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Preventing and Responding to Child Abuse and Neglect: A Review of Best Practice System Approaches

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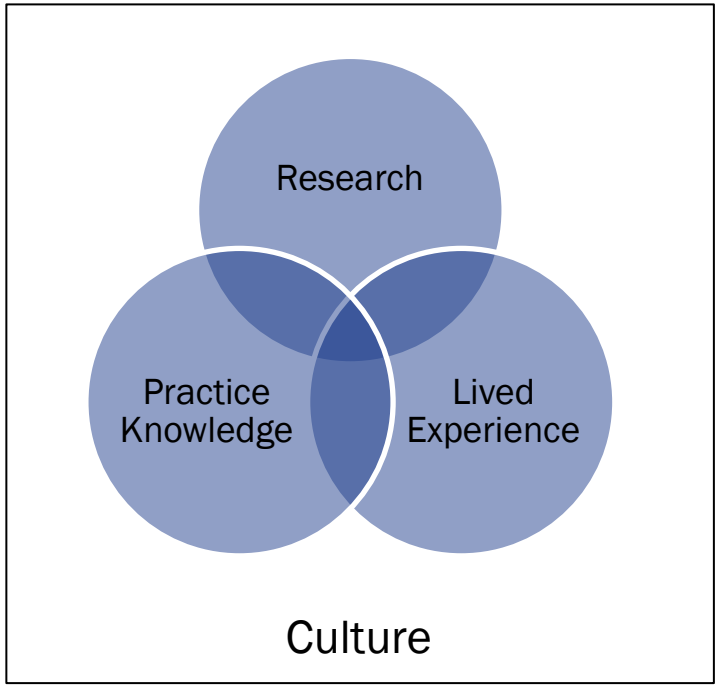
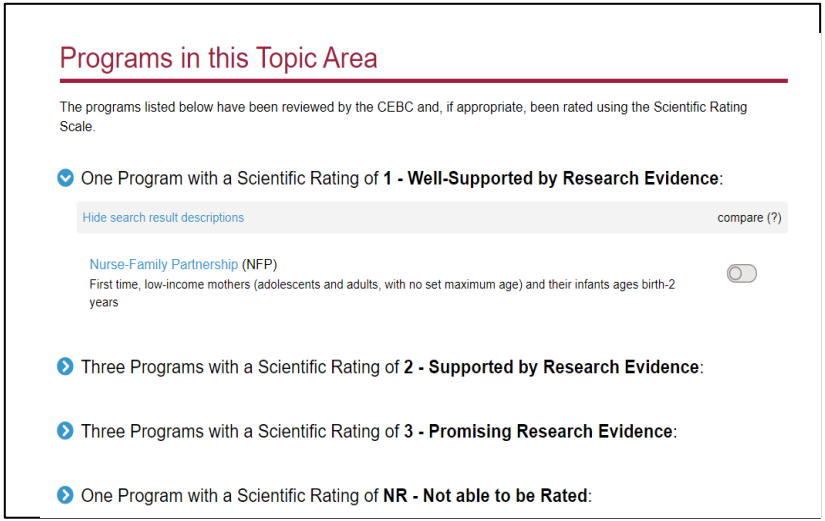


- Program Theory – Target Group Match (Segal et al. 2012)
- Quality of Implementation – Program Fidelity (Fixsen et al. 2019)
- Draw on the Evidence Base - Realist Synthesis (Pawson et al. 2004)



Programs in this Topic Area

The programs listed below have been reviewed by the CEBC and, if appropriate, been rated using the Scientific Rating Scale.

One Program with a Scientific Rating of **1 - Well-Supported by Research Evidence**:

Hide search result descriptions compare (?)

Nurse-Family Partnership (NFP)
First time, low-income mothers (adolescents and adults, with no set maximum age) and their infants ages birth-2 years

Three Programs with a Scientific Rating of **2 - Supported by Research Evidence**:

Three Programs with a Scientific Rating of **3 - Promising Research Evidence**:

One Program with a Scientific Rating of **NR - Not able to be Rated**:

