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

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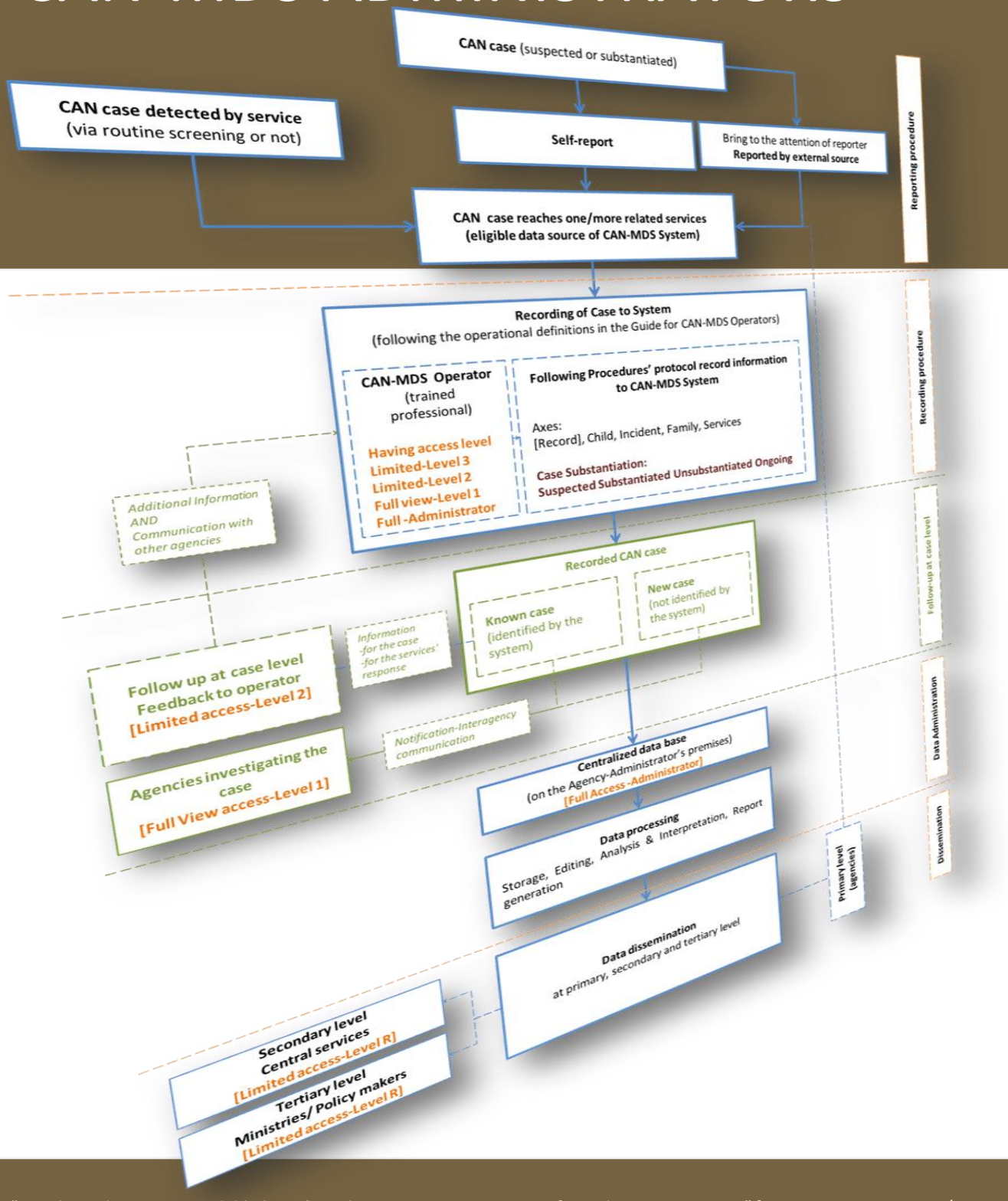
# D3.2 EVALUATION OF TRAINING OF NATIONAL CAN-MDS ADMINISTRATORS




CAN-MDS Toolkit
Synergy
Capacity
Lobbying
Coordinated response to Child Abuse & Neglect

## Action's Identity

| | |
|---|---|
| **Title** | Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice* (CAN-MDS II) |
| **Grant agreement No.** | 810508 |
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## Deliverable's Information

| | |
|---|---|
| **Work package** | 3<br>Building the Capacity of CAN-MDS Operators |
| **Activity** | Activity 3.1: Training of CAN-MDS National Administrators and LC to proceed with the training of professionals at a national level |
| **Deliverable No.** | Deliverable D3.2 |
| **Drafted** | A. Ntinapogias, A. Chouchourelou, J. Gray, G. Nikolaidis |
| **Deliverable title** | Evaluation of Training of National Administrators |
| **Target group** | National Partners, National CAN-MDS Administrators, All interested parties to replicate the training |

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


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

**COORDINATING ORGANIZATION**

**Institute of Child Health, Department of Mental Health and Social Welfare - GREECE**
*George Nikolaidis, Project Leader*
*Athanasios Ntinapogias, Project Coordinator/Principal Investigator*
*Metaxia Stavrianaki, Researcher*
*Aggeliki Skoumbourdi, Researcher*
*Fotis Sioutis, Senior Software Developer*
*Babis Perdikoulis, IT Engineer Web Developer*

**PARTNERS' ORGANIZATIONS**

**State Agency for Child Protection – BULGARIA**
*Eleonora Lilova, Local Coordinator*
*Milena Anastasova, Chief Expert*
*Yanko Kovachev, State Expert*
**South West University "Neofit Rilski", Faculty of Public Health and Sport – BULGARIA**
*Vaska Stancheva-Popkostadinova, Scientific leader and Local Coordinator*
*Maya Tcholakova, Researcher*
**Hope for Children - CYPRUS**
*Andria Neocleous, Local Coordinator*
*Sofia Leitao, Researcher*
**Ministry of Labour and Social Insurance, Social Welfare Services - CYPRUS**
*Tapanidou Hara, Local Coordinator*
*Efthymiadou Marina, Researcher*
**Observatoire national de l'enfance en danger (GIPED) – FRANCE**
*Agnès GINDT-DUCROS, Global Project Manager*
*Anne-Lise STEPHAN, Local Coordinator*
*Michel ROGER, Computer Engineer*
*Elsie Joëlle MEHOBA, Data Analyst*
*Claudine Burguet, Consultant*
**Departamentul de Asistenţă Socială şi Medicală (DASM) – ROMANIA**
*Aura Diana Totelecan, Local Coordinator*
*Arianda Maneula Popa, Local Thematic Expert*
*Cristian Florin Iclodean Lazar, Local Administrator*
**Federatia ONG pentru copil (FONCP) – ROMANIA**
*Daniela Boșca-Gheorghe, Local Coordinator*
*Ivona Păun, Researcher*
**Babes-Bolyai University, Department of Sociology and Social Work – ROMANIA**
*Maria Roth, Local Coordinator*
*Gabriela Tonk, Researcher*
**Fundació AROA – SPAIN**
*Neus Pociello Cayuela, Local Coordinator*

**NATIONAL CAN-MDS ADMINISTRATORS**
*Arieta CHOUCHOURELOU, National CAN-MDS Administrator in GREECE*
*Christine MAVROU, National CAN-MDS Administrator in CYPRUS*
*Rodika-Corina ANDREI, National CAN-MDS Administrator in ROMANIA*
*Joaquim MILLAN, National CAN-MDS Administrator in SPAIN*

**Expert on Ethical Issues**
Andreas Jud, Ulm University-GERMANY
**External Evaluator**
Jenny Gray, UK



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# Table of Contents

Coordinated Response to CAN via MDS
Training of CAN-MDS National Administrators

Athens, December 4-5 2019
Location: Acropolis Select Hotel
Falirou 37-39
Athens, GREECE

# Evaluation of National CAN-MDS Administrators' (NAs) Training

The Training Module consisted of two distinct and intertwined parts:

1. CAN-MDS National Administrators' Training (Day 1 of Training Module) &
2. Simulation of Training Workshop for CAN-MDS Operators (Day 2 of Training Module)

Thus, the Evaluation of the NAs Training Module was, respectively, designed to address the core parts of the Training Module.

Aim of the Evaluation of National Administrators' Training (at an international level) (Activity 3. 3)
To assess the effectiveness of National Administrators' training in their roles and prescribed activities and to proceed to improvements and clarifications within the Training Material and the CAN-MDS Administrator's Manual (where and if needed).
Moreover, the Evaluation Report of the Training of National Administrators (D3.2) is, also, one of the milestones of the project (MS6). Based on the evaluation results, the Consortium will proceed with any necessary modifications of the training module before proceeding with the national seminars for professionals-operators.

## NATIONAL ADMINISTRATORS' TRAINING MODULE

| Identity of Training of National CAN-MDS Administrators | |
|---|---|
| **Work Package 3:** | Building the Capacity of CAN-MDS Operators |
| **Lead Beneficiary:** | ICH |
| **Participants:** | ONPE, AROA FOUNDATION, FONPC, SACP, BBU, SWU, HFC , DASM, SWS-MLSI |
| **Activity 3.1:** | Description: Training of CAN-MDS National administrators immediately after the 2-day managerial meeting; the Local coordinators will participate in the training, too; both, Local coordinators and trained administrators of the national systems will proceed with the professionals' training in each country. |
| **Objectives:** | To build the capacity of national Administrators as their role is most critical for the whole project. The training will make them capable of:<br>- identifying eligible professionals-operators to participate in their trainings at a national level (as multipliers)<br>- undertaking the day by day administration of CAN-MDS at a national level (they probably will be the ones that either will continue as system administrators after the piloting phase or will train further administrators). |
| **Deliverable 3.1:** | Training of CAN-MDS National Administrators<br>**Participants**: 6 National Administrators AND 9 Local Coordinators (all of them will be trained as trainers for the national seminars where we plan to have recruited 900 professionals-operators as participants).<br>**Tangible outputs**: agenda; signed list of participants; presentations (English); training material package (electronic format; English, D2.1, D2.2); evaluation report (see D3.2), photos of the event.<br>**Target groups**: National Partners; National CAN-MDS Administrators. |
| **Deliverable's type:** | Other |
| **Dissemination:** | Confidential, only for members of the consortium (including the Commission Services) |
| **Timeline:** | **Provisioned**: M12 (end of October 2019)<br>**Implemented**: M14 (4-5 December 2019) (in conjunction with the MM) |
| **Duration:** | 2-days (16 hours) |
| **Date:** | December 4-5, 2019 |
| **Place:** | Athens, Greece |

The aims of the training, which included two distinct and separate training modules, were:

DAY 1 – role and responsibilities of NAs

- to train National Administrators and the Local Project Coordinators. They will then train the NAs in their respective countries as soon as they hire them - as trainers of the national Groups of CAN-MDS Operators. This first aim is aligned with the larger objective of building the capacity of national Groups of CAN-MDS Operators in the 6 countries (BG, GR, FR, CY, RO, ES)
- to familiarize National Administrators with their role, scope and exact nature of activities in the CAN-MDS project, across all phases of the program.
- to maximize National Administrators' ease in working with the e-app and in executing all related to the e-app daily tasks.

DAY 2 – simulation of CAN-MDS Operators' workshop

- to build the capacity of professionals working with or for children in all eligible sectors (social welfare, health, mental health, justice, education, law enforcement), in order for them to:
    - be able to identify potential CAN victims (and apply routine screening, where applicable) depending on the nature of their everyday activities
    - be familiarized with the definition of CAN as is detailed in Art. 19 of CRC and GC 13 of the UN Committee (2011)
    - be aware of what reporting/mandated reporting are and be sensitized to the importance of reporting for the effective administration of CAN at a case and a population level
    - be familiarized with the CAN-MDS system, its aim, objectives, operational characteristics, usage;
    - become CAN-MDS Operator's during the piloting phase.

## TRAINING EXPECTATIONS

NAs after their participation in the specific Training Seminar are expected to understand:

- what is the role of CAN-MDS surveillance system in facilitating CAN monitoring, at both case-administration and public health level
- 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 the CAN-MDS surveillance system
- the ethical issues that are governing CAN data collection (the importance of data confidentiality, national and global legislative provisions, professionals' codes of ethics)
- the technical characteristics of the CAN-MDS e-app design and function and understand how to most comfortably use it (via mock recordings into the e-app on the basis of case studies)

Having received the information described above, trained NAs are expected to be able:

- to train the members of National Groups of CAN-MDS Operators of the pilot phase
  - on the project, its aims, and scope
  - on the Operators' specific tasks and responsibilities within the CAN-MDS project framework
  - on the CAN-MDS characteristics, design, and best use within their existing employment and role in CAN monitoring and case administration.

Importantly, NAs are expected to learn how to implement further trainings with the CAN-MDS Operators, at a national level, based on a common methodology across partner countries and across professionals of various fields within each partner country. Specifically, NAs are expected to learn how:

- to devise a specific plan for lobbying with potential members of agency's Inter-Sectoral Board
- to create a well-informed tentative list with eligible agencies that can be invited to become Data Sources in their countries and well-structured arguments that explain the CAN-MDS value and applicability
- to work efficiently and at ease with both of the CAN-MDS e-app Administrator's and Operator's Interfaces.

## CONTENT OF THE TRAINING

DAY 1 – Role and responsibilities of National CAN-MDS Administrators:

- How to select and invite Agencies and their Operators to become part of CAN-MDS: practice using the offline templates included
- How to plan the Operators' Training Workshops based on the national customized plans: recruitment, invitation, training scheduling, training implementation
- Practice Administrator's tasks using the CAN Toolkit Guide for Administrators: real time simulation/based on e-app
- The specific ethical and practical implications of the Administrator's tasks surrounding the offline linkage of the Child's ID (pseudonym) with the child's and the incident's identifying information: with discussion on real-life, country-specific current practices
- How to prepare for intake and record a CAN incident in CAN-MDS: real time simulation/based on e-app.

DAY 2 – Simulation of CAN-MDS Operators' workshop:

- Data Collection Protocol/ CAN-MDS Operator's step-by-step routine practices (Parts I, II and III): real time simulation included/based on e-app

- CAN-MDS Rationale/ Role of multiple sectors, disciplines and how they inter-relate: theoretical presentation with empirical, country-specific findings
- Tackling Underreporting: theoretical presentation with empirical findings and their analysis.
- National mandates to report/legislative CAN framework per country
- CAN signs/indices/ Learning to recognize CAN across professions likely to come across CAN Incidents
- How to prepare for intake and record a CAN incident in CAN-MDS: practice with two mock cases/based on recording forms and the e-app

## PARTICIPANTS

Project's Coordinating Team, ICH-MHSW, GR

Sakis NTINAPOGIAS, Project Coordinator (trainer)
Arieta CHOUCHOURELOU, National Administrator/Researcher (trainer DAY 2)
Jenny GRAY, External Evaluator (consultant)
Fotis SIOUTIS, IT specialist (support with real time simulations on the app)
Charalambos PERDIKOULIS, IT specialist (support with real time simulations on the app)

Trainees: 9 Project's Local Coordinators and 3 National Administrators as follows:

| | |
|---|---|
| Bulgaria: | Vaska STANCHEVA POPKONSTANTINOVA (Local Coordinator SWU) |
| France: | Agnès GINDT-DUCROS (Local Coordinator ONPE) |
| France: | Anne Lize Stephan (Local Coordinator ONPE) |
| Romania: | Daniela GHEORGHE (Local Coordinator FONCP) |
| Romania: | Diana TOTELECAN (Local Coordinator DASM) |
| Romania: | Gabriella TONK (Local Coordinator BBU-RO) |
| Romania: | Rodika-Corina ANDREI (National Administrator) |
| Cyprus: | Marina EFTHYMIADOU (Local Coordinator SWS-MLSI) |
| Cyprus: | Andria NEOCLEOUS (Local Coordinator HFC) |
| Spain: | Neus POCIELLO (Local Coordinator AROA Foundation) |
| Spain: | Joaquim MILLAN (National Administrator) |
| Greece | Arieta CHOUCHOURELOU (National Administrator –trainee DAY 1) |

## EVALUATION METHODOLOGY & TOOLS

For the evaluation of the National Administrators' Training Seminar, three separate but intertwined evaluation processes were applied.

1. The first formal evaluation was conducted through one set (pre/post) of evaluation questionnaires that were completed by the trainees before the onset of the module's Day 1 and after Day 1's completion (see ANNEX I). Day 1 of the Training Module was dedicated to the National Administrators' preparation for their duties, responsibilities, ease with the CAN-MDS e-app and familiarization with the need to know the ethical and legal frameworks that define and constrain CAN-MDS applicability, generally, and in their respective countries, specifically. Both questionnaires, with identical sets of questions, aimed to measure the

trainees' expectations as well as their self-assessment regarding their knowledge, awareness and self-confidence on issues related to CAN surveillance, country-specific laws, regulations, training and ethical culture around reporting and administering CAN cases, and task-specific functions of the CAN-MDS e-app. The pre-questionnaire, in addition to the above, contained a small section with questions investigating the trainees' past experience of (personally) reporting CAN incident(s).

2. The second part of the formal evaluation was implemented through one set (pre/post) of evaluation questionnaires, filled-in by the trainees before the onset of the module's Day 2 and after Day 2's completion (see ANNEX II). Day 2 of the Training Module was dedicated to the National Administrators' preparation for the CAN-MDS Operators' training workshops that they must plan, hold and evaluate in their respective countries. Importantly, Day 2 of the NAs Training Module was designed to be a 1-day Simulation Workshop, meant to be used as a model for the ensuing Operators' training workshops. The training in Day 2 addressed learning from the perspective of the future CAN-MDS Operators, while, at the same time, aiming to further educate participating NAs on CAN underreporting, the need for inter-sectoral collaboration when handling CAN, how to seek and present their country's laws about CAN and how to increase sensitivity in detecting CAN signs, when working with, or in contact - while at work - with a child-victim. Both questionnaires (pre/post), with identical sets of questions, aimed to measure the trainees' expectations, as well as their self-assessment, regarding their knowledge, awareness and self-confidence on issues related to: CAN surveillance, country-specific laws, regulations, training and ethical culture around reporting and administering CAN cases, underreporting, signs of CAN, local coordination of inter-sectoral responses to CAN and task-specific functions of the CAN-MDS e-app. The post- training questionnaire, in addition to the above, contained a small section that had questions investigating the participants' attitudes on the factors found to correlate most with the professionals' dilemma whether to report CAN or not.
   Lastly, a final section in the post-training questionnaire, included questions about participants' satisfaction with the training's duration, content completeness, least and most valuable aspects of the Module, and the accommodation. Participants were, also, invited to submit in writing their recommendations for the Training Module's improvement.

