline staff to see which services a child and family are currently (or were previously) engaged with and who are the key personnel. It should also build and strengthen the capacity of Tusla to generate comprehensive and useful data from their services for a variety of purposes.
Improved data collection and the routine publication of quality data metrics provides a national insight into the reporting of concerns relating to child welfare and abuse, including neglect, in Ireland. It plays a key role in the Government Department's oversight of Tusla in relation to budgetary decisions and informs quality assurance and checks of the services provided. The national picture assists Tusla management in decisions regarding the distribution of workforce and resources.

Understanding and addressing key trends in data

Analysis of child abuse and neglect data has highlighted a number of key trends, currently being considered and addressed by DCEDIY and Tusla. These include:

- High level of attrition or case closure as referred children and families make their way through Tusla's child protection and welfare services. Factors which could be contributing include: the availability of prevention and family support services, thresholds, and resources both in terms of workforce and service availability.
- New metrics being developed to show where referred children and families are diverted when they don't require a child protection service. Reporting on re-referral rates is imminent.
- Currently data is only available at the level of the 17 administrative areas, which limits the possibility of a more detailed analysis of data trends. Work is underway to address this deficit including the use of postcodes to analyse data gathered.
- Data collected on children and families referred to Tusla, and on the children and young people placed in alternative care, is aggregate and cross sectional. Consideration is being given to the best way to garner better insights into the pathways of individual children through the system, their experiences and outcomes.
- To date Ireland has not carried out any longitudinal research on children in care and leaving care. A working group is currently considering the best way to address gaps in knowledge including how adults, who were in State care, fare in life.
- Work is commencing on the development of an outcomes framework to systematically analyse the impact of services provided on the lives of children and young people. Outcome frameworks have been developed by some individual services and the knowledge gained is being considered.
- Currently DCECIY, Tusla and the Central Statistics Office (CSO) (www.cso.ie) are working to link data on children in care with educational data held by the CSO. This project will serve as a proof of concept for future potential data linkage projects.

Current Situation in European Countries

CAN-data collection in EU Countries

Austria

Croatia

Denmark

Estonia

Germany

Hungary

Ireland

Italy

Latvia

Lithuania

Malta

Poland

Portugal

Slovakia

Sweden

CAN-data collection Outside EU countries

USA

UK

CAN-MDS Piloting

Greece

Cyprus

Spain

Bulgaria

Romania

External Evaluator

Next steps

France-EuroCAN Action

(Ireland cont.)

Interface with other agencies

Organisations and service providers maintain their own databases or methods of recording their interaction with children and families. There is no formal data exchange between Tusla and external agencies, other than with those who are commissioned by Tusla to provide certain services, for example DSGBV services.

An Garda Síochána (AGS), the Irish police force and Tusla have an agreed joint working protocol (https://www.tusla.ie/uploads/content/CF_Joint_Protocol.pdf), which sets out the procedure for the notification by Tusla to AGS and vice versa in the instance of a suspected case of emotional, physical or sexual abuse or the intentional neglect of a child.

Referral and prevalence data

As outlined, Ireland collates and publishes a range of data on child abuse and neglect. However, there are some indications that compared to other jurisdictions referral rates are low and also there is very limited data available regarding the prevalence of child abuse and neglect.

Carrying out reliable international comparisons is a complex task due to the legislative and policy context of different jurisdictions and variations in definitions and processes. However, when considered alongside a number of other Anglophone jurisdictions, there is some evidence to suggest that Ireland's overall referral rate to Tusla services and the proportion of referrals, which are put forward for further assessment are low (Furey and Canavan, 2019).

There has been no research carried out to date in Ireland, which looks at the prevalence of physical abuse, emotional abuse or neglect. The most contemporary piece of empirical research, that attempted to address the prevalence of sexual abuse in Ireland was published in 2002. This research showed almost one in three women and one in four men reported experiencing some form of sexual abuse in childhood. However, the study also showed a 'strikingly low' level of reporting of child sexual abuse to professionals (Mc Gee et al., 2002).

While the applicability of these findings to contemporary society has limitations given, for example, the retrospective nature of the data gathered and the changes that have occurred to service availability and awareness of child sexual abuse, it still provides an interesting insight into the levels of abuse that remain unreported. Work is currently underway to develop and administer a national survey on the prevalence of sexual violence in Ireland. It is also worth noting that there have been significant cultural shifts in relation to the tolerance of emotional and physical abuse in Irish society.

Conclusion

The advent of the National Child Care Information System in 2018 has greatly contributed to the development of good, reliable and consistent data on child abuse and neglect in Ireland. This data greatly assists DCEDIY and Tusla in the joint aim of improving outcomes and the wellbeing of children and young people in Ireland. Trends in the data are regularly reviewed and analysed by the DCEDIY to inform policy, budget and service development. The data also plays a key role in the management, oversight and quality assurance of services delivered. Both DCEDIY and Tusla are engaging in ways to address gaps and challenges as they arise in the pursuit of even better data.

References

Child Care Act, 1991. Available at: http://www.irishstatutebook.ie/eli/1991/act/17/enacted/en/print.html

Children First Act, 2015. Available at: http://www.irishstatutebook.ie/eli/2015/act/36/enacted/en/pdf

Furey, E. and Canavan, J. (2019) *A review on the availability and comparability of statistics on child protection and welfare, including children in care, collated by Tusla: Child and Family Agency with statistics published by other jurisdictions*. Available at: https://www.tusla.ie/uploads/content/COMPWELFINALREPORTMARCH29_-_Final.pdf

Mc Gee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy. R. (2002) *The SAVI Report. Sexual Abuse and Violence in Ireland*. Dublin: The Liffey Press and The Dublin Rape Crisis Centre. Available at: https://repository.rcsi.com/articles/report/The_SAVI_report_sexual_abuse_and_violence_in_Ireland/10770797/1

Current Situation in European Countries

BAMBI: an Italian experience

Elena Coppo, Benetto Yitiello & Anna Salvalaggio,
A.O.U Città della Salute e della Scienzadi Torino, Ospedale Infantile Regina Margherita

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

BAMBI: the origin

Started in 2002 at the Regina Margherita Children's Hospitalwithin the Emergency Department.
Mission: a multi-disciplinary approach to diagnosis, care, and follow up of child abuse
THE CHILD AS THE MAIN FOCUS: each evaluation or interview has to be respectful of the individual child as the possible victim of a physical and/or psychological abuse
Urgency in child abuse assessment and management
Rationale for a prompt intervention:

- To provide immediate attention to children often in a context of fear and stressful circumstances;
- To prevent ongoing abuse;
- To protect child and family from possible retaliation form abuser;
- To provide medical care when needed;
- To document possible signs of sexual abuse (genital lesions are transitory and undergo quick healing the clinical examination is recommended in 24-72 hours)

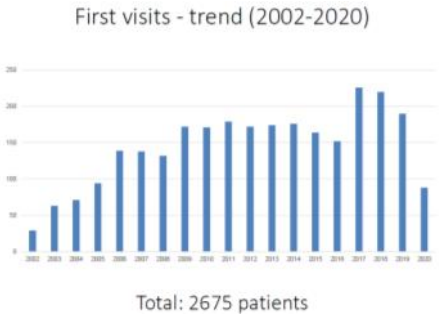
Expert Center in Piemonte: Multidisciplinary team

4 pediatricians, 2 psychologists, 2 dedicated nurses + Social Workers, Forensic Pathologist, Child Neuropsychiatrist, Hospital Administration + Other Consultants if needed

The patients

Sexual abuse victims: females <14 and males <18 y

Physical abuse victims: females and males <18 y



Comments

- Information about and prevention of child maltreatment must be improved in kindergarten, preschool, pediatricians' offices
- High Level formation should be offered at university in order to improve child abuse recognition in teachers, doctors, nurses, psychologists, social assistant etc.
- Errors caused by lack of experience or subjectivity have to be avoided implementing multidisciplinary working protocols

Limitations and challenges

- The first contact usually occurs in emergency conditions
- Lack of bed availability for children who need to be hospitalized (for medical reason or social protection)
- Delay in the activation of 'out of hospital' resources (at residential level)
- Growing fragmentation of family units
- Lack of long-term follow-up limits the evaluation of intervention efficacy

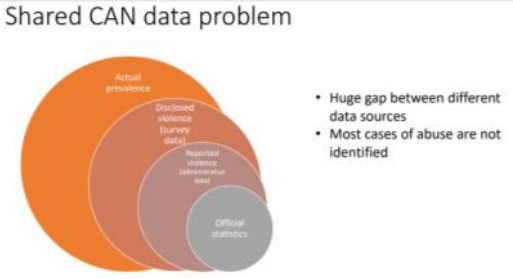
It takes a village to raise a child!
(African proverb)

Child abuse and neglect data collection in EU-27: challenges and good practices in Latvia

Zane Linde-Ozola, University of Latvia

Presented in the CAN-MDS EU Conference, June 29-30, 2021

The presentation addresses child abuse and neglect data collection issues in Latvia by focusing on key data sources – official statistics, registered violence (administrative data), and reported violence (prevalence studies). Firstly, although there is some yearly statistics on violence against children available, more comprehensive statistics are needed. Secondly, there are three main administrative data sources: police, social rehabilitation services, and trauma register in hospitals. However, administrative data across these sectors are not collected on the same basis, for example police collects data on offences, while social rehabilitation services collect data on children. Moreover, while data are accumulated across these sectors, there are no attempts for in-depth analysis, making them a lost knowledge, i.e. these data present a missed opportunity to gain an in-depth understanding of national dynamics of specific forms of violence, risk factors, characteristics of victims, perpetrators and context where violence occurs. Although there are only some prevalence studies conducted in Latvia, data from surveys indicate high prevalence of child abuse and neglect, and high tolerance of violence. Some methodological challenges can be identified, for example prevalence studies are usually one-off and do not allow monitoring dynamics of the problem over time. The presentation also identifies couple of positive efforts to improve data quality and thus work towards more realistic understanding of child abuse and neglect in Latvia. For example, administrative data quality issues on child abuse and neglect currently are on the national political agenda, and some small efforts are made to analyse some registered cases (in-depth analysis of child sexual abuse).



