



Never Stand Still

Faculty of Arts & Social Sciences

Social Policy Research Centre

Scoping study for research into the prevalence of child abuse in Australia

Prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse

September 2016

Ben Mathews, Kerryann Walsh, Michael Dunne, Ilan Katz, Fiona Arney, Daryl Higgins, Olivia Octoman, Samantha Parkinson, Shona Bates

September 2016

Research team

Social Policy Research Centre, University of New South Wales Australia

Professor Ilan Katz, (Chief Investigator), Shona Bates

Australian Institute of Family Studies

Associate Professor Daryl Higgins

Queensland University of Technology

Professor Ben Mathews (Australian Centre for Health Law Research, Faculty of Law), Associate Professor Kerryann Walsh (Children and Youth Research Centre, Faculty of Education), Professor Michael Dunne (Children and Youth Research Centre, Faculty of Health), Dr Lisa Kruck (Research Assistant)

Australian Centre for Child Protection, University of South Australia

Professor Fiona Arney, Olivia Octoman, Samantha Parkinson

For further information

Ilan Katz, ilan.katz@unsw.edu.au or (02) 9385 7810

Social Policy Research Centre
Level 2, John Goodsell Building
Faculty of Arts and Social Sciences
UNSW Australia
Sydney 2052 Australia
Telephone: +61 (02) 9385 7800
Fax: +61 (02) 9385 7838
sprc@unsw.edu.au
www.sprc.unsw.edu.au

The Social Policy Research Centre is based in Arts & Social Sciences at UNSW Australia. This report is an output of the Prevalence Scoping Study research project, funded by the Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

Disclaimer

The views and findings expressed in this report are those of the authors and do not necessarily reflect those of the Royal Commission.

Copyright information

Mathews B, Walsh K, Dunne M, Katz I, Arney F, Higgins D, Octoman O, Parkinson S, Bates S (2016). *Scoping study for research into the prevalence of child abuse in Australia: report to the Royal Commission into Institutional Responses to Child Sexual Abuse*. Sydney: Social Policy Research Centre (SPRC Report 13/16) , UNSW Australia in partnership with Australian Institute of Family Studies, Queensland University of Technology and the Australian Centre for Child Protection (University of South Australia).

ISSN: 1446-4179

ISBN 978-1-925289-80-0

© Commonwealth of Australia 2016

All material in this report is provided under a Creative Commons Attribution 4.0 Australia licence.



Please see www.creativecommons.org/licenses for conditions and the full legal code relating to this licence.

Contents

| | |
|--|----|
| Tables..... | v |
| Glossary | vi |
| Executive summary | 1 |
| 1 Background to study | 7 |
| 1.1 The importance of a prevalence study | 8 |
| 1.2 Existing research on the prevalence of child maltreatment | 9 |
| 1.3 Research questions | 10 |
| 2 Methodology | 13 |
| 2.1 Systematic review of international literature and critical analysis | 13 |
| 2.2 Review of Australian surveys and official data collections..... | 13 |
| 2.3 Consultation..... | 14 |
| 2.4 Governance..... | 15 |
| 2.5 Synthesis of findings..... | 15 |
| 2.6 Limitations of the scoping study..... | 15 |
| 3 Systematic review and critical analysis of the international literature, and recommendations for the study design | 17 |
| 3.1 Summary of recommendations about five key elements of the framework | 18 |
| 3.2 Scope: All five forms of maltreatment, their nature and context, health outcomes and risk factors | 19 |
| 3.3 Instrument: Modification of the Juvenile Victimization Questionnaire | 22 |
| 3.4 Method of administration: Computer assisted telephone interview..... | 31 |
| 3.5 Administration of surveys involving child and adult participants: A single study conducted concurrently with required adaptations to meet the needs of young people and adult participants | 37 |
| 3.6 Preferred approach to surveying three subpopulations: Two models | 40 |
| 4 Review of existing Australian surveys and official data sources | 47 |
| 4.1 Can an existing survey be used to carry out the prevalence study? | 47 |
| 4.2 Overview of existing national surveys and data collections in Australia.... | 49 |
| 5 Recommendations | 55 |
| 5.1 Recommended framework for the prevalence study | 55 |
| 5.2 Governance structure | 63 |
| 5.3 Costs | 72 |
| 5.4 Data linkage..... | 72 |
| 5.5 Timing..... | 74 |
| 5.6 Risks and mitigation..... | 74 |
| 5.7 Reporting..... | 78 |
| 5.8 Limitations | 78 |
| 6 Conclusion | 79 |
| 6.1 Specific findings..... | 79 |
| References | 81 |
| Appendix A: Research options..... | 89 |
| Appendix B: Systematic literature review methodology and PRISMA flow diagram | 91 |

| | |
|--|-----|
| Appendix C: Summary of literature, identification of key features and collation of subgroups of studies..... | 100 |
| Appendix D: Instrument analysis..... | 151 |
| Appendix E: Juvenile Victimization Questionnaire – provisional instrument | 164 |
| Appendix F: Overview of existing national surveys | 168 |
| Appendix G: Potential suitability of surveys for including additional items | 184 |
| Appendix H: Data extraction tables for surveys..... | 192 |
| Appendix I: Summary characteristics of Australian studies | 241 |
| Appendix J: Stakeholders invited to participate..... | 250 |
| Appendix K: Delphi instrument..... | 251 |

Tables

| | |
|--|-----|
| Table 1 Summary of strengths and limitations of JVQ, ICAST, ACE-IQ and SAVI survey instruments for Option 1 and Option 4 | 27 |
| Table 2 A detailed comparison of JVQ, ICAST, ACE-IQ and SAVI survey instruments | 28 |
| Table 3 Breakdown of survey components and estimated timings for Option 1 | 31 |
| Table 4 Breakdown of survey components and estimated timings for Option 4 (preferred option) | 31 |
| Table 5 Identified national Australian surveys | 50 |
| Table 6 Forms of governance investigated | 64 |
| Table 7 Estimated time line for Option 4 | 74 |
| Table 8 Systematic literature review – database search strategy | 93 |
| Table 9 Systematic literature review: Inclusion and exclusion criteria | 94 |
| Table 10 The 49 studies with nine key dimensions | 105 |
| Table 11 Studies with child participants only: key features of study design, sample, procedure, ethics and instrument | 115 |
| Table 12 Nationwide studies with adult participants (with two involving adults and children): key features of study design, sample, procedure, ethics and instrument | 126 |
| Table 13 Phone studies: key features of study design, sample, procedure, ethics and instrument | 136 |
| Table 14 Studies of all five maltreatment types: key features of study design, sample, procedure, ethics and instrument | 146 |
| Table 15 Rigour criteria | 156 |
| Table 16 Feasibility criteria | 157 |
| Table 17 Alignment with Royal Commission’s research objectives (Option 1; Option 4) | 158 |
| Table 18 JVQ screener items | 164 |
| Table 19 JVQ follow-up items | 164 |
| Table 20 Identified national Australian surveys | 171 |
| Table 21 Potential suitability of including items about children’s experiences in Australian studies* | 184 |
| Table 22 Potential suitability of Australian studies of adults’ experiences* | 187 |
| Table 23 Potential suitability of Australian studies of children’s and adults’ experiences* | 188 |
| Table 24 Surveys of children | 192 |
| Table 25 Surveys of adults’ experiences | 208 |
| Table 26 Surveys that include adult and child report information | 215 |
| Table 27 Summary of characteristics of Australian studies of children’s experiences | 241 |
| Table 28 Summary of characteristics of Australian studies of adults’ experiences | 245 |
| Table 29 Summary of characteristics of Australian studies of children’s and adults’ experiences* | 246 |

Glossary

| | |
|------------------|---|
| AIFS | Australian Institute of Family Studies |
| CSA | Child sexual abuse |
| CATI | Computer assisted telephone interviewing |
| HREC | Human Research Ethics Committee |
| JVQ | Juvenile Victimization Questionnaire |
| NH&MRC | National Health and Medical Research Council |
| PRISMA | Preferred reporting items for systematic reviews and meta-analyses |
| QUT | Queensland University of Technology |
| RDD | Random Direct Dialling |
| Research team | Comprises SPRC (of UNSW Australia), AIFS, QUT and UniSA |
| Royal Commission | The Royal Commission into Institutional Responses to Child Sexual Abuse |
| SPRC | Social Policy Research Centre, UNSW Australia |
| UniSA | University of South Australia |
| UNSW | UNSW Australia |

Executive summary

The Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) is inquiring into how institutions have engaged with and responded to allegations and instances of institutional child sexual abuse. Key to this inquiry is the need to generate an understanding of the extent of child sexual abuse in Australia. Determining the prevalence of child sexual abuse, and institutional child sexual abuse in particular, provides valuable contextual information to inform the work of the Royal Commission. While thousands of people have come forward to testify in private and public sessions, it is not known whether these victims/survivors are representative of the population of victims of child abuse, how the prevalence and type of abuse has changed over the decades, or what effect past policies have had in addressing these issues. In response to this gap in the knowledge base, the Royal Commission appointed a team of researchers to scope the research design, methodology, cost and governance structure of two studies investigating the prevalence of child maltreatment in Australia, including the prevalence of institutional child sexual abuse. The first study would estimate the prevalence of child maltreatment in a representative sample of Australian adults, while the second study would estimate the prevalence among Australian young people.

The Royal Commission specified research questions to guide the study's scope (definitions of abuse, institution, age group), design of the study instrument (use of existing surveys, considering the context of maltreatment and prior victimisation), study methodology (sampling, subpopulations, recruitment, ethics), analysis (sample size, sample size of subpopulations, ethics), governance and costs.

In commissioning this research, the Royal Commission provided four research options for each of the two studies (see Appendix A). These can be considered on a continuum of specificity:

Option 1 – to estimate the prevalence of child sexual abuse in institutional and all contexts, and to explore the nature and context of child sexual abuse.