3. The third line of evaluation of this Training Module was based on the actual entries into the CAN-MDS app that participants made during their training, on both days. This input was generated as part of the real time simulations which were based on mock cases. The entries have been examined in terms of accuracy, completeness, and frequency and the analysis section of this report describes the inferences, thus, generated.

### What was evaluated before and after National Administrators' Training (Day 1 of the Training Event)

Trainees' Expectations of the seminar and how well they were addressed, regarding the following issues:

- ethical issues related to piloting CAN-MDS in each country


- responsibilities of National CAN-MDS Administrator
- how to identify and invite agencies to become CAN-MDS Data Sources
- how to identify and invite professionals to become CAN-MDS Operators
- how to implement and evaluate the national training of CAN-MDS Operators
- how to maintain and administer the offline data base containing children's personal data
- how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources' Administrations when necessary
- how to create and administer pseudonyms of children involved in CAN incidents
- how to create and administer Organizations' and Operators' accounts
- how to communicate with professionals when a CAN incident is recorded in the system
- how to extract and edit disaggregated anonymized incidence data

- Trainees' self-assessment concerning:
  - *their knowledge on:*
    - what CAN-MDS is
    - the specific ways CAN-MDS addresses the need for CAN surveillance
    - what the main problems related to CAN surveillance are
    - the groups of professionals that are mandated by law, in their country, to report CAN incidents
    - penalties & legal immunity, in their country, for the professionals mandated by law to report CAN
    - the implementation of CAN specific training for certain professional groups, in their country.
  - *their awareness on issues related to:*
    - the role of National Administrator
    - their country's customized plan for the pilot phase of CAN-MDS System
    - selection of Agencies and their professionals who could become involved in the CAN-DMS
    - cooperation with (their) National CAN-MDS Inter-sectoral Board
    - invitation to eligible Organizations to become CAN-MDS Data sources
    - invitation to eligible professionals to become CAN-MDS Operators
    - evaluation of the training of CAN-MDS Operators.
  - *their self-confidence*
    - to act as a National CAN-MDS Administrator
    - to identify and invite agencies and professionals to be involved in the piloting of CAN-MDS system
    - to train the national group of Operators
    - their past choices and reflections on specific decisions to report CAN incidents that they may have made.


What was evaluated before and after the Simulation of the Operators' Training Workshop (Day 2 of the Training)

Trainees' current knowledge, expectations in terms of acquiring new knowledge during the seminar, and how well these were addressed, regarding the following issues:

- what CAN-MDS is
- their role as CAN-MDS Operator
- how to use the CAN-MDS tools
- how to recognize signs of child abuse and neglect
- the legal framework in their country, including professional mandates, concerning reporting suspected CAN
- what CAN underreporting is
- what are the main problems related to estimation of the magnitude of child abuse and neglect

- Trainees' self-assessment about:
  - *their awareness of:*
    - how to report concerns for a potential case of child maltreatment
    - where (to which authority) to submit a report for a potential case of child maltreatment
    - what are the main problems related to estimating the CAN magnitude
    - what their role as CAN-MDS Operator will be.
  - *their self- confidence regarding:*
    - recognizing signs indicating that a child might be suffering abuse and/or neglect
    - how best to respond to a child that reveals they suffer abuse and/or neglect
    - recording and reporting concerns for a potential CAN case to the appropriate authority
    - acting from a CAN-MDS Operator position.

In addition, Day 2's evaluation tools (pre- and post- training questionnaires) included a section with information on the professionals' specialty, sector of current employment, work experience with various populations of children, type and duration of previous training(s) on CAN related issues, and previous experience with reporting CAN.

An additional section, in both questionnaires, covered current estimates of the size of underreporting of CAN in their country, the adequacy of professional training on CAN, the effectiveness of inter-sectoral cooperation in CAN administration, the awareness about legal mandates for CAN reporting, and of the adequacy of their country's epidemiological data for CAN.

Furthermore, a final section on the post-questionnaire of Day 2, addressed professionals' estimates of the degree that a list of various (recognized in the literature[1]) factors might hinder decisions to report CAN. The list included the following variables:

- Attitude "It's not my responsibility"
- Amount of time it takes to make a report
- Being uncomfortable intervening in a family's life
- Belief that "nothing would be done to help the situation, anyway"
- Concern that reporting will not help the child or the family
- Confidentiality associated with reporting CAN cases
- Currently applied policies or procedures
- Currently applied reporting process
- Currently applied screening processes
- Difficulty for the professional to make a report
- Existing step-by-step process to follow when making a report
- Family violence against professionals
- Fear of legal ramifications for false allegations
- Fear of making inaccurate report
- Fear of negative effects on the child's family
- Fear of violence or unknown consequences against the child
- Fear that reporting would damage professional's relationship with family
- Fear that someone would find out you made report
- Fears of a negative impact on professional's practice, fear of litigation
- Feedback currently provided to reporters by the authorities about status of report
- Lack of adequate history
- Lack of adequate knowledge about abuse and neglect and professionals' role in reporting
- Lack of certainty about the diagnosis of CAN
- Lack of confidence in child protection authorities and their ability to handle such cases
- Lack of professionals' knowledge about the signs and/or symptoms of abuse/neglect
- Lack of professionals' knowledge of referral procedures
- No apparent physical sign of abuse
- Not knowing what happens after report is made
- Not knowing what is expected
- Not knowing where to report
- Previous poor experience with responsible authorities
- Adequacy of training that mandated reporters receive
- Uncertainty about the consequences of reporting
- Unclear statutory laws
- Vague organizational protocols

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

What was evaluated regarding the organization of the whole training module:

- Seminar's overall duration
- Information provided during the Seminar
- Training means (presentations, mock cases, process)
- Recommended improvements
- Seminar's least valuable aspect - with explanation
- Seminar's most valuable aspect - with explanation
- Unmet personal expectations
- Accommodation (i.e. seating comfort, facilities)

What was evaluated regarding their use of the e-app to perform the practice tasks of both Day 1 and Day 2 of the Training Module:

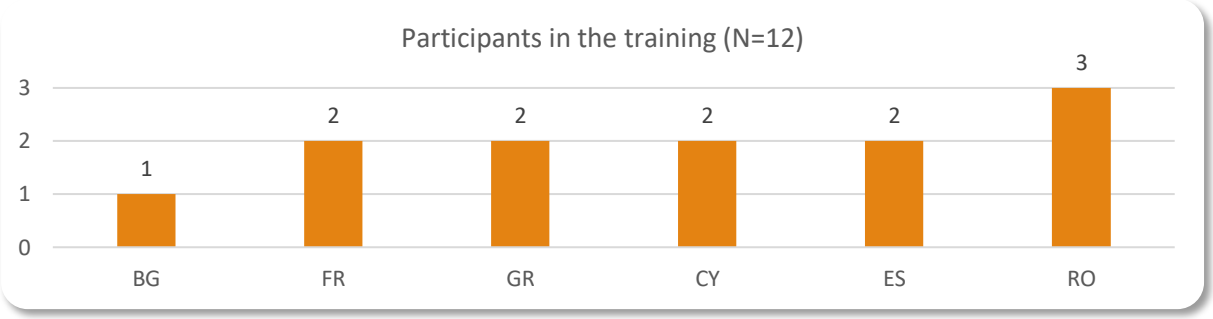
Correctness of record based on a mock case (see Annex 3)

| Mock case (along with instructions for the referee) | Data to be recorded and/or auto-calculated |
|---|---|
| RECORD<br><br>(DE_R1-DE_R4) | Operator's id (auto-completed)<br>Agency's ID (auto-completed)<br>Date of Record (auto-completed)<br>Information provided by: |
| Child (alleged) victim<br><br>(DE_R1-DE_R4) | ID:<br>Sex:<br>Date of birth:<br>Citizenship status: |
| Family and Caregiver(s)<br><br>(DE_R1-DE_R4) | Type of family:<br>Family's member(s):<br>Primary caregiver(s):<br>1st caregiver:<br>2nd caregiver: |
| Incident<br><br>(DE_R1-DE_R4) | Incident ID:<br>Date of incident:<br>Form(s) of maltreatment:<br>Place of incident: |

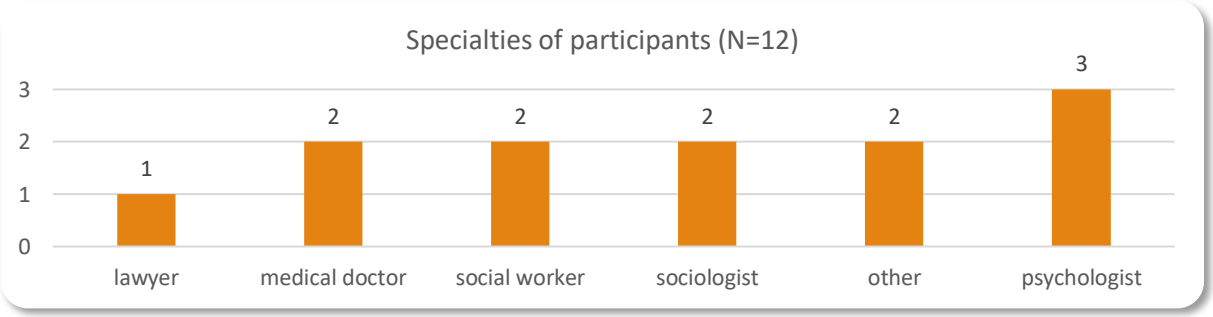
# Evaluation Results

## DAY 1 – Role and responsibilities of National CAN-MDS Administrators

Twelve trainees from all six of the partners' countries participated In the first day of the training.




Concerning their professional background, most of the trainees were social work/welfare and health professionals as well as one nutritionist and one IT professional. The mean duration of their working experience in the field is 12,8 years (SD=7,59, min 0; max 20 years).

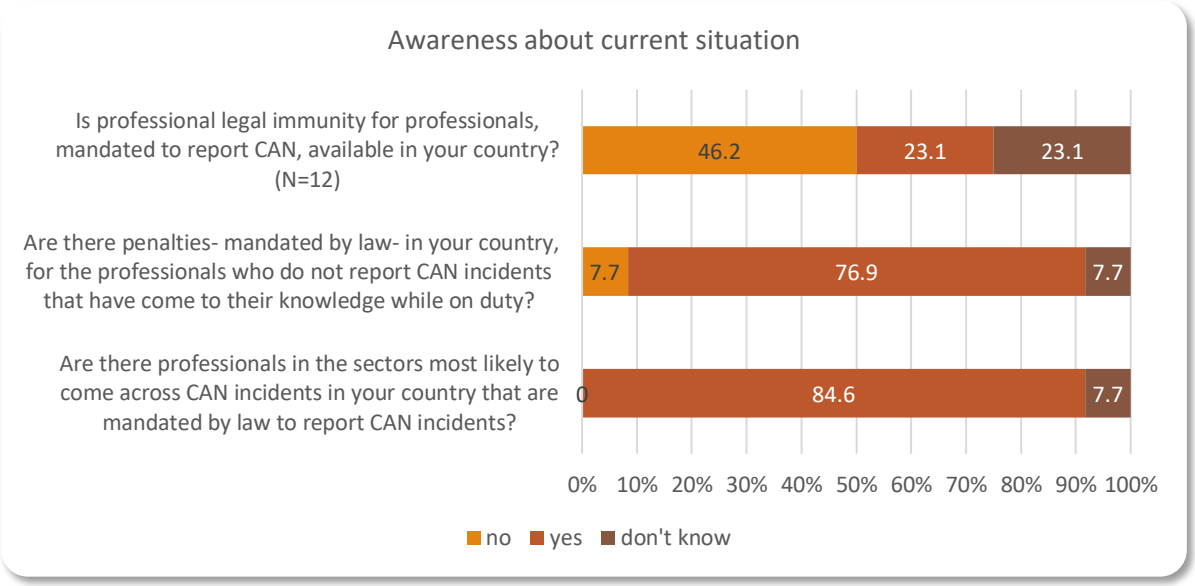



Concerning the current situation in their countries, only 2 of the trainees replied that they are not aware, while the remaining replied positively or negatively to questions related to whether there are mandated professionals to report CAN cases to the authorities; legal provisions on issues such as legal immunity of professionals mandated to report CAN cases; and penalties for non-reporting of CAN cases by mandated professionals.

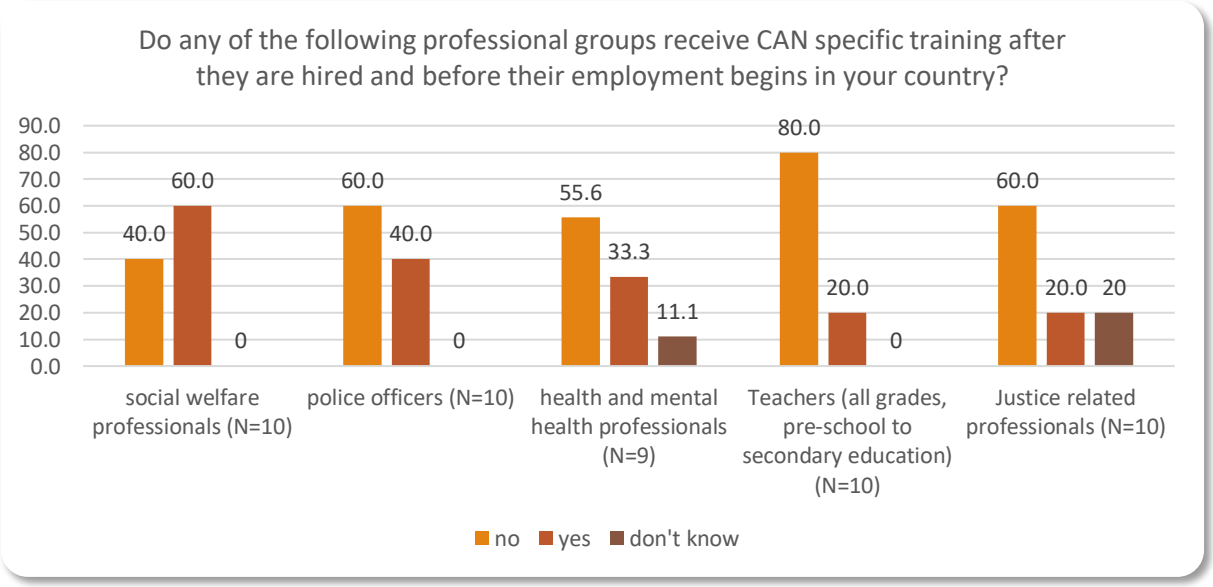
Considering that the trainees come from six different countries, no common replies were expected to be collected. It is noted, however, that in the question about mandated by law, professionals who work in relevant sectors to report CAN cases respondents mentioned police (4); CP/social services (4); prosecutors/justice officers (3); teachers/education services (4); health services (2); professionals working in all sectors (2); all practitioners who work with children (1) and all private citizens, regardless of profession (1).

As for the penalties in the cases of professionals who do not report CAN cases although mandated, there were 10/12 positive replies. In 4/10 cases trainees replied "*yes BUT … not implemented by the authorities … they are not applied … they are not always applicable … are rarely activated*".

In the question about legal immunity of professionals who are mandated to report CAN cases 3 trainees weren't aware of any, 5 trainees replied negatively and 2 more wrote that "no, but the professional can be inferred by more general laws" and only 2 (from Cyprus) replied positively.

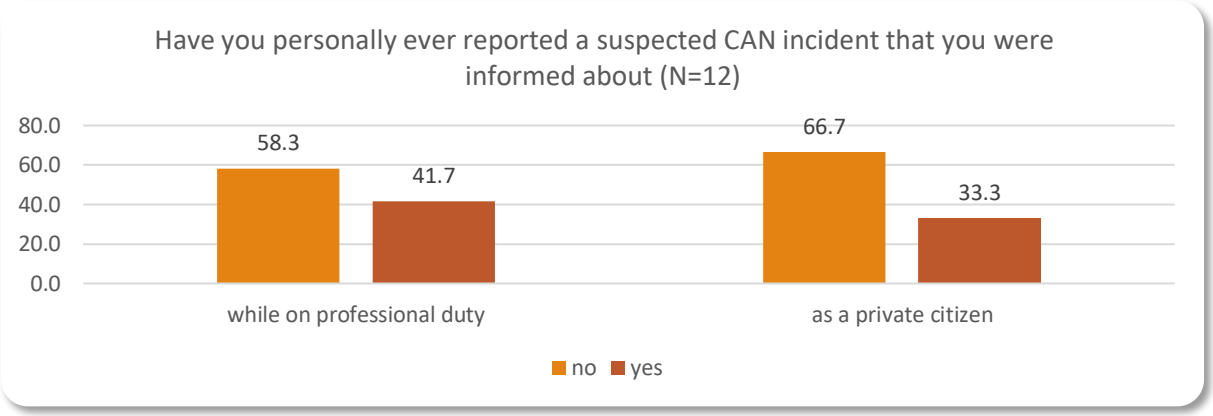



Trainees were also asked whether various professional groups receive CAN specific training after they are hired and before their employment begins in their countries. Trainees' responses in this question were also different. In all cases of professional groups, however, except social welfare professionals, trainees in their majority replied negatively, that there is no policy for CAN specific training to be provided to professionals after they are hired and before their employment begins (education 80%; police and justice 60%; health and mental health 56% and social welfare 40%).




