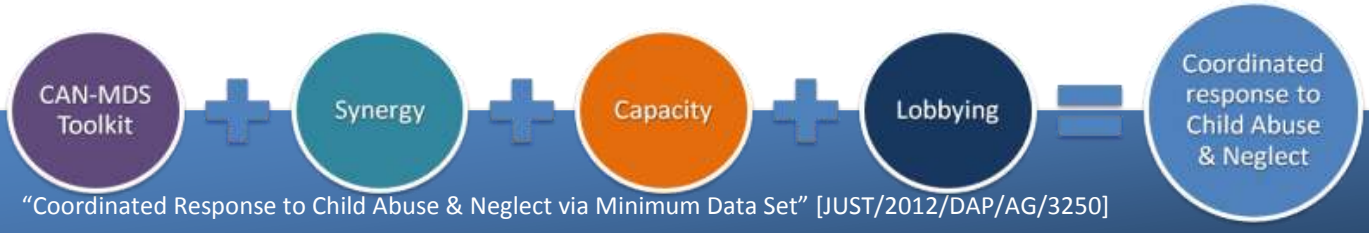
With financial support from the DAPHNE III Programme of the European Union

Coordinated Response to CAN via MDS

Trainer's Manual

for CAN-MDS Core Group members



"Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]

Project's Information

Project's Title	Coordinated Response to Child Abuse & Neglect (CAN) via Minimum Data Set (MDS)
Grant agreement No.	JUST/2012/DAP/AG/3250
Funding	With the financial support of the EU DAPHNE III Programme
Duration	28 months
Project's website	www.can-mds.eu

Deliverable's Information

Workstream	Workstream 4 Capacity Building: Train of Trainers and of National Core Groups of CAN-MDS
Activity	1. Development of a training module for professionals/potential operators of CAN-MDS on the basis of CAN-MDS Toolkit including a special session on CAN monitoring ethical aspects
Deliverable No.	Deliverable D4.6 (Annexed to D4.1 CAN-MDS Training Module)
Deliverable title	Trainer's Manual
Target group	Partners and any other national focal point who is interesting to undertake the training of national Core Group CAN-MDS Operators
Drafted	A. Ntinapogias, Project Coordinator, G. Nikolaidis, Project Leader

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ISBN: 978-960-9766-14-2

This publication has been produced with the financial support of the DAPHNE III Programme of the European Commission. The contents of this publication are the sole responsibility of the authors and can in no way be taken to reflect the views of the European Commission.

Coordinated Response to Child Abuse & Neglect (CAN) via Minimum Data Set (MDS)

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ANNEX

Folder "Training Module CAN-MDS"

Notes to Trainer

BACKGROUND INFORMATION

The training module for professionals/potential operators of CAN-MDS on the basis of CAN-MDS Toolkit is developed for use as part of the capacity building process for the usage of CAN-MDS Surveillance System. It is aims to be used to train eligible professionals working in the fields of social welfare, health and mental health, justice, low enforcement and education who are dealing with cases of child maltreatment in order for them to become operators of a national surveillance system for child abuse and neglect.

PURPOSE OF THE MANUAL

The "Trainers' Manual" annexed to the module is developed for use by professionals of Core Groups of CAN-MDS already trained to act as *trainers* for Expanded Groups of potential CAN-MDS Operators. The material contained in the manual are designed for use by a variety of front line professionals who are going to become members of the national core group of operators and are geared toward an also broad range of professionals providing services to maltreated children according to their professional background and the settings where they are working (social welfare, health and mental health, justice, low enforcement and education, puglic agencies or accredited NGOs) and are eligible to become operators of a future CAN-MDS Surveilance System.

It is noted, however, that these material is not intended to substitute for expert knowledge or in-depth training for subjects such as child maltreatment in general and codes of ethics; professionals who are going to participate in the trainings is expected to be already familiarized with these subjects (given that they are already involved in administration of CAN cases and are already subjected in a professional code of ethics). Instead, the material intended to provide to trainers and, subsequently to trainees, all necessary information, knowledge and skills for become operators of a potential CAN-MDS surveillance system.

LEARNING OBJECTIVES

The Trainer's Manual includes an overview of how to use both, the training and the evaluation material in the context of a group training.

The manual's learning objective is to provide eligible professionals-*multipliers* (i.e. members of core groups) necessary information and skills to follow the procedures for conducting expanded groups' trainings in order for the trainees to be able to contribute in CAN surveillance via CAN-MDS, in case that such a system will be established.

Specifically, trainers are expected to be able to inform trainees about the necessity for surveillance of child maltreatment and enable them to:

- Identify incidents and cases
- Record (suspected) cases, along with specific information (related to conditions, child and family)
- Record information for services' response (institutional response and referrals made)
- Communicate with and provide feedback
  - to the community (public health level)
  - to professionals-operators (at case-level)

Content of Manual

As for its content, the Trainer's Manual includes information for both, the training for expanded groups and the training of Core-Groups.

The training for expanded groups consists of the following sessions:

- Introductory session
- The role of trainees as members of Expanded-Groups
- Exploring the CAN-MDS: *a variable by variable review*
- Ensuring understanding of CAN-MDS (working with mock cases)
- Key Ethical Issues related to CAN Surveillance

The content of this training is actually similar to the one of the Core Groups. The difference is that here are not included the following sessions:

- Building the National expanded groups of Operators
- Planning, conducting and evaluating the training of national CAN-MDS Expanded Groups

These sessions, however, are also included in the current manual.

Note to Trainer: For a more comprehensive description of the trainings, please read the Training Module for Professionals-Potential Operators of CAN-MDS including the following information:

1. Identity
2. Brief Introduction
3. Aim & Objectives
4. Trainers & Trainees
5. Content of Training & Learning objectives
6. Duration
7. Material to be used
8. Suggested Training Programme
9. Financial Resources
10. Evaluation

DO'S AND DON'TS OF TRAINING	
	▶ ***prepare in advance*** ▶ ***use visual aids*** ▶ ***encourage questions*** ▶ ***recap at the end of each session*** ▶ ***use good time management*** ▶ ***check to see if your instructions are understood***
▶ ***talk to the presentation or flip chart*** ▶ ***block the visual aids*** ▶ ***stand in one spot-move around the room*** ▶ ***ignore the participants' comments & feedback*** ▶ ***read from manual*** ▶ ***shout at participants***	

Further Reading

The module for training of CAN-MDS core and expanded groups of operators is based on a series of work done in the context of the Daphne co-funded project *"Coordinated Response to Child Abuse and Neglect fia a Minimum Data Set"*. All information related to the training of professionals either as future trainers or as future operators of a CAN-MDS Surveillance System are available to any interested party to use the module.

Further reading

Apart from the CAN-MDS Toolkit, it is strongly recommended that future trainers in the context of their preparatory work to read the documents related to CAN-MDS trainings (namely the "*Trainer's Manual"*) as well as the documents related to their country specifics (such as the "*Country profile reports*").
Moreover, future trainers may read the reports under the title "*How the CAN-MDS was developed"*, especially for issues they may consider as not clear enough (such as the definition of the eligibility criteria for formatting core and expanded groups of operators or how the content of the MDS was decided).
Optionally, further Informational reading material suggested for future CAN-MDS trainers (namely the core groups' members) is the *CAN-MDS Policy and Procedures Manual, informational leaflets, and the website of the project "coordinated response to child abuse and neglect via a minimum data set".*

CAN-MDS Toolkit

- Content:
  - *CAN-MDS Operator's Manual*
  - *CAN-MDS Data Collection Protocol*
  - *e-CAN-MDS registry (online or stand-alone application)*
- To whom the Trainer's Manual is addressed: All relevant stakeholders and CAN-MDS core-groups' members who are interesting in training professionals either as further core-groups or as members of expanded groups of CAN-MDS Operators
- *Trainees: All potential CAN-MDS Toolkit Users in partners' and other EU countries (core- and expanded groups of a CAN-MDS surveillance system's future operators): Professionals working in the field of CAN secondary and tertiary prevention, Professionals working in the field of CAN primary prevention, Social and Health Scientists. Also, Epidemiolgoists and Policy Makers.*
- *Available at: www.can-via-mds.eu and in the CAN-MDS USBs, DVDs or CDs*

Country specific information

- ***Country Profile Report***
  - Content: *Review of practices applied, mapping of existing mechanisms for CAN cases follow up and of national CAN sureillance mechanisms (if applicable)*
  - Target groups: *Professionals working to social welfare, Health and Mental Health-, Justice-, Low Enforcement-, Education-related professionals, statisticians, epidemiologists, policy makers*
  - *Available at: www.can-via-mds.eu*

Information for training (addressing Core Group of CAN-MDS Operators)

- ***Training Module***
  - Content: *Training module for professionals-potential operators of CAN-MDS on the basis of CAN-MDS Toolkitincluding a special session on CAN monitoring ethical aspects*
  - Target groups: *Any national stakeholder ("focal point") who is interesting to undertake the training of national core group of CAN-MDS operators*
  - *Available at: www.can-via-mds.eu*

How the CAN-MDS was developed

- Developing of evaluation methodology and tools for CAN-MDS Toolkit
- Evaluatin of Toolkit in terms of Feasibility & Experts' evaluation results
- Developing of eligibility criteria for the creation of national CAN-MDS Core and Expanded Groups of Operators
- Designing of methodology and tools for effectiveness evaluation of training
- Evaluation Results from the *train-of-trainers* seminar
  - *All the above are available at: www.can-via-mds.eu*

Further Informational material

Developed in the content of project

- CAN-MDS Policy and Procedures' Manual
- CAN-MDS Surveillance System (Informational leflet)
- CAN-MDS Flyer
- Website www.can-via-mds.eu

Further Literature

- *For a more comprehensive understanding* the United Nations' Committee on the Rights of the Child's General comment No. 13 (2011), "The right of the child to freedom from all forms of violence" [CRC/C/GC/13 (2011) §19-33][1], UNCRC Article 19,[2] the World Report on VAC (2006),[3] the WHO and ISPCANs definitions (2006)[4] and CDCs (2008)[5] definitions

[1] Available at: http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf

[2] Available at: http://www.unicef.org.uk/Documents/Publication-pdfs/betterlifeleaflet2012_press.pdf

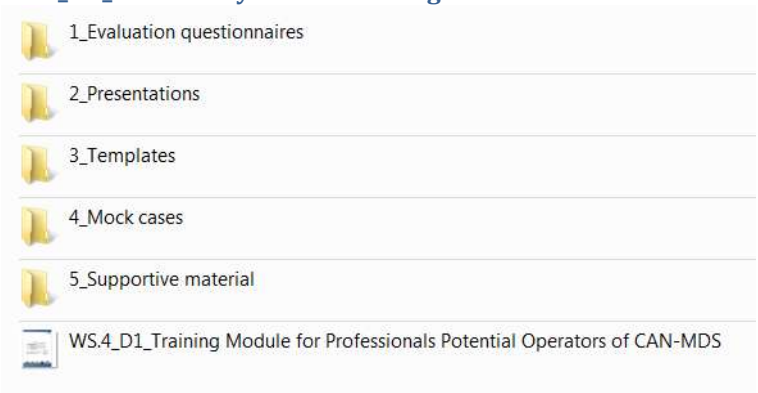
[3] Available at: http://www.unicef.org/violencestudy/reports.html

[4] World Health Organization and International Society for Prevention of Child Abuse and Neglect. (2006). Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: WHO Press
Available at: http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf

[5] Leeb R, Paulozzi L, Melanson C, Simon T, Arias I. (2008). Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements. Centers for Disease Control and Prevention, National Center for Injury Control and Prevention: Atlanta, GA.
Available at: http://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf

Content of the e-folder Training Module CAN-MDS

WS.4_D5_Final ready-to-use training material



Sub-folder "1. Evaluation methodology & tools"

1. Evaluation Methodology

- Report "*WS 4_D2 Evaluation Methodology and Tools for Training*"

2. Evaluation Questionnaires

[to be translated]

- Pre & Post-Evaluation questionnaires
  - for Core Group workshops
  - for expanded group trainings

Sub-folder "2. Presentations"

PowerPoint presentations [*.pptx]

[to be adapted according to country specifics and according to the content of training]

1. "Workshop of National Core-Group of CAN-MDS Operators"

- Part 1_Train of National Core Groups_Introduction to the Project
- Part 2_Train of National Core Groups _The role of Core-Group Members
- Part 3A_Train of National Core Groups_Exploring the CAN MDS (optional)
- Part 3B_Train of National Core Groups_Exploring the CAN MDS_Application CAN-MDS
  - *Folder "Part 3B_4 alternative (without use of e-application)"*
    - *Part 3B*_Train of National Core Groups_Exploring the CAN MDS a variable by variable review
- Part 4_Train of National Core Groups_Towards the understanding of CAN-MDS_ Simulation Process
  - *Folder "Part 3B_4 alternative (without use of e-application)"*
    - *Part 4_Train of National Core Groups_Towards the understanding of CAN-MDS*
- Part 5_Train of National Core Groups_Key ethical issues related to CAN-Surveillance
- Part 6_Train of National Core Groups_Building the National expanded groups of Operators
- Part 7_Train of National Core Groups_Planning the training of national CAN-MDS Expanded Groups

2. "Training of Expanded Expanded Groups of future CAN-MDS Operators"

- Part 1_ Train of Expanded Groups _Introduction to the Project
- Part 2_ Train of Expanded Groups_The role of CAN-MDS Operators
- Part 3A_ Train of Expanded Groups _Exploring the CAN MDS (optional)
- Part 3B_ Train of Expanded Groups_Exploring the CAN MDS_Application CAN-MDS
- Part 4_ Train of Expanded Groups _Towards the understanding of CAN-MDS_ Simulation Process
- Part 5_ Train of Expanded Groups _Key ethical issues related to CAN-Surveillance

Sub-folder "3. Templates"

Templates [*.docx]

[to be translated and adapted accordingly for core and expanded group trainings]

- Training Programme
- List of Trainees /attendance form
- Certifications of Attendance

Sub-folder "4. Mock cases"

Material [*.docx]

[to be translated and adapted according to country specifics, if needed]

- **Mock (vignette) cases** including material
  - for actors ("referrals" or "sources of information")
  - for trainees ("professionals"-"operators of CAN-MDS))
  - recording forms (phases A, B and C) OR recording in the e-CAN-MDS
- For detailed information on use of mock cases in trainings' evaluation, please see the "*WS 4_D2 Evaluation Methodology and Tools for Training"*

Note: Vignette cases can be adapted according to country specifics or replaced by more appropriate mock cases

Sub-folder "5. Supportive material"

Material [*.pdf]

List of supportive material developed in the context of the project

Other material (e.g. further reading on subjects related to ethical issues etc)

Note: USB/DVD/CD including the **National** version of **CAN-MDS Toolkit** will be provided to interested parties from national CAN-MDS *Focal Points* (namely project's partners)

Available material for Core- and Expanded- Group of CAN-MDS Operators' training; The Trainer's Manual (see orange outline) is part of the supportive material

Overview of Sessions for Core-Group Workshops

presentation "Part 1"		Outline ▶ Overview of the Programme ▶ Project's Identity, *Aim & Objectives* ▶ *From the project to the proposal of a CAN-MDS Surveillance System* ▶ CAN-MDS Surveillance System: *Aim & Objectives* ▶ Possible uses of data collected through a CAN-MDS Surveillance System ○ *CAN-MDS flowchart* *Note: Similar to the presentation Part 1 for expanded group trainings*
presentation "Part 2"		Outline ▶Who are the members of the CAN-MDS core-group? ▶The role of Core-Group in the context of the project ▶Why Core-Group members' participation in this workshop is important ▶What Core-Group members should do after the Workshop *Note: For expanded group trainings there is a different presentation*
presentation "Part 3"		Outline ▶ Case definition ▶ *Conceptual and Operational CAN definitions* ▶ CAN-MDS ▶ *a variable by variable review* ▶ Data Collection Protocol ▶ *Common indicators of CAN* *Note: Similar to the presentation Part 1 for expanded group trainings*
presentation "Part 4"		Outline ▶ Working with mock (vignette) cases ▶ *Simulation of the recording procedure* ▶ Discussion *Note: Similar to the presentation Part 1 for expanded group trainings*
presentation "Part 5"		Outline ▶ Public Health Surveillance ▶ Child Maltreatment Surveillance ▶ Ethical issues posed by public health surveillance ▶ Review of CAN-MDS on the basis of *a tool for ethical analysis of public health surveillance plans* ▶Discussion *Note: Similar to the presentation Part 1 for expanded group trainings*
Following sessions will not be part of trainings of expanded groups of future CAN-MDS Operators		

presentation "Part 6"		Outline ▶ Expanded Groups of CAN-MDS Operators ▶ How the eligibility criteria were defined ▶ Level of access to CAN-MDS ▶ Assignment of Responsibilities to different level of access ▶ *How a 20-professionals expanded group of future CAN-MDS operators can be formulated* *Note: ONLY for core-group workshops*
presentation "Part 7"		Outline ▶ Algorithm for planning a training ▶ Budget for trainings ▶ Accommodation, Material, Fees ▶ Procedure (after identifying professionals) ▶ preparation of invitations (Templates) ▶ Discussion *Note: ONLY for core-group workshops*

Structure of Session's presentation

Each session comprises a separate part which includes the following information:

- Outline
  - estimated duration
  - learning objectives
  - trainer's preparation
    - review learning objectives of the sessions
    - rehearse with slide presentation
  - activities (where applicable)
    - instructions for activities (where applicable)
  - training resources
  - tips for trainers
- Handouts of the respective Presentation and suggested comments

Part 1	Introduction to the Project CAN-MDS at a glance	
OUTLINE	*estimated duration*	15 min
	learning objectives	To inform trainees on - the concept of the development the CAN-MDS - the aim and the objectives of the CAN-MDS surveillance system - the potential uses of data to be collected via the CAN-MDS - the aim of the workshop
	instructions to trainers	- Before start with this first session, please distribute the pre-questionnaires to trainees (available time for completion: ~5) - For the first session please use the first presentation included in the material - Please have in mind to have available coloured post it in order for the trainees to write donw their expectations from the training (this is going to be used at the end of the training as an evaluation measure for the extent to which the trainees' expectations were fulfilled.
	activity	- expectations and vital components of the training
	training resources	CAN-MDS Informational leaflet
	tips to trainers	- Please have in mind to keep this session as short as possible (for example you may just mention some information on the slides 4-10, 11-14) - NOTE: the wording under slides is indicative; you may use it as a basis for develop your own presentation

Part 1 – Presentation (please, adapt the slides where necessary)

Slide 1

Trainer(s) introduce his/her/their selves

Instruction: Before starting please distribute to trainees the pre-questionnaire provide them ~5 min to complete it

This is an overview of the project "Coordinated Response to child abuse and neglect via a minimum data set" which was implemented with the financial support of the DAPHNE III Programme of the European Union.

Slide 2

what are your main expectations from this workshop?

what do you consider that is vital to be included in this workshop?

TIP: while trainees fill in the pre-questionnaire, you can distribute the colored post it and show the current slide with the instruction

Instruction
Ask the trainees the following questions and record their responses on a flipchart paper (apart from the first question the other two questions can be optional questions):

- *what are your main expectations from this training?*
- *what do you consider that is vital to be included in this training?*

Slide 3

Outline

- Programme
- Project's Identity
  - Aim & Objectives

From the project to the proposal of a CAN-MDS Surveillance System

- CAN-MDS Surveillance System
  - Aim & Objectives
- Possible uses of data collected through a CAN-MDS Surveillance System
  - CAN-MDS flowchart

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

This is the outline of this first session of the training, namely an overview of the project and how from the project the proposal for a surveillance system for child abuse and neglect on the basis of a minimum data set was developed. Moreover, aim, objectives and possible uses of data colleted via a CAN-MDS surveillance system will be presented in brief.

Slide 4

Programme of today's seminar

[pre-questionnaire]

- **Introduction to the Project**
- **The role of Trainers**
- **Exploring the CAN-MDS: a *variable by variable review***
- **Towards the understanding of CAN-MDS**
  - **Discussion**
- **Key Ethical Issues related to CAN Surveillance**
- **Building the National Core Groups of Operators**
- **Planning the training of national CAN-MDS core groups**

[post questionnaire]
End of Seminar

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

Apart from the introductory session, the remaining programme of the today's training includes a discussion on your role as operators of a potential can-mds system as well as members of the Core Group. Then we will proceed by exploring each individual data element of the CAN-MDS and a simulation of the recording procedure will take place targeting in common understanding of the system. An overview on the key ethical issues related to CAN surveillance will follow and lastly, for the core-group members, steps and criteria will be presented for building national expanded groups of operators and for planning, conduction and evaluation of trainings for these expanded groups (In the context of a cascade process where you are expected to act as "multipliers")

Slide 5

Aims of Workshop

- **to understand**
  - what is the purpose of a CAN-MDS surveillance system
  - which are the agencies and the operators who are eligible to be involved in the CAN-MDS surveillance system
  - which are the cases that are eligible to be recorded in a CAN-MDS surveillance system and what are the information to be collected
  - what are the main ethical issues that govern CAN data collection (the importance of data confidentiality, legislative provisions, professionals' codes of ethics)

- **get acquainted with**
  - the technical characteristics of CAN-MDS and understand how to use it
    - working with via mock cases

- **to be informed on**
  - how to build your national Expanded groups of future Operators of a potential CAN-MDS SS
  - how to plan your national trainings of expanded groups of CAN-MDS future Operators

Here the main aims of the workshop are listed

Slide 6

Project's Identity

Programme:	• DAPHNE III
Project's Title:	DAPHNE III Programme
GA No:	The Daphne III programme aims to contribute to the protection of children, young people and women against all forms of violence and attain a high level of health protection, well-being and social cohesion.
Call:	
Priority:	Its specific objective is to contribute to the prevention of, and the fight against all forms of violence occurring in the public or the private domain, including sexual exploitation and trafficking of human beings.
Funding:	
Duration:	

The identity of the project is presented in this table. The project co-founded by the DAPHNE III Programm, Directorate General Justice.

Daphne is a programme aiming [see the information provided in the slide]

Slide 7

Project's Consortium

Coordinating Organization

- Institute of Child Health, Dept. of Mental Health & Social Welfare (ICH-MHSW)-EL
  - Prof P Durning (Ethical Issues)
  - Ms J Gray (External Evaluator)

Partners Organizations

- Child and Family Agency-BE
- South-West University "Neofit Rilski" (SWU)-BG
- University Ulm, Dept. of Child and Adolescent Psychiatry/ Psychotherapy-DE
- National Observatory of Children in Danger (ONED)-FR
- Istituto degli Innocenti (IDI)-IT
- Babes-Bolyai University, Dept. of Social Work (BBU)-RO

Associate partner

- Lucerne University of Applied Sciences & Arts, School of Social Work-CH

And here there are some basic information for the identity of the project's consortium.

