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| First National Study of Child Maltreatment in Australia: Prevalence, Health Outcomes and Burden of Disease  |  |
| [First National Study of Child Maltreatment in Australia - video transcript] |  |
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[Professor Ben Matthews speaks] Hello everyone and hello to those who are streaming in. I hope you enjoy this presentation. It's a real pleasure to be here today. I'm presenting this on behalf of our team and you'll see them noted on a slide in a moment.

So, this - today we're talking about the first national study that's been done in Australia of the prevalence of all five forms of child maltreatment, and as well we're looking at the mental and physical health outcomes of experiencing those forms of child maltreatment, and we're measuring the burden of disease. So, this is a big study for our country. It's also significant globally. It's very comprehensive work.

I should first of all just acknowledge the traditional owners of the land of the Kulin nation on which we meet, and I acknowledge the Wurinjuri people as the traditional custodians of this land, and I pay respect to community members and elders, past and present.

So, I'm presenting this on behalf of our team and it's quite a large team. Several of us from Queensland University of Technology, several from University of Queensland. We also have Daryl Higgins who a lot of you will know I'm sure from Australian Catholic University. We have Franziskac Meinck from the University of Edinburgh and Professor David Finkelhor from the University of New Hampshire.

Doctor Divna Haslam is at QUT. She is our project manager. She's in an office literally three metres from me so we're working very hard and very closely on this on a daily basis.

Doctor Nikki Honey is also noted there. She is at the Social Research Centre right here in Melbourne. Social Research Centre are our partner research lab on this project. They are the group that are actually going to conduct the computer assisted telephone interviews for this study and I'll talk a bit more about that shortly.

So, today I'm going to give a bit of an overview of the study but first I'll talk about why do we need to study child maltreatment and its health outcomes. I'm very likely preaching to the converted here but just to give the study a bit of context, I'll give a quick summary of a systematic review of global prevalence studies that have been done on a national basis which pointed to some of the limitations in existing work and also demonstrated that Australia hasn't done such a study, and then I'll talk about our study and we'll have some time for questions.

So, first of all why should we study child maltreatment at all? Well, I think it's pretty simple. Child maltreatment is very common. We know that and we know that its harmful, both in the short, medium and long term through the lifespan.

Just to clarify, when I'm talking about child maltreatment today, I'm talking about the five forms of maltreatment that are traditionally recognised in the literature and in the field today. So, we're talking about physical abuse, sexual abuse, emotional abuse which is often called psychological abuse, neglect and we're also talking about exposure to domestic violence and that's a fairly recently acknowledged addition to this panoply of child maltreatment, but they're the five forms we're looking at in this study.

We should study child maltreatment because it's a severe phenomenon. It violates children’s physical, psychological and sometimes sexual integrity. It's accompanied by psychological trauma. It's often experienced and endured repeatedly in childhood, so it's often not just a one-off occurrence, and it sometimes involves serious criminal conduct. It's a breadth of fundamental human rights of children and its recognised by the United Nations Sustainable Development Goals as a serious public health issue and something that severely affects child development.

So, goal sixteen in the UN SD Goal 16 actually aims to end child maltreatment. Okay, now that's probably not going to happen but that's a goal and as part of that goal, the UN requires every state party or every government to report on its efforts to end child maltreatment. Now, to do that, you need to know how much of it there is and whether its prevalence is going up or down over time as well as what else it's doing.

We should also study child maltreatment because it causes severe adverse health, behavioural and economic consequences through the lifespan. So, we know that with neonates and infants and very young kids, it can cause failure to thrive, impaired development generally, physically injuries and fatalities. It can be severe mental health outcomes, often including depression, anxiety, PTSD, self-harm and suicide, physical health outcomes from coping strategies to deal with the trauma caused by maltreatment and these can include obesity and cardiovascular disease.

So, we know it affects kids’ ability to concentrate and focus and perform at school, and that's a really big factor for kids. So, it affects their academic achievement and then their employability and economic achievement in later life. It affects people’s adult relationships. They're prone to revictimization and intergenerational maltreatment; the substantial long-term disease caused from coping mechanisms such as smoking, alcohol use and drug use; and from chronic stress which is caused by maltreatment and that can produce say coronary artery disease and other inflammatory disorders.

There's a whole body of scientific evidence about this now, okay, and this is why we need to look at this and we need to develop better ways of preventing maltreatment before it starts but also of interrupting it at an early stage.