The next question concerned professionals-trainees' personal experiences in terms of reporting CAN cases either while on professional duty or as a private citizen. As presented below, almost half of them had previously reported to authorities CAN cases while on professional duty and some of

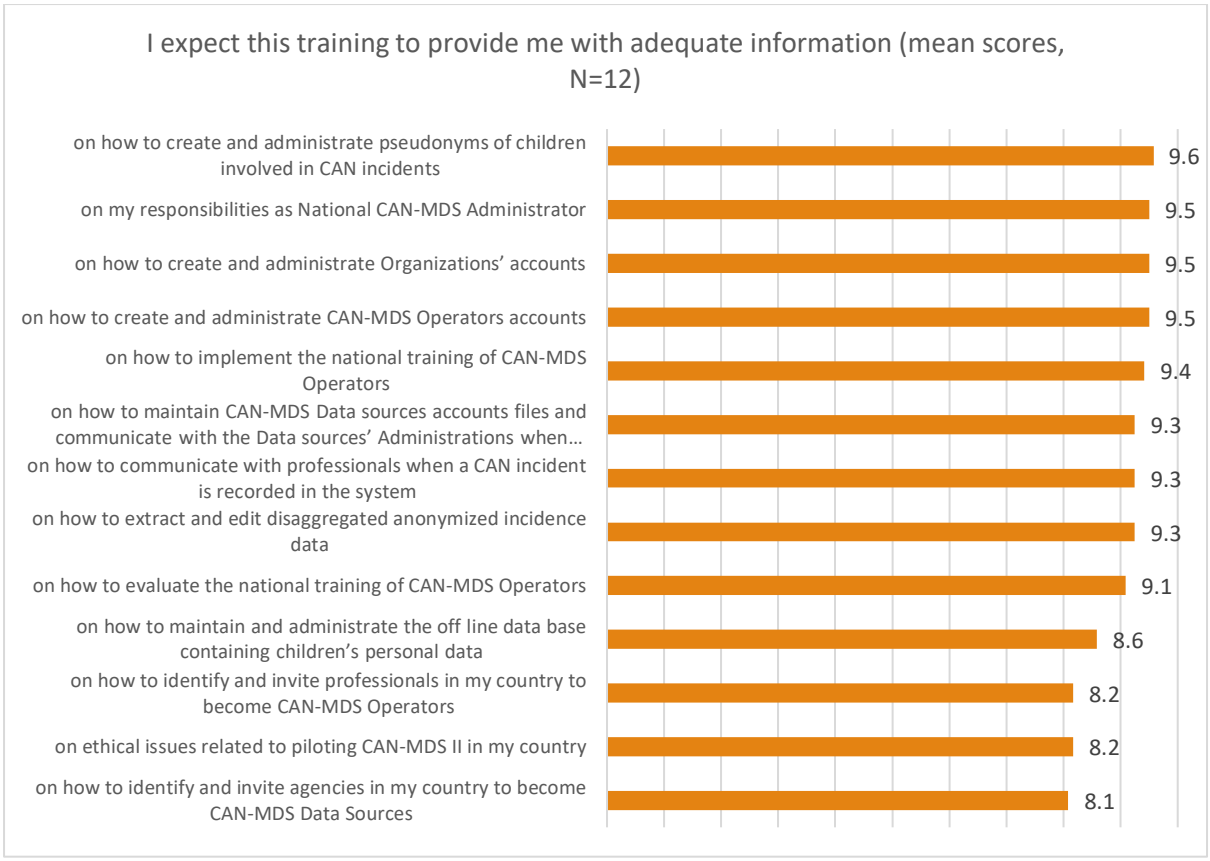
them as citizens. They, however, didn't mention the number of cases (but one who replied around 20 cases per year for 19 years); Concerning where - to which exact authorities - they reported the suspected CAN incidents, the replies included the police (2); child protection services (1); county/municipal level directorate for child protection (3); social welfare services (1); and children's house welfare services (1). Professionals were also asked to provide some descriptions of the suspected CAN incidents that they decided to report. These descriptions included: "*I represented two children in a juridical procedures (sexual abuse)*"; "*I reported many cases of CAN because is my duty to do so. The danger for the child is very important when you decide to report. We have a procedure (and a law) who told us to report any abuse/neglect child or suspicions about it)*"; "*suspected incident: violence against children (possible sexual abuse; quick response of the involved services to deal with the case*"; "*mainly physical violence was involved*"; "*it was a case of neglect*".




*Expectations*

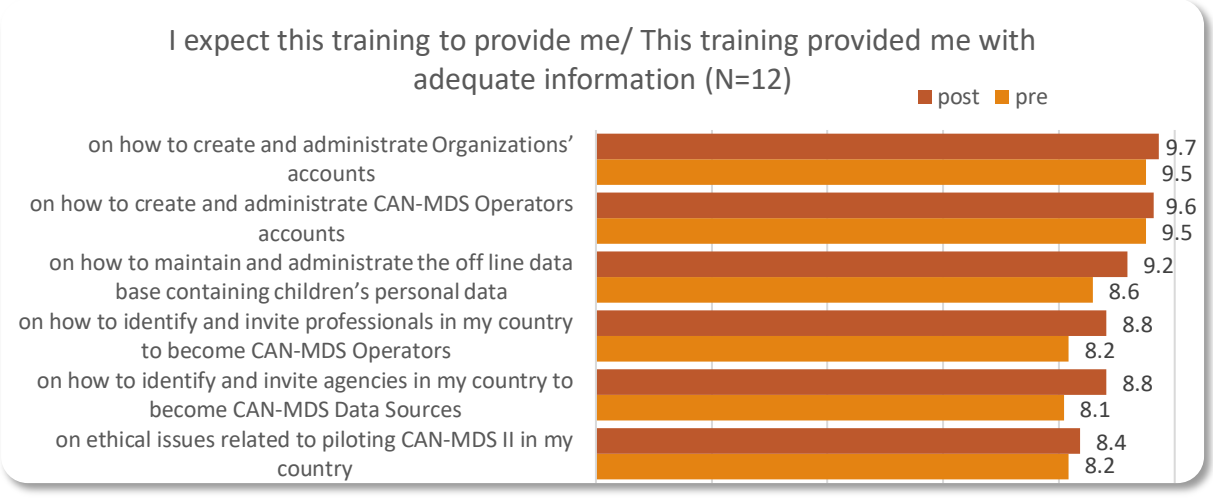
A set of 13 items was used to explore expectations of trainees from DAY 1 of the training regarding the role and responsibilities of National CAN-MDS Administrators: The identical set was also used to identify the extent to which trainees' expectations were met after the training.

Higher expectations of trainees from the training were about their responsibilities as National Administrators in general (9,5/10); practical issues related mainly to creation and administration of pseudonyms (9,6); operators accounts (9,5); agencies accounts (9,5); and, the organizing of national trainings for operators (9,4). Identification and invitation of agencies to become data sources (8,1); (identification) of professionals to become operators (8,2) and ethical issues related to piloting of the system (8,2) were the aspects on which trainees had the lower expectations. Mean scores of expectations for the remaining issues (*how to maintain and administrate the off line data base containing children's personal data; how to evaluate the national training of CAN-MDS Operators; how to extract and edit disaggregated anonymized incidence data; how to communicate with professionals when a CAN incident is recorded in the system; and how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources' Administrations when necessary*) ranged between 8,6 and 9,3/10.

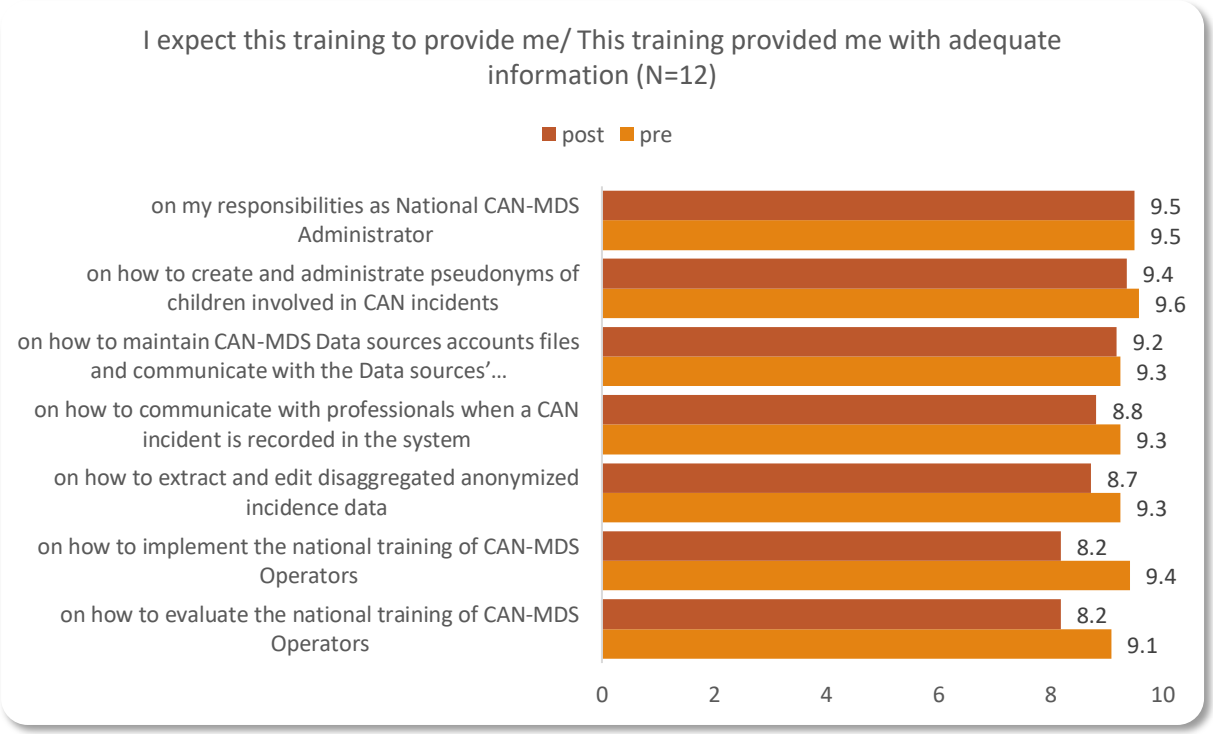



After the end of the training trainees were asked to reply to what extent each of their initial expectations was fulfilled.

In half of the items (see figure below) trainees' expectations seem to have been adequately fulfilled as the mean scores in the second measurement were higher than the respective ones in the first measurement, suggesting that the training provided them with adequate information on the specific aspects of their future role as National Administrators such as on how to create and administer accounts of agencies and operators; how to maintain off line data bases; how to identify and invite agencies and operators to be involved in the CAN-MDS system and on ethical issues related to piloting of the system in their countries.



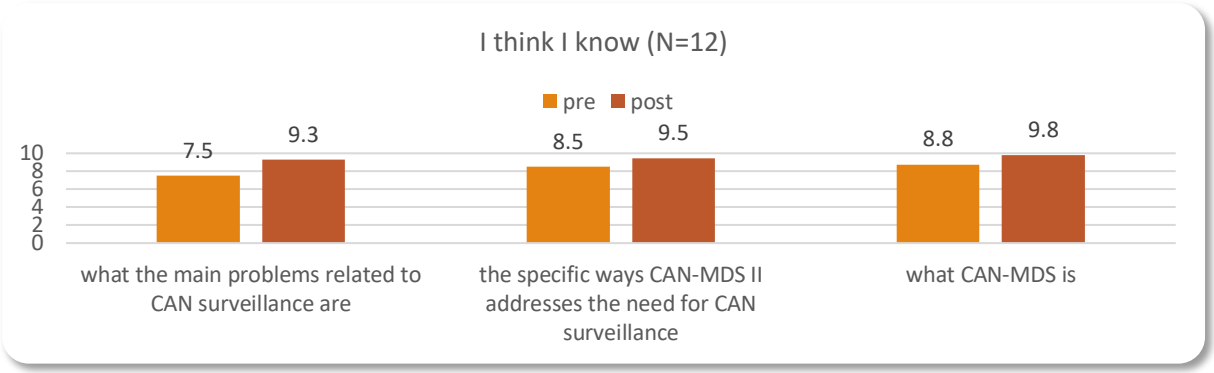
In the remaining items, however, trainees' expectations appear not to have been fulfilled adequately as the mean scores in the second measurement were equal to or lower than the respective ones in the first measurement, suggesting they found that the training did not provide them with adequate information on these specific aspects of their future role as National Administrators.




It seemed that trainees needed more information on *how to implement and evaluate the national training of CAN-MDS Operators; how to extract and edit disaggregated anonymized incidence data; how to communicate with professionals when a CAN incident is recorded in the system; on how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources' Administrations when necessary;* and *on how to create and administrate pseudonyms of children involved in CAN incidents*.

### *Self-assessment of knowledge*

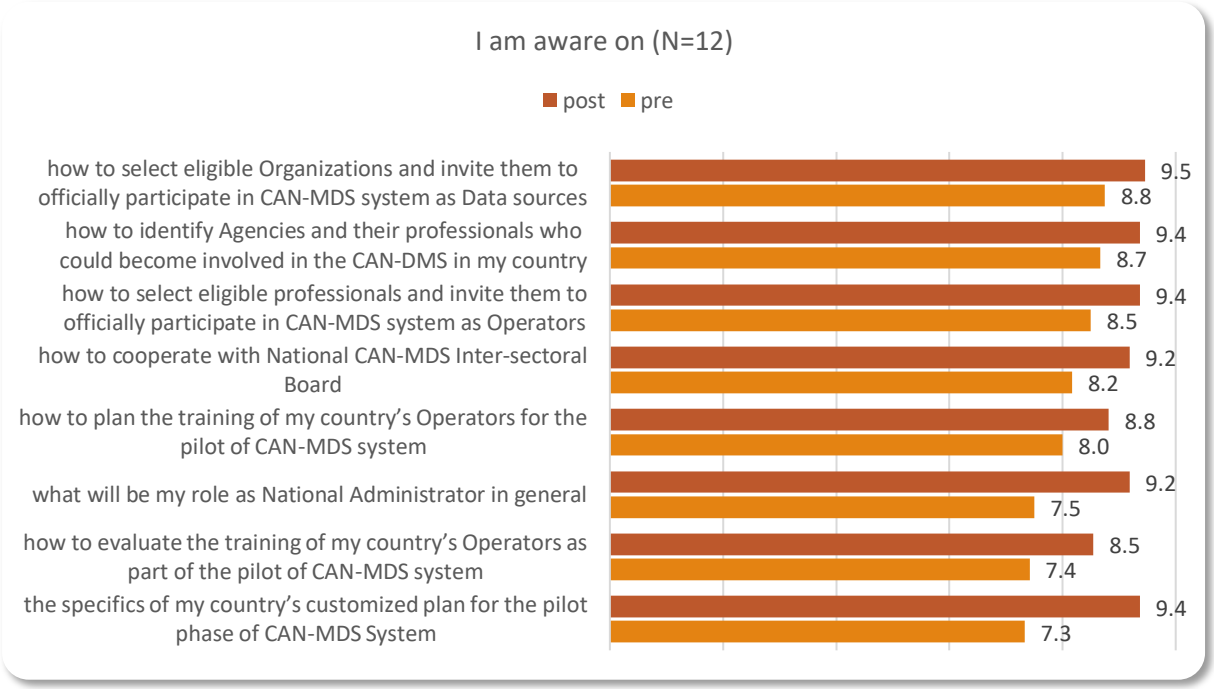
Three questions were asked before and after the training concerning knowledge related to CAN surveillance and the CAN-MDS system; specifically the trainees were asked to self-assess what they know (based on a scale from 0 to 10) about what the CAN-MDS system is, what are the main problems related to CAN surveillance and in what specific ways the CAN-MDS addresses the need for CAN surveillance.



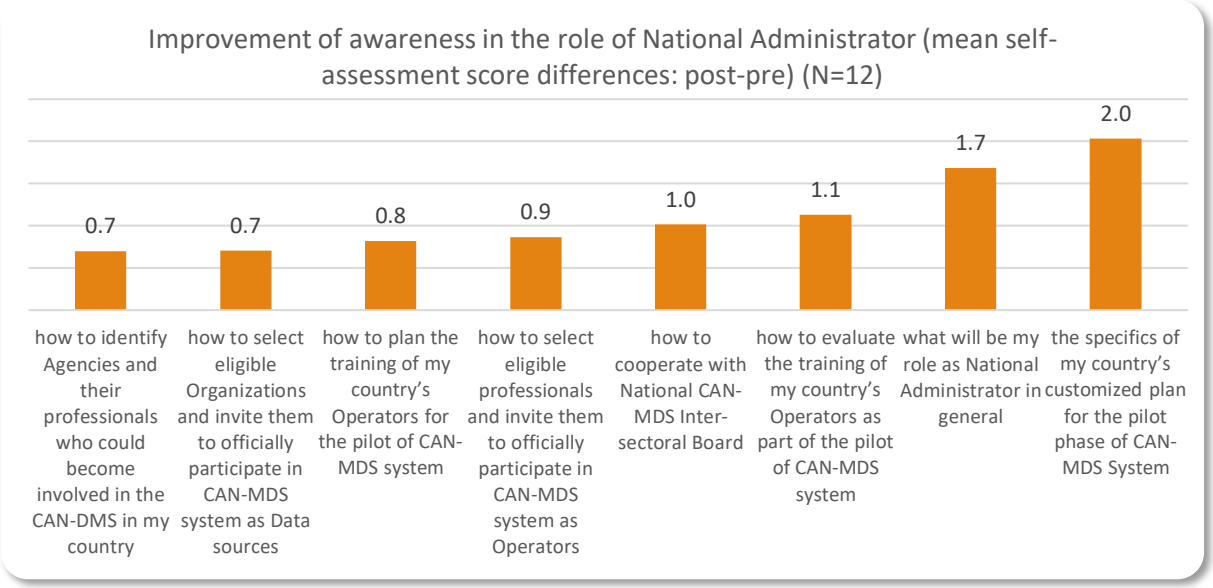

In all three questions mean scores of self-assessment were high enough even in the first measurement, ranging from 7,5 (SD=1,45) to 8,8 (SD=1,14)/10. This finding was expected providing that all trainees had either been involved in the past in the development of the system or read relevant information. It is of interest, however, that after the short training mean scores of self-assessment of knowledge on the above issues were higher than the respective ones before the training, ranging from 9,3 (SD=0,65) to 9,8 (SD=0,4)/10, suggesting that the training provided adequate relevant information to trainees.