Slide 8

Child abuse & neglect: *public health importance*

1999: Child abuse was recognized as a **"major public health problem"** (WHO, 1999)

2008: CM was recognized as a **"social problem that lends itself to a public health framework of study & subsequent prevention activities"** (O'Donnell *et al*. 2008)

2010: CM was identified as a **"*'critical'* and *'significant'* public health problem that warrants a comprehensive prevention strategy "** (US CDC 2010)

2012: **"the burden of CM is substantial, indicating the importance of prevention efforts to address the high prevalence of CM"** (Xiangming *et al.* 2012)

2012: **"promoting child-friendly services and systems in the areas of justice, health and social services"** (CoE Strategy for the Rights of the Child 2012-2015)

Public health importance of CAN data collection

1999: WHO recommended that the international community prioritize **"the development of worldwide data collection on CAN, the estimation of the impact on public health and also the associated economic cost"**

2008: CDC noted that **"the lack of reliable information as to the number of children affected by CAN has been identified as a serious limitation in lodging an effective public health response"** (Leeb *et al*. 2008).

2014: **"use data to inform actions"** to prevent child abuse and promote well-being (U.S. Department of Health and Human Services 2014)

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

Child abuse and neglect is a public health problem which occurs in all societies and as it is already well-known this is true for the European Union Member States too.

In 1999, the World Health Organization issued a press release announcing that "RECOGNIZES CHILD ABUSE AS A MAJOR PUBLIC HEALTH PROBLEM'; it is stated that "abused children suffer from multiple physical, emotional and developmental problems, which can hamper their ability to live healthy and productive lives"

First among the main recommendations to the international community was "the development of worldwide data collection on child abuse and neglect, the estimation of the impact on public health and also the associated economic cost"

Slide 9

The necessity of CAN surveillance

FACT: 'the true extent of child maltreatment is unknown'

- on the basis of a variety of estimations for the extent of the phenomenon **"between half to four fifths of all victims of maltreatment are not known to child protection services"** (Sedlak and Broadhurst 1996)
- the **"tip-of-the-iceberg analogy easily comes to mind when one thinks of the scope of child maltreatment"** (Trocmé *et al*. 2005)

- The necessity for CAN National Surveillance Systems is advocated by the need
  - to understand the incidence of CAN based on data deriving from services' response to CAN cases
  - to monitor demand for services administrating cases
  - to set priorities for prevention
  - to identify the needs of professionals involved
  - to understand CAN consequences; and
  - to determine the costs associated with CAN

  (Ntinapogias, Tsirigoti and Nikolaidis 2012 [Report *CAN: Why monitoring is necessary? BECAN Project*])

- **Vision:** ***Developing national Surveillance Systems on the basis of an MDS***
  - ***Subject of Surveillance:*** *Child Abuse & Neglect through recording services' responses to individual cases*

- **Project's mission:** ***Developing a proposal for CAN Surveillance Systems on the basis of an MDS***

Up to today (2015), despite the importance of the problem, accurate estimates of CAN extent and its characteristics in the general population are not available for various reasons leading to an underestimation of the magnitude of the problem among which the

- under-reporting due to the silence that surrounds maltreatment cases because of shame, social stigma and the consequent criminal liability and the

-under-recording due to the lack of coordinated national CAN monitoring mechanisms.

Over and beyond of its particularities, surveillance efforts for child abuse and neglect phenomenon systems are further subjected to limitations related to data collection, analysis and interpretation as they appeared also in well established public health surveillance systems as for the communicable diseases. Such limitations include, for example, data collection through different tools, procedures and methodologies, lack of feedback to stakeholders lead to the perception that there is no action on the record and lack of commitment for continuous recording.

Slide 10

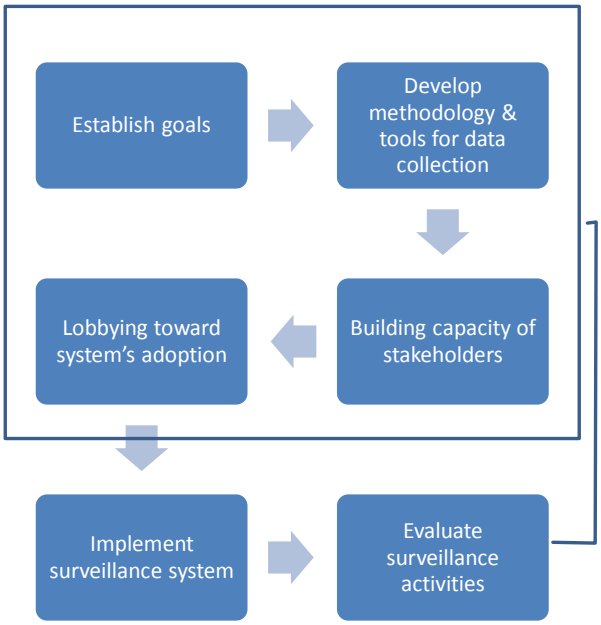
Aim of the project 'Coordinated Response to CAN via MDS'

To create the scientific basis, necessary tools and synergies for supporting the establishment of CAN National Surveillance Systems (where such mechanisms are not available) or improving of CAN National Surveillance Systems (where they exist)

Prerequisites:

- to commit
  - political support
  - human resources
  - financial resources
- to involve competent, motivated professionals to be trained
- to design necessary steps for establishment of a CAN-MDS Surveillance System

Thacker, S. B., and D. F. Stroup. 1998a. Public Health Surveillance. In Applied Epidemiology: Theory to Practice, ed. R. C. Brownson and D. B. Petitti, 105–35. New York: Oxford University Press



Source: adapted from Thacker and Stroup 1998a

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

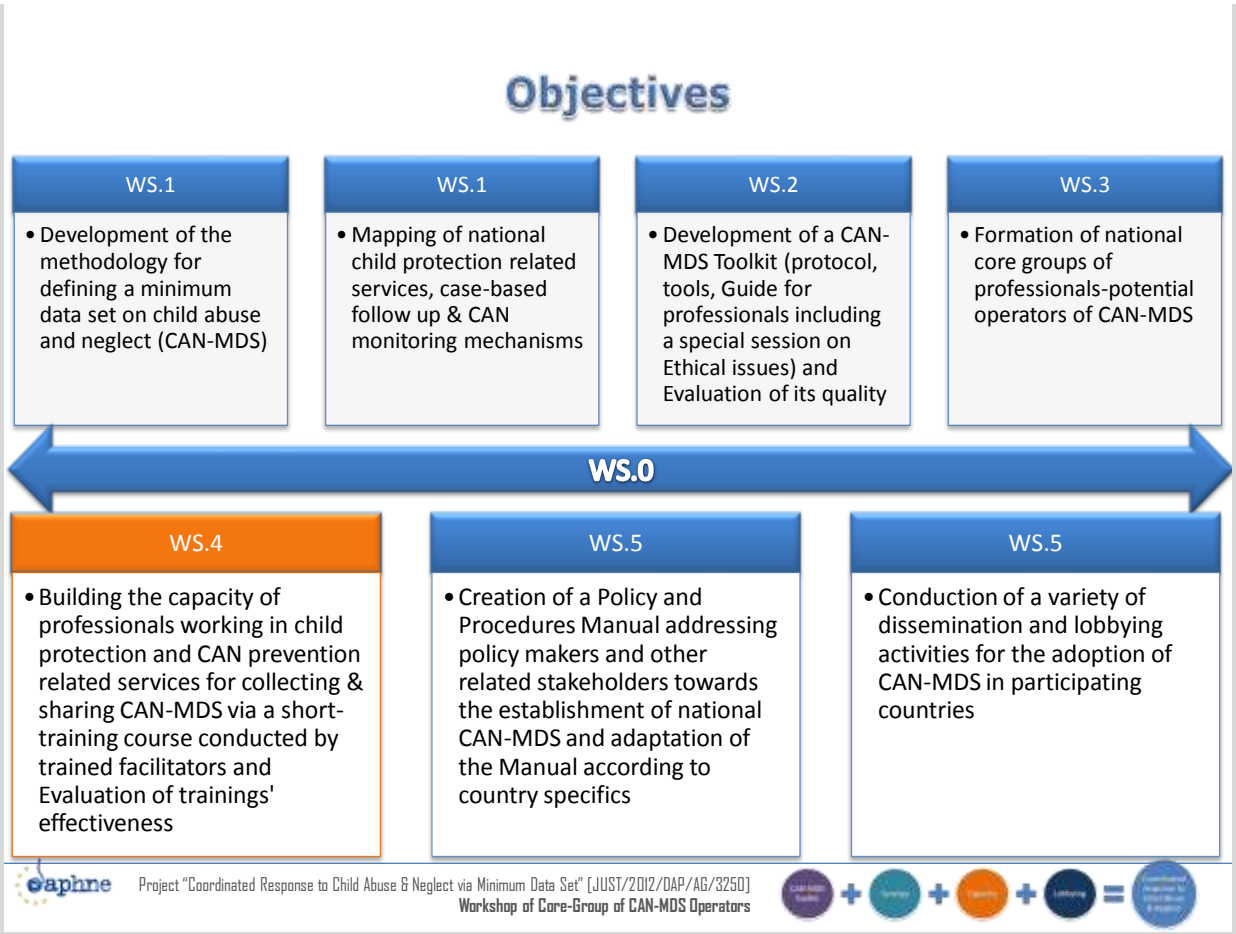
The purpose of the DAPHNE Project "Coordinated Response to Child Abuse and Neglect via a Minimum Data Set" was to create the scientific basis, necessary tools and synergies for establishing national CAN monitoring systems using a minimum data set (MDS). Such systems would provide comprehensive, reliable & comparable case-based information at national level for children who have used child protection services (social, health, educational, judicial & public order, depending on countries' specifics).

By achieving the objectives of the project, we actually targeted the achievement of the six steps for establishing and maintaining of a specialized (vertical) public health surveillance mechanism, as these steps described by Thacker and Stroup in 1998.

Source: GAO analysis.

http://www.gao.gov/assets/240/239193.pdf

Slide 11



Here are the objectives of the project.

First the development of the methodology for defining the elements of a MDS on CAN

Then to map the available infrastructures in each participating country

Next to develop a toolkit including a protocol, ready to use tools and a guide for professionals with an emphasis on ethical issues related to CAN data collection

To evaluate the quality of the CAN-MDS toolkit – and this is the part that we would like to have your comments, as you can see in the open invitation in this leaflet

After finalizing the toolkit, the development of national core groups of potential operators of CAN-MDS is follows and their training on why and how they could use the toolkit and additionally how they can operate as multipliers by transferring their knowledge to other professionals in their countries.

Lastly, a Policy and procedures manual is going to be developed addressing mainly policy makers and other stakeholders with the aim to present the argumentation for considering the adoption for such a system in their countries, at least in a piloting phase initially.

Slide 12

Overview of Activities

WS.0 Management & Coordination	• This WS is intended for all activities related to the general management and coordination of the project and all the activities which are cross cutting and therefore difficult to assign just to one specific workstream
WS.1 Preparatory phase	• Literature review on methodologies for building MDS and Country reports on available CAN surveillance mechanisms
WS.2 Transfer the MDS practice to CAN field	• Definition of MDS content, Creation of CAN-MDS Toolkit and Development of evaluation components
WS.3 Creating Synergies	• Building of national CAN-MDS Core Groups of Operators
WS.4 Capacity Building	• Training of Trainers and of National Core Groups of CAN-MDS Operators
WS.5 Coordinated response to CAN via MDS	• A Policy & Procedures Manual for establishing National CAN-MDS Surveillance Systems & Project's Products Dissemination

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

Capacity building activities (such as the training of the core and expanded groups of operators) belong to worksream 4

Slide 13

from the project to the proposal of a CAN-MDS Surveillance System

Coordinated	Response	to CAN	via MDS
• **promoting uniform data collection from all sectors involved in administration of CAN cases** • using a common user-friendly registry tool • **creating a communication channel among involved sectors** • involving all eligible professionals working in the above sectors following pre-defined criteria • providing them with different levels of access • building their capacity through training AND material (Guide for Operators & Protocol)	• **at a population level (public health surveillance)** • allowing comparisons within and between countries • targeting policy makers and related stakeholders • providing them with necessary information (e.g. CAN trends, clues, risk factors) for evaluation of existing practices & policies AND guiding prevention & intervention planning • **at a case-level (follow-up of individual cases)** • facilitating case-investigation & further administration (based on level of access of operators)	• **using broad CAN operational definitions** • describing "case definitions" in detail for ensuring a common understanding among (non homogeneous) involved parties • **targeting to collect all cases noticed by services** • regardless substantiation	• **using a standard set of variables (endorsed by all stakeholders)** • fulfilling pre-defined criteria concerning ethics, quality, completeness, accessibility, feasibility • providing comprehensive, comparable and reliable data • targeting a standard framework of measurable indicators that are sound, practical and usable • providing eligible operators with necessary information for investigation & follow up at case-level

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

By analysing the title of our project, we may demonstrate the main aims and attributes of the suggested surveillance mechanism for child abuse and neglect

***Coordinating means** promoting uniform data collection from all sectors involved in administration of CAN cases **AND** creating a communication channel among involved sectors*

***Response at a population level** refers to public health surveillance and **at a case-level** refers to follow up of individual cases*

***Child abuse and neglect** defined on the basis of the UN CRC/C/GC/13 (2011) and operationalized in a way ensuring a common understanding among (non homogeneous) involved parties*

***Via a MDS refers in the** Usage of a standard set of data elements evaluated and finally endorsed by all stakeholders*

(the remaining as in the slide)

Slide 14

Public health surveillance

- **Definition:** "the ongoing systematic collection, analysis, and interpretation of outcome-specific data, closely integrated with the timely dissemination of these data to those responsible for preventing and controlling disease or injury" and as 'an end unto itself, but rather a tool" (Thacker and Berkelman 1988)
  - this definition contains two very different activities (Choi 2012; Stoto 2003)
    - **case surveillance** focuses on individuals, to identify those with certain diseases and take action
    - **statistical surveillance** focuses on populations, to identify differentials and trends that can inform public health policymaking, including the allocation of resources

- **Public health approach:** surveillance data should be able to be utilized as a tool for the identification and tracking of the health threat at the population level **and** as a means of determining risk and protective factors among subgroups. This information can then be used to develop targeted prevention and intervention programmes (Putnam-Hornstein *et al.* 2011)
  - "it may be valuable to think about improvements to these systems as well as possible creation of new data systems or hybrids of existing systems" (Finkelhor and Wells 2003)
    - **example**: in the US the NCANDS data are used for a wide range of purposes including **"the development and monitoring of outcome measures related to child safety (recurrence of maltreatment, maltreatment in foster care)** as part of the Child and Family Service Reviews conducted by the federal government"
      (AlEissa *et al*. 2009, commentary on national child maltreatment surveillance systems)

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
Workshop of Core-Group of CAN-MDS Operators

(Finkelhor and Wells 2003) concluded in their study exploring the limitations of 13 different data sets and systems in the US, in order to improve the statistics on juvenile victimization, in addition to thinking about specific shortcomings related to existing data systems it may be valuable to think about improvements to these systems "as well as possible creation of new data systems or hybrids of existing systems" (p.98). They suggested that changes to the systems under study, such as the improvement of the data on children's trajectories within the child protection systems and adoption systems to find out how investigations influence ultimate outcomes could benefit, for example, practitioners in child protective services. In a commentary on national child maltreatment surveillance systems, among the examples of progress presented, AlEissa et al. (2009) noted that in the US the NCANDS data are used for a wide range of purposes, including "the development and monitoring of outcome measures related to child safety (recurrence of maltreatment, maltreatment in foster care) as part of the Child and Family Service Reviews conducted by the federal government".

In a commentary on national child maltreatment surveillance systems, among the examples of progress presented, noted that in the US the NCANDS data are used for a wide range of purposes, including "the development and monitoring of outcome measures related to child safety (recurrence of maltreatment, maltreatment in foster care) as part of the Child and Family Service Reviews conducted by the federal government". AlEissa et al. (2009)

Slide 15

Aim of a future CAN-MDS Surveillance System

The twofold character of the suggested CAN-MDS Surveillance System

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

  ➔ ***Information for action*** *linked to public health initiatives*

- *To serve as a ready-to-use tool in investigation and follow-up of child victims of CAN or those at risk of being (re-) victimized, by respecting the national legislation and applying all the rules necessary for ensuring ethical data collection and administration.*

  ➔ ***Case-level information*** *linked to follow-up of individual cases*

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Workshop of Core-Group of CAN-MDS Operators

As mentioned before, the purpose of this DAPHNE Project was to create the scientific basis, necessary tools and synergies for establishing national CAN monitoring systems using a minimum data set.

In order to fulfill the project's aim, country specific as well as common needs among EU countries along with the limitations of public health surveillance in general were taken into account

As a result, the aim of the developed system is two-fold

1. *To provide **Information for action** linked to public health initiatives. In other words, to provide comprehensive, reliable & comparable case-based information for child victims who have used any relevant services.*

2. *To provide **Case-level information** linked to follow-up of individual cases, namely to serve as a ready-to-use tool in investigation and follow-up of child victims of CAN or those at risk of being (re-) victimized. This entails respecting the national legislation and applying all the rules necessary for ensuring ethical data collection and administration.*

Among its main objectives, are for the system to be ethical, secure, low cost, simple, practical, continuous, real time, uniform, all inclusive, informative and able to be revised.

Slide 16

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

information for action

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

AND

case-level information

- to outline the administrative practices applied for CAN cases
  - to detect changes in administrative practices of CAN cases and the effects of these changes
- to operate as a communication channel among sectors involved in administration of CAN cases[1]
  - to facilitate follow-up at case-level
- to operate as a ready-to-use tool during new or suspected cases investigation by certified authorities
- to provide feedback to services at a case-level for already known cases

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Workshop of Core-Group of CAN-MDS Operators

Possible uses of data collected through a national CAN-MDS Surveillance System are
At a public health level:
- to periodically measure the incidence of CAN and its specific forms on the basis of harmonized, valid and reliable data
- to be used as a baseline for evaluation of services' needs and for setting priorities for allocation of resources for CAN prevention
AND at a case level
- to outline the administrative practices applied for CAN cases
- to operate as a communication channel among sectors involved in administration of CAN cases
- to provide feedback to services at a case-level for already known cases thereby strengthening their commitment to the system

Slide 17

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

information for action

- to periodically measure the incidence of CAN and its specific forms based on data deriving from services' responses to CAN cases
  - in general, per sector/ service/ specific forms of CAN/ child's, caregiver's, family's characteristics
- to monitor trends in child maltreatment
  - at national level and local levels, per specific forms of CAN / child's, caregiver's, family's characteristics
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  - effectiveness of CAN prevention practices and interventions (and to identify good practices)
  - effectiveness of CAN prevention policies (for planning future policies & legislation)

AND

case-level information

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

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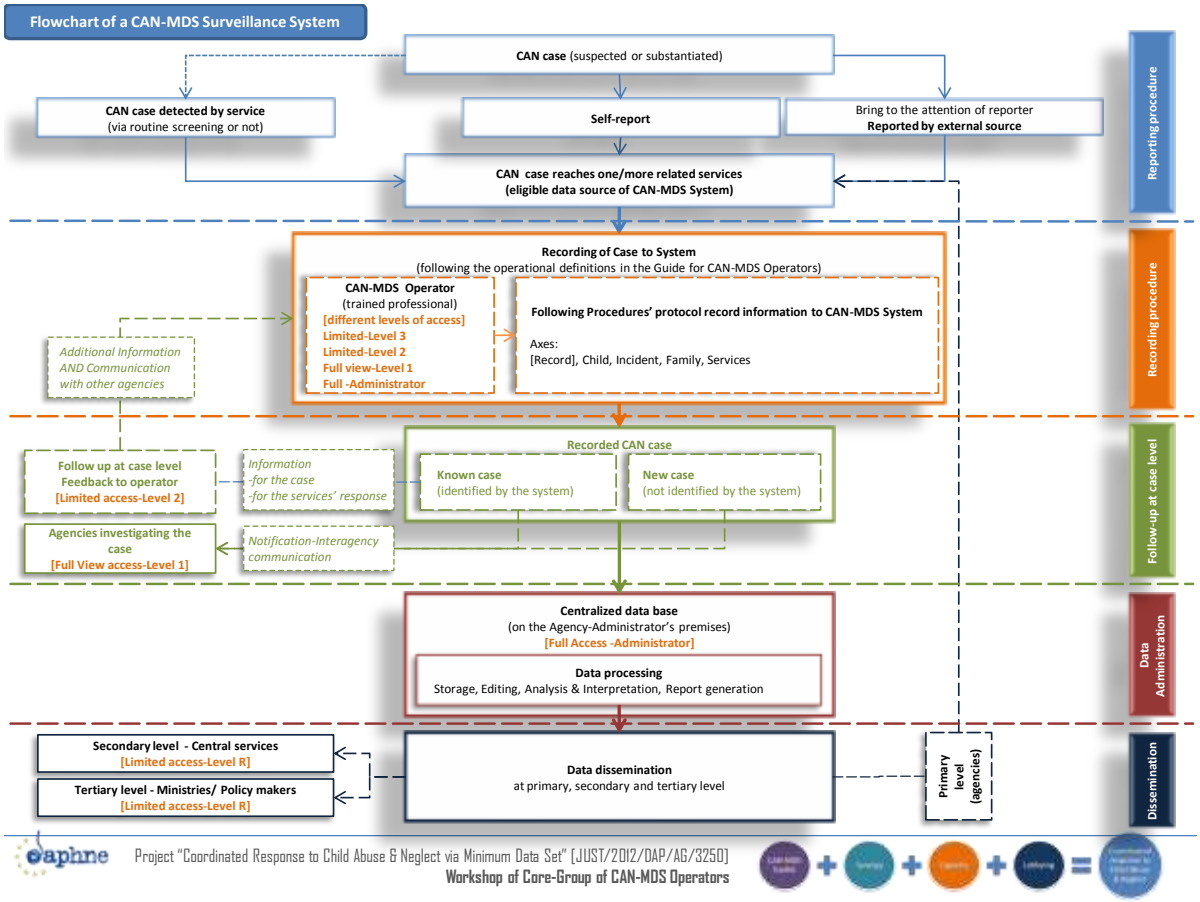
Workshop of Core-Group of CAN-MDS Operators

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

[As is written in the blue shape]

Slide 18



And here is a flowchart of the provisioned operation of a potential CAN-MDS system: starting from reporting procedures, the recording procedures, the monitoring at a case-level, the central data administration and the dissemination of appropriate information to different stakeholders;
Today we will discuss mainly for the first three phases (Reporting, recording and follow-up at a case level)

Part 2	The Role of National CAN-MDS Core Group Members	
OUTLINE	*estimated duration*	35 minutes - 15 minues for the presentation - 10 minutes for introduction of the group members - 10 minutes for discussion
	learning objectives	at the end of the part 2 trainees is expected - to be fully aware on their role as Core-Group members including their potential involvement as "*multipliers*" in case of CAN-MDS System piloting and/or operating
	instructions to trainers	- rehearse with slide presentation Part 2 - discuss with trainees potential concerns related to their expected role or issues such as the cascade process of learning
	activity	- short introduction of group members (name, specialty, sector/agency)
	training resources	Presentation "Part 2" Please adapt the presentation accordingly (e.g. slide 3)
	tips to trainers *Note!*	PowerPoint Part 2 currently comprises from 17 slides. - Please have in mind that slides 9-17 are explanatory for the slides 8: you can present these slides with as much detail as the available time allows. This part 2 is the only part totally different for expanded groups trainings For expanded groups see the respective session (Part 2 for the role of CAN-MDS Operators) after the Part 2 "The role of National CAN-MDS Core Group Members

Part 2 – Presentation (please, adapt the slides where necessary)

Slide 1

Daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]

Place_____
Date _____

The role of national CAN-MDS Core Group Members

Workshop of

CAN-MDS Core-Group of Operators

Your logo

daphne With financial support from the EU DAPHNE Programme

The second part of the training is related to your role as members of the national core group of CAN-MDS Operators

Slide 2

2. The Role of National Core Group of CAN-MDS Operators

- **Who are the members of the CAN-MDS core-group?**
  - The role of Core-Group in the context of the project
- **Why Core-Group members' participation in this workshop is important**
  - What Core-Group members should do after the Workshop

First we will have the opportunity to know each other better; then we will discuss on the role of the CAN-MDS core group members and why your participation in this workshop is important. Lastly we will review in brief the material you will receive as members of this group.

