The Australian Child Maltreatment Study:
A landmark study of the national prevalence of child maltreatment, its mental and physical health outcomes, and burden of disease

Presentation to Australian Government agencies

Monday 21 September 2020

Professor Ben Mathews (Lead Investigator)
Principal Research Fellow, Faculty of Law, QUT
Director, Childhood Adversity Research Program, Faculty of Health, QUT
Adjunct Professor, Johns Hopkins University, Bloomberg School of Public Health
b.mathews@qut.edu.au 0407 809 678 https://www.australianchildmaltreatmentstudy.org/

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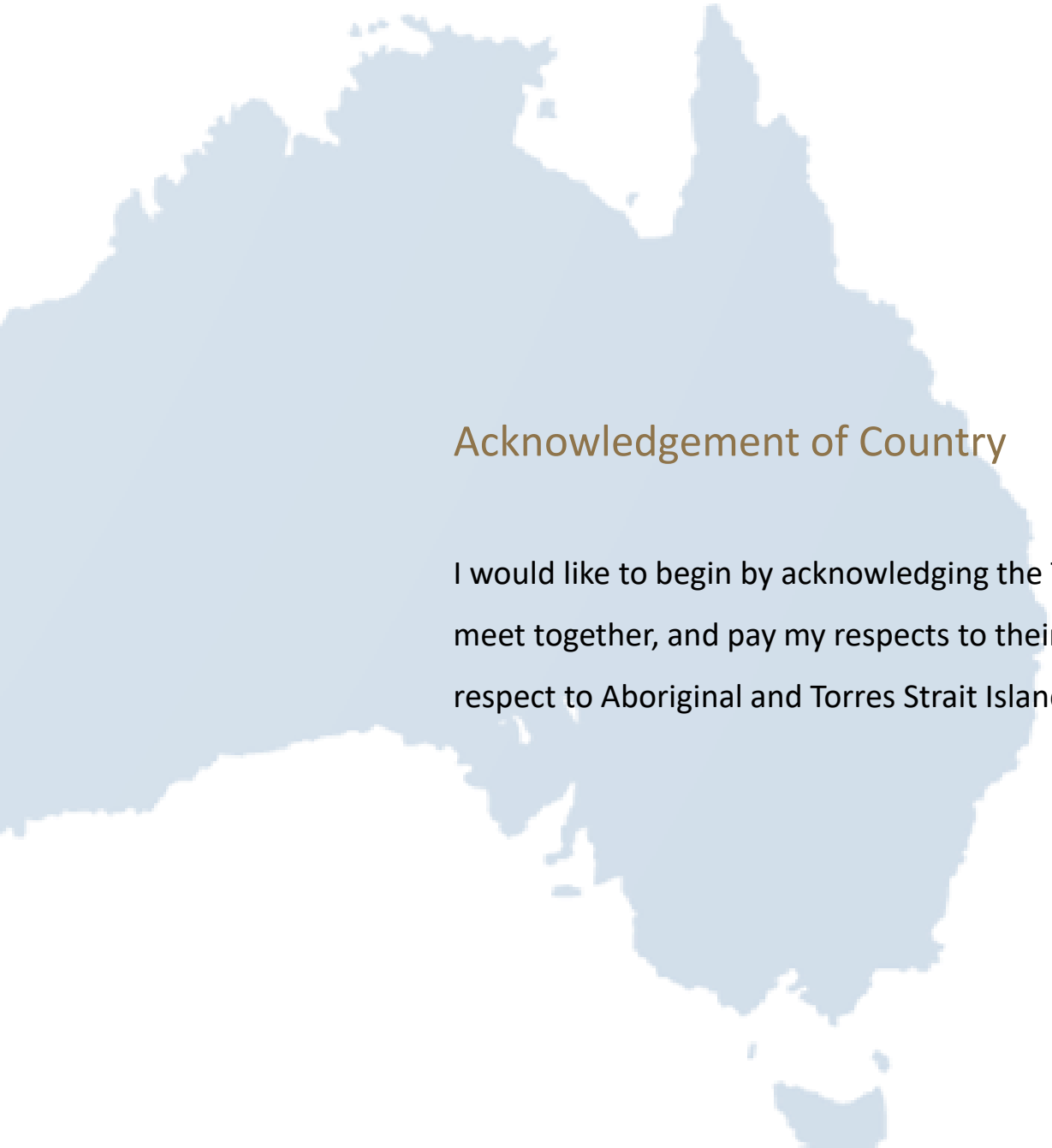

Acknowledgement of Country

I would like to begin by acknowledging the Traditional Custodians of the lands on which we meet together, and pay my respects to their Elders past, present and future. I extend that respect to Aboriginal and Torres Strait Islander people who are joining us today.

Australian Government
National Office for Child Safety

I would also like to pay my respects to survivors of child sexual abuse and recognise the importance of hearing their voices. I extend that respect to any victim survivors here today.