Option 2 – identical to Option 1, with the addition of estimating the prevalence of physical abuse, emotional abuse, neglect and exposure to family violence (but without exploring the nature and context of any of these, or health outcomes)

Option 3 – identical to Option 2, with the addition of exploring the nature and context of these other forms of maltreatment, although this is limited to situations in which the additional maltreatment is accompanied by institutional sexual abuse.

Option 4 – to estimate the prevalence of all five forms of child maltreatment (child sexual abuse, physical abuse, emotional abuse, neglect and exposure to family violence), including their prevalence within institutional contexts, the nature and context of each form of maltreatment, and the impacts of child sexual abuse such as their effect on mental and physical health.

A consortium of researchers from the Social Policy Research Centre (SPRC) at UNSW Australia, Queensland University of Technology (QUT), the Australian Centre for Child Protection (ACCP) at University of South Australia, and the Australian Institute of Family Studies (AIFS) was commissioned to scope the prevalence study.

Approach

To inform the proposed research framework, the project involved:

- A systematic review and critical analysis of the international literature regarding national population-based studies of the prevalence of child maltreatment. This systematic review complied with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (reported in Section 3).
- Examination of existing Australian surveys and data collections to explore the potential for the prevalence studies to be incorporated into an already-existing framework (reported in Section 4).
- Consultation with international experts about key aspects of these studies (reported in Section 5).
- Consideration of governance approaches, along with other operational matters including ethics, timing and cost (reported in Section 5).

The researchers developed a proposed framework to meet three fundamental criteria:

- rigour
- feasibility
- alignment with the Royal Commission's research objectives.

As indicated above, one of the objectives was to examine the feasibility of conducting the study before the Royal Commission ends in December 2017. The Royal Commission has determined that this is not feasible and the report should be read bearing this in mind.

This review identified an urgent need for a prevalence study in Australia, which is one of the few developed countries where such a study has not been conducted. In line with international best practice, a prevalence study should be a self-standing project, which could be supplemented by additional questions on existing surveys. It should be repeated at regular intervals to track changes in prevalence over time and the impact of policy and social changes on prevalence. Rather than two separate studies, the research indicated that a single study would be the most cost-effective model. The study should recruit a sample of Australians aged 16 and older. This would provide a baseline for tracking prevalence rates and retrospective analysis of past trends. People with disability and people from culturally and linguistically diverse backgrounds should be included in the main study, but separate studies should be conducted of Aboriginal and Torres Strait Islander peoples and people who have been in residential institutional care.

It is important that the study includes all forms of abuse and neglect, as these very often co-occur and influence each other. The study should also examine the context and

consequences of abuse, including disclosure, support and outcomes for the victim/survivor. Simply identifying the proportion of the population that has experienced any particular type of abuse will not provide the information necessary for policy development and evaluation.

Only a very small number of survey instruments have been validated internationally for the purposes of surveying participants' experiences of child abuse and neglect. The review identified the *Juvenile Victimization Questionnaire* as the most appropriate existing instrument for the study, but indicated that it would have to be adapted for the specific purposes of the study. In addition, extensive piloting would be required to tailor an instrument and mode of administration for the study.

Although researchers identified an optimal governance structure for the study, this would be contingent on when the study took place and which organisation took ultimate responsibility for the project.

Specific findings

The overall recommendations arising from the review are that the optimal and most viable option for the design of the study has the following key features:

- 1) **Scope:** The study should explore all five forms of maltreatment and their nature and context, and, if feasible, should also explore their health outcomes and risk factors. Thus **Option 4** is the preferred approach (see Section 3.2).
- 2) **Instrument:** The *Juvenile Victimization Questionnaire* should be the basis for this study, supplemented by demographic data, questions about current wellbeing and other scales relevant to the research objectives. The instrument should be carefully piloted before being used for the full study (see Section 3.3).
- 3) **Method of administration:** The study should be conducted with computer-assisted telephone interviewing (CATI) using land lines and mobile phones (see Section 3.4).
- 4) **Administration of child and adult study:** Rather than two separate studies, a single study of 10,000 randomly selected Australians should be conducted, using similar methods across the age ranges. The study should involve around 1,000 participants aged 16–17, and adult participants with about 1,500 people in each of the following age cohorts: 18–25, 26–35, 36–45, 46–55, 56–65, 66 and over (see Section 3.5).
- 5) **Surveying three subpopulations:** The three subpopulations of particular interest to the Royal Commission have different characteristics; two (people from culturally and linguistically diverse groups and people with disability) may be accommodated within the general population survey, but Aboriginal and Torres Strait Islander peoples should be surveyed in a connected study with a convenience sample; other subpopulations such as people who have lived in institutions would need to be treated in the same way (see Section 3.6).

Further consideration should be given to exploring the option of asking participants for permission to link their survey findings with administrative data. This will provide

information about issues such as service use, educational achievement, receipt of benefits and employment history.

The above study does not pose significant ethical challenges and would be among the most robust prevalence studies internationally. The study should cover all five forms of maltreatment; their nature and context, health outcomes and risk factors. Ignoring any of these would lead to problems in analysing the data and could ultimately result in policies and programs that would be based on misleading interpretations of the findings. The sample size and methodology will allow an estimate of Institutional Child Sexual Abuse prevalence but not the prevalence in different sorts of institutions.

Our review indicates that conducting such a study would need a high level of project management skills on the part of the contractor and the commissioning agency and the process would have to begin as soon as possible. It is also recommended that piloting work on the recruitment strategy and survey methodology begin as soon as possible.

The review considered the possibility of a study of children aged younger than 16. Although some of the overseas studies reviewed had taken this approach, it was not considered a viable or cost-effective option for the current study. The costs of such a study and the ethical challenges would not justify any potential benefits of asking children directly about their experiences. In addition, the study would take several years to implement.

Governance

Four possible forms of *governance* were considered for the implementation of a prevalence study. They are:

- Governance A: A commissioning agency conducts the prevalence study wholly in-house.
- Governance B: A commissioning agency project manages the study in-house (contracting out key elements).
- Governance C: A commissioning agency contracts out all elements of the study to an external agency or consortium.
- Governance D: A commissioning agency funds additional modules in existing surveys.

The review concluded that Governance C is the preferred option. Governance D is recommended for supplementary studies but not for the main study, as indicated above.

The review found that the study should be overseen by an advisory committee of key internal and external stakeholders and technical experts. This should meet three-monthly for the duration of the project and should review all draft deliverables.

Subpopulations

The study should be supplemented by specific studies of subpopulations. People with disability, as well as people from culturally and linguistically diverse backgrounds should be represented in the main study and need not be over-sampled. With regard to Aboriginal and Torres Strait Islander peoples, the commissioning agency should begin negotiating with relevant community representatives to establish the optimal design and timing of such a study. A separate study of people currently or previously in residential institutions such as out-of-home care, juvenile justice facilities and in patient mental health facilities should be conducted separately. These groups are important for policy but are generally under-represented in general population surveys. The studies should use the same research instruments or similar instruments adapted for the specific populations. The main study will act as a benchmark for these studies so that these population groups can be compared to the Australian population.

Review of existing Australian surveys and data collections

One option for estimating the prevalence of maltreatment in Australia would be to add questions on maltreatment to existing population surveys. The advantages of adding questions to existing surveys include:

- it would cost much less than a self-standing study
- it would produce much more information about participants
- it would use existing structures for governance, sampling, data collection, data storage and analysis
- most studies already have protocols for linking survey data to administrative data.

The key disadvantage would be that the questions would be very limited and would not conceivably provide information about all five forms of abuse, or the context and consequences of the abuse.

A review of existing surveys and data collections identified 24 relevant studies that include information about children and adults. None of these surveys include measures of all five child maltreatment types, or details of the context of abuse. A small number of studies were identified that could potentially include information about child maltreatment, either for the whole population or for specific subpopulations. However, the survey would have to accept the inclusion of a large additional component even if the narrowest option is chosen; and the additional components would be far more extensive if more information is to be included.

The review found that further exploration of these studies is needed before decisions are made as to which surveys are most suitable and the specific questions which should be added to those surveys.

The review indicated that *using an existing Australian survey or data collection is not viable for the main study* as they do not meet the requirements of rigour, feasibility or alignment

with the Royal Commission's research objectives. However, there are strong advantages to including questions on child maltreatment in existing surveys and this approach would add valuable supplementary information to the study.

Risks

The review considered the main risks to the study were not meeting the time lines or compromising the rigour of the study to meet tight deadlines or strict budgetary requirements. The other significant risk is that the proposed methodology will not meet the expectations of policy requirements of the Royal Commission. Mitigation strategies have been suggested for these risks, including:

- A streamlined project management and accountability structure
- Careful planning and piloting
- Adequate resourcing and accurate costing
- Clear and constant communication with the commissioning agency
- The employment of consultants and sub-contractors with the requisite skills and experience.

Structure of the report

This report is organised as follows:

- Section 1 presents the background to the study and the research questions
- Section 2 describes the methodology used to address the research questions
- Section 3 considers the optimal design of a new study based on a systematic review of the literature. This includes scope of the study, instrument, method of administration, subpopulations and a recommended framework for the prevalence study
- Section 4 considers whether an existing survey can be used to calculate prevalence or to supplement a prevalence study, with or without additions
- Section 5 summarises each of the options and indicates the preferred options for study scope, instrumentation, method of administration, sample, ethical issues, costs and governance, based on the range of methodologies used for this review
- Section 6 concludes the study.

1 Background to study

On 11 January 2013, the Governor-General of the Commonwealth of Australia, appointed a six-member Royal Commission to investigate Institutional Responses to Child Sexual Abuse. The Royal Commission seeks to understand the extent of child sexual abuse in Australia by determining the prevalence of child sexual abuse, and in particular the extent of child sexual abuse in institutions. This provides contextual information to inform the Royal Commission; previous research has identified this information as lacking.