Slide 3

Who are the [country?] CAN-MDS Core-Group Members

- **Grant Agreement, Annex I**
  - ***Work Stream 4: Capacity building***
    - Training of Trainers and of **National Core Groups of CAN MDS Operators**

- **[NATIONAL-please specify] Core-Group**
  - Names of the 20 members of your core group (please, present per professional background or field they are working)
    - ….
    - ….

    - Additionally, in the workshop also participating (as trainers)
      - **[please add trainers' names]**

First we will have the opportunity to know each other better

[self-introduction of group members: their names, their specialties and sectors/agencies where they are working to; ~10 min]

The role of Core-Groups in the context of the project

- **to act as multipliers** for implementing activities related to capacity building
  - **to organize**
  - **to implement** expanded Groups of CAN-MDS Operators' trainings
  - **to evaluate**

All capacity building activities related to CAN-MDS is to provide the necessary knowledge and skill to eligible professionals in order to become system's operators.

Over and beyond of this aim, the members of national core groups are expected **to act as multipliers** for implementing activities related to capacity building in close collaboration with the national "focal point" of the system (namely the Administrating organization or the agency who is responsible for the initiative in your country).

Such activities have two main targets

-Firstly, to support the national Administrative organization to build Expanded Groups of CAN-MDS future Operators (if and when needed) following the eligibility criteria resulted from the respective study (available in the supportive material)
-Secondly, to proceed –along with the national Administrative organization in activities such as

to organize Expanded Groups of CAN-MDS Operators' trainings by using your skills from this training and the national version of the necessary material (that will be presented at the end of this session)

to participate in the implementation of Expanded Groups of CAN-MDS Operators' trainings (it is recommended for such trainings to have a minimum duration of 8-hour and with 20 professionals-trainees per group-see also the Training Module) and, finally,

to proceed with the evaluation of the Expanded Groups of CAN-MDS Operators' trainings (using the suggested evaluation methodology and tools or modifying them if needed). Based on your experience from these trainings and the evaluation result you may suggest to national Administrative organization adaptations of the material you considered as necessary.

Slide 5

Why participation in this workshop is important

- For being informed on the project and its aims
- For being familiarized with the specific training process
  - As Core-Group members are going to implement the same training (as *multipliers*) for other professionals (future *"operators"*)

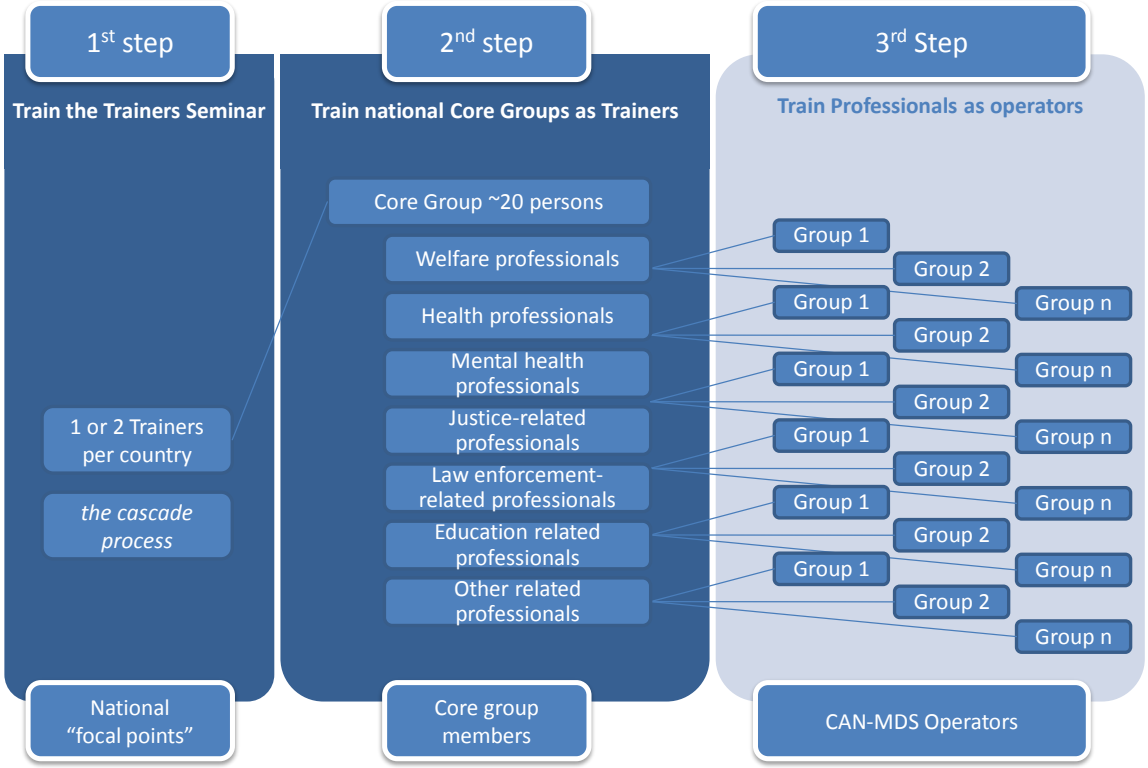
Moreover

- to ensure
  - a common understanding of the aim and the content of the training
  - that a common methodology will be used in expanded groups' trainings
- to improve the training module and material via the evaluation by
  - identifying potential omissions
  - suggesting modifications (eliminations/ additions)

The importance of your participation in all activities of this training is underlined by what is expected by you as CAN-MDS core-group members. In this slide some main points are stressed

[as in the slide]

Slide 6



In this diagram the cascade process is illustrated: this is generally accepted as an low resources but effective learning practice (here is combined with "peer education" methods, as trained professionals undertake the role of other professionals).

Slide 7

What Core-Group should do after the Workshop

- **activities following your participation in this training**
  - Preparation
    - As future CAN-MDS Operators
      - to gain knowledge & skills to follow the procedures for contributing in CAN surveillance via CAN-MDS
    - As trainers (*multipliers)*
      - review the Trainer's Guide and Informational material
      - review learning objectives of the sessions
      - rehearse with slide presentation

In cooperation with the national *Focal Points*

- Building of Expanded Groups of Operators on the basis of eligibility criteria
  - Identification & invitation of professionals working in relevant services
    - to be the trainees in national trainings for become future CAN-MDS Operators
- Planning of training for Expanded Group of Operators
- Implementation and evaluation of trainings of Expanded Groups of Operators
- Suggest modifications for the national training module according to evaluation results (if needed)

Summarizing, given your participation in the CAN-MDS core group, in case that a CAN-MDS Surveillance System will established, you may proceed with activities such as refreshing and/or enriching your knowledge on issues related to child abuse and neglect and the public health surveillance and cooperate with the national Administrative organization for implementing capacity buildling activities.

Slide 8

Material for CAN-MDS Core Group of Operators

- **Core-Group members will receive**
  - **Training Module** for Professionals/Potential Operators
  - **Trainer's Guide**
  - **National CAN-MDS Toolkit**
    - Necessary material
      - presentations
      - mock cases and other material/aids
      - evaluation methodology & tools
        - further supportive material
        - templates

Expanded Group members will receive

- National CAN-MDS Toolkit

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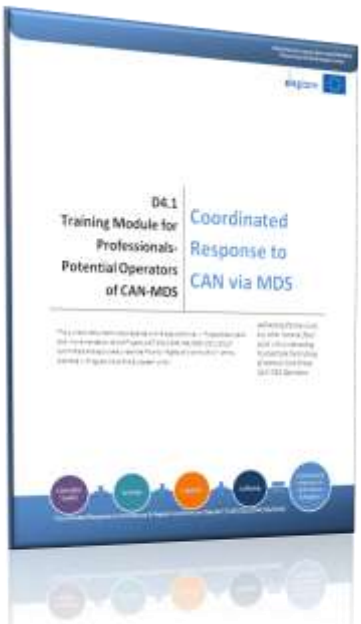
CAN-MDS Core-Group of Operators - Workshop

Upon the completion of the workshop you will receive a certification of attendance of the training indicating that you have the necessary information for acting as a core-group member. In addition each one of you will receive a CAN-MDS "training package", including the material indicated in the slide.

In the following part of the presentation some more information is provided for each one of the material. This training will focus mainly in the CAN-MDS Toolkit.

Slide 9

Training Module of Professionals/ Potential CAN-MDS Operators



(see contents)

Slide 10

Training Module

Content of National Workshops

- Introduction to the Project
- The role of trainees as members of Core-Groups
- Exploring the CAN-MDS: *a variable by variable review*
- Ensuring understanding of CAN-MDS (working with mock cases)
- Key Ethical Issues related to CAN Surveillance

Content of National Trainings

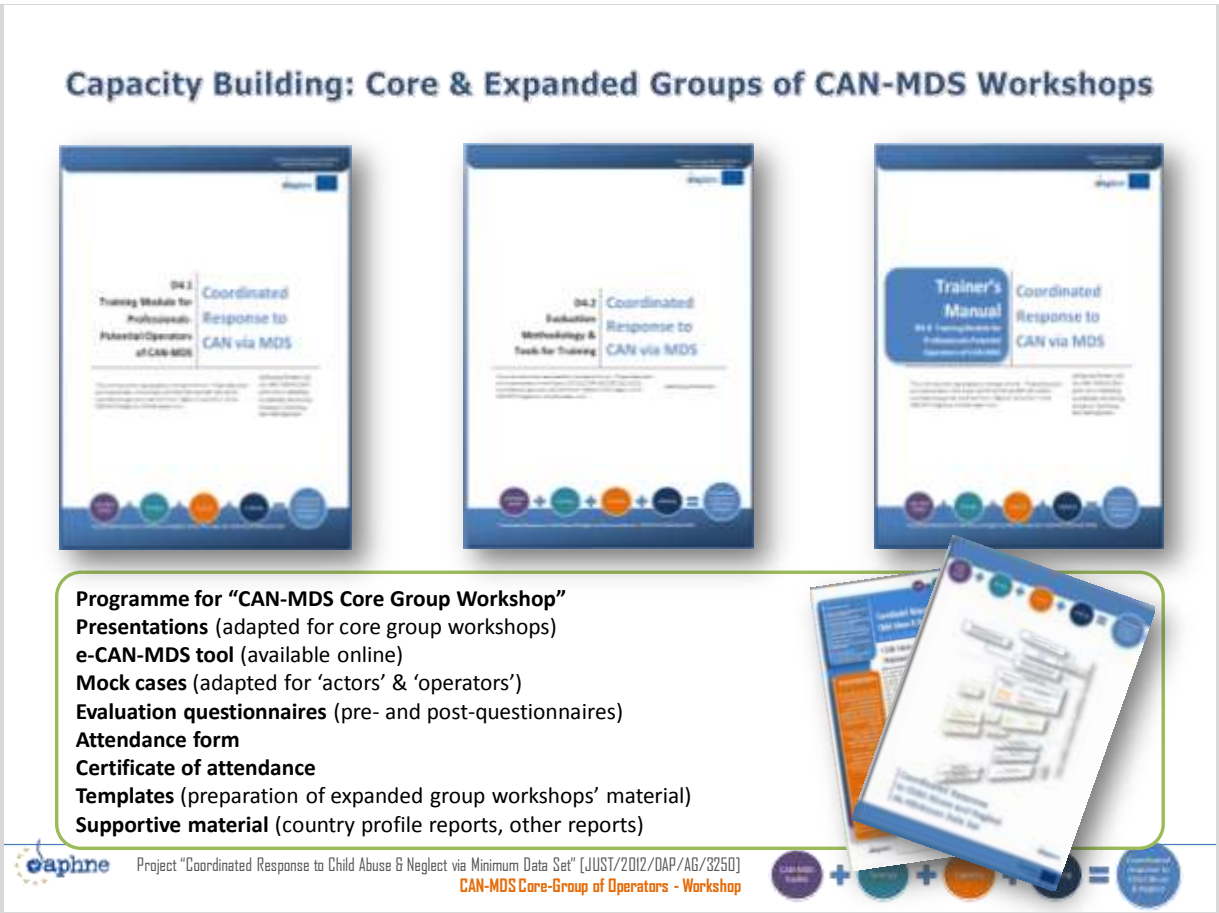
(see also "Trainer's Manual")

- Introductory section
- The role of trainees as members of Expanded-Groups
- Exploring the CAN-MDS: a variable by variable review
- Ensuring understanding of CAN-MDS (working with mock cases)
- Key Ethical Issues related to CAN Surveillance

- Building the National Expanded Groups of Operators
- Planning the training workshops of expanded groups CAN-MDS operators
- Questions & Answers on building expanded groups & planning national trainings

What is the difference in the content between the core and the expanded groups of operators' trainings

Slide 11

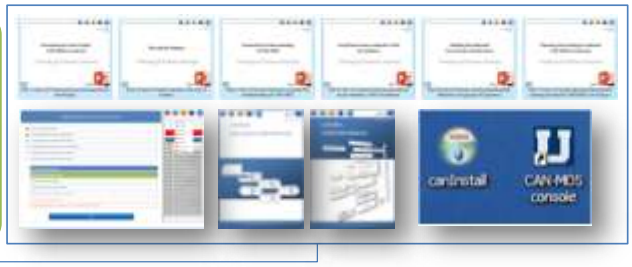


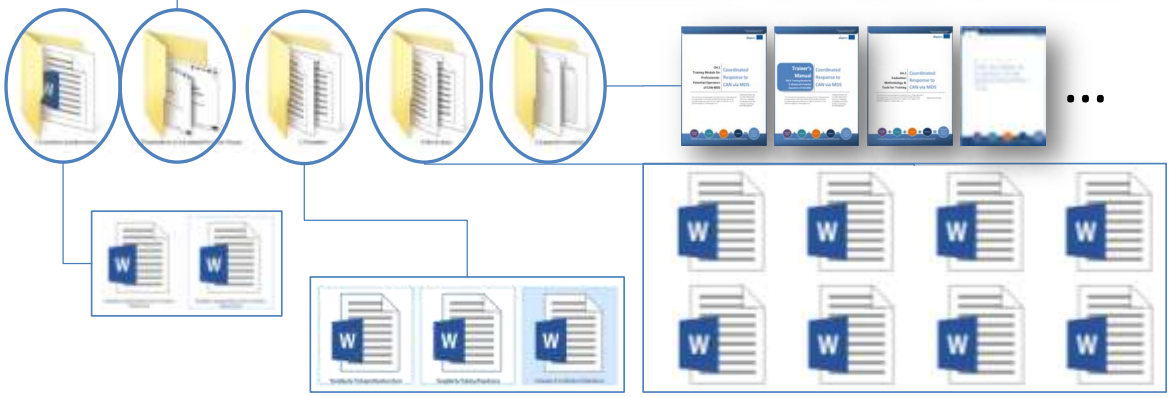
Additionally to the training module, all necessary material is also available for building capacity of professionals to become operators of a CAN-MDS system as well as some informational material

Slide 12

Capacity Building: Train of Trainers & National Core Groups of CAN-MDS Operators

Programme for "CAN-MDS Core Group Workshop"
Presentations (6 parts, adapted for core group workshops)
e-CAN-MDS tool (available online)
Mock cases (4, adapted for 'actors' & 'operators')
Evaluation questionnaires (pre- and post-questionnaires)
Attendance form
Certificate of attendance
Templates (preparation expanded group workshops' material)
Supportive material (country profile reports, other reports)





daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
CAN-MDS Core-Group of Operators - Workshop

In more detail

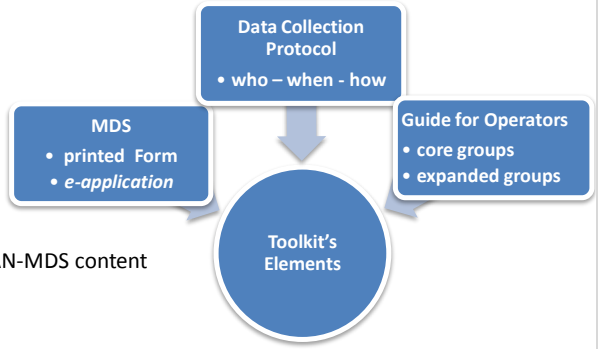
Slide 13

CAN-MDS Toolkit

Structure of the Toolkit

- **Guide for Professionals-CAN-MDS Operators**
  - it could be used autonomously by all professionals who have already been trained to become operators
- ***Step-by-step* procedure** for using the CAN-MDS
  - namely a short operations' protocol
- **CAN-MDS forms**
  - e-application

➔ The whole material are developed on the basis of the CAN-MDS content



Final material: a CD addressing Expanded National Groups including EU and national version of CAN-MDS Toolkit . The CD will be disseminated either along with a **Policy and Procedures Manual** (printed) addressing mainly policy makers and related stakeholders or along with the **CAN-MDS Informational leaflet** (printed)

daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]
CAN-MDS Core-Group of Operators - Workshop

What is the CAN-MDS Toolkit?

The CAN-MDS Toolkit consists of three main elements: a. a Minimum Data Set comprising 18 data elements which resulted from a multiple round quality and feasibility evaluation process, in which international stakeholders participated; an e-version and a printed version of the CAN-MDS tool are available for use (mainly for training purposes); b. a data collection protocol drafted to support use of the CAN-MDS that suggests a *step-by-step procedure for using the CAN-MDS; this* protocol could be used by any professional who has already been trained to become an operator; and c. a Guide for Operators where all the necessary background information is included for those professionals who fulfill the eligibility criteria and prerequisites to use the system. Apart from information concerning the necessity for child maltreatment surveillance in the country, a special section on ethics, privacy and confidentiality issues related to CAN data collection is also included in the Guide. The main body of the document is dedicated to the detailed presentation of the variables included in the CAN- MDS along with technical specifications and definitions of data elements.

Slide 14

CAN-MDS Operator's Manual

Slide 15

e-CAN-MDS

Slide 16

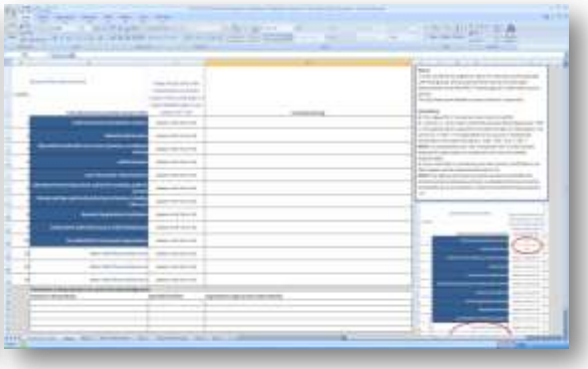
CAN-MDS Data collection protocol

Procedure

- **Who records a CAN incident to CAN-MDS**
  - **trained professionals fulfilling the eligibility criteria**
- **When to record an incident of child maltreatment**
  - **in which cases**
    - **when a child discloses that s/he suffers any type of abuse**
    - **when receiving a referral (with adequate information) from a source other than the child**
    - **when there is at least one reason to suspect that a child has been harmed as a result of physical, mental, psychological, or sexual abuse**
  - **at what time**
    - **during the intake**
    - **during the assessment**
    - **at a later time**
- **How to make the record**
  - **how to collect the information**
    - **what questions/ prompts to ask**
    - **how to use the forms**
    - **how to obtain the CHILD ID**

Slide 17

Building of national CAN-MDS Groups of Operators



Belgium-Van Poyenbroeck, B., **Bulgaria**-Stancheva, V., **France**-Séraphin, G., Bolter, F., **Germany**-Goldbeck, L., Witt, A., **Greece**-Ntinapogias, A., Stavrianaki, M., Nikolaidis, G., **Italy**-Mammini, S., Bianchi, D., **Romania**-Roth, M., Antal, I., Tonk, G., **Switzerland**-Jud, A., **Spain**-Castellanos Delgado, J. L.., Solis de Ovando, R.

Available information on how to proceed with building expanded groups of CAN-MDS operators

Part 2 – Presentation (please, adapt the slides where necessary)

Slide 1

Daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]

Place_____
Date _____

The role of CAN-MDS Operators

Train of Expanded Groups

Your logo

daphne With financial support from the EU DAPHNE Programme

The second part of the training is related to your role as CAN-MDS Operators

The Role of CAN-MDS Operators

- *Who are the CAN-MDS Operators?*
  - The role of CAN-MDS Operators
- *Why participation in this training is important?*
- Roles of CAN-MDS Operators and Levels of Access to e-CAN-MDS registry
  - Levels of access
- Responsibilities & Benefits
- Material for CAN-MDS Operators

First we will have the opportunity to know each other better; then we will discuss on the role of the CAN-MDS operators and why your participation in this training is important.
Lastly we will review in brief the material you will receive as members of this expanded group of CAN-MDS Operators.

Slide 2

Slide 3

Who are the [country] CAN-MDS Operators?