On Behalf of the ACMS team

- Prof Ben Mathews (QUT)
- Prof Rosana Pacella (Greenwich University)
- Prof Michael Dunne (QUT)
- Prof James Scott (QIMR Berghofer)
- Prof Daryl Higgins (ACU)
- Dr Hannah Thomas (UQ)
- Dr Holly Erskine (UQ)
- Dr Franziska Meinck (University of Edinburgh)
- Prof David Finkelhor (University Of New Hampshire)
- Dr Divna Haslam (Project Manager, QUT)
- Dr Nikki Honey (Senior Research Director, Social Research Centre)

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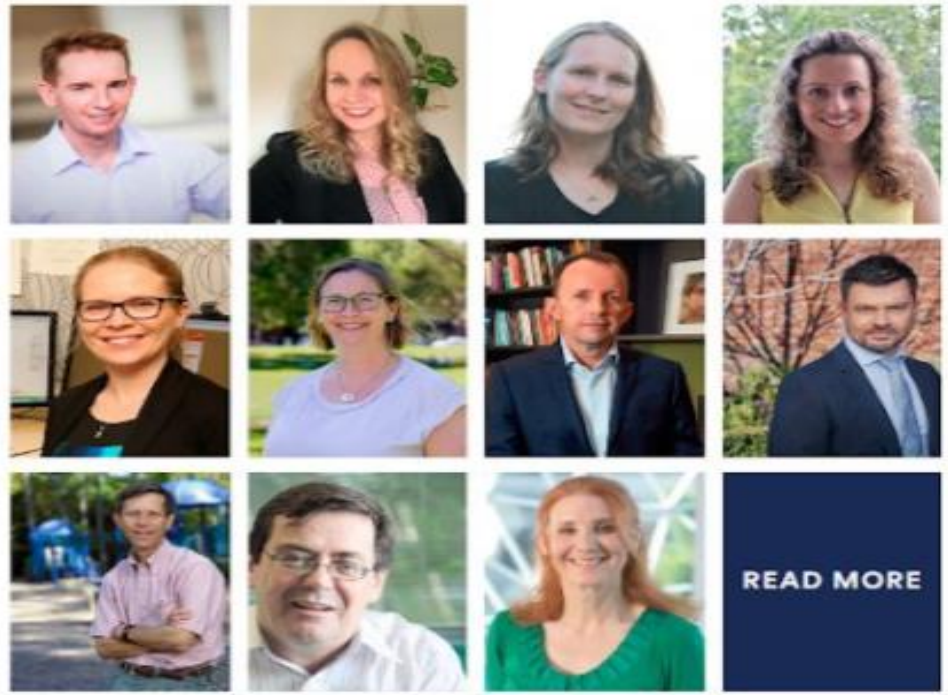


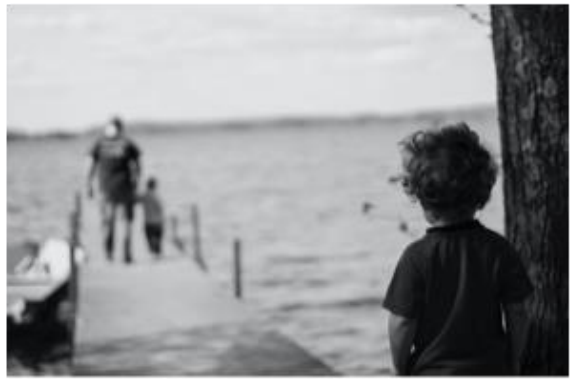
Overview of presentation

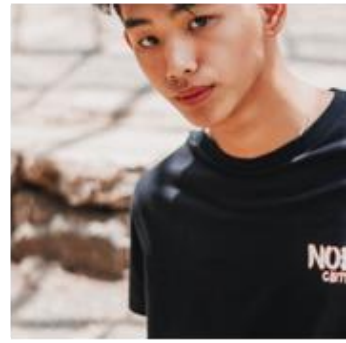
1. Why we need to study child maltreatment and its health outcomes

2. Summary of a systematic review of global prevalence studies

3. The Australian Child Maltreatment Study:

- Study design
- Representative sample / cohorts
- Maltreatment data obtained
- Health outcome data obtained
- Distress protocols
- Wellbeing/referral protocols
- Publications and timeline
- Knowledge translation and engagement





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1. Why Should We Study Child Maltreatment?

- In sum: massive significance for individuals, families, communities, society, and the economy
- Child maltreatment (physical, sexual, and emotional abuse, neglect, and exposure to domestic violence) is common and harmful
- Violates physical, psychological, sexual integrity; often endured repeatedly; sometimes criminal
- Breach of fundamental human rights of vulnerable individuals
- Psychological trauma: depressive disorders (22.8% females;15.7% males); anxiety disorders (30.6% females; 20.9% males); self harm (33% females; 23.5% males) (Moore et al., 2015)
- UN Sustainable Development Goals view child maltreatment as a major public health issue: **Goal 16** aims to end child maltreatment and requires governments to report on their efforts
- Impact on broader social systems of care for children, including out-of-home care
- ROGS 2018: single year cost 2016/17: >$5 billion (child protection, OOH care, intensive family support and family support services) – not counting downstream costs

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Adverse Health, Behavioural and Economic Consequences through the Lifespan


Failure to thrive; impaired development; physical injuries and fatalities


Mental health outcomes: depression, anxiety, PTSD, self-harm, suicide


Physical health outcomes from coping strategies, including obesity


Academic impact and economic achievement


Effects on adult relationships, re-victimisation, violence, intergenerational maltreatment


Long-term disease caused via coping mechanisms (e.g., smoking, alcohol, drug abuse) and chronic stress (e.g. coronary artery disease, inflammation)


Impairs brain development and function; shortens telomeres, accelerates cellular ageing


Produces lifelong disease burden with intergenerational effects


Those who experience poly-victimisation / multi-type maltreatment have greatest effects

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Brain studies show profound adverse effects on human development

"Maltreatment-related childhood adversity is the leading preventable risk factor for mental illness and substance abuse"

"Childhood abuse alters the development of particular brain regions, in an experience-dependent plastic manner, to facilitate survival … in what seems, so far, to be a threatening and malevolent world."

Martin Teicher et al., 2016, *Nature Reviews Neuroscience*.

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Why Should We Study Prevalence?