Current Situation in European Countries

Data collection on child abuse and neglect in Lithuania

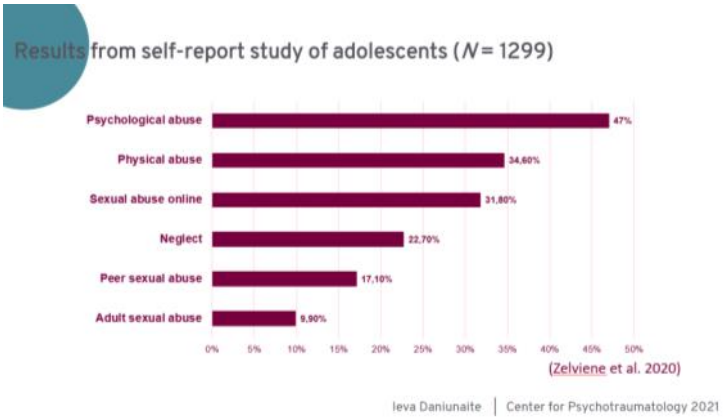
Ieva Daniunaite & Evaldas Kazlauskas

Center for Psychotraumatology Vilnius University

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Child abuse: Context in Lithuania

– A legal prohibition of corporal punishment by law in 2017;
– Reorganization of child protection system;
– The national child abuse prevention strategy missing;
– A lack of studies of childhood abuse prevalence.



Official Statistics

5122 children –victims of abuse (1,03 %)
(State Child Rights Protection and Adoption Service, 2019):
– Emotional abuse –37%,
– Physical abuse –34%,
– Neglect –25%,
– Sexual abuse –4%.

1591 children –victims of abuse
(IT and Communications Department, Ministry of Interior)

Child Abuse: Data collection

– Mandatory reporting;
– Data is registered to the Social Support for the Families Information system;
– Cooperation between responsible institutions.

Challenges

– Awareness; Recognition and evaluation; Cooperation.

Data collection on child abuse and neglect in Malta

Mariella Mangion, Mater Dei Hospital - Malta

Clarissa Sammut-Scerri, University of Malta

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Background information

– Malta – island population approx. 500,000
– Child population 0-17 years approx. 70,000

Legislation related to child abuse and neglect

– Mandatory reporting introduced this year (2021); all professionals working with children are obliged to report cases of CAN which reaches threshold of significant harm.
– Directorate of Child Protection Services is the statutory agency to tackle cases of CAN. Receive around 100 referrals monthly and increased to 140 during COVID.

Data collection of CAN in Malta

There is no centralised data collection system. There are different sources which use different definitions and populations of study. Specifically:

– Directorate of child protection services only gathers statistics for cases registered within their services
– Police and Legal system
– Education child safety services
– Health Services

National statistics office (NSO) does not collect data on child maltreatment.

Domestic Violence Commission is meeting all stakeholders working with children to gather information about children. The DV Commission will carry out retrospective survey on 18-24 year olds. People 18-24yr olds will be offered phone survey using quota sampling and coded phone numbers. The tool that will be used is the *Juvenile Victimisation questionnaire* (David Finkelhor - adult retrospective version). This cohort was chosen mainly because research shows that disclosure rates generally increase after the age of 18 years, as it is likely that these young adults would feel more comfortable disclosing childhood abuse experiences, rather than when they were children (www.childrenscommissioner.gov.uk/wpcontent/uploads/2017/06/Protecting-children-from-harm-executive-summary_0.pdf, 2015). Another reason was because of difficulties to access children in schools due to the COVID pandemic.

The way forward

There is a need to make data collection of CAN a priority at national level and to find partners who will collaborate on such projects. For example:

– NSO has set up designated unit for crime statistics - data collection on child maltreatment should become part of the regular collection of such data.
– The Children's Rights Observatory Malta (CROM) will identify gaps and priority areas in implementing children's rights, advocate for change, and bring together, interdisciplinary and cross-sector contributions, to advance the implementation of these rights.

Current Situation in European Countries

Data collection on child abuse and neglect in Poland

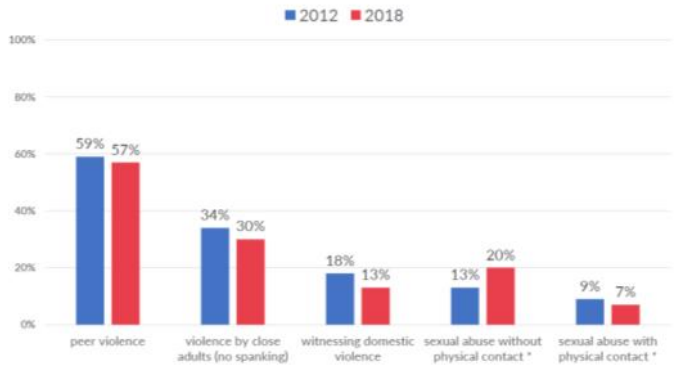
Joanna Włodarczyk, Empowering Children Foundation, Univereity of Warsaw

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Main issue: Lack of a central data collection system on violence against children

Healthcare: ICD-10 Classification; T 74 -Maltreatment syndromes
Less the a 100 every year
It is not mandatory to add this code by health care professionals

Prevalence population studies among young people (11-17)



Nationwide diagnosis of the scale and determinants of child abuse based on Juvenile Victimization Questionnaire by Empowering Children Foundation (2012, 2018, 2023…)

Official statistics 2019

2,803 children-victims of the crime under Art. 207 §1 of the Penal Code (domestic violence)
- 5% children till 16 years old
- 12% young people till 20 years old

12,161 the total number of minors suspected of having been affected by domestic violence

69,429 the number of children supported by interdisciplinary teams

Recommendations

- Ensure reliable collection of statistics by designated services, according to a common methodology, using standardized concepts and definitions, broken down into detailed victimological information concerning, inter alia, the age and sex of children, place of residence, origin and family situation
- collect statistics not only on the risk factors of child abuse, but also on the factors protecting against harm, in order to have a full knowledge of the mechanisms of the phenomenon and effective forms of counteracting its occurrence
- ensure the general availability of statistics on threats to the safety and development of children
- conduct regular social surveys using the same methodology to track trends associated with the phenomenon of abuse of children and young people are impossible to identify the level of official statistics
- make an in-depth systemic analysis of each case of a child's death or serious damage to his health as a result of abuse or unexplained causes, in order to assess the effectiveness of implemented procedures & solutions and to suggest possible improvements

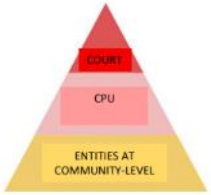
Data collection on child abuse and neglect in Portugal

Leonor Bettencourt Rodrigues | ProChild CoLAB

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Child and Youth Protection System in Portugal

Reporting CAN in Portugal is mandatory for anyone who knows any situation that puts at risk the physical and psychological integrity and freedom of a child (less than 18 years old).
No-judicial System, which relies on a community-based principle of subsidiarity, i.e. a hierarch of responsibility in intervention towards children, depending on the level of risk (risk-danger).
There are 310 Child protection units around the country, at least one for each Municipality. These non-judicial entities are autonomous, yet regulated by the National Commission for the Promotion and Protection of Children and Youth.



Child maltreatment Data Collection in Portugal

- Only administrative data is available and there is no specific practice in place for intersectoral/multidisciplinary cooperation on CAN-Cases administration and data collection.
- Therefore, each entity (Education, Health and Judicial) has its own data collection procedures and there is not an integrated common database for CAN;
- In terms of Child Protection Units,
  - Data begun to be collected in 1990/1991, and since 2008 there is an online electronic platform which integrates data from all the Child Protection Units throughout the Country.
  - A National report based on CPU administrative data is launched every year;
  - Quality of data and missing data is still an issue
  - Since 2011, there have been an investment in Child protection Units' Professionals' Training and the gathering of information on Children and their Families is now mandatory – there is a growing awareness for the need to CAN surveillance
- There was only one attempt of an National Incidence Study in 1986; There are other non-national self-report studies.

COVID-19 Pandemic and CAN

- The confinement and closure of community support services favored the invisibility of CAN to Child Protection System:
  - 29.7% decrease in communications to the CPU between January and April 2020, compared to the similar period of 2019.
- ProChild CoLAB is now starting a study together with the National Commission for Child Protection to analyse administrative data during different phases of 2019 pandemic.

Current Situation in European Countries

Child Abuse and Neglect data collection in Slovakia

Mária Vargová, National Coordination Centre
for Resolving the Issues of Violence against Children
Ministry of Labour, Social Affairs & Family of the Slovak Republic

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

2014: National Coordination Centre for Resolving the Issues of Violence against Children
2014: National Strategy on the Protection of Children against Violence
2017: Coordinator of the Protection of Children against violence

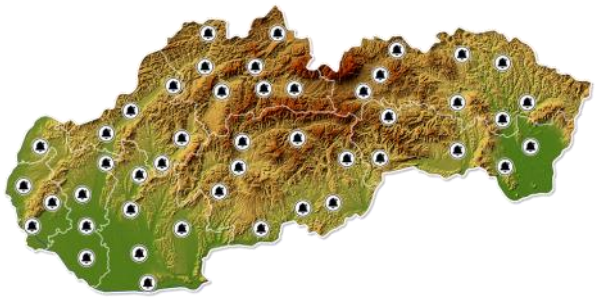
A tragic event forced us to think differently and give a multidisciplinary approach, which was a trend in Europe and was also recommended by the UN

National Coordination Centre for Resolving the Issues of Violence against Children receives legislative support for this activity

- amendment of the Act on the Competences of the Ministry of Labour, Social Affairs and Family
- modified coordination of entities (police force, general prosecutor 's office, schools)

Multidisciplinary cooperation

at national level – NCC at regional level - Coordinators

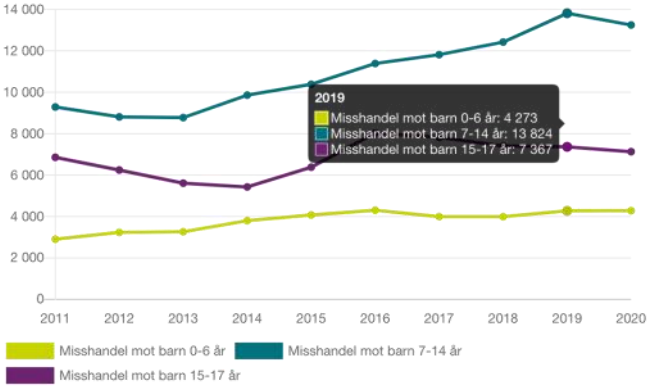


Child Abuse and Neglect data collection in Sweden

Gabriel Otterman, Child Protection Team
Uppsala University Children's Hospital

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

The Swedish National Council for Crime Prevention is a knowledge Centre for the criminal justice system.