Eligible professionals' groups per sector or "working field" to become CAN-MDS operators

Welfare related professions:	Social Workers, Health Visitors, Care providers in institutions, other personnel (e.g. working in antitrafficking agencies, directorates for disability, Child Ombudsman etc.)
Justice-related professions:	Judges (family courts, juvenile courts), Probation Officers, Public Prosecutors, Forensic surgeons' professionals, Lawyers, other justice related professions)
Health related professions:	Medical Doctors (general doctors and specialized doctors such as gynecologists, pediatricians, orthopedists, and radiologists), Midwives, Nurses, and Dentists
Mental health professions:	Child-Psychiatrists, Psychiatrists, Psychologists, Licensed Counselors (Youth Counselors, Family Counselors, etc.)
Law enforcement related professions:	Police Officers (in general and specialized police investigators e.g. in forensic interviews, for crimes against minors etc.)
Education-related professions:	Teachers/Educators (pre-school, kindergarten, primary and secondary education, for children with special needs), School Principals
Other professionals:	Researchers, Data administrators, other school personnel (e.g. school guardians), other Public officials (e.g. ministries' employees), other NGOs personnel (e.g. volunteers, priests, sisters)

First we will have the opportunity to know each other better

[self-introduction of group members: their names, their specialties and sectors/agencies where they are working to; ~10 min]

Not all professionals working in the various sectors are involved in the administration of CAN cases, while professionals with the same background are working to more than one sector.
The eligible frontline professionals (namely which that are involved in CAN cases' administration per sector) were recorded, grouped (on the basis of the results from all countries) and presented per sector or "working field" as presented in the slide. These are the eligible professionals' groups to become CAN-MDS operators.

Prerequisites for an eligible professional to become CAN-MDS Operator

- *to be active (not a student, not a pensioner)*
- *to work in an organization/agency and participating as a representative on behalf of his/her agency*
- *to successfully complete a short training (and be certified)*

The role of CAN-MDS Operators

- **to record any child maltreatment incident**
  - **either identified, recognized** or suspected by **them**
  - **or they are informed about by any** sources of information
    - the child-victim itself (self-reporting)
    - other professionals who are mandated for reporting of child maltreatment
    - or any other citizen

- **regardless the status of substantiation of the maltreatment**
- **on the basis of a commonly agreed minimum data set**

  - **by using**
    - **same definitions** (included in the CAN-MDS Operator's Manual)
    - **same tools** (e-CAN-MDS registry)
    - **same methodology** (following the CAN-MD Data Collection Protocol)

CAN-MDS operators are expected to have different professional backgrounds and responsibilities. On the other hand, it is of crucial importance for all operators to make records following identical definitions, tools and methodology.
The CAN-MDS incorporates the main types of CAN, sub-types under each main type and form(s) under each sub-type (maltreatment acts committed and omissions in child's care). Depending on his/her familiarization with CAN definitions, the operator who is not familiarized can follow a bottom up process (from commonly understood acts and omissions to broader concepts of CAN) while the operator who is familiarized can follow a top-down process (from main conceptually defined CAN types to specific acts and omissions).

The ultimate aim for the CAN-MDS is

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

•to serve as a ready-to-use tool in investigation and follow-up of child victims of CAN or those at risk of being (re-) victimized, by respecting the national legislation and applying all the rules necessary for ensuring ethical data collection and administration (**Case-level information** linked to follow-up of individual cases)

Why participation in this training is important

- Eligible professionals-future operators of CAN-MDS gain necessary knowledge and skills to follow the procedures for contributing in CAN surveillance via CAN-MDS.
  - Specifically, training intends to enable trainees to:
    - Identify incidents and cases
    - Record (suspected) cases, along with specific information (related to conditions, child & family)
    - Record information for services' response (institutional response and referrals made)
    - Communicate with and provide feedback to the community (public health level) and to professionals-operators (at case-level)

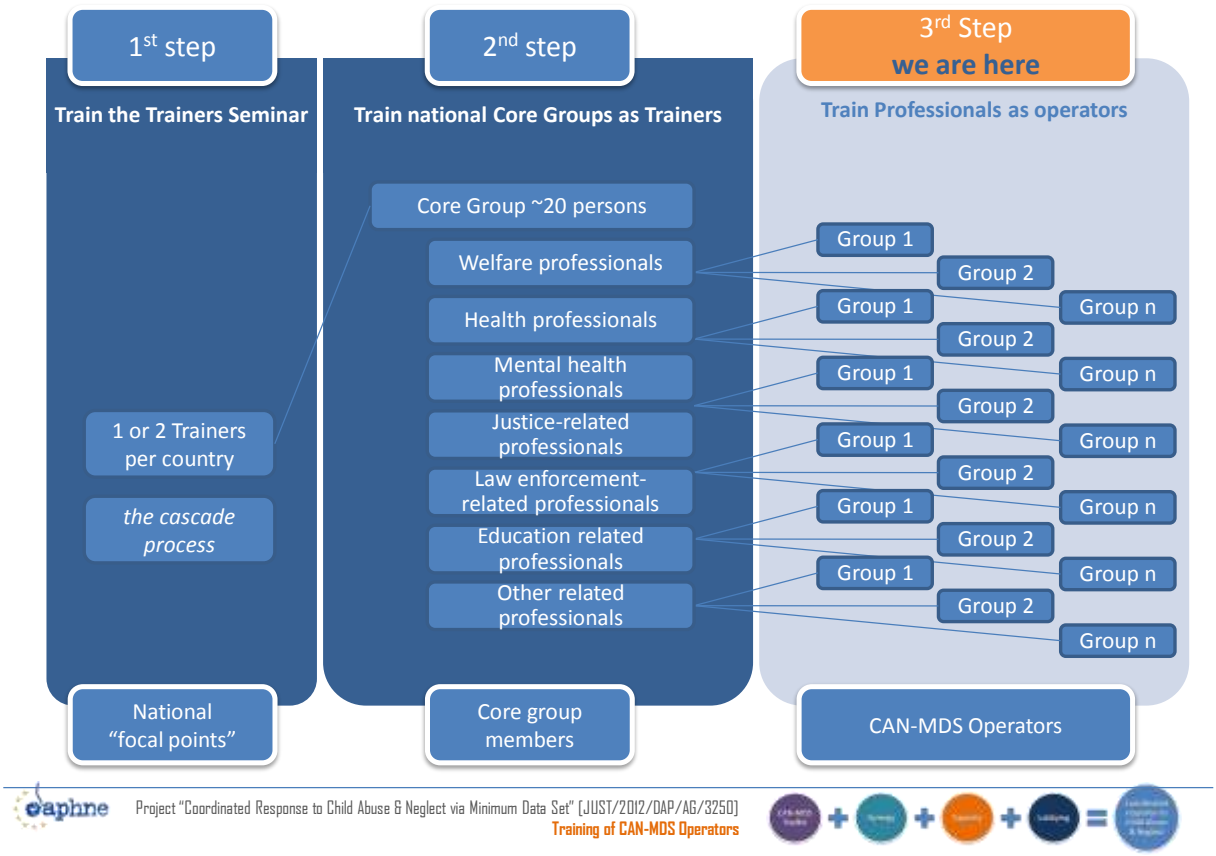
and additionally to contribute through the evaluation of the training

- to improve the training module and material by
  - identifying potential omissions
  - suggesting modifications (eliminations/ additions)

Slide 5

The importance of your participation in all activities of this training is underlined by what is expected by you as CAN-MDS operators. In this slide some main points are stressed
[as in the slide]

Slide 6



In this diagram the cascade process is illustrated: this is generally accepted as an low resources but effective learning practice (here is combined with "peer education" methods, as trained professionals undertake the role of other professionals). Here we are in the 3rd step of the cascade process.

Slide 7

Roles of CAN-MDS Operators as the basis for assignment of Levels of Access to e-CAN-MDS registry

Responsibilities	Level of access
System Administrator	Full Access
Making decisions on legal action such as - to remove the child from the family - to remove parental rights - to decide whether sufficient evidence exists to prosecute (alleged) offenders	Full View access (level 1)
Involvement in administration of reported/detected cases & follow-up - Conducting initial assessments for suspected CAN cases - Providing services to CAN victims (diagnostic/ treatment/ consultation/care) - Providing services to CAN victims' families (supporting) - Following-up of CAN cases	Limited access (level 2)
Non actual involvement in administration of reported/detected cases - Notifying (optionally) authorities of (suspected) CAN cases - Reporting mandatorily (suspected) CAN cases - Applying screening in the general child population for CAN - Providing emergency protective measures to CAN victims - Providing legal advice/ consultation/ advocacy for CAN cases	Limited access (level 3)

Four different levels of access are provisioned for a CAN-MDS. Assignment of access level to an Operator depends on his/her professional responsibilities concerning CAN incidents (if any), namely if his/her role focuses exclusively on reporting CAN incidents (without further involvement in cases' administration) or includes responsibilities related to administration of cases (such as assessment, care, and support) or making decisions on legal consequences (e.g. for (alleged) offenders). Specifically: [as in the slide]

Levels of access:

Level of access	Operations (user *"rights"*) according to level of access
Full Access	enters data WITH access to ALL data, aggregated AND disaggregated (at case-level) (view/ edit/ delete) and to users' accounts create/edit/delete)
Full View access (level 1)	enters data WITH view access to ALL data, aggregated AND disaggregated (at case-level) (view/ edit/ delete) and to users' accounts (view)
Limited access (level 2)	enters data WITH access to data entered by the same user (view/ edit/delete) AND to data entered by other users for the same case (view)
Limited access (level 3)	enters data WITH access ONLY to data entered by the specific user (view/edit/delete)]

Slide 8

Depending on your involvement in CAN cases administration as explained before, you will assigned with a level of access; here is a brief description of the "rights" for each level of access into e-CAN-MDS registry.

Slide 9

responsibilities & benefits

- ***What a CAN-MDS Operator can contribute to CAN-MDS***
  - *to record new CAN incidents for new cases (children) identified or following a report*
  - *to add data for new incidents under already known cases*
  - *to update data for already recorded incidents for known cases (follow-up)*

- ***What CAN-MDS can provide to a CAN-MDS Operator***
  - *a user- friendly tool for reporting CAN incidents (especially when the professional is mandated to report)*
  - *a user- friendly tool for keeping basic information for all new incidents of CAN brought to his/her attention*
  - *a tool for checking demographic and other data for already known children (via auto-produced reports)*
  - *a communication channel with other professionals working in the same or different sectors on the same case*
  - *basic information on previous incidents for already known cases (children) (according to his/her level of access)*
  - *a ready-to-use tool for*
  - *informing other agencies on his/her agency's response (e.g. what services have already been provided)*
  - *notifying other agencies of new cases (for example, via referrals)*

As it was mentioned below, your contribution in this system is crucial and the commitment of each one of you in your role is of major importance for the successful operation of the systems.
On the other hand, however, it is expected that your participation in the CAN-MDS will provide you with some benefits
[as in the slide]

Slide 10

Material for CAN-MDS Operators

- **CAN-MDS Operators will receive**
  - **National CAN-MDS Toolkit**
    - CAN-MDS Operator's Manual
    - Access to e-CAN-MDS registry
    - CAN-MDS Data Collection Protocol

    and
    - a certification that they attended the provisioned training

Upon the completion of the workshop you will receive a certification of attendance of the training indicating that you have the necessary information for acting as a CAN-MDS Operator. In addition each one of you will receive a national CAN-MDS Toolkit, including the material indicated in the slide.
In the following part of the presentation some more information is provided for each one of the material. This training will focus in the CAN-MDS Toolkit.

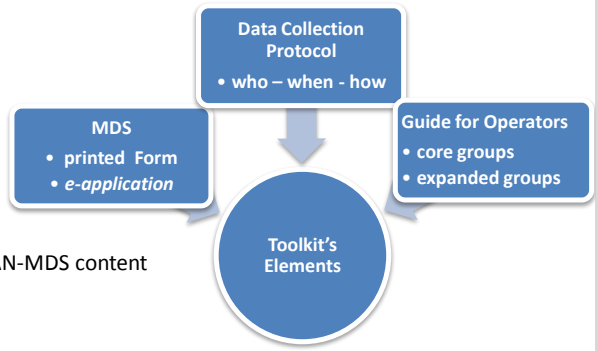
Slide 11

CAN-MDS Toolkit

Structure of the Toolkit

- **Guide for Professionals-CAN-MDS Operators**
  - it could be used autonomously by all professionals who have already been trained to become operators
- ***Step-by-step* procedure** for using the CAN-MDS
  - namely a short operations' protocol
- **CAN-MDS forms**
  - e-application

➔ The whole material are developed on the basis of the CAN-MDS content



What is the CAN-MDS Toolkit?

The CAN-MDS Toolkit consists of three main elements: a. a Minimum Data Set comprising 18 data elements which resulted from a multiple round quality and feasibility evaluation process, in which international stakeholders participated; an e-version and a printed version of the CAN-MDS tool are available for use (mainly for training purposes); b. a data collection protocol drafted to support use of the CAN-MDS that suggests a *step-by-step procedure for using the CAN-MDS; this* protocol could be used by any professional who has already been trained to become an operator; and c. a Guide for Operators where all the necessary background information is included for those professionals who fulfill the eligibility criteria and prerequisites to use the system. Apart from information concerning the necessity for child maltreatment surveillance in the country, a special section on ethics, privacy and confidentiality issues related to CAN data collection is also included in the Guide. The main body of the document is dedicated to the detailed presentation of the variables included in the CAN- MDS along with technical specifications and definitions of data elements.

Slide 12

CAN-MDS Operator's Manual

Slide 13

e-CAN-MDS

CAN-MDS Data collection protocol

Procedure

- **Who records a CAN incident to CAN-MDS**
  - **trained professionals fulfilling the eligibility criteria**
- **When to record an incident of child maltreatment**
  - **in which cases**
    - **when a child discloses that s/he suffers any type of abuse**
    - **when receiving a referral (with adequate information) from a source other than the child**
    - **when there is at least one reason to suspect that a child has been harmed as a result of physical, mental, psychological, or sexual abuse**
  - **at what time**
    - **during the intake**
    - **during the assessment**
    - **at a later time**
- **How to make the record**
  - **how to collect the information**
    - **what questions/ prompts to ask**
    - **how to use the forms**
    - **how to obtain the CHILD ID**

Part 3	Exploring the CAN-MDS	
OUTLINE	*estimated duration*	- 30 – 90 minutes (depending on whether you will use the optional Part 3A or not)
	learning objectives	- At the end of this part 3 trainees should be fully informed on the CAN-MDS - to be aware for the synthesis of the MDS - to know data elements per axis - to know the identity of each individual data element (apart from the permissible values that is not feasible to fully presented for all data elements) also - to be informed on the case-definitions - [to be aware on the indicators per main type of CAN]
	instructions to trainers	[Start the 3rd part by presenting the optional part (in order to be sure that all group members understand in the same way what is a child maltreatment incident)] Use the e-CAN-MDS to present the data elements of the CAN-MDS; proceed with the record of a vignette as you present each individual element Ask from trainees to follow the discussion on the data elements from the Operator's Manual during the presentation
	activity	- You may ask from a professional to provide you the information needed for a "mock case" having in mind a child maltreatment incident s/he dealt with in the recent past
	training resources	- Presentations - Part 3A (optional) - Part 3B (namely 2 slides) and the e-CAN-MDS - CAN-MDS Operator's Manual, Part 2, pages 24-44. - CAN-MDS Data collection protocol - Alternative presentation - In case that you are not will or able to use the e-CAN-MDS registry (either online or installed in a computer) you may use this presentation simulating the CAN-MDS (first, however should be updated according to the modifications made in your national CAN-MDS Toolkit) - It is recommended to use the e-CAN-MDS tool than this presentation
	tips to trainers	Part 3A - OPTIONAL PART This part contains more general information related to identification/ recognition of child abuse and neglect incidents that could potentially recorded in the CAN-MDS registry. Common indicators are presented per main type of abuse (physical, sexual and psychological abuse and neglect) and the difficulties related to CAN definitions are discussed. Lastly, the rationale of operationalization of CAN conceptual definitions in the context of CAN-MDS is presented. - The trainer should decide whether such a part should be included in the core & expanded groups' workshops –according to needs of professionals (if yes, more time for the training is required) - Given that trainees groups are not expected to be homogeneous and therefore at least some of the professionals are not familiarized with CAN definitions, it is recommended that this part should be included in the training. Note: This presentation can be used for both, the core- and the expanded-group trainings

Part 3 OPTIONAL– Presentation (please, adapt the slides where necessary)

Slide 1

Daphne Project "Coordinated Response to Child Abuse & Neglect via Minimum Data Set" [JUST/2012/DAP/AG/3250]

Place_____
Date _____

Exploring the CAN-MDS:
a variable by variable review

Core Group of CAN-MDS Operators Workshop

Your logo

daphne With financial support from the EU DAPHNE Programme

Slide 2

recognizing child abuse and neglect

Trainer should decide whether such a part should be included in the core & expanded groups' workshops – according to professional needs

(if yes, more time for the training is required)

Slide 3

Data collection protocol

Procedure

- **WHO**
- **WHEN**
- **HOW**
  - **Based on information available in the Toolkit**

Slide 4

When should a record of (suspected) CAN incident be made?

- **A record must be made by an eligible professional in any case when**
  - **a child (alleged victim) discloses that s/he suffers any type of abuse**
  - **receiving a referral (with adequate information) from a source other than the child**
  - **there is at least one reason to suspect that a child has been harmed as a result of physical, mental, psychological, or sexual abuse**

Slide 5

What does "reason to suspect" mean?

- **Reason to suspect** means that there are **adequate indications-warning signs** that a child is probably a victim of CAN
  - Indicators/signs by themselves do not prove CAN; in many cases, however, they warrant adequate reason for initiating assessment of the child's (alleged victim) conditions
    - it is important for professionals administrating CAN cases (especially those who are mandated to report CAN) to know what the signs are in order to report them
  - for making a referral proof that CAN has actually occurred is not required
    - for recording the incident included in a referral the same applies
    - does not mean that the operator witnessed the incident in question
  - recording of an incident to CAN-MDS aims to operate as a request for an assessment into the condition of a child (see "notifications" function in the flowchart)
    - the allegation can be false or true; the determination of whether maltreatment has actually occurred is the responsibility of appropriate law enforcement agencies

Slide 6

Source: http://www.safekidsbc.ca/physical.htm

Common Indicators of Physical Abuse

Physical indicators

(Many physical indicators can be similar to neglect indictors)

- injuries (bruises, welts, cuts, burns, bite marks, fractures, etc.) that are not consistent with the explanation offered (e.g. extensive bruising to one area)
- presence of several injuries (3+) that are in various stages of healing
- repeated injuries over a period of time
- injuries that form a shape or pattern that may look like the object used to make the injury (e.g. buckle, hand, iron, teeth, cigarette burns)
- facial injuries in infants and preschool children (e.g. cuts, bruises, sores, etc.)
- injuries not consistent with the child's age and development
- bald patches on child's head where hair may have been torn out
- repeated poisonings and/or accidents

Behavioural indicators

- runaway attempts and fear of going home
- stilted conversation, vacant stares or frozen watchfulness, no attempt to seek comfort when hurt
- describes self as bad and deserving to be punished
- cannot recall how injuries occurred, or offers an inconsistent explanation
- wary of adults or reluctant to go home
- often absent from school/child care
- m
- sui

Showing such e.g. physical indicators, professional/operator should ask his/her self:

-Is the explanation consistent with physical evidence?

-Are there any other physical or behavioral indicators?

-Are there family/environmental stresses that are apparent?