Informed public health responses about where and when our prevention approaches are best targeted require evidence about:

- **Prevalence** of each type of abuse and neglect
- **Characteristics of the abuse:** child's sex and age at onset; severity of abuse; frequency of abuse; relationship to person inflicting abuse; family factors
- **Risk profiles** of children, especially for poly-victims

- Major gaps in Australian evidence about prevalence of each type of maltreatment
- Reliable prevalence data is needed for Australia to report on UN SD Goal 16
- Due to intrinsic limitations, official/agency sources of data are the tip of the iceberg…

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Why Should We Study Prevalence?

Official sources of data are the tip of the iceberg…

Prevalence studies: self-report with national samples using rigorous measurement

Finkelhor 2015 (USA):
15.2% prior year maltreatment (physical abuse, sexual abuse, emotional abuse, neglect) (children 2-17)
24.9% lifetime maltreatment (children 2-17)
38.1% lifetime maltreatment (children 14-17)

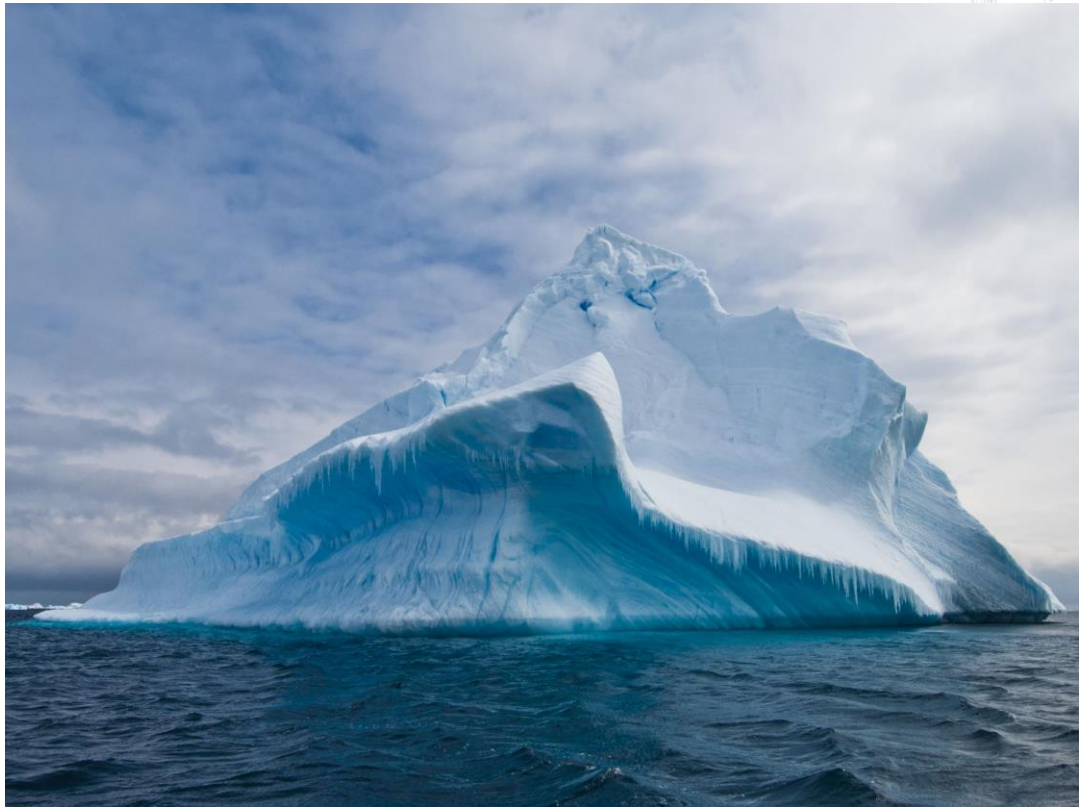
Radford 2013 (UK):
6% prior year maltreatment by parent/guardian (children 0-17)
21.9% lifetime maltreatment by parent/guardian (children 11-17)
24.5% lifetime maltreatment by parent/guardian (retro: 18-24)

Radford, lifetime:
- Physical abuse: 8.4%
- Sexual abuse: 24.1%
- Emotional abuse: 6.9%
- Neglect: 16%
- EDV: 23.7%

Contrast: AIHW 2020

8.5/1000 children (0.85%)
(children in substantiated cases)

- 9354 physical abuse
- 5950 sexual abuse
- 31,631 emotional abuse
- 15,586 neglect



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Why Should We Study Health Outcomes?

"*In Australia, as in most countries, there has not been a comprehensive assessment of the health consequences of child maltreatment at the national level*" (Moore et al., 2015)

Better evidence is needed to inform targeted prevention policy and clinical responses

Multiple, major evidence gaps exist, including:

1. health consequences of emotional abuse
2. health consequences of exposure to domestic violence
3. health consequences of multi-type abuse / poly-victimization
4. effect on health consequences of developmental timing of maltreatment
5. effect on health consequences of relationship between the child and the person inflicting the abuse

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What Data is Needed?

We need evidence to understand:

1. The prevalence of each single type of child maltreatment
2. The prevalence of multi-type maltreatment
3. Health consequences (short-term, medium-term, and long-term over lifespan) of:
    - Each single type of child maltreatment
    - Multi-type maltreatment / Poly-victimization (co-occurrence of multiple forms of maltreatment, any time in childhood)
    - Specific risk profiles (e.g., associations between outcomes and relational pathways)