We even know now that it impairs brain development. It shortens telomeres which are the ends of strands of DNA, and that accelerates cellular aging so it shortens life. Okay, so we now know scientifically a lot more about the effects of child maltreatment.

So, in sum it produces lifelong disease burden with intergenerational effects and we also know - and I'll just note this last point on this slide - we now know more about the importance of what's called in the literature 'poly-victimisation' meaning multiple victimisation. This is sometimes used in different terms but generally it refers to those kids who experience multiple forms of maltreatment at different points in their childhood. It's also used to refer to kids who experience multiple incidents of the same kind of maltreatment within a certain more compressed timeframe.

Now, these kids are particularly important. They're particularly important and that's because they are more likely to suffer adverse and severe health consequences. So, if we're considering optimal policy and prevention efforts, it's those kids where governments and societies may get most bang for their buck. They are the highest priority of prevention. Okay, that's not to discount all of the other kids of course, but it's this group that is particularly important.

Okay, quickly, why should we study prevalence? Because of UN SD Goal 16 and government reporting requiring reliable prevalence data. We need our public health prevention responses to be informed by information about where and when our prevention approaches are best targeted. So, for example we need to know at what age of childhood we can best intervene and at what time of parenthood we can best intervene. We need to know prevalence of different forms of maltreatment so that we can tailor our prevention and intervention responses to those forms.

Okay, so for example if we know that the most severe neglect of kids happens in the first year of life, that's where we need to intervene there; not milder neglect when kids are fifteen, okay? If we know that severe repeated emotional abuse happens to kids when they're six and seven, that's where we need to intervene; not milder forms of emotional maltreatment when perhaps they're seventeen, if we know that doesn't cause as much damage. Again, that's not to discount that, it's a matter of identifying optimal times and optimal needs.

So, we need to issues about prevalence. We need to know key facts about the nature and context of abuse, about its prevalence, but also about the child's age, the child's gender, the relationship of the child to the person who is inflicting the abuse - so who is it, who is doing it - and other family factors associated with it.

So, it's one thing. It's one useful thing to get raw prevalence data about numbers and proportions of kids experiencing these forms of maltreatment but it's quite another - it takes it to a whole elevated level to get this more nuanced sophisticated data about not only prevalence but these other contextual features of the maltreatment. That's what we're going to do in our study and that will be a first for Australia and one of the first times it's been done worldwide.

What about the health outcomes? Why should we study health outcomes? Principally because good evidence, reliable evidence is needed to inform policy and clinical responses. In the literature, worldwide but also in Australia, there are major evidence gaps about the health consequences of certain kinds of maltreatment and the timing of those consequences.

There has been a lot of work traditionally done, so even going back to say the eighties about physical abuse and sexual abuse - that's what most of the studies tended to focus on back then. Even when the field started to get a bit of a better understanding of the importance of emotional abuse, there still haven't been that many studies done about that and about its effects. That’s partly because it's hard to measure but it's also partly because the field generally and society and our whole kind of western view of the world tends to be more focused on physical acts and their significance, not as much on invisible but emotional or psychological interactions and their consequences. So, they're more difficult to deal with but we have a hypothesis that emotional abuse can be just as, if not more, damaging though the lifespan and over the long term as perhaps some forms of physical abuse.

So, that's something that we're paying particular attention to in our study. So, there's major evidence gaps about the effects of emotional abuse and similarly, exposure to domestic violence and that's an even more recently recognised significant form of maltreatment.

There are also evidence gaps about the effects of multi-type abuse. So, for example if a child experiences four or five of these five types of maltreatment, what are the proportional likelihoods of experiencing certain kinds of health outcomes of that kind of pattern of maltreatment, as opposed to for example just experiencing one kind and a different kind?

Similarly, effects of poly-victimisation - so exposure in a certain condensed period of time to multiple incidents of the same kind of maltreatment, there's less evidence about that, and specific aspects of those experiences. So, for example the effects of experiencing maltreatment at a certain age. There's not as much evidence about this as we would like.

Also, that final dot point on the slide about the effect of the emotional relationship or the relationship of dependence between the child and the person who inflicts the abuse, we feel is likely to be very important in its influence on the health outcomes experienced by the child. That I think dovetails nicely with that hypothesis about the significant and potential effects of emotional abuse and EDV, exposure to domestic violence. We could be wrong about that but our study will find out.

So, what prevalence data is needed? We need a whole body of data in this country to obtain a more complete understanding of the health consequences, short, medium and long term through the lifespan of each kind of child abuse and neglect, of multitype maltreatment and poly-victimisation, also of specific experiential profiles of maltreatment. Our study is going to gather this and so we hope to make a major contribution, not just for Australia but for the world.