Slide 7

Source: http://www.safekidsbc.ca/physical.htm

Common Indicators of Sexual Abuse

Physical indicators

- fatigue due to sleep disturbances
- sudden weight change
- cuts or sores made by the child on the arm (self-mutilation)
- recurring physical ailments
- difficulty in walking or sitting
- unusual or excessive itching in the genital or anal area due to infection(s)
- torn, stained or bloody underwear
- sexually transmitted disease(s)
- pregnancy
- injuries to the mouth, genital or anal areas (e.g. bruising, swelling, sores, infection)

Behavioural indicators

In a younger child:

- sad, cries often, unduly anxious
- short attention span
- inserts objects into the vagina or rectum
- change or loss of appetite
- sleep disturbances, nightmares
- excessively dependent
- fear of home or a specific place
- excessive fear of men or women, lacks trust in others
- age-inappropriate sexual play with toys, self, others
- age-inappropriate, sexually explicit drawings/descriptions
- bizarre, sophisticated or unusual sexual knowledge
- reverts to bedwetting/soiling
- dramatic behavioural changes
- sudden non-participation in activities
- poor peer relationships, self-image
- overall poor self-care

In an older child:

- sudden lack of interest in friends or activities
- fearful or startled response to touching
- overwhelming interest in sexual activities
- hostility toward authority figures
- fire setting
- need for constant companionship
- regressive communication patterns (e.g. speaking childishly)
- academic difficulties or performance suddenly deteriorates
- truancy and/or running away from home
- wears provocative clothing or wears layers of clothing to hide bruises
- recurrent physical complaints that are without physiological basis
- lacks trust in others
- unable to "have fun" with others
- suicide attempts
- drug/alcohol misuse
- poor personal hygiene
- promiscuity
- sexual acting out in a variety of ways

Slide 8

Source: http://www.safekidsbc.ca/physical.htm

Common Indicators of Psychological Abuse

Physical indicators

(often co-exists with other CAN types' indicators)

- bedwetting and/or diarrhea
- frequent psychosomatic complaints, headaches, nausea, abdominal pains

Behavioural indicators

- mental or emotional development lags
- behaviours inappropriate for age
- fear of failure, overly high standards, reluctance to play
- fears consequences of actions, often leading to lying
- extreme withdrawal or aggressiveness, mood swings
- overly compliant, too well-mannered
- excessive neatness and cleanliness
- extreme attention-seeking behaviours
- poor peer relationships
- severe depression, may be suicidal
- runaway attempts
- violence is a subject for art or writing
- complains of social isolation
- forbidden contact with other children

Slide 9

Source: http://www.safekidsbc.ca/physical.htm

Common Indicators of Neglect

Physical indicators

- abandonment
- lack of shelter
- unattended medical and dental needs
- consistent lack of supervision
- ingestion of cleaning fluids, medicines, etc.
- consistent hunger
- nutritional deficiencies
- inappropriate dress for weather conditions
- poor hygiene
- persistent (untreated) conditions (e.g. scabies, head lice, diaper rash, or other skin disorders)
- developmental delays (e.g. language, weight)
- irregular or nonattendance at school or child care
- not registered in school
- not attending school

Behavioural indicators

- depression
- poor impulse control
- demands constant attention and affection
- lack of parental participation and interest
- delinquency
- misuse of alcohol/drugs
- regularly displays fatigue or listlessness, falls asleep in class
- steals food, or begs for food from classmate(s)
- reports that no caregiver is at home
- frequently absent or tardy
- self-destructive
- drops out of school (adolescent)
- takes over adult caring role (of parent)
- lacks trust in others, unpredictable
- plans only for the moment

Slide 10

Case definitions

- Conceptual definitions
  - Difficulties related to conceptual definitions
- Operationalizing conceptual definitions

Slide 11

Difficulties related to CAN definitions

- **Variations in definitions of CM ➔ major challenge in researching CAN**
  - **here:** involvement of professionals with different professional backgrounds, working in different sectors within and between countries
- **Statistics are rarely presented in enough detail➔** considerable variation in the forms of maltreatment being reported ➔underestimation of specific forms of CAN (Fallon *et al* 2010)
  - **here:** this also occurs in child populations reaching services (which are the population targeted by the CAN-MDS) because of the failure to collect information on multiple forms of abuse
- **"at what point a child is identified as maltreated"➔** fundamental issue for understanding the limitations of CAN epidemiological data
  - **here:** considering that CAN-MDS address different stakeholders, the difficulty of defining this "point" in a commonly accepted way is even higher in the context of any CAN conceptual definition
- "**how a child maltreatment event is measured"** is a crucial issue when comparing within and between countries rates of CAN ; thus, comparisons across sectors require at the very least, that the data be disaggregated
  - **here:** collection of disaggregated data concerning the form(s) of maltreatment are preferable

Slide 12

Use of common conceptual definitions *to overcome the definitions-related obstacle*

- In the context of the CAN-MDS, case definitions are based on **the United Nations' Committee on the Rights of the Child's General comment No. 13 (2011), "The right of the child to freedom from all forms of violence" [CRC/C/GC/13 (2011) §19-33]**
  - *Available at: http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf*

- Apart from these conceptual definitions, a further review was made including
  - UNCRC Article 19
    - *Available at: http://www.unicef.org.uk/Documents/Publication-pdfs/betterlifeleaflet2012_press.pdf*
  - the World Report on VAC (2006)
    - *Available at: http://www.unicef.org/violencestudy/reports.html*
  - WHO and ISPCANs definitions (2006) and
    - *Available at: http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf*
  - CDCs (2008) definitions
    - *Available at: http://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf*

S;ode 13

Classification of CAN

operationalizing CAN case definitions for the needs of the CAN-MDS

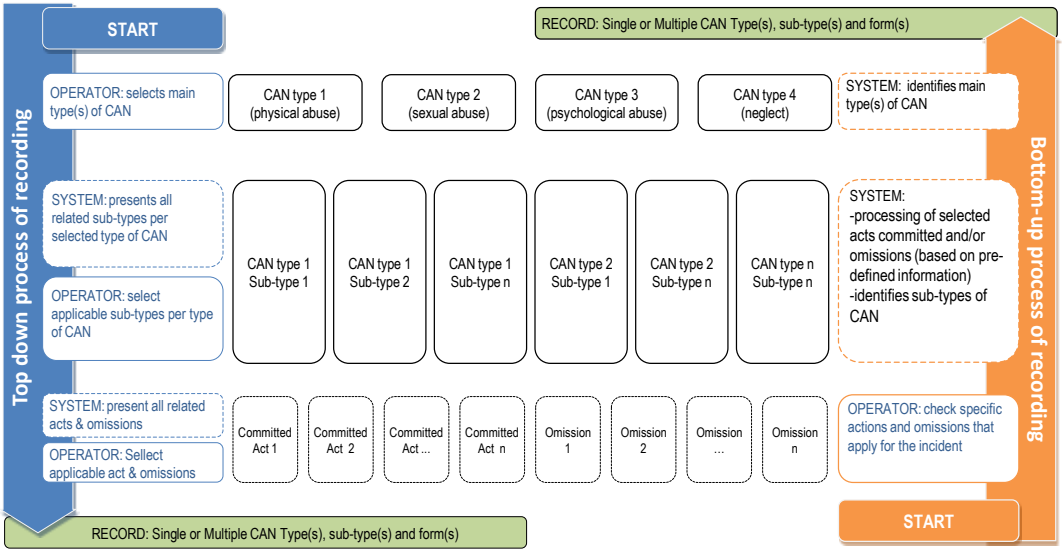
- **bottom-up process for classifying the type(s) of CAN**
  - to ensure to the greatest possible extent
    - a common understanding by any potential operator
    - The collection of reliable and comparable information

- **bottom-up process**
  - instead of using a broad classification of the main types and subtypes of CAN, pre-coded exhaustive [check]lists of clearly defined specific maltreatment actions committed and omissions in child's care are developed
  - these actions can be identified via
    - Observation
    - Interview
    - available information or other means

    AND
    - indicate (*automatically based on an algorithm*) specific subtypes and consequently main types of CAN
    - allow at the same time the recording of multiple forms of maltreatment

Slide 14


Real events (cultural perceptions and used definitions in different countries)
Conceptualization (ISPCAN 2000)
Conceptual definitions (WHO & ISPCAN 2006; CDC 2008)
Operational definitions (CDC 2008; CAN-MDS ongoing)
Measurements of CAN in the real world via MDS


START
RECORD: Single or Multiple CAN Type(s), sub-type(s) and form(s)
Top down process of recording
OPERATOR: selects main type(s) of CAN
CAN type 1 (physical abuse)
CAN type 2 (sexual abuse)
CAN type 3 (psychological abuse)
CAN type 4 (neglect)
SYSTEM: identifies main type(s) of CAN
SYSTEM: presents all related sub-types per selected type of CAN
OPERATOR: select applicable sub-types per type of CAN
CAN type 1 Sub-type 1
CAN type 1 Sub-type 2
CAN type 1 Sub-type n
CAN type 2 Sub-type 1
CAN type 2 Sub-type n
CAN type n Sub-type n
SYSTEM:
-processing of selected acts committed and/or omissions (based on pre-defined information)
-identifies sub-types of CAN
SYSTEM: present all related acts & omissions
OPERATOR: Sellect applicable act & omissions
Committed Act 1
Committed Act 2
Committed Act ...
Committed Act n
Omission 1
Omission 2
Omission ...
Omission n
OPERATOR: check specific actions and omissions that apply for the incident
Bottom-up process of recording
START
RECORD: Single or Multiple CAN Type(s), sub-type(s) and form(s)

Slide 15

Indicators targeted to be measured

The data framework for indicators to be measured through a CAN-MD surveillance system

- The following 4 main categories of indicators are suggested to be measured via the CAN-MDS
  - Exposure to child maltreatment (e.g. CAN incidence on the basis of services' response)
  - Child maltreatment outcomes (e.g. related to school attendance)
  - Surveillance of determinants for child maltreatment (e.g. risks related to family and caregiver(s) characteristics)
  - Surveillance of services' response to child maltreatment (institutional response, legal action taken, referrals)
- Each variable can be related to one or more indicators

Exposure to child abuse and neglect	**Child abuse and Neglect incident** per type/form of abuse/neglect, per child (alleged) victim age/ per time period/ per geographic area (Axes: **RECORD** and **INCIDENT**)
Exploration of risk determinants for child abuse and neglect	**Characteristics** of children (alleged) victims/ children's families/ primary caregiver(s) when the incident took place (Axes: **RECORD** and **CHILD** and **FAMILY**)
Services' response to child abuse and neglect	**Services' & Professionals' Response** (immediate and log-term) in recoding/ reporting/ investigating/ assessing/ administrating of child abuse and neglect at a case-level (Axes: **Record** and **SERVICES** and **INCIDENT**)

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CAN-MDS Core Group of Operators - WORKSHOP

When setting up a new surveillance system, such as CAN-MDS, the first question to be answered is which categories of information should be tracked by the system, namely the outlining of the data framework (Abelsohn, Frank and Eyles 2009). The data framework is usually defined in terms of indicators, measurable factors that allow objective estimations of the size of the problem under surveillance and monitoring of the processes, the products or the effects of an intervention on the population (Nsbuga *et al*. 2006).

By using the same standardized variables and protocol for recording, all countries could use the data collected not only for monitoring within-country trends of child maltreatment, but also for making comparisons across countries. Such an approach, according to WHO (2003) encourages the collection of small amounts of useful information on a regular and continuing basis, as suggested in the context of a CAN-MDS Surveillance System.

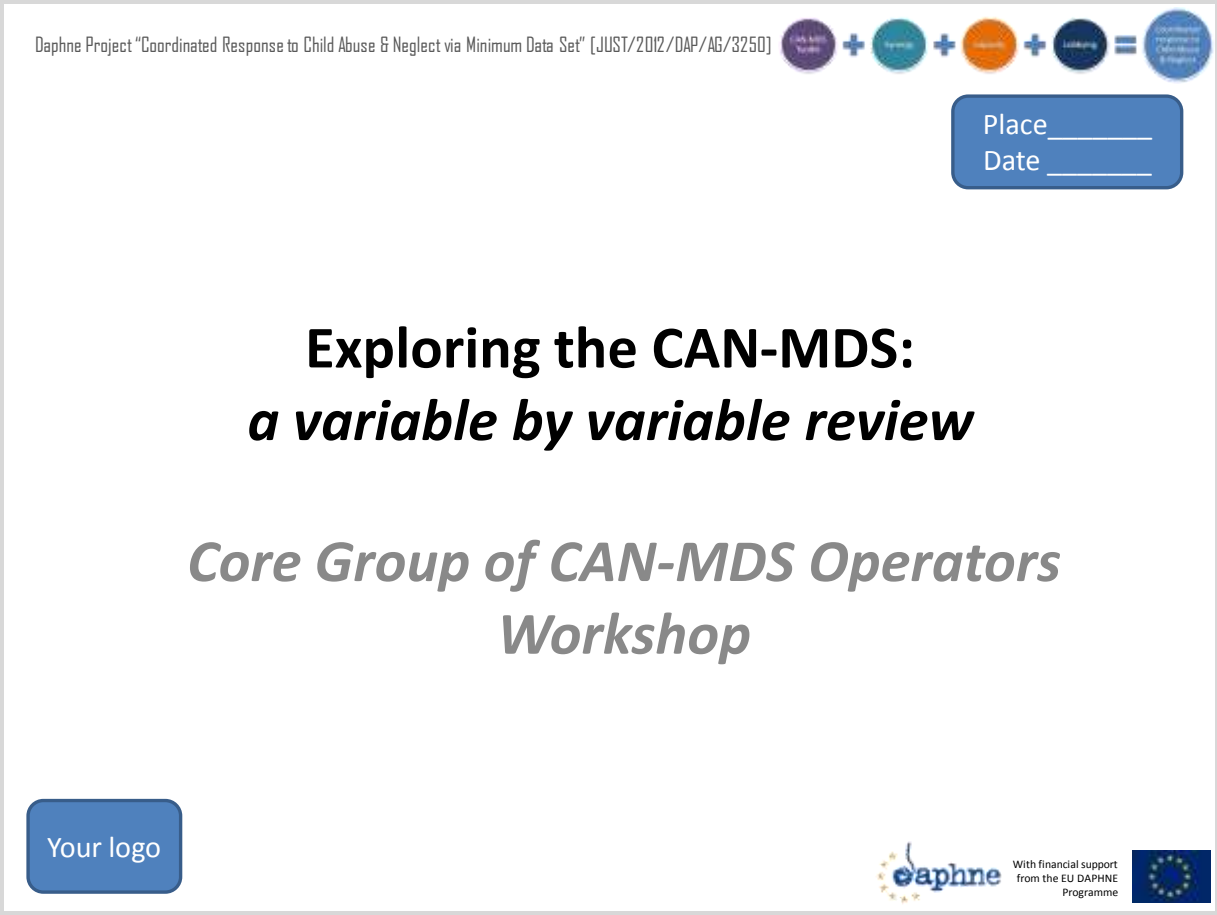
Thacker *et al*. (1996) proposed three categories of surveillance information: exposure surveillance, hazard surveillance (here *determinants*) and health outcome surveillance. For the specific set of child maltreatment indicators being developed, a fourth category of surveillance information has been added: surveillance of services response.

Slide 16

CAN-MDS TOOL

Part 3 – Presentation (please, adapt the slides where necessary)

Slide 1



This, along with the simulation process that will follow, is probably the most important parts of this training. If at the end of these parts the group has a complete picture of what the CAN-MDS is and how it is work, then the objectives of this training would be achieved.

Slide 2

CAN-MDS axes & data elements

The CAN-MDS aims, among others, to promote:

- *standard description of data*
- *common understanding, harmonization and standardization of data within and across organizations activated in the same or different sectors*

The data that comprise the CAN-MDS registry are derived from 18 data elements classified (following the rationale of ISO/IEC 11179) under 5 broader *axes* (*data element concepts*): RECORD, INCIDENT, CHILD, FAMILY & SERVICES

CAN-MDS Evaluation*

Evaluation of qualitative aspects of CAN-MDS DE**

Relevance	: 8,98/10
Usefulness	: 8,76/10
Understandability	: 9.33/10
Accessibility	: 8,32/10

Evaluation of feasibility aspects of CAN-MDS DE***

Availability	: 8,14/10
Reliability	: 7,92/10
Validity	: 7,84/10
Timeliness	: 8,56/10
Confidentiality	: 8,90/10
Cost	: 8,92/10

Data Elements related to INCIDENT	
DE_I1:	Incident ID
DE_I2:	Date of Incident
DE_I3:	Form(s) of maltreatment
DE_I4:	Location of Incident
Data Elements related to CHILD	
DE_C1:	Child's ID
DE_C2:	Child's Sex
DE_C3:	Child's Date of Birth
DE_C4:	Child's Citizenship Status
Data Elements related to FAMILY	
DE_F1:	Family Composition
DE_F2:	Primary Caregiver(s) relationship to child
DE_F3:	Primary Caregiver(s) Sex
DE_F4:	Primary Caregiver(s) Date of Birth
Data Elements related to SERVICES	
DE_S1:	Institutional response
DE_S2:	Referral(s) to Services
Data Elements related to RECORD	
DE_R1:	Agency's ID
DE_R2:	Operator's ID
DE_R3:	Date of Record
DE_R4:	Source of Information

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Here is an overview of the CAN-MDS:
In the blue column it is indicated how the CAN-MDS is structured in five different axes and what data elements belong under each axis.

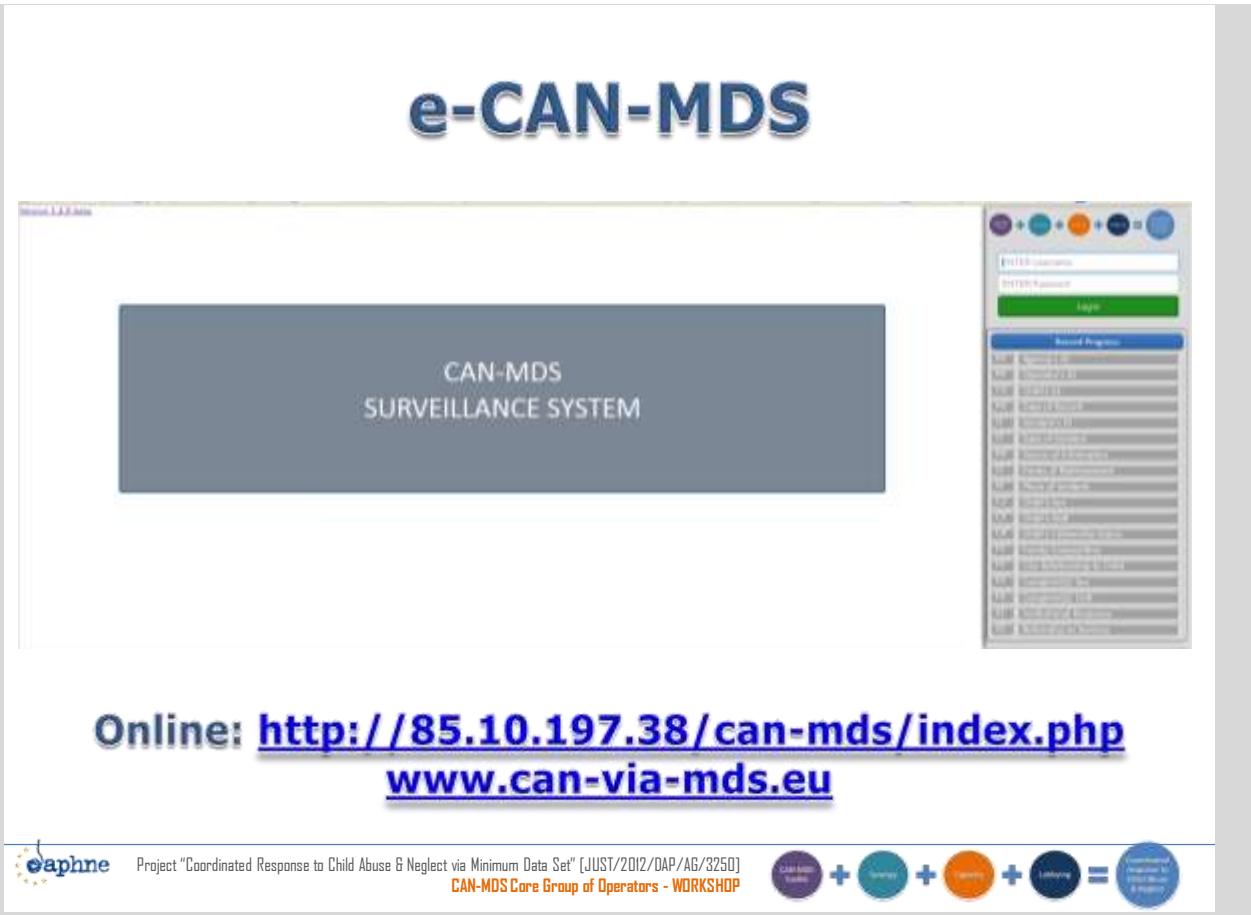
In the Orange column the evaluation results are indicated for the data elements finally included in the CAN-DMS
Comments on the evaluation

* Both of the evaluation components above present mean scores for all the Data Elements of the CAN-MDS. After each of these evaluations, further modifications to the CAN-MDS took place with the aim of improving of the MDS in accordance with the evaluation results.

** An evaluation of the qualitative aspects of the CAN-MDS was made by the members of the Consortium representing seven countries (BG, DE, FR, GR, IT, RO, CH). ONLY data elements that are considered as "ethical" were included in the evaluation.

*** An evaluation of the feasibility aspects of the CAN-MDS was made by an international group of experts in the field of data collection on child abuse and neglect; members of this international group were from 4 continents (Europe, Asia, Oceania, America) and 11 countries (USA, Canada, Australia, Saudi Arabia, Turkey, Israel, Greece, Italy, Belgium, UK, Ireland) and the Directorate-General Justice, Unit C.1: Fundamental rights and rights of the child.

Slide 3



Instruction: Run the e-CAN-MDS

TIP: You can ask from a trainee to provide you information for a vignette case as you will proceed in the presentation of the individual data elements (and the operational characteristics of the application).

For the presentation of the data elements please use the CAN-MDS Operator's Manual, Part 2, pages 24-44.

Part 4	Towards the Understanding of CAN-MDS	
OUTLINE	*estimated duration*	- 60 minutes - 15 minutes for review the data collection protocol by trainees - 15-20 minutes for the simulation process - 25-30 minutes discussion on the recording
	learning objectives	- At the end of part 4 trainees should be in place to proceed with the recording of an eligible child maltreatment incident in the e-CAN-MDS registry
	instructions to trainers	Ask from trainees to read the data collection protocol (especially the prompts at the end of the document) (provide them with 15 minutes for this task) Ask them to have their mobile phones open in a specific time Inform them that they have 15-20 minutes available to complete the process of recording
	activity	- Simulation of recording procedure in the CAN-MDS by trainees
	training resources	- Copies of CAN-MDS Data Collection Protocol - A vignette case adapted for the "source of information" (the "actor") and for the professional-"CAN-MDS Operator" - e-CAN-MDS application moreover - create user accounts (username and password) for each one of the trainees - create a CHILD's ID for each one of the trainees - prepare the templates (see templates) for keep information on what information you (as the national administrator) received by each trainee - be sure that actors are equipped with the necessary information (scenario and contact details of the trainee each one of those will communicate)
	tips to trainers	- Be sure in advance that - all trainees will have computers or tablets either with internet access or with already installed the CAN-MDS application in their computers - "actors" that will communicate with trainees (by phone or even face to face – depending on the desing of the simulation) will be adequately informed on their role, they will have all information needed for the "mock case" and will be on time for the simulation process - If you proceed with the simulation via phone calls, please provide "actors" with the necessary information for the respective operators (phone numbers, specialties, agencies where they are working) -

Part 4 – Presentation (please, adapt the slides where necessary)

Slide 1

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Date _____

Recording child maltreatment incidents into CAN-MDS e-registry

Simulation

Core Group of CAN-MDS Operators Workshop

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In this part of the training each one of you will be asked to act as a CAN-MDS Operator.
Please take 15 minutes to take a look at the CAN-MDS Data Collection Protocol; please, pay attention at the last part of the document (suggested questions and prompts for data collection), especially if you are not familiarized with the process of intake of CAN cases or interview in general.