Robust data on crime statistics, police-reported cases of suspected assaults against children

National Board of Health and Welfare

- CPS are municipality based; 290 municipalities afforded self-government according to Constitution
- Strict mandatory reporting for professionals
- First national data analysing reports to CPS published in 2019 with participation of 80% of municipalities
  - 180 000 children, corresponding to 8 percent of children in Sweden were reported to CPS in 2018; 66% 0-12yo
- NBHW also conducts limited child death review and some very limited serious case review in accordance with new legislation

Children's Welfare Foundation Sweden

- School based studies on physical violence and neglect
- Population-based, serial cross-sectional surveys of violence against children in Sweden conducted (2006, 2011, 2016, 2021)
- In collaboration with Karlstad University
  - 2016: 4700 pupils in 9th grade in primary school (14-15 years of age) and in high school (16-17 years of age) responded to questions about their exposure to violence in the course of their childhoods.
  - Ongoing survey 2021 to be completed and published in 2022
- School-based study of sexual abuse and exploitation
- Nationally representative sample of more than 3,000 high school students about their experiences of sexual abuse and sexual exploitation while growing up
- Elements of the survey instrument were employed in previous studies, making comparisons possible.
- In collaboration with Ersta Sköndal Bräcke College; To be published August 2021

A nation of registers

- Unique personal identification number – based on birthdate + 4-digit code allows for linkage of individual-level data across registries
- National Board of Health and Welfare and Statistics Sweden are the two national agencies responsible for management of a wide array of registers
- Individual level data linked across agencies requires approval by the Swedish Ethical Review Authority, approval by the registries; charges for linkage of data apply
- Linked data across the Nordic countries is also possible

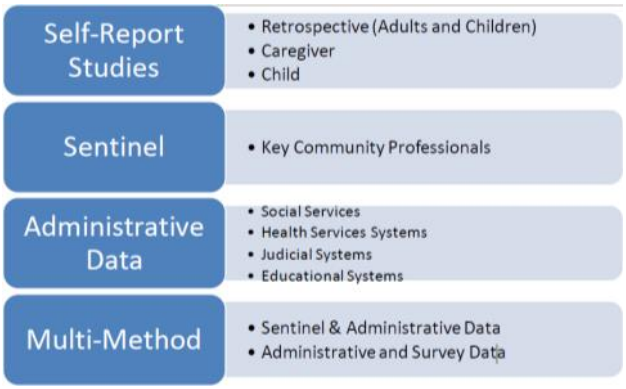
Current Situation in other Countries

Systems of Child Maltreatment Data Collection in the US; Triangulation, Sustainability, and Learning.

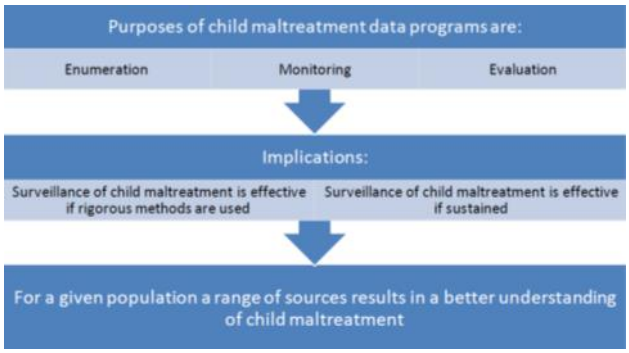
John Fluke, KEMPE Center, Department of Pediatrics, University of Colorado, School of Medicine

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Methods: Sources of Data Collection



A data value proposition for Child Maltreatment Surveillance



US Data Collection Programs

Brief History US

Early Studies in the US

– Incidents Extracted from Media Reports (1950s –1970s)
– National Reporting Study on Child Abuse and Neglect (1976 –1988)
– 1st National Incidence Study (1979)

Other Studies of Incidence

– Strauss and Gelles (introduced Conflict Tactics Scale)
– Finkelhor
– Prevent Child Abuse America

NCANDS initiated in 1988

Brief Context Review US

– Child maltreatment is both a Federal and a State responsibility
– Child maltreatment is considered primarily a social service issue, key sectors in the US: Social Services; Public Health and Health Care; Justice System
– Reporting is "required" of professionals –Mandatory Reporting

National US Data Programs: Many acronyms many ways of knowing

NCANDS | NIS | NSCAW | NatSCEV(JVQ) | AFCARS | WISQARS | HCUP | NYTD | BRFSS (ACES) | Longscan | NEISS

Administrative data | Sentinel data | Self-report data | Longitudinal/Mixed Methods

Self Report Studies

– *Behavioral Risk Factor Surveillance System (BRFSS) ACEs* (Centers for Disease Control and Prevention -CDC)
Random-digit-dial telephone survey of adults
Annual Retrospective Survey of Adverse Childhood Experiences (does not include neglect); At one point since 1999 at least 32 states have collected ACES
– *Behavioral Risk Factor Surveillance System (BRFSS) ACE* Outcomes

Myocardial infarc-	Smoking	Lowered educational attainment
Asthma	Disability	Coronary heart disease
Mental distress	Reported in-	Stroke
Depression	Unemployment	Diabetes

Resources: www.cdc.gov/violenceprevention/acestudy/ace_brfss.html

Sentinel Studies

– *NIS-4:Fourth National Incidence Study*
Congressionally mandated, periodic research effort to assess the incidence of child abuse and neglect in the United States. NIS-1, NIS-2, and NIS-3 conducted between 1979 and 1993.
Estimates the number of children who are abused or neglected with information about:
– nature and severity of the maltreatment,
– characteristics of the children, perpetrators, and families,
– changes since the last national incidence study.
Data in a nationally representative sample of 122 counties (originally 20 counties for NIS-1)

Administrative Data

Question Foci for Administrative Systems (event/encounter driven): *Who are the people? What are the service events? When are events occurring? Where are events occurring? Who is involved in the events?*

– National Child Abuse and Neglect Data System (NCANDS): Methods
Sample: Universe uses no systematic "sampling" approach; Data are administrative and derived annually from state Child Protective Service Agencies.
Representation: Represents only cases known to one particular service sector (child welfare); Includes data from all US states (case level data from 52 States/territories in 2019).
Data Collection: Aggregate Data are survey; Case level from State information systems.

NCANDS: Some Achievements

– Establishes national data source
– Enables analyses of outcomes longitudinally (> 20 years)
– Provides a research database for secondary analyses
– Supports governmental policy initiatives (program improvement)
– Provides data for other stakeholders
– Data available through the National Data Archive on CAN https://www.ndacan.cornell.edu/index.cfm

Current Situation in other Countries

(USA cont.)

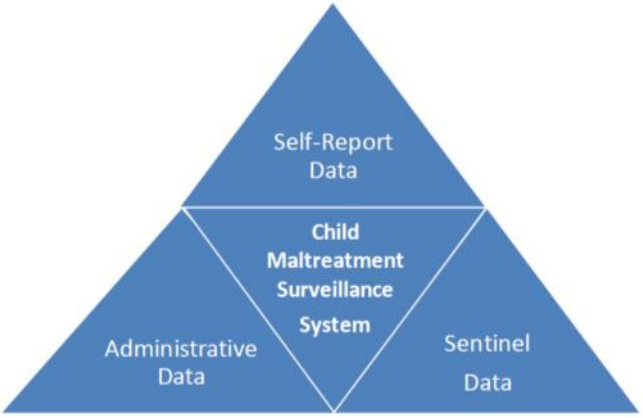
Longitudinal Data

NSCAW: National survey of child and adolescent well-being
Nationally representative geographical based sample of children and families who have contact with child welfare system
Prospective longitudinal study:
– NSCAW I: 5 waves, 60 months (1999-2007)
– NSCAW II: 3 waves currently, baseline and at 18 months (2008-2009)
– NSCAW III: initiated in 2015 and ongoing

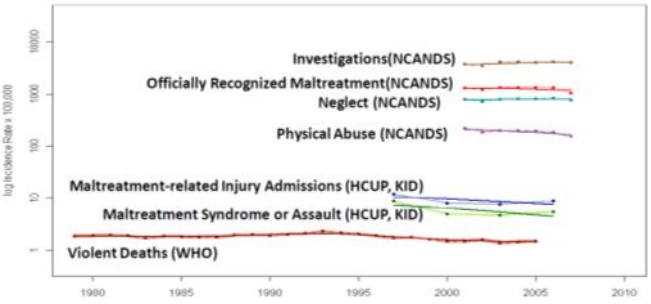
Numerous published research studies using data from NSCAW I & II
– Data available through the National Data Archive on CAN https://www.ndacan.cornell.edu/index.cfm

Other Longitudinal and Multi-Method Data Resources
– LONGSCAN
https://sites.cscc.unc.edu/cscc/projects/LONGSCAN
– National Youth in Transition Data
https://www.ndacan.cornell.edu/index.cfm

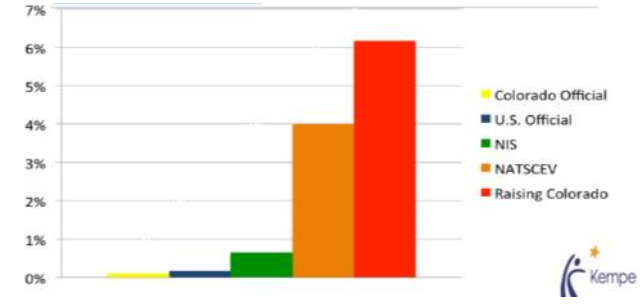
Child Maltreatment Data Source Triangulation



Comparison: US Data Ages 1-10



Comparison of Physical Abuse Rates by Study Type



Endearing and Enduring Issues

Data Sources
– What can be done to improve data quality?
– What can be done to improve data availability?
– What can be done to insure the sustainability of the data?
Triangulation
– How can we maximize the use of existing data sources?
– What is different about cases that are in the official system(s) compared to the general population?
– How can the data be leveraged to promote prevention programs?