Research and Evaluation Approach

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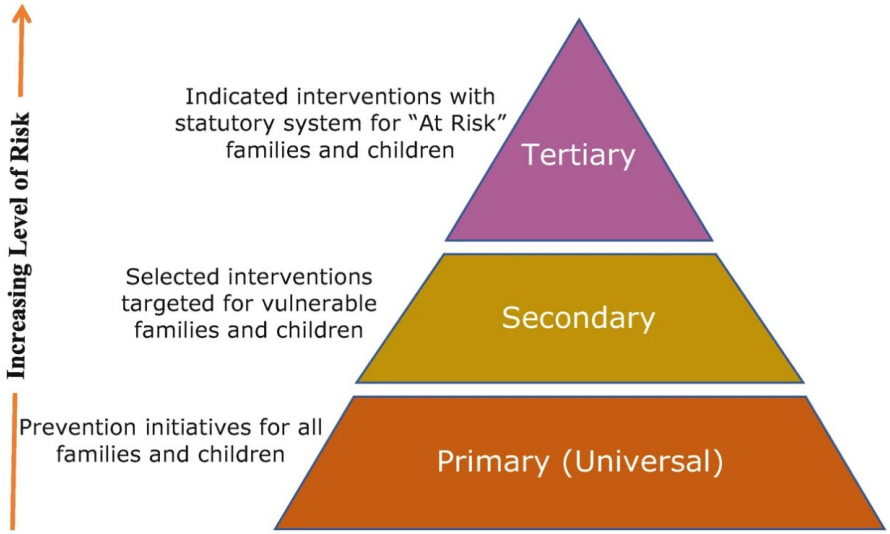
- Prevalence: Physical Abuse 32.0%; Sexual Abuse - 28.5%; Multi-Type Abuse is the Majority Pattern – Chronic abuse is common (>50 incidents) Australian Child Maltreatment Study 2023
- Mental Health Disorders, Health Risk Behaviours Australian Child Maltreatment Study 2023
- Estimated $4 Billion per Year in Current Costs Kezelman et al. 2015
- Up to $17.4 Billion per Year in terms of reduced quality of life and premature mortality Mcarthy et al. 2016
- Long term re-victimization rate following child sexual abuse - 47.7% Papalia et al 2017

- Address structural drivers of abuse and neglect (e.g., poverty, social isolation, intergenerational trauma)
- Whole of population approach
- Early intervention
- Evidence-Based programs matched to the needs of the people referred to them
- Non-Stigmatising platforms (i.e., existing universal systems)
- Change at scale



Public Health Approach Higgins et al. 2022

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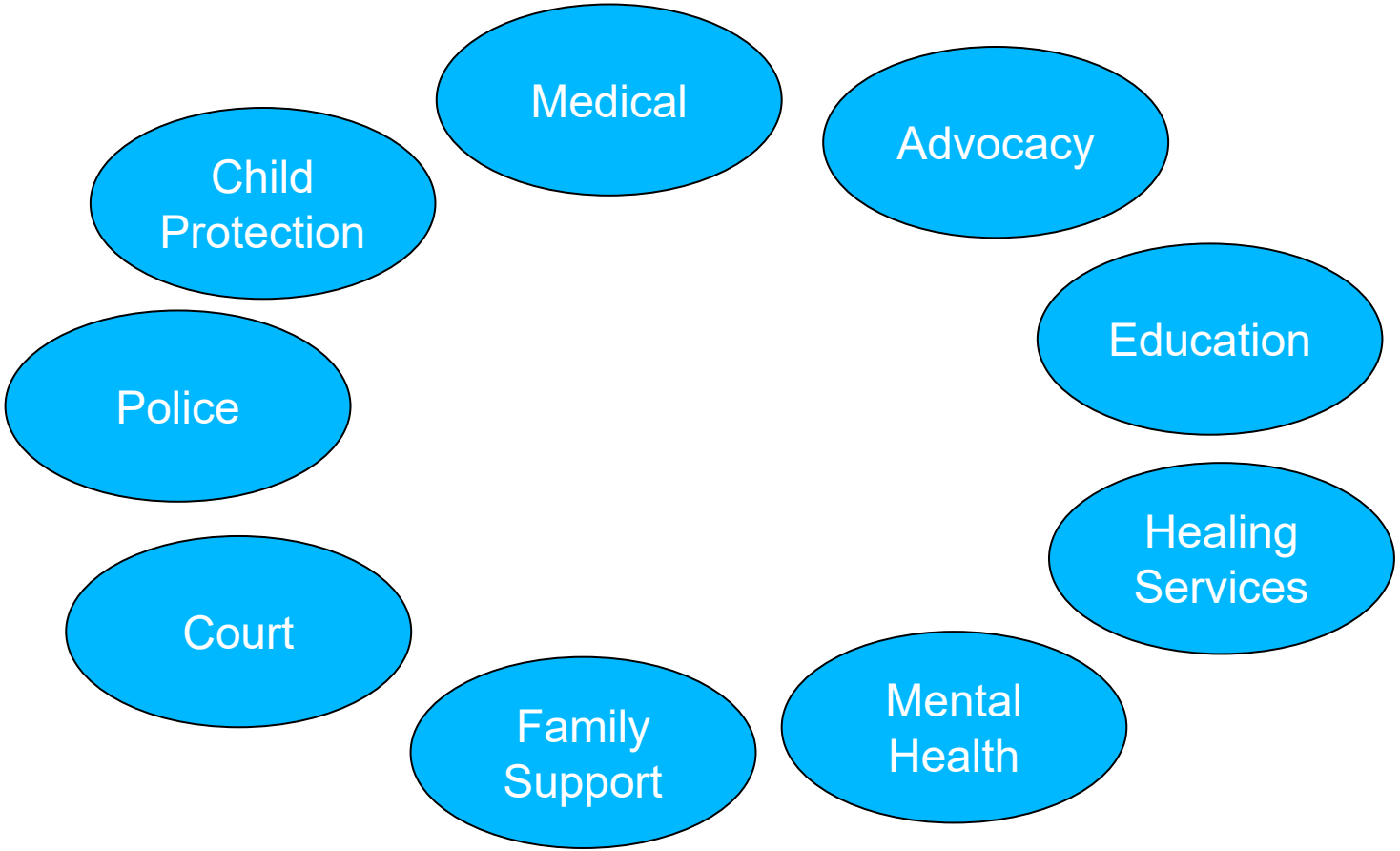