The overview of services required acknowledges the complexities of child sexual abuse in that it may be accompanied by other forms of unlawful and improper treatment of children. Therefore, the requirements extend the investigation of prevalence not just of child sexual abuse (inside and outside institutional contexts), but also matters relating to child maltreatment more broadly. More specifically, the Royal Commission sought to commission a project to:

- scope the research design, methodology, cost and governance structure of two separate though related studies investigating the prevalence of child maltreatment in Australia, including the prevalence of institutional child sexual abuse:
 - Study One: The prevalence of child maltreatment in a representative community sample of Australian adults.
 - Study Two: The prevalence of child maltreatment within a representative sample of Australian young people. (Royal Commission, Request for Quotation).

In the context of the two studies, the Royal Commission identified four research options of interest for each of the studies, thereby providing a total of eight options (Appendix A). These options are:

Option 1, to estimate the prevalence of child sexual abuse in institutional and all contexts, and to explore the nature and context of child sexual abuse.

Option 2 is identical to Option 1, with the addition of the prevalence of physical abuse, emotional abuse, neglect, and exposure to family violence (but without exploring the nature and context of any of these, or health outcomes).

Option 3 is identical to Option 2, but also explores the nature and context of these other forms of maltreatment, although this is limited to situations in which the additional maltreatment is accompanied by institutional sexual abuse.

Option 4 studies the prevalence of all five forms of child maltreatment (child sexual abuse, physical abuse, emotional abuse, neglect, and exposure to family violence), including their prevalence within institutional contexts, the nature and context of each form of maltreatment, and the outcomes of child sexual abuse such as mental and physical health.

This research team, led by the Social Policy Research Centre (SPRC) at UNSW Australia, with the Australian Institute of Family Studies (AIFS), Queensland University of Technology (QUT), and the Australian Centre for Child Protection (ACCP) at University of South Australia (UniSA), scoped the research design, method, cost and governance structure of both studies to help inform the Royal Commission's future research work in this area. The QUT team led the systematic and literature reviews and the synthesis. AIFS led the governance and costings. ACCP led the review of existing Australian surveys and SPRC led the modified Delphi and stakeholder consultations.

1.1 The importance of a prevalence study

To date, the Royal Commission has heard testimony from many thousands of victims/survivors of institutional child sexual abuse as well as hundreds of perpetrators. These deliberations have uncovered a huge amount of evidence relating to the nature of child sexual abuse in institutions and its consequences. Yet the extent of child sexual abuse, as well as other forms of abuse, in institutions and in the population as a whole, is not known. Measuring the prevalence of abuse in the population through direct surveys is important because evidence presented to the Royal Commission, as well as empirical research, has indicated that many victims only disclose many years after being abused, and some never disclose, even to loved ones. Thus administrative data on reports of abuse can never provide the full picture of the nature or extent of abuse. It is also not known whether and how the prevalence of abuse has changed over the past decades. Since the 1980s, major policy and practice developments have been aimed at better protecting children from abuse, including in institutional contexts. These developments include:

- the closure of most large residential institutions
- the introduction of child protection systems
- mandatory reporting of abuse
- specialist investigation teams
- working with children checks
- increased access to parenting and family support programs
- children in schools being provided with programs aimed at helping them to prevent being abused and encouraging them to disclose abuse
- treatment facilities for victims of abuse and for abusers.

Unlike in previous eras, child sexual abuse is now a high profile topic in the media and is openly discussed and debated. Child abuse has become an important issue in public policy in Australia and internationally. There is also recognition of the inter-generational effects of child sexual abuse and the impact of abuse on victims through the life course.

However, a number of developments have potentially increased the risk to children, including:

- higher levels of family breakdown

- increased access to the internet, which contains easily sourced sexual material and provides a forum for online grooming, sexting and other forms of abuse
- sexualisation of children in advertising
- violence in the media and in computer games.

We do not know whether and how these societal, policy and practice changes have affected the prevalence of abuse in the general population or in specific vulnerable subpopulations, or whether abuse in institutional contexts is growing or declining as a proportion of overall levels of child abuse. Thus it is vital for policy development to understand the current prevalence of child sexual abuse, in institutional and non-institutional contexts, and understand how this has changed over time. It will also be important in the future to track changes in prevalence to see whether any policies recommended by the Royal Commission, as well as other policy developments aimed at addressing child abuse, are effective over the longer term.

In summary, a prevalence study is needed to:

- provide detailed information about the current extent of abuse and in particular how this differs in different groups within the general population of children
- develop a baseline for measuring the effectiveness of future policies and programs to combat child abuse
- better understand how previous policies have impacted different groups of children to guide prevention and response efforts.

1.2 Existing research on the prevalence of child maltreatment

There has been limited research into various forms of child abuse, neglect and other childhood adversity in Australia that can be considered representative of the general population. Academic and health and social welfare agency researchers have conducted studies of child sexual abuse and other forms of maltreatment. However, very few have conducted nationwide or even state-wide studies using representative samples of the population to determine prevalence, and none have explored the prevalence of all five forms of maltreatment, or their nature and context, with either child participants or adult participants.

Moore et al. (2015)¹ drew together data from 23 studies that used a range of methodologies to generate pooled estimates of the prevalence of violence in childhood and the consequences for mental health. Importantly, Moore et al.'s (2015) review showed that even these 23 studies were based on different methodologies ranging from government statistics of officially reported or confirmed cases, to community studies by non-government organisations and small community-based studies. There were very few

¹ Available at www.sciencedirect.com/science/article/pii/S0145213415001684

national or region-wide studies involving representative samples across the broader population. This supports the findings of our literature review, which found that only four published peer-reviewed studies had been conducted into the prevalence of child maltreatment using nationwide or regional samples (de Visser et al., 2003; Dunne et al., 2003; Moore et al., 2010; Rosenman & Rodgers, 2004).² Notably, three of these are studies that only focused on sexual abuse and they adopted substantially different methodologies. A valuable contribution of the Moore et al. (2015) review is that it synthesised the evidence regarding the probable long-term impact of maltreatment on mental health. Among females, 33 per cent of self-harming behaviours and 23 per cent of depressive disorders were attributable to maltreatment; the same estimates for males were 24 per cent and 16 per cent. The Australian evidence is consistent with a vast body of research internationally that shows that child maltreatment is one of the most serious threats to mental health in childhood and through the life course.

Significant gaps

There are significant gaps in Australian research into the prevalence, nature and context of all forms of child abuse and neglect, including child sexual abuse and in particular child sexual abuse in an institutional context. The data currently available can best be described as indicative rather than definitive. There is little consistency in survey design, samples and research methods, thus limiting comparability over time and place. A particular weakness is that most studies in Australia (and internationally) do not identify the nature and context of the maltreatment, including the settings in which abuse occurs. Thus we have limited insight into the extent to which abuse occurs in institutional, family, neighbourhood and other settings. The major conclusion we have reached after considering the existing evidence is that further research is needed in Australia.

1.3 Research questions

The following research questions, identified by the Royal Commission in the original request for tender (RFT Number 1.2.4, pp 9–10), were used to guide the research.

1.3.1 Research design

- How should key terms (e.g. child; young person; adult; maltreatment) be defined to ensure comprehensive measurement of prevalence?
 - In particular, how (if at all) should the definitions of ‘sexual abuse’ and ‘institution’ be modified from the working definitions used by the Royal Commission? Why are modifications necessary, and what implications

² Moore et al. (2015) found that child sexual abuse has been measured most often. Prevalence estimates for sexual abuse involving physical contact for females in Australia were highest when the survey respondents were adults (aged 18 and over) rather than adolescents (11.8 per cent versus 7.7 per cent). The opposite trend is apparent among males, where prevalence was higher among younger survey respondents (6.4 per cent versus 4.4 per cent). Pooled estimates of the prevalence of physical abuse, emotional abuse and neglect all fell below 10 per cent of the people surveyed, with females more likely to report each type of maltreatment by a margin of 2 per cent to 3 per cent.

might departure from these definitions have on the work of the Royal Commission?

- Which research option, detailed in Appendix A, is preferable for each of the studies? What are the advantages and disadvantages of each approach? What issues should be considered if the research option for Study One is different to that for Study Two?
- The age of consent varies across Australian state and territory jurisdictions, and Queensland distinguishes between anal sex and other sexual acts in age of consent legislation.³ What implications does this have for the definition and prevalence of child sexual abuse?⁴ Prior victimisation is a risk factor for future maltreatment (Boney-McCoy & Finkelhor, 1995). What are the implications of this for determining the nature and context of maltreatment? For example, should the nature and context questions be asked repeatedly for all abuse episodes, or for only the most recent episode (e.g. Australian Bureau of Statistics, 2012)?
- How should the two groups (adult and young people) be sampled?
- Should people living in institutions be included in the samples? What are the implications of excluding or including people living in institutions?
- Should the two studies (adult and young people) be conducted separately or together? What efficiencies might there be from conducting the studies together? How comparable are the prevalence estimates across the two samples if different methodologies are used across studies?
- What consideration should be given to the validity of retrospective reports?
- What ethical issues should be considered, and how should they be dealt with? In particular, how should instances of abuse disclosure (current and historical; by adults and young people) be handled?

1.3.2 Methodology

Participants

- How would the study ensure representation from the following groups?
 - Aboriginal and Torres Strait Islander peoples
 - culturally and linguistically diverse groups
 - people with disability
- What sample size is required to reliably estimate the prevalence of child maltreatment?
- What sample size is required to estimate institutional child sexual abuse in both Study One and Study Two?
- What sample size is required in Study One to determine prevalence of child sexual abuse by age cohort (e.g. born 1930–39; 1940–49; 1950–59; etc.) and gender?

³ *Criminal Code 1899* (Qld) s 208, s 215.

⁴ This issue was determined not to be relevant and it was agreed with the Royal Commission that this issue would not be explored further in this report.

- What weightings (if any) should be used to ensure that descriptive statistics reflect the Australian population?
- How should participants be recruited?