Some Other Self Report Surveys

– National Survey of Children's Exposure to Violence I, 1990-2014 (NatSCEV) Using the JVQ
http://www.unh.edu/ccrc/jvq/available_versions.html
http://www.icpsr.umich.edu/icpsrweb/NACJD/studies/35203
– PRAMS (Perinatal risk assessment module)
www.cdc.gov/prams/index.htm
– YRBS (Youth risk behavior surveillance system)
www.cdc.gov/healthyyouth/data/yrbs/index.htm
– NHIS (National Health Interview Survey)
www.cdc.gov/nchs/nhis/index.htm
– National Crime Victimization Survey (NCVS)
https://www.bjs.gov/index.cfm?ty=dcdetail&iid=245

Other Administrative Data Sets

– Social Services: Adoption and Foster Care Analysis and Reporting System
https://www.ndacan.cornell.edu/index.cfm
– Health Care: Health Care Cost and Utilization Project -Kids' Inpatient Database (HCUP-KIDS) (Administration for Healthcare Research and Quality -AHRQ)
https://www.hcup-us.ahrq.gov/kidoverview.jsp

Nonfatal injury data-in-patient care

In-patient hospital data
– National hospital discharge survey (NHDS) –data on overnight stays in hospital
https://www.cdc.gov/nchs/nhds/index.htm
– National hospital care survey (integrates hospital data, with ED and outpatient data)
https://www.cdc.gov/nchs/nhcs/index.htm

All Claims Payer Data: State databases (30 states) that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers.
https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/apcd/index.html

Medicaid data: data on care for Medicaid recipients
https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/

Kempe

Self-report studies in CAN surveillance

Beyond agency data: the use of self-report studies in child maltreatment surveillance

Franziska Meinck , School of Social & Political Science, University of Edinburgh

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Background

– Estimated 1 billion children experience violence (Hillis et al., 2016)
– WHO recommends regular monitoring and surveillance of violence against children using national prevalence studies (WHO., 2015)
– UN SDG 16.2.3 – recommends surveys with young adults for surveillance of national prevalence of sexual violence

Why do we need self-report surveys on VAC

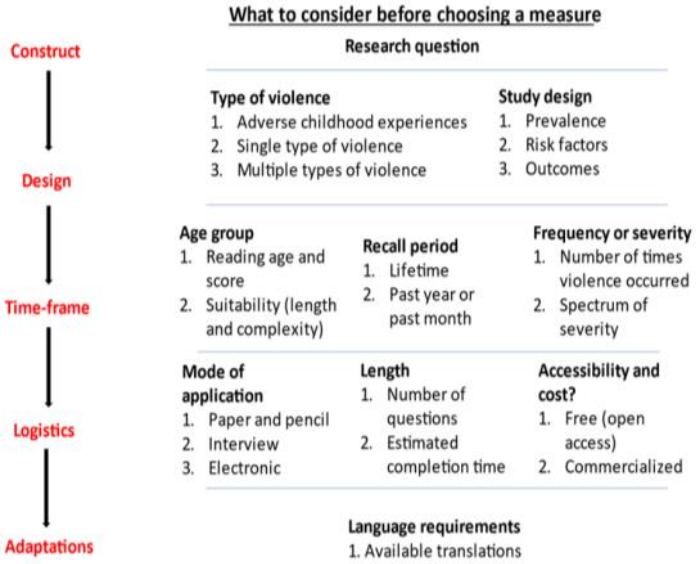
Types of self-report studies

– Child self-report
– Adult retrospective self-report
– Parent report of use of discipline/VAC
– Parent report of child's violence exposure
– Sentinel surveys with professionals

Purpose of self-report studies

– Estimate past-year and/or lifetime prevalence
– Ability to monitor trends over years
– Highlights burden of violence among those never referred to services
– Provides estimates in countries where services do not collect/compile routine data

Measurement selection



Considerations for self-report studies

– Which population group will be surveyed
– Ethical challenges around some population groups
– Access challenges around some population groups
– Sampling
– Need for reliable and valid measures
– Types of violence measured
– What additional information should be captured? E.g. perpetrators, locations, onset

EXAMPLES

Balkan Epidemiological Study on Child Abuse & Neglect—BECAN

Cross-sectional nationally representative survey of lifetime and past-year prevalence
–Nine countries
–School-children aged 11, 13 and 16 (n=63,250)
–Three stage random sampling frame (MoE, schools, classrooms)
–Classroom-based pseudonymous interview
–Response rate 66.7% (n=42,194)
–Matched caregiver (n=46,526)
–Response rate 56.5% (n=25,203)
Ethical approval granted by educational authorities in each country

ACMS

–1st prevalence study of maltreatment in Australia
–10,000 people (aged 16 and up) will be surveyed
–Types of maltreatment assessed: physical, sexual, emotional abuse, neglect and exposure to DV
–Types of health outcome measured: physical and mental health
–Identifying the burden of disease to assess the real costs
–Informing both policy and practice

VACS

–Nationally representative household survey ages 13-24
–Lifetime and past year prevalence of sexual, physical and emotional violence
–Risk factors, protective factors and health outcomes
–Implemented by national governments with CDC support

Benefits of self-report studies

–Knowledge about extent and characteristics of the problem
–Ability to assess trends
–Regular surveillance
–May identify specific types of violence/frequency/severity which might not be captured by agency data
–Investigations of associations between violence and outcomes/risk/protective factors
–Children's rights to participation

Difficulties of self-report studies

Response rates | Access to samples | Consent/assent | gatekeepers | Ethics committees may be overly cautious | Logistics of survey and safeguarding procedures | Costs | Entry level overview

Entry level overview

Preparation of CAN-MDS Piloting in Bulgaria: Results, Challenges & Lessons Learned

Vaska Stancheva-Popkostadinova & Maya Tcholakova, South-West Univeresitty „Neofit Rilski", Blagoevgrad
Eleonora Lilova, Yanko Kovachev, Milena Anastasova State Agency for Child Protection, Sofia

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Bulgarian CAN-MDS Toolkit & Training Module

–**CAN-MDS Toolkit** (Electronic System CAN-MDS in Bulgarian language)
  –**Tools for Operators** (Operators' Manual and Data Collection Protocol)
  –**Tools for the Administrator** (Step by step guide for the Administrator of the System)
–**CAN-MDS Training Module** (available version for in person training and for online training)
–**Content: Child Abuse & Neglect** (definitions, warning signs, reporting mandates and procedures, handling of self-report); **CAN-MDS Methodology & System** (rationale of the system, toolkit, understanding the operation (mock cases), operators' and administrators' role)

CAN-MDS Administrative Authority

– State Agency for Child Protection
  –Provisions taken about data protection and ethical issues
  –Constant communication between the Bulgarian partners, with the Greek coordinating team and with the Social Assistance Agency
– Communication with Commission for Personal Data Protection and request for a formal statement regarding CAN-MDS implementation
– Statement from the Commission was received on February 2021 –there are no issues regarding personal data processing through CAN-MDS, as administered by the responsible national authorities.
– Final decision of the Social Assistance Agency was to provide simulated data only, and did not agree CAN-MDS to be piloted in a real setting.

National Inter-sectoral Board

Ministry of Labour and Social Policy | Ministry of Interior | Prosecutor's Office | Regional management of education | UNICEF Bulgaria | Ombudsman | Commission for Personal Data Protection | National Statistical Institute

First meeting of the Board was held on July 2020; all the members of the Board showed readiness to support the implementation of the project activities

Training of front line Professionals

– 21-22 June, 2021: Online training through the Big Blue Button platform, Blagoevgrad region
– 21 participants: 6 social workers | 5 nurses | 3 psychologists | 4 kindergarten teachers | 3 nursery staff

Feedback and evaluation

– Most of the professionals have not received specific training related to CAN, and did not feel confident in dealing with CAN cases in their practice.
– Not fully aware about the reporting procedure for CAN cases
– Some of the participants shared personal professional experience in reporting CAN cases.

Most useful topics	Topics that need more attention
– CAN –MDS system as a well-designed tool for recording data – Demonstration of data recording in CAN-MDS through mock cases – Professionals' role as CAN-MDS system operators	– Recognition of the signs of CAN – How to respond to a child who reveals that she/ he has been abused – Dealing with under- reporting
Satisfaction with the training	**Recommendations**
– The training was interesting and useful; created a space for discussion and opportunity for the participants to share cases from their practice. – Many issues in CAN became clearly outlined and we learned a lot within these days.	– Training in a real setting in order to try out the system in person – All teams working with children should undergo such training, they could even be trained as trainers in order to conduct it for the parents.

Challenges

- Main concerns were about GDPR and legislation related issues
- Time consuming processes in various settings (agreements with the state authorities, communication with organizations & professionals)
- COVID conditions were leading to delays and change of initial plans
- Recent government election
- There were some delays during the preparatory phase and organizational issues (staff turnover within the State Agency for Child Protection, including change of the Chairperson). Current staff of the project (SACP) start real work in 2020
- Actions taken to deal with the challenges: extension was asked, the trainings were reorganized to take place online, new experienced staff was recruited; consultations with GDPR experts were held)

Lessons learned

- It was difficult to convince some of the relevant third parties to commit to such a target in such a short period (as the project's duration); they were also overloaded with work and COVID-19 unpredicted conditions make it even harder. Some overlap in responsibilities regarding CAN management at national level, communication problems, leadership issues. competitions between some sectors.
- Some "positive" lessons: some of the stakeholders were very supportive when they gain understanding of the need for data collection on CAN and how the CAN-MDS could contribute to this (especially as it relates to children).
- Strong network of professionals for CAN prevention was built
- To introduce and maintain CAN-MDS as a permanent operation/ service needs time and more awareness and joint efforts by the respective authorities.

Main message: CAN-MDS provides **common definitions**, an **easy access** and **quick procedure** for registration and monitoring child abuse and neglect cases. However, recognizing the advantages and implementing CAN-MDS is time consuming process. **We must be optimistically realistic!**

CAN-MDS Piloting in Cyprus: Results, Challenges & Lessons Learned

Marina Efthymiadou, Social Welfare Services , MLSI, Cyprus
Rafaella Georgiou, 'Hope For Children' CRC Policy Center
(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Nationally adapted CAN-MDS Toolkit & Training Module

- **CAN-MDS Toolkit** (Electronic System CAN-MDS)
  - **Tools for Operators** (Operators' Manual, Data Collection Protocol)
  - **Tools for the Administrator** (Step by Step Guide)
- **CAN-MDS Training Module** (for in person & distance training)
- **Content: Child Abuse & Neglect** (definitions, warning signs, reporting mandates and procedures, handling of self-report); **CAN-MDS Methodology & System** (rationale of the system, toolkit, understanding the operation (mock cases), operators' and administrators' role)

CAN-MDS Administrative Authority

Ministry of Labour, Welfare & Social Insurance, Social Welfare Services

- Data Protection: Agreed on following the data protection protocol; Discussions started on how to protect the data regarding the process as well as designing a plan of a functional model to be discussed with the Commissioner of Personal Data Protection
- Ethics: After receiving feedback from the professionals, the Administrative authority decided to plan –at a later stage- a code of ethics taking into account each authority's/service /organization's internal regulations

Agencies involved & National Inter-sectoral Board (possible) members

Law Office of the Republic of Cyprus | Ministry of Justice and Public Order-Police |Ministry of Health-Mental Health Services | Cyprus Police | Ministry of Education, Sport, Culture and Youth, Cyprus Pedagogical Institute | Children's House |Ministry of Labour, Welfare and Social Insurance, Social Welfare Services | 'Hope For Children' CRC Policy Center | Association for the Prevention and Handling of Violence in the Family (SPAVO)

Training of front line Professionals

- Approx.: 70 participants (until June 30, 2021) [Social Workers, Police Officers, Psychologists, Hotline Operators]
- Specialties: DV, Sexual Abuse, Juvenile Offenders, and Teachers

Basic training feedback from the trainees:

- Concerns on time consuming on the platform/ increases their workload | about the National Administrator | on double entry of the same incident from different professionals that will count as two
- Importance of such platform needed and data collection need in the country

Challenges

- COVID conditions leading to delays and change of initial plans. Re-adaptation needed on trainings and difficulties arranging meetings with authorities
- Time consuming processes in various settings Concerns about GDPR related issues
- Difficulties on Operational Manual at the adaptation process regarding the national legal framework, the internal procedures and terminology of each authority/service and the gaps that already exist in a national level
- Delays during the preparatory phase, organizational issues

Action taken to deal with each of the challenges: Part of the trainings reorganized to be pre-recorder; also, extension were asked, more hours needed to be dedicated to the project

Lessons learned

- Underreporting vs over-reporting from professionals: A serious issue that CAN-MDS addressed and helped professionals to gain more understanding rewardingly
- Difficulties related to the awareness of the professionals regarding the importance of data collection – Different perspective when they enhance their understanding regarding the importance and realizing what CAN MDS could contribute to
- To introduce and maintain CAN-MDS as a permanent operation/service needs time and this is why in the country the decision was made to keep the system after the project
- Heavy workload and understaff services

Main message: In, Cyprus, a plan will be developed after the piloting phase, taking into consideration the feedback of professionals that will work with the platform at this stage, in order to address any issues and find solutions if possible.