Our ACMS will generate this data – a major contribution

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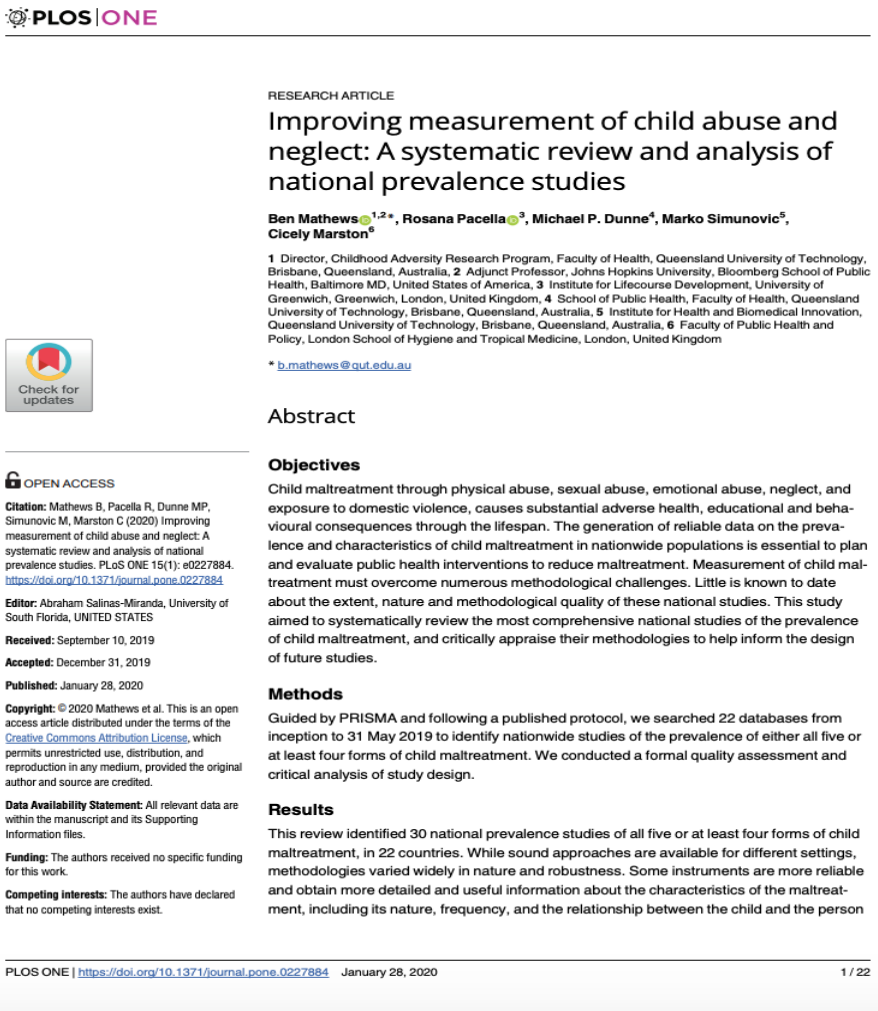
2. Findings from global systematic review (Mathews et al., 2020)

- Review and critical analysis informed our approach
- Only 30 national studies of all 5 or 4 types of maltreatment
- Only 2 studies involved adults providing data about abuse and neglect over their entire childhood up to age 18
- Wide variation in methodology
  - Measures: JVQ, ICAST-CH, CTQ, other
  - Samples: adults, children, parent report
  - Administration: school, household, CATI
- **Item congruence** with conceptual models is variable
- Few studies asked adequate **follow-ups** about context
- Ethically legitimate to gather data from youth, adults



PLOS ONE

RESEARCH ARTICLE

Improving measurement of child abuse and neglect: A systematic review and analysis of national prevalence studies

Ben Mathews[1,2]*, Rosana Pacella[3], Michael P. Dunne[4], Marko Simunovic[5], Cicely Marston[6]

1 Director, Childhood Adversity Research Program, Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia, **2** Adjunct Professor, Johns Hopkins University, Bloomberg School of Public Health, Baltimore MD, United States of America, **3** Institute for Lifecourse Development, University of Greenwich, Greenwich, London, United Kingdom, **4** School of Public Health, Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia, **5** Institute for Health and Biomedical Innovation, Queensland University of Technology, Brisbane, Queensland, Australia, **6** Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, United Kingdom

* b.mathews@qut.edu.au

Check for updates

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Abstract

Objectives

Child maltreatment through physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence, causes substantial adverse health, educational and behavioural consequences through the lifespan. The generation of reliable data on the prevalence and characteristics of child maltreatment in nationwide populations is essential to plan and evaluate public health interventions to reduce maltreatment. Measurement of child maltreatment must overcome numerous methodological challenges. Little is known to date about the extent, nature and methodological quality of these national studies. This study aimed to systematically review the most comprehensive national studies of the prevalence of child maltreatment, and critically appraise their methodologies to help inform the design of future studies.

Methods

Guided by PRISMA and following a published protocol, we searched 22 databases from inception to 31 May 2019 to identify nationwide studies of the prevalence of either all five or at least four forms of child maltreatment. We conducted a formal quality assessment and critical analysis of study design.

Results

This review identified 30 national prevalence studies of all five or at least four forms of child maltreatment, in 22 countries. While sound approaches are available for different settings, methodologies varied widely in nature and robustness. Some instruments are more reliable and obtain more detailed and useful information about the characteristics of the maltreatment, including its nature, frequency, and the relationship between the child and the person

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Mathews, B., Pacella, R., Dunne, M., Simunovic, M., & Marston, C. (2020). Improving measurement of child abuse and neglect: a systematic review and analysis of national prevalence studies. PLoS ONE 15(1): e0227884. https://doi.org/10.1371/journal.pone.0227884

Conclusions from the systematic review

1. Substantial evidence gaps in almost all nations about prevalence of all forms of child maltreatment
2. No studies in Australia
3. Widespread international need to invest in robust national studies
4. Different methods shown suited to different contexts (household/school/CATI)
5. Studies should use an instrument with demonstrated validity and reliability
6. Studies should capture past year incidence (youth), and childhood prevalence
7. Studies must ensure maltreatment constructs are soundly defined and operationalised
8. Information should also be captured about the context of maltreatment: its specific nature, severity, frequency, age of onset, and the relationship of the child to the person inflicting the acts

