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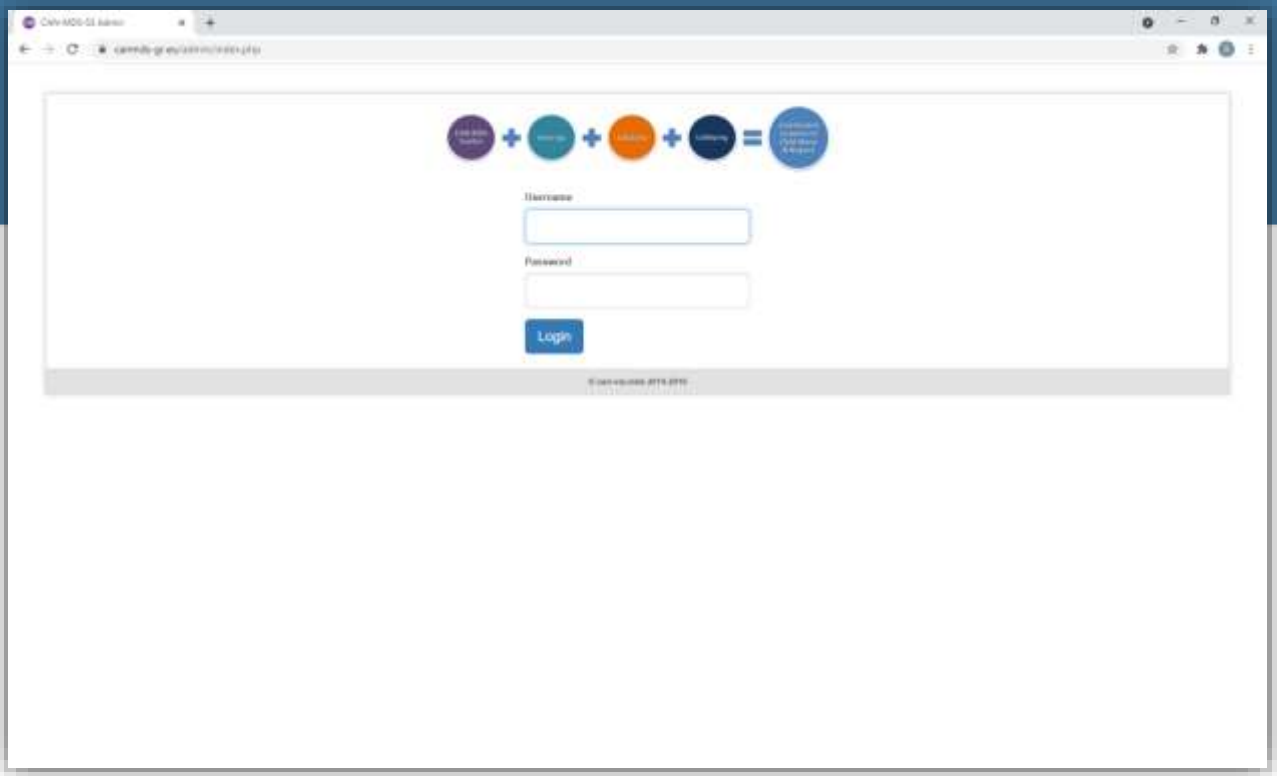
D4.4 GREECE

Reporting on CAN-MDS pilot implementation at a national level



Action's Identity

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

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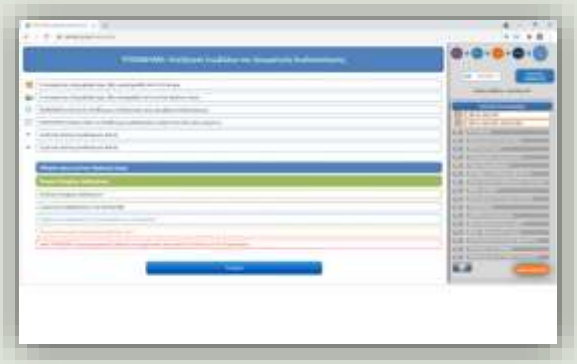


Administrator's Interface

Work Package 4: Piloting of CAN-MDS System

The aim of this work package was the transition of the revised CAN-MDS System from the planning to practice in order for the system's operational aspects to be tested and monitored in real settings in the context of a specific national plan. According to the customized plan that was initially prepared for Greece, piloting would take place at a national level and key-stakeholders of all relevant sectors would be involved as well as frontline professionals of various specialties working in relevant sectors with or for children. The system would be evaluated in terms of its effectiveness, applicability, and usability.

To achieve this aim, a number of activities took place in the context of WP4. Since the starting of piloting the National CAN-MDS Administrator (who signed the Annex 1 of the ToR D2.6) in close collaboration with National Coordinator of the project (representing the National Administrative Authority (ToR 2.6) continuously monitored the system's operation, including communication with operators, when needed, asking for their feedback, extracting and checking the anonymized data collected and collecting evaluation data via evaluation tools. Any developments and results related to the piloting of the system as well as the training of the professionals-operators and any relevant activities were presented in the plenary of the National Inter-Sectoral Board Report at a monthly basis (in three distinct meetings). In addition, a series of 4 online meetings took place where all members of the Consortium participated as well as the Expert on Ethics, the IT experts and the External Evaluator; progress, achievements and difficulties related to piloting of the system were presented and discussed for each country. The last WP4 activity concerns reporting on CAN-MDS pilot implementation at a national level, namely preparation of national piloting reports. Each national CAN-MDS piloting implementation and evaluation report is considered as a milistone for the project because an assessment of the system's operation in real conditions in each of the participating countries is presented. Results of these national reports are the basis for the drafting of an international report (D4.5) while relevant information along with operators' seminar evaluation results will be used for the development of national policy brief series and recommendations advocating against under-reporting and the necessity for systematic CAN monitoring.

For the evaluation of the CAN-MDS System operation in real conditions in Greece, the following indicators were applied (as it was discussed during the 1st Managerial Meeting, 2-3 Dec 2019, see presentation *"Development of the evaluation methodology & tools for assessing piloting results at national level"*):

Involved parties (before piloting)

- Representation of relevant sectors in the National Inter-Sectoral Board
    - Number of Sectors invited/accepted the invitation and participate in the Board
    - Number of meetings and participation rate in the meetings
- Number of agencies participating in the piloting as data sources
    - Rate of invited/accepted invitation
- Number of professionals participating in the training to become operators
    - Rate of invited/accepted invitation to be trained
- Number of professionals participating in the piloting as operators
    - Rate of trained/participated in piloting

Monitoring process

- National Inter-sectorial Board Meetings where progress assessed, potential problems and ways to overcome were discussed
- Online Consortium meetings involving local coordinators, national administrators, project leader and coordinator, external evaluator and experts on ethics and IT

Piloting – indicators for evaluation

- Deviations from the national plan in terms of
    - Level of piloting (national, regional or local)
    - Sectors to be involved
    - Number of professionals to be involved as operators
- Number of cases recorded
    - Totally
    - Geographically (per region)
    - Per sector
    - Per professionals' group
- Number of inter-sectoral cooperation via system (referral to services)
- Completeness of records (concerning data elements)
- Problems faced with the methodology (misunderstandings etc)
    - Periodic group discussion with Administrators in 6 countries (bimonthly)
- Technical problems faced with the system
    - Log recorded by the system

Involved parties

By design the CAN-MDS System aims to involve as much as possible potential stakeholders in order to widening the data sources of CAN reports, namely eligible professionals having various professional specialties and backgrounds working with or for children in organizations and services activated in relevant sectors (justice, law enforcement, social welfare, health, mental health, education, hotlines, governmental and NGOs). Involvement of various stakeholders in the context of CAN-MDS Piloting took place at three levels: the National CAN-MDS Inter-Sectoral Board; the cooperating Agencies (who signed bilateral relevant Memoranda of Collaboration) and the participating Professionals (who declared their willingness to participate in both, the required training and the piloting of the system signing also the necessary informed consent).

Representation of relevant sectors in the National Inter-Sectoral Board

To promote data collection on child abuse and neglect and support the piloting of the CAN-MDS system in Greece, a National Inter-sectoral Consultative Committee was formatted where **ALL relevant sectors are represented**. Currently 13 Authorities, Ministries and Organizations are participating (see also D2.7):

NATIONAL GREEK INTER-SECTORAL BOARD FOR CAN-MDS SYSTEM

Independent Authorities

National Commission for Human Rights

The Greek Ombudsman, Deputy Ombudsperson for Children's Rights

Ministries

Ministry of Education and Religious Affairs

Ministry of Health

Ministry of Justice

Ministry of Labour & Social Affairs

Ministry of Citizens Protection, Hellenic Police

National level Organizations

Institute of Child Health-Department of Mental Health and Social Welfare (Coordinator)

National Center for Social Solidarity-EKKA/ SOS Line 1107

National Union of Municipalities of Greece - KEDE

Non-governmental Organizations

The Smile of the Child/ SOS Line 1056

ELIZA – Prevent & Identify Child Abuse

UNICEF Greece Country Office

- **Number of Sectors invited/accepted the invitation and participate in the Board**

  In December 9, 2020 ICH-MHSW sent out a total of 15 invitations to Authorities/Organizations according to the customized pilot plan. Out the 15 Authorities 12 eventually replied positively that they are willing to cooperate and to support the piloting of the CAN-MDS System. Two Authorities, Ministry of Citizens Protection and Hellenic Police, are represented in common by 3 members in the Committee; Prosecutor's Office replied that due to some specific rules they

are not able to participate while the Ministry of Digital Governance and the General Secretariat of Information Systems didn't replied in the invitation (and reminders) at all. While the Committee was under formation, Eliza –an Association against Violence Against Children was also invited to participate in the Committee. The Committee decided to approach again the Prosecutors' Offices as there was probably a miscommunication of the information and typically there is no obstacle for them to participate in the effort. The process is ongoing. General Secretariat for Information Systems informed the ICH that another General Secretariat called IDIKA is more appropriate for health related issues (including also the hosting of the CAN-MDS system in the governmental cloud). Invitations sent to IDIKA along with request for hosting the app (see Annex 2) and the process is also ongoing.

Step-by-step Process of National CAN-MDS Inter-Sectoral Board formation

1. Terms of Reference for National Inter-Sectroral Boards was translated in Greek and adapted according to country specifics.
2. The template of a 3-page invitation/informational letter (see Annex 1) was prepared including a. brief information on the necessity for CAN data collection; b. brief information on the identity and the aim of the CAN-MDS system; c; invitation to participate in the Committee/Board (by defining 2 at least specific members per Authority/Organization). In order for the receivers to be clear what will be their role, the Greek version of the ToR for Inter-Sectoral Board sent attached for approval and signatures. In addition, for the information of the receivers the Policy and Procedures Manual of the System sent annexed as well as the Greek CAN-MDS Policy Brief.
3. The invitations along with the accompanying material adapted per Authority and sent out by the ICH in December 9, 2020. Reminders sent where necessary and a series of bilateral communication with each of the Authorities took place. Eventually the 1st plenary meeting of the Board was organized for the beginning of April 2021 (and finally 3 meetings were conducted in total until the end of June).
4. Over and beyond of the activities of the Board (as they mentioned in the respective ToR), most of the Members of the Committee participated also in the European CAN-MDS Conference that took place in June 29 and 30, 2021, while some of them had short speeches during the opening session of the Conference (such as the Deputy Minister of Health, the General Secretary from the Ministry of Education, and the Child's Ombudsperson)

- Number of meetings and participation rate in the meetings

  1st Meeting: April 5, 2021; 15 participants / 13 Authorities-Organizations
  2nd Meeting: May 10, 2021; 14 participants/ 11 Authorities-Organizations
  3rd Meeting: June 16, 2021; 12 participants/ 10 Authorities-Organizations
  (For more details such as agendas and minutes, see also D4.1)

  Important note: During the 3rd Meeting of the Inter-Sectoral Board (that was the last one according to the initial plan and the ToR), ICH-MHSW suggested the continuation of the operation of the Committee/Board along with the continuation of the piloting of the

system and the training activities for at least the next period until the end of December 2021 (over and beyond of the project). All present members were positive to such a development and many of them already agreed and committed to continue to work according to the ToR while for some others (such as the Police) the decision has to be made by the hierarchy. In addition, a number of members of the Committee suggested during the same period to take action towards the preparation of the appropriate legal framework for the operation of the system (probably in the context of an Inter-Ministerial Decision) (see also Minutes of the 3rd Meeting).