Slide 2

e-CAN-MDS

Go to: http://85.10.197.38/can-mds/index.php

OR
at www.can-via-mds.eu

OR
in the installed CAN-MDS application in your computer

[After 15 minutes]
Please go to the e-CAN-MDS (online or in the installed application respectively)
[You distribute the users accounts you have created in advance]
Make sure that you have your mobiles open. You have 15-20 minutes to complete the process of recording into CAN-MDS from the time that you will receive a call for a child maltreatment incident

Slide 3

Using the stand alone application

- Open the application (double click):

Click

- first "Start Apache"
- Next "Start mySQL

The application will open in the browser

[these are the instructions in case that the trainees will use the stand alone application]

Slide 4

e-CAN-MDS

Enter your username & password & start the record

Key Ethical Issues related to CAN Surveillance Part 5		
OUTLINE	*estimated duration*	30 minutes - 20 minutes for presentation - 10 minutes for discussion
	learning objectives	at the end of part 5 trainees should be aware on - the main ethical issues posed by public health surveillance - the assessment of the CAN-MDS on the basis of a specific tool - the main national legislation related to confidentiality and privacy of personal data
	instructions to trainers	- review the learning objectives of Part 5 - rehearse with slide presentation Part 5 - discuss with trainees potential concerns related to ethical issues of
	activity	- *NA*
	training resources	- Presentation "Part 5" - Read the *Country Profile Report, e*specially "Chapter 3 Legal framework" - 3.1 Legislation, policies and mandates for reporting and recording of CAN cases in different professional fields - 3.2 Legal provisions for administration of sensitive personal data Further reading - Related references - Petrini, C. Ethics in public health surveillance. Ann Ist Super Sanità; 2013.49;4. - Centers for Disease Control and Prevention. CDC's Vision for Public Health Surveillance in the 21st Century. MMWR 2012;61(Suppl; July 27, 2012). - Lee LM, Heiling CM, White A. Ethical Justification for Conducting Public Health Surveillance Without Patient Consent. Am J Public Health. 2012;102. - Heilig CM, Sweeney P. Ethics in public health surveillance. In: Lee LM, Teutsch SM, Thacker SB, St. Louis ME (Eds.). Principles and practice of public health surveillance. Oxford: Oxford University Press; 2010.
	tips to trainers	PowerPoint Part 5 currently comprises from 18 slides. - In order the presentation to be feasible in terms of time, seven Slides (4-9 and 12) are hided: you can present them if you have adequate time or in the case that you think these information is useful during the discussion. - In this way, PowerPoint Part 5 for the training of national groups can be made only on the basis of 11 slides (1-3, 10-11, 13-18)

Part 5 – Presentation (please, adapt the slides where necessary)

Slide 1

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Date _____

Key Ethical Issues related to CAN Surveillance

Workshop of

Core-Group of CAN-MDS Operators

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At this point we have already discussed on the necessity for child maltreatment surveillance, your role as members of national core group and the role of operators (expanded groups). Moreover, we reviewed the CAN-MDS variable by variable and tested the tool via the mock cases.
Apart from the technical aspects for data collection, however, there is a crucial subject related to public health surveillance, including a system such as the CAN-MDS: Ethics!
In this fifth part of the workshop we will review the key ethical issues related to public health surveillance and how the CAN-MDS deals with these issues.
More information on the issue you will find in the CAN-MDS Toolkit, Guide for Operators, in the Country Profile Report, which is available in the project's website as well as in suggested pepers from the international literature.

Slide 2

Public Health Surveillance

- **Surveillance** in the field of public health
  - ***the ongoing and systematic collection, analysis, interpretation and dissemination of health information*** (ICD-10, 1994; CDC, 2012)
- It involves
  - keeping of records on individual cases, analyzing and interpreting and reporting to interested parties
    - health, mental health and welfare professionals, government officials, international agencies, the general public and anyone else with an interest in public health
- surveillance data allows
  - identification of trends
  - tracking of information on the determinants of specific health issues
  - Tracking various risk and protective factors
  - establishing national research priorities
  - guiding the development and evaluation of policies and programs

  (Health Canada, 2004)

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As it was already mentioned in the introductory part of the training, Surveillance in the field of public health is the ongoing and systematic collection, analysis, interpretation and dissemination of health information. It involves keeping of records on individual cases, analyzing and interpreting and reporting to interested parties (such as individual professionals, government officials, international agencies, and the general public)

Data collected via surveillance allows, among others, identification of trends, guiding the development and evaluation of policies and programs and establishing national research priorities.

Slide 3

Child Maltreatment Surveillance

- Child Maltreatment Surveillance System
  - must collect and eventually link data from the professionals and agencies involved in the administration of cases of child maltreatment

    Aim: to provide valuable information on the circumstances of incidents related to child abuse and neglect (Bernstein & Haring Sweeney, 2012)

  - Data collected should be readily available and easily accessed by the maximum number of users as possible

BUT

  - in a manner that protects confidentiality and privacy of the data's subjects

  - *This particular point begins the discussion on the ethical aspects related to child maltreatment surveillance systems*

The aim of a child maltreatment surveillance system is to provide valuable information on the magnidude of the problem, namely incidence rates, as well as for the circumstances of incidents related to child abuse and neglect. In order to achieve this aim, the system must collect and eventually link data from the professionals and agencies involved in the administration of cases of child maltreatment. The data to be collected should be useful, relevant, understandable, valid and reliable and readily available and easily accessed by the maximum number of users as possible. At the same time, data collection should be realized in a manner that protects confidentiality and privacy of the data's subjects.
At this particular point begins the discussion on the ethical aspects related to child maltreatment surveillance systems.

Slide 4

Ethical Issues posed by public health surveillance

- *have been specifically addressed in numerous studies in the past*
- *various factors have led to an increase in this interest in recent years*

[Heilig & Sweeney, 2010]

- **assessment of the compatibility of public health surveillance programmes with ethical principles**
  - **➔ via checklists**
    - American Public Health Association. Public Health Code of Ethics. Whashington DC: AFA; 2004.
    - Bayer R, Fairchild A. The limits of privacy: surveillance and the control of disease. Health Care Anal 2002;10(1):19-35.
    - Freeman M (Ed.). The ethics of public health. Farnham: Ashgate; 2010. Vol. 1 and 2.
    - Pounder CNM. Nine principles for assessing whether privacy is protected in a surveillance society. Identity in the information society 2008;1(1):1-22.
    - Désy M, Filiatrault F, Laporte I. A tool for ethical analysis of public health surveillance plans. In: Canadian Institutes of Health Research. Institute of Population and Public Health. Population and public health ethics: cases from research, policy, and practice. Toronto: University of Toronto, Joint Centre for Bioethics; 2012. p. 52-7.
    - Childress JF, Faden RR, Gaare RD, Gostin LO, Kahn J, Bonnie RJ, Kass NE, Mastroianni AC, Moreno JD, Nieburg P. Public health ethics. Mapping the terrain. J Law Med Ethics 2002;30(2):170-8.
    - Kass NE. An ethics framework for public health. Am J Public Health 2001;91(11):1776-82.

[Petrini, 2013]

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Ethical issues posed by public health surveillance should also considered for a CAN-MDS system.
Ethical issues related to public health surveillance have been specifically addressed in numerous studies in the past while various factors have led to an increase in this interest in recent years [Heilig & Sweeney, 2010].

The compatibility of public health surveillance programmes with ethical principles is often assessed by using specific checklists. In the slide references related to this kind of checklists is presented (as they mentioned by Petrini in his paper entitled Ethics in public health surveillance and published in 2013).

In this part of the training we will discuss about compatibility of CAN-MDS with ethical principles by using the tool developed by Desy and colleagues, Canadian Institutes of Health Research (2012).

Related references

Heilig CM, Sweeney P. Ethics in public health surveillance. In: Lee LM, Teutsch SM, Thacker SB, St. Louis ME (Eds.). *Principles and practice of public health surveillance. Oxford: Oxford University Press; 2010. p. 198-216. DOI: 10.1093/acprof:oso/9780195372922.003.0009*
Petrini, C. Ethics in public health surveillance. Ann Ist Super Sanità 2013 | Vol. 49, No. 4: 000-000

Slide 5

Here is the tool for ethical analysis of a public health surveillance plan, which is comprises eleven criteria: proportionality, usefulness, transparency, representativeness, equity, participation, independence, stigmatisation, privacy, informed consent, understandability.

In following slides we will discuss on aspects of CAN-MDS responding to the criteria for assessment of system's compatibility with the ethical principles. It is noted that often, apart from purely ethical aspects, legal, policy, ethical, regulatory, and practical issues are also involved.

Slide 6

Fundamental questions about surveillance systems *proportionality and usefulness*

Proportionality: refers to the idea that the drawbacks of implementing a particular surveillance plan must be offset by its benefits, which it is hoped will be greater. One of the primary justifications for surveillance is that it informs decision-making about public health programmes and activities.

Usefulness: The question of usefulness has been addressed implicitly above. The ultimate usefulness of a surveillance plan is the contribution that it makes to public health. The decisions made regarding surveillance plans must therefore have this potential to improve public health.

- **What is the purpose of surveillance?**

  CAN-MDS purpose: combating of child maltreatment through policies and interventions formulated and evaluated on the basis of reliable data derived from the monitoring of the magnitude of the phenomenon, its specific characteristics and the trends at a national and international level

- **What is the *necessity***

  ➔ the most important condition for justified surveillance

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

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Concerning the criteria of proportionality and usefulness of a CAN-MDS Surveillance system the following questions can be posed:
What is the necessity for a surveillance system on child maltreatment? Why should we involved in demanding surveillance processes? Are the benefits of such a system greater than the related drawbacks?

The justification can summarized in a few sentences:
Despite child abuse and neglect is a major public health problem worldwide, *"the true extent of child maltreatment is unknown"; "between half to four fifths of all victims of maltreatment are not known to child protection services"* and therefore the *"tip-of-the-iceberg analogy easily comes to mind when one thinks of the scope of child maltreatment"* . This situation do not allow either the effective prevention of the problem or the effective intervention to existing but unknown cases.

An effective CAN surveillance mechanism can contribute essentially at combating child maltreatment through policies and interventions formulated and evaluated on the basis of reliable data derived from the monitoring of the magnitude of the phenomenon, its specific characteristics and the trends at a national and international level (mainly primary prevention); at the same time, the vision for the suggested system is to become a practical tool facilitating the follow up of can cases at an individual level (secondary and tertiary prevention).

Slide 7

Fundamental questions about surveillance systems
transparency

Transparency is the attribute that a surveillance plan has when its purposes are explicit

- **What is the purpose of surveillance via a CAN-MDS Surveillance System?**

- Apart from the *public health surveillance of CAN*, an additional purpose is included for the suggested CAN-MDS Surveillance System *-the utilization of information at a case-level*.

- Thus, the purpose is defined at two levels:
  - *To provide comprehensive, reliable & comparable case-based information for (alleged) child victims of CAN who have used social, health, educational, judicial & public order services at national and international level. (**Information for action** linked to public health initiatives.)*
  - *To serve as a ready-to-use tool in investigation and follow-up of child victims of CAN or those at risk of being (re-) victimized, by respecting the national legislation and applying all the rules necessary for ensuring ethical data collection and administration (**Case-level information** linked to follow-up of individual cases.)*

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As for its transparency, the purpose of a CAN-MDS Surveillance System is clearly set, as presented in the slide.

The twofold character of the suggested CAN-MDS Surveillance System takes into account the difficulties relating to the nature of CAN (continuous and repeated, involving multiple sectors and professional groups without well-established common language and channels of communication), and the critical aspects required for the effective operation of a public health surveillance system (related to its acceptance and stakeholders' agreement to collect data elements).

By serving as a practical tool (following strict criteria) for the dedicated involved parties it is expected to strengthen their commitment to the system and therefore to result in better information for action. The twofold character is also expected to improve the results of a cost-benefit assessment of such a system.

Slide 8

Fundamental questions about surveillance systems *representativeness and equity*

Representativeness: *A surveillance plan that is representative is one in which: a) the phenomena to be placed under surveillance accurately reflect the health determinants and health problems that are recognized as important, and b) the populations studied are represented equitably.*

Equity: While representativeness refers to the extent to which a surveillance plan allows all of the subgroups in a population to be depicted accurately, equity refers to the need to devote particular attention to certain of these sub-groups, because certain health problems affect them disproportionately; in other words, the burden of disease is greater among them.

Child maltreatment recognized as

- a *major* public health problem (WHO 1999)
- a social problem that lends itself to a public health framework of study and subsequent prevention activities (O'Donnell *et al*. 2008)
- a 'critical' and 'significant' public health problem that warrants a comprehensive prevention strategy (CDC 2010)

- The effort to involve all sectors working with children and responding to child maltreatment is expected to cover equitably the population in question

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The phenomenon under surveillance is child maltreatment and its importance is generally accepted: In 1999 the World Health Organization (WHO) recognized child abuse as a major public health problem (WHO 1999). In 2010 the US Centers for Disease Control and Prevention (CDC) identified child maltreatment as a 'critical' and 'significant' public health problem that warrants a comprehensive prevention strategy (CDC 2010). In 2008, child maltreatment was recognized as a social problem that lends itself to a public health framework of study and subsequent prevention activities (O'Donnell *et al*. 2008) while in 2010 it was noted that "child abuse and neglect prevention efforts have already moved significantly into public health terrain" (Zimmerman and Mercy 2010).

The population targeted by the system is the general population of children who are addressing to a variety of services belonging to sectors of social welfare, health and mental health, justice and law enforcement and education; the effort to involve all potential stakeholders is expected to cover equitably the population in question.

Slide 9

Fundamental questions about surveillance systems *participation and independence*

Participation: Participation, by partners at least, if not by the public, is assuming growing importance in the field of public health. It helps to ensure that the data gathered will be more relevant and will be put to better use.

Independence: The increased presence of players external to the health system who have the financial capacity to take action on certain problems can place pressure on the public health authorities who develop surveillance plans to include subjects and indicators whose importance may not really have been demonstrated. Special care is advisable in such situations.

CAN-MDS Surveillance System

- **Governance of a CAN-MDS Surveillance System**
  - *CAN-MDS should be operated by a dedicated national authority working towards the promotion of welfare and the protection of the rights of children*

- **Who are going to be Operators and have access to data?**

➔Only Professionals
➔working in eligible sectors and
➔subjected to a Code of Ethics and/or other related legislation
➔will be invited to be trained and become Operators

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Participation is a core objective of the CAN-MDS. The development of the idea, the tools and the criteria for eligibility of stakeholders are results of group effort. Especially the long negotiation for reaching the final content of the MDS with the contribution of professionals from many different countries is expected to lead in collection of data of sufficient quality, valid and reliable and eventually that will be put to better use.

As for its independence, all potential stakeholders in a CAN-MDS system will be invited to participate following pre-defined mutually agreed criteria and will be subjected to ethics code or related rules legislation –depending on country specifics. The process for involving agencies is similar.
In regards to the system administration, which is also a core aspect for system's independence, suggested authorities to undertake this role should also fulfill specific prerequisites.
More information concerning the governance of a potential CAN-MDS system as well as the operators to be involved are discussed in the next slides.

Slide 10

Fundamental questions about surveillance systems

- **Governance of a CAN-MDS Surveillance System**
  - *CAN-MDS should be operated by a dedicated national authority working towards the promotion of welfare and the protection of the rights of children*

- ***Which is the (suggested) authority for carrying out the surveillance?***
  - [PLEASE ADD INFORMATION FOR YOUR COUNTRY - see Report on Eligibility criteria – Step 5]
  - Title (name) of the agency
  - Field where the agency belongs
  - Legal status of the agency

  Why this agency is considered that can guarantee appropriate operation of the system in terms of ethics?
  - Adequacy to undertake this role
    - **Legal authorization** *(already available or feasible to be achieved e.g. from national authorities for administration of sensitive personal data)*
    - **Adequacy of expertise** *(namely whether there are currently available in the agency experienced professionals working with administration of child abuse and neglect cases AND at the same time are experienced in maintaining records/ registries/ archives for the cases)*
    - **Sufficiency in terms of human resources and technical means**

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A necessary condition for gain the potential benefits of bringing together frontline workers with different professional backgrounds working in different sectors and are involved in the administration of CAN cases, is the existence of strong leadership and coordination of surveillance activities. Strong leadership can also ensure the independence of the system.
To this end, a national administrative authority of a CAN-MDS Surveillance system should be in charge for ensuring the smooth operation of the system, coordinating the capacity building activities (where the core groups are involved), checking the quality of data collected, analyzing and disseminating the data deriving from the system and providing guarantee that ethical principles are fully respected throughout the CAN surveillance procedure.

In our country the [agency] is suggested/ is the responsible to undertake the role of administrator of the CAN-MDS Surveillance System.
It is considered that it can guarantee the appropriate operation of the system in terms of ethics because of its adequacy concerning [please complete]

Slide 11

Fundamental questions about surveillance systems

CAN-MDS Surveillance System

Who are going to be Operators and have access to data?

➔Only Professionals
- ➔working in eligible sectors and
- ➔subjected to a Code of Ethics and/or other related legislation

will be invited to be trained and become Operators

➔Please add information from country profile report

Chapter 4 Brief overview of child maltreatment prevention & child protection

4.1 Roles and responsibilities

4.2 Agencies mandated with the recording of child maltreatment

4.2.1 Creating synergies: Who could participate in the CAN-MDS? Core and extended national CAN-MDS groups

4.3 Available infrastructures and resources

➔add as much slides as necessary

Concerning the criterion of "participation", all necessary steps were followed for ensuring the optimum participation in regards to the data sources. Specific eligibility criteria were posed for involving professional groups and sectors –mainly as data sources in a potential CAN-MDS. A basic eligibility criterion is for any potential operators to be subjected in a professional code of ethics or other related legislation.

Specifically [please add country specific information]

Slide 12

Fundamental questions about surveillance systems
stigmatization, privacy and informed consent

Stigmatization Some indicators, when cross-referenced with social and demographic data that identify certain vulnerable sub-groups of the population and that are available for fairly small geographic units, may contribute to the stigmatization of these sub-groups by reinforcing certain prejudices.

Privacy: Privacy is the fundamental concern of surveillance authorities not to disclose information that could be used to identify individuals, households, or communities, depending on the kinds of characteristics on which data are being disseminated.

Informed consent Medical administrative data are usually anonymized before being put to secondary use for surveillance purposes. But this is not always the case, particularly in projects attempting to monitor problems of comorbidity and multimorbidity. In such cases, consent to secondary use of data might pose problems, because it might not be possible to give this consent at the time that the data are collected.

- **Provisions against stigmatization**
  - Data sources providing services to the whole population (not specific subgroups) (see also representativeness & equity)
  - Use of pseudo-anonymization for avoiding identification –and subsequently- stigmatization of children
- **National rules and legislation for ensuring privacy of personal data**
- **Informed consent**
- public health surveillance by necessity often occurs without explicit consent on behalf of the subject of the data (here maltreated children, children at risk and their caregivers)
- data elements collected without consent must represent the minimal necessary interference, lead to effective public health action, and be maintained securely
  - CAN-MDS content & data collection procedures

Although CAN has been recongized as a major bublic health problem, it occurs however in every country across all social, cultural, religious and ethnic population-groups, resulting in immediate and longterm social, health and financial consequences. Despite the importance of the problem, accurate estimates of its extent and characteristics in the general population are difficult to achieve. One main reson is the silence that surrounds maltreatment cases because of shame, social stigma and the consequent criminal liability leading to CAN underreporting.

Measures against stigmatization at population and individual level are respectively the inclusion in the data sources of sectors, agencies and professionals providing services to the general population of children (and not only to specific subgroups) and at the same time the exclusion of variables related to ethnotic, socio-economic or other related information indicating a specific sub-group of population; at an individual level, the adoption of pseudoanymization prohibiting the identification of subjects of data.

National rules and legislation are also taken into account for ensuring privacy of personal data with a special emphasis to computerized data.

As for the informed consent, public health surveillance by necessity often occurs without explicit consent on behalf of the subject of the data (here maltreated children, children at risk and caregivers). Public health surveillance ethics suggests that data elements collected without consent must represent the minimal necessary interference, lead to effective public health action, and be maintained securely. As it is also mentioned, the core of the suggested surveillance system is a minimum data set.

Slide 13

Country Legislation

- Please add information on the basis of the Country Profile Report, chapter

3 Legal framework

3.1 Legislation, policies and mandates for reporting and recording of CAN cases in different professional fields

3.2 Legal provisions for administration of sensitive personal data

- [*the report will be also provided to trainees-future CAN-MDS SS operators as further reading*]

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Concerning the criterion of privacy

[please add country specific information]

✓e.g. for Greece (given that a potential CAN-MDS surveillance system can be considered as a "personal data file"), it should be taken into account the related provisions according to the Law 2472/1997 [articles 4-14] and especially the "controller's" (namely the administrator's) obligations, as they summarized below:

✓To collect personal data in a legal and convenient way

✓To elaborate only these personal data that are necessary for the set aims

✓To take care in order the data to be precise and updated

✓To maintain the data only for the time period that is required for the fulfillment of the aims of data collection and processing

✓To recruit for data processing appropriate personnel in terms of professional qualification that guarantee technical sufficiency and personal integrity to ensure confidentiality

✓To undertake appropriate organizational and technical measures for the security of the data and their protection against accidental or unfair destruction, accidental loss, falsification, unauthorized disclosure or access and any other form of unlawful processing.

✓In case that the data processing is carried out of a person on behalf of the Controller but not dependent upon him/her, the relevant assignment should be made in written.

✓To respect the rights of the subjects of data such as information, access and objection.

✓To be consistent with its obligations towards the Authority (early notification, get the needed permission).

✓To be informed in regards to Authority's decisions, directives and recommendations that may concern him.

Slide 14

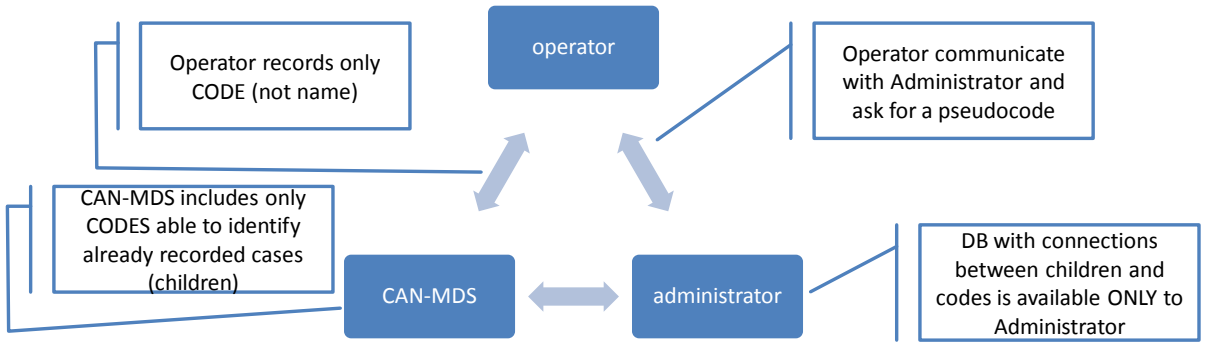
Country Legislation

Add as more slides as necessary for providing the information

Slide 15

Ethical issues related to usage of computerised data

- Ensuring the privacy of data
  - following all national and EU legal provisions concerning administration of sensitive personal data
    - the respective information is already available in National Country Profiles
  - Adoption of a *pseudoanymization* procedure



The usage of computerized data is also related to the criteria of privacy and avoidance of stigmatization. In the context of CAN-MDS the adoption of a *pseudoanymyzation procedure* is suggested, as presented in the slide.