Multi-Disciplinary Responses to Abuse

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Standards

01. Multidisciplinary Team Standard
02. Diversity, Equity and Access of Services Standard
03. Forensic Interview Standard
04. Victim Support and Advocacy Standard
05. Medical Evaluation Standard
06. Mental Health Standard
07. Case Review and Coordination Standard
08. Case Tracking Standard
09. Organizational Capacity Standard
10. Child Safety and Protection Standard

Survey of US CAC Directors Herbert et al. 2017

- Small number of highly resourced urban centres with in-house services and co-location of agencies.
- Most are in small communities (<300 cases), operate more as a shared office and interview facility.

- Multi-agency Investigation & Support Team (WA): Two Sites
- Multi-Disciplinary Centres (Vic): Seven Sites
- Joint Child Protection Response Program (NSW): State-wide (22 sites)
- South Australia State Interagency Response - Children's Protection Service (SA): State-wide (3 sites)
- Child Abuse Taskforce (NT): State-wide (2 sites)
- Suspected Abuse & Neglect Teams (Qld) (30 sites)
- ARCH (Tas) (1 site)

Australian Responses Herbert & Bromfield (2018)

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- Reasons for integrated responses;
- Evidence reviews
  - (1) CJ Focused Evidence Base
  - (2) Caregiver Satisfaction
  - (3) Limited Research on Child and Family Outcomes;
  - (4) Some evidence of increased referral & receipt of services;
- Comparison to conditions very different in previous studies to evaluation context.

Key Differences:
Co-Location;
Earlier involvement of investigating officer, interviewer and CPFS worker;
Involvement of the Advocate at the point of interview;
Localised response;
Advocate and therapeutic service follow-up on cases;

Multi-Agency Investigation & Response Team
Herbert & Bromfield, 2019, 2020

- MIST more rapid response – Some evidence of efficiencies – High satisfaction from caregivers;
- No difference in headline rates of arrests & CP actions – Differences at priority levels – Suggesting different thresholds;
- High level of uptake of supportive and therapeutic services;
- From interviews staff perceived the response to be more victim centred and addresses gaps in responses.