CAN-MDS II Action—Results

CAN-MDS Piloting in Greece: Results, Challenges & Lessons Learned

Athanasios Ntinapogias, CAN-MDS II Action Coordinator / Principal Investigator
Institute of Child Health, Department of Mental Health and Social Welfare, Athens—Greece

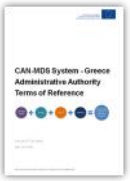
(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Greek CAN-MDS Toolkit & Training Module

- **CAN-MDS Toolkit** (Electronic System CAN-MDS in Greek language)
  - **Tools for Operators** (Operators' Manual and Data Collection Protocol)
  - **Tools for the Administrator** (Step by step guide for the Administrator of the System)
- **CAN-MDS Training Module** (available version for in person training and for online training)
- **Content: Child Abuse & Neglect** (definitions, warning signs, reporting mandates and procedures, handling of self-report); **CAN-MDS Methodology & System** (rationale of the system, toolkit, understanding the operation (mock cases), operators' and administrators' role)

CAN-MDS Administrative Authority

Aiming to comply with the principle of transparency for any involved party a relevant agreement was prepared, accepted and signed. During the piloting of the system, Institute of Child Health undertook the role of the National Administrative Authority. In the respective ToR a detailed description of main responsibilities of the National CAN-MDS Administrative Authority ('data controller') is included concerning issues such as pseudonymization, offline data maintenance & granting level of access to operators



National Inter-sectoral Board

To promote data collection on child abuse and neglect and support the piloting of the CAN-MDS system, a national inter-sectoral Consultative Committee was formatted where all relevant sectors are represented. Up to June 2021, three plenary meetings took already place and numerous bilateral meetings. Currently 12 Authorities, Ministries and Organizations are participating:

Organizations and Agencies involved

- On May 2021 invitations sent to organizations and services sent out inviting them to participate in the piloting of the system. Again, bilateral agreements were developed to be signed by each one of the interested organizations where the aim and the responsibilities of the parties are clearly described and mutually agreed.
- Currently 61 organizations accepted the invitation and are part of the effort. The target is to reach a higher number of agencies-data sources per sector and to have representatives from all sectors. This process is ongoing.

CAN-MDS II Action—Results

Professionals involved

– After the organization accepts the invitation and signs the protocol, the professionals working there are also informed for the CAN-MDS and invited to participate first in the relevant training and next in the piloting of the system. Again professionals are asked to fill in and sign a form including an informed consent where declare that they agree to participate.
– Currently >125 professionals are involved (social workers, psychologists, medical doctors, social scientists, teachers, lawyers).

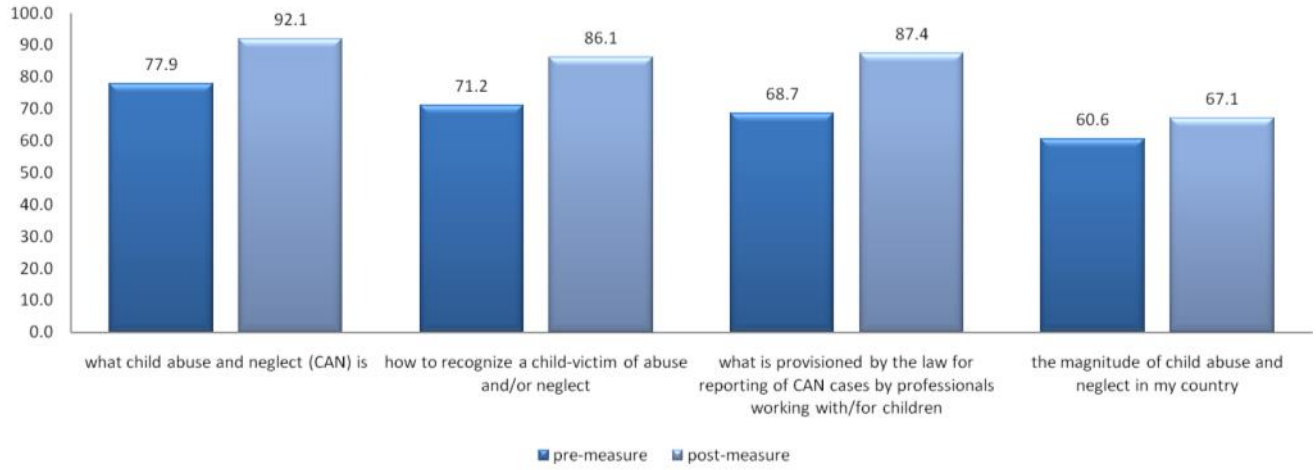
Training—Operators' Seminar

Type: Asynchronous e-learning training: https://canmds.talentlms.com/
Content: 4 Main Sessions | 10 Lessons | 20 Videos | 10 Manuals /docs | 5 evaluations/ exercises
Duration: ~6.5 hours (continuous training) ~ 2 day seminar in person training

Evaluation results from the ongoing training

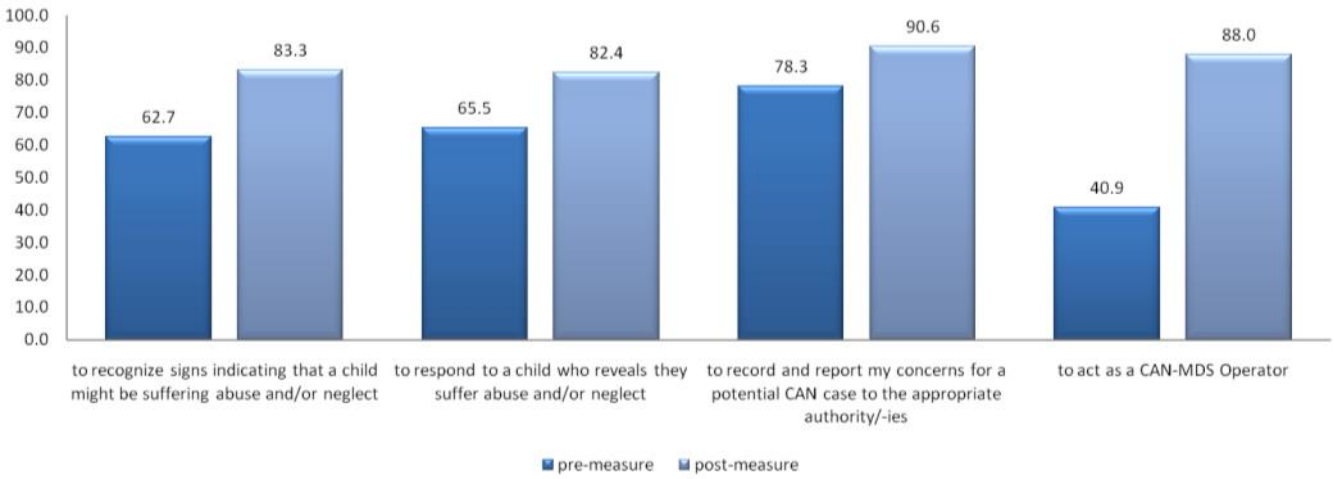
Social workers is among the most sensitized professional groups on child abuse and neglect issues and this is why their self-assessment of knowledge is relatively high since the first measure; in all cases however their assessments for what they know on issues like CAN definitions, signs to recognize child maltreatment, legal issues etc. is further increased

Mean scores of self-assessment of knowledge (where 0 = I know nothing and 100 = I know everything) **on issues related to** (pre N=50, post N=30)



Similar are the estimations about how much confident professionals feel to recognize a case of CAN based on signs, on how to respond to a child who reveals that suffer abuse, to report and record cases for a suspected case of CAN and –as it was expect- how confident feel to act as operators of the CAN-MDS system. Although the increases presented here did not tested in regards to their statistical significance, they suggest, however, how a short online training can contribute on such a subject even already sensitized professionals.