Questionnaire

- Are there existing validated, reliable questionnaires measuring the prevalence of child maltreatment? What modification (if any) would be required for use in one or both of the proposed studies?
- What control measures should be included to minimise or eliminate confounding factors?
- How should the questionnaire be designed to ensure that information on child maltreatment is complete and reliable, while maximising participation and maintaining sample representativeness?

Data collection

- What data collection method(s) (e.g. face to face, telephone, online) should be used?

1.3.3 Governance structure

- What expertise is required to manage the data collection, data analysis and reporting? Should these stages be put to tender separately or as a group?
- What is a realistic time frame to complete the studies?
- What role should an expert advisory group have in the direction of the research?
- What disciplines should be represented in the advisory group? Who should be invited to participate?

1.3.4 Cost

- What is the indicative cost for each of the methodologically feasible research options?⁵

⁵ The scoping study has estimated the cost of the prevalence studies but this has been provided to the Royal Commission separately.

2 Methodology

A number of methods were used to address the research questions, including:

- a systematic literature review to examine best practice design of prevalence studies, and detailed literature reviews on specific aspects that arise
- a review of existing Australian surveys and data collections to establish whether any can be used as the basis for a prevalence study or to make prevalence estimates
- consulting with experts to identify best practice
- identifying governance and cost implications of the optimal approach
- synthesising the findings.

Ethics approval was provided by the UNSW Human Research Ethics Advisory Panel I (HREAP), reference HC 15551, and ratified by each of the research partners.

2.1 Systematic review of international literature and critical analysis

A comprehensive literature review (Grant & Booth, 2009) with evidence synthesis (Gannan et al., 2010, Khangura et al., 2012) was conducted to identify and then critically assess optimal methodological and ethical approaches to prevalence studies. The review considered both national and international sources of grey and academic literature from 1990–2015, and included consideration of reports of all relevant research commissioned or conducted by the Royal Commission and other authorities. The systematic literature review was limited to studies of the prevalence and incidence of child sexual abuse and other forms of child maltreatment in adult and child samples. The methodology is presented in Appendix B. Rapid targeted literature reviews were also carried out, focusing on issues identified by the systematic review process and using the same sources of literature as the systematic review.

The reviews and analysis inform the preferred scope, instrument, method of administration, approach and framework, as outlined in Section 6.1.

2.2 Review of Australian surveys and official data collections

Numerous existing data sources provide information about adults, young people and children who have experienced child sexual abuse and other forms of child maltreatment. However, no single data source provides comprehensive evidence on all issues of interest to the Royal Commission and other Australian policymakers.

The review examined the kinds of information available and the variation across existing survey data sources. A systematic search was conducted of national Australian surveys

and national data collections for measures and indicators relating to child sexual abuse and child maltreatment, and their impacts, and the potential to include such measures. We used the US Department of Health and Human Services audit methodology to assess the need for a national disability survey (Livermore et al., 2011a, b).

In selecting the surveys and data collections to be reviewed, we used the following selection criteria:

- the survey was federally-sponsored and national in scope
- the survey addressed issues relevant to child maltreatment
- the survey was fielded in 2005 or later, or if the survey has not been fielded since 2005, it contains significant content relating to child maltreatment or other information particularly relevant to the Royal Commission and Commonwealth Government to assist policymaking and resource allocation.

Information was recorded and tabulated from each data source. There was substantial variation across surveys in terms of target populations, the measures used, topics covered, frequency and design. A summary of the key features of each survey that can be used either with current data or that has the best potential for adding questions is provided in Section 4 of this report as a quick reference guide when considering national prevalence studies relating to institutional child sexual abuse and other forms of maltreatment. More detailed information is provided in Appendices F, G, H and I.

The findings from this component also inform whether and how one or both of the proposed studies could be linked to or become part of current surveys and therefore potentially provide a more cost-effective methodology than undertaking two separate self-standing prevalence studies.

2.3 Consultation

Stakeholders were engaged in this research in a number of ways, including through a workshop, modified Delphi study and one-to-one discussions.

A workshop with the Royal Commission (6 August 2015) was used to gain a better understanding of the background to this study, the Royal Commission's intentions in terms of conducting primary research, and how else this study may be used; for example, in the Royal Commission's final report. At this workshop, the membership of the advisory group was confirmed as Leah Bromfield (Chair), Cathrine Lynch, Andrew Anderson, Judy Cashmore, David Zago Anne Sanson and Michael Sawyer.

A modified Delphi study was conducted to invite key experts to share their recent experiences of population-level child maltreatment prevalence studies to help establish consensus on the optimal design of an Australian child maltreatment prevalence study with respect to governance, ethics, instruments, strategies for sampling specific groups, and particular aspects of methodology. Expert participants from Australia and overseas were asked to respond to a series of questions with ratings and free-text answers for each of the

prevalence study characteristics based on their experience of conducting prevalence studies.

On 25 August 2015, invitations and reminders were sent out to 48 national and international experts identified by the research team in consultation with the Royal Commission, of which 13 responded within the three-week consultation period. Due to the timing of the consultation coinciding with summer in the Northern Hemisphere, the response to the Delphi study was low and a second wave was not conducted. However, through this process the research team identified and *consulted seven experts one to one*. These experts have helped validate the approach recommended in Section 3, as well as identify considerations for implementing any study.

2.4 Governance

The research team identified the optimal governance arrangements for the proposed prevalence study, in terms of both the design and delivery of the survey(s). This included different commissioning methods, governance structure, composition of the oversight body(s), and the levels of involvement of different components of the governance structure. This is based on the expertise and experience of team members in conducting other national large-scale and/or longitudinal studies, as well as expert consultations.

Governance structure, oversight and stakeholder engagement are discussed in Section 5 of this report.

2.5 Synthesis of findings

A draft research framework has been prepared (see Section 5.1) for the two proposed prevalence studies, which identifies the optimal design for each study. This framework draws together findings from the systematic and detailed literature reviews, the review of pre-existing Australian data sources, and the consultation exercises. In addition, considerations for implementing the study were identified and are presented in Section 5.

2.6 Limitations of the scoping study

This study was conducted in a relatively short time, from July to September 2015. Ideally the stakeholder consultation and Delphi survey would have taken place after the review of the literature. Further, the short timescale meant the team was unable to fully test our proposed methodology through a second Delphi exercise. The timescale did not allow for extensive examination of the options identified for the supplementary studies of subpopulations. Similarly the timescale did not allow the research team to explore in-depth the practicalities of supplementing existing studies with questions about child maltreatment; the methodology only allowed for identifying studies that could potentially be used in this way based on publicly available information about each study.

The costings provided in this report are of necessity high level. Further work will need to be done to accurately cost the various components of the study.

Despite these limitations the methodology used for this project is robust. It has applied a number of different approaches, all of which point to similar conclusions. Thus, the research team is confident that the model presented here represents the optimal approach to meet the policy relevance, cost-effectiveness, and methodological rigour the Royal Commission requires for such a study.

3 Systematic review and critical analysis of the international literature, and recommendations for the study design

This section provides a summary and analysis of the literature review and international best practice in epidemiological research into child maltreatment, and recommendations for the study design.

The purpose of this research project has been to draw together the best national and international studies of child abuse experiences of people in community settings, to conduct a critical analysis of these studies, and to propose a framework for the optimal manner in which to conduct a study to capture evidence of the prevalence and incidence of child maltreatment, its nature and context, and its health consequences. The framework also accommodates related interests of the Royal Commission: to involve children as research participants; to enable repeated studies over time; and to conduct the study with subpopulations of particular interest.

In conducting our analysis and developing our proposed framework, we have been guided by three fundamental criteria:

- 1) **Rigour of research design**, which includes the need to ensure that the study methodology and method of administration:
 - a) employs a valid, proven survey instrument to capture information about prevalence, nature and context of maltreatment
 - b) secures a sufficient sample size
 - c) secures a sample that is representative of the general population
 - d) attracts a sufficient participation rate
 - e) meets ethical standards to protect the interests of participants
 - f) uses a governance framework to ensure the study is completed.
- 2) **Feasibility**, which includes considerations of:
 - a) the time the study would require
 - b) the cost of the study
 - c) the likelihood of ensuring access to participants
 - d) the likelihood of ensuring participants complete the survey.
- 3) **Alignment with the Royal Commission's study objectives**, which includes:
 - a) ensuring the study can be repeated over time to track trends in prevalence
 - b) directly involving children as research participants

- c) involving three key subpopulations of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, and people with disability.

The literature review set high standards to select surveys that used methodologically sound epidemiological designs, rigorous data collection procedures and, where possible, psychometrically validated measurement tools. An eight-phase systematic review of international literature was conducted, which yielded 49 eligible peer-reviewed studies of nationwide or region-wide prevalence of child abuse and neglect (full details of the search and screening process are recorded in Appendix B).

Key data from each study were extracted and recorded in excel spreadsheets. Further analysis by investigators Walsh and Mathews synthesised key elements of the 49 studies. In addition, subgroups of these studies were identified and analysed to provide necessary insights into the questions that must be addressed by this proposal. These subgroups were nationwide studies of adults; studies of children only; studies conducted by telephone; and studies involving all five forms of maltreatment.

In Appendix C, this document summarises key dimensions in prose and tabular form of:

- the 49 studies (Table 10)
- nationwide studies of adults (two involving children also) (Table 11)
- studies of children only (Table 12)
- studies conducted by telephone (Table 13)
- studies of all five forms of maltreatment (Table 14).

Most of the studies are from North America (n = 13) and the UK/Europe (n = 15), although there has been a recent increase in research in Asian countries (n = 9). Notably, only four Australian surveys met the stringent inclusion criteria (de Visser et al., 2003; Dunne et al., 2003; Moore et al., 2010; Rosenman & Rodgers, 2004). The guiding questions, designs, sampling methods and methods of administering interview procedures for these surveys have changed considerably over time and vary in their rigour, feasibility and capacity to meet the Royal Commission's study objectives. In addition, different instruments have been used, few of which have been proved to be reliable and valid.