The Australian Child Maltreatment Study (ACMS)

Funded for 5 years 2019-23: National Health and Medical Research Council Project Grant 1158750 ($2.3m)

Additional funding and contributions for the ACMS have been provided by the Department of the Prime Minister and Cabinet, Department of Social Services, the Australian Institute of Criminology and by the Queensland University of Technology

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Australian Government
Department of Social Services

Australian Government
Australian Institute of Criminology

Why Australian prevalence data is essential

Australia lacks fundamental evidence about:

- the true national prevalence of each different kind of child abuse and neglect
- the characteristics of these experiences
- mental and physical health effects
- specific high-risk profiles

This impedes evidence-based, targeted public health approaches to prevent maltreatment, and reduce associated health conditions and other adverse outcomes

Our Study will provide this evidence, add to international scientific knowledge, and can inform national public health policy

Implications for intergenerational prevention

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ACMS: Aims

For the first time in Australia, the ACMS will comprehensively examine:

1. The **prevalence** of each form of maltreatment (and of multi-type abuse)
2. The **characteristics** of these experiences (e.g., child age, sex, timing, frequency, relationship to person inflicting abuse: specific risk profiles)
3. Key **mental and physical health** outcomes through the lifespan
4. **Burden of disease** associated with maltreatment (and other health utilisation outcomes)

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Study Design

- **Nationwide cross-sectional survey** of ~10,000 participants aged 16 and over, via computer-assisted telephone interviews (CATI)
- Sample size
  - ~ 5000 adolescent/young adult participants aged 16-24 years
  - 1000 adults in each of the following strata: 25-34, 35-44, 45-54, 55-64, >65
- Obtains self-reported retrospective data about child maltreatment experiences
- Obtains diagnostic information about mental health outcomes and information about physical health outcomes and behaviors
- Also obtains information about other adversities (confounders): bullying, ACEs
- Lays foundation for further essential studies, examining intergenerational effects

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Sampling Frame

- People aged 16 years and over, accessible by mobile phones
- Nationally representative: metropolitan, regional, rural, remote
- Mobile phone numbers selected through random digit dialing (commercial vendor mobile number database)
- Pre-approach text message
- Note hard-to-reach subpopulations
- The Social Research Centre is our partner organization
  - expert, highly trained telephone interviewers
  - further intensive training by ACMS team
  - special support and oversight / monitoring / quality assurance

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Parameter 1: Experiences of child maltreatment (all five types)

Data obtained from all participants about their experience across childhood up to age 18 of each type of child maltreatment:

- Physical abuse (by parent/caregiver)
- Sexual abuse (by anyone)
- Emotional abuse (parent/caregiver)
- Neglect (parent/caregiver)
- Exposure to domestic violence (family violence)
- Also other key adversities (peer / sibling violence; ACES; corporal punishment)

Data also obtained from 16-17 year-olds on past year prevalence

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Instrument: The JVQ-R2: Adapted Version (Australian Child Maltreatment Study)

We have adapted the best available instrument to suit the ACMS purposes

The Juvenile Victimization Questionnaire (JVQ-R2) was the best instrument:

- **Proven use**: 6 studies in original/enhanced/modified form (US, UK, Germany) with demonstrated comprehensiveness and construct validity
- **Follow-up questions** after screeners, to capture nuanced information on characteristics of maltreatment experiences e.g., frequency, severity, person, age)
- **Captures other major adversities** (confounders) & key parental features
- **Practicability** (time and cost to administer, and minimise missing data)

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Instrument development and configuration:
The JVQ-R2: Adapted Version (Australian Child Maltreatment Study)

We have modified the JVQ-R2 to ensure our maltreatment questions:

- meet Study aims
- comprehensively measures each of the five types of maltreatment
- are congruent with robust conceptual models of each maltreatment type (essential)
- are linguistically and culturally suited to the Australian setting

Multiple stages of testing and iterative refinement:

1. Conceptual analysis of all existing questions
2. Refinement of existing questions; and addition of questions
3. Technical Expert Panel feedback on all draft questions
4. Cognitive testing (2 phases: Melbourne) + abuse survivors, youth
5. Full pilot test (n=100) + re-test 3-4 weeks
6. Analysis of pilot data

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The JVQ-R2: Adapted Version (Australian Child Maltreatment Study)

20 screener questions: behaviorally-specific questions about different manifestations of each maltreatment type (*severity*) – Yes/No

1. Physical abuse: **2** (+ one item on corporal punishment)
2. Sexual abuse: 5 (+ 2 on internet victimisation): **7**
3. Emotional abuse: **4**
4. Neglect: **3**
5. Exposure to domestic violence: **4**

Follow-up questions: (also indicating *severity*)

- *frequency* (number of times; or duration over time)
- *age of onset and cessation*
- *relationship* with person(s) who did the acts
- (specialized, selected): institutional physical and sexual abuse + disclosure (4 follow-ups)

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A Note on Conceptual Models and Item Congruence

Many studies have asked questions that are not congruent with sound conceptual constructs of the different forms of child abuse and neglect[1] – leading to over-estimates and under-estimates

A key strength of the ACMS is that its items robustly embody each theoretical construct

Physical Abuse: an intentional act of physical force by a parent/caregiver that is intended to and does cause injury, harm, pain, or breach of dignity, or has a high likelihood of doing so (excludes lawful corporal punishment)[2]

Sexual Abuse: contact and non-contact sexual acts by any adult or child in a position of power over the victim, to obtain sexual gratification for the person or another person whether immediately or deferred in time and space, when the child either does not have capacity to provide consent, or has capacity but does not provide consent[3]