*Self-assessment of awareness on the role and responsibilities of National CAN-MDS Administrators*

The next set of 8 questions aimed to explore the extent to which trainees considered that they were already aware of the role and the responsibilities of National Administrators. Before the training, mean scores of assessments ranged from 7,3/10 (SD=1,61) on the item related to the specifics in each trainee's country customized plan for the pilot phase of CAN-MDS to 8,8/10 (SD=1,6) in the item "*I am aware how to select eligible Organizations and invite them to officially participate in CAN-MDS system as Data sources*".

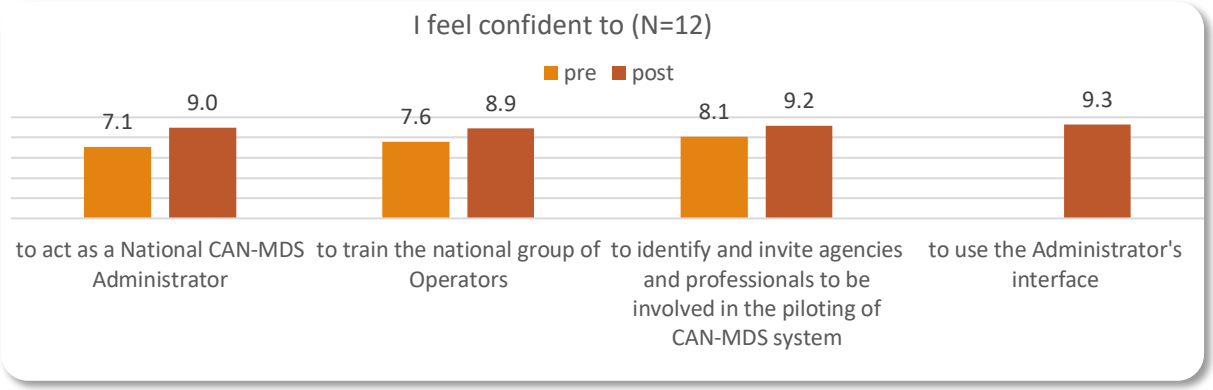


Mean self-assessment scores in the second measurement where higher than the respective ones of the first measurement for all 8 items (see figure above) ranging from 8,5 (SD=0,99) ("*I am aware how to plan the training of my country's Operators for the pilot of CAN-MDS system*") to 9,5 (SD=0,52) ("*I am aware how to select eligible Organizations and invite them to officially participate in CAN-MDS system as Data sources*"). The differences in the mean scores between pre- and post-measurements ranged from 0,7 to 2,03/10 (see figure below) indicating that the training provided adequate additional information on the role of National CAN-MDS Administrators, although there is ground for some further improvement on issues related to the organization and evaluation of workshops for CAN-MDS Operators at a national level.




### *Self-confidence to undertake the role of National CAN-MDS Administrator*

Trainees were asked how confident they feel to act as National Administrators, to identify and invite agencies and professionals to be involved in the piloting of the CAN-MDS system and to train the national groups of Operators. Mean scores before the training ranged from 7,1 (SD=2,71) ("*I feel confident to act as a National CAN-MDS Administrator*") to 8,1/10 (SD=1,24) ("*I feel confident to identify and invite agencies and professionals to be involved in the piloting of CAN-MDS system*").



Again, mean scores in the second measurement, after the end of the training, were higher than those of the first measurement in all questions ranging from 8,9 (SD=1,04) to 9,2 (SD=0,75), as presented in the graph above. Self-confidence in using the Administrator's interface in the online system was measured only after the training given that this is a new element in the system and trainees had not known anything about it from before. After the presentation of the Administrator's interface and its use by trainees in practice via exercises, trainees replied that they feel confident in using this tool (mean score 9,3/10 (SD=0,9).

Taking into account the mean scores of the second measurement (after the training) concerning self-confidence and awareness of trainees on the role and the responsibilities of National Administrators, it can be noted that the more aware trainees report they are, the more self-confident to become National Administrators they report to feel.

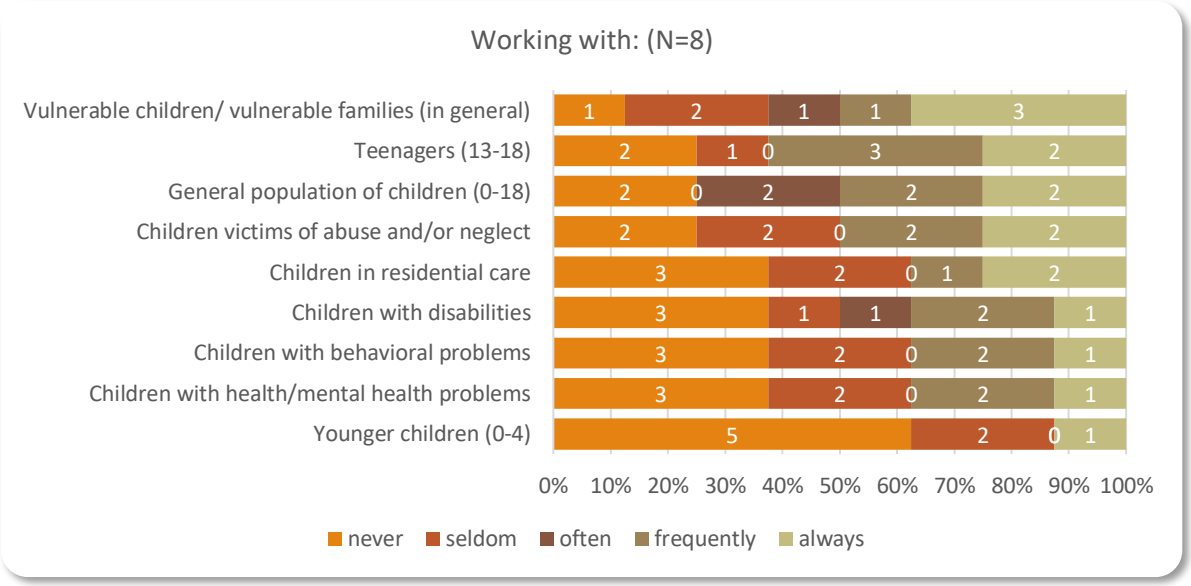
## DAY 2 – Simulation of CAN-MDS Operators' workshop

### *Professional, field, years of experience working with children, population of children most experienced with and formal training on CAN*

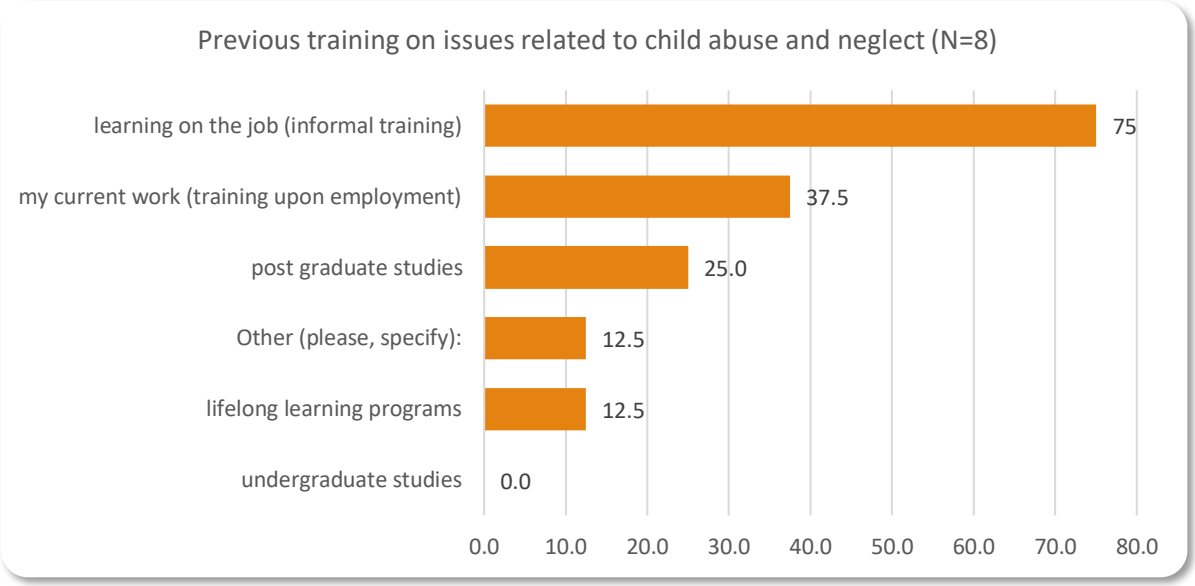
Eight people participated in this training (categorized, by formal education, into: 3 sociologists, 1 psychologist, 1 medical doctor, 1 social worker, 1 lawyer and 1 nutritionist); 3 out of the 8 participants worked at the time in NGOs relating to childrens' protection, 2 in governmental child protection services and 3 in the academic field. Participants' work experience with children had a mean duration of 7,9 years (SD=6,81, min 1; max 20 years).

The more specific populations of children that the trainees have worked with are presented in the figure below.

The majority of the participants responded that they have had experience of working with young teens and 62.5% said they never worked with children aged between 0-4 years old. Most of them (62.5%) report that they have worked with vulnerable children and families often, whereas half of the participants have had experience of working with children victims of abuse frequently or always.




Data on previous training on issues related to child abuse and neglect can be seen in the graph below. The majority of the participants (87.5%) report having been trained before on issues of CAN, while remarkably 75% say the training they have had was "on the job", and based on their reports there is a glaring paucity of formal (i.e. undergraduate, post-graduate) training in their (collective, minus one person's missing data) experience.



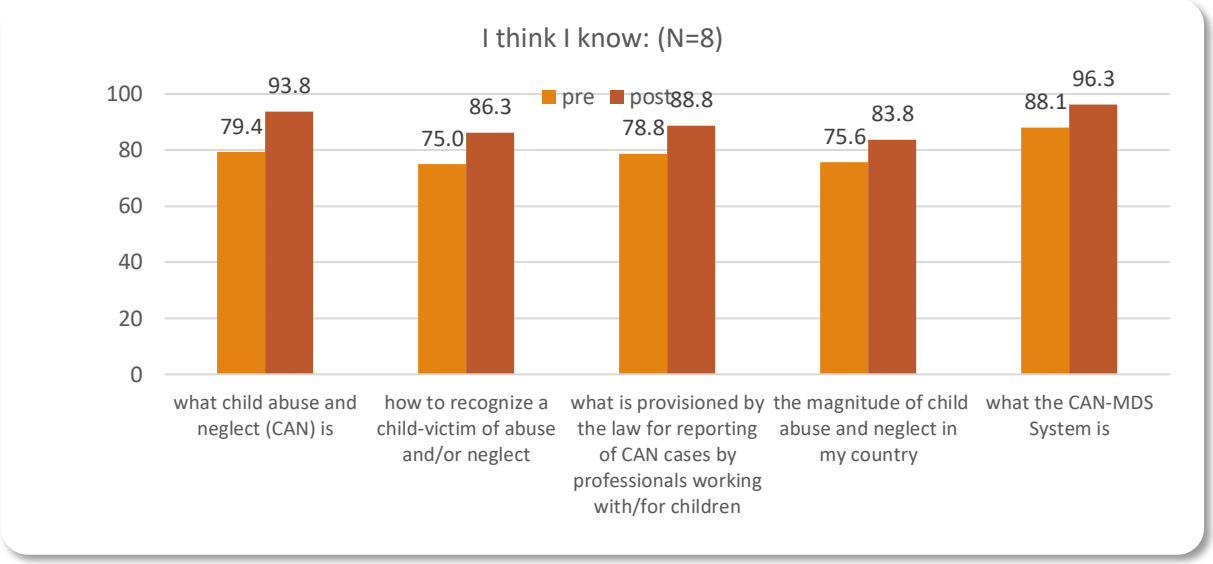

### *Having previously reported CAN experience*

Half of the Day 2 participants have reported a suspected CAN incident they had either learned about or witnessed while on professional duty, while 37.5% of the participants said they have reported a suspected CAN incident as private citizens (i.e. notwithstanding their professional identity).


### *Self-perceived Knowledge*

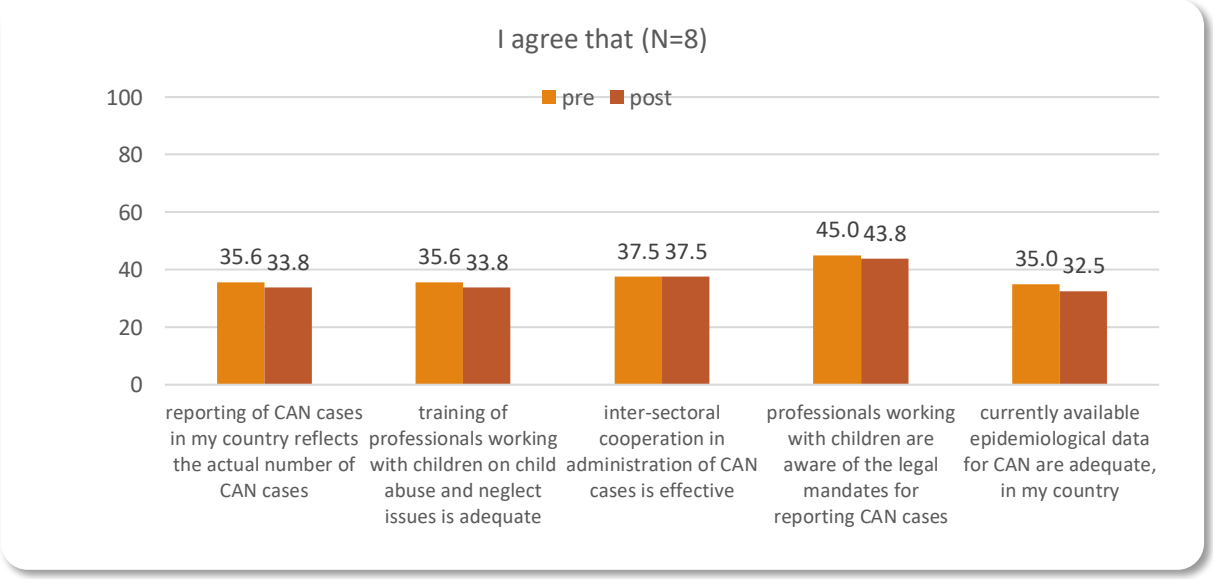
The following figure presents the Mean Scores of pre- and post- measurements of self-assessed knowledge (out of 100) on issues related to CAN. It is noteworthy , perhaps that the mean pre-training scores are high (min 75.0; max 88.1) but in a modest way, perhaps, considering the level of expertise with CAN and with the earlier milestones of CAN-MDS development for most of the participants. Nonetheless, while all post-training scores on the five knowledge items show increases these were more salient for questions 1, 2 and 5. Namely, participants think they know more at the end of the training about what CAN is (M=93,75, SD=7,44, min 80; max 100), how to recognize a

child-victim of CAN (M=86,25, SD=15,06, min 60; max 100), and what the CAN-MDS system is (M=96,25, SD=5,17, min 90; max 100).



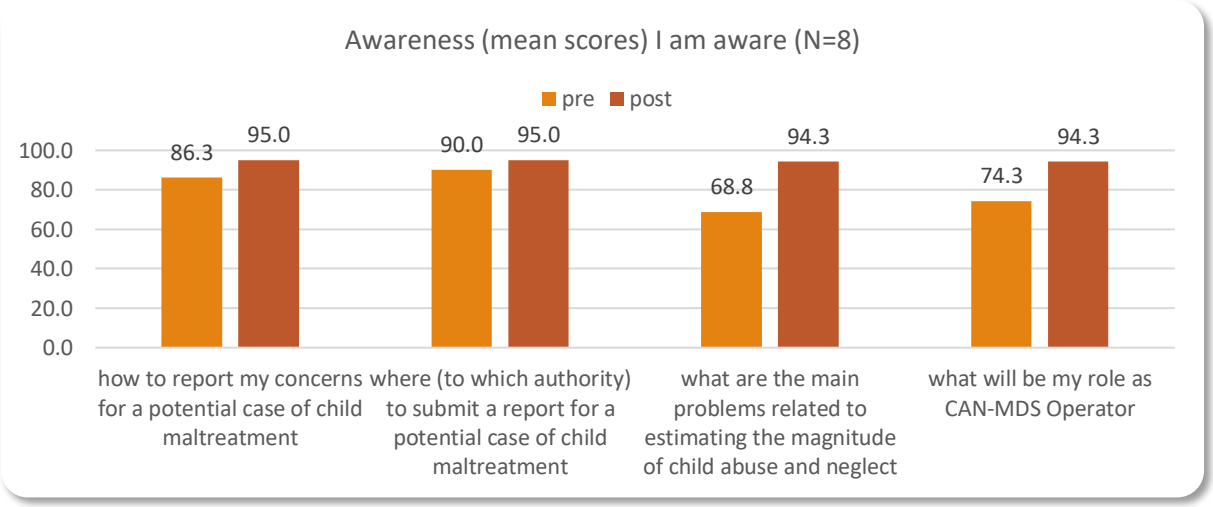

*Agreement*

The mean ratings (both pre-and post-training) of agreement with 5 statements describing critical aspects of CAN management, within the partner countries, indicate that participants view these CAN management dimensions as mostly inadequate. The post-training mean ratings decreased for 4 statements out of 5, with the exception of the statement regarding inter-sectoral cooperation.