Okay, some very brief points about a systematic review we did. So, to inform the design of our study, we did or some of our team did a global systematic review of national prevalence studies. So, we asked what studies have been conducted of either four or five types of maltreatment, what approaches did they use - so what methodologies did they use - and what strengths and weaknesses did they have?

So, we planned this over a long period of time. We also did a scoping study about prevalence studies for the Royal Commission, as a result of which the Royal Commission recommended that a national prevalence study should be done. Our study is kind of related to that, although it goes beyond what the Royal Commission recommended.

Some of the key findings from the systematic review are that only 29 national studies have been done using a representative sample of the population of all four or five types of maltreatment, okay, and that's not in 29 countries because some countries have done more than one. So, America has done several and some other countries have done more than one as well.

Only two studies anywhere involved a sample of adults giving data about their experiences of five forms of maltreatment over their entire childhood up to age eighteen. Only two studies. Now, one of those was in the UK by Lorraine Radford and her colleagues. That was published in 2013. The other - this always surprises people - was done in Saudi Arabia and that was by a woman and her team. Her name is Maha Almuneef. She's a force of nature. She's a paediatrician, a real pioneer in that country.

Now, just incidentally, those studies did not explore health consequences, simply prevalence. We found a wide variation in methodologies and all of these studies are very complex and whichever method they adopt, there are limitations of each method.

Nevertheless, we found they used different measures or different instruments to measure child abuse and neglect. The JVQ cited there is the Juvenile Victimisation Questionnaire and that's the instrument developed over time and enhanced by David Finklehor and he's on our team. That one, we feel, is the most rigorous instrument and that's the one that we're adopting.

Studies also used different samples. So, often studies ask adults to give retrospective accounts about their experience over childhood. Other studies ask children to give accounts of their experiences while they're still children. Other studies do a mix. Some studies ask parents to give evidence about essentially what they've done to their own children or to give proxy evidence about their children's experience.

There are also different modes of administration. Just a reminder to those streaming in, if you could turn your volume to mute, that would be great thank you. There are also different modes of administration. So, some studies are done in schools with kids. Some studies are done by household visits and some are done by Computer Assisted Telephone Interviewing or CATI. In our study, we're using CATI; that's the only feasible method in our country.

Two final key points there. First, many studies that have been done - and granted, it is hard to develop questions that are conceptually congruent with robust models of what child abuse actually is - but many studies have asked questions that are perhaps not particularly well worded to gather reliable, valid data about the actual experience of abuse and neglect.

So, I'll give you an example. Many studies that ask people were they sexually abused only define sexual abuse as involving contact acts of sexual abuse. Now, we know that on any sound robust conceptual model of what child sexual abuse is, it must include non-contact sexual acts as well such as voyeurism, exhibitionism and other things that don't necessarily involve direct physical contact. So, studies like that will generate data about prevalence but it will be not quite as reliable as asking questions that are well mapped onto conceptual models - robust conceptual models - of each maltreatment type. That's a big limitation and that's something that we are going to solve in our study.

Few studies asked adequate follow up questions about the nature and context of maltreatment. That's something we're also doing, but these studies do show - and there's no doubt about this - that it is ethically feasible and methodologically feasible to gather data from adults about their experiences retrospectively and also from youth.

So, conclusions from that review. There are big gaps in knowledge almost everywhere about the prevalence of maltreatment. No studies in Australia. There's a widespread international need to invest in these studies. Different methods are suited to different contexts.

Okay. Alright, so that's a bit of background context to our study. Am I going okay for time? Alright. So, we applied for funding from the National Health and Medical Research Council. A lot of our team had worked together before over many years and all of us - we've got kind of these webs of collaborative relationships over many years. Combined members of our team have conducted 14 prevalence studies in other nations and done all kinds of other work in this field. So, it's a multidisciplinary team that works really well together.

We were very fortunate and we're eternally grateful that we were successful in getting funding from the NHMRC for this study for five years.

This is basically what we're doing in a nutshell and I'll elaborate on this in the next few minutes but first of all, we're doing the first national study of the prevalence of child maltreatment in Australia and that is covering all five types of maltreatment - physical abuse, sexual abuse, emotional abuse, neglect and exposure to domestic violence.