Agencies participating in the piloting as data sources

The process for recruiting agencies to participate in the piloting of CAN-MDS has as follows:

Steps	
1. Informational material and Invitations sent out to relevant Organizations/Services along with a bilateral Protocol of Collaboration to be signed; Invitations sent either by the ICH or by other Members of the Inter-Sectoral Committee (up to now by EKKA, Ministry of Health and Eliza)	See Annex 3 "Step 1, A1, A2"
2. When a Protocol of Collaboration was signed, an individual account was prepared for the Agency in the CAN-MDS System (according to the instructions in the Step by Step Guide for the Administrator) At the same time, informational material and invitation sent to Professionals working in the specific Organization/Service along with a form to be filled in and returned to Administrator where the Professionals declare their willingness to participate in the training and to become CAN-MDS System's Operators as well as written informed consent that their data will be used in the system	See Annex 3 "Step 2, 5a, 5b" For a full list of the Agencies see also D2.8_Greece

Since May 10, 2021 59 organizations signed the bilateral Protocol of Collaboration and nominated professionals to participate in the CAN-MDS, as follows:

Code	Type of Organization/ Sector	N (59)	%
SWS	Social Welfare Services (SWS)	*39*	*66.1*
MHS	Mental Health Services (MHS)	*5*	*8.47*
NGO	Non-Governmental Organization (NGO)	*5*	*8.47*
ORS	Other related Services (ORS)	*3*	*5.08*
THC	Tertiary Health Care Services (THC)	*2*	*3.39*
CPS	Child Protection Services (CPS)	*1*	*1.69*

IAU	Independent Authorities (IAU)	*1*	*1.69*
PHC	Primary Health Care Services (PHC)	*1*	*1.69*
ROI	Research Organizations (ROI)	*1*	*1.69*
SMS	Social and Medical Services (SMS)	*1*	*1.69*
COM	Community Organizations (COM)	*0*	*0*
JUD	Judicial Services (JUD)	*0*	*0*
LES	Law Enforcement related Services (LES)	*0*	*0*
PEF	Preschool Educational Facilities (PEF)	*0*	*0*
PES	Primary Educational Services (PES)	*0*	*0*
POL	Police (POL)	*0*	*0*
RSS	Existing Registries (RSS)	*0*	*0*
SES	Secondary Educational Services (SES)	*0*	*0*
SHC	Secondary Health Care Services (SHC)	*0*	*0*
VES	Vocational Educational Services (VES)	*0*	*0*

In terms of Sectors, the distribution has as follows:

Sector	N	Notes
Education	0	No invitations sent yet by ICH or other Member; this is because the Legal Department of the Ministry of Education asked for a revised bilateral Memorandum of Understanding to be prepared and signed by September 2021. Ministry of Education undertook the responsibility to invite internally education-related professionals (namely representatives of each Primary and Secondary Education Offices located in each of the Greek Prefectures, in total 116 plus 13 per Periphery and at a later time of 71 Centers for Counseling and Support of Students (KESY). Due to the fact that schools were not open (during the whole period online education took place) the Ministry of Education decided to proceed with the invitations on September 2021. The process is ongoing.
Health & Mental Health	10	Ministry of Health undertook the initiative to invite health and mental health organizations/ services and professionals; 16 invitations sent out (since April 2019) and several organizations and professionals replied positively. In addition a discussion was made for the invitation of representatives from the 125 Hospitals of the country including the Social Services of the Hospitals, Emergency Departments, Pediatric Clinics, Orthopedic Clinics etc. as well as of representatives from the ~ 55 relevant agencies

		such as 44 Medical-Pedagogical Centers, 11 Centers EKEPSYE, EKPA, YEKA The process is ongoing (reminders sent out again). ICH also sent also invitations to Centers for Social Policy (KKPPA), Children's Hospital A Kyriakou; Community Health Center of Kessariani, and Hellenic Red Cross.
Justice & Law Enforcement	0	Ministry of Justice was asked to proceed with the invitation of professionals working in prosecutors' offices and in the 63 First Instance Courts nationwide. The request initially discussed during the 1st Meeting of the Board (see minutes) and again in a bilateral online meeting that took place in June 2021. No invitations sent yet. Minutes of the 1st Meeting: *Justice (the most representative sample of professionals per Regional Unit or, if this is not possible, by Region)* *- Representatives of the 3 Juvenile Prosecutor's Offices (Athens, Piraeus, Thessaloniki)* *- Representatives of the Prosecutor's Offices of the Court of First Instance (at best 63 Prosecutions of the Court of First Instance, if not those that are possible)* *- Representatives of the 41 Juvenile Court Bailiff Services* Hellenic police timely informed the Board that it wasn't in position to undertake such an initiative because such a decision should be made by the relevant Ministry (for Protection of Citizens) in cooperation with the Prosecutors' offices. In the case that the permission will be granted, it is expected to participate representatives of Police Departments (if possible 1 / Regional Unit, Total 74 and, if not, 1 / District, Total 13) as well as representatives of the Department of Police Psychologists
Social welfare & hotlines	40	National Center for Social Solidarity undertook the initiative to invite Social Welfare professionals working mainly in municipal social services through the national network of Teams for Protection of Minors (OPA). A number of 105 Municipal Social Services were invited and ~40 of them were positively replied. The process is ongoing. Ministry of Labour and Social Welfare discussed the possibility to invite professionals working in social welfare organizations such as the daycare centers for infants and toddlers, child summer campuses, Residential Care Structures KKP etc. Because of the preparation of a national action plan where the above services are involved, Ministry of Labour decided to proceed with the invitations on September 2021. The process is ongoing. Other invitations to be sent concern SOS line representatives

		(Ombudsman for Children, EKKA 1107, Child's Smile 1056, Together for the Child, etc.). Lastly, KEDE will be asked to send invitation to remaining of the 325 Municipalities that have Social Services after September 2021.
Independent Authorities & NGOs	9	Other members of the Board, including UNICEF, the Smile of the Child, Eliza Association against Child Abuse, Ombudswoman for Children's Rights, National Committee for Human Rights, Central Union of Hellenic Municipalities, were offered to invite any relevant organization they collaborate to participate in the process (training and piloting of the system). A number of invitations sent out and some organizations and professionals were positively replied. Specifically Eliza already invited Children Hospital A Kyriakou and Attikon Hospital, and UNICEF the NGOs Solidarity Now and Elix. The process is ongoing.

Geographic Coverage

Area	N of Agencies: 59
Attica	44
Thessaloniki	8
Chios	1
Thesprotia	1
Messinia	1
Korinthia	1
Evrytania	1
Viotia	1
Aitoloakarnania	1

At least one participating agency is located in 7 out of the 13 peripheries (most of them in Attica); none agency is still participating in the remaining 6. Once invitations will be sent by Ministry of Education, Ministry of Justice and KEDE this expected to be improved.

Comments by the main stakeholders (Independent Authorities, Ministries and NGOs)

National Committee for Human Rights: *From the side of NCHR we have repeatedly stressed the importance of having a record of incidents as an integral part of a specific strategy to deal with any phenomenon that falls within the field of child protection and we are very happy with this initiative. We intend to assist in the implementation of the tool through our Members and as an advisory body of the State with an independent role.*

National Center for Social Solidarity-EKKA, Child Protection Line 1107: *In regards to the current initiative, firstly we consider that the tool is of very good quality and helpful; it is clearly a recording tool that aims to collect data to support evidence based planning of measures for a more effective administration of the CAN problem. There is a need to be a Service that has the specialization and the professionals who will be able to carry out the investigation of reports and complaints and also will cooperate with other Agencies, because currently every effort is fragmented. Often many services deal with a single CAN incident and at the end the case is lost. This could be addressed via such an umbrella-service from the Prosecutor's Office, for example, which is a main stakeholder in the administration of such cases. So, we consider as very important to start this effort immediately with this tool which is easy and does not require time from professionals as it is based only in closed options and there are no open fields to be completed. EKKA agrees to participate in the implementation of the system through Child Protection line 1107.*

Hellenic Police, Department of Juvenile Protection of the Attica Security Directorate and Department of Domestic Violence of the General Police Directorate. *Although issues like to what type of data the Police could enter in the system is a decision that can only be made by the Hierarchy, it is considered that it would be particularly helpful in police officers daily work to have such a tool where they can refer when a CAN complaint is received about a child and history of abuse should be investigated (for issues such as services received from hospitals or interventions made by Municipal Social Services in the family for issues related to the safety of the child). It would be helpful to get an initial picture of the case, even cross-referencing information from services already involved, about what is happening and what the child itself is saying, especially in cases where child is trying to protect his family or because s/he is afraid that it will removed from the family. The fact that one Service/organization is not aware what the other Service has done has caused very serious problems in the management of serious incidents against children, and there have even been deaths of children. There is a tool that should work, since no one has an interest in*

not working and in fact the effort should not be canceled by details, as happened before, that are not insurmountable. In terms of cooperation between stakeholders, so far it seems to be effective, so at this level there does not seem to be an issue and it may be a good start for the use of the tool.

Greek Ombudsman, Deputy Ombudsperson for Children's Rights: *The Ombudsman's experience is that there is no actually Child Protection System in the country, since there is no interconnection between the individual elements of the existing child protection services. The Services are not aware of what exactly are to do with CAN cases, the training is fragmented and optional - which means that are always involved the already sensitized persons, the funding is not continuous and favors opportunistic initiatives, especially in countries of the first memorandum, such as Greece, which do not already had a CPS that could be further developed. Thus, the opportunity is lost in three schematic categories of action related to CAN administration: recognition of the problem (lack of tools and training of professionals such as teachers); investigation of CAN cases (since there is no a commonly agreed task-book with responsibilities for Social Services to collect the necessary data but also to systematically record the violations) and, finally, in the intervention that we are well aware that favors systemic abuse and secondary victimization of the child in contrast to what is provided in Article 39 of Law 2101 (CRC). For all these reasons recording of CAN cases is therefore valuable. On a practical level, after this Board meeting, the first step that should be done is the ratification in some way by the competent Ministries, which will have to embrace the initiative, possibly institutionalizing it. The members of the Committee have to see how this can be done. Also, a technical team should be created to support the effort. Finally, to start immediately the piloting with some Services and Organizations and to come back evaluating the findings of the recording after a period of a few months to see what further configuration is needed; at the same time the Committee should attempt the approach and participation of the Prosecutor's Office, which is necessary in this direction, as it is a pillar for recording of the problem.*

CAN-MDS System is an effort that should be supported as it seems that professional front-line employees want it very much. It seems that e-app is very easy to use and therefore it constitutes a good first attempt to collect epidemiological data in the context of the discussion on National Action Plans and child protection policy development. System's piloting should start because it would be very helpful and the Committee will support the participation of Agencies and Professionals.

Ministry of Labour and Social Affairs: *It is very positive that there is the will from all parties to proceed with the implementation of this tool in a realistic way, gradually, Agency to Agency and Ministry to Ministry. Regarding the general picture of the direction in which MLSA is working with the competence and political responsibility at the moment, the first is that priority has been given to the issue of child abuse and neglect in the wider context of work for the protection of the child, since it is among the first three issues. Secondly, the Ministry is working in two directions. One direction is purely regulatory, as in addition to mandatory legislation we need to work in other levels, such as law and regulations, because there are shortcomings such as the fact that we do not yet have a common definition of child abuse and neglect or a perimeter of the Services and Agencies we are addressing. Domestic violence has its own logic, and the Law 3500/2006 addressed mainly teachers; here with the CAN-MDS we go to something wider as a perimeter that teachers. We do not yet have a definition of what the CAN incident is, or what a CAN case report is. Therefore, the goal of Ministry is to approach the whole issue in a regulatory and holistic way, starting from definitions and a distribution of roles - especially the role of the person who receives and processes the reports of incidents of child abuse and neglect is very specific. We are also considering preventive measures that mainly concern the recruitment of staff in agencies that provide services to children. The second direction we work in is that of capacity building of professionals. Whatever initiative we take at regulatory level, the contribution of the people who are invited to participate in the implementation and who need to be trained on very specific issues is very important. In fact, training should have a continuum and not be a fragmented effort. In this issue, MLSA discusses a coalition of institutions depending on the categories of professionals and institutions that will be trained. As for the time-schedule, from the side of Ministry the regulatory part and the trainings need some time, for the slider until the beginning of summer, for the trainings until the end of summer. And although the CAN-MDS tool may be ready, from our side we could practically see it from September. Another point concerns the perspective, the next day. Indeed, as we have seen, there is no systematic contact and cooperation between services in incident management. We can start with the recording but if we do not proceed to interconnect the Agencies and Services that have the responsibility of recording and in an opening to manage the incident, or even process the information about the same child coming from another body. Of course, attention is needed here, but it is a step that needs to be taken. There will need to be the appropriate Organization that will be able to process such cases and coordinate the recording. In addition, the time-schedule mentioned refers to very*

specific categories of Operators. Maybe on the part of the MLSA we can start with some other services, such as EKKA and probably with the Regional Centers of Social Welfare.

Ministry of Education: *We consider the CAN-MDS tool very interesting as the database that can be created by this system at a national level will be able to provide a picture of the phenomenon of abuse-neglect to all interested parties. This is why collaboration and interconnection of stakeholders is required. At the Ministry of Education, the primary target population of interest is children. Very often the Services of the Ministry are called to deal with situations related to abuse and neglect; currently there is no satisfactory mechanism in place for dealing with such cases or adequate prevention practices. Although action has been taken on other forms of violence, such as school violence, e.g. the establishment of the Observatory of School Violence, concerning sexual abuse, for example, which is a taboo issue that has never been discussed no action has been taken yet despite the fact that we know that it is a phenomenon that exists and we need to focus on that. For this reason, the CAN-MDS system is expected to provide us with important information on the basis of which at a next phase we will be able to create protocols for prevention, management and response to CAN cases. It is very important for the teachers, but also for the special scientists of the Ministry of Education who are the ones who mainly deal with such incidents (essentially the Centers of Educational and Counseling Support (KESYs), in cooperation with the Prosecutors for Minors and the Medical-Pedagogical Centers) to have such a system, which will strengthen the basis of our collaboration. Of course, there is a need for the necessary training of professionals of the Services of the Ministry of Education in the use of the tool and in the recording, especially of them who will potentially be called to proceed with the recording as Operators. The main work may be done at KESY, but in order to get there, the information must first have been located in the school unit and start from there. Teachers and teachers in schools for children with special needs, namely the reference persons in the school units, should have an idea of how this tool works. We should collect data through a mechanism, such as the CAN-MDS, and utilize the results and conclusions that will emerge, to disseminate and communicate them and, finally, to improve the cooperation between the relevant Services and to promote the training of professionals. On behalf of the Ministry of Education, we are at your disposal to decide together and to facilitate access to KESY in this effort.*

Ministry of Health: *The Ministry of Health welcomed the cooperation in the framework of this initiative for the pilot implementation of CAN-MDS, considering that it begins intensively at the specific point of time when because of the specific circumstances it seems that the cases of child*

abuse-neglect have increased and may be largely covered up. The Ministry of Health supports the initiative and wants to be present in the effort in any way it can, supervising the Services and Organizations under its responsibility, promoting the tool to these agencies and supporting actions, programs and stakeholders involved in the administration of CAN cases. Health and Mental Health is a broad good with many components; child abuse and neglect blatantly violates this good and human right and, therefore, it is the duty of the Ministry to stand in this effort with as much vigilance and responsibility as possible, so that the effort can go ahead and have the results it is expected to have. The Ministry of Health will participate as much as it can and will try to provide support to this project. Note: *In July 15, 2021 an in person meeting took place in the premises of Ministry of Health where ICH, Eliza and Ministry of Health representatives participated and discussed about the institutionalization of the CAN-MDS System on the basis of an inter-ministerial decision. Further steps were decided to take place during September 2021.*

Central Union of Greek Municipalities (KEDE): *KEDE welcomed the initiative, which will be supported by KEDE that appreciate that is part of the Inter-Sectoral Committee. The need for action is fully understandable. KEDE is totally aware that the Social Services of the Municipalities are the largest network of social structures that exist in the country and KEDE will support through its role the effort (without this meaning that KEDE do not has reservations regarding the understaffing of the Social Services of Municipalities; KEDE mentioned that with the mobility of employees, the Municipalities are constantly losing staff despite the efforts to react and to promote practices such as, for example, having the consent of the Mayor for the transfer of employees). The CAN-MDS tool should be very easy to use and very short, otherwise the employees of the Municipalities will not be able or willing to use it and they cannot force to do it. Regarding the Minors Protection Groups (OPA), they do not exist in all the Municipalities and where available, they often need re-coordination. Also, the Social Service of a Municipality informed us that there was a similar project before (ICH-SKLE-EKKA-Lumos) which was lost in the everyday routine of a civil servant who has to do with many objects, and especially with the objects of a Municipal Social Service. Again, all the above do not mean that KEDE will not support the effort. Municipalities are the structure that supports the social web of the country; especially in this COVID era Municipalities have undertaken all actions to combat poverty and child protection along with other actions. The implementation of CAN-MDS is expected to rely on employees who love their work; KEDE will support them to participate in the effort, since KEDE is member of the Inter-Sectoral Committee; KEDE will take care for continuous feedback of the system*

to professionals, in order to keep the interest of the SWs or other employees for system's operation with the prerequisite that system is a user friendly and easy-to-use tool that ensures time savings.