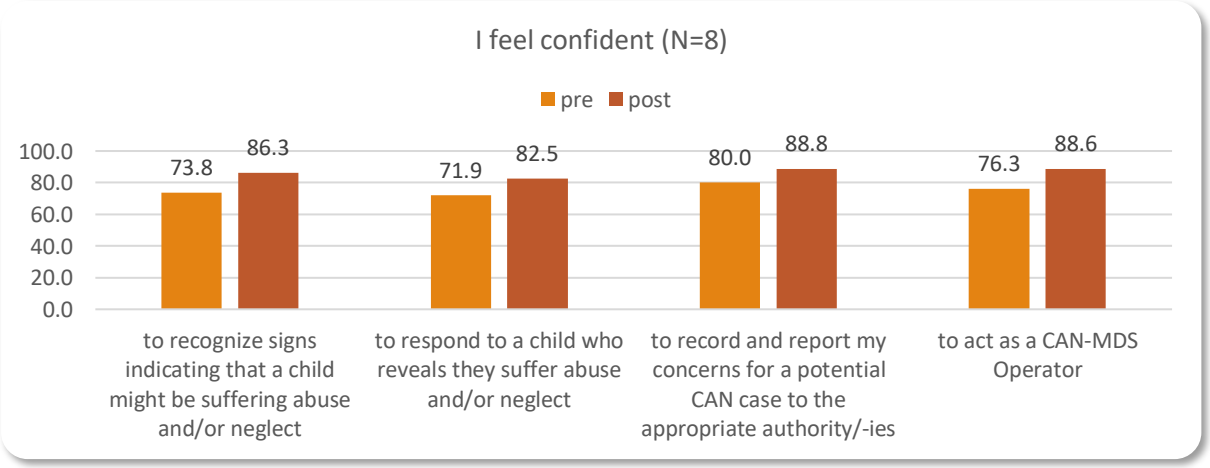
### *Awareness*

The mean ratings of awareness of the reporting protocol (within their country) and the phenomenon of underreporting, along with the prescribed CAN-MDS Operator's role are displayed below. Participants, initially, reported that they are, on average, 90% aware what authority to report a potential case of child maltreatment to, and, on average, 86.3% aware of how to report their concerns for a potential case of CAN. The post-training mean ratings of awareness on the same items reflect increases (to 95% for both, SD=7,56, min 80; max 100, for both items). Participants reported, in their initial ratings, awareness of 68.8% of the main problems related to estimating the magnitude of child abuse and neglect and a 74.3% mean awareness of their prospective role as CAN-MDS Operators. Mean ratings of awareness regarding both statements increased to (average) 94.3% after the training (SD=5,34, min 90; max 100, for both items).



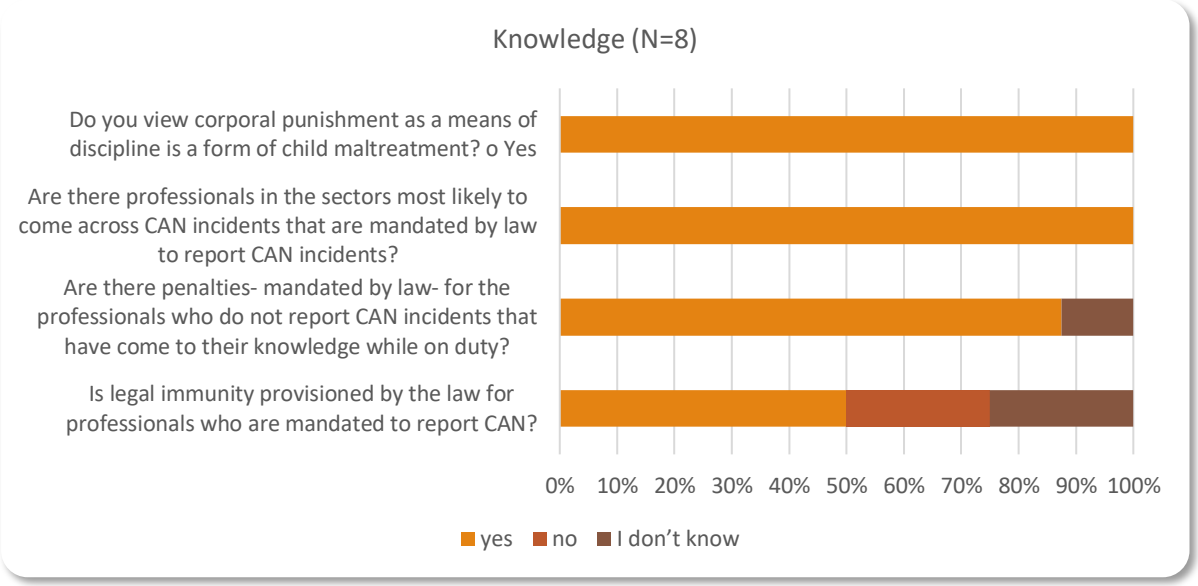

### *Confidence*

The mean ratings (both pre- and post-) of confidence regarding recognizing, responding to, recording and reporting CAN and acting as CAN-MDS Operator are shown below. All post-training confidence ratings increased.



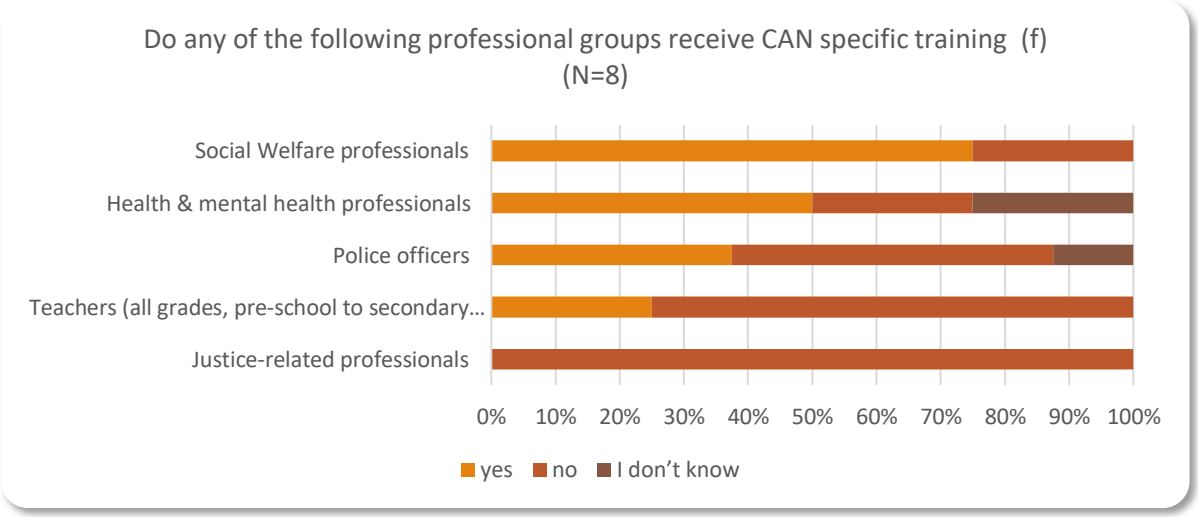
### *Knowledge*

The "knowledge" stacked bar chart demonstrates that one (1) out of the 8 participants responded that they did not know whether the law mandates penalties for the professionals who do not report CAN incidents they learn of or witness while on duty. The chart, further, shows, that two (2) out of the 8 participants do not know whether legal immunity is provisioned for the professionals mandated by law to report CAN, whereas two more (2) participants responded that no, there is no immunity provisioned in their country.




### *Knowledge about CAN specific training per professional group*

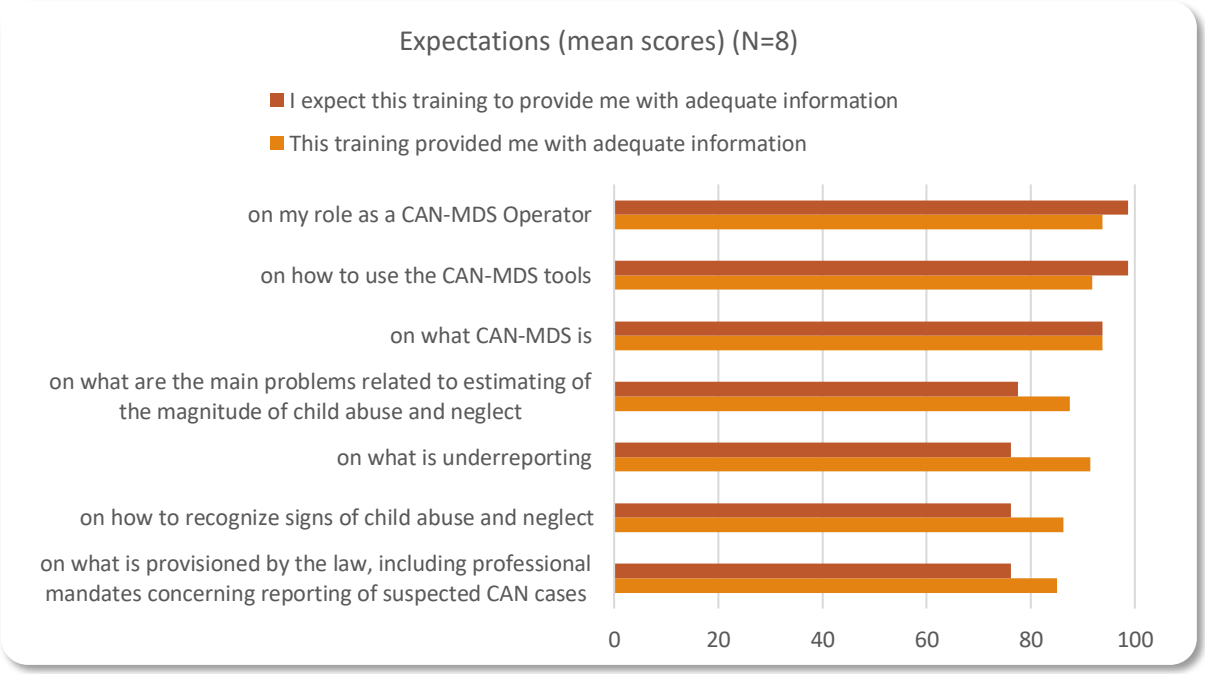
The stacked bar chart displaying the frequencies of the "yes", "no", "I don't know" responses of the participants on the CAN-specific training received shows that one participant out of the 8 reported they did not know whether police officers do, and four said police officers, in their country, do not.



Two participants reported that they do no know whether health and mental health professionals, receive such training, either, and two participants responded that these professional groups, in their country, do not. All participants noted that justice-related professionals in their countries do not receive CAN-specific training, and neither do teachers, according to 6 out of 8 respondents.

*Expectations and how they were met or not*

The mean scores of expectations (out of 100) before the training and those of expectations fulfilled after the training reveal that participants, on average, felt that they learned more about the underreporting issue (M=91,43, SD=14,64, min 60; max 100) than they initially expected to (M=76,25, SD=25,04, min 30; max 100). They also reported they received, on average more information on how to recognize signs of child abuse and neglect (M=86,25 , SD=15,06, min 60; max 100) than what they were expecting (M=76,25, SD=27,74, min 30; max 100), as well as on the provisions and law mandates on suspected CAN reporting (M=85, SD=16,04, min 60; max 100), than what they had in mind the training might give them (M=76,25, SD=27,74, min 30; max 100). However, participants, on average reported their expectations to learn about their role as CAN-MDS Operator (M=98,75 SD=3,53, min 9; max 10) were not exactly met (M=93,75 SD=10,6, min 70; max 100). Similarly, participants, on the whole, noted that their expectations regarding learning to use the CAN-MDS tools (M=98,75 SD=1,81, min 60; max 100) were, also, not met (M=91,87, SD=11,32, min 70; max 100).




The sample is very small (8) for the differences in the mean scores to be able to provide a single-storied account of what the data mean: for instance, regarding the expectations on how to use the CAN-MDS tools, seven participants had scored 100% in the pre-measurement and 1 gave a 90%, whereas in the post-measurement phase 5 participants scored 100% (meaning their expectations were perfectly met), and 2 scored 90%. One participant gave a 70%, which means that this trainee

considerd the training did not provide the expected information on using the CAN-MDS tools. This information is being examined with the utmost attention, since the group in the NA training consists of professionals with expertise both with CAN, in general, and with the learning process itself (i.e. they have had a long history, collectively, of formal education, and many rounds of various trainings on multiple subjects during their respective careers). Therefore, we have already made adaptations in the training material and structure to incorporate step-by-step, in multiple rounds, instructions on how to use all parts of the Toolkit and the e-app. We have, also, added a separate presentation with an analytical, lay-language worded preface on the role of CAN-MDS Operators, outside the official descriptions included in the Toolkit.

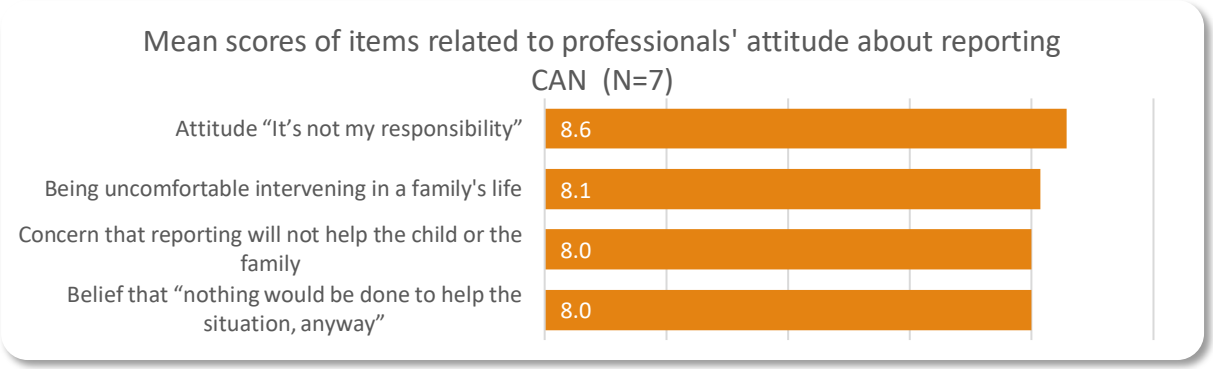
*Factors that hinder or prevent the decision of a professional to report suspected child abuse and/or neglect*

After the end of the simulation of he Operators' workshop, trainees were asked to assess, in their opinion, the extent to which each of a list of 35 factors hinders or prevent professionals from reporting suspected child abuse and neglect cases, namely the extent to which each factor contributes in underreporting.

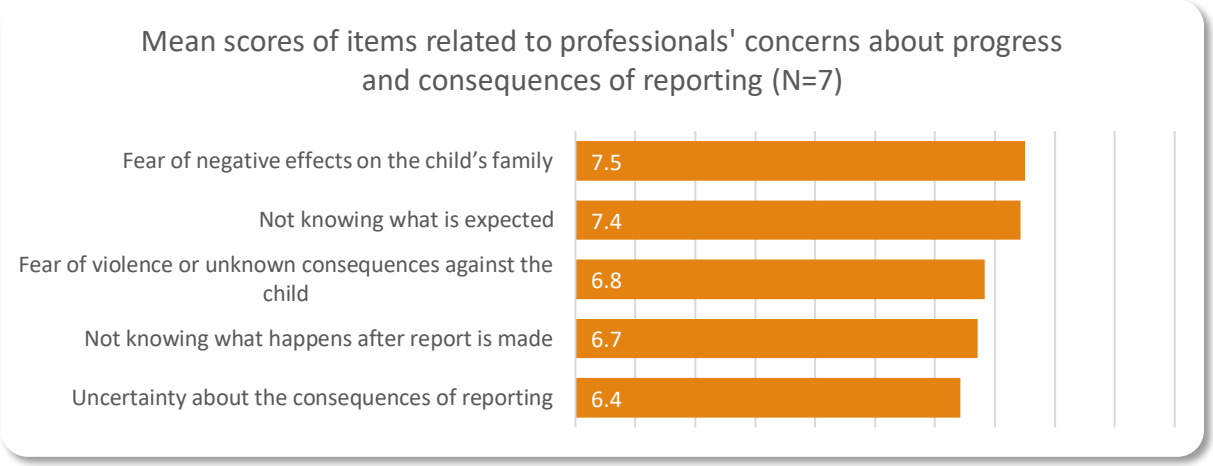
The results from the post-training questionnaires' section that rates the extent to which participants believe a number of listed factors hinder/prevent professionals from reporting suspected CAN incidents are featured in the figure above. On average, trainees indicated they find the attitude of "not my responsibility" as the most hindering factor on the list (M=8,57, SD=1,81, min 6; max 10), followed by "feeling uncomfortable to intervene in a family's life" (M=8,14,SD=1,34, min 6; max 10) and concern that "reporting will not help the child or their family" (M=8, SD=1,82, min 5; max 10), together with "nothing would be done to help the situation, anyway" (M=8, SD=2, 08, min 4; max 10). The next three most hindering factors are identified as "confidentiality associated with reporting CAN cases" (M=7,86, SD=1,57, min 5; max 10) , "fear that someone would find out they made the report" (M=7,67, SD=2,94, min 2; max 10) , and "lack of professionals knowledge of CAN signs" (M=7,57, SD=1,72, min 6; max 10). "Not knowing where to report" (M=7,43, SD=1,51, min 5; max 9) , and "not knowing what is expected" (M=7,43, SD=1,81, min 4; max 10) also feature high (on average) on the list with possible reasons preventing professionals from reporting CAN incidents.