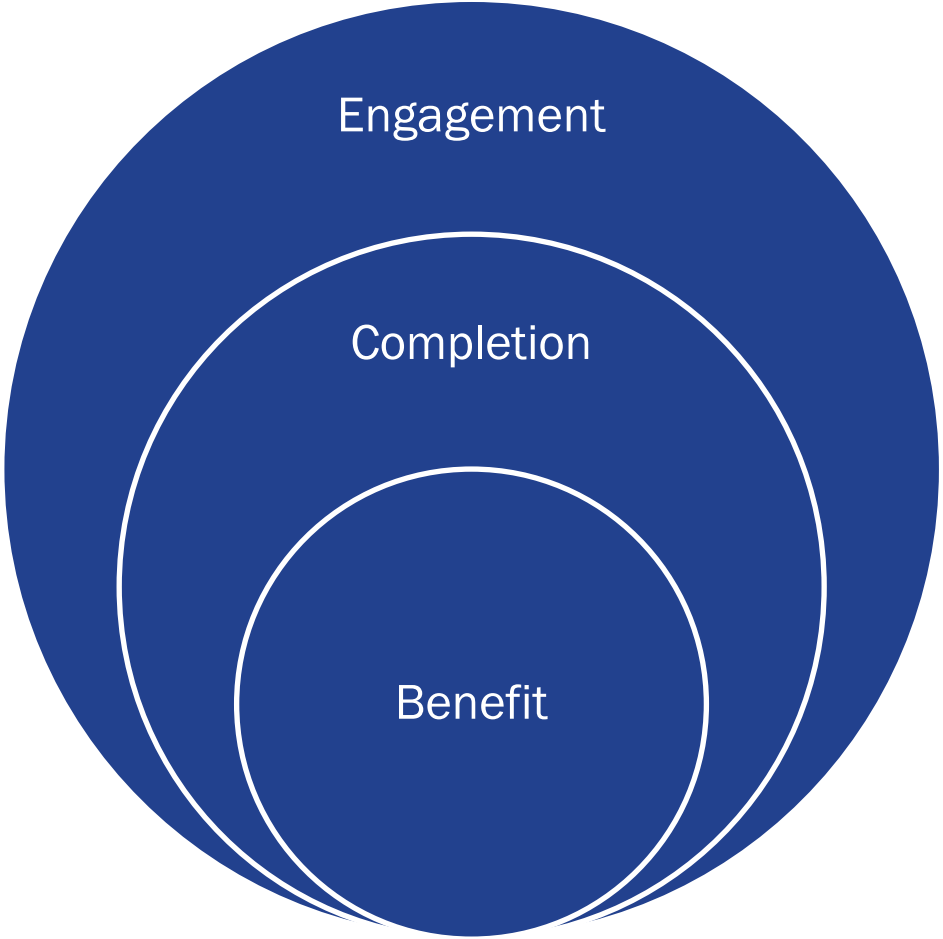
Multi-Agency Investigation & Response Team
Herbert & Bromfield, 2019, 2020

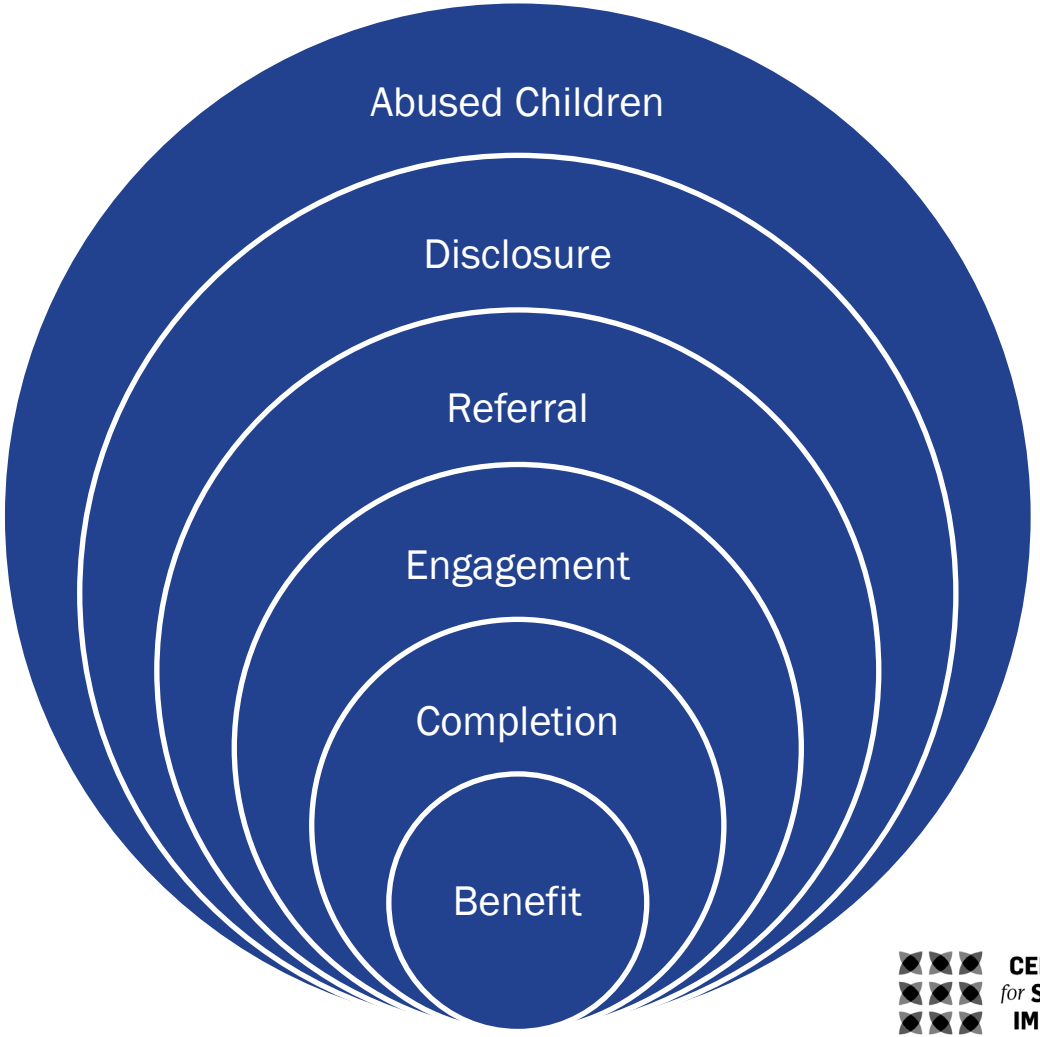
- **Addressing Safety** – Including those that don't meet the criteria for statutory intervention or a criminal justice response.
- **Addressing Underlying Risks** – All the services needed to address underlying risk factors in the family/community.
- **Addressing Barriers to Child Therapy** – Taking care of immediate needs and
- **Providing Access to High Quality Specialist Therapy** – Addressing harms before they manifest as mental health symptomatology.