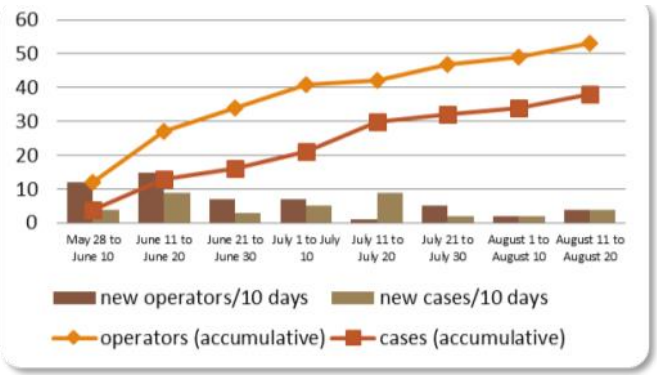
Mean scores of self-confidence (where 0 = no confident and 100 = fully confident) **on the following issues** (pre N=50, post N=30)



CAN-MDS Piloting Results in Greece

Period: May 28-August 20, 2021 | Number of cases: 38

Professionals participated in the piloting (N=53) and CAN-incidents recorded (N=38) during May 28-August 20, 2021



Type of agencies where CAN-incidents were recorded (N=38)
Child Protection Services: 6 | Socio-Medical Services: 9 | Municipal Social Services: 14 | Health Services (Hospitals): 9

Professional specialties of Operators (N=38)
Social Worker: 28 | Medical doctor: 9 | Psychologist: 1

Source of referrals of the CAN-Incidents (N=38)
26,3% Parent/ foster parent/ parent's partner/ care provider
15,8% Identified (via routine screening)
15,8% Personnel working in Juvenile/Ordinary Court
15,8% Anonymous reporter
13,2% Child (alleged) victim
5,3% Friend/ neighbor
2,6% Personnel working in Helpline
2,6% Personnel working in Health Services
2,6% Other

Child related information (N=38)
sex: male 21% | female 79%
citizenship status: citizen 90% | not a citizen 10%
age: 0-5: 26,3% | >5-10: 13,2% | >10-15: 36,8% | >15-18: 23,7%

Family related information (N=38)
82,0% child lives with his/her family (biological/adoptive)
13,0% child lives in foster/relatives' family (other than his/her family)
5,0% child lives in a recomposed family
Family members: **Parents; Parents' Partners; Grandparents**
52,6% two-parent family
28,9% single-parent family
18,4% none parent in the family
7,9% parent-parent's partner family
7,9% one-grandparent family
7,9% two-grandparent family
Family members: **siblings**
none: 39,5% | 1: 28,9% | 2: 26,3% | 3: 2,6% | 4: 2,6%
Family members: **other relatives**
none: 89,5% | 1: 2,6% | 2: 2,6% | 3: 2,6% | 5: 2,6%
Primary caregivers when the incident took place (N=57): M 47% |F=53%

>2 caregivers			1 caregiver
N	1st or 2nd (regardless order)	3rd or >3	N
10	Mother	father	11 parent *(7 father; 4 mother)*
3	grandmother	grandfather	3 professional caregiver
3	Mother	father	adult sibling	*(2 female; 1 male)*
2	Mother	father	grandparent	5 temporary caregiver
1	Mother	mother's partner		*(5 female)*

CAN incident related information (N=38)
15,8% a "distinct event" took place-Not continuous maltreatment
36,8% continuous maltreatment - including "distinct event(s)"
23,7% continuous maltreatment - No "distinct event" took place
23,7% unknown

Type of CAN incident (N=38)
45,0% abuse | 34,0% abuse and neglect | 21,0% neglect

Forms of violent acts committed (N=38)
50,0% psychological violence acts (with or without injury)
42,1% physical violence acts committed (with or without injury)
18,4% sexual violence acts committed (with or without injury)
7,9% violent acts against self/ self-harm

Forms of omissions in children's care (N=38)
31,6% physical neglect related commissions
26,3% emotional neglect related commissions
21,1% medical neglect related commissions
15,8% supervision related commissions
13,2% risk exposure related commissions
10,5% educational neglect related commissions
10,5% refusal of custody/ abandonment

Location of incident (N=38)
71,1% home/ family
13,2% home/ relatives
7,9% other place
2,6% unspecified/ unknown place
2,6% home/ friends
2,6% public transportation
2,6% public place/ street/ commercial & surrounding area

SERVICES PROVIDED
Institutional Response, **Immediate interventions**
42,1% immediate interventions, as follows:
- 26,3% child protection/ welfare services assessment
- 13,2% mental health exams
- 10,5% physical/ medical exams
- 7,9% forensic evaluation initiated
- 2,6% police intervention

Institutional Response, **Action Taken, No Court Involvement** (N=38)
34,2% action taken, no Court or Equivalent Authority involvement
- 28,9% supportive intervention for current caregiver(s)
- 23,7% child remains in family with planned intervention
- 5,3% CP/SWS emergency protection procedures
- 2,6% referral to Child Protection Services
- 2,6% police emergency protection procedures
- 2,6% emergency out of home placement

Institutional Response, **Action Taken, Court Involvement** (N=38)
63,2% action taken with Court or Equivalent Authority involvement
- 44,7% court measures initiated
- 21,1% CP/SWS emergency protection procedures
- 5,3% action to protect victim by court orders
- 5,3% referral to CP/welfare services
- 5,3% abuser to leave the home by court order
- 2,6% police emergency protection procedures
- 2,6% action to remove parent(s)' rights

Institutional Response, **Out of home placement** (N=38)
7,9% out of home placement of the child
- 5,3% children's home institution (residential care)
- 2,6% kinship care (relatives/ extended family)

Referrals to other Services (N=38): NO 52,6% | YES 47,4% as follows
Mental Health Services 10,5% | Judicial Services 10,5% | Medical Services 7,9% | Educational Services 5,3% Social Welfare Services 2,6% | Other related Services 13,2%

Challenges

Child abuse and neglect is a complex public health problem caused by numerous factors in every country across all population-groups, resulting in immediate and long-term social, health and financial consequences. Despite the importance of the problem, however, accurate estimates of its extent and characteristics in the general population are not available because of two main interlinked problems: underreporting and under-recording of child abuse and neglect cases. There is sufficient evidence in international literature suggesting that large numbers of abused and neglected children are not coming to the attention of child protective agencies and services. From those eventually coming to authorities a large part is not registered appropriately. In this context:

- CAN-MDS aims to achieve a true intersection in the child protection systems of the participating countries in terms of data collection and management of CAN incidents towards the increase reporting, identification and recording of cases reaching one at least agency
- Pilot testing of such a system in real settings, however, requires involvement and commitment of multiple stakeholders across and within relevant sectors in all countries
  - at a policy level (appropriate agency to undertake the role of System's Administrator AND sectors' representatives in the National Inter-Sectoral Board)
  - at an agency level (to participate as data sources) and
  - at individual level (front line professionals to participate as operators)
- All necessary measures had to be taken in order for the System's operation to
  - be in alignment with the legal framework of each country
  - satisfy the prerequisites related to the protection of personal data (GDPR)
- There were some delays during the preparatory phase because of internal issues (such as underestimation of the required time, staff turnover, organizational reform)
- Implementation of the Action was influenced by external conditions related to national specific political or other situations including governmental reforms, elections at various levels and
- … the Covid-19 along with the restrictive measures taken in all partners' countries (such as the lockdown)

Main difficulties

- Capacity building activities
  - in person Seminars for Professionals were scheduled to start in the 13 Prefectures on March 16, 2020
    - in person seminars were canceled due to lockdown and an amendment procedure was started to modify the initial plan
    - training module and material had to be re-prepared and adapted for online trainings
    - training of professionals was re-organized as distance asynchronous e-learning process
- Time consuming processes in approaching stakeholders and proceed with necessary bilateral agreements
  - Ministries, Authorities, Agencies/Services/Organizations and individual front line Professionals
  - Governmental services related to hosting of the System in the cloud etc.
- Concerns about processing of personal data
  - In many cases the measures taken in the context of CAN-MDS to comply with the GDPR rules had to be repeatedly presented

Lessons Learned

It is not an easy task

- to deal with under-reporting of child maltreatment especially if there are gaps in the relevant legal framework
- to introduce a new service across public sector agencies and to convince relevant stakeholders for the necessity of data collection on child abuse and neglect and the importance of such data for the prevention of the problem
- to achieve anything when unexpected problems arise like the COVID-19 pandemic; however, pandemic and the consequent lockdown seems to influence the prevalence of the problem (as it will be discussed in some presentations tomorrow)

It is very encouraging

- how much supportive are relevant stakeholders when they gain understanding of the CAN-MDS initiative and how this can contribute to collection of data on child maltreatment
- how much positive are the front line professionals, after the approval of their Organizations, to be involved in such an effort and become operators that means to record data in a system in the context of their everyday work
- how effective can be a short training module on issues related to definitions, signs to recognize CAN cases, how to deal with revealing of CAN incidents and understanding the reasons of under-reporting
- how feasible seems to collect information from multiple multi-sectoral sources by multidisciplinary groups of professionals working with and/or for children using the same tool, definitions and methodologies in a single database

Main message

- To introduce and maintain an inter-sectoral mechanism for child maltreatment data collection like the CAN-MDS at a national level requires time and continuous effort
- Thus, the Institute of Child Health with the support of the National Inter-Sectoral Board made the decision to continue with the piloting of the system until the end of 2021 (after the project's end)
- Having sufficient data, a coordinated effort will be made in order for the System to continue its operation at a permanent basis under the auspices of the appropriate Authority

In this context all relevant stakeholders, Authorities, Organizations, Agencies and Professionals are kindly invited to participate in this effort

Coordinated Response to Child Abuse & Neglect via Minimum Data Set: from planning to practice in Romania

Maria Roth, Gabriela Tonk, Imola Antal, Babes-Bolyai University—UBB, Cluj, Romania
Daniela Bosca, Corina Andrei, Oana Clocotici, FONPC, Bucharest, Romania
Diana Totelecan, Cristian Iclodean-Lazar, Arianda Popa, DASM Cluj, Romania
M. Bonea, K. Pesek, L. Mark, K. Szasz, DGASPC Satu Mare and DGASPC Covasna, Romania
(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Objectives

– to show the advantages of digitalization of child abuse referrals and data collection
– to give a framework to the collaboration processes between agencies and between specialists in CAN
– to improve the rate of referrals on CAN.

Context

– Data in child abuse and neglect cases in Romania have been collected till now on paper files, by each agency
– This resulted in different definitions of maltreatment depending on local and institutional policies, so the data in different counties of the country are extremely different.
– Though law requires teamwork, on the field, the collaboration and the coordinated interventions are rare (school educators, psychologists, NGO workers, municipality social workers, police, prosecution, judges, doctors and nurses discretionally communicate with each other)

Training: Topics and results based on pre-post evaluation

6 training sessions
– The challenges of the case management and reporting CAN in Romania
– The advantages of the common work on the platform were shown to participants.
– 57.89% of the specialists from Bucharest and 36.99% of the specialists from the 3 counties have never reported CAN incidents.
– For 50% of the professionals from Bucharest and for 37.68% from the counties this training was the first training on CAN, while 59.45% from Bucharest and 68.42% are working with child victims of CAN many times or frequently
– 50% of the respondent from the 3 counties and 33,33% from Bucharest know professionals are mandated by the law to report CAN
– 38.60% from Bucharest and 43.24% the counties know that there are consequences of not reporting
– Regarding training efficiency: there are almost 3 point difference in the mean score of the knowledge of the participants (according to their self-evaluation questionnaires).