Mean scores for the extent to which is factor hinder/prevent reporting of suspected CAN cases by professionals (scale 0=not at all-10=fully) (N=8)
Attitude "It's not my responsibility" 8.6
Being uncomfortable intervening in a family's life 8.1
Concern that reporting will not help the child or the family 8.0
Belief that "nothing would be done to help the situation, anyway" 8.0
Confidentiality associated with reporting CAN cases 7.9
Fear that someone would find out you made report 7.7
Lack of professionals' knowledge about the signs and/or… 7.6
Lack of confidence in child protection authorities and their ability… 7.6
Fear of negative effects on the child's family 7.5
Not knowing where to report 7.4
Not knowing what is expected 7.4
Lack of certainty about the diagnosis of CAN 7.3
Lack of adequate knowledge about abuse and neglect and… 7.0
Fears of a negative impact on professional's practice, fear of… 7.0
Fear that reporting would damage professional's relationship… 6.8
Fear of violence or unknown consequences against the child 6.8
Adequacy of training that mandated reporters receive 6.7
Previous poor experience with responsible authorities 6.7
Not knowing what happens after report is made 6.7
Currently applied screening processes 6.6
Feedback currently provided to reporters by the authorities… 6.5
Fear of making inaccurate report 6.5
Uncertainty about the consequences of reporting 6.4
No apparent physical sign of abuse 6.3
Amount of time it takes to make a report 6.1
Currently applied reporting process 5.9
Lack of professionals' knowledge of referral procedures 5.7
Currently applied policies or procedures 5.6
Vague organizational protocols 5.3
Lack of adequate history 5.3
Unclear statutory laws 5.2
Existing step-by-step process to follow when making a report 5.0
Difficulty for the professional to make a report 4.9
Fear of legal ramifications for false allegations 4.7
Family violence against professionals 4.4
0
2
4
6
8
10

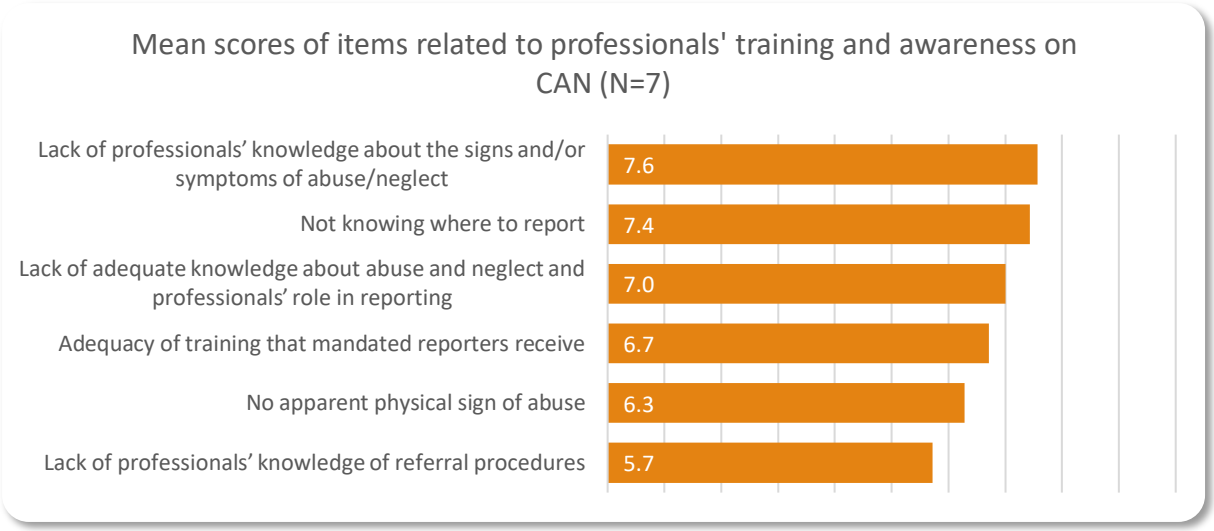
By grouping the potential reasons hindering reporting, it seems that trainees rated higher than others those related to *professionals' attitude about reporting CAN*. All relevant items had the highest scores among the 35 reasons assessed by trainees, while the first reason hindering the decision of a professional to proceed with a report of CAN was the attitude "*it's not my responsibility*".




The next group of reasons assessed by trainees to hinder the decision of professionals to proceed with CAN reporting is related to professionals' concerns about the consequences of reporting and that they are not informed about the progress of the case after the submission of the report. It is of note that the reason with the highest mean score in this case is the "*fear of negative effects on the child's family*" while the fear for the child (alleged) victim received a lower score.

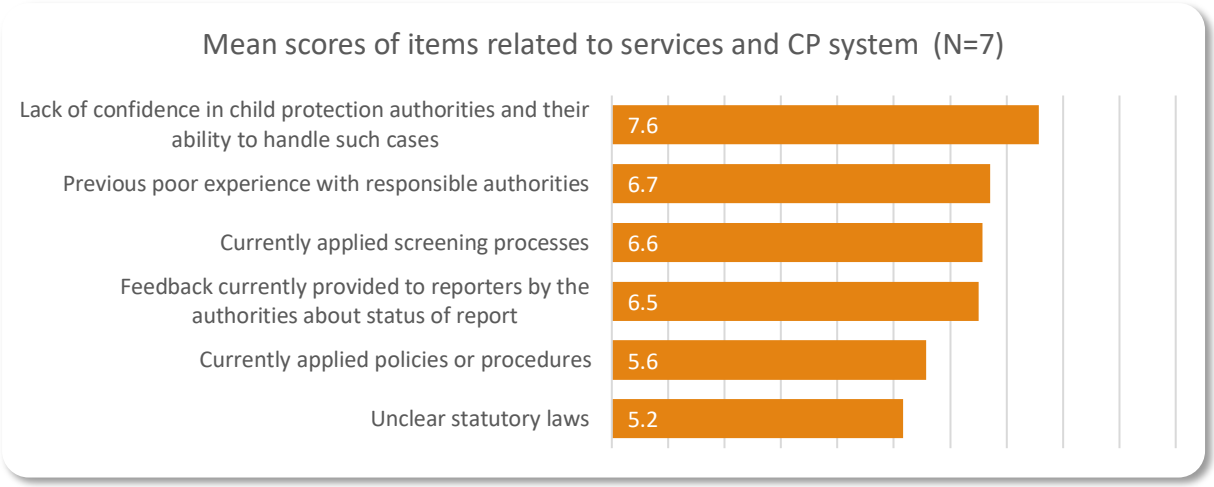



Another category of reasons that have been assessed by trainees as factors hindering reporting of CAN are related to the adequacy of professionals' training and awareness of CAN issues relating to recognition of CAN and the reporting procedures. The highest score in this category was for the item "*lack of professionals' knowledge about the signs and/or symptoms of CAN*" followed by "*(professionals) not know where to report*".




Professionals' concerns related to their work relationships with a child and family as well as concerns about their own safety was the next group of factors assessed by trainees to hinder professionals making the decision to report CAN cases. It is indicative that one of the highest scores in this category concerned the "*fear (of professional) that someone would find out that s/he made the report*" which would not be expected (especially in regard to mandated professionals) taking into account the relatively low scores for items "*(fear of) family violence against professionals*" and "*fear of legal ramifications for false allegations*".

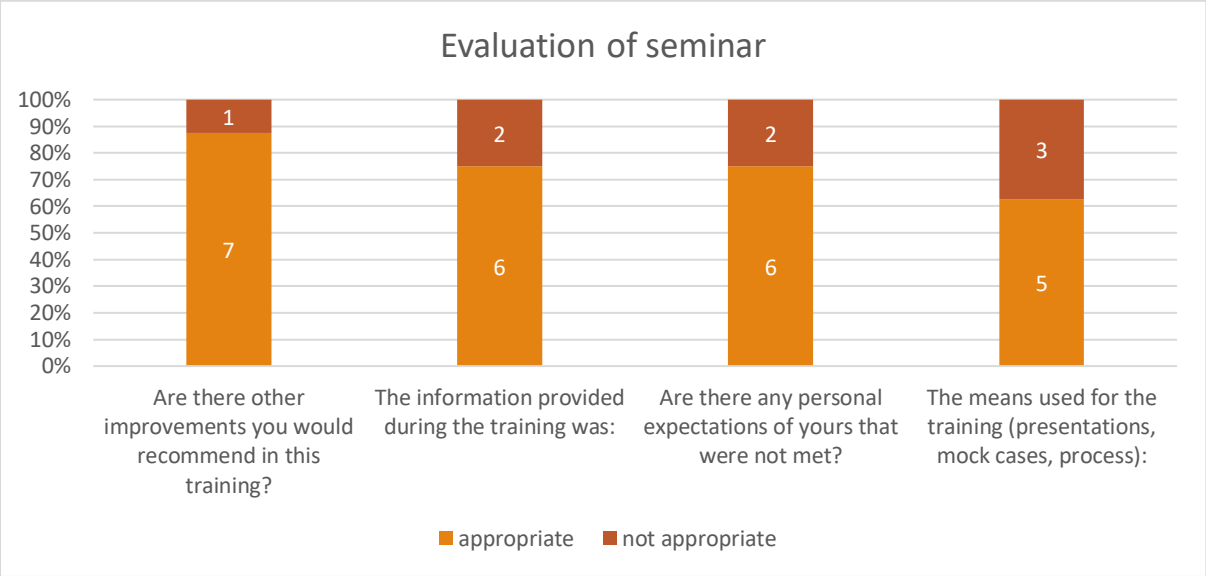

The reasons given related to the confidence of professionals to authorities and the currently applied practices received on average lower scores that the above groups of factors. However, "*lack of confidence in CP authorities and their ability to handle such cases*" was given as a main reason for non reporting, followed by "*previous poor experience (of professional) with responsible authorities*".




Lastly, the group of items with the lower mean scores given as reasons hindering CAN reporting is related to preparation of reports and the reporting process. The highest score, however, concerned "lack of certainty about the diagnosis of CAN" which is also closely related to the adequacy of knowledge and training of professionals. "*Difficult for the professionals to make a report*" received the lowest mean score as a factor hindering reporting of CAN.

## *Seminar Evaluation*

The final figure in this report presents the frequencies, in percentages and actual numbers, of participants responses to four evaluation questions regarding the seminar's quality. The one participant who reported they found the seminar in need of improvement recommended incorporating use of role play. The written explanation for expectations being unmet indicates that the specific participant would have wanted more bilateral time (i.e. time for bilateral meetings between the project coordinating team and each of the partner representatives).




Accomodation ratings (i.e. seating comfort, facilities mean score (0-10) was 9,25 (SD=0,88, min 8; max 10).


## *The Mock Case script used for the Simulation*

| | | |
|---|---|---|
| **Mock case** (along with instructions for the referee) | **> Initial referral**<br>"Good morning. I would like to report the case of a child that I suspect is being severely maltreated."<br>« About 5 months ago, a small girl with injuries was admitted in the clinic I work at. During the physical examination, I noticed an obvious swelling of the right eyelid, along with bruises on the thighs and buttocks. It was clear she had been beaten with some object, a stick, or something similar. Her parents, visibly overwhelmed, claimed the girl had been attacked by an older, unknown child in the street, where they were playing, and no further inquiries were made. Today, however, the girl was admitted, for a second time, with even more critical injuries than the first time. The parents said they found her in this state, beaten, in her bed." The child's name is Kate Miller. | **Data to be recorded and/or auto-calculated** |
| **RECORD** | > in case you receive a question about «the agency's ID» say "I do not know/I do not understand the question"<br>> in case you receive a question about «the operator's ID» say «I do not know /I do not understand the question»<br>> if you get asked about today's date, say «April 25th, isn't it?;»<br>> if you receive a question about your relationship with the child, say « I am a pediatrician and, as I said, I work at the Children's Hospital of "Saint Marina", in Athens»<br>> if you receive more questions about the child (such as names/surnames of caregivers, address, contact phone number) respond «The names of the parents are Giannis and Eleni. The address on file says 10 Portland St. in Athens and their phone number is 210 3333444» | Operator's id (auto-completed)<br>Agency's ID (auto-completed)<br>Date of Record (auto-completed)<br>Information provided by: |
| **Child (alleged) victim** | > if you receive a question about «child's ID» say «I do not know/I do not understand the question»<br>> if you get asked about the child's sex, say « I told you, she is a girl»<br>> if you get asked the child's age, say «she must be approximately 7.5 years old»<br>> if you receive a question specifically about her date of birth, reply «I have her birth date on file. Would you please give me a minute to locate it?» then pause for two seconds and continue « she was born January the 3rd, 2012»<br>> if you receive questions regarding the child's citizenship, say «her parents are Greek nationals. Based on the child's health record she is a Greek national, too. By the way, since I mentioned the record, the child has received, almost, none of the mandatory vaccinations, until now» | ID: (TEMP auto-completed)<br>Sex:<br>Date of birth:<br>Citizenship status: |
| **Family and Caregiver(s)** | > if you get asked about the child's family or family situation, respond «she was brought in both times by her parents; I suppose she lives with them»<br>> if you receive a question regarding the family composition/ other family members, or, whether you know who else lives with the child, say «Based on the conversation I had with her parents the first time, when I asked whether perhaps Kate had had a fight with her siblings, they mentioned she is the only child in the family. This is the extent of my knowledge»<br>> if you get asked who was responsible for the child's care when the incident took place, say «The parents, I believe, although, both times, for both incidents, the parents mentioned Kate was by herself»<br>> if you receive a question regarding the caregivers' sex, say «what do you mean? … we are talking about the mother and the father»<br>> if you receive questions regarding the caregivers' date(s) of birth, say «I cannot know that, we keep no records of the parents' dates of birth»<br>> if you get asked about the probable ages of parents, say «they are in their 30s» | Type of family:<br>Family's member(s):<br>Primary caregiver(s):<br>1st caregiver:<br>2nd caregiver: |


| | | |
|---|---|---|
| | > if you are asked to be more specific regarding the caregivers' probable ages, say «the mother seems like she could be 25-30, and the father a little older, like 30-35» | |
| **Incident** | > in case you receive a question about the «incident ID» say «I do not know/I do not understand the question»<br><br>> if you get asked when did the incident take place, say «judging from the wounds' state, I suppose it probably happened about two days before she was brought into the hospital. I cannot know with certainty but I believe it must have been a couple-or 3 days before she came in»<br><br>> if you get asked about where the incident took place, say «her parents mentioned that, this time, they found her at home, in this state, whereas, the first time they brought her in, they had claimed some child had beaten her on the street»<br><br>> if you receive questions seeking more information regarding (possible) acts of maltreatment or omissions in the child's care relating to the CURRENT incident, say « she was flogged, most likely with a belt, her back has scratches and bruises everywhere; in addition, she presents with an aggravated inflammation inside the mouth cavity, possibly because she ate something really spicy, like some sauce, chilli pepper or something like that; in any case she was very scared, when she came in, she was trembling and crying; I tried to ask her about what happened, but she could not utter a single word. I am not sure if it's due to the inflammation in the mouth, or she is just very scared»<br><br>> if you get asked does she go to school, say «I do not know, but I would not think so, she is really young» | Date of incident:<br><br>Place of incident:<br><br>Form(s) of maltreatment: |
| | > When, upon finishing the incident's recording, you are asked whether you might want to add anything, please, provide the following statement:<br>« I was not sure whether I should be calling you, but I am afraid something is off with this family, I mean with the child and her parents. The truth is I first brought it up with my stomatologist colleague, because the parents' explanations, both this time, and the time before, sound a little shady. Since there is no relevant social service/welfare provider in our place of employment, we decided to call you regarding any further action, so that we may be able to prevent something worse, if, indeed, it is the parents' doing. We are not certain that something is really going on, but it looks likely-I wanted to make this clear» | |


*Working with Mock case Simulation Results*

| FULL RECORD | 1st RECORD | 2nd RECORD | 3rd RECORD | Notes |
|---|---|---|---|---|
| **GR-A1-ROI-001-2634-0-559** | ES-ILF-JUD-135-242-0-001 | ES-CT-NGO-001-2265-1-001 | CY-01-CPS-002-2632-0-002 | Correct (auto-completed) |
| **GR-A1-ROI-001** | ES-ILF-JUD-135 | ES-CT-NGO-001 | CY-01-CPS-002 | Correct (auto-completed) |
| **2019-12-05 [15:58]** | 2019-12-05 [14:58] | 2019-12-05 [14:58] | 2019-12-05 [15:16] | Correct (auto-completed) |
| **Personnel working in Health services** | Personnel working in Health services | Personnel working in Health services | Personnel working in Health services | Correct |
| **CHILDTEMP_X** | CHILDTEMP_X | CHILDTEMP_X | CHILDTEMP_X | Correct (auto-completed) |
| **Female** | Female | Female | Female | Correct |
| **2012-01-03 (age 8)** | 2012-01-03 (age 8) | 2012-01-12 (age 8) | 2012-01-03 (age 8) | typo in birth date |
| **Citizen** | Citizen | Citizen | Citizen | Correct |
| **Child lives with his/her family (including biological/ adoptive)** | Child lives with his/her family (including biological/ adoptive) | Child lives with his/her family (including biological/ adoptive) | Child lives with his/her family (including biological/ adoptive) | Correct |
| **2 Parent(s)** | 2 Parent(s) | 2 Parent(s) | 2 Parent(s) | Correct |
| **Parent(s) - Parent(s)** | Parent(s) - Parent(s) | Parent(s) - Parent(s) | Parent(s) - Parent(s) | Correct |
| **Male Parent(s), born: 80's, (age approximately 30 - 40)** | Male Parent(s), born: Unknown | Male Parent(s), born: Unknown | Male Parent(s), born: Unknown | parents-caregivers were recorded but none of the Operators asked for parents' age |
| **Female Parent(s), born: 90's, (age approximately 20 - 30)** | Female Parent(s), born: Unknown | Female Parent(s), born: Unknown | Female Parent(s), born: Unknown | |

| | | | | |
|---|---|---|---|---|
| **Continuous maltreatment – including "distinct event(s)" - 2019-07 for approximately 5 Months 6 Days or less - Last known CM incident date: 2019-12-03** | Continuous maltreatment – including "distinct event(s)" - 2019-07 for approximately 5 months 4 days or less - Last known CM incident date: 2019-12-05 | Continuous maltreatment – including "distinct event(s)" - 2019-07 for approximately 5 months 4 days or less - Last known CM incident date: 2019-12-05 | Continuous maltreatment – including "distinct event(s)" - During the last 12 months<br><br>(correct but it could be more precise) | none of the Operators noted that the referral said that incident took place 2-3 days before |
| **Home/ Family** | Home/ Family | Home/ Family | Home/ Family | Correct |
| **(1) Physical violence acts committed [with or without injury] - Physical violent acts/ corporal punishment/ "disciplines" - Hitting with an object**<br>**(2) Psychological violence acts committed [with or without injury] - Psychological violence acts with or without obvious consequences - terrorization / scaring**<br>**(3) OMISSIONS - medical neglect related omissions - refusal to provide preventive health care (vaccinations, vision, and dental care) - supervision related omissions - inadequate/ lack of supervision resulting in physical harm** | (1) Physical violence acts committed [with or without injury] - Physical violent acts/ corporal punishment/ "disciplines" - Smaking - hitting with an object -<br>(2) Physical violence acts committed [with or without injury] - Violence acts known as harmful practices - forcing to ingest spicy food | (1) Physical violence acts committed [with or without injury] - Physical violent acts/ corporal punishment/ "disciplines" - Smaking - hitting with an object -<br>(2) Physical violence acts committed [with or without injury] - Violence acts known as harmful practices - forcing to ingest spicy food | (1) Physical violence acts committed [with or without injury] - Physical violent acts/ corporal punishment/ "disciplines" - hitting with an object - beating<br>(2) Physical violence acts committed [with or without injury] - Other described physical acts<br>(3) Psychological violence acts committed [with or without injury] - Psychological violence acts with or without obvious consequences - no specific information for reported/suspected psychological violence acts | All Operators recorded physical violence and specifically "hitting with an object"; also 2 of them recorded harmful practices ("forcing to ingest spicy food"); 1 of them recorded "psychological violence" and none of them "omissions"; the reporting of the incidents in all cases provides a good idea but it could be more complete and detailed. |

During the intake and recording of mock cases, for the CAN-MDS Operators' simulation exercise, the group ran into technical problems with the application-possibly due to incorrectly following instructions regarding the coding of agency by inputting the ISO codes and the software's random glitches, which at the time of this report writing have been rectified. In addition, one of the participants, the NA for Greece was also, informally, performing duties of trainer's assistant, thus, not being able to conclude her mock case input. Hence, the resulting recordings are only three.