3.1 Summary of recommendations about five key elements of the framework

An extensive analysis of these studies and the key subgroups of studies, and consideration of the three fundamental criteria outlined above (rigour, feasibility and alignment with the Royal Commission's study objectives) has informed our recommendations about the framework for the proposed study and its guiding questions, designs, sampling methods, instruments and method of administration.

In short, the review found that the approaches have paid particular attention to the following fundamental elements and have reached these conclusions:

- 1) **Scope:** The study should explore all five forms of maltreatment and their nature and context, and ideally their health outcomes and risk factors (see Section 3.2).
- 2) **Instrument:** The study should be based on an adapted and supplemented version of the Juvenile Victimization Questionnaire (JVQ) (see Section 3.3).
- 3) **Method of administration:** The study should be conducted by computer assisted telephone interview (CATI) (see Section 3.4).
- 4) **Administration of child and adult study:** A single study involving child participants aged 16–17 and adult participants should be conducted concurrently using similar methods (see Section 3.5).
- 5) **Approach to surveying three subpopulations:** The three subpopulations of particular interest to the Royal Commission have different characteristics; People with disabilities and Culturally and Linguistically Diverse people may be accommodated within the general population survey, but Aboriginal and Torres Strait Islander peoples may be surveyed in a connected study with a convenience sample, and further consultation with the Aboriginal and Torres Strait Islander community would be required before undertaking such a study; other subpopulations would need to be treated in the same way (see Section 3.6).

Further details are provided for each of these elements below. A framework for the study is then provided (Section 5.1).

3.2 Scope: All five forms of maltreatment, their nature and context, health outcomes and risk factors

The first key element in the proposal addresses the recommended scope of these studies: which forms of abuse and neglect should be covered, and should they also cover the nature and context of the maltreatment? Informed by the considerations below, as well as for reasons of rigour, feasibility and alignment with the Royal Commission's study objectives (see Section 3, item 3) above), we have concluded that *overall, the optimal scope of the study is to cover the prevalence of all five types of child maltreatment, their nature and context, and health outcomes.*

This conclusion promotes using Option 4 as set out by the Royal Commission in its Request for Quote document. Option 1 was the Royal Commission's minimum requirement, namely to explore the prevalence of child sexual abuse only, and the nature and context of institutional child sexual abuse only. Achievement of Option 1 is included within our proposed framework – that is, our approach will obtain data on the prevalence of institutional child sexual abuse. For reasons described above and for reasons of rigour and feasibility, Option 1 by itself is not deemed preferable or viable. In addition to data on the nature of abuse, the study should capture data on outcomes and risk factors and our proposed framework enables this.

Prior to about 2005, the content of interviews in many surveys was limited to one or at most two types of child maltreatment. In Western countries, the majority of early studies

focused either solely on child sexual abuse, or child physical and sexual abuse. In Asian societies, the initial studies generally examined physical maltreatment, including harsh parental discipline.

However, over the past decade researchers have shown a strong preference for examining multiple types of child maltreatment (sexual, physical and emotional abuse, and neglect). Exposure to domestic violence is also included in the more recent studies (Fang et al., 2015a, b; Moore et al., 2015). In the US in particular, there has been a trend to measure adversity more broadly, characterised either as childhood victimisation including all five forms of maltreatment (Finkelhor et al., 2015) or Adverse Childhood Experiences (ACEs) (Anda et al., 2010).

Significantly, there is now general recognition that various types of child abuse and exposure to adversity co-occur, and therefore studies limited to a single type of abuse (such as sexual or physical abuse only) cannot capture the complex nature of maltreatment, or its nature and context. When research correlates the experience of child abuse with poor health and social functioning, if only one type is measured the effects can be overestimated because the negative influences of other forms of maltreatment are not considered. In addition, the substantial investment required to explore prevalence, nature and context of one type of maltreatment does not differ greatly from the investment required to explore multiple forms. As well, the reliable, validated instruments are purposely designed to capture the prevalence, nature and context of multiple forms of maltreatment.

In our literature review, of the 49 eligible studies, nine studies covered all five forms of maltreatment (but without identifying institutional abuse) and a further five studies covered four forms. Of these nine studies exploring all five forms of maltreatment, eight involved nationwide representative samples of participants. Seven of these nine studies involved children participating directly and two studies also involved young adults aged up to the early 20s (Radford et al., 2013; van der Kooij et al., 2015). None of these studies were conducted in Australia. Only one study in the 49 eligible studies focused narrowly on institutional child sexual abuse (Langeland et al., 2015) and this was conducted in a jurisdiction of very small geographical size, with adults only, and with a methodology unproven for the context of this study.

Our proposed approach, to explore the prevalence, nature and context of all five forms of maltreatment, health outcomes and risk factors, can best meet all three criteria of rigour, feasibility and alignment with the Royal Commission's study objectives. Key points are summarised here and are elaborated on in the sections below.

Rigour of research design

- a) The study can explore all five forms of maltreatment and their nature and context using a valid, proven survey instrument.
- b) The study can be conducted with a sufficiently rigorous sample size.

- c) The study can be conducted with a sample that is representative of the general population.
- d) The study can be conducted with a sufficient participation rate.
- e) The study can meet ethical standards to protect the interests of participants.
- f) The study can employ a governance framework to ensure completion.

Feasibility

- a) The study covers all five types of maltreatment without compromising cost or timescales.
- b) The cost of the study is not unduly greater than a study of one type of maltreatment.
- c) The likelihood of ensuring access to participants is not compromised, and may even be heightened, by framing the study as one of all five forms of maltreatment rather than, for example, of sexual abuse only.
- d) The likelihood of ensuring participants complete the survey is also not unduly compromised and may be superior.

Alignment with the Royal Commission's study objectives

- a) The study can be repeated over time to track trends in prevalence.
- b) The study can directly involve children as research participants.
- c) The study can be designed to involve three key subpopulations of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and people with disability, although Aboriginal and Torres Strait Islander peoples will have to be studied in a supplementary study.

In summary:

- **Option 4** is optimal and preferable, and meets all requirements of rigour, feasibility and alignment with the Royal Commission's research objectives. It is the only option that is consistent with best practice research in the international field. It is also the only option that is capable of exploring health outcomes and their relationship with the various forms of maltreatment.
- **Option 1** can be implemented technically as a stand-alone study to identify prevalence of child sexual abuse including institutional child sexual abuse, but is not consistent with best practice research into the prevalence of child maltreatment, and would not explore associated maltreatment accompanying institutional child sexual abuse. Also, it could not explore health outcomes and their relationship with sexual abuse. To be sufficiently rigorous, and under our preferred approach, Option 1 requires use of four screener questions and 19 follow-ups to explore the nature and context of the abuse, hence requiring a stand-alone study.

- **Options 2 and 3** are not consistent with best practice research into the prevalence of child maltreatment, and would not explore health outcomes and their relationship with sexual abuse. Option 3 is more developed than Option 2, but would pose substantial logistical and methodological difficulties in its exploration of nature and context questions only relating to institutional sexual abuse.

3.3 Instrument: Modification of the Juvenile Victimization Questionnaire

The second key element in the proposal regards the preferred instrument to be used to conduct these studies. Informed by the considerations below, as well as for reasons of rigour, feasibility and alignment with the Royal Commission's study objectives, *the findings of this review indicate that the study should be based on the Juvenile Victimization Questionnaire (JVQ). This should be adapted to Australian conditions and, if feasible, supplemented by other scales.* The analysis and reasoning for this recommendation is provided below, along with considerations of rigour, feasibility and alignment with the Royal Commission's study objectives. The quality and utility of data on child maltreatment is affected by various elements of measurement tools. Most research identified in the literature review and other reviews in this field has used homegrown instruments that lack standardisation, have not demonstrated validity and reliability, and compromise the reliability of findings (see also Hovdestad et al., 2015; Ji, Finkelhor & Dunne, 2013; Stoltenborgh et al., 2011). Many researchers in this field have argued for the adoption of standardised instruments because they yield better quality data and enable comparability assessment over time and across regions or social groups (Finkelhor, Ji, Mikton & Dunne, 2013; Runyan, Dunne and Zolotor, 2009; Stoltenborgh et al., 2015). Although there have been hundreds of surveys internationally, remarkably few have used a standardised measurement (Hovdestad et al., 2015).

Numerous instruments were used across the 49 studies reviewed. Instruments differed according to study aims, research questions and child maltreatment definitions applied. Items assessing prevalence ranged from one item screening for absence or presence of child sexual abuse (e.g. de Visser et al., 2003), to multiple items screening for behaviourally-specific child maltreatment subtypes with several follow-up items to determine the nature and context of each (e.g. Finkelhor et al., 2014, 2015).

From the 49 studies, hand searching and personal communications with experts in the conduct of national or regional population-based prevalence studies identified only four instruments with published reliability and validity data for further detailed scrutiny:

- the Juvenile Victimization Questionnaire (JVQ)
- the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) Child Abuse Screening Tool (ICAST)
- the Adverse Childhood Experiences International Questionnaire (ACE-IQ)
- the Sexual Abuse and Violence in Ireland Survey (SAVI Survey).

We compared these instruments across multiple dimensions shown in Table 15 to Table 17 of Appendix D, considering rigour, feasibility and alignment with the Royal Commission's study objectives.

Although the ICAST, ACE-IQ and SAVI Survey all have some advantages, the JVQ stands out as the most valid instrument and is also reasonably reliable. Thus, this review identified *the JVQ as the preferred instrument*. Across the 49 studies, the JVQ was the most frequently used and most rigorously tested instrument available. It has been used in four landmark national child studies in the US (Finkelhor et al., 2005, 2009, 2014, 2015), a study of young people aged 15 to 16 in Denmark (Helweg-Larsen & Larsen, 2006), and a child and young adult study conducted concurrently in the UK (Radford et al., 2013). This proves its utility in studies capturing the experiences of child participants (Finkelhor et al., 2005, 2009, 2014, 2015; Helweg-Larsen & Larsen 2006; Radford et al., 2013) as well as adult participants (Radford et al., 2013). All these studies are recent, having been published within the past 10 years and many appear in high-ranking journals such as *The Lancet* and *JAMA Pediatrics*. The JVQ is also used in repeated studies to enable tracking of trends over time. It can be employed with both child and adult participants concurrently. It can also be used readily to capture data on childhood prevalence and incidence in the prior year.