Emotional Abuse: parental behaviour, typically repeated, that conveys to the child they are worthless, unloved, unwanted, or only of value in meeting another's needs. Exemplified by acts of hostility; terrorizing; rejection; isolation; corruption; and denying emotional responsiveness[4]

Neglect: parental failure to provide the basic necessities of life as suited to the child's developmental stage and as recognised by the child's cultural context; includes physical, emotional, medical, supervisory and educational neglect[5]

Exposure to Domestic Violence: witnessing a parent/family member subjected to assaults, threats, or property damage by another adult/teenager who lives in the household; includes other forms of inter-parental coercion[6]

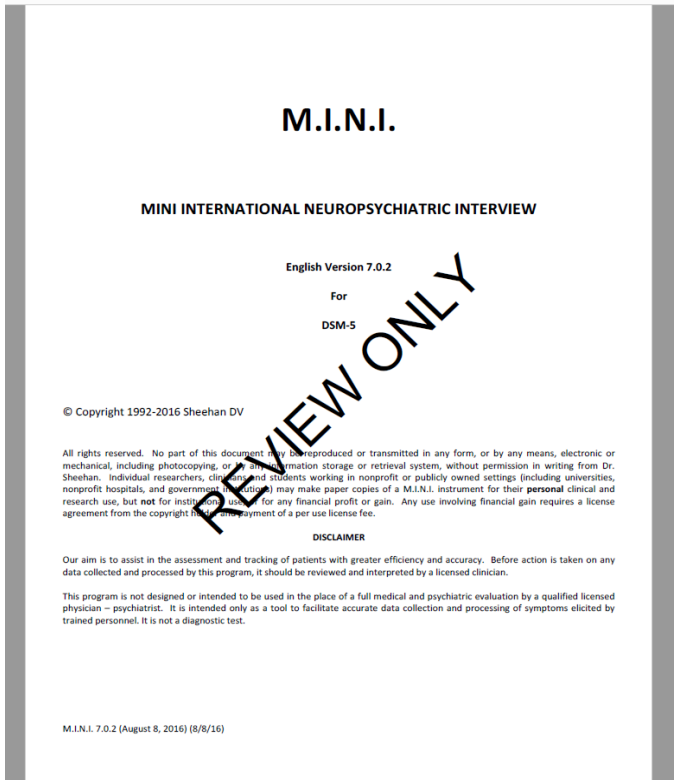
[1] Mathews et al, 2020, [2]WHO and ISPCAN 2006.) [3]Mathews & Collin-Vezina, 2019; [4]Glaser 2011; Kairys et al., 2002. [5]Dubowitz et al., 2005, [6]Hamby, Finkelhor et al., 2010; Ford-Gilboe et al., 2016.

Parameter 2: Health Outcomes - Mental Health

We use the MINI (Mini International Neuropsychiatric Interview) survey instrument

Key advantage: obtains diagnostic information for four key mental health conditions

1. Generalized anxiety disorder (current: past 6 mths)
2. Post-traumatic stress disorder (current)
3. Alcohol use disorder (current: past 12 mths)
4. Major depressive disorder (lifetime)



M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 7.0.2

For

DSM-5

DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician.

This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel. It is not a diagnostic test.

M.I.N.I. 7.0.2 (August 8, 2016) (8/8/16)

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Parameter 2: Health Outcomes - Physical Health

Major physical health conditions and adverse health and behavioural outcomes are assessed using NSMHW modules (chronic conditions, suicidality) and tailored items

Physical health diagnoses

1. Obesity (current)
2. Cardiovascular disease (LT, PY)
3. Diabetes (LT, PY)
4. STI (LT, PY)

Adverse Health Behaviours

1. Tobacco use (LT, PY)
2. Alcohol use (sub-clinical) (LT, PY)
3. Substance use (cannabis) (LT, PY)
4. Self-harm (LT, PY)
5. Suicidal thoughts / attempts (LT/PY)

Parameter 3: Burden of Disease

Personal, community and national costs of maltreatment will be assessed via:

Burden of disease attributable to health conditions from child maltreatment, calculated based on prevalence data and relative risks of disease

- Years of Life Lost (YLLs)
- Years Lived With Disability (YLDs)
- Disability Adjusted Life Years (DALYs)

Health service utilisation data gathered on a range of HSU measures using NSMHW service utilisation module

- hospitalisations
- medical and mental health consultations
- medication use

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Participant care and safety (Part 1): Distress protocol

Distress protocol (6 components)

Purpose: prevent, minimise, and manage participant distress (including risk of harm to self/others)

1. Ensure confidentiality and private setting
2. Use a proven, non-aversive instrument
3. Employ experienced, trained interviewers
4. Implement a structured protocol to respond to different levels/types of distress (5 steps)
    1. Stage 1a Initial distress: response system
    2. Stage 1b Initial distress: next steps
    3. Stage 2a Ongoing or significant distress: initial response
    4. Stage 2b Ongoing or significant distress: next steps
    5. Stage 3 Immediate risk of participant harming self/others
5. Provide all pts with contact details for counselling/support
6. Follow-up calls (3 elements: provided to any pt showing high distress; offered to any pt who shows any distress; provided to anyone who requests one)

Participant care and safety (Part 2): Referral protocol

Referral protocol

Purpose: To protect participants (primarily youth, but also adults) who may be at imminent risk of abuse/harm

Informed by analysis of (see **references):

- legislative duties to report child abuse and neglect
- common law duties towards research participants
- ethical duties of researchers towards participants
- best practice in the international field

- Primary application: 16-17 yr old pt potentially at imminent risk of further abuse or significant harm by another person, through disclosure of physical or sexual abuse in the prior year
- Secondary application: any other disclosure of clear imminent risk of further abuse or significant harm by another person
- Cases referred daily to ACMS Lead Investigator and Project Manager (clinical psychologist)
- **Detailed protocol for management**, informed by case-by-case risk assessment (12 factors)