The last two data elements related to services' involvement (DE_S1. Institutional Response and DE_S2: Refferal(s) to Services) were not assessed as it wasn't expected from trainees to reply in a specific-predefined way. Concerning the remaining 16 data elements:

Data Elements related to RECORD

| | |
|---|---|
| DE_R1: Agency's ID | - auto-completed |
| DE_R2: Operator's ID | - auto-completed |
| DE_R3: Date of Record | - auto-completed |
| DE_R4: Source of information | - completed by trainees-Operators (3 correct inputs) |

Data Elements related to CHILD

| | |
|---|---|
| DE_C1: Child's ID | - temporary Child's ID (produced by the system) |
| DE_C2: Child's Sex | - completed by trainees-Operators (3 correct inputs) |
| DE_C3: Child's Date of Birth | - completed by trainees-Operators (2 correct inputs – 1 typo) |
| DE_C4: Child's Citizenship Status | - completed by trainees-Operators (3 correct inputs) |

Data Elements related to FAMILY

| | |
|---|---|
| DE_F1: Family Composition (type of family) | - completed by trainees-Operators (3 correct inputs) |
| Member(s) of family | - completed by trainees-Operators (3 correct inputs) |
| Number per member's identity | - completed by trainees-Operators (3 correct inputs) |
| Indication of Child's Primary Caregiver(s) | - completed by trainees-Operators (3 correct inputs) |
| DE_F2: 1st Primary caregiver relationship to child | - completed by trainees-Operators (3 correct inputs) |
| 2nd Primary caregiver relationship to child | - completed by trainees-Operators (3 correct inputs) |
| DE_F3: 1st Primary caregiver's sex | - completed by trainees-Operators (3 correct inputs) |
| 2nd Primary caregiver's sex | - completed by trainees-Operators (3 correct inputs) |
| DE_F4: Primary Caregiver(s)' date of birth | - completed by trainees-Operators (NO input – none asked for information) |
| 2nd Primary caregiver's date of birth | - completed by trainees-Operators (NO input – none asked for information) |

Data Elements related to INCIDENT

| | |
|---|---|
| DE_I1: Incident ID | - incident ID produced by system |
| DE_I2: Date of Incident-chronicity of CAN | - completed by trainees-Operators (3 correct inputs) |
| Specific date of incident | - completed by trainees-Operators (3 correct but NOT presice inputs – 2 had a deviation of 2 days and 1 replied "during the last 12 months" instead of a specific date) |
| DE_I3: Form(s) of maltreatment | - completed by trainees-Operators (3 correct but NOT full inputs – All Operators recorded physical violence and specifically "hitting with an object"; also 2 of them recorded harmful practices ("forcing to ingest spicy food"); 1 of them recorded "psychological violence" and none of them "omissions"; the reporting of the incidents in all cases provides a good idea but it could be more complete and detailed) |
| DE_I4: Location of Incident | - completed by trainees-Operators (3 correct inputs) |

Summarizing, the quality of the input reveals some (random) typing errors, a systematic failure to enquire at intake for more information regarding the parents/caregivers, and the need to perhaps put more emphasis during training on studying, learning and practicing using all of the omissions and actions of maltreatment categories in order for each incident to be as fully documented as possible.

# Conclusion

The trainees' group in this training was heterogeneous as participants derived from six different countries and, therefore, no common replies were expected to be collected, especially on issues relating to country specifics. Several similarities, however, were identified in partners' countries; some of them are expected to facilitate the piloting of the CAN-MDS (e.g. about mandatory by law reporting by professionals who work in relevant sectors and provision of penalties for non-reporting) while others would probably hinder the piloting (e.g. often the provisioned penalties in case of non-reporting by mandated professionals are not fully implemented and, in addition there is lack of policies ensuring *legal immunity* of professionals who submit CAN reports to authorities).

Trainees were asked whether various professional groups receive CAN specific training after they are hired and before their employment begins in their countries. From the replies it seems that adequate training does not take place in most of the countries, especially for professional groups who work with children (as teachers, police, justice, health and mental health). This result indicates that CAN-MDS training is expected to have a crucial role for a successful pilot implementation of the system and to provide to a number of professionals the opportunity to attend a workshop on issues related to identification, recognition and reporting of CAN cases.

**DAY 1 – Training on the role and responsibilities of National CAN-MDS Administrators**

The expectations of trainees from the 1st day of the training (role and responsibilities of National Administrators) were high especially in regard to learning about their responsibilities as National Administrators in general as well as on practical issues (such as creation and administration of pseudonyms, operators and agencies accounts and the organization of workshops for the operators in their countries). On completion of the training, trainees were asked to reply to what extent each of their initial expectations was fulfilled. With respect to half of the issues, it seems that trainees' expectations have been adequately fulfilled, suggesting that the training provided them with adequate information on specific aspects of their future role as National Administrators (such as on how to create and administrate accounts of agencies and operators; how to maintain off line data bases; how to identify and invite agencies and operators to be involved in the CAN-MDS system and on ethical issues relating to piloting of the system in their countries). In some cases, however, trainees' expectations appear to not have been met adequately, suggesting that they found the training did not provide them with adequate information on the specific aspects of their future role as National Administrators. Specifically, the results indicate that trainees needed more information on *how to implement and evaluate the national training of CAN-MDS Operators, how to extract and edit disaggregated anonymized incidence data; how to communicate with professionals when a CAN incident is recorded in the system, how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources, when necessary* and *how to create and administrate pseudonyms of children involved in CAN incidents*. These specific issues will be addressed with more information being included in the training material for the workshop of Operators.

Trainees were also asked to assess their knowledge on what the CAN-MDS system is, what are the main problems related to CAN surveillance and in what specific ways the CAN-MDS addresses the need for

CAN surveillance. In all relevant questions there was an increase in the scores after the training compared to scores given before the training, suggesting that the training provided adequate relevant information to trainees on these specific issues.

The extent to which trainees considered that they are aware of issues relating to the role and the responsibilities of National Administrators was assessed also. The comparison between pre- and post-measurement suggests that the training provided adequate additional information to trainees on the role of National CAN-MDS Administrators, although there is room for some further improvement on issues relating to the organization and evaluation of workshops for CAN-MDS Operators at a national level.

Trainees were also asked how confident they felt to act as National Administrators, to identify and invite agencies and professionals to be involved in the piloting of the CAN-MDS system and to train the national groups of Operators. Again, scores after completion of the training were higher than the first measurements. Taking into account self-assessments of trainees concerning their awareness and confidence to become National Administrators it is observed that the more aware trainees assess they are, the more self-confident they report feeling about becoming National Administrators.

**DAY 2** – Simulation of CAN-MDS Operators' workshop

Eight persons participated in this training representing sectors working with and/or for children (health and mental health; social werlfare/child protection; justice). The majority of participants in the simulation of Operators' workshop report having been trained before on issues relating to CAN, while 3/4 remarkably say the training they have received was "on the job": based on their reports they had had no relevant formal training (i.e. undergraduate, post-graduate). Participants' work experience with children had a mean duration of ~8 years while the majority responded that they have had experience of working with young teens but not with very young children (0-4 years old). Most trainees reported they have worked with vulnerable children and families often, whereas half of the them have had experience of working with children victims of abuse frequently or always. Lastly, half of them have reported at least one suspected CAN incident they either learned about or witnessed while on professional duty and, moreover, two of them as private citizens (i.e. notwithstanding their professional identity).

Concerning their expectations about this training, comparison of pre- and post-training evaluation suggests that participants, on average, considered that they learned more about the underreporting issue than they had expected to initially. They also reported they received, on average more information on how to recognize signs of child abuse and neglect than what they were expecting from the training, as well as on the provisions and law mandates on suspected CAN reporting. All these issues are among the main learning objectives of this training. However, participants, on average reported their expectations to learn about their role as CAN-MDS Operator were not met exactly and, similarly, that their expectations regarding learning to how to use the CAN-MDS tools were, also, not met. Although this could be a weakness of the training of operators, it should be reminded that simulation of workshop took place in half of the time (compressed in 1 instead of 2 days) and, in addition, some technical issues required the training to pause at some points. This information is being examined with the utmost attention, since the specific group of trainees consisted of professionals with expertise both with CAN, in general, and with the learning process itself (i.e. they have

had a long history, collectively, of formal education, and many rounds of various trainings on multiple subjects during their respective careers). In response to this feedback, adaptations have been already made to the training material and structure to incorporate step-by-step, in multiple rounds, instructions on how to use all parts of the Toolkit and the e-app. Moreover, a separate presentation with an analytical, lay-language worded preface on the role of CAN-MDS Operators has been added, outside the official descriptions included in the Toolkit.

Concerning their knowledge, pre-training scores were high enough but in a modest way, perhaps, considering the level of expertise with CAN and with the earlier milestones of CAN-MDS development for most of the participants. Post-training scores show increases as trainees at the end of the training considered that they know more about what CAN is, how to recognize a child-victim of CAN, and what the CAN-MDS system is.

Trainees were asked about the current situation in their countries regarding the adequacy of the available CAN epidemiological data based on currently applied reporting practices; the adequacy of relevant professionals' training on CAN issues; in status of inter-sectoral cooperation in the administration of CAN cases and the awareness of professionals about mandates for reporting cases. Mean scores of agreement with all the above issues were low indicating that trainees consider these data are not adequate: There is underreporting of cases, inter-sectoral cooperation is not strong and professionals are not adequately aware of their mandates to report CAN cases. As was expected, no changes were noted before and after training given that the professionals in this specific group are very familiar with the above mentioned issues (which would probably will not be the same for professional-Operators).

After the end of the simulation of Operators' workshop, trainees were asked to assess, in their opinion, the extent to which various factors hinder or prevent professionals from reporting suspected child abuse and neglect cases, namely the extent to which each factor contributes in underreporting.

On average, trainees indicated they find the attitude of "not my responsibility" is the most hindering factor on the list, followed by "feeling uncomfortable to intervene in a family's life" and concern that "reporting will not help the child or their family"[2] together with "nothing would be done to help the situation, anyway"[3].

Hindering factors for reporting of CAN cases were explored also by groups, namely: factors related to professionals' attitudes; training adequacy and knowledge; awareness about procedures; concerns about reporting consequences on child and family; concerns about their work and safety; and services' response according to their experience. The following was found:

- Trainees rated higher than others those factors relating to *professionals' attitude about reporting CAN*. All relevant items had the highest scores among those assessed by trainees, while the first

[2] Similarly as in the findings of Walsh & Jones, 2015; this was found as the most frequent reason in decision to report suspected child abuse

[3] Ibid; this was found as the most important factor in decision to report suspected child abuse


reason for hindering the decision of a professional to proceed with a report of CAN was the attitude "*it's not my responsibility*".

- The next group of factors was related to professionals' concerns about the consequences of reporting and that they are not informed on the progress of the case after the submission of the report. It is of note that the reason with the highest mean score in this case is the "*fear of negative effects on the child's family*" while the fear for the child (alleged) victim received a lower score.
- Another category of reasons that have been assessed also by trainees as high was factors hindering reporting of CAN that are related to the adequacy of professionals' training and an awareness of CAN issues relating to the recognition of CAN and the reporting procedures. The highest score in this category was for the item "*lack of professionals' knowledge about the signs and/or symptoms of CAN*" followed by "*(professionals) not know where to report*".
- Professionals' concerns relating to their work relationships with a child and family, as well as concerns about their own safety, were the next group of factors assessed by trainees to hinder professionals from making the decision to report CAN cases. It is indicative that one of the highest scores in this category concerned the "*fear (of professional) that someone would find out that s/he made the report*" which would not be expected (especially with regard to mandated professionals) taking into account the relatively low scores for items "(*fear of) family violence against professionals*" and "*fear of legal ramifications for false allegations*".
- Reasons relating to the confidence of professionals in the authorities and in the currently applied practices received on average lower scores that the above groups of factors. However, "*lack of confidence in CP authorities and their ability to handle such cases*" was assessed as a main reason for non reporting, followed by "*previous poor experience (of professional) with responsible authorities*".
- Lastly, the group of items with the lower mean scores for items that were given as reasons for hindering CAN reporting is related to preparation of reports and the reporting process. The highest score, however, concerned "lack of certainty about the diagnosis of CAN" which is also closely related to the adequacy of knowledge and training of professionals. "*Difficult for the professionals to make a report*" received the lowest mean score as a factor hindering reporting of CAN.

The above findings along with the assessment of the current situation constitute valuable information indicating where the training's learning objectives should be focused towards the achievement of a more effective reporting. CAN-MDS workshops may contribute to this aim by providing targeted training to professionals from various sectors on identification, recognition, reporting and follow-up of cases. Afterwards, the objective of the piloting of the system is to contribute an effective practice for the collection of CAN incidents data to be used in planning and improving the currently applied practices and policies for preventing and administrating CAN cases.

The evaluation results of the records via the CAN-MDS application seem to be positive as trainees-operators produced adequate records of the mock case presented. Given that for the trainees this was their first experience of recording an incident in the system, data input was complete in general and all records

provided a good description of the incident that, however, they could be more precise. The quality of the input revealed some typing errors while there were some missing information relating to the process of intake rather than the operability of the system (i.e. trainees-operators didn't asked the referee for more information regarding the parents/caregivers). This issue is going to be resolved in national trainings where more emphasis will be given to this area in the data collection protocol. Lastly, this part of the evaluation highlighted the need to put more emphasis during training on studying, learning and practicing using all of the omissions and actions of maltreatment categories in order for each incident to be as fully documented as possible. It is of note, however, that although specific types of violent acts and ommissions were not included in all records (in the mock case *hitting with an object* and *forcing to ingest spicy food*), the general types (*physical violent acts/corporal punishment/"disciplines"* and *harmful practices*) were recorded by all operators suggesting that the classification of various forms of maltreatments in CAN-MDS is operative.


CAN-MDS Toolkit
Synergy
Capacity
Lobbying
Coordinated response to Child Abuse & Neglect

# ANNEXES

## 1st Day (Training in the role of National CAN-MDS Administrator)-Pre-questionnaire

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

**National Administrators Training Workshop**
Date: December 4, 2019

| | |
|---|---|
| 1. 2nd | letter of your mother's name |
| 2. 3rd | letter of your father's name |
| 3-5: | 3 last digits of your phone number |

**5-digit Code:** |__|__|__|__|__|

Dear National Administrator,

Please rate each of the following statements on the basis of an 11-degree scale where 0=not at all (minimum evaluation) and 10=totally (maximum evaluation).

***Your feedback is sincerely appreciated. Thank you in advance!***

Country: _____ Professional Specialty: _____ Years in professional field (either in contact or working for children): _____

0 1 2 3 4 5 6 7 8 9 10
Not at all — Totally

| | I think I know | Rate |
|---|---|---|
| 1 | what CAN-MDS is | |
| 2 | the specific ways CAN-MDS II addresses the need for CAN surveillance | |
| 3 | what the main problems related to CAN surveillance are | |

| | I am aware of | Rate |
|---|---|---|
| 1 | what will be my role as National Administrator in general | |
| 2 | the specifics of my country's customized plan for the pilot phase of CAN-MDS System | |
| 3 | how to identify Agencies and their professionals who could become involved in the CAN-DMS in my country | |
| 4 | how to cooperate with National CAN-MDS Inter-sectoral Board | |
| 5 | how to select eligible Organizations and invite them to officially participate in CAN-MDS system as *Data sources* | |
| 6 | how to select eligible professionals and invite them to officially participate in CAN-MDS system as *Operators* | |
| 7 | how to plan the training of my country's Operators for the pilot of CAN-MDS system | |
| 8 | how to evaluate the training of my country's Operators as part of the pilot of CAN-MDS system | |

| | I feel confident | Rate |
|---|---|---|
| 1 | to act as a National CAN-MDS Administrator | |
| 2 | to identify and invite agencies and professionals to be involved in the piloting of CAN-MDS system | |
| 3 | to train the national group of Operators | |

| | I expect this training to provide me with adequate information | Rate |
|---|---|---|
| 1 | on ethical issues related to piloting CAN-MDS II in my country | |
| 2 | on my responsibilities as National CAN-MDS Administrator | |
| 3 | on how to identify and invite agencies in my country to become CAN-MDS Data Sources | |
| 3 | on how to identify and invite professionals in my country to become CAN-MDS Operators | |
| 4 | on how to implement the national training of CAN-MDS Operators | |
| 5 | on how to evaluate the national training of CAN-MDS Operators | |
| 6 | on how to maintain and administrate the *off line data base* containing children's personal data | |
| 7 | on how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources' Administrations when necessary | |
| 8 | on how to create and administrate pseudonyms of children involved in CAN incidents | |
| 9 | on how to create and administrate Organizations' accounts | |
| 10 | on how to create and administrate CAN-MDS Operators accounts | |
| 11 | on how to communicate with professionals when a CAN incident is recorded in the system | |
| 12 | on how to extract and edit disaggregated anonymized incidence data | |

INSTITUTE OF CHILD HEALTH




**Please provide really short answers (YES/NO/I DO NOT KNOW where applicable and/or a couple of short sentences where not) to the following questions.**

1. Are there professionals in the sectors most likely to come across CAN incidents in your country that are mandated **by law** to report CAN incidents? If yes, please list the professions/sectors.