Importantly, the JVQ thoroughly covers *all five types of maltreatment* and captures detailed information concerning the *nature and context* of maltreatment (including capture of prevalence of institutional child sexual abuse; for example, see follow-up questions 5 and 7 in the instrument in Appendix E) and other factors of interest to the Royal Commission (since the JVQ contains items on disclosure and outcomes). This distinguishes it from all the other instruments. The JVQ is a modularised cross-sectional survey instrument designed to obtain lifetime prevalence and/or one-year incidence estimates of a comprehensive range of childhood victimisations.

The JVQ comprises screening questions in *all five types of maltreatment* to ascertain prevalence in childhood and where desired, incidence in the prior year of physical abuse, sexual abuse, emotional abuse, neglect, exposure to domestic violence, peer and sibling victimisation, conventional crime and indirect victimisation. In addition, 14 possible follow-up questions collect further information on the *nature and context* of each type of maltreatment frequency, severity, perpetrator, place, disclosure and help-seeking (see Appendix D, Table 17). The rates of maltreatment identified through the JVQ are consistent, are neither unduly low nor unduly high, and do not suggest there are conceptual flaws in design (Finkelhor et al., 2005, 2009, 2014, 2015).⁶ Significantly, the

⁶ See also D Finkelhor et al. (2013); D Finkelhor et al. (2014). Some tables in the articles cited in the text may at first appear misleading but on closer analysis they are sound, since they report only prior year incidence (Finkelhor et al., 2014, 2015). Some other tables only report a subset of child sexual abuse (for example, see Finkelhor et al., 2014, p 1423, para 2).

JVQ is the only instrument to have been successfully used in repeated cross-sectional administrations that have enabled tracking of changes in prevalence over time.

The final study should use an instrument based on the core elements of the JVQ but adapted to the Royal Commission's requirements, refined for Australian culture and vernacular, and within constraints imposed by feasible survey methods and mode(s). Many of the studies reviewed used components or scales from a number of different instruments and this would be a reasonable approach to take in this instance, given the specific requirements of the Royal Commission. Any instrument or combination should be carefully piloted before it is used in the full study.

Administration of the JVQ The JVQ has been administered directly with child participants aged 10–17, and with parents or caregivers to capture the maltreatment experiences of children aged under 10. In addition, in the UK study (Radford et al., 2013), the JVQ was used with a sample of young adults aged 18–24. In all four US studies, the JVQ was administered through CATI.

In the US and UK studies, when they involved children younger than 10 in the US and 11 in the UK, proxy interviews were conducted with the adult in the household most familiar with the child and their activities. Children aged 10–17 completed a self-administered format. In the Danish study, the JVQ was adapted for self-administration on a laptop. Our extensive searches did not uncover any studies that had used the JVQ in a national population-based study of adults aged over 24, although the study administration manual endorses such an approach (Hamby et al., 2004) and the experience of Radford et al. (2013) indicates there are no impediments to using the JVQ with adults. Further information on health outcomes can be elicited by incorporating the instrument adopted by Radford et al. (2013, p 804) for this purpose (for child participants, the *Trauma Symptoms Checklist for Children* (Briere, 1996) and for adults, the *Trauma Symptoms Checklist* (Briere & Runtz, 1989). Information on risk factors can be obtained by incorporating items from similar Australian studies (de Visser et al., 2003; Richters et al., 2014) and the UK study by Radford et al. (2013).

Rigour

The JVQ has multiple features contributing to our assessment of it as the preferred instrument. These include all criteria of rigour, as follows:

- a) The JVQ is a valid, proven instrument, which captures information about prevalence, nature and context of maltreatment: internal consistency, test-retest reliability, and construct validity have been established (Finkelhor et al., 2005) (see Appendix D, Table 15).
- b) The JVQ has secured and been administered with a sufficient and feasible sample size in repeated studies in the US and in studies in the UK and Denmark (1,000–2,000 children aged 10–17 in the four US studies administered by CATI; 2,275 children aged 11–17 in the UK household study by Radford et al., 2013;

7,241 children aged 15–16 in the Danish schools study by Helweg-Larsen & Larsen, 2006).

- c) The JVQ has been implemented with samples that are representative of the general population.
- d) The JVQ has been used successfully in studies attracting a sufficient participation rate (60–79.5 per cent in the US studies; 60 per cent in the UK study by Radford et al., 2013; 86 per cent in the Danish study by Helweg-Larsen & Larsen, 2006).
- e) The JVQ has been implemented with accompanying procedures that meet rigorous ethical standards to protect the interests of participants: comprehensive guidelines for ethical conduct are detailed in several papers (Table 16) (Abt SRBI, 2008; Finkelhor et al., 2005). These ethical guidelines can be supplemented by the extensive guidance provided by McGee’s Irish study (the SAVI Report), which is on file with the authors of this proposal.
- f) The JVQ and its mode of administration uses a governance framework to ensure study completion; for example, administration and scoring manuals are publicly available (Hamby et al., 2004) and the questionnaire is modularised enabling inclusion or exclusion of component parts (see Appendix D, Table 16 and Table 17).

Feasibility

Adoption of the JVQ in the Australian context is the most feasible option for the following reasons:

- a) The time the study would take using the JVQ is feasible. It is highly advantageous both in terms of time and cost to be able to use a validated ready-to-use instrument, rather than to design and test a new instrument. In addition, based on the studies using the JVQ with administration by CATI, data collection can occur in a feasible time (see Section 3.4). The JVQ is compatible with administration by CATI, as shown by repeated studies by Finkelhor and his colleagues and by Radford et al. (2013), and is far superior in administration compared with other methods. We have provided information at the end of Section 3.3 about the different estimated time periods the JVQ would require, based on Options 1 and 4, and based on respondents having different levels of exposure to abuse and other maltreatment.
- b) The cost of using the JVQ is not substantially different to that of alternative instruments.
- c) The JVQ has been successfully implemented in studies that obtained access to participants.
- d) The JVQ has been successfully implemented with participants who completed the survey.

Alignment with the Royal Commission’s study objectives

- a) The JVQ can be used in a relatively short period to gather data. It enables the elicitation of data on prevalence (and for young people aged under 18, prior-year incidence) of each of the five forms of maltreatment, their nature and context, disclosure, injury and health outcomes (Radford et al., 2013) and risk factors.
- b) The JVQ has been used in repeated studies in the US to track trends in prevalence and incidence.
- c) The JVQ directly involves children and young people as research participants and through various means it can achieve optimal speed, sample recruitment and compliance with research ethics. For example, the JVQ can be used with a sample of children of a broad age range (e.g. aged 11–17), a higher age range (e.g. aged 14–17 or 16–17) or even a single age (e.g. aged 17).
- d) The JVQ can be used with the subpopulations of interest to the Royal Commission (see Section 3.6 below).

Summary The review found the JVQ to be the optimal instrument as:

- it is proven to be reliable and valid in repeated studies
- it can be administered with CATI
- it meets the Royal Commission’s research objectives of being suitable for Option 4, and would also meet the requirements of Option 1.

Informed by the literature and the Royal Commission’s research objectives, we have developed a provisional abridged JVQ (see Appendix E). Table 1 and Table 2 below capture key elements of the different instruments and demonstrate the superiority of the JVQ.

Table 1 Summary of strengths and limitations of JVQ, ICAST, ACE-IQ and SAVI survey instruments for Option 1 and Option 4

| Strengths and limitations | Juvenile Victimization Questionnaire (JVQ) | ISPCAN Child Abuse Screening Tool (ICAST) | Adverse Childhood Experiences International Questionnaire (ACE-IQ) | Sexual Abuse and Violence in Ireland Survey (SAVI Survey) |
|---|---|---|--|--|
| Optimal use by option | Optimal for use for Option 1 and Option 4 | Cannot be used for Option 1 or Option 4 | Cannot be used for Option 1 or Option 4 | Can be used for Option 1 |
| Age range | Used with children and adults in previous studies | Used with children aged 12 through to adults in previous studies | Used with adults only in previous studies. Currently being tested with children and adolescents | Used with adults only in previous studies |
| Scope | Collects data on prevalence, nature and context | Collects data on prevalence, nature and context | Collects data on prevalence only. Recommended for use combined with other instruments | Collects data on prevalence, nature and context |
| Use with CATI | Proven effective in CATI mode in multiple administrations | Not tested in CATI format | Not tested in CATI format | Proven effective in CATI mode in a single administration |
| Mode of questioning | Not feasible for administration in paper and pencil format owing to questionnaire's branching structure (screening and follow-up items) | Typically administered in schools, which is not feasible for a nationally-representative population-based study in Australia | Currently being tested with children in schools and original administration was face to face in a clinic setting. Neither option is feasible for a nationally-representative population-based study in Australia | Not tested in any other format |
| Adaptation to Australian context | Would require minor adaptations for administration in Australia | Would require minor adaptations for administration in Australia | Would require minor adaptations for administration in Australia | Would require minor adaptations for administration in Australia |
| Suitability for collecting data on outcomes | If wanting to collect data on health and other outcomes, additional instruments would need to be added | If wanting to collect data on health and other outcomes, additional instruments would need to be added | If wanting to collect data on health and other outcomes, additional instruments would need to be added | If wanting to collect data on health and other outcomes, additional instruments would need to be added |
| Validity and reliability testing | Instrument has been tested in multiple studies and validity and reliability data have been published | Instrument has been tested in multiple studies and some validity and reliability data have been published | No validity and reliability data have been published to date | No validity and reliability data have been published from the study's single administration |
| Effectiveness for measuring prevalence changes over time | Proven effective for measuring prevalence over time | Not used to measure changes in prevalence over time | Not used to measure changes in prevalence over time | Not used to measure changes in prevalence over time |
| Availability of support materials | Detailed support materials available to assist with ethical and safety issues, survey administration, scoring, and staff training | Some support materials available to assist with ethical and safety issues, survey administration, scoring, and staff training | Some support materials available to assist with ethical and safety issues, survey administration, and staff training | Some support materials available to assist with ethical and safety issues, survey administration, and staff training |