Slide 16

Consent-related issues

- public health surveillance, such as regarding the issue of child maltreatment, by necessity often occurs without explicit consent on behalf of the subject of the data (here maltreated children, children at risk and their caregivers),
  - data elements collected without consent must represent the minimal necessary interference, lead to effective public health action, and be maintained securely
- For infectious diseases, for example, there is strong legal and scientific support for maintaining name-based reporting; the same is also valid for other types of public health surveillance
  - however, overriding individual autonomy must be justified in terms of the obligation of public health to improve population health, reduce inequities, attend to the health of vulnerable and systematically disadvantaged persons, and prevent harm (Lee et al., 2012)
- In the case of CAN, recommendations to countries by WHO, the UN Committee and other authorities stress the necessity for data collection
  - "Public health: Ethical Issues" report (UK Nuffield Council of Bioethics, 2007)
    - public health agencies collect and analyze significant identifiable health data from multiple sources to perform an array of public health activities including surveillance, epidemiological investigations, and evaluation and monitoring. Concerning collection and use of surveillance data and consent, it is mentioned in paragraph 4.40 that *"in some circumstances it may be necessary to collect surveillance data in a non-anonymised way, but provided adequate systems are in place to ensure confidentiality of the collected data, it may be justifiable to collect such data without consent. We are aware of several examples of surveillance policies in which consent requirements have had, or could have had, serious negative consequences for the surveillance in question"*
    - Although this notion is mainly related to surveillance of infectious diseases, it should be considered whether it could also be valid for the surveillance of CAN

Concerning the informed-consent criterion, the same issues are valid for the CAN-MDS as for the public health surveillance. To this end, a minimum data set was opted instead of other alternative way for collecting data for individual cases, as discussed before.

Some more information for the MDS is presented in the following slide.

Slide 17

Fundamental questions about surveillance systems

CAN-MDS Surveillance System

- **What are the means?**

Child Abuse and Neglect Minimum Data Set:

➔ALL variables considered as non-ethical for any reason even in one only country were excluded (partners evaluation)

➔ONLY variables considered as of sufficient quality, relevant, useful, understandable and accessible are included (partners evaluation)

➔ALL variables considered as non-feasible to be used were excluded (experts' evaluation)

➔ONLY variables requiring readily available data, considered as valid and reliable, ensuring confidentiality and timeliness and considered as cost-effective are included (experts' evaluation)

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A core element of a surveillance system directly related to ethical issues is the means and the procedures used for data collection. This is also related to the issue of the informed consent.
During the development of the CAN-MDS all necessary provisions taken into account toward the creation of a tool respecting the public health ethical principles, including the confidentiality and the protection of subjects' personal data. Additionally, the data to be collected should be useful, relevant, understandable, valid and reliable and readily available and easily accessed by the maximum number of users as possible.

Specifically

➔ ALL variables which were considered as non-ethical for any reason even in one only country were excluded (partners evaluation)

➔ ONLY variables considered as of sufficient quality, relevant, useful, understandable and accessible are included (partners evaluation)

➔ ALL variables considered as non-feasible to be used were excluded (experts' evaluation)

➔ ONLY variables requiring readily available data, considered as valid and reliable, ensuring confidentiality and timeliness and considered as cost-effective are included (experts' evaluation)

Lastly, no variables-identifiers are included in the MDS.

Slide 18

Fundamental questions about surveillance systems

CAN-MDS Surveillance System

- **What are the procedure?**

➔A child maltreatment incident record in the CAN-MDS Surveillance System will be made

- **In case of referral from an external source**
  - The MDS is filled in on the basis of information provided by the person-*source of information* and on the basis of questions asked by the Operators for identifying further information
- **In case of disclosure by a child**
  - The MDS is filled in on the basis of information the child provide; further questions can be asked ONLY from professionals trained to interview children; in any other case full information is completed from the appropriate professional during the case investigation
- **In case the Operator suspects maltreatment** (e.g. via screening)
  - The MDS is filled in on the basis of the information provided by the child AND the signs the trained professional observe. Further questions can be asked ONLY from professionals trained to interview children; in any other case full information is completed from the appropriate professional during the case investigation

In all above conditions, the person providing the information (*source of information*) is informed by the Operator about the recording of incident in CAN-MDS

Moreover, information for an incident of child maltreatment can be extracted from related reports

As for the procedure for the data collection, in all conditions the person providing the information (referral, source of information) is informed by the operator about the recording of the information on the CAN-MDS.

Part 6	Building of Expanded Groups of CAN-MDS Operators	
OUTLINE	*estimated duration*	30 minutes - 20 minutes for presentation - 10 minutes for discussion
	learning objectives	at the end of part 6 trainees should be aware on - the importance of the expanded groups of CAN-MDS future operators - the methodology followed for the definition of eligibility criteria for CAN-MDS operators - the eligibility criteria forbuilding expanded groups of CAN-MDS future operators - their role in building expanded groups of CAN-MDS operators and train them
	instructions to trainers	- review the learning objectives of Part 6 - rehearse with slide presentation Part 6 - read the report *"Eligibility criteria for CAN-MDS Operators' Core Groups and Expanded Groups" (optionally)* - discuss with trainees whether the process of building national groups is clear
	activity	- *NA*
	training resources	- Presentation "Part 6"
	tips to trainers	- If you have no enough time available, you may skip slides 11-16 (related to gradiation of levels of access in a CAN-MDS surveillance system) *NOTE: This part is applicable only for the core-group workshops (not for the expanded groups)*

Part 6 – Presentation (please, adapt the slides where necessary)

Slide 1

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Place_____
Date _____

Building of Expanded Groups of CAN-MDS Operators

Workshop of Core-Group of CAN-MDS Operators

Your logo

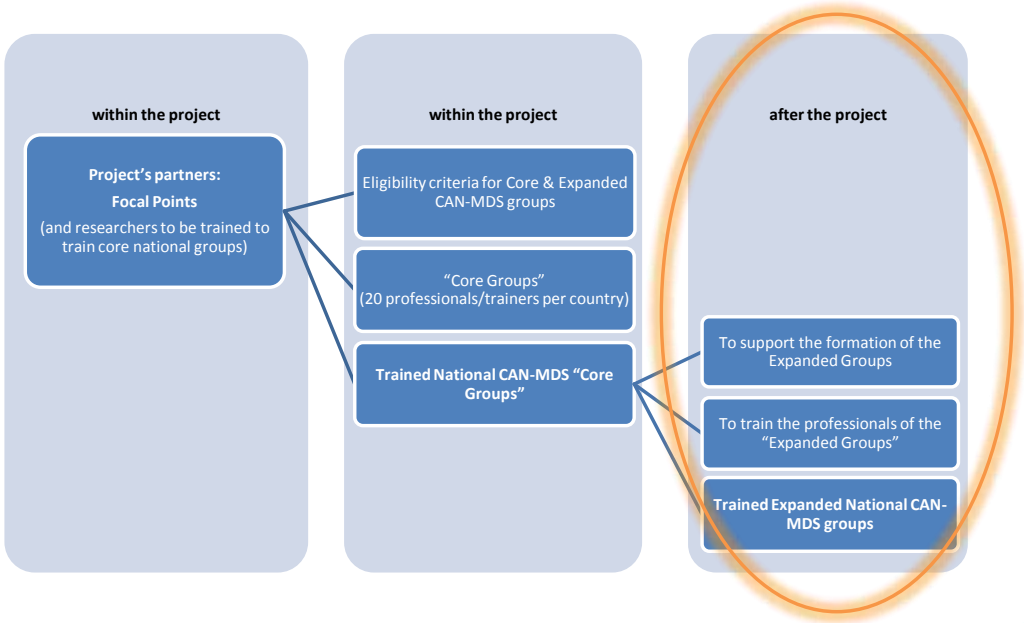
daphne With financial support from the EU DAPHNE Programme

Up to now, apart from the content of the CAN-MDS, you have also received information related to necessity for CAN surveillance, on what the CAN-MDS is and which is going to be your role as members of the national core-group.
Specifically, as it was discussed in t the second part of this training in regards to the role of Core-Group members, first among their main tasks is to act as multipliers for implementing activities related to capacity building and specifically to create Expanded Groups of CAN-MDS future Operators (if and when needed) following the eligibility criteria resulted from the respective study.
In this part of the workshop we will discuss how each member of the core group could build expanded groups of CAN-MDS future operators, which is a core step for establishing a CAN-MDS surveillance system.

Slide 2

Expanded Core Groups of Operators

- Size per group: ~20 professionals



Let's have an overview of the procedure followed in the context of the project for the implementation of activities aim to build the capacity of eligible professionals to be involved in the CAN-MDS

- *as focal points (developers and potential administrators of a CAN-MDS surveillance system and trainers of national core groups),*
- *as core-group members (trainers of national groups of operators -multipliers- and future operators) and*
- *as expanded group members (future operators of CAN-MDS Surveillance System).*

Following the cascade process

- *one group (of national focal points derived from seven countries) was participated in a train-of-trainers seminar (within the project)*
- *trained focal point s undertake the task to train their national 20 person-core groups of CAN-MDS operators (as this group) in each of the 7 countries following a uniform methodology (within the project)*
- *each of the ~140 trained professionals (20 per country) will be able to conduct similar trainings to one or more groups of 20 professionals) in order for them to become operators of a CAN-MDS surveillance system in the future, in case that such a system will be implemented.*

In each step the same criteria are used for the identification of eligible professionals to be involved in a CAN-MDS surveillance system and, therefore, to participate in the respective trainings

Slide 3

Criteria for identifying eligible stakeholders

- **Deriving from relevant fields-data sources**

- **Belonging to an eligible professional group working in one of the relevant fields**
  - having a valid professional license (social worker/ medical doctor/ nurse/ health visitor/ pediatrician/ psychologist/ teacher/ justice officer) or being certified professionals (e.g. police officer)
  - being subjected to a professional code of ethics or a similar condition, depending on the profession
  - being active (not pensioners/ students)
  - working in an organization/agency and participating as representatives on behalf of their agencies

- **According to the responsibilities of each eligible professionals' group a decision has been made on:**
  - their level of access they will have as operators in a potential CAN-MDS system and
  - whether they should be represented in the Core, Expanded or both groups (given the limited number of participants in the core groups)

In this slide the prerequisites for considering the involvement of a professional in the CAN-MDS (core and/or expanded group) are listed. Specifically:

The professional should
- *derive from a relevant field-data source*
- *belong to an eligible professional group working in one of the relevant fields*

AND
- *have a valid professional license (social worker/ medical doctor/ nurse/ health visitor/ pediatrician/ psychologist/ teacher/ justice officer) or being certified professionals (e.g. police officer)*
- *subjected to a professional code of ethics or a similar condition, depending on the profession*
- *be active (not pensioner/ student)*
- *work in an organization/agency and participate as representative on behalf of his/her agency (not as free launcher)*

Given that the above prerequisites are satisfied, according to his/her responsibilities in administration of CAN cases a decision will be made on his/her level of access s/he will have as operator in a potential CAN-MDS system

Slide 4

How the eligibility criteria were defined

- **Identification of potential sources of data for a CAN-MDS Surveillance System**
- A **5-step methodology** was developed to define the eligibility criteria for CAN-MDS Core & Expanded Groups of Operators:

DEFINING ELIGIBILITY CRITERIA FOR CAN-MDS DATA SOURCES & GROUPS OF OPERATORS	
Step A	Identification of relevant fields to be involved in a future CAN-MDS system as data sources
Step B	Identification of eligible professionals to be invited as potential operators of a CAN-MDS system per working field
Step C	Identification of responsibilities of each eligible professionals' group and suggested involvement (core group, expanded group, both groups)
Step D	Decision for level of access of eligible professionals to be included in the expanded groups of operators in a future CAN-MDS according to their responsibilities for the administration of CAN cases
Step E	Suggestions for potential Agencies/Organizations to undertake the role of the "Administrator" of a future national CAN-MDS system

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Here is an overview of the methodology followed for defining the eligibility criteria for CAN-MDS Groups of Operators and agencies-data sources.
First, all fields relevant to administration of CAN cases and therefore eligible to be involved in a future CAN-MDS system as data sources were identified and recorded in 9 countries.
Next, all professionals working in the selected fields and eligible to be invited as potential operators of a CAN-MDS system per country were identified and recorded.
In the third step, the responsibilities of each eligible professionals' group were identified and recorded. It is noted, however, that this step was applied only for professionals which are subjected in professional ethical codes or similar legislation were considered for inclusion in the core and expanded groups of operators.
At the fourth step, a decision for level of access of eligible professionals-trained operators in a future CAN-MDS according to their responsibilities for the administration of CAN cases were made; this step is however out of the scope of the current workshop and will be further discussed.
Lastly, country representatives participating in this process were also asked to suggest Agencies/Organizations to undertake the role of "Administrator" of a future national CAN-MDS System.

If you are interested for further information on this procedure, you can read the document "Eligibility criteria for CAN-MDS Operators"

Slide 5

Identification of potential sources of data for a CAN-MDS Surveillance System

Respondents

- Van Puyenbroeck, B. Child and Family Agency, **BELGIUM**
- Stancheva-Popkostandinova, V. South-West University "Neofit Rilski" (SWU), **BULGARIA**
- Seraphin, G. and Bolter, F. National Observatory of Children in Danger (ONED), **FRANCE**
- Goldbeck, L. and Witt, A. University Ulm, Dept of Child and Adolescent Psychiatry/Psychotherapy, **GERMANY**
- Stavrianaki, M., Ntinapogias, A. and Nikolaidis, G. ICH, Dept of Mental Health and Social Welfare, **GREECE**
- Mamini, S. and Bianchi, D. Istituto degli Innocenti, **ITALY**
- Roth, M., Antal, I. and Tonk, G. Babes-Bolyai University, Dept. of Social Work (BBU), **ROMANIA**
- Jud, A. Lucerne University of Applied Sciences & Arts, School of Social Work, **SWITZERLAND**
- Castellanos Delgado, J. L. and Solis de Ovando, R. Ministerio de Sanidad, Servicios Sociales e Igualdad, **SPAIN**

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For your information, here are listed
-The countries participated in the procedure
-The professionals provided information and the agencies they are working

Slide 6

Eligible fields relevant to CAN cases to be used as data sources for a CAN-MDS Surveillance system

Fields related to CAN-cases administration	Eligible field	Non-eligible field
CPS/ Social Welfare Services	BE-BG-CH-DE-ES-FR-GR-IT-RO	Core data sources
Physical Health Care Services (primary, secondary & tertiary)	BE-BG-CH-DE-ES-FR-GR-IT-RO	
Judicial Services	BE-BG-CH-DE-ES-FR-GR-IT-RO	
Accredited NGOs/ Community Organizations	BE-BG-CH-DE-FR-GR-IT-RO	Expanded data sources
Mental Health Services	BE-BG-DE-FR-GR-IT-RO-ES	
Law Enforcement related Services	BE-BG-CH-ES-FR-GR-IT-RO	
Educational Services (preschool, primary & secondary)	BE-BG-DE-ES-FR-GR-RO	
Already existing registries/monitoring mechanisms	BE-BG-DE-ES-FR-RO	
Research Organizations/ Institutions	BE-BG-DE-FR	To be considered for inclusion
Independent Authorities (such as Child Ombudsman)	BE-FR-GR	
Other	BE-ES-RO	

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Before we proceed with the results of the above mentioned "survey", it should be noted that these results are indicative rather than definite. By using the same methodology and tools in additional countries or in the same countries after a time period, these results can be modified.

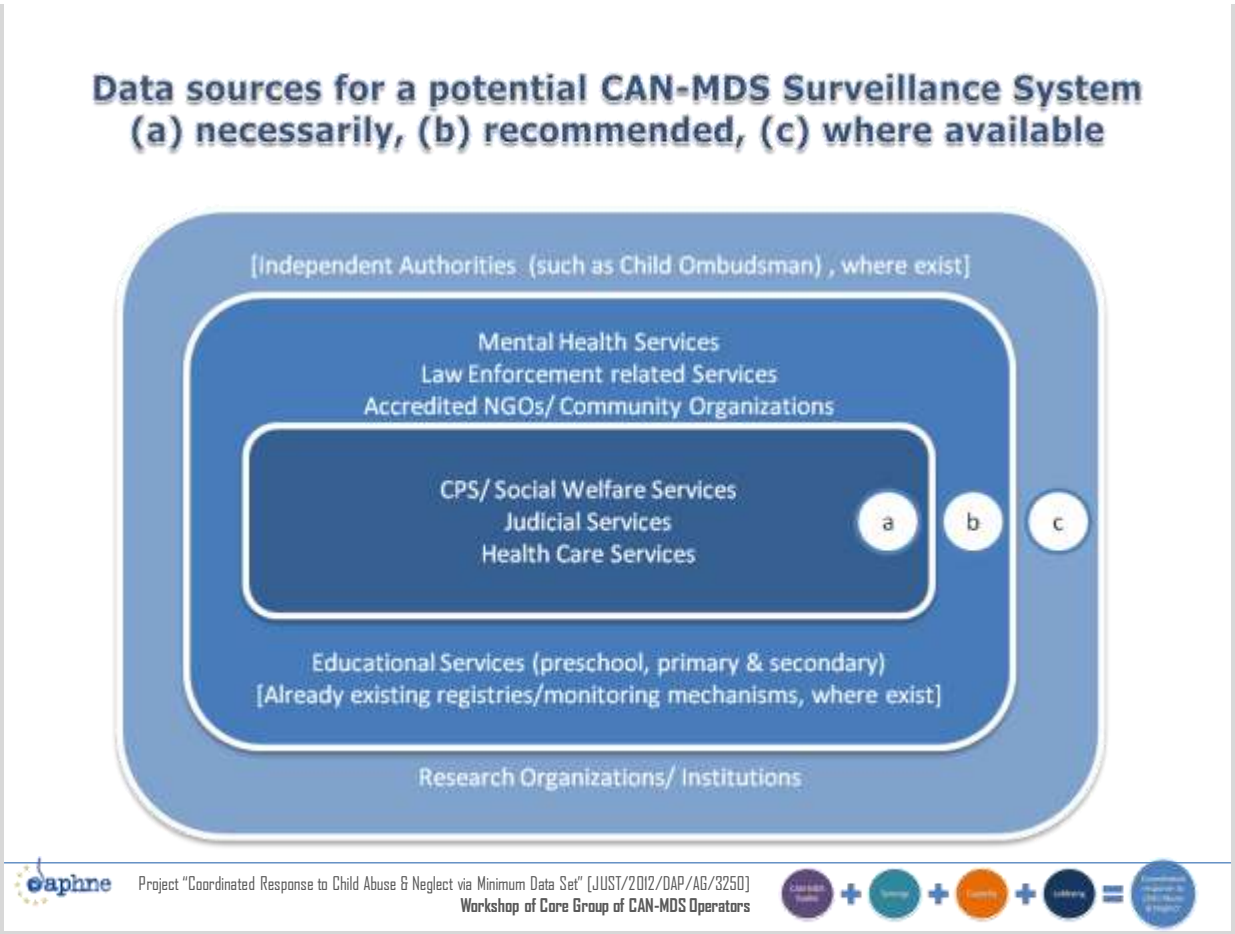
Here the eligible fields relevant to CAN cases to be used as data sources for a CAN-MDS Surveillance system are presented. Some fields were common in all countries (9/9), other fields in most of the countries (at least 7 out of the 9) and other in a restricted number of countries (ranging from 1 to 6 out of the 9 countries).

Child protection system or social welfare services, Health care services and Judicial services belong to first group of data-sources for a potential CAN-MDS system. These fields should be represented in both, the core and the expanded groups of operators, if feasible with at least two representatives per field.

Accredited NGOs, Mental health services, Law enforcement related services, education-related services and already existing registries should also being represented with at least one (or even more) representative in national core group and in expanded groups accordingly.

Research organizations, Independent authorities and other relevant organizations can be represented in both groups, according to country specifics.

Slide 7



This figure depicts graphically the data sources for a potential CAN-MDS Surveillance System
(a) In the center the core data sources are presented which should necessarily being involved in the core and expanded groups and therefore in the trainings
(b) Next, the expanded data sources are presented which are recommended to being represented in both groups and trainings
(c) Eventually, in the periphery the fields-data sources are presented to be involved in both groups –and the trainings- according to their presence in the various countries.

Slide 8

Fields should be represented in national core groups

- Core data sources for a CAN-MDS Surveillance System
  - CPS/ Social Welfare Services
  - Health Care Services (primary, secondary & tertiary)
  - Judicial Services
- sectors that could also be among the main data sources (common in at least 7 out of the 9 countries)
  - Mental Health Services
  - Accredited NGOs/ Community Organizations
  - Law Enforcement related Services
  - Educational Services (preschool, primary & secondary)
  - Already existing registries/monitoring mechanisms *(not available in all countries)*
- sectors that would probably be difficult to be included as data sources because their involvement seems to be more as a country specific attribute rather than a common practice among countries
  - Independent Authorities (such as Child Ombudsman)
  - Research Organizations/ Institutions
  - Other fields

Here the same information is presented in text

Slide 9

Grouping of eligible professionals' groups per sector or "working field"

Welfare related professions: Social Workers, Health Visitors, Care providers in institutions, other personnel (e.g. working in antitrafficking agencies, directorates for disability, Child Ombudsman etc.)

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

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

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

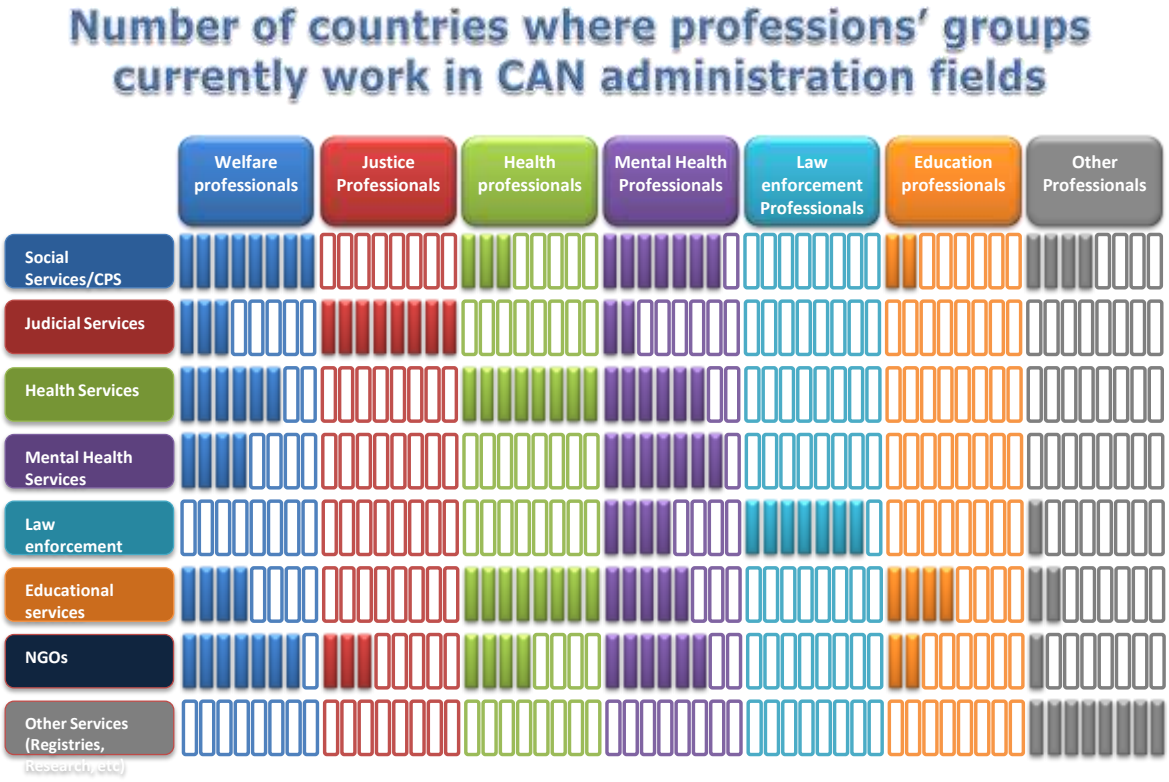
Law enforcement related professions: Police Officers (in general and specialized police investigators e.g. in forensic interviews, for crimes against minors etc.)