How are we doing this? We're going to survey 10,000 Australians. That will be 10,000 actual participants, so to get that sample we'll be making a lot more phone calls to get those participants, and we're interviewing people who are aged 16 and over. Just so you know, there will be 5,000 people aged sixteen to 24 and then there will be 1,000 people each in five subsequent strata of a decade each. So, 1,000 25-34-year old’s, 1,000 35 to 44-year old’s and so on. I'll tell you more about that shortly.

We are also measuring physical health outcomes and mental health outcomes. So, a benefit of asking people of older ages about their experiences that we get their prevalence data from a certain period in time, but also, we can generate evidence about these health outcomes over the entire life course. So, if we only ask 16 to 24-year old’s about their experience, some of the mental and physical health outcomes may not have crystallised or worsened yet. So, we will have really strong data about this.

We’ll also identify the burden of disease to assess other kinds of costs to the community and the bottom point there is last but not least. We are absolutely not going to just do a scientific study and publish in academic journals. We will do that but we are acutely conscious of the need and committed to taking our results and translating them for policy makers and for community sectors and professional organisations. We want this to matter for the community. We want this ultimately to inform better policy and prevention approaches in future for the grand purpose of reducing child abuse and neglect for future generations of Australians. That's what we're here to do.

So, even though the study itself will take five years, we're going to have a very strong engagement strategy with organisations exactly like the CECFW and every state and government health agency and others. We have already commenced that and that will continue as time goes on, and even in the two to three years after the study ends, that will be continuing.

So, the aims are for the first time to get data about the prevalence of each form of maltreatment and the nature of those experiences. We'll also identify selected physical and mental health outcomes through the lifespan that are associated with the experience of child maltreatment and to assess the burden of disease associated with maltreatment and other health system utilisation outcomes.

Study design. So, we do a nationwide, cross sectional survey of 10,000 participants, sixteen and over. We use the CATI methodology. Just in case everyone isn't quite clear on that, that doesn't mean that a computer itself does the interview. It's a person doing the telephone interview, a person who is trained and experienced in doing extremely sensitive interviews and that's why we've partnered with the Social Research Centre. So, we have extremely experienced and well-trained interviewers conducting these interviews and they plug in the data while the interview is happening into this computer software. That's the basic method.

That methodology is optimal in terms of cost of conducting a study like this, in time for participant burden and geography. A household study is simply unviable in Australia. A school-based study, obviously you're not going to get adult participants. So, we get self-reported retrospective data about these experiences and health outcomes. I've already told you about the sample there.

Okay, so how do we access these people? Just very quickly without giving you too much of the dry methodological detail. Basically, you access people, you generate a random sample through databases of telephone numbers. They're not identified so at no time - at no time - is any participant identifiable. It's all anonymous and confidential. There's only one exception to that and that's if a youth participant is at immediate risk or imminent risk of danger.

We anticipate that there will be 70% to 80% participants engaging in this by mobile phone. By the time data is actually collected, it may even be more than that. But we have built into the design 20% to 30% landline participants, more likely by those of more mature years.

This kind of method has been adopted by other studies, including recent Australian studies and it’s been shown to be effective. So, the Social Research Centre for example conducted the national study of community attitudes to violence against women using this method.

So, we'll get data on three parameters. The first one is experiences of all those five types of child maltreatment; physical abuse by parents or caregivers, sexual abuse by anyone, emotional abuse by parents or caregivers, neglect by parents or caregivers and exposure to domestic violence.

Just a quick point on physical abuse. In Australia - and this is a difficult question which occupied our minds for a long time. In Australia, corporal punishment is actually lawful provided it is reasonable. My primary discipline is law by the way so this is kind of, of particular interest to me, although the whole study is of course as well.

Some people think and some studies have been done recently overseas which are tending to find that the experience of corporal punishment can be close to or as damaging as some forms of physical abuse.

Now, we need to look closer at that data but some people are advocating for the designation of corporal punishment as a form of abuse or adversity. We haven't reached a view on that yet but nevertheless, what's important for our study to do is to ask a separate question on the experience of lawful corporate punishment and to do that in a rigours reliable way, and that will enable us to identify the effects of that and to tease those effects apart or to understand the effects of that form of experience as opposed to physical abuse conceptualised more rigorously or more traditionally, I should say. So, that's an interesting little side bar that we hope to make a separate and potentially important contribution too.

Just the final dot point there is an important one. We will also be asking a short number of questions on other key childhood adversities or adverse childhood experiences for short such as peer violence or bullying, major illness and major family conflicts such as say drug abuse by parents.