Table 2 A detailed comparison of JVQ, ICAST, ACE-IQ and SAVI survey instruments

| | Juvenile Victimization Questionnaire (JVQ) | ISPCAN Child Abuse Screening Tool (ICAST) | Adverse Childhood Experiences International Questionnaire (ACE-IQ) | Sexual Abuse and Violence in Ireland Survey (SAVI Survey) |
|---|---|---|--|---|
| Age range | Child (parent proxy report): 1 month to 9 years Child (self-report): 10–17 years Adult (self-report): 18 years and older | ICAST-C (child self-report) V1: 12–17 years ICAST-R V3.0 2014 (adult self-report): 18 years and older | Adult (self-report): 18 years and older | Adult (self-report): 18 years and older |
| Number of items | Screening items (up to 52) Follow up items (up to 18 for each victimisation module) | 'Stem' items (15) 'Leaf' items (4) | Screening items only (10) | Screening items only (12) |
| Time required to complete | Average 55 minutes (see Appendix E for Options 1 and 4, with different respondent features) | Not reported | Not reported | Approximately 35 mins (sexual abuse only) |
| Administration method | CATI(Finkelhor studies) Face-to-face interview and computer assisted self-interview (CASI) (Radford et al., 2011, 2013) | Paper and pencil, conducted in schools | Face-to-face interview (original ACE study conducted in clinic setting) Paper and pencil (currently being tested by World Health Organisation in schools) | CATI |
| Maltreatment subtypes covered | Child sexual abuse Physical abuse Emotional/psychological abuse Neglect Witnessing family violence Other victimisations | Child sexual abuse Physical abuse Emotional/psychological abuse Neglect | 10 adverse childhood experiences | Child sexual abuse only |
| Asks about prevalence, nature, and context | Prevalence, nature, and context | Prevalence, nature, and context | Prevalence only | Prevalence, nature, and context |
| Reliability | <i>Internal consistency</i> Child version: 0.35–0.64 for different subscales (Finkelhor et al., 2005, p 401) Adult adaptation (Radford et al., 2011, 2013): data not reported <i>Test-retest</i> | <i>Internal consistency</i> ICAST-C: 0.69–0.86 for home subscales; 0.78–0.86 for institutional subscales (Zolotor et al., 2009, p 837) ICAST-R: 0.61–0.82 for different subscales (Dunne et al., 2009, p 821) <i>Test-retest</i> | <i>Internal consistency</i> Field testing as part of broader health surveys in 6–8 countries is underway <i>Test-retest</i> | <i>Internal consistency</i> Not reported <i>Test-retest</i> |

| | Juvenile Victimization Questionnaire (JVQ) | ISPCAN Child Abuse Screening Tool (ICAST) | Adverse Childhood Experiences International Questionnaire (ACE-IQ) | Sexual Abuse and Violence in Ireland Survey (SAVI Survey) |
|---|---|--|---|---|
| | Child version: 0.59 (0.22–1.00) (Finkelhor et al., 2005, p 399) Adult adaptation (Radford et al., 2011, 2013): data not reported | Not reported | Not reported | Not reported |
| Validity | Child version: Moderate, significant convergent validity established with Trauma Symptom Checklist for Young Children (Briere et al., 2001) and Trauma Symptom Checklist for Children (Briere, 1996) (reported in Finkelhor et al., 2005, pp 396–99) Adult version: Not reported | ICAST-C: Construct validity via extensive pilot testing (Zolotor et al., 2009, p 837) ICAST-R: Not reported, however extensive field testing conducted (Dunne et al., 2009, pp 819–820) | Not reported | Not reported |
| Replicability | Proven effective for measuring victimisation over time (Finkelhor studies) | Not used to measure victimisation over time | Not used to measure victimisation over time | Not used to measure victimisation over time |
| Published materials to assist with risk of harm and duty of care | Yes Child version: JVQ Administration & Scoring Manual (Hamby et al., 2005); NatSCEV 1 Methods Report (Finkelhor & Turner, 2008) Adult adaptation (Radford et al., 2011, Appendix C, pp 169–176) | Yes Available via application to ISPCAN | No | Yes Ethical and safety considerations in SAVI full report (McGee et al., 2002, pp 30–35) |

Additional information on how much time the instrument would take to administer (Provisional JVQ in Appendix E): Option 1 and Option 4

Table 3 and Table 4 below provide a breakdown of survey components and estimated timings for **Option 4** (preferred option) and **Option 1**, using our provisional abridged JVQ instrument set out in Appendix E. Timing breakdowns for survey components are not reported in any publicly available material in existing survey reports provided by Finkelhor and colleagues (US, using CATI), or Radford and colleagues (UK, using face-to-face interviews and computer assisted self-interview (CASI)). Therefore, we have estimated approximate timings and ranges.

These estimates should be treated with caution as the instruments have not yet been tested with an Australian population. We are providing these rough estimates at the request of the Royal Commission (in response to the Internal Reviewer's Report, 8 October 2015) and these would need to be confirmed in piloting.

The survey components identified here include (i) preamble, (ii) screener items, (iii) follow-up items, (iv) health outcomes, (v) duty of care, and (vi) close. McGee et al. (2002) in the SAVI Survey identified that the additional components of demographics and participant distress would add to the survey time:

- The *minimum time for completion of both Option 1 and Option 4* would be approximately 4 minutes (where the participant answers 'no' to all screening items).
- The *maximum possible time for completion of Option 1* (where the participant answers 'yes' to all four sexual abuse screener items) would be approximately 63 minutes (four screeners plus 19 follow-up questions for each).
- The *absolute maximum time for completion of Option 4* (where the participant answers 'yes' to all nine screener items for all maltreatment types + all follow-ups) would be approximately 105 minutes.
- The *mid-range time for an Option 4 respondent* who answers 'yes' to two screener items (with follow-ups) would be approximately 45 minutes.

Table 3 Breakdown of survey components and estimated timings for Option 1

| Option 1 – Ask questions about prevalence of sexual abuse, nature and context (which identifies institutional abuse) of sexual abuse only, and health outcomes | | | | | |
|---|--|----------------------|---|--|--|
| | Total number of items | Time per item | Minimum completion time | Maximum completion time | Range |
| Preamble | n/a | n/a | n/a | 1–2 min | 1–2 min |
| Screeners items | SA (4) | 20–30 sec each | Answer ‘yes’ to 1 screener = <1 min | Answer ‘yes’ to 4 screeners = 2 min | 1–2 min |
| Health outcomes | 26 items for children 40 items for adults | Not estimated | n/a | n/a | 10–15 min (Radford et al., 2011, 2013) |
| Follow-up items | SA (19 x 4 = 76) | ~30 sec each | Answer ‘yes’ to 1 screener + 19 follow-ups = 10 min | Answer ‘yes’ to all screeners + 76 follow-ups = 38 min | 10–38 min |
| Duty of care | n/a | n/a | <1 min | >5 min | 1–5 min |
| Close | n/a | n/a | n/a | n/a | 1 min |
| Total | | | | | 4–63 min |

Table 4 Breakdown of survey components and estimated timings for Option 4 (preferred option)

| Option 4 – Ask questions about prevalence of child maltreatment, nature and context of child maltreatment regardless of whether it occurred in the context of sexual abuse, and health outcomes | | | | | |
|--|---|----------------------|--|--|--|
| | Total number of items | Time per item | Minimum completion time | Maximum completion time | Range |
| Preamble | n/a | n/a | n/a | 1–2 min | 1–2 min |
| Screeners items | Total (9): SA (4); PA (1); EA (1); N (1); WFV (2) | 20–30 sec each | Answer ‘yes’ to 1 screener = <1 min | Answer ‘yes’ to 9 screeners = ~4 mins | 1–4 min |
| Follow-up items | SA (19 x 4 = 76) PA (16 x 1 = 16) EA (15 x 1 = 15) N (16 x 1 = 16) WFV (8 x 2 = 16) | ~30 sec each | Answer ‘yes’ to 1 screener + 8 follow-ups = ~4 min | Answer ‘yes’ to all screeners + 139 follow-ups = ~70 min | 4–70 min |
| Health outcomes | 26 items for children 40 items for adults | Not estimated | n/a | n/a | 10–15 min (Radford et al., 2011, 2013) |
| Duty of care | n/a | n/a | <1 min | >10 min | 1–10 min |
| Close | n/a | n/a | n/a | n/a | 1 min |
| Total | | | | | 4–105 min |

3.4 Method of administration: Computer assisted telephone interview

The third key element in the proposal is the preferred method for administering the study. Informed by the considerations below, as well as for reasons of rigour, feasibility and alignment with the Royal Commission’s study objectives, we have concluded that the only feasible and proven format in which to administer the study is by CATI. This conclusion is supported by our literature review and further analysis of the CATI methodology, discussed at length below.

CATI is our preferred method of administration – Telephone interviewing or computer-assisted telephone interviewing (CATI) have been used in research by the world leader in the field of child maltreatment prevalence studies, Professor David Finkelhor from the Crimes Against Children Research Center at the University of New Hampshire. Finkelhor has used telephone interviewing and CATI in studies conducted at regular intervals to estimate prevalence of a broad range of child victimisations, with both adult-proxy and child respondents (Finkelhor et al., 2005, 2009, 2013, 2014, 2015). Telephone interviewing was also used in the landmark Sexual Abuse and Violence in Ireland (SAVI) study of adults undertaken in 2002 (McGee et al., 2011), prior to the *Commission of Investigation into Catholic Archdiocese of Dublin* (Murphy, Mangan & O'Neill, 2009). Telephone interviewing was also used in two Australian studies included in our systematic review (de Visser et al., 2003; Dunne et al., 2003), both conducted with adults and achieving response rates of 73 per cent and 61 per cent respectively. Mode of questionnaire administration influences data quality (Bowling, 2005; de Vaus, 2014). Five indicators of data quality are: study response rates, questionnaire item response rates, accuracy of responses, presence or absence of bias and completeness of data obtained (Bowling, 2005). In studies of child maltreatment prevalence, data quality from telephone interviewing has been shown to be comparable to face-to-face modes of data collection (Finkelhor et al., 2014).