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Depending on the **circumstances***, actions that may be taken by the research team are:

1. No further action
2. Follow-up call to seek more information
3. Informing participant of standard sources of support available to all participants
4. Offering access to more extensive counselling and other support
5. Informing participant they have the ability to self-refer to the child protection agency
6. Referring the situation to the child protection agency
7. Referring the situation to police
8. Subsequent follow-up calls

* **Circumstances** include (12 factors):

1. the participant's age and State/Territory (relevant to child protection jurisdiction)
2. the **type** of abuse
3. the **severity** of abuse and/or readily apparent harm or imminent risk of harm
4. the **frequency** of abuse
5. the **recency** of the abuse
6. the participant's own genuine **preference**
7. the participant's **safety**
8. the **risk** of further abuse/immediate danger, incl:

i. is participant living with the abuser
ii. is participant currently experiencing the abuse, or harm from it
iii. is the abuser the participant's parent/caregiver
iv. is the person who inflicted the abuse still posing an imminent risk to the participant
v. is participant cared for by another person who is able and willing to protect them

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Pilot performance (April – May 2020)

Conducted to replicate full main survey environment (+ stress-test under Covid-19)

Strong performance + useful information for final revisions (time, comfort, ending)

Initial administration (Time 1): entire instrument (n=100)

Subsequent administration (Time 2, 3-4 weeks later): maltreatment only (n=74)

Key outcomes:

1. Demographics sufficiently representative
2. Minimal missing data (clarity, face validity, participant comfort)
3. Descriptive frequencies for maltreatment types within expected ranges
4. Frequencies for other components also within expected ranges (MINI, bullying)
5. Testing of maltreatment questions:
   - strong percentage agreement at Time 1 and Time 2
   - strong internal consistency via Cronbach's alpha, especially compared with other instruments
   - strong test-retest via Cohen's kappa

Initial scholarly publications: methodology, law, ethics, conceptual models

Submission date	Primary focus
September 2020	Protocol article
October 2020	The nature and operation of legal duties towards research participants in studies of child maltreatment
November 2020	The ethics of research on child maltreatment: promoting participant confidentiality, welfare, and research participation
December 2020	Adaptation and validation of the Juvenile Victimization Questionnaire to the Australian context
February 2021	Conceptual models of physical abuse and corporal punishment: a critical analysis

Forthcoming work

Date	Primary focus
2021 Jan - June	**Publications**: Key methodological issues, and further conceptual models Technical reports and administration manuals (ongoing)
2021 Mar - Oct	**Main survey** **Ongoing engagement** (**Advisory Board**, incl multiple government and non-government stakeholders at national, State and Territory level) Preparation for **knowledge translation** (Advisory Board, Expert Panel)
2021 Oct - Dec	Data cleaning; **initial descriptive data**
2022	Data analysis; multiple articles on maltreatment trends, health outcomes **Ongoing engagement** (Advisory Board, multiple government and non-government stakeholders at national, State and Territory level) Accelerating **knowledge translation** (Advisory Board, Expert Panel)
2023 **Continuing**	Multiple articles on maltreatment trends, health outcomes, burden of disease, numerous specialized topics and scientific and policy advances **Ongoing engagement** (Advisory Board, Expert Panel); knowledge translation; policy briefs; reform submissions; impact focus; **further projects**

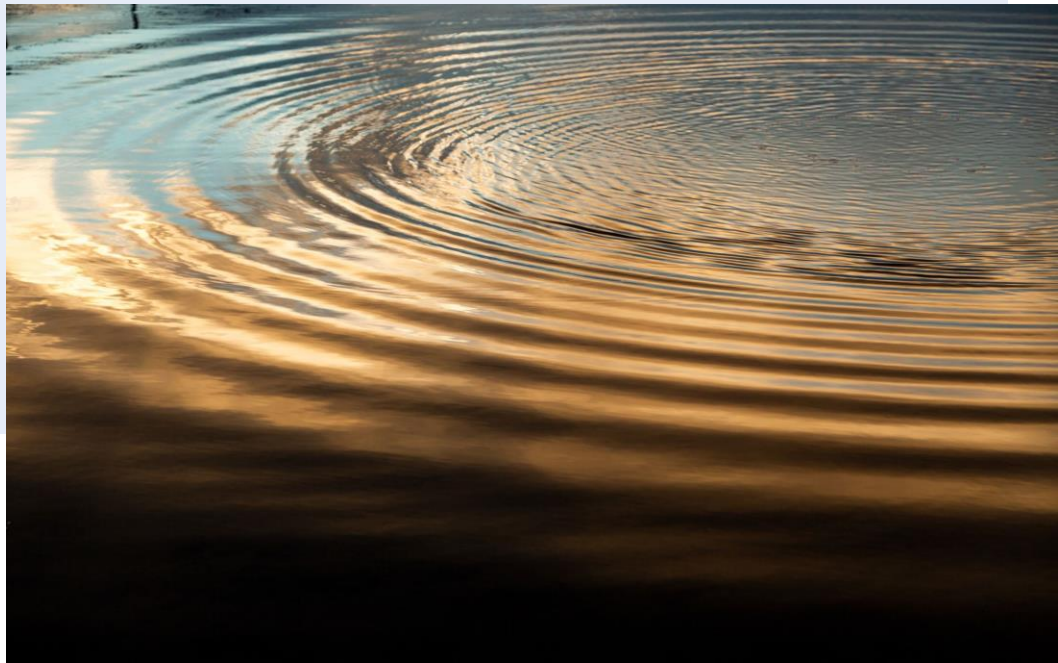
Limitations

1. Not possible to assess all health / other outcomes
   - strategic decisions, constraints of time and cost
   - requires other methods e.g., data linkage