That's important because these kinds of experiences can be what I call confounders or they may explain someone's mental and physical health outcomes as opposed to their experience to child maltreatment. So, we need to gather that data, not because it's a primary research question but because they are potential confounders for those health outcomes.

The instrument we use is enhanced and revised version of the Juvenile Victimisation Questionnaire. We've been working closely as a team and especially with David Finklehor on this. We're having a week-long workshop next month with David, he's coming out for this, and we'll be doing a lot of work on the instrument design and that work will be continuing in the next 12 to 15 months. So, we're really doing a very systematic, very painstaking process of refining and testing and refining and testing and refining the instrument.

The JVQ though is the optimal instrument for this study. It has proven psychometrics. It's been used in six studies in the US, the UK and Germany. It has another advantage of having the most detailed follow up questions which obtain that really essential nuanced information about the nature of the experience, so the child's age at the time, who it was who inflicted the maltreatment, how often it happened for example. So, it's clearly the best instrument for our purpose. It's also quite practicable in terms of the time taken to administer.

Just on that point, this is a pretty comprehensive study and so we need to calibrate the instrument and configure the instrument so that it's not too burdensome for participants to complete in terms or time or sensitivity, and that's something we pay particular attention to.

The second major parameter is the health outcomes, so mental health, and here we use other instruments that are proven as well. We use the Mini International Neuron Psychiatric Interview. This obtains clinical diagnosis. So, it's not just someone saying, "Yes, I was depressed," or "Yes, I felt anxious." This actually obtains clinical diagnoses. So, that's much more reliable; it gives a much more solid evidence base on which government agencies can rely.

So, we cannot assess every single health outcome for reasons of time and cost, but we will assess the conditions which are most closely and universally recognised as being related to child maltreatment. So, here we're looking at depression, anxiety, PTSD, substance use disorders, psychotic disorders, suicidal thoughts and attempts and self-harm, and bipolar disorder.

In terms of physical health, we use modules from the NSMHW, the National Survey of Mental Health and Wellbeing, which used sections from the CIDI, the Composite International Diagnostic Interview. Here, we look at obesity, cardio vascular disease, diabetes and auto immune disorders and other adverse health behaviours - tobacco use, alcohol use and abuse and substance use and abuse.

The third parameter is the one I myself know least about. This is quite a technical area but we have several members of the team who are experts at this. So, here we look more at the personal community and national costs of maltreatment through assessing burden of disease, including through DALYs or Disability Adjusted Life Years attributable to health conditions from child maltreatment calculated from the prevalence data.

We will also add some simple questions to explore health service use. So, for example, how many hospitalisations have people experienced, doctors’ visits and medication use.

We're getting close to the end so I hope you're still with me, but just a quick note on conceptual models. I won't go into this too much but I can refer you to some papers on this and we will be writing separate papers on just this topic.

So, I mentioned earlier that many other studies have asked people questions about certain forms of abuse that did not map or in our view, did not map sufficiently well onto what are now seen as robust models conceptually of each of these kinds of maltreatment.

So, the obvious consequence of that is that if they ask a question about for example only contact sexual abuse, the estimate of that - the prevalence estimate of that will underestimate the experience of sexual abuse, and as well you will miss health outcomes from non-contact sexual abuse.

Similarly, if you do not ask about medical neglect but you ask about other forms of neglect, you will miss data on medical neglect and its health outcomes. So, it's really important - it's essential for any prevalence study to make sure that the questions asked about the experience of each form of maltreatment are congruent with robust conceptual models and this is actually really hard to do. However, we are going to do what we think is optimal practice in this. So, we're going to map our items as closely as possible to each theoretical construct and configure the instrument accordingly and make any refinements necessary to the JVQ.

So, physical abuse generally includes intentional acts of physical force by parent or caregiver. So, it doesn't include say peer bullying. Within our field, that's not the kind of physical violence we're looking at. We can assess that through other questions though.

Sexual abuse, contact and non-contact sexual acts, and that can be by any adult or child, not just a parent or caregiver.

Emotional abuse is particularly difficult to conceptualise but Danya Glaser has written two key papers on this, one in 2002, one in 2011. That is the most robust model, conceptually, of emotional abuse in this field and some studies have adopted it.

Here, it's inflicted by parent or caregiver, so not incidents, not matter how violent, between peers because this is just not how we conceptualise this. It must be by parents or caregivers, constituted by separate categories of emotional unavailability, hostile interaction - hostile interaction is generally the one that questions are asked about - developmentally inappropriate interaction, failure to acknowledge the child's individuality and failure to integrate the child into the social world.