Results	Pre- and post-training questionnaire	
Self-evaluation* scale from 1 to 10)	Pre-Mean (N=74)	Post-Mean (n=53)
What child abuse means	8.108	9.54
How I can recognize child abuse	7.811	9.56
Legislative framework of child abuse	6.635	9.50
Information of the prevalence of CAN	6.338	8.64
How does CAN-MDS operate	4.27	9.73
Total	6.632	9.40

Advantages of MDS, as perceived after the training

– New context and structure for networking which gives opportunity to:
  – Work on the common understanding of CAN between sectors (through discussions around clarification of modalities of introducing a specific case in the system)
  – Clarify sectoral, institutional and professional roles related to reporting (Ex. Education)
  – Enhance coordinated inter-sectorial interventions in CAN cases - the monthly meetings of the local network of operators gave the opportunity to present difficult cases and plan case conference
– Evidence based planning of human and material investments in responding to needs related to CAN
– Bringing forward the efforts of the child protection system and other related systems in responding to accountability issues and justifying budgets.

More concrete data on the process and results of the MDS2 Consortium in Romania (Dec. 2018-June 2021)

– 40 collaboration agreements between the MDS consortium and different agencies
– 8 Online training sessions
  – 2 Bucharest, 2 Cluj, 2 Covasna, 2 Satu Mare
– Piloting the system in real settings (12/2020-6/2021)
– 140 professionals opened accounts on the platform
– 287 cases of abuse and neglect were registered
– Improved intersectorial and interprofessional collaboration

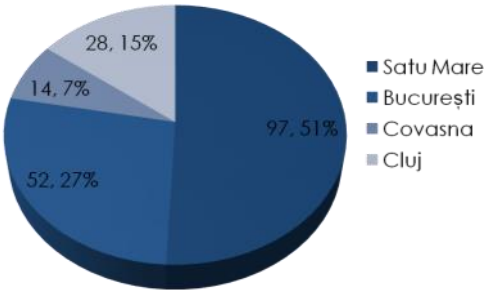
Involved institutions for piloting the data base

Duration: 4.12.2020- 4.06.2021
– General Directorates of Social Assistance & Child Protection
– Social Assistance Directorates in Municipalities and Mayoralties
– School Directorates and the relevant Counselling Centers
– Police inspectorate Satu Mare
– Mental Health Centers and Pediatric hospitals
– Children's Ombudsman
– NGOs

Professionals participating (Dec 2020- June 2021)

SWs in Child Protection Directorates, local authorities, hospitals, NGOs | Psychologists and school councilors | Teaches | Policemen | Prosecutors, judges | Ombudsmen | Physicians | Psychologists, mental health professionals | Sociologists | Academics

Number of cases introduced (N=287; male: 122; female: 165)



Sources of information

77 Personnel working in Social Services/Public–Central/Local
55 Parent /foster parent/ parent's partner/ care provider
49 Personnel working in Health services
42 Personnel working in Police /low enforcement
20 School /preschool /kindergarten personnel
10 Relative (siblings, grandparents, etc.) not living with the child
25 Other source of information

Type of incident (N=287)

140 A distinct event took place (not continuous CAN)
75 Continuous maltreatment including distinct events
30 Continuous maltreatment—no distinct events
42 unknown

Forms of maltreatment (N=287)

16 Violent acts against self /Self-harm actions
52 Physical violence acts committed
41 Sexual violence acts committed
40 Psychological violence acts committed
158 Neglect/ Omissions

Location of incident (N=287)

175 home/ family
25 Public place/street, commercial & surrounding area
23 Other place
20 Medical services
18 Unknown/unspecified place
14 Home/relatives
10 Leisure /playground/ recreational are
6 School
1 Child care institution (residential care)

Type of Family (N=287)

248 Child lives with his family
14 Child lives in residential care
6 A recomposed family
5 Child lives with relatives
6 Child lives in a friends' family
2 Child lives in a foster family
7 Not known

Institutional Response (N=287)

4% None | **9%** Unknown | **87%** Yes, out of which:
48% Immediate interventions
39% Action taken-No Court involvement
13% Action taken-Court involvement

Referrals to Services (N=287) (type of services)

9 Judicial Services
122 Social Welfare Services
8 Law Enforcement related Services
6 Educational Services
6 Community Organizations and NGOs
61 Unspecified

Conclusions

– The results of the project demonstrate an increase in the motivation of the majority of participants to respond to the needs of maltreated children.
– Development in the agency's digital competencies initially skeptical in using the platform.
– Learning that better cooperation is possible on a common platform, without threats to security, and in an ethical way, is another strength of the program.

CAN-MDS II Action—Results

CAN-MDS Piloting in Catalonia (Spain): Results, Challenges & Lessons Learned

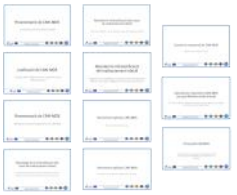
Susana Rodríguez Pereiro & Saskia Pelzer, Fundació Aroa

(based on the presentation in the CAN-MDS EU Conference, June 29-30, 2021)

Results –National CAN-MDS Toolkit and Training Module

– Nationally adapted CAN-MDS Toolkit and Training Module translated, adapted to local context and reviewed (by 3 experts)
– Policy briefs, Data Collection Protocol & Guide for Operators


– Nationally adapted CAN-MDS Toolkit and Training Module translated, to local context and reviewed
– Application translated and reviewed by a group of 3 experts



CAN-MDS Administrative Authority

– General Directorate of Child and Adolescent Care of the department of social rights of the Government of Catalonia (DGAIA)
– The DGAIA is the body that promotes the well-being of children and adolescents at high risk of social marginalization with the aim of contributing to their personal development. It also exercises the protection and guardianship of helpless children and adolescents.

Organizations & Agencies involved

Stakeholders to be invited as members of the Board Meeting (60+ bilateral meetings)
– Director of the General Directorate of Children and Adolescence Support (Government of Catalonia)
– (Head of Victim Support Office), Justice Department (Government of Catalonia)
– Education Department (Government of Catalonia)
– Mossos d'Esquadra (Government of Catalonia)
– Official of the Barcelona Urban Police and president of European Network of Policewomen
– Catalan Institute of Health Department (Government of Catalonia) –
– Social Services Department (Government of Catalonia) -
– Social Services Barcelona CityHall
– Institute of Forensic Medicine (Government of Catalonia)
– Ombudsman of Children
– Child Promotion Barcelona

Stakeholders to be invited as members of the Board Meeting with the social entities (June 2019)
– Barcelona Diocesan Charity
– Vicky Bernadet Foundation
– Association for Family and Community Health Ventijol
– Health and community Foundation
– Intress - Institute of Social Work and Social Services
– ABD - Welfare and Development Association
– EDUVIC social initiative cooperative

National Inter-Sectoral Board

Final signed Terms of Reference (ToR)/ agreements with:
– Association for Welfare and Development ABD (NGO)
– Worker cooperative and social initiative EDVIC (NGO)
– Municipal Institute of Social Services of Barcelona City Council (IMSS).
– General Directorate of Children and Adolescence Support DGAIA

Inter-sectoral Board:

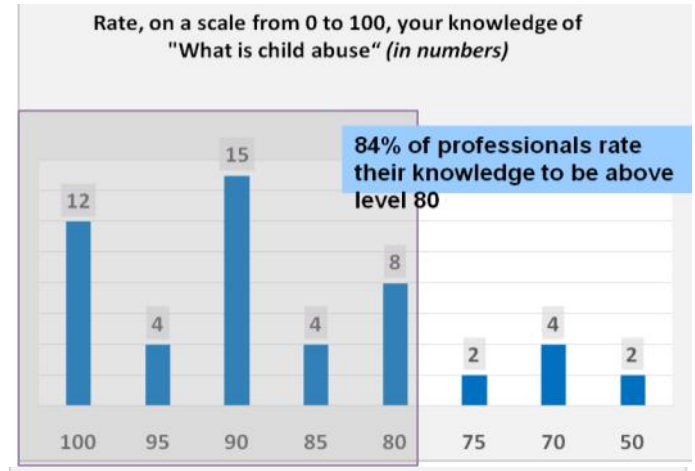
4 meetings

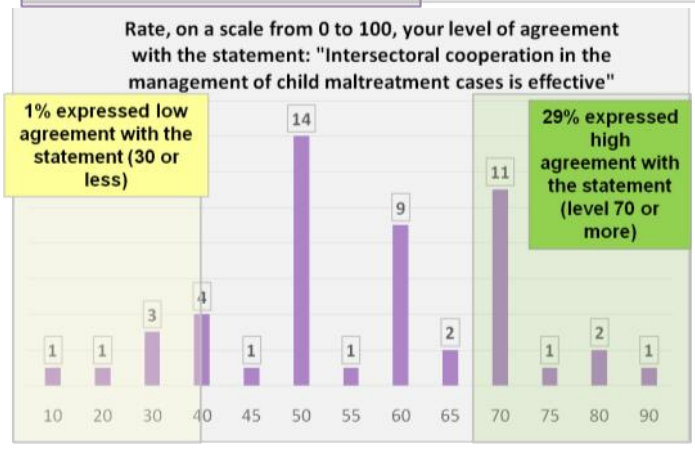
February 2020,
December 2020,
March 2021,
June 2021

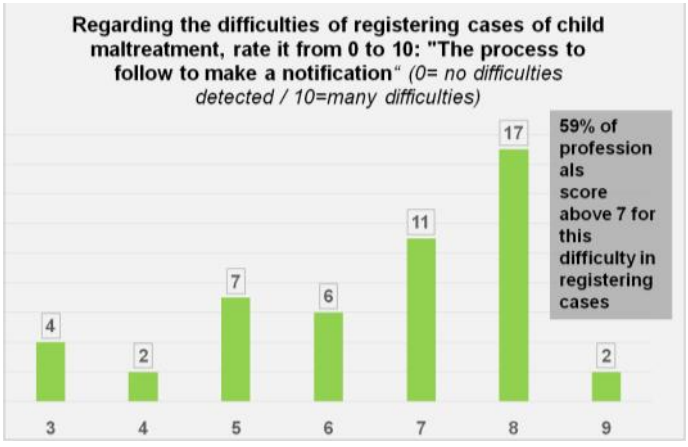
Training of front-line professionals: profiles

Agencies involved in the training OF PROFESSIONALS
– Association for Welfare and Development ABD (NGO)
– Worker cooperative and social initiative EDVIC (NGO)
– Municipal Institute of Social Services of Barcelona City Council
– General Directorate of Children & Adolescence Support DGAIA
– Aroa Foundation

Professions of participants (N=59): Training assessment







Professionals-trainees' comments:

"Registration is not always easy, there are services that do not encourage it"

"Many professionals do not know who to notify, do not know or do not understand their respective protocol"

Set-up of the CAN-MDS System and Piloting of the CAN-MDS System in real settings

Intensive work carried out at different levels, from December 2019 to June 2021 with the LEGAL SERVICES of DGAIA (to obtain authorization and define the agreement) AND with IT and CYBERSECURITY SERVICES of DGAIA & Institute of Child health Greece (to realize the installation of the application on their server).