The Smile of the Child: *The Smile of the Child, NGO expresses its willingness to cooperate with the remaining stakeholders in the context of the pilot effort to record CAN cases via the CAN-MDS; CAN data collection has been a demand for many years in the field. If the proposed system works, it will fill an existing gap regarding the measurement of the extent of the phenomenon, which is a request of all relevant Services and Organizations. It would be good for this system to work in addition to the CAN incident's management protocols developed by the ICH a few years ago. In addition to the epidemiological data that is the primary benefit, the operation of such a system will have secondary benefits, such as helping to create a culture and specialization in the reporting and management of incidents by professionals in the field, who are already dealing with the problem. It is expected that the pilot test of the system itself as a process, in addition to the evaluation of the system's operability will also serve as an incentive for more and more services to show willingness to participate in the recording and use the tool with the ultimate goal of having a better picture of the magnitude and characteristics of child abuse and neglect. The Smile of the Child, including the SOS Line 1056, which follow specific telephone reporting protocols, are willing to contribute. It is clarified that the Line 1056, like the EKKA 1107, from the statute cannot accept reports that do not have the minimum necessary information about the identity of the child (such as name and address of the child or the school to which the child goes) - and therefore automatically the risk of duplication is also reduced. There are also on-site interventions - where there is a direct involvement of at least three different Agencies (Smile of the Child, Police, Hospital), which will have an interest in how the management of the recording will be done. In any case, we are in tune with the effort.*

Eliza Association: *The Eliza Association is happy to be a member of the CAN-MDS Committee, which considers it an exceptional effort, as it is highly desirable to record abuse rates and not just assess them on the basis of some research. It is very important to finally know the landscape in order to devise strategies. That is why it is important that all this effort has been made, which is self-evident that it must be institutionalized and embraced by the Ministry. As Eliza we do and will do what is needed mainly to educate people who are close to the children and who can validly, timely and correctly record the Kappa incidents they detect. We are very happy that both the units from Attikon and the Children's Hospital will be alert and will participate in the recording because it is very important that this work is done in hospitals. At Eliza we aim to build units in all university*

pediatric NSCs and in this context we believe that over time what we do here will be an excellent contribution to correctly recording which incident is located. On behalf of Eliza, thank you for starting this whole effort and we will be close to you to complete it.

UNICEF Partnership Office in Greece: *UNICEF is the country office of Greece, which started operating in November 2020 (which previously operated as an autonomous office for the country since 2016 but only for the refugee and immigrant population, due to the refugee flow). Since last year the role of the Office has expanded and changed and now the Office deals with all issues of children wellbeing in Greece, regardless of their origin. The UNICEF representative to the CAN-MDS Inter-Sectoral Board is the reference person for the Child Guarantee program, a large multi-pillar international program targeting, among others, to the prevention of children admissions to residential care institutions and the support of the families in the community; this aim is directly related with the issue of systematic recording of CAN incidents under discussion. UNICEF's general approach, which we should adopt, must be systemic. If we do not look at the program holistically, we will not be able to achieve anything, since every specific European or other program is completed at some point and stops. Very important thoughts were heard that are necessary for UNICEF, since one of the difficulties it faces with its role as guardian of the UN-CRC is how to proceed to support governments in implementing the CRC since we have fragmented services and fragmented data and generally there is no a complete picture. The necessity for CAN data collection is something everyone has been recognizing for many years and something needs to be done about it. This tool looks very good, but even if it was not, it is good to make a start, to start somewhere to gather some data. Without data, no planning can be done either by any organization or by the government. As mentioned by the National Center for Social Solidarity, when a tool is institutionalized and has a mandatory character by the law somehow many practical or other problems are overcome. Therefore, here too, especially from the side of the competent Ministries, we should see how it could be done in order to utilize the tools we have and all this work that has been done for years by the ICH (such as the protocol for administration of CAN cases) and other stakeholders. These available tools should therefore be used in a more systematic way. All parties assess that there is a need; all children are at risk of re-victimization as no one gathers all this information. In our opinion, a reform of the child protection system is needed and since piecemeal interventions cannot work, as UNICEF we are here to support the effort at every level, whether technical or otherwise.*

Professionals participating in the training to become operators and Professionals participating in the piloting of the CAN-MDS as Operators

The process for recruiting professionals to participate in the piloting of CAN-MDS has as follows:

Steps	
1. As it was mentioned above, informational material and Invitations sent out to relevant Organizations/Services along with a bilateral Protocol of Collaboration to be signed; Invitations sent either by the ICH or by other Members of the Inter-Sectoral Committee	See "recruitment of Agencies"
2. After a Protocol of Collaboration was signed, informational material and invitation sent to Professionals working in the specific Organization/Service along with a form to be filled in and returned to Administrator where the Professionals declare their willingness to participate in the training and to become CAN-MDS System's Operators as well as written informed consent that their data will be used in the system	See Annex 4 "Step 2, 5a, 5b" For a full list of the Professionals see also D2.8_Greece
3. When a completed form received by the Coordinator, an account for the CAN-MDS e-learning platform was prepared per professional and individualized message sent back to each professional providing information for the procedure (namely first about the completion of the pre-questionnaire and next for the online training).	See also D3.7
4. When one Professional trainee completed the nine first sections, s/he communicated with the Administrator (according to written instructions within section 10) providing necessary (mock) information for the pseudonymization and asking for a pseudonym.	See also D3.7
5. Upon the receipt of the required information (and check of their correctness) individualized communication followed with each professional providing either further instructions (when information wasn't the expected) or the pseudonym for the recording of the mock incident in the system. At the same time individual account was prepared per professional for the CAN-MDS System (according to the instructions in the Step by Step Guide for the Administrator)	An email account was created for this aim (canmds.ich@gmail.com; currently the emails related to the Greek Inter-Sectoral Board, the professional-Operators & the Conference includes >1350 messages)
6. When a Professional complete the recording of the mock case and the replacement of the temporal ID with the Pseudonym, s/he receives an individualized message by the Administrator including the instructions and link for the post-training evaluation, the Certificate of successful Attendance of the training and a certification that s/he is an operator of the CAN-MDS system (along with final username/ password for entering in the system).	See also D3.7 and D2.8 for the current list of Operators.

Since May 10, 2021 112 professionals sent completed declaration of interest form and signed consent form for the use of their personal data (name, surname, contact details).

According to the initial plan CAN-MDS Operators' seminars would include 16*2-day seminars x 25 participants (400 trainees-operators) nationwide. Conduction of seminars had been scheduled to start during March 2020; due to the restrictive measures, however, that adopted because of the COVID-19 pandemic on March 5, 2020, an amendment was submitted to the EU in order for the seminars to take place online (instead of in person). EU accepted the amendment on Oct 2020. According to the revised plan it was decided to be used asynchronous e-learning methodology (based on the talentlms.com platform) with the aim to involve at least 400 trainees (as it was initially planned). Due to delays, recruitment of professionals started in April 2021 (see also comments about Agencies above).

Concerning their Professional specialties, the distribution has as follows:

Profession	ILO 2008, ISCO-08 Code	N (112)	%
Social Work associate professionals	3412	81	72.3
Psychologists	2634	16	14.3
Medical doctors	221	4	3.6
Health associate professionals	32	2	1.8
Nursing professionals	2221	2	1.8
Counselling professionals	2635	2	1.8
Teaching professionals	23	1	0.9
Software and applications developers and analysts	251	1	0.9
Special needs teachers	2352	1	0.9
Lawyers	2611	1	0.9
Sociologists, Anthropologists and related professionals	2632	1	0.9

As regards the sectors where the 112 professionals work, the distribution has as follows:

Sector	Code	N (112)	%
Social Welfare Services	SWS	77	68.8
Research Organizations	ROI	9	8.0
Mental Health Services	MHS	6	5.4
Primary Health Care Services	PHC	6	5.4
Non-Governmental Organization	NGO	5	4.5
Other related Services	ORS	3	2.7
Independent Authorities	IAU	2	1.8
Tertiary Health Care Services	THC	2	1.8
Child Protection Services	CPS	1	0.9
Social and Medical Services (SMS)	SMS	1	0.9

Rate of trained professionals / participated in piloting

Stage in the process (since May 10, 2021)	N=112 professionals	%
Sent signed declaration of interest & consent form	112	100.0
Started the training	112	100.0
Completed the training	71	63.0
Recorded one at least mock case in the System (60 mock cases)	63	56.7
Active Operators:	63	100.0
Active Operators (that not recorded real case yet)	52	82.5
Active Operators who recorded one at least REAL case in the System (38 real cases)	11	17.5

As it was noted above, because of these delays in the training and the piloting phase of the system, the National Inter-Sectoral Board made the decision to support the training and the piloting of the project for at least the next 6 months (until December 2021), over and beyond the CAN-MDS II Action. In this context, Board Member Authorities/Organizations will continue the recruitment of Agencies and Professionals from ALL sectors to participate in the piloting and, afterwards, in the normal operation of the system while ICH undertook the responsibility to coordinate both, training and piloting for this period.

Professional's assessment of training platform and content:

I have used the training platform and it was fine! At some points there was a repetition of specific information which was good because this information it was about basic issues. Personally, this training helped me because it gave me the opportunity to systematize knowledge I already have empirically from my everyday work and create a theoretical context where relevant pieces of information grouped together. I believe that this will also help us (the professionals in the field of child protection) in recording the incidents of the platform. Anyway, the training personally helped me a lot to systematize the information on a theoretical level. Both measurements (before and after) were very useful for us because they helped us to perceive the changes and to re-think some issues that we may have initially had a little differently in our minds. In conclusion the training was very good, it seemed helpful and I certainly did not get tired of the process.

Evaluation of CAN-MDS Operability via Simulation (working with Mock Cases)

What was evaluated regarding the use of the e-app to perform the practice tasks?

1. Correctness of record based on a mock case (64 records)
2. Completeness of record based on living cases the trained operators entered in the system (38 cases)
3. Correctness of the procedure for the pseudonymization

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

The Mock Case script used for the Simulation

Mock case (along with instructions for the referee)	**> Initial referral** "Good morning. I would like to report the case of a child that I suspect is being maltreated." « 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" > in case you receive a question about «the operator's ID» say «I do not know /I do not understand the question» > if you get asked about today's date, say «April 25th, isn't it?;» > 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» > 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) Agency's ID (auto-completed) Date of Record (auto-completed) 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» > if you get asked about the child's sex, say «I told you, she is a girl» > if you get asked the child's age, say «she must be approximately 7.5 years old» > 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» > 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) Sex: Date of birth: 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» > 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» > 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» > if you receive a question regarding the caregivers' sex, say «what do you mean? … we are talking about the mother and the father» > 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» > if you get asked about the probable ages of parents, say «they are in their 30s»	Type of family: Family's member(s): Primary caregiver(s): 1st caregiver: 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» > 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» > 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» > 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» > 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: Place of incident: 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: « 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

AXES	DATA ELEMENTS	Correct info	Correct record	Notes
RECORD (DE_R1-DE_R4)	Operator's ID	Per case	Auto-completed	
	Agency's ID	Per case	Auto-completed	
	Date of Record	Per case	Auto-completed	
	Source of Information	Personnel working in Health services	53/64 (82.6%)	In 2 cases the Operators recorded "identified via routine screen" (that's no valid) and in 9 cases "Other" (operators did not identify the correct pre-coded value and considered that the source of referral was not among the predefined list)
Child (alleged) victim (DE_C1-DE_C4)	ID:	Per case	64/64 (100.0%)	All operators' contacted by email the Admin, provided all necessary information for the off line database correctly, asked and received the child's pseudonym. Documentation (relevant files and emails) are available. Some operators used the TEMP ID option (12/63) but in their majority the proceeded with the record after receiving the Child's ID (pseudonym).
	Sex:	Female	64/64 (100.0%)	
	Date of birth:	Exact date 2008-03-03	57/64 (89.1%)	
		Exact Year (YYYY) Exact Month (MM) Exact Day (DD) Under 18	60/64 (93.7%) 57/64 (89.1%) 57/64 (89.1%) 4/64 (6.2%)	 Wrong selection from the dropdown list for DD (13; 31 instead of 03) Wrong selection from the dropdown list for MM (04; 05 instead of 03) This is correct also but not exact
	Citizenship status:	Child is a citizen with ID	64/64 (100.0%) 62/64 (96.8%)	 In 2 cases operators recorded "not known"
Family and Caregiver(s) (DE_F1-DE_F4)	Type of family:	Child lives with his/her family (including biological/ adoptive)	64/64 (100.0%)	
	Family's member(s):	Identity: Parents Number/identity: Parents 2 Total Family Members: 3 [2 Parents+ the specific Child]	64/64 (100.0%) 64/64 (100.0%) 64/64 (100.0%)	
	Primary caregiver(s):	1st - Parent 2nd - Parent	64/64 (100.0%) 38/64 (63.5%)	63 (all) operators consider at least one parent as primary caregiver 38 of the Operators record the 2nd parent as primary caregiver; this is also correct (1 primary caregiver is enough); however the information here could be more completed Specifically: 34 operators (53.1%) recorded both parents as primary caregivers when the incident took place; 19% recorded only fathers; 19%