Most Critical Elements of an Integrated Response

Herbert & Bromfield, 2018

- Detection/Disclosure Allen et al. 2014
- Service Complexity Budde & Waters, 2015
  - Pathways from Investigation to Services Cross et al. 2008
  - Lack of Culturally Appropriate Services Black, Frederico, & Bamblett, 2019
- Family Barriers
  - Motivation to Seek Therapy Lippert et al. 2008
  - Attitudes about Mental Health Care Lippert et al. 2008
  - Support for Disclosure Barnett, 2007
  - Initial Lack of Symptomatology Chasson et al. 2013
  - Complex Needs (Parental MH, FDV, Child Protection History, Homelessness etc.) DeLorenzi, Daire, & Bloom, 2016; Macias, 2004


Engagement
Completion
Benefit


Abused Children
Disclosure
Referral
Engagement
Completion
Benefit

To Intervene to Improve Accessibility We Need to Know:

1) Current rates of engagement and completion following a disclosure;
2) Factors that influence engagement and completion.

A Synthesis of Previous Studies Provides:

- A potential benchmark of accessibility rates;
- Considerations to improve accessibility across contexts

Rapid Evidence Review

Criteria:

- Peer Reviewed
- Since 1990
- Disclosed Abuse
- Children/Young People

Search terms identified 2374 individual records

49 studies were extracted and coded

Typical Rates – Post Disclosure Herbert (2021)

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Referral
Suspected Abuse (47%)
Substantiated Abuse (79%)

Engagement with Therapy
Post Investigation – Self & Professional Referral (30%)
Post-Investigation – Specified Professional Referral (61%)
Therapy Initiators (80%)

Completion
Clinical Samples (73%)
Community Samples (59%)

Typical Rates – Post Disclosure Herbert (2021)

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Engagement

- Higher Severity/Frequency
- Ethnicity (in US context)
- Parental Attitudes & Supportiveness

Completion

- Differences between Clinical v Community Samples
- Caregiver Involvement/Supportiveness
- Abuse Severity/Frequency
- Initial Symptomatology
- Relationship to Perpetrator

Population Characteristics/ Needs

Lived Experience

Cultural Safety/Competency

Engagement/Completion Data

Phase 1: Baseline Data

Phase 2: Problem Identification

Phase 3: Solution Development

Phase 4: Solution Testing

- Monitoring trends in referral and access
- Intervention
  - Centralised Waitlist w/ Standard Intake Assessment & Triage (considering motivation to engage)
  - Standardising of Treatment Across MH Providers in Chicago
  - Active Waitlist Management (w/Motivational Interviewing)
  - Hope & Healing Groups
- Reductions in wait for services, reduced disengagement

Providing Access Toward Hope and Healing Budde et al., 2023

- Need for a move to supported referral as a standard part of the response to abuse and neglect.
- Need to be able to observe the current accessibility of the specialist therapy system – Mapped against the volume of disclosures.
- Timeliness matters.

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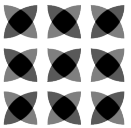

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