2. Are there penalties- **mandated by law-** in your country, for the professionals who do not report CAN incidents that have come to their knowledge while on duty?

3. Is professional legal immunity for professionals, mandated to report CAN, available in your country?

4. Do any of the following professional groups receive CAN specific training after they are hired and before their employment begins in your country?
   - Social Welfare professionals _____
   - Police officers_____
   - Health & mental health professionals _____
   - Teachers (all grades, pre-school to secondary education) _____
   - Justice-related professionals_____

5. Have you personally ever reported a suspected CAN incident that you were informed about while on professional duty?
   No___ Yes___; if yes,
   How many cases?
   to whom/which authority/-ies? _____

6. Have you personally ever reported a suspected CAN incident that you were informed about while living your life as private citizen (meaning, not while you were on professional duty)?
   No___ Yes___; if yes,
   How many cases?
   to whom/which authority/-ies? _____

7. If you answered YES to any of the questions 5 & 6 please provide 2-3 sentences explaining what was in the suspected CAN incident you reported that made you decide to report? Do you recall a specific dimension of the case that stood out most for you at that time as likely to indicate CAN? What made you worry for the child in that case most?

## 1st Day (Training in the role of National CAN-MDS Administrator)-Post-questionnaire

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

**National Administrators Training Workshop**
Date: December 4, 2019

| | |
|---|---|
| 1. 2nd | letter of your mother's name |
| 2. 3rd | letter of your father's name |
| 3-5: | 3 last digits of your phone |

**5-digit Code:** |__|__|__|__|__|

Please rate each of the following statements on the basis of an 11-degree scale where 0=not at all (minimum evaluation) and 10=totally (maximum evaluation).

0 1 2 3 4 5 6 7 8 9 10
Not at all — Totally

| | I think I know | Rate |
|---|---|---|
| 1 | what CAN-MDS is | |
| 2 | the specific ways CAN-MDS II addresses the need for CAN surveillance | |
| 3 | what the main problems related to CAN surveillance are | |

| | I am aware of | Rate |
|---|---|---|
| 1 | what will be my role as National Administrator, in general | |
| 2 | the specifics of my country's customized plan for the pilot phase of CAN-MDS System | |
| 3 | how to identify Agencies and their professionals who could become involved in the CAN-DMS in my country | |
| 4 | how to cooperate with National CAN-MDS Inter-sectoral Board | |
| 5 | how to select eligible Organizations and invite them to officially participate in CAN-MDS system as *Data sources* | |
| 6 | how to select eligible professionals and invite them to officially participate in CAN-MDS system as *Operators* | |
| 7 | how to plan the training of my country's Operators for the pilot of CAN-MDS system | |
| 8 | how to evaluate the training of my country's Operators as part of the pilot of CAN-MDS system | |

| | I feel confident | Rate |
|---|---|---|
| 1 | to act as a National CAN-MDS Administrator | |
| 2 | to identify and invite agencies and professionals to be involved in the piloting of CAN-MDS system | |
| 3 | to train the national group of Operators | |
| 4 | to use the Administrator's interface | |

| | This training has provided me with adequate information | Rate |
|---|---|---|
| 1 | on ethical issues related to piloting CAN-MDS II in my country | |
| 2 | on my responsibilities as National CAN-MDS Administrator | |
| 3 | on how to identify and invite agencies in my country to become CAN-MDS Data Sources | |
| 3 | on how to identify and invite professionals in my country to become CAN-MDS Operators | |
| 4 | on how to implement the national training of CAN-MDS Operators | |
| 5 | on how to evaluate the national training of CAN-MDS Operators | |
| 6 | on how to maintain and administrate the *off line data base* containing children's personal data | |
| 7 | on how to maintain CAN-MDS Data sources accounts files and communicate with the Data sources' Administrations when necessary | |
| 8 | on how to create and administrate pseudonyms of children involved in CAN incidents | |
| 9 | on how to create and administrate Organizations' accounts | |
| 10 | on how to create and administrate CAN-MDS Operators accounts | |
| 11 | on how to communicate with professionals when a CAN incident is recorded in the system | |
| 12 | on how to extract and edit disaggregated anonymized incidence data | |

INSTITUTE OF CHILD HEALTH

## 2nd Day (Simulation of training of CAN-MDS Operators)-Pre-questionnaire

| Please create your personal code as follows: | | | | |
|---|---|---|---|---|
| AA. Day of birth (number from 01 to 31)<br>BB. Last 2 digits of your phone number | AA | AA | BB | BB |

Dear Participant,

Firstly, we would like to thank you for accepting the invitation to become a CAN-MDS Operator and for your participation in this training. Your replies in the following questions will be useful for us in order to proceed with the further improvement of the training module to be used in future trainings. The completion of the evaluation questionnaires is **ANONYMOUS**. Apart from the current questionnaire, at a later phase you will be asked to fill in two more questionnaires. In order for us to be able to match the replies per person, it will be necessary to have a code that will replace your personal data. To this end we would like to kindly ask you to create your personal code above following the instructions.

*Thank you in advance!*

*CAN-MDS Administrative Authority*

**GENERAL INFORMATION**

**1. Professional specialty** (e.g. teacher; social worker…): _____

**2. Sector where you are currently employed** (e.g. primary education; social services; …): _____

**3a. Work experience with children: _____ years**

| **3b. population of children I am working with:** | **Never** | **Seldom** | **Often** | **Frequently** | **Always** |
|---|---|---|---|---|---|
| General population of children (0-18) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Younger children (0-4) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Teenagers (13-18) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children with health/mental health problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children with disabilities | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vulnerable children/ vulnerable families (in general) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children with behavioral problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children in residential care | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children victims of abuse and/or neglect | ☐ | ☐ | ☐ | ☐ | ☐ |

**4. Previous training on issues related to child abuse and neglect:** ☐ No ☐ Yes. If "Yes", please provide details:

| | **in the context of** | **main subjects** |
|---|---|---|
| ☐ | undergraduate studies | |
| ☐ | post graduate studies | |
| ☐ | lifelong learning programs | |
| ☐ | my current work (training upon employment) | |
| ☐ | learning on the job (informal training) | |
| ☐ | Other (please, specify): _____ | |

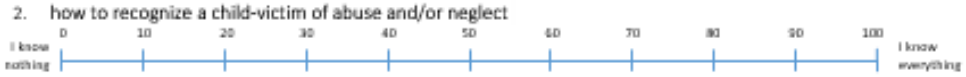
**5. Previous experience on reporting CAN:**

| Have you personally ever reported a suspected child abuse and/or neglect incident that you learned about or witnessed | |
|---|---|
| **while on professional duty?** | **while living your life as private citizen?** |
| ☐ No ☐ Yes. If "Yes", how many cases? _____<br>To whom/which authority/-ies?<br>_____<br>_____ | ☐ No ☐ Yes. If "Yes", how many cases? _____<br>To whom/which authority/-ies?<br>_____<br>_____ |
| If "Yes", please provide 2-3 sentences explaining what information was in the suspected CAN incident you were informed about and/or witnessed that made you decide to report? Do you recall a specific dimension of the case that stood out most for you at that time as likely to indicate CAN? What made you worry most for the child in that case? | |

6. Please assess your current knowledge using the scales below (*where 0 = I know nothing and 100 = I know everything*) on issues related to:

1. what child abuse and neglect (CAN) is


2. how to recognize a child-victim of abuse and/or neglect




3. what is provisioned by the law **for reporting of CAN cases by professionals working with/for children**


4. the magnitude of child abuse and neglect in my country


5. what the CAN-MDS System is

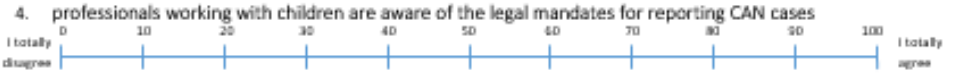

7. Please indicate to what extent you agree on the following issues on the basis of the scales below (*where 0 = I totally disagree and 100 = I totally agree*):

1. reporting of CAN cases in my country reflects the actual number of CAN cases

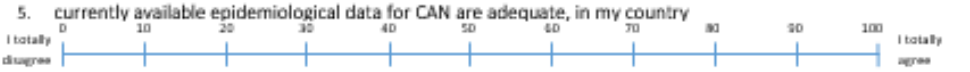

2. training of professionals working with children on child abuse and neglect issues is adequate


3. inter-sectoral cooperation in administration of CAN cases is effective


4. professionals working with children are aware of the legal mandates for reporting CAN cases




5. currently available epidemiological data for CAN are adequate, in my country




| **8.** | **In my country, I am aware of** | **Rate (0-100)** |
|---|---|---|
| **a** | how to report my concerns for a potential case of child maltreatment | |
| **b** | where (to which authority) to submit a report for a potential case of child maltreatment | |
| **c** | what are the main problems related to estimating the magnitude of child abuse and neglect | |
| **d** | what will be my role as CAN-MDS Operator | |
| **9.** | **I feel confident** | **Rate (0-100)** |
| **a** | to recognize signs indicating that a child might be suffering abuse and/or neglect | |
| **b** | to respond to a child who reveals they suffer abuse and/or neglect | |
| **c** | to record and report my concerns for a potential CAN case to the appropriate authority/-ies | |
| **d** | to act as a CAN-MDS Operator | |

**10. Please provide really short answers (YES/NO/I DO NOT KNOW where applicable and/or a couple of short sentences where not) to the following questions regarding the following situations in your country :**

a. Are there professionals in the sectors most likely to come across CAN incidents that are mandated **by law** to report CAN incidents?

☐ Yes ☐ No ☐ Don't Know. If yes, please list the professions/sectors.

b. Are there penalties- **mandated by law**- for the professionals who do not report CAN incidents that have come to their knowledge while on duty?

☐ Yes ☐ No ☐ Don't Know

c. Is **legal immunity** provisioned by the law for professionals who are mandated to report CAN?

☐ Yes ☐ No ☐ Don't Know

d. Do any of the following professional groups **receive CAN specific training after being hired and before employment begins**?

| | | | |
|---|---|---|---|
| Social Welfare professionals | ☐ Yes | ☐ No | ☐ Don't Know |
| Police officers | ☐ Yes | ☐ No | ☐ Don't Know |
| Health & mental health professionals | ☐ Yes | ☐ No | ☐ Don't Know |
| Teachers (all grades, pre-school to secondary education) | ☐ Yes | ☐ No | ☐ Don't Know |
| Justice-related professionals | ☐ Yes | ☐ No | ☐ Don't Know |

e. Do you view corporal punishment as a means of discipline is a form of child maltreatment? ☐ Yes ☐ No

Because:

| 11 | I expect this training to provide me with adequate information | Rate (0-100) |
|---|---|---|
| a | on what CAN-MDS is | |
| b | on my role as a CAN-MDS Operator | |
| c | on how to use the CAN-MDS tools | |
| d | on how to recognize signs of child abuse and neglect | |
| e | on what is provisioned by the law, including professional mandates concerning reporting of suspected CAN cases | |
| f | on what is underreporting | |
| g | on what are the main problems related to estimating of the magnitude of child abuse and neglect | |

## 2nd Day (Simulation of training of CAN-MDS Operators)-Post-questionnaire

Please create your personal code as follows:

| AA. Day of birth (number from 01 to 31) | AA | BB | BB |
|---|---|---|---|
| BB. Last 2 digits of your phone number | | | |

Dear Participant,

As before, please reply to the questions below following the respective instructions. It is important to not forget to fill-in your personal code in the upper right corner of this page.

Thank you again for your participation!
National Administrative Authority

1 Please assess your current knowledge on the basis of the scales below (*where 0 = I know nothing and 100 = I know everything*) on the following issues:

1. what child abuse and neglect (CAN) is

I know nothing 0 10 20 30 40 50 60 70 80 90 100 I know everything

2. how to recognize a child-victim of abuse and/or neglect

I know nothing 0 10 20 30 40 50 60 70 80 90 100 I know everything

3. what is provisioned by the law **for reporting CAN cases by professionals working with/for children**

I know nothing 0 10 20 30 40 50 60 70 80 90 100 I know everything

4. the magnitude of child abuse and neglect in my country

I know nothing 0 10 20 30 40 50 60 70 80 90 100 I know everything

5. what the CAN-MDS System is

I know nothing 0 10 20 30 40 50 60 70 80 90 100 I know everything

2. Please indicate to what extent you agree on the following issues on the basis of the scales below (*where 0 = I totally disagree and 100 = I totally agree*):

1. reporting of CAN cases in my country reflects the actual number of CAN cases

I totally disagree 0 10 20 30 40 50 60 70 80 90 100 I totally agree

2. training of professionals working with children on child abuse and neglect issues is adequate

I totally disagree 0 10 20 30 40 50 60 70 80 90 100 I totally agree

3. inter-sectoral cooperation in administration of CAN cases is effective

I totally disagree 0 10 20 30 40 50 60 70 80 90 100 I totally agree

4. professionals working with children are aware of the legal mandates for reporting CAN cases

I totally disagree 0 10 20 30 40 50 60 70 80 90 100 I totally agree

5. currently available epidemiological data for CAN are adequate in my country

I totally disagree 0 10 20 30 40 50 60 70 80 90 100 I totally agree


| 3. | In my country, I am aware of | Rate (0-100) |
|---|---|---|
| a | how to report my concerns for a potential case of child maltreatment | |
| b | where (to which authority) to submit a report for a potential case of child maltreatment | |
| c | what are the main problems related to estimating the magnitude of child abuse and neglect | |
| d | what will be my role as CAN-MDS Operator | |
| **4.** | **I feel confident** | **Rate (0-100)** |
| A | to recognize signs indicating that a child might be suffering abuse and/or neglect | |
| B | to respond to a child that reveals they suffer abuse and/or neglect | |
| C | to record and report my concerns for a potential CAN case to the appropriate authority/-ies | |
| D | to act as a CAN-MDS Operator | |
| **5** | **This training provided me with adequate information** | **Rate (0-100)** |
| A | on what CAN-MDS is | |
| b | on my role as CAN-MDS Operator | |
| c | on how to use the CAN-MDS tools | |
| d | on how to recognize signs of child abuse and neglect | |
| e | on what is provisioned by the law, including professional mandates concerning reporting of suspected CAN | |
| f | on what underreporting is | |
| g | on what the main problems related to estimation of the magnitude of child abuse and neglect are | |

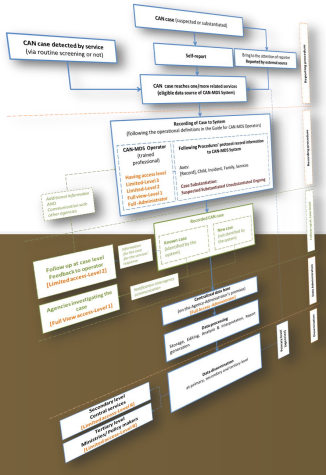
**6. Please rate (0-10 or NA-not applicable)** the extent that, **according to your opinion,** each of the following factors hinder, or prevent the decision of a professional to report suspected or actual child abuse/neglect:

_____ Attitude *"It's not my responsibility"*
_____ Amount of time it takes to make a report
_____ Being uncomfortable intervening in a family's life
_____ Belief that "*nothing would be done to help the situation, anyway*"
_____ Concern that reporting will not help the child or the family
_____ Confidentiality associated with reporting CAN cases
_____ Currently applied policies or procedures
_____ Currently applied reporting process
_____ Currently applied screening processes
_____ Difficulty for the professional to make a report
_____ Existing step-by-step process to follow when making a report
_____ Family violence against professionals
_____ Fear of legal ramifications for false allegations
_____ Fear of making inaccurate report
_____ Fear of negative effects on the child's family
_____ Fear of violence or unknown consequences against the child
_____ Fear that reporting would damage professional's relationship with family
_____ Fear that someone would find out you made report
_____ Fears of a negative impact on professional's practice, fear of litigation
_____ Feedback currently provided to reporters by the authorities about status of report
_____ Lack of adequate history
_____ Lack of adequate knowledge about abuse and neglect and professionals' role in reporting
_____ Lack of certainty about the diagnosis of CAN
_____ Lack of confidence in child protection authorities and their ability to handle such cases
_____ Lack of professionals' knowledge about the signs and/or symptoms of abuse/neglect
_____ Lack of professionals' knowledge of referral procedures
_____ No apparent physical sign of abuse
_____ Not knowing what happens after report is made
_____ Not knowing what is expected
_____ Not knowing where to report
_____ Previous poor experience with responsible authorities
_____ Adequacy of training that mandated reporters receive
_____ Uncertainty about the consequences of reporting
_____ Unclear statutory laws
_____ Vague organizational protocols
_____ Other? Please, specify:_____

| | Organization of the Seminar | |
|---|---|---|
| 1 | The duration of Seminar was: | 0. As much as needed<br>1. More than needed, I would suggest to last _____ hours<br>2. Less than needed, I would suggest to last _____ hours |
| 2 | The information provided during the Seminar was: | 0. As much as needed<br>1. More than needed<br>2. Less than needed<br>If 1 or 2: ***I would suggest to eliminate/add***: _____ |
| 3 | The means used for the training (presentations, mock cases, process): | 0. Was appropriate<br>1. Needs improvement; ***I would suggest to:*** _____ |
| 4 | Are there other improvements you would recommend in this Seminar? | 0. No<br>1. Yes; I would suggest:_____ |
| 5 | What is least valuable about this seminar? Why? | _____ |
| 6 | What is most valuable about this seminar? Why? | _____ |
| 7 | Are there any personal expectations of yours that were not met? | 0. No<br>1. Yes (*what and why*)_____ |
| 8 | How would you rate the accommodation (e.g. seating comfort, facilities) | _____ (please provide a rating from 0=min to 10=max) |


CAN-MDS Toolkit
Synergy
Capacity
Lobbying
Coordinated response to Child Abuse & Neglect

+




Action "Coordinated Response to Child Abuse & Neglect via Minimum Data Set: *from planning to practice*"
[REC-RDAP-GBV-AG-2017/ 810508]
[WP.3, Activity 3.3: D 3.2: Evaluation Report of Training of National CAN-MDS Administrators]

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