				recorded only mothers; in 5 cases the identity of caregivers noted as "unknown"
	1st caregiver:	Relationship to child: parent 1st Caregiver's Sex (male or female) Date of birth (estimated based on age '80s (~30-35) and '90s (~25-30)	59/64 (93.7%) 59/64 (93.7%) 38/64 (63.5%)	5 cases "not known" Male or Female; both correct (depends on the subject, father or mother) 9 (14.2%) cases inserted age instead of decade; 17 (26.9%) "not known"
	2nd caregiver:	Relationship to child: parent 2st Caregiver's Sex (male or female) Date of birth (estimated based on age '80s (~30-35) and '90s (~25-30)	38/38 (100.0%) 38/38 (100.0%) 26/38 (68.4%)	5 cases "not known" Male or Female; depends on the subject, father or mother; 26 cases with no answers 6 (15.8%) cases inserted age instead of decade; 5 (13.2%) "not known"
Incident (DE_I1-DE_I4)	Incident ID:	Per case	Auto-completed	
	Date (and type) of Incident:	Type: Continuous maltreatment – including "distinct event(s)" Date of event: 2021-04-18 (or 19 or 20) Previous event (~ five months before)	47/64 (73.5%) 45/64 (70.3%) 17/47 (36.2%)	7 operators recorded correct type *Continuous maltreatment – including "distinct event(s)"* and that the last event took place *during the last 12 months* (which is also correct but not as much precise as possible) 10 operators recorded "a distinct event took place" (with correct date); 2 operators recorded "unknown information" and 2 operators recorded "*Continuous maltreatment - No "distinct event" took place*".
	Form(s) of maltreatment: **Basic form** ***Sub-form 1*** Sub-form 2	**[I3_A_2] Physical violence acts committed** ***[I3_A_2.1] corporal punishment/"disciplines"*** [I3_A_2.1.03] spanking [I3_A_2.1.07] hitting with an object ***[I3_A_2.2] violent acts/ harmful practices*** [I3_A_2.2.02] forcing to ingest spicy food **[I3_A_4] Psychological violence acts** [I3_A_4.1] with/no obvious consequences [I3_A_4.1.15] terrorization / scaring [I3_A_4.88] no specific info /suspected I3_A_4 **[I3_B] OMISSIONS** ***[I3_B_3] medical neglect related omissions*** [I3_B_3.01] refusal to provide preventive health care (vaccinations, vision, dental care) [I3_B_3.03] unjustified delay to seek med care ***[I3_B_5] risk exposure related omissions*** ***[I3_B_6] supervision related omissions***	**64/64 (100%)** ***52/64 (81.25%)*** 25/52 (48.1%) 45/52 (86.5%) ***49/64 (76.6%)*** 45/49 (91.8%) **37/64 (57.8%)** 21/37 (56.8%) 11/37 (29.7%) 24/37 (64.9%) **41/64 (64.1%)** ***37/41 (90.2%)*** 30/37 (81.1%) 29/37 (78.4%) ***18/41 (43.9%)*** ***16/41 (39%)***	Main form of CAN (physical violence) was identify by all professionals, regardless of professional background and sector where they are working. More specific forms of physical violence, such as corporal punishments practices, were also recognized (>80% of operators) and in many cases even more specific sub-forms of corporal punishment. Many operators also recognized harmful practices (e.g.~77% recorded "forcing to ingest spicy food"). Secondary main types of violence were also recognized and recorded by almost 6 out of the 10 professionals (e.g. psychological violence acts with or without consequences or without specific information). Lastly, regarding neglectful parental behaviour, although no clear suspicion and/or information was provided almost 65% of the operators recognized and recorded 1 to 3 specific forms (in the 9/10 of cases medical neglect related omissions, delay in seeing medical needed care or refusal to provide preventive health care such as vaccinations) and in 4/10 cases risk exposure related omissions and inadequate supervision related omissions).
	Place of incident:	Child's Home (possibly) Street/ Surrounding area (possibly)	29 (48.4%) 23 (39.1%)	52/64 (87.5%) recorded Child's Home and/or street/surrounding area (both are correct in the specific incident); 23 operators recorded "unknown"; 3 operators recorded other place

Summarizing:

The last two data elements related to services' involvement (DE_S1. Institutional Response and DE_S2: Referral(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:

C1 (Child's ID)
- **100%** correct completion, after the provisioned process for acquiring the child's pseudonym

C2 (Child's Sex)
- **100%** correct completion

C3 (Child's Date of Birth)
- **89.1%** Exact full date (YYYY-MM-DD)
- **93.7%** Exact Year (YYYY)
- **89.1%** Exact Month (MM)
- **89.1%** Exact Day (DD)
- **100%** Under 18

C4 (Citizenship status)
- **100%** correct completion of whether the child is a citizen or not
- **96.8%** correct completion on whether the child has an ID or not

F1 (Family Composition)

F1A (Type of family)
- **100%** correct completion

F1B (Family composition) – IDENTITIES (relationship to the child) of Family Member(s)
- **100%** correct completion

F1B (Family composition) – NUMBER of Family Member(s) per IDENTITY of Family Member(s)
- **100%** correct completion

F1_C (Definition of Primary Caregivers)
- **100%** completion (of at least 1 primary caregiver); 63.5% of the 2nd Primary Caregiver

F2 (Relationship of the child with the Primary Caregiver(s) when the incident took place)
- **93.7%** correct completion for the 1st Caregiver; 100% for the 2nd Caregiver (where defined)

F3 (Primary Caregiver(s) Sex)
- **93.7%** correct completion for the 1st Caregiver; 100% for the 2nd Caregiver (where defined)

F2 (Primary Caregiver(s) Date of Birth based on relevant information or based on the reported age, real or estimated)
- **63.5%** correct completion for the 1st Caregiver; 68.4% for the 2nd Caregiver (where defined)

I2 (Date and Type of Incident)

70.3% correct completion of the type of CAN case (continuous or not with distinct events or not) **73.5%** correct completion of the date of the event

I3 (Form(s) of maltreatment)

Main Form of CAN: 100%

Specific Sub forms of violence under the main form of CAN: 81.3%; 76.6%

Specific types (violent acts or omissions in care): 91,8%; 86,5%; 48,1%

Secondary (concurrent) main form(s) of CAN: *64,1%; 57,8%*

Specific sub forms of violence under the secondary main forms of CAN: 90,2%; 43,9%

Specific types(violent acts or omissions in care): 81.1%; 78.4%; 64.9%; 56.8%; 29.7%

I4 (Location of Incident)

87.5% correct completion

4 out of the 18 data elements were auto-completed and by definition the completion is full and correct (R1, R2, R3, I1)

Conclusion

The above are the results of the record of a specific mock case provided as a written script to 64 professionals of various specialties that work in various Agencies in sectors relevant to child protection and wellbeing in the context of an online asynchronous e-learning seminar.

In most of the cases after a very short bilateral discussion or written comment professional-operators understood exactly the observed wrongly inserted information (as, for example, in the data element F4 Date of Birth of Primary Caregiver(s) (often the operators wrote the estimated age e.g. "30" (years old) instead of the decade when potentially the caregiver was born, namely in "'90s"); or the I2 Date and Type of Incident (when there is an information that previous CAN took place, then the current incident is considered as "distinct event" in the context of continuous violence).

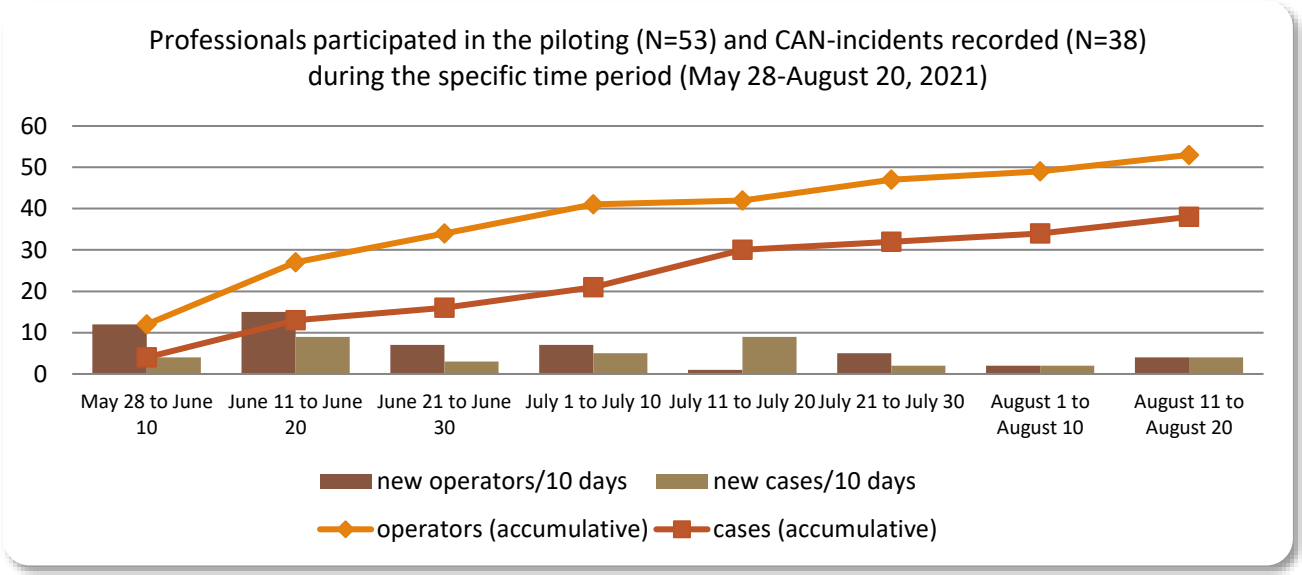
It is expected that after some more practice and familiarization of the professionals with the toolkit and the electronic tool the records will be even more complete and correct (regardless of the professional specialties, sectors or other characteristics of the operators)

Professional's assessment of e-app: In terms of the application itself, it is very easy to use and helps the professional in capturing the data and to approach the incident in many ways and make a more complete presentation.

Living Cases Data Collection through CAN-MDS during piloting phase in Greece

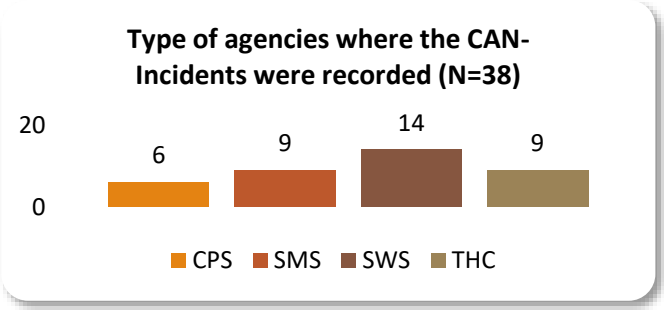
Pilot operation of the CAN-MDS System in Greece started in May 28, 2021 initially with a group of 10 professionals who completed their training (since May 10, 2021). The data that will presented below were collected during the period May 28 to August 20 from 11 operators out of a group of 53 professionals who gradually entered in the piloting phase of the system (after the completion of the mock case recording). A total of 38 CAN incidents were entered in the system.[1]

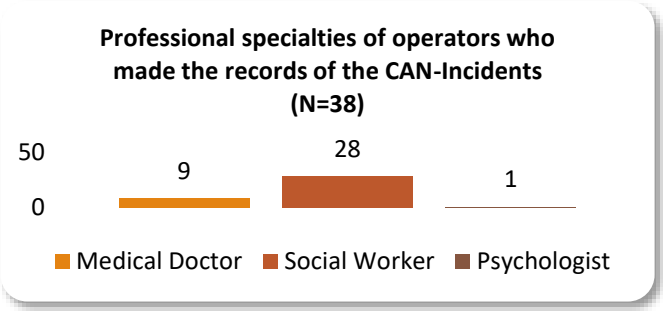
Professionals participated in the piloting and CAN-incidents recorded during the specific time period



From the figure above it seems that the number of new operators during the period July 10 to August 20 was lower than in the previous period (May 28 to July 10), probably because of summer vacations; number of new CAN-incidents recorded in the system, however, seems to have a similar distribution during the above periods. In both cases, of course, the cumulative number of both, operators and recorded CAN-incidents increases over the time in a more or less similar way (as it was expected).

All 38 records of incidents in the system made by 11 different operators (from now on "*active*"), 9 of them working in 7 Agencies located in Attica and 2 in 2 Agencies located in Thessaloniki. Detailed information follows:





[1] No data are available from other sources for the same or similar period (of past year, for example) in order to proceed in comparisons.

AXIS: RECORD

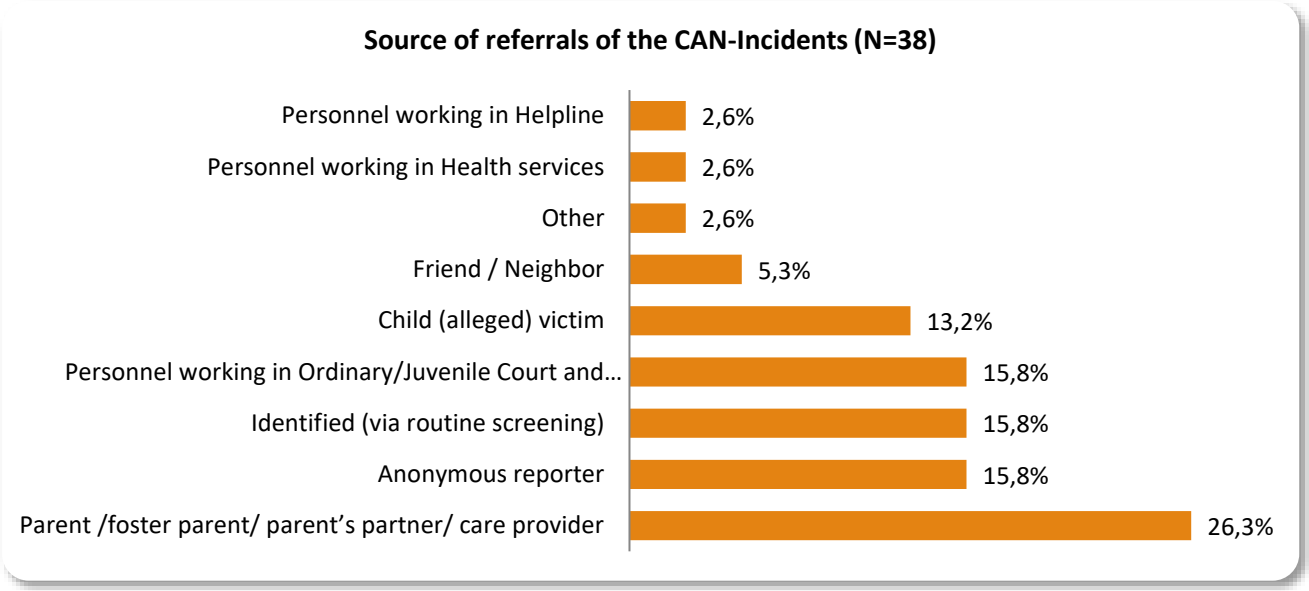
DE_R1 AGENCY's ID DE_R2 OPERTOR"S ID DE_R3 DATE OF RECORD

The above information were extracted by the auto-completed data elements R1, R2 and R3. Examples below:

DE_R1: Agency's ID [12]	DE_R2: Operator's ID [13]	DE_R3: Date of Record YYYY-MM-DD [HH:MM] [14]
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-001	2021-06-11 12:14
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-002	2021-06-23 11:14
GR-A1-SWS-001	GR-A1-SWS-001-3412-2-002	2021-07-06 09:11
GR-54-SWS-004	GR-54-SWS-004-3412-3-001	2021-07-29 11:08

DE_R4: SOURCE OF REFERRAL

Source of information for each of the recorded incidents in the system, as it is presented in the graph below, in most of the cases it was one of the parents (the non-abusive); almost half of the cases were identified through screening by the professionals-operators or reported by professionals working with or in prosecutors' offices or by anonymous reporters (often in SOS lines); ~1/10 incidents the information was provided by the children-(alleged) victims themselves. In some cases the information was provided to the CAN-MDS Operator by health professionals, by friends or neighbors of the child (alleged) victim or by other source.