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

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

However, not all professionals working in the previously mentioned sectors are involved in the administration of CAN cases, neither the same professionals' groups are working in the same sectors in all countries, while professionals with the same background are working to more than one sectors.
To this end, the eligible frontline professionals (namely which that are involved in CAN cases' administration per sector) were recorded, grouped (on the basis of the results from all countries) and presented per sector or "working field".

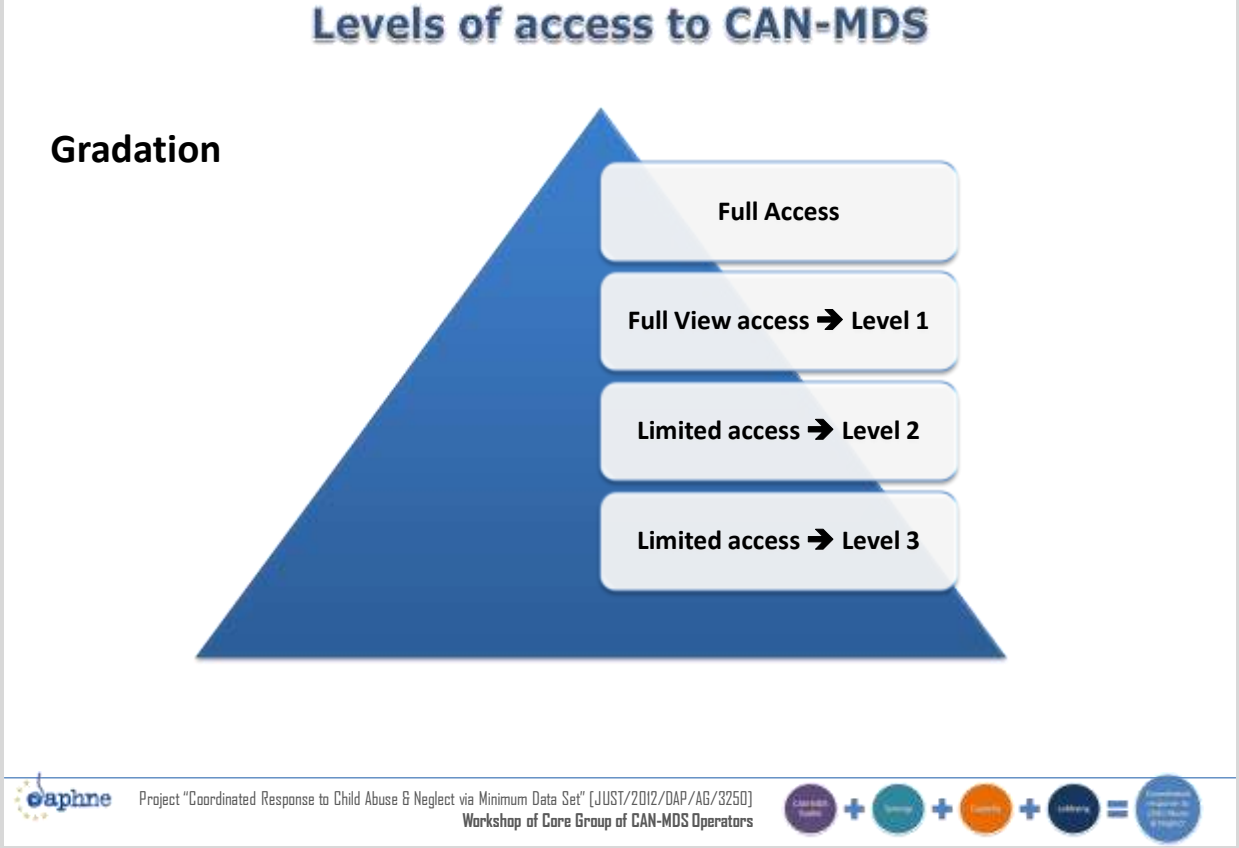
Slide 10



As it was expected, some professionals are working in multiple fields (such as the mental health professionals and the welfare professionals) while others (e.g. police officers) are working only in law-enforcement related services. On the other hand, in some sectors multiple professional groups are involved (such as in accredited community organizations and education related services) while in others only specific professional groups are working (such as the law enforcement related services and existing registries).

In the figure is presented the number of countries where a specific professional group is identified in each of the relevant sectors.

Slide 11



A 4-level accessibility for operators is suggested to be used in a future CAN-MDS surveillance system: Considering all potential stakeholders involved in a CAN-MDS system are represented in this pyramid, the more restricted access (level 3) is the basis of the pyramid while full access (namely the CAN-MDS administrator) in the top.

Even professionals with similar background have different responsibilities in regards to CAN cases administration depending on the sector they are working. This information is important in the context of the CAN-MDS in order a decision to be made for the level of access to be graded per case (which will be based in the combination of the responsibilities of a professional group in a given sector).

Slide 12

Assignment of Responsibilities to different level of access of a potential CAN-MDS System

Responsibilities	Level of access
System Administrator	**Full Access**
- Making decision on whether sufficient evidence exists to prosecute (alleged) offenders	**Full View access (level 1)**
- Conducting initial assessments for suspected CAN cases - Providing services to CAN victims (diagnostic/ treatment/ consultation/ care) - Providing services to CAN victims' families (supporting) - Following-up of CAN cases	**Limited access (level 2)**
- Notifying (optionally) authorities of (suspected) CAN cases - Reporting mandatorily (suspected) CAN cases - Applying screening in the general child population for CAN - Providing emergency protective measures to CAN victims - Providing legal advice/ consultation/ advocacy for CAN cases	**Limited access (level 3)**
- No administration-Making referrals to other services for ALL cases - Professionals not subjected to a code of ethics or related national legislation	**No access**

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In this slide the assignment of responsibilities to different level of access of a potential CAN-MDS System is presented. Each professional depending of his/her responsibility will be graded with a different level of access.
For example, the system administrator will have full access, professionals working in authorities who make the decision whether sufficient evidence exists to prosecute alleged perpetrators will be graded with full view access (in order to use the information available in the system), professionals conducting initial assessments, following-up the cases etc. will be graded with limited access level 2 (namely they will have the right to receive available information for specific cases) while professionals which are involved only for reporting cases or providing emergency protective measures will be graded with limited access level 3 (namely only to provide information on the system –data base feeders). Professionals not subjected to a code of ethics or refer all cases they identify to other services will have no access at all in the system.

Slide 13

Definition of operations per level of access

Responsibilities	Level of access	Attributes & *"rights"* of the level of access
System Administrator	**Full Access**	enters data WITH access to ALL data, aggregated AND disaggregated (at case-level) (view/ edit/ delete) and to users' accounts create/edit/delete)
- Making decision on whether sufficient evidence exists to prosecute (alleged) offenders	**Full View access (level 1)**	enters data WITH view access to ALL data, aggregated AND disaggregated (at case-level) (view/ edit/ delete) and to users' accounts (view)
- Conducting initial assessments for suspected CAN cases - Providing services to CAN victims (diagnostic/ treatment/ consultation/ care) - Providing services to CAN victims' families (supporting) - Following-up of CAN cases	**Limited access (level 2)**	enters data WITH access to data entered by the same user (view/ edit/delete) AND to data entered by other users for the same case (view)
- Notifying (optionally) authorities of (suspected) CAN cases - Reporting mandatorily (suspected) CAN cases - Applying screening in the general child population for CAN - Providing emergency protective measures to CAN victims - Providing legal advice/ consultation/ advocacy for CAN cases	**Limited access (level 3)**	enters data WITH access ONLY to data entered by the specific user (view/edit/delete)]
- No administration-Making referrals to other services for ALL cases - Professionals not subjected to a code of ethics or related national legislation	**No access**	no *"rights"*

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In the right column the "rights" of operators graded in each level of access are presented.

Slide 14

Full View Access (Level 1)

(with the responsibility "making decision on whether sufficient evidence exists to prosecute alleged offenders")

Necessary data sources & Eligible Professionals ≥ 2 professionals (in a 20 person group)	Recommended data sources & Eligible Professionals Where applicable ≥ 2 professionals (in a 20 person group)
♦ Public Prosecutors working in Judicial Services	♦ Social Workers working in Child Protection System/Social Welfare Services

In core group, sectors and professionals that will be graded with full view access should necessarily represented (it is suggested to invite at least two professionals per category).

Slide 15

Limited Access (Level 2)

(with at least one responsibility corresponding in level 2)

Necessary data sources & Eligible Professionals ≥ 1 professionals (in a 20 person group)	Recommended data sources & Eligible Professionals Where applicable ≥ 1 professionals (in a 20 person group)
♦ Social Workers working in Child Protection System/Social Welfare Services ♦ Social Workers working in Accredited NGOs/ Community Organizations ♦ Child Psychiatrists working in Health Care Services ♦ Child Psychiatrists working in Mental Health Services ♦ Psychologists working in Child Protection/Social Welfare Services ♦ Psychologists working in Health Care Services ♦ Psychologists working in Mental Health Services ♦ Pediatricians working in Health Care Services ♦ Medical Doctors (different specialties, e.g. orthopedists, radiologists) working in Health Care Services ♦ Police Officers working in Law Enforcement-related Services	♦ Mental Health Professionals *(psychologists, psychiatrists)* working in Law Enforcement related services ♦ Licensed Counselors working in CPS/Social Welfare Services ♦ Licensed Counselors working in Mental Health Services ♦ Judges working in Judicial Services ♦ Gynecologists working in Health Care Services ♦ Nurses working in CPS/Social Welfare Services ♦ Midwives working in CPS/Social Welfare Services ♦ Data administrators working in available related registries

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Moreover, is recommended at least one representative per professional group that will be graded with access level 2 to be included in the group.

Slide 16

Limited Access (Level 3)

(with at least one responsibility corresponding in level 3)

Necessary data sources & Eligible Professionals **≥ 1 professionals** (in a 20 person group)	Recommended data sources & Eligible Professionals **Where applicable** **≥ 1 professionals** (in a 20 person group)
♦ Social Workers working in Health Care Services ♦ Mental Health Professionals *(psychologists, psychiatrists, licensed counselors)* working in Accredited NGOs/Community Organizations	♦ Social Workers working in Education Services ♦ Social Workers working in Mental Health Services ♦ Care Providers in Institutions working in Child Protection System/ Social Welfare Services ♦ Psychologists working in Educational Services ♦ Licensed Counselors working in Educational Services ♦ Probation Officers working in Judicial Services ♦ Other Justice-related professions working in Judicial Services ♦ Nurses working in Accredited NGOs/Community Organizations ♦ Teachers/educators (pre-school, kindergarten, primary and secondary education, for children with special needs, school principals) working in Educational services ♦ Other personnel working in antitrafficking, directorate for disability, Child Ombudsman, etc.) working in Independent Authorities

The same is valid also for professionals will be graded with access level 3 (this category of data sources is as important as the remaining categories, given that these operators will act as feeders of the data base); at least one representative per category should be included in the group.

Slide 17

Summarizing: while in a 20-professionals *core group* of future CAN-MDS operators is suggested to participate…

≥ 2 professionals per category

- Public Prosecutor working in Judicial Services
- Social Worker working in Child Protection System/Social Welfare Services

AND

≥ 1 professionals per category

- Social Workers working in Accredited NGOs/ Community Organizations
- Child Psychiatrists working in Health Care Services
- Child Psychiatrists working in Mental Health Services
- Psychologists working in Child Protection/Social Welfare Services
- Psychologists working in Health Care Services
- Psychologists working in Mental Health Services
- Pediatricians working in Health Care Services
- Medical Doctors (different specialties, e.g. orthopedists, radiologists) working in Health Care Services
- Police Officers working in Law Enforcement-related Services
- Social Workers working in Health Care Services
- Mental Health Professionals *(psychologists, psychiatrists, licensed counselors)* working in Accredited NGOs/Community Organizations

AND

≥ 1 professionals per category, where applicable

- Mental Health Professionals *(psychologists, psychiatrists)* working in Law Enforcement related services
- Licensed Counselors working in CPS/Social Welfare Services
- Licensed Counselors working in Mental Health Services
- Judges working in Judicial Services
- Gynecologists working in Health Care Services
- Nurses working in CPS/Social Welfare Services
- Midwives working in CPS/Social Welfare Services
- Data administrators working in available related registries
- Social Workers working in Education Services
- Social Workers working in Mental Health Services
- Care Providers in Institutions working in Child Protection System/ Social Welfare Services
- Psychologists working in Educational Services
- Licensed Counselors working in Educational Services
- Probation Officers working in Judicial Services
- Other Justice-related professions working in Judicial Services
- Nurses working in Accredited NGOs/Community Organizations
- Teachers/educators (pre-school, kindergarten, primary and secondary education, for children with special needs, school principals) working in Educational services
- Other personnel working in antitrafficking, directorate for disability, Child Ombudsman, etc.) working in Independent Authorities

Summarizing: a 20-professionals CAN-MDS core group of CAN-MDS is suggested to include professionals representing all sectors AND professional groups

Slide 18

...a 20-professionals *expanded group* of future CAN-MDS operators can be formulated

- either as a ***mixed group*** (similar to core groups)
  - including eligible representatives from all sectors-data sources

- or as ***homogeneous*** group
  - including professionals with similar backgrounds and responsibilities
  - working in the same or different sectors

    (probably with similar characteristics as the *trainer)*

BUT satisfying the prerequisites and eligibility criteria

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An expanded group of future CAN-MDS operators however it is not necessary to be formulated as a mixed group, as the core-groups.
It could be consisted by professionals with similar backgrounds and responsibilities which are working in the same or different sectors. You, as members of the national core group may opt to create a group of professionals with characteristics similar to yours (e.g. professional background and/or sector) –always, however, satisfying the prerequisites and eligibility criteria.
Such an approach it could be probably more helpful for the implementation of the training of future CAN-MDS operators. Additionally, in case that a CAN-MDS system is going to be implemented, members of core-group in cooperation with the national focal point (or the administrator, if different than the focal point), can coordinate themselves in order to undertake the training of homogeneous expanded groups in a way that eventually will include all eligible professionals and sectors-data sources.

Part 7	Planning the training of national CAN-MDS core groups	
OUTLINE	*estimated duration*	30 minutes - 15 minutes for presentation - 05 minutes for activity - 10 minutes for discussion
	learning objectives	inform trainees for the logistics of a training in order for them to know what are - the algorithm for preparing a training - the anticipated costs and how to prepare the budget for a training - the procedures for recruiting trainees
	instructions to trainers	- review the learning objectives of Part 7 - rehearse with slide presentation Part 7 - discuss with trainees *- whether they think that specific costs can be eliminated* *- [ideas for raising funds for implement CAN-MDS trainings]*
	activity	- *drafting a training's budget* - after the presentation, ask trainees to draft a training budget by filling-in the Handout 7.1
	training resources	- Presentation "Part 7" - Handout 7.1 - you may use as an example the budget calculated for the workshop implemented with the core-group of CAN-MDS (see Slide 6)
	tips to trainers	- Distribute Handout 7.1 to trainees (core-group members) when you present the 5th slide - If you have no enough time available, you may skip the activity and proceed to discussion immediately after the presentation

Part 7 – Presentation (please, adapt the slides where necessary)

Slide 1

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Place_____
Date _____

Planning the training of national CAN-MDS groups

Workshop of

Core-Group of CAN-MDS Operators

Your logo

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This is the last part of the workshop. At this point it is considered that all of you (namely the members of the core-group and future trainers of national groups) you have already the necessary information on what the CAN-MDS is, which is the necessity of CAN surveillance, and how to build national groups of future operators, in case that such a system will be implemented.

Slide 2

Outline

- Algorithm for planning a training

- Budget for trainings
  - Accommodation (room rental, coffee breaks, etc.)
  - Material (forms, questionnaires, etc.)
  - Fees (trainees, trainers)

Procedure (after identifying professionals)

- preparation of invitations *(Templates)*
  - *keep record for the invited professionals*

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This part of the workshop is dedicated to practical issues related to planning of a training that the person in charge for the training (potentially each one of you) should have in mind.
As it is shown in the outline, the issues to be discussed here are related to the process of planning a CAN-MDS workshop, to estimation of financial costs and to procedures for recruiting the participants.

It is noted that no specific suggestions for funds-raising are discussed, given that at this time no trainings for expanded groups of operators are provisioned. In case that a CAN-MDS surveillance mechanism will be initiated and eventually you will be asked to plan a training, a discussion concerning financial resources and logistics for the training can be made with your national "focal point" (namely the partner) and/or other stakeholders.

Slide 3

Algorithm for planning a training

- Once a member of the national Core-Group is prepared to deliver a training, s/he recommended to:
  - review the material and get acquainted with
    - the training process (see Trainers' Guide)and
    - technical characteristics of CAN-MDS and its usage
  - **verify the availability of necessary resources and that they will be sufficient to implement the training**
  - prepare and package the necessary material including
    - training agenda (see template)
    - powerpoint presentations (translated and adapted according to country specifics)
    - printed informational material (see informational leaflet and other handouts)
    - evaluation questionnaires (see pre- and post- questionnaires)
    - form of attendance (see template)
    - certificates of participation (see template)
  - communicate information to identified professionals

  and afterwards to
  - schedule the training
  - book and prepare training location

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An overview of the steps to be followed for planning a training (including trainer's preparation) is presented.
The material to be reviewed is detailed in the second part of the training module under the title "further reading".
For all of the material necessary for the training templates are available. You should, as the trainer in charge, to adapt the templates for the specific training and have them available during the training in adequate copies.
At the same time the trainer-responsible for the planning in cooperation with the national "focal point" should start the communication with the potential trainees and invite them to become members of the expanded groups of CAN-MDS operators.
Booking and preparation of the training room is the last step in the process. Do not forget that the necessary hardware for the training should be also available and tested.

Slide 4

Invitation for Professionals

- Template

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Considering the recruitment of the potential professionals, first contact is suggested to be made via formal written communication (i.e. an Invitation).
The invitation should inform in brief the recipient on the CAN-MDS and its aim and that s/he is among the professionals considered eligible to become members of expanded group of future CAN-MDS Operators.
Further information should be included on what decided about workshop's date, place, reimbursement as well as a deadline for recipient to express his/her interest.
[The template for the invitation will be drafted by CAN-MDS focal points, namely the project's local coordinators]

Slide 5

Estimation of necessary resources for one 1-day Training*20 Trainees

ACCOMODATION	**Room rental**	1*???=???€
	2 coffee breaks	2*20*???=???€
MATERIAL*	**folders, notepads, badges**	20*???=???€
	photocopies (material, questionnaires)	20*100*???=???€
FEES	**trainees' fees**	20*???=???€
	trainers' fees	2*???=???€
	Total costs	€

** Specific material (such as CDs including the CAN-MDS Toolkit, Informational Leaflet) will be provided to Core-Groups members by national focal points*

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Concerning the anticipated costs to be calculated for a 1-day workshop involving 20 trainees and 2 trainers, the suggested budget headings to be taken into account are related to 1. Accommodation and refreshments, 2. Material (including printing costs) and 3. Fees (for trainers and trainees).
It is noted that specific material (such as USB/DVD/CDs including the CAN-MDS Toolkit and Informational Leaflet) will be provided to Core-Groups members by national focal points.

Activity

➔Distribute the Handout 7.1 to trainees
➔**Instructions**
Let's try to draft a budget for a potential training. You have 5 minutes to fill-in the table. At the end of the session we will have the opportunity to discuss on the budgets you drafted

Discussion of Activity 7-1, Slide 6

Training of National CAN-MDS Group

Provisioned budget	1-day Workshop * 20 trainees per country * 7 countries						
	ACCOMODATION		MATERIAL		FEES		
Country	Room rental	2 coffee breaks	folders, notepads, badges	photocopies (material, questionnaires)	trainees' fees	trainers' fees	Total costs
Belgium	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€
Bulgaria	1*300=300€	2*20*4=160€	20*4=80€	20*100*0,1=200€	20*50=1000€	2*250=500€	2240€
Germany	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€
Greece	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€
France	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€
Italy	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€
Romania	1*350=350€	2*20*6=240€	20*4=80€	20*100*0,1=200€	20*100=2000€	2*250=500€	3370€

For the estimation of the cost of the today's workshop (1 group of 20 professionals), the following amounts were provisioned in the context of the project.

Issues for discussion

- *How close is the budget you drafted with the one we used?*
- *Do you think that some of the costs could be eliminated?*
- *Any ideas for raising funds for implement CAN-MDS trainings?*
- *Other comments?*
-

End of Part 7

In this session we saw some practical aspects related to planning of a training for professionals on CAN-MDS as future operators.
Is there anything you would like to clarify or discuss further?

Thank you!

Handout 7.1

Estimation of necessary resources for one 1-day Training*20 Trainees

Name of Trainee: _____

Specialty/Agency: _____

_____

Budget Heading	Specific cost categories	Calculation
ACCOMODATION	**Room rental**	1 * _____=_____€
	2 coffee breaks	2 * 20 * _____=_____€
MATERIAL*	**folders, notepads, badges**	20 * _____=_____€
	photocopies (material, questionnaires)	20 * 100 * _____=_____€
FEES	**trainees' fees**	20 * _____=_____€
	trainers' fees	2 * _____=_____€
	Total costs	_____ €

** Please note that specific material (such as CDs including the CAN-MDS Toolkit, Informational Leaflet) are already available and will be provided to Core-Groups members by national focal points*

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[WS.4, Activity 7: D6: CAN-MDS Trainer’s Manual]

CAN-MDS Trainer’s Manual

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ISBN: 978-960-9766-14-2