Link CAN-MDS System in Catalonia, hosted on DGAIA's server:
https://canmds.extranet.gencat.cat/canmds/index.php

Piloting of the CAN-MDS System

Piloting finally started on 15 June 2021 (reduced piloting period; reduced personnel's availability on short notice; reduced availability of data as less cases were registered). The existence of other registration systems makes it difficult for operators to register cases in such a short pilot testing period

Piloting results

48 CAN cases registered between June 15 and June 29 (majority by social services specialised in childcare)

Challenges

– Political and healthcare landscape: 2 Catalan elections during the project and the COVID-19 pandemic :
  – delay in signatures of agreements.
  – the political changes, health & social emergency led many sectors that were initially involved to leave the project.
– Low numbers of trainees: despite efforts through numerous bilateral meetings -> still a long way to achieve a coordinated response to child maltreatment.
– Time consuming processes in various settings (to proceed with agreements with agencies, modifications of commitments, namely number of professionals involved, and IT issues).
– Catalonia's own system for children and adolescents at risks: is a great advantage in tackling abuse at the regional level, despite some sectors are excluded (NGOs), but in relation to the project it generated duplications that hindered its implementation.

Lessons learned

Training provoked discussion and awareness for improvement and shortcoming of the Catalan model (CAN-MDS as proposal).

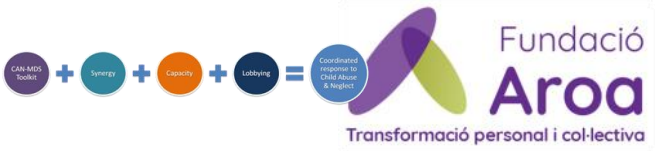
– The existence of legislation, specialized services and protocols for the care of children at risk in Catalonia is highly valued by professionals.
– Need for more joint forces & implication of a) public health (primary services), b) education (schools), c) justice sector, etc.

(Lessons Learned cont.)

- Need to improve communications between professionals and different departments.
- Childcare teams should have a shared digital alert system.
- Need for unification of the different systems.
- Difficulties in involving non-specialized sectors in child maltreatment care.
- Resistance from some professional sectors that are not involved or are very superficial in relation to the registration of child abuse (the advances obtained in Catalonia may generate the feeling that "everything is already done").
- Specialized childcare system is overburdened, making it difficult to evaluate and propose changes & improvements.
- Feedback of frontline professionals: they are very aware of child abuse and the weaknesses of the registration and coordination system in Catalonia.
- To introduce and maintain CAN-MDS as a permanent service needs a lot of time, which requires involvement at political and institutional level that is difficult right now and we cannot work to obtain now due to the lack of resources.

Recommendations

- Leveraging experiences/difficulties across countries - best practices can be exchanged between countries with similar problems during the project
- Foresee that mechanisms can delay processes in similar projects – longer period for engagement with regulators
- Envision even longer preparation and actual testing period for pilot
- Promote and facilitate spaces for reflection and listening to professionals, as they are the real experts.
- Identify and respond to reluctance to undertake changes in the recording of child maltreatment: the complexity of the changes and the slow processes generate resistance that must be managed.
- Be aware that slow processes do not mean that change is not happening.



The outlook for France: National hospital data available in France that could contribute to the CAN-MDS

Catherine QUANTIN, Centre Hospitalier Universitaire de Dijon Bourgogne Biostatistics and Medical Informatics Division, France

(presented in the CAN-MDS EU Conference, June 29-30, 2021)

The project "CAN-MDSII" resulted in the creation of a final data set of the CAN-MDS system including specific data collection for 18 items. This is a major step forward in creating the scientific basis, tools and synergies for establishing national child maltreatment surveillance systems using a minimum data set, but it is very difficult to collect all of this information on a national level, in particular in France. However, we are able to gain access to national data collected in every public and private hospital in France, which represents approximately 2,000 hospitals overall. We identified 5 variables that are available and collected in all French hospitals: age, sex, date of record, child anonymous identifier, and form of maltreatment identified through ICD-10 diagnoses codes. We have also designed a specific algorithm to identify physically abused children among the population of hospitalized children.

For example, we conducted a study focused on physical abuse during the first lockdown for COVID-19. In this study, presented at the 16th ISPCAN European Conference on child abuse and neglect in June 2021, we observed that there was a decrease in the number of children admitted to hospital during the first lockdown, as reported in other countries. Second, we found that the relative frequency of physical abuse among all hospitalizations for children aged less than 5 years was significantly higher (≈50%) than in previous years. We also showed an increase in severe cases (and more in-hospital deaths) among children hospitalized for physical abuse. These results were transmitted to the French Ministry of Health and had an influence on the decision not to close schools during the second lockdown in France.

> new perspectives for the CAN-MDS: cooperating with the COST Action EuroCAN, WG2 "Promoting Secondary Analyses"

Our figures probably only show the tip of the iceberg of an overall increase in violence against young children, and, using available data, there is still work to be done to identify physical and other forms of abuse.

Our team is part of the COST Action called "Multi-sectoral responses to child abuse and neglect in Europe: Incidence and trends" (Chair: Dr Andreas Jud), including 34 countries mainly in Europe. In the framework of WG2 "Promoting secondary analyses" (Leadership: Pr Catherine Quantin), we have started to look at available data to determine whether the 5 hospital variables already collected in France could be collected in several other European countries. We are also investigating how to harmonize the collection of these variables. Our proposal is therefore to use the results of this COST Action, which look promising, to participate in the creation of a future European project which could continue the important work undertaken by the CAN-MDS in the previous project.

Challenges and success Stories in the Action CAN-MDS II: Towards the establishment of an inter-sectoral epidemiological surveillance mechanism for child abuse and neglect incidents in European countries. An expert evaluation of the project.

Jenny Gray, Social Work Senior Expert-Consultant, UK
CAN-MDS II Action External Evaluator

(presented in the CAN-MDS EU Conference, June 29-30, 2021)

Developing an inter-sectoral epidemiological surveillance mechanism for child abuse and neglect incidents is a very challenging but necessary undertaking to prevent and protect children from child abuse and neglect. The initial training meeting held in December 2019 went extremely well and participants from all partners left fired up with enthusiasm and confident of the next steps. However, no-one could have predicted a global pandemic was imminent and the impact that it would have on our personal and professional lives. By March 2020, our worlds and this project had been turned upside down. Professionals had to work from home and the use of IT for communication, including training became essential and virtually the sole method of interacting. No-one had any understanding of how long the pandemic would last for.

Methodology: Attendance of the expert evaluator at the initial training meeting as a participant observer; reviewer of all documentation produced by the project in English; participation in project zoom calls and in the final project conference.

Findings: After some hesitation, all partners embraced online training, making the necessary revisions to the training materials and how the planned training was to be delivered. Although the intended timeline was delayed, the training was delivered successfully, demonstrating pluses (e.g. wider geographical participation at a lower cost) and minuses (e.g. loss of informal exchanges of information and the development of professional relationships).

Initially, some organisational staff and policy makers lacked an understanding of how CAN-MDS could support the protection and prevention of CAN at the individual child level; and, in monitoring and achieving national policy aims and strategies to achieve the 2030 goal of a world where children are free from violence. This changed to a positive stance once the project became a reality and demonstrated its benefits to those involved.

The legality of sharing child level data within this project was a key issue which in some countries resulted in major delays. From this project it seems that many European Government Ministries, organisations and individuals are yet to fully understand the General Data Protection Regulation (EU) 2016/679 (GDPR) and how the CANMDS system is compliant with this regulation. This lack of knowledge was a barrier to the efficient implementation of the project to a greater or lesser extent in all partner countries.

This project showed, once again that support from key Ministries is crucial: commitment at government level supports involvement of sub-national and local agencies, and later the relevant Ministry taking on responsibility for the CAN-MDS and a national roll-out. In addition, having IT systems fit-for-purpose and ongoing IT support are essential. An efficient system encourages and supports participation and organisational buy-in: Good quality, responsive IT support enables implementation to be more successful and sustainable.

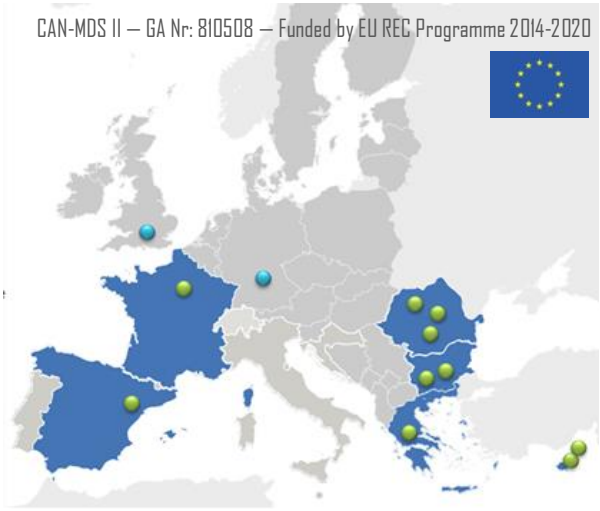
Despite all the barriers, including a tight project time-scale and the COVID-19 pandemic, country partners (with the exception of France) completed the project and succeeded against the odds. Those driving the CAN-MDS forward have been exemplary in their dedication, resourcefulness and creativity. CAN-MDS project members have worked hard to deliver it and learned valuable lessons about what works to support successful implementation of CAN-MDS. Children have been involved the project, demonstrating that they can be involved in a meaningful way, even if, initially, the content may seem child un-friendly. Some Government ministries have already indicated that they will take over the project and take responsibility for its future implementation – the best long-term outcome.

Conclusion

CAN-MDS, when implemented can meet all its objectives and contribute to the protection of abuse and neglect and prevention of CAN. Once participants are engaged and competent in using CAN-MDS, they are converts and advocates for it – realising its benefits for children and families and society. It takes time, commitment at all levels (national, sub-national and local) and funding to deliver CAN-MDS effectively.

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: **32 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-up
- provide -at a population level- aggregated data essential to identify trends, measure responses & feed into policy development .

National CAN-MDS Policy Brief Series

Institute of Child Health,
Department of Mental Health and Social Welfare

Fokidos 7
11526 Athens
GREECE

Phone: +30-210-7715791
Fax: +30-210-7793648
E-mail: ich_dos@otenet.gr

Institute of Child Health
Department of Mental Health and Social Welfare
Athens, GREECE

Action's Website:

can-via-mds.eu

available at: can-via-mds.eu