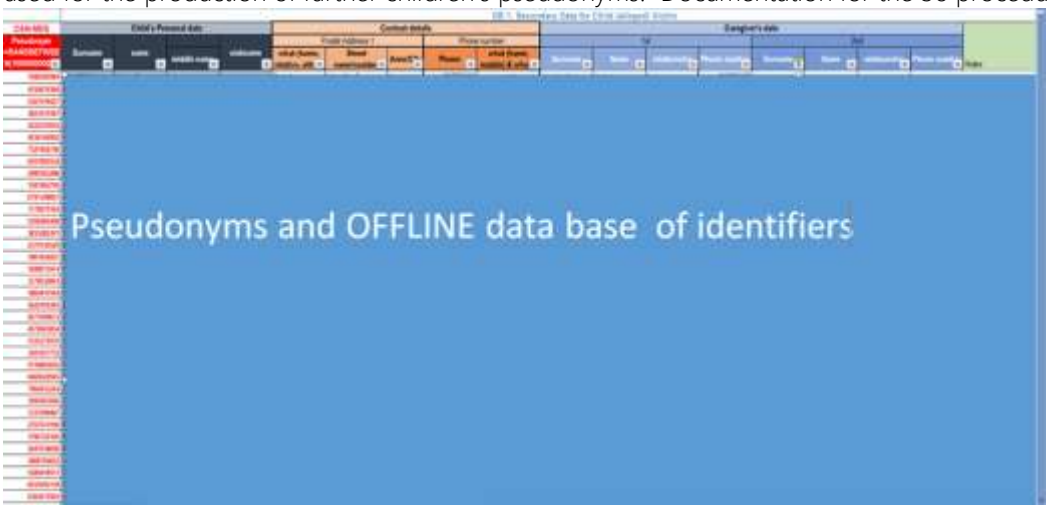


In the following pages a brief presentation of the data collected via the CAN-MDS for a number of CAN-incidents will be presented; as it will become obvious completeness of data is satisfactory (missing data in live cases are observed only in a few cases) and details are also available. The data that are presented below are the basic descriptive data, without further analysis as it would be in a full periodic report based on data collected via the system.

AXIS: CHILD

DE_C1 "CHIILD's ID"

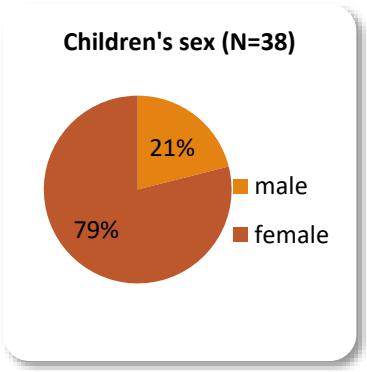
In all 38 cases professionals-operators communicated with the CAN-MDS Administrators and applied the process to acquire a pseudonym for the child suffered CAN (namely the incident that recorded in the system). The offline database is available in the premises of ICH-MHSW (National Administrative Authority of the System) and it can be used for the production of further children's pseudonyms. Documentation for the 38 procedures is available.

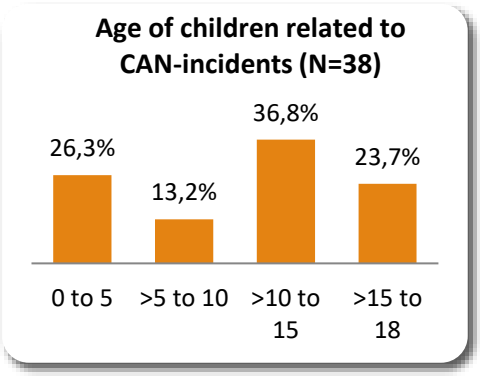


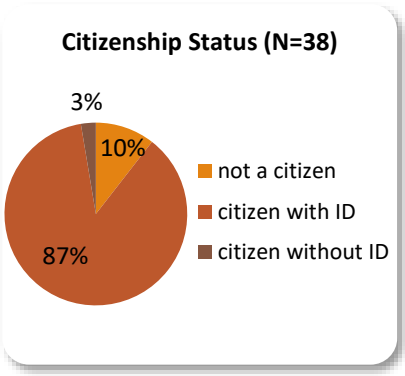
Use of pseudonymization and maintenance of offline database with personal data ensures that CAN-MDS operates in alignment with GDPR provisions and according to what provisioned by the law about protection of personal data

DE_C2 "CHILD's Sex", DE_C3 "Child's DoB" and DC_4 "Citizenship Status"

Concerning children characteristics, 30 out of the 38 (78.9%) are girls and 8 (21.1%) are boys. As for their citizenship status, 34 (89.5%) are Greek citizens and all but 1 with ID (the remaining 4 children are not Greek citizens). Age of children range from a few months up to 17 years and 9 months. The distribution is presented below:



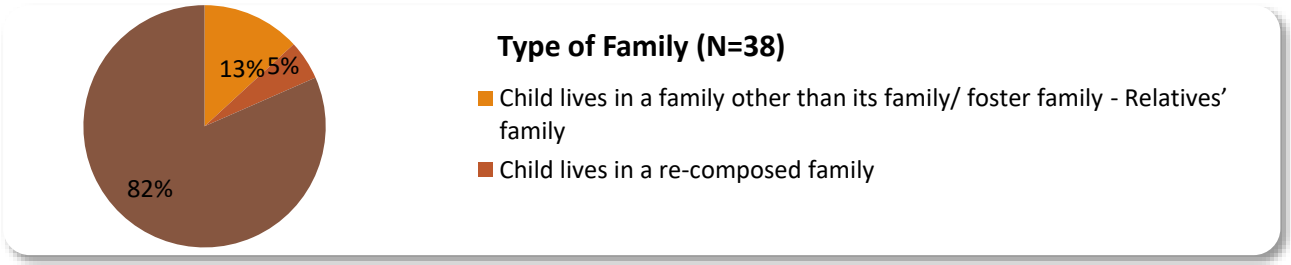




AXIS: FAMILY

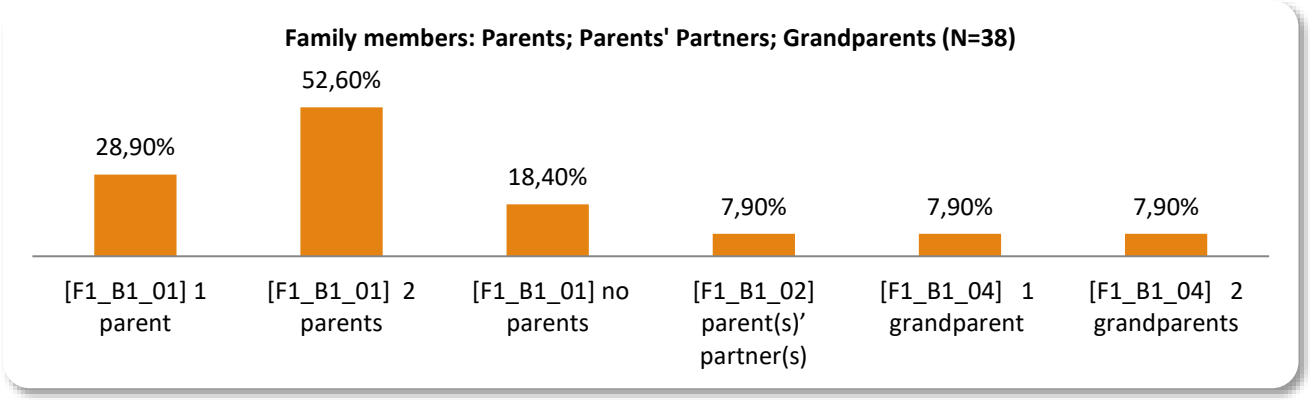
DE_F1.A "FAMILY COMPOSITION"

In most of the cases children live with their families while in 2/10 cases children live with foster or relative families or in re-composed families.



[F1_B1] MEMBER(s) OF FAMILY – IDENTITIES/RELATIONSHIP TO CHILD & NUMBER PER IDENTITY

In 7 out of the 38 cases children live without their parents; in 11 cases children live with one of their parent while in more than half of the cases 20) children live with both of their parents. In some cases apart from parents children live in the same house with the partner of their parent (3 cases) or with one (3 cases) or two (3 cases) grandparents.



Twenty three out of the 38 children have one to four siblings while 40% (15 children) have no siblings. In most of the cases children have 1 or 2 siblings and in two cases there are 3 and 4 siblings. The total number of siblings is 38; 16 of them are younger than the children (alleged) victims, 16 are older than the children (alleged) victims but also under 18 years old while 6 of the siblings are adults (>18). This information, especially for the minor siblings, is important for services and professionals depending on the nature of the CAN incident.

[F1_B1_03] sibling(s) number	N (38)	(%)	[F1_B1_03.1] sibling(s) younger than the (alleged) victim	[F1_B1_03.2] sibling(s) older than the (alleged) victim (<18)	[F1_B1_03.3] sibling(s) older than the (alleged) victim (>18)
0	15	39.5%	NA	NA	NA
1	11	28.9%	5	5	1
2	10	26.3%	10	5	5
3	1	2.6%	1	2	0
4	1	2.6%	0	4	0

In 3 cases children live in families with relatives other than their parents, siblings and grandparents. In 1 case with 1 adult blood relative; in 1 case with 2 adult blood relatives; in 1 case with 2 blood relatives, one adult and one child and in 1 case with 5 relatives, 3 children and 1 adult blood relatives and 1 adult relative by law.

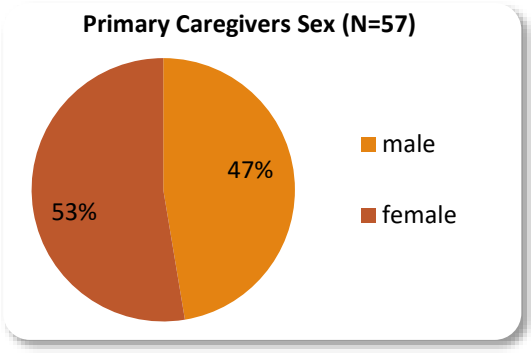
[F1_B1_05] other relative(s)	N	%	[F1_B1_05.1] blood relative (s)	[F1_B1_05.1.1] blood relative(s) [child(ren)]	[F1_B1_05.1.2] blood relative(s) [adult(s)]	[F1_B1_05.2] relative(s) by law	[F1_B1_05.2.1] relative(s) by law [child(ren)]	[F1_B1_05.2.2] relative(s) by law [adult(s)]
None	34	89.5%	NA	NA	NA	NA	NA	NA
1	1	2.6%	1	0	1	0	0	0
2	1	2.6%	2	0	2	0	0	0
3	1	2.6%	2	1	1	0	0	1
4	0	0.0%	0	0	0	0	0	0
5	1	2.6%	3	3	1	1	0	1

[F1_C] PRIMARY CAREGIVERs AND DE_F2 CAREGIVER(s) RELATIONSHIP TO CHILD

As for the primary Caregivers that were responsible for the children when the recorded incidents took place in half If the cases there were 2 and in the remaining half cases there was one primary caregiver responsible for the child.

Cases with two or more primary caregivers when the incident took place				Cases with one primary caregiver when the incident took place	
Cases	1st or 2nd (regardless order)		3rd or more	**Cases**	
10	Mother	father		**11**	**parent**
3	grandmother	grandfather		*7*	*father*
3	Mother	father	sibling	*4*	*mother*
2	Mother	father	grantparent	**3**	**professional caregiver**
1	Mother	mother's partner		*2*	*female*
				1	*male*
				5	**temporary caregiver**
				5	*female*

DE_F3: CAREGIVER(s) SEX

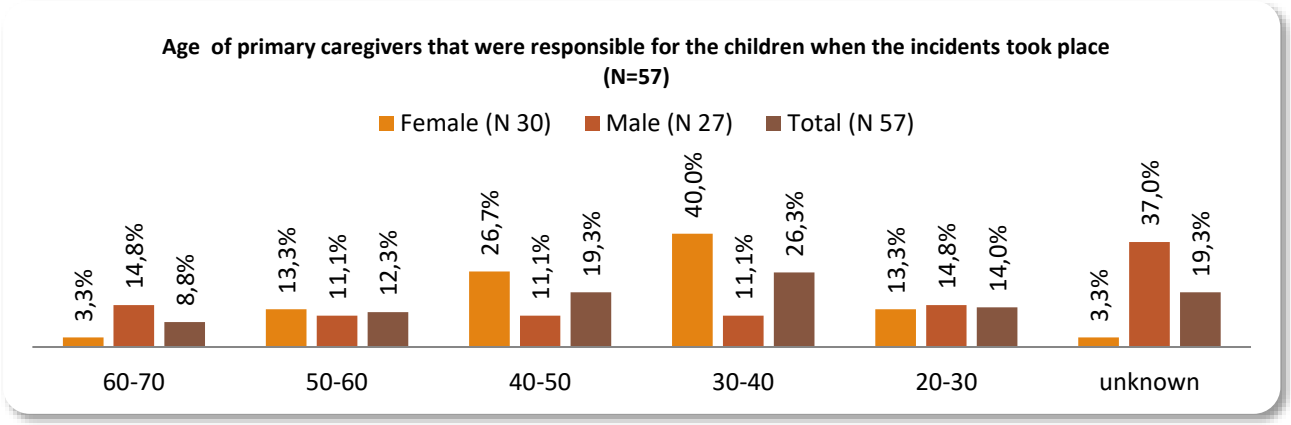


In 15 cases father and mother were both primary caregivers of the child when the incident took place; in 1 case mother and her partner were responsible for child's care while in 3 cases grandfather and grandmother were in charge for the care of the child.