Now, that's the conceptual model. Operationalising that in questions is a challenge but that's something that we are engaging in.

Neglect also presents challenges, particularly based on perhaps culture and ethnicity, and that's something that we're acutely aware of, but neglect based on Howard Dubowitz's conceptual model is where a parent or caregiver fails to provide a child with the basic necessities of life as suited to the child's developmental stage and as recognised by the child's cultural context. Now, categories of neglect can include several - physical neglect, emotional neglect, medical neglect, supervisory neglect and educational neglect.

Exposure to domestic violence is also hard to conceptualise. Generally, it's seen as witnessing a parent or family member subjected to assaults, threats or property damage by another adult or teen who normally lives in the household, but other emerging models and ways that legal systems treat this can include other forms - economic coercion, surveillance and stalking of a partner. That's something that's also going to occupy our minds but we are confident that we can do a good job there.

Some limitations and future goals. So, first of all limitations. It's not possible for us or for any study to assess all health and other outcomes, but you can do connected studies to generate other data about that. So, for example you could use data linkage studies to assess for example children's involvement in say the criminal justice system or the out of home care system where they've experienced maltreatment.

There are also some hard to reach sub-populations. So, for example it's unlikely or we can accept that in the 16- and 17-year old’s who participate in this study, its less likely that we will have any of those participants who are for example in juvenile detention facilities. Now, that's simply an unavoidable limitation. Again, to examine their experience, you would need to do a separate study tailored just for them.

We will though use weights, statistical weights and adjustments to accommodate perhaps the lower representation of some sub-populations, perhaps people of certain ethnicities, and that's just commonly done in these studies, but also separate studies could be done with a methodology tailored just for that group.

Future goals and ambitions. So, one thing we want to do in this study is obviously the study as it stands, but we want to generate this benchmark data for another purpose as well. We want to be able to do after this study, another repeated study just of 16 to 24 year old’s perhaps in another five years’ time from now so that with a different group of 16 to 24 year old’s, we can ascertain their experience and the prevalence there and be able to compare the rates over time so that we know in Australia are we having less child physical abuse, are we having more? Are we having less child neglect or more? Is sexual abuse exposure getting better or worse?

That data is what we really need then to know, if our policy and prevention efforts are having an effect - again you'd need more than just the prevalence study to do that as well - but that's also needed for our governments and our professions and our providers and our practitioners and our kids and our families of course. Ideally, you could also do longitude in all prospective studies to identify mechanisms of impact over time and that's, you know, the ultimate goal.

Progress to data. February to August this year, we've been working very hard. We're a bit tired but we're satisfied with the progress. So, we're actually if anything, dare I say it, slightly ahead of schedule. We've recruited the staff and created project infrastructure, contracts. We did a national media launch in March on radio and TV. We'll be doing pulsed media about the study, especially in the lead up to the field work to create awareness that the study is being done. That's partly just because that's our responsibility to the community but it’s partly also to hopefully boost actual participation.

We have obtained ethical clearance that is always a challenge, but we obtained that just about 10 days ago. We've done preliminary analyses of key practical and ethical issues, data management, initial website development. We'll have a dedicated website so that everyone can see what we're doing and we can publish our outcomes and that should go live later this year.

We've developed a draft instrument for initial testing, an advisory group. Terms of reference have been drawn up, so we're engaging with government about that, and other engagement with community end users such as the CECFW here.

Just so you know, I'm the kind of initial point of contact for the study. Anyone here in any service provider agency or any other community organisation in this field, please consider that you have a standing invitation to contact me if you want to know anything about the study or if you want to engage or partner with us. From now until the end of the study, you have a standing invitation.

Publication planning and the team workshop planning. So, next steps - just so you know, there's actually a typo on this slide, I apologise - but probably the key thing - the first key thing you might want to know is when are you actually going to do the study, the survey, and we'll be doing that in the first half of 2021. So, that third line there, that should read 2021; the one after that should be 2022. So, the actual survey - the actual interviews will be done in the first half of 2021. So, from now until the end of 2020, we're doing the instrument configuration testing and refinement and other things including publications and engagement.

We hope to have - after we have our initial raw prevalence data in say mid-2021 to the third quarter of that year, we hope to convene a stakeholder workshop to share that initial data. Then, we will do lots and lots of other kind of more sophisticated analyses and pulsing engagement and then we hope to meet with those groups again later on in the study, say 2022 and 2023.

There are some references there in case you need them, and that's basically it from me, so I'm happy to field any questions to the best of my ability. Thank you.

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