2. Hard-to-reach subpopulations
   - Considered at length in planning and design
   - For some (e.g., ethnic groups), may naturally obtain sufficient participation
     - May also use orthodox statistical weights and adjustments
   - For some (e.g., those in detention) – need separate dedicated study, likely with adjusted methodology / administration
   - Indigenous Australians – may naturally obtain sufficient participation, but may need separate dedicated study especially for some subsamples

Future goals

1. Prevalence studies with separate youth samples 16-24
   - track trends in maltreatment generally over time in Australia
   - enables further and deeper analysis of specialized contemporary topics
   - enables consideration of effects of policy and practice
2. Longitudinal study (cohort studies)
   - identify mechanisms/pathways of impact over time, incl neurobiological research
   - intergenerational trends
   - efficacy of interventions
   - breaking cycles of maltreatment
   - identify mechanisms/pathways of resilience



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Progress to date February 2019 - September 2020

- Staff recruitment
- Project infrastructure
- Institutional contracts
- National media launch
- Analyses of practical, legal & ethical issues
- Ethical clearance obtained
- Data management plan
- Website development (live March 2020)
- **Advisory Board** terms of reference & invitations
- **Technical Expert Panel** recruitment
- Seeking supplementary funding
- Initial engagement with government stakeholders and community end-users including service peak bodies
- Ongoing team meetings
- Ongoing engagement with Social Research Centre
- Publications in progress
- Draft survey instrument developed
- Team workshop September 2019
- Draft instrument external review by international Technical Expert Panel
- Revised instrument
- Interviewer training
- Interview software design and testing
- Cognitive testing of instrument (2 stages, Melbourne)
- Qualitative testing with abuse survivors, youth
- Further instrument refinement
- Pilot survey (n = 100) and test-retest
- Instrument debrief with SRC interviewers
- Analysis of pilot data: excellent results
- Reporting to Australian Government and other funding bodies

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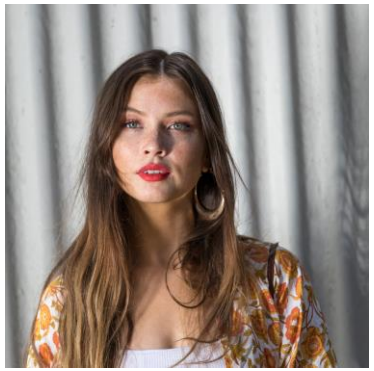

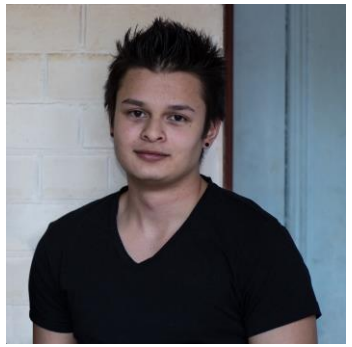

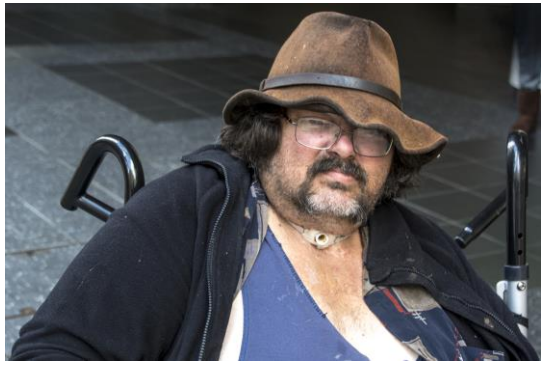

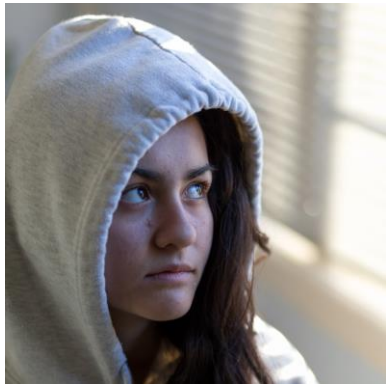

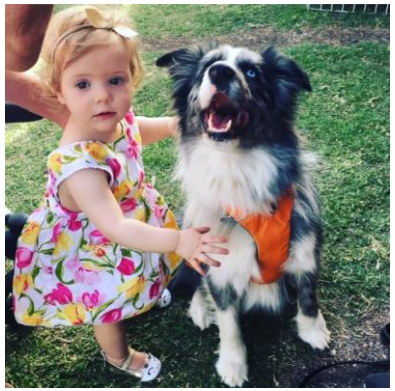

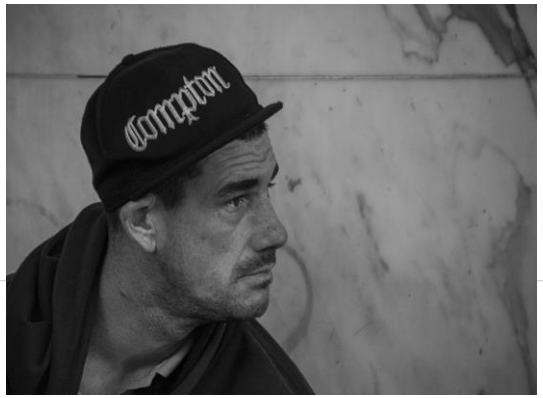

Questions?

For more information:

See: ACMS website

Contact:

Lead Investigator Professor Ben Mathews

b.mathews@qut.edu.au - 0407 809 678

Project Manager Dr Divna Haslam

acms@qut.edu.au