From the remaining 19 cases where one primary caregiver was recorded, in 11 cases the caregiver was a parent (in 7 cases the father and in 4 cases the mother), in 3 cases were professional caregivers (2 female and 1 male) and in 5 cases were temporary caregivers (all female).

DE_F4: Primary Caregiver(s) DoB

Concerning their age of female caregivers, 65% were between 30-50 years old (while either younger than 30 or older than 60 were fewer). Concerning the age of male caregivers, the distribution was similar in the various age groups with slightly more over 6o and under 30 years old (reversed pattern than females); however, the information for almost 4/10 male caregivers was not known. In total, half of the caregivers (female and male) were between 30 to 50 years old.



AXIS: INCIDENT

DE_I1 INCIDENT ID

Auto-completed code by the system identify a single CAN-incident; the ID is composed by the CHILD ID, Date and Time of Record [DE_C1 + DE_R3]. Examples:

I1: Incident ID [24]
4322341652-20210611-121416
1591962798-20210623-111407
1690875974-20210706-91140
1708728166-20210729-110855
1776978164-20210616-120437
2374138529-20210629-164501

DE_I2 DATE (and TYPE) of INCIDENT

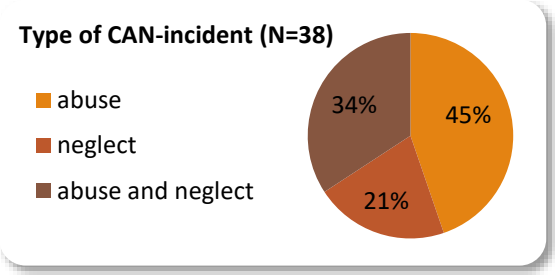
In the table below type of CAN-cases is presented, namely whether the specific incidents were distinct events or is about continuous maltreatment with or without distinct events.

Date (and Type) of incident	N	%
[I2_01] a "distinct event" took place – Not continuous maltreatment	**6**	**15.8%**
[I2_01.01] [YYYY/MM/DD] [26]	5	13.2%
[I2_01.88] Unknown	1	2.6%
[I2_02] continuous maltreatment – including "distinct event(s)"	**14**	**36.8%**
[I2_02.01] start date	0	0.0%
[I2_02.01.01] duration	0	0.0%
[I2_02.02] during the last 12 months	3	7.9%
[I2_02.03] before the last 12 months	1	2.6%
[I2_02.04] lifelong	6	15.8%
[I2_02.88] Unknown	4	10.5%
[I2_02.0A] last known CM incident date (YYYY-MM-DD)	7	18.4%
Continuous maltreatment - No "distinct event" took place	**9**	**23.7%**
[I2_03.01] start date	3	7.9%
[I2_03.01.01] duration	0	0.0%
[I2_03.02] during the last 12 months	2	5.3%
[I2_03.03] before the last 12 months	0	0.0%
[I2_03.04] lifelong	4	10.5%
[I2_03.88] Unknown	0	0.0%
Unknown	**9**	**23.7%**

In ~37% of the cases continuous maltreatment is recorded including distinct events (and the dates of most recent events is provided in half of the cases). As for the chronicity of maltreatment, in almost half cases (6/14) is lifelong maltreatment, in 3 cases during the last year and in 1 case lasted for more than 1 year. In 4 cases is not known when the maltreatment started.

In ~24% of the cases continuous maltreatment is recorded without distinct events to be mentioned (neglectful care and psychological abuse). In 4 cases the maltreatment is lifelong, in 2 cases started during the last year and in 3 cases specific starting date is recorded.
In ~16% of the cases is recorded that one "distinct event took place" and not continuous maltreatment is recorded. In most of the cases (5/6) the specific date when the incident took place is recorded.
Lastly, for about 24% of the cases the type of maltreatment in terms of chronicity and specific date when the incident took place was recorded as "unknown".

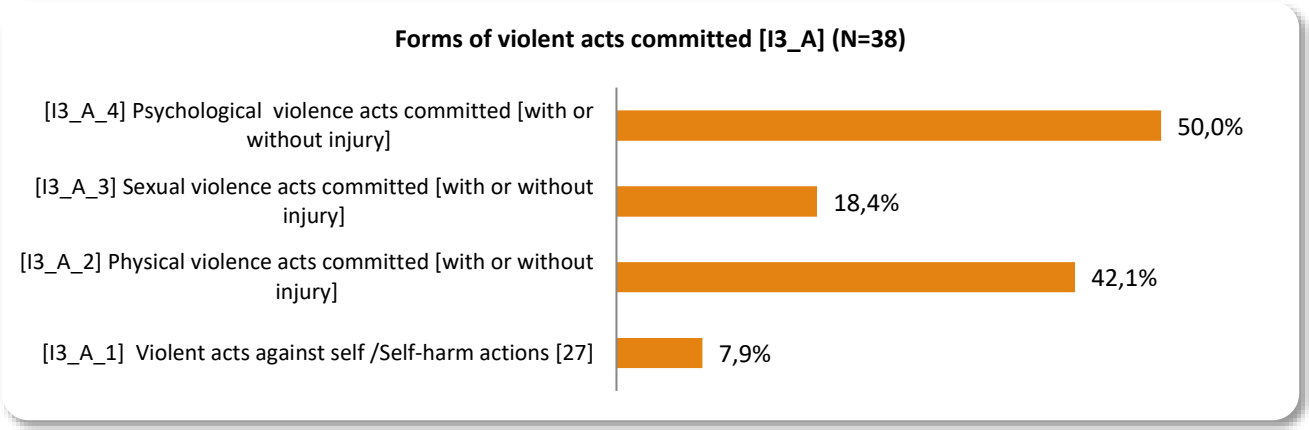
DE_I3: Forms of Maltreatment



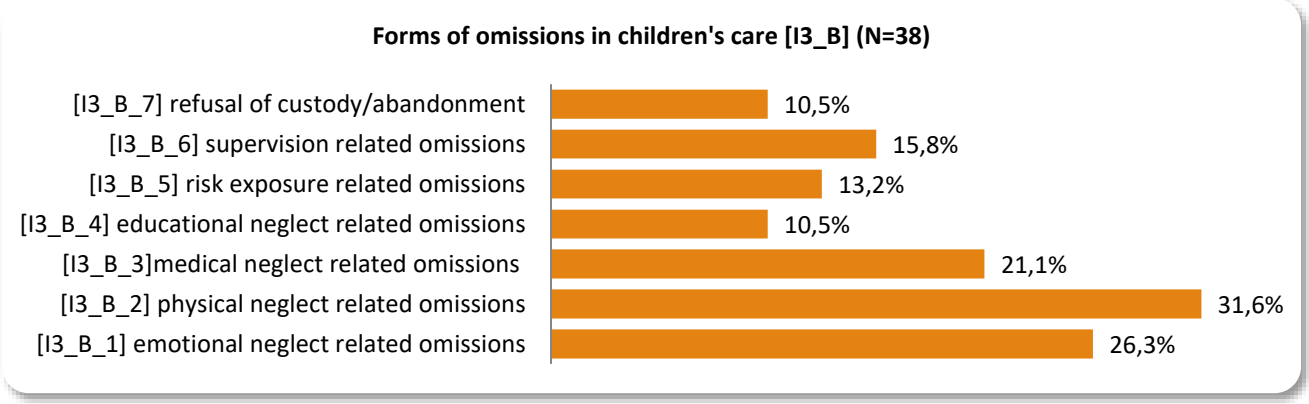
In 45% of the cases it was recorded that children suffered abuse, in 21% of the cases children suffered neglect and in 34% suffered both, abuse and neglect.

In the 2 graphs that follow specific information on the main form of abuse (forms of violent acts committed) and neglect (forms of omissions in children's care) is presented respectively.

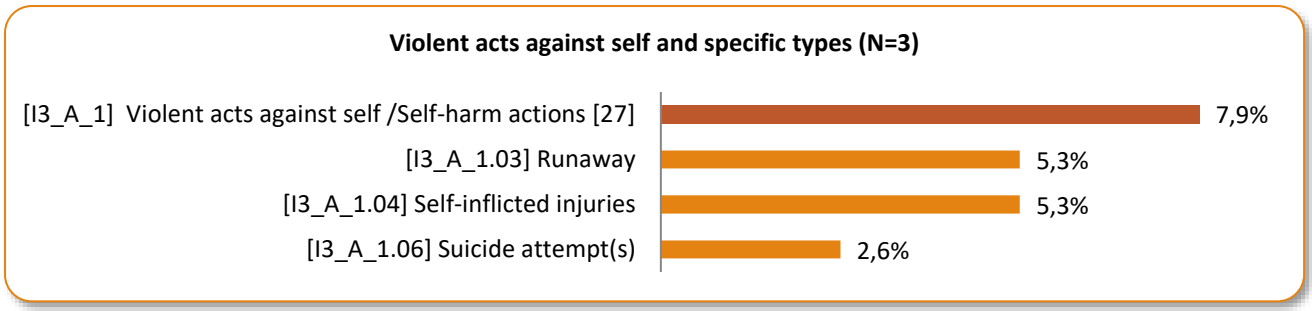
In half of the cased psychological violence was recorded; in more than 4/10 cases physical abuse was recorded while in 2/10 cases sexual abuse is recorded. Lastly in almost 1/10 cases violent acts against self were recorded.

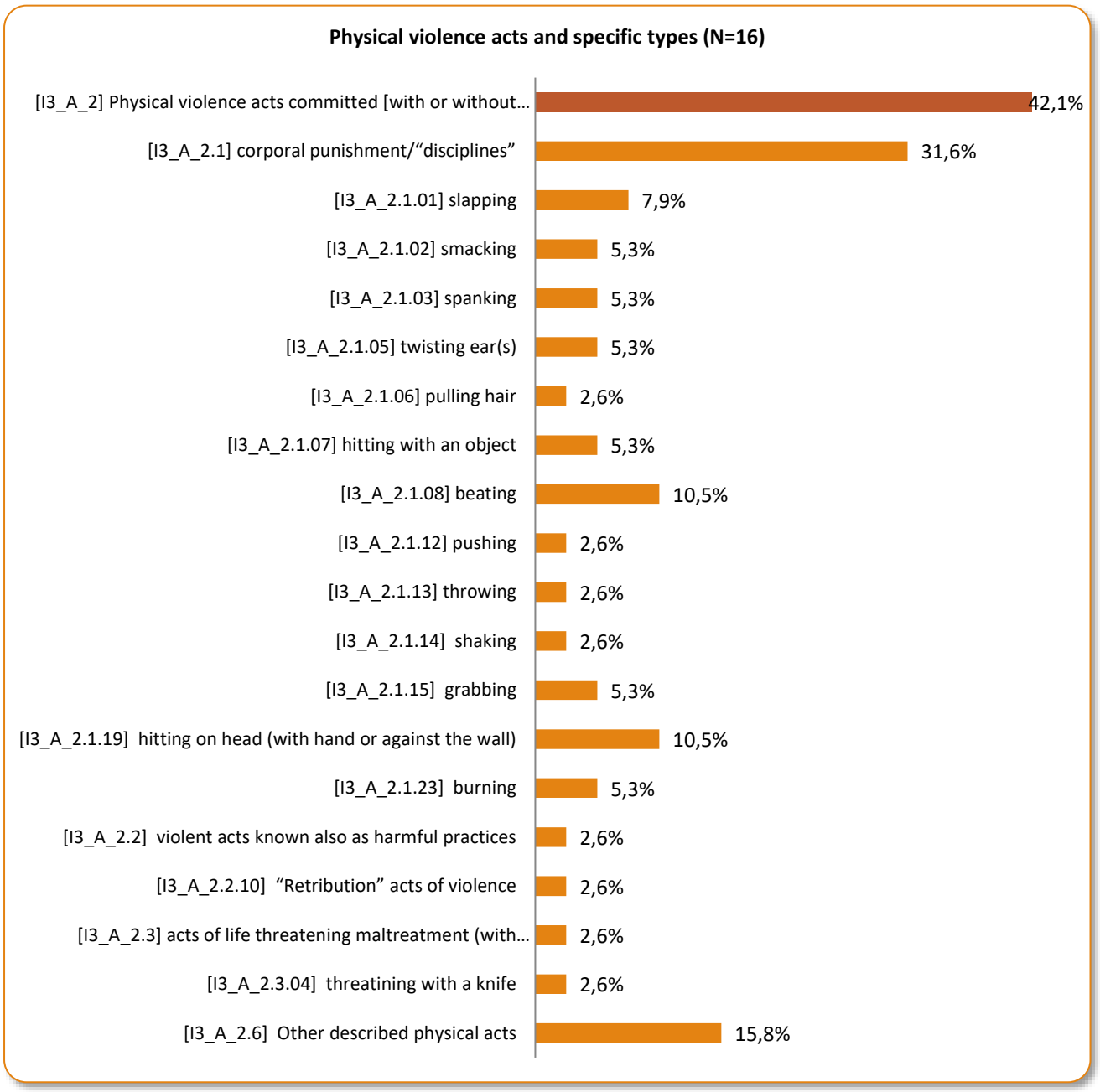


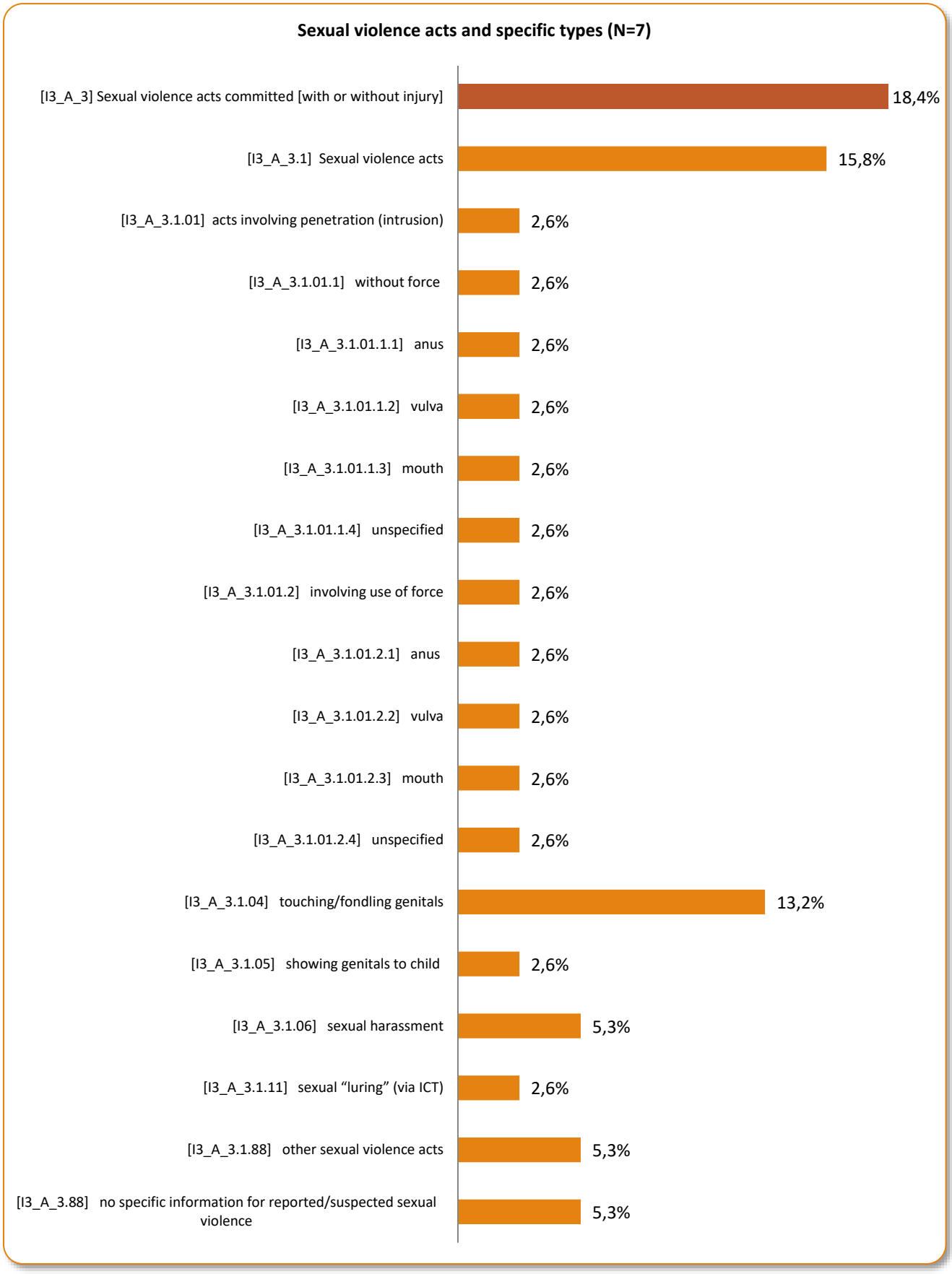
As for the cases of neglect, the most frequent type is physical neglect related omissions, followed by medical and emotional neglect. Other cases (1/10) were refusal of custody, educational neglect, risk exposure and supervision related omissions.



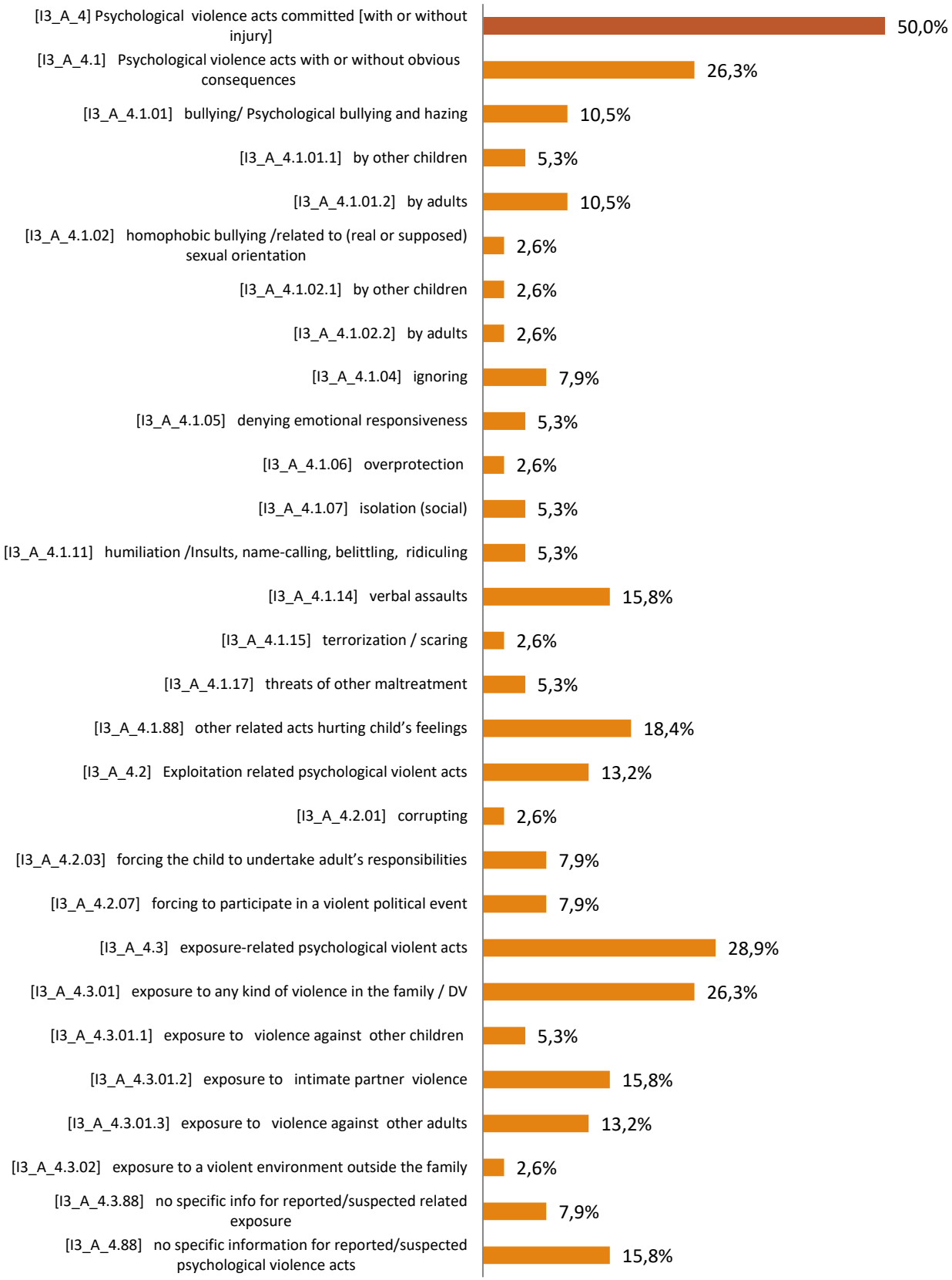
In the graphs below specific types per form of maltreatment are detailed.






Sexual violence acts and specific types (N=7)
[I3_A_3] Sexual violence acts committed [with or without injury]
18,4%
[I3_A_3.1] Sexual violence acts
15,8%
[I3_A_3.1.01] acts involving penetration (intrusion)
2,6%
[I3_A_3.1.01.1] without force
2,6%
[I3_A_3.1.01.1.1] anus
2,6%
[I3_A_3.1.01.1.2] vulva
2,6%
[I3_A_3.1.01.1.3] mouth
2,6%
[I3_A_3.1.01.1.4] unspecified
2,6%
[I3_A_3.1.01.2] involving use of force
2,6%
[I3_A_3.1.01.2.1] anus
2,6%
[I3_A_3.1.01.2.2] vulva
2,6%
[I3_A_3.1.01.2.3] mouth
2,6%
[I3_A_3.1.01.2.4] unspecified
2,6%
[I3_A_3.1.04] touching/fondling genitals
13,2%
[I3_A_3.1.05] showing genitals to child
2,6%
[I3_A_3.1.06] sexual harassment
5,3%
[I3_A_3.1.11] sexual "luring" (via ICT)
2,6%
[I3_A_3.1.88] other sexual violence acts
5,3%
[I3_A_3.88] no specific information for reported/suspected sexual violence
5,3%

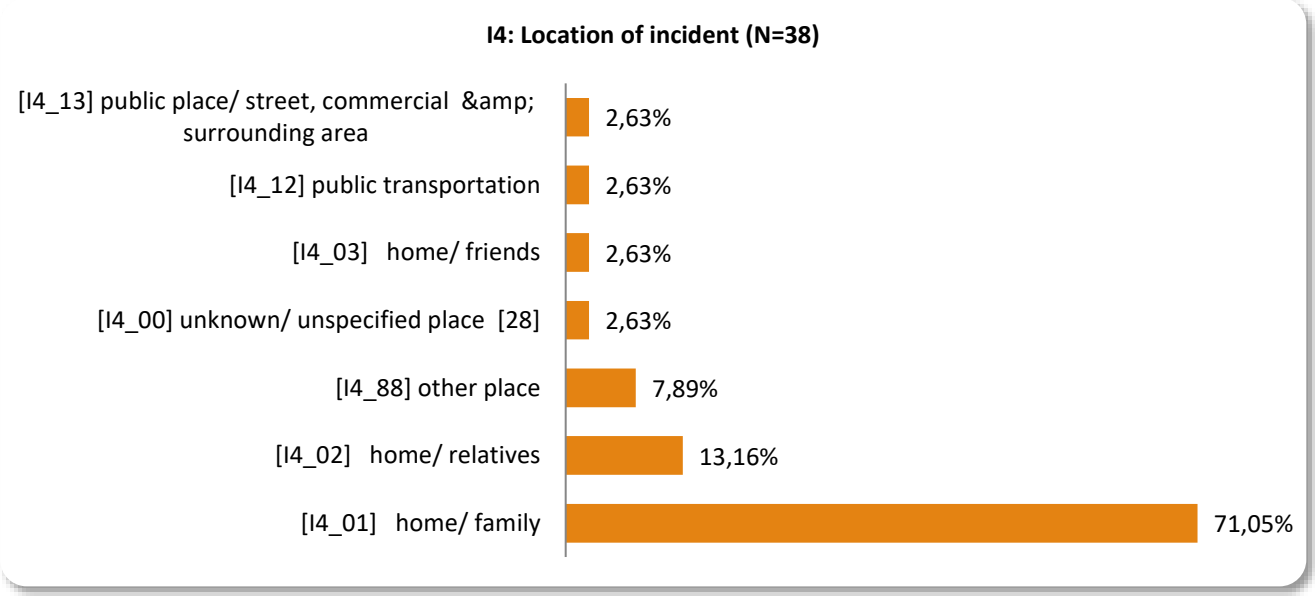
Psychological violence acts and specific types (N=19)



Forms and specific types of omissions in children's care [I3_B] (N=38)

DE_I4: Place of Incident

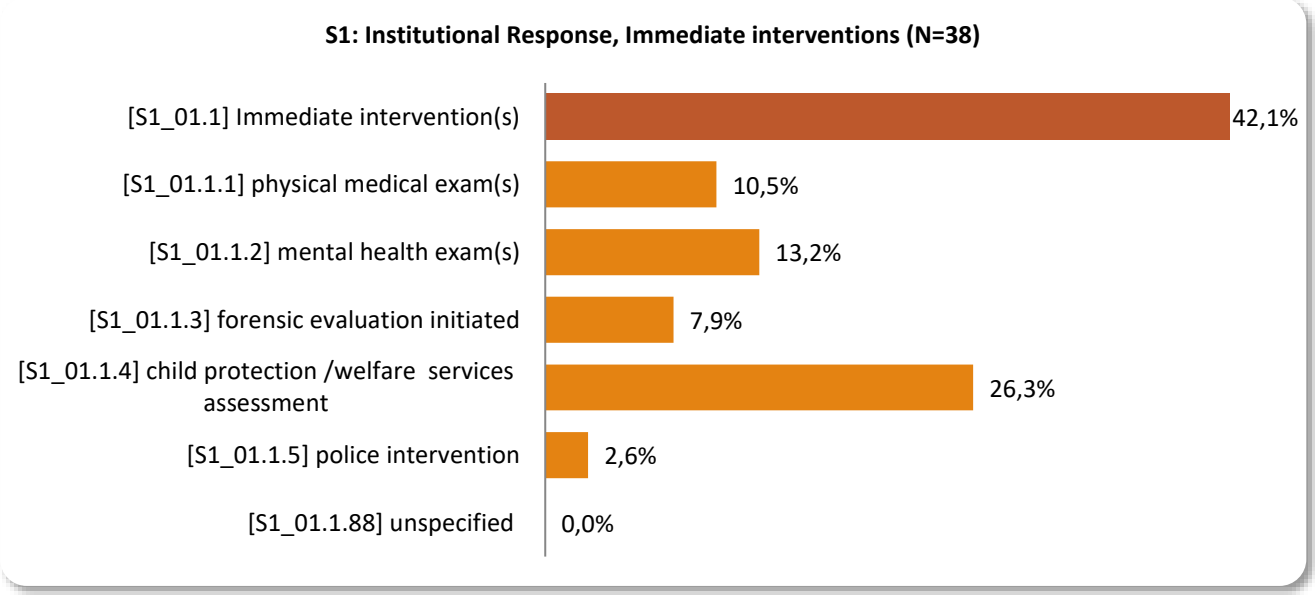
Lastly, the location where the specific incidents took place was recorded in the system by the professionals-operators; home of children is the most common place where abuse and neglect take place followed by home of relatives (for children who lived outside home. In some cases other locations were indicated as the place where the incidents took place.



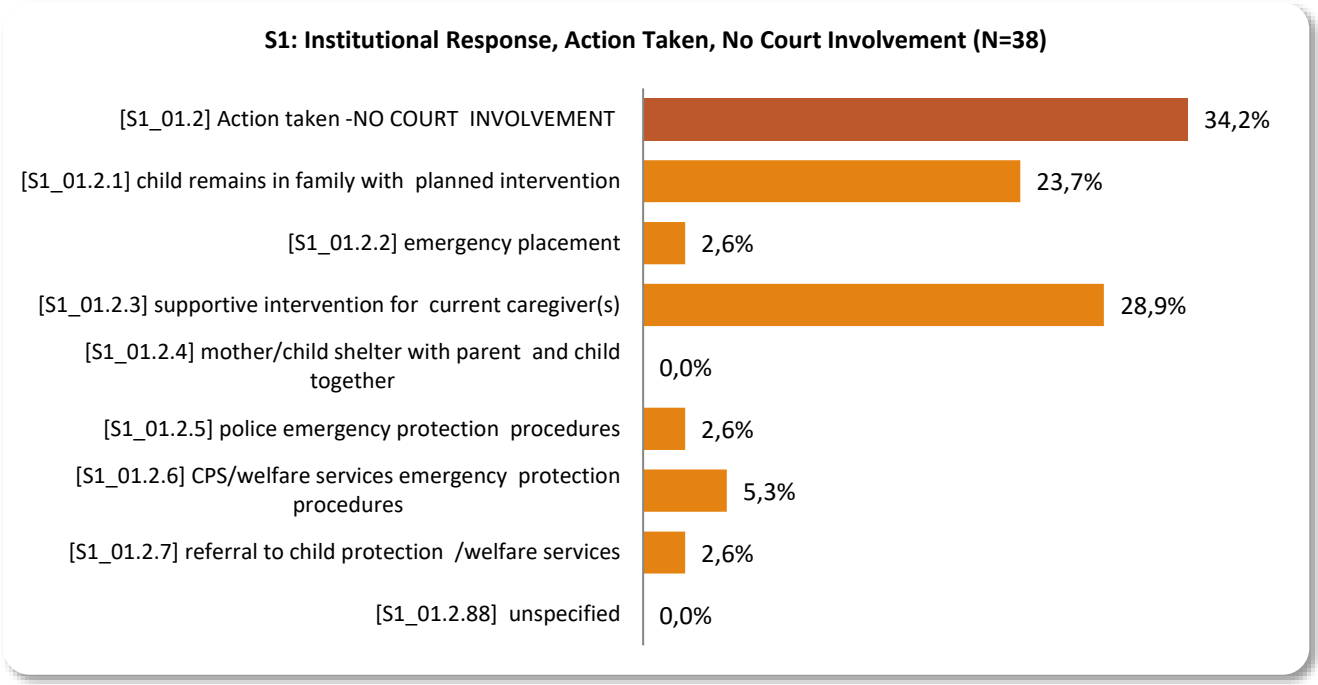
DE_S1: SERVICES PROVIDED

In 37 out of the 38 cases specific services were provided to the child and/or his/her family from the Agency where the professional-operator is working.

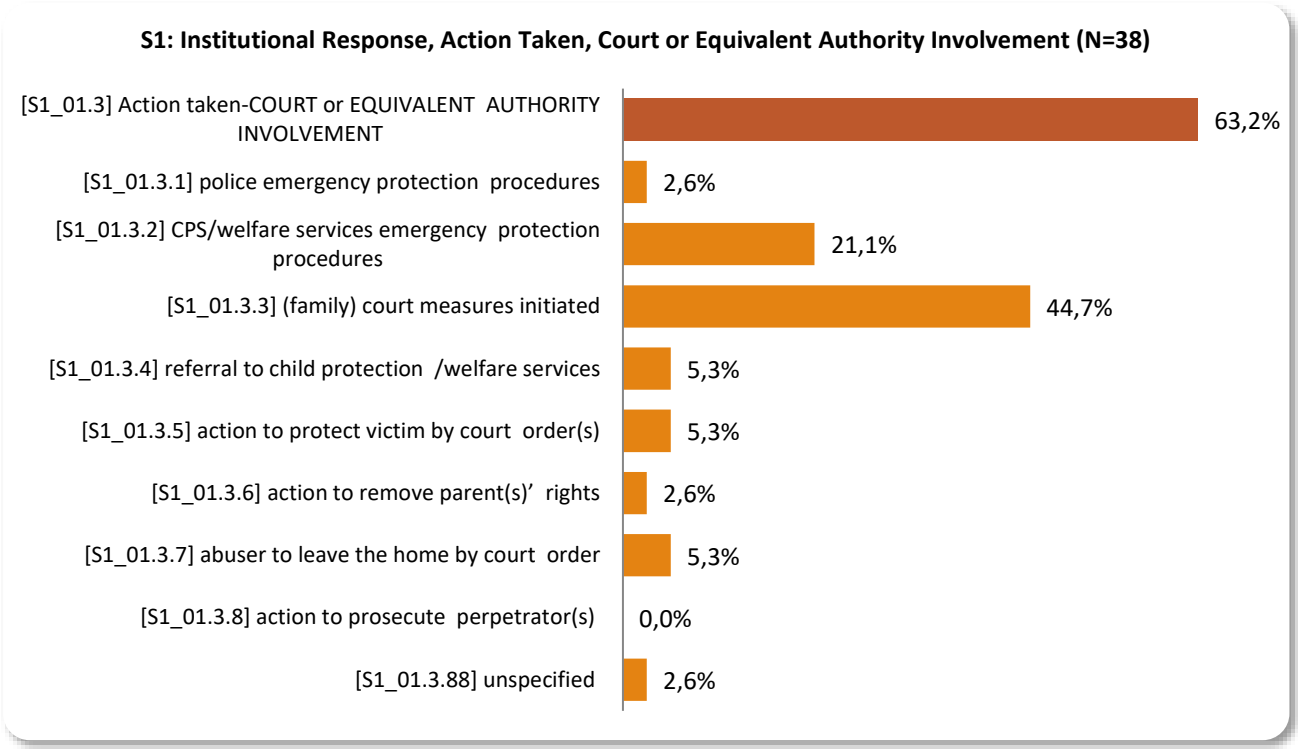
In more than 40% of the cases immediate intervention took place, as is presented below. In most of the cases immediate intervention was the assessment of the child by welfare or child protection services (often after a prosecutor's order). In other cases physical and mental health exams were conducted while in one case police intervention was also initiated by the Agency.



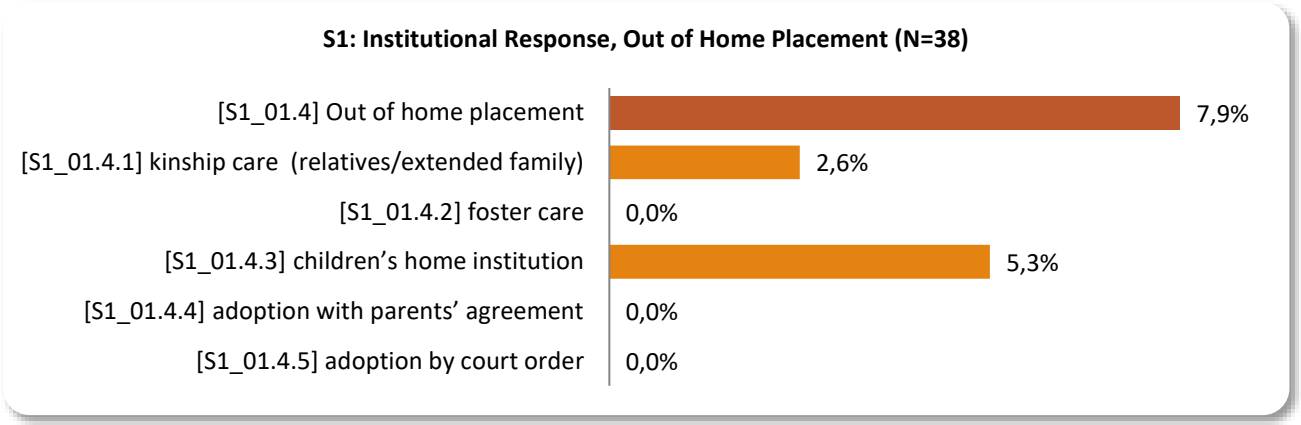
Moreover, in 34% out of the 38 cases further action was taken without, however, court or equivalent authority involvement. Action was mainly related to cases where child remained to his/her family and further intervention was planned (~24%) while the most frequent action was supportive measures for the current caregivers. In 2 cases child protection emergency protection services were involved and in 1 case an emergency placement was conducted and a referral to child protection services.



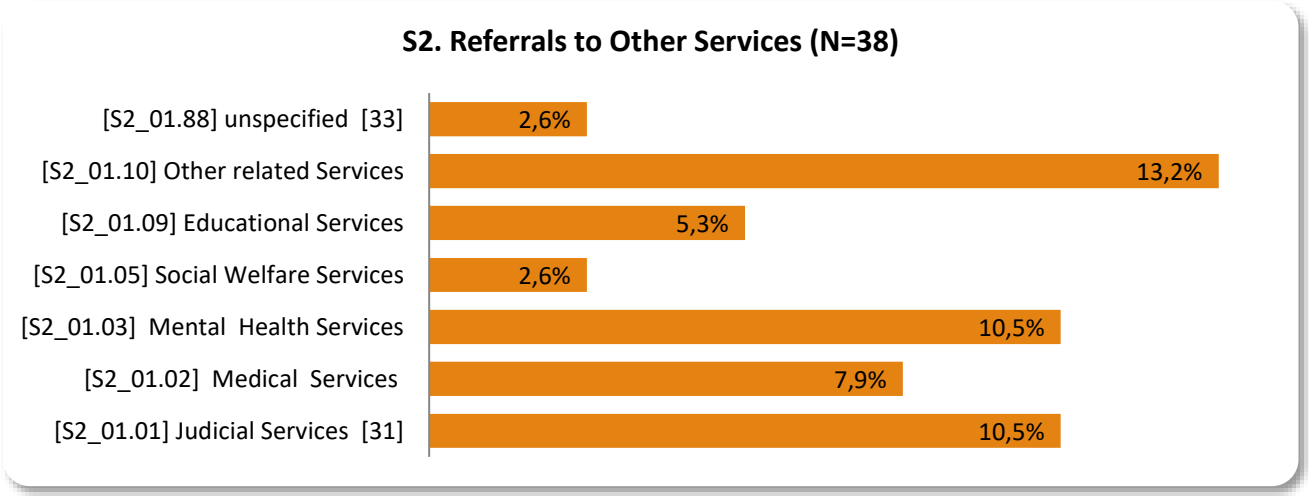
In most of the cases, however (~63%) the action taken involved justice or other authorities. Specifically, in ~45% of the cases court protection measures initiated and in 21% of the cases welfare emergency protection procedures were initiated. In 2 cases protective measures were released by the court and in another 2 cases abuser left the home by court order; in 1 case action taken to remove parental rights.



In 3 cases the child war removed from home and placed either in a children's home institution (2 cases) or the child placed in kinship care (1 case).



Apart from the action taken on the part of the Agency where the professionals-operators working in, referrals to other services took place for the further administration of 18 out of the 38 cases, as presented below.



Among the 18 cases, 5 specific referrals made via the system from one service (initially worked with the incident) to another service (in 3 cases of Mental Health Services for child and family and in 2 cases in tertiary health care, hospital, for child and family too). Up to the date of the report the services received the referrals had no reacted yet by sending a feedback to referees.

CONCLUSION

Although the duration of the piloting of the CAN-MDS System in real settings in Greece was shorter than the planned one and despite the fact that the number of participating professionals-operators was lower than the provisioned one in the customized national plan, the data collected through the system seem to provide an adequate picture of the cases. The pseudonymization process worked timely and without difficulties, cases were recorded without missing values concerning the record, the child, the incident, the family and the services provided and referrals took place among participating organizations. These preliminary results suggest that longer operation of the system with the participation of more agencies and more trained professionals nationwide will provide the data that are necessary for the epidemiological surveillance of the child abuse and neglect incidents in Greece and their specific characteristics; at the same time, continuous operation of the system is expected to further contribute in the multidisciplinary and inter-sectoral collaboration in the administration at a case level and at the same time will support capacity building of all relevant professionals and especially improvement of their knowledge on issues related to child maltreatment.

Discussion

The necessity for data collection on child abuse and neglect is a commonly accepted priority worldwide, in the EU countries and in Greece in particular. Therefore, the necessity for child maltreatment surveillance mechanisms that provide continuous and systematic data to monitor the magnitude and impact of CAN is undeniable. However, as resulted from the BECAN Project (2013) in it is a fact that child abuse and neglect case-based data in Greece are derived from a variety of inter-sectoral sources involved in the administration of each case, and follow up of victims at local and national levels is not sufficiently coordinated among the involved services. Moreover, available data are collected by various agencies and professionals on the basis of different definitions, methods and tools usually in distinct databases and even though all this information unified in single databases, data are not comparable and it is not feasible to draw valid and reliable results from their analyses and therefore not so useful for planning preventive polices and measures. In the General Comment 13 (2011) of the UN CRC it is noted that "[…] The impact of measures taken is limited by lack of knowledge, data and understanding of violence against children and its root causes, by reactive efforts focusing on symptoms and consequences rather than causes, and by strategies which are fragmented rather than integrated."

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

CAN-MDS System was developed to deal with all of the above issues. Piloting of the CAN-MDS System in Greece suggest that the system it could work, especially if all relevant sectors will be actively involved nationwide and sufficient number of professionals with multiple cognitive backgrounds will be trained to become operators of the system.

Sustainability of the system; National Inter-Sectoral Board decided to continue the supporting of the system after the end of the project and to strengthen professionals' commitment to systems' use and operation. Concerning the support of relevant stakeholders, current synthesis of the National CAN-MDS Inter-Sectoral Board suggests that the effort will be enforced during the piloting phase (until Dec 2021) but also –and this is the most important commitment- afterwards. A discussion was started for the institutionalization of the system involving all relevant ministries.

CAN-MDS Training results suggest that Operators' seminars are effective while the asynchronous online training is a convenient method for the participants, especially in the new pandemic-related conditions

where in person training is often not feasible or taking into account that many professionals work from home.

CAN data (both, mock and real cases) collected for a short period of time via a fully controlled surveillance mechanism could be used for the assessment of system's operability and as a baseline for evaluation of existing or new CAN prevention practices and policies. Simulation (working with mock cases) after the training indicate that training is adequate in order for the professionals to record sufficiently a CAN-incident into the system, regardless of their professional specialty and the agency where they are working. Data collection on living cases suggest that they system is able to provide the results that it was developed to collect and at the same time facilitate CAN incidents administration at a case level.

At an international level, EU-wide uniform CAN data would support mainstreaming among EU MSs (national reports will be considered comparatively).

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