Of the 49 eligible studies in our review, 11 involved data collection by telephone interview or CATI. Of these 11 studies, four covered all five maltreatment types and each of these involved nationwide representative samples of child participants in the US (Finkelhor et al., 2005, 2009, 2014, 2015). A further four studies were conducted solely about child sexual abuse (but not identifying institutional abuse), all in Western jurisdictions (Ireland, Canada and Australia). Ten of these 11 studies involved nationwide representative samples, with six involving adult participants. There are two Australian studies in this group of 11, both of which covered sexual abuse only (de Visser et al., 2003; Dunne et al., 2003); de Visser et al., 2003 involved participants aged 16–59 and Dunne et al. 2003 involved adult participants aged 18–59.

Recent Australian studies using CATI obtain participation rates from landline and mobile numbers, and are conducted in a timely manner – Our further analysis of Australian literature on the use of telephone interviews and CATI support our conclusion. Most recently, Richters et al. (2014) conducted a nationwide study of health and relationships with a representative Australian population using the CATI method and obtained an overall participation rate of 66.2 per cent, which comprised participation rates of 63.9 per cent (landline, men), 67.9 per cent (landline, women) and 66.5 per cent (respondents who only used mobile phones). Data was collected over 12 months from 20,094 participants using a 20-minute interview. Dunne et al. (2003) obtained data from 1,784 participants over one month using CATI, with a 61 per cent participation rate. De Visser et al. (2003) gathered data from 19,307 participants over 13 months using CATI with a 73 per cent participation rate. Finkelhor et al. (2009) obtained participation from 4,549 participants over five months using CATI with a participation rate of 71 per cent. Our proposed number of participants is approximately 10,000, which is half the size of

de Visser et al. (2003) and Richters et al. (2014), and five times the size of Dunne et al.'s sample. Pilot studies can be conducted with sufficient samples over a relatively short period; for example, Holden et al. (2005) conducted a one-month pilot with 433 respondents before implementing the main study in which CATI was used to capture data over three and a half months from 5,990 participants using a 20-minute interview with a 78 per cent participation rate. Overall, the data collection time is estimated at roughly five to six months, but the amount of funding that supports the study and the number of staff involved in data collection will affect the time it takes. CATI requires sufficient personnel and staff training and supervision, and these elements can be built into the design, in particular being informed by the experience of Finkelhor et al. (2005, 2009, 2014, 2015; Abt SRBI, 2008) and McGee et al. (2011).

Our conclusion that CATI is the best format for conducting data collection is further strengthened because the literature review revealed that the Australian context and the Royal Commission's three criteria made other modes of administration unviable. In essence, considerations beyond cost and time include:

- The geographical size of Australia makes a household study unviable. Household studies have only been conducted in either very small nations or in small regions of nations. Other scholars in Australia who have conducted nationwide studies share this conclusion (Aday & Llewellyn, 2006; de Vaus, 2014; Richters et al., 2014; Tucker & Lepkowski, 2008). Dunne et al. (2003) and de Visser et al. (2003) both conducted their studies of child sexual abuse by CATI. More recently, Richters et al. (2014, p 385), who conducted a nationwide study of adult health and relationships using CATI, concluded that 'the low population density in Australia rendered the cost of face-to-face interviews prohibitive'.
- For the same reason, it is not viable to conduct the child study through schools. The implementation of a school-based study is further fundamentally compromised and rendered unviable by insurmountable logistical impediments. It would be impossible to obtain the necessary research approvals from eight jurisdictions (and across different regions within each) and each of these jurisdictions' multiple educational authorities (government and non-government), and to obtain parental and child approval through school networks.
- There is no evidence in the peer-reviewed literature to support the viability of conducting a prevalence study of this breadth and complexity using an online survey. In our review, only one study used an online methodology (Langeland et al., 2015), and this study did not establish instrument psychometrics, involved only adults aged over 40, concerned sexual abuse only and only the experience of it. Neither the JVQ nor any of the other validated instruments have been used in an online survey.
- Finally, it is not feasible to add the proposed study to an existing nationwide cohort study given the scale of the prevalence study, the desirability of implementation with both child and adult participants, the desirability of being able to repeat the study, and the limits of existing studies with nationwide cohorts.

A summary of our reasoning is provided below against dimensions of rigour, feasibility and alignment with the Royal Commission's study objectives.

Rigour – The CATI method of administration has multiple features that contribute to our assessment of it as the preferred approach. These include all criteria of rigour, as follows:

- a) The CATI method has been used in multiple studies of child maltreatment, including child sexual abuse, and its nature and context. CATI has also been used in six studies to administer the JVQ, a valid, proven instrument, which captures information about prevalence, nature and context of maltreatment (Finkelhor et al., 2005).
- b) The CATI method has been administered with a sufficient and feasible sample size in studies in the US (1,000 to 2,000 children aged 10–17 in four US studies), the UK and Denmark.
- c) The CATI method has been used with nationwide representative population samples in multiple studies in the US, Ireland, Australia and Denmark.
- d) The CATI method has been repeatedly proven to attract sufficient response rates (60–79.5 per cent in the US studies; 73 per cent in the Australian study by de Visser et al. 2013; 61 per cent in the Australian study by Dunne et al., 2003). Maximising study response rates is crucial for the validity of prevalence estimates. All survey modes have experienced declines in response rates over the past 25 years (Curtain et al., 2005; Tourangeau, 2004; Tucker & Lepkowski, 2008). The trend is evident even in Finkelhor's five studies, which have been repeated over time: the 1994 study yielded a response rate of 88 per cent for parent-proxy interviews of focus children aged up to nine years and 82 per cent for self-report interviews of children aged 10–17 years, whereas the most recent study, conducted in 2013, yielded 60 per cent overall (Finkelhor et al., 2005, 2009, 2013, 2014, 2015). Finkelhor et al. (2014, 2015) and others have consistently stated that these rates are more than adequate and are comparable with surveys conducted on comparable topics (e.g. Reddy et al., 2006). In addition, to maximise response rates in the SAVI study, McGee et al. (2002) followed a protocol involving call backs, reviewing the call strategy after six calls, calling each number a maximum of 10 times, checking disconnection and second-chance 'conversion calls' (p 45). Finally, almost 29 per cent of adult Australians (more often those aged 18–34) exclusively use mobile phones (Australian Communications and Media Authority, 2014). A sampling frame that includes both landlines and mobile phones is necessary. Finkelhor et al. (2014, 2015) used the JVQ with a fourfold approach, including random digit dialling sampling from landlines, mobile phones, address-based phone number elicitation, and pre-screened households with recent participation in a random digit dial (RDD) survey. Richters et al. (2014) successfully used a dual frame of landline and mobile numbers, attracting a response rate of 66.2 per cent (comprising 6.5 per cent of mobile only users, 63.9 per cent of male landline users and 67.9 per cent of female landline users).

- e) CATI meets ethical standards that protect the interests of participants. Comprehensive guidelines for ethical conduct are detailed in several papers (Table 16 (Abt SRBI, 2008; Finkelhor et al., 2005). These guidelines can be supplemented by the extensive guidance provided by McGee's *The SAVI Report*, which is on file with the authors of this study. CATI also:
- i) enables anonymous follow-up post interview (McGee et al., 2002)
 - ii) ensures centralised administration for training and supervision, safety and quality control (de Vaus, 2014) with highly trained and skilled interviewers (McGee et al., 2002)
 - iii) enables follow up for participant distress, disclosure and referral (Finkelhor et al., 2014; McGee et al., 2002). CATI is effective for managing situations with distressed participants and disclosures of clear risk of harm. Interviewers would receive training in managing situations where a respondent is distressed or a child may be at risk (McGee et al., 2002; NHMRC, 2007; 2015). NATSCEV 1 (JVQ), included a one-day two-phase training for interviewers (see report pp 11–12). In McGee et al. (2002), training modules were delivered over 12 days (105 minutes per day) (see McGee et al., 2002, Appendix III) with all researchers present. Interviewers would monitor distress throughout the interview, with standardised strategies built into the question sequence at the end of each section of the interview.

Distressed participants would be referred to an independent counsellor and/or a toll-free helpline, and, with consent, follow-up calls would be made to ascertain whether the respondent needed further assistance (McGee et al., 2002). In the McGee et al. SAVI study (2002), all participants were asked if they could be re-contacted for a brief follow-up interview one to two days later, to assess the degree of distress following interview; provide a second chance to offer referral to appropriate services if necessary; allow the participant a chance to change their responses; and allow the researcher to clarify any initial information that was unclear (*The SAVI Report*, pp 52–53). Priority appointments can be arranged with specialist services if participants identify as part of the national study (*The SAVI Report*, p34).

Where a respondent aged 16–17 discloses abuse, considerations of research ethics, respondent confidentiality and child safety intersect, but can be managed. Previous studies including Finkelhor et al.'s NATSCEV studies and Radford et al. (2013) have adopted 'red flag' protocols for cases of disclosure, where the respondent's case is reviewed by a senior clinician, who would re-contact the child if necessary to determine what if any further action was required. In rare cases, this may include the need to notify a government child protection department if the child is currently experiencing significant harm from maltreatment. In Finkelhor's work, this clinician has been a senior clinical psychologist with experience in telephone counselling. Limiting the study to child respondents who are aged 16 and over is also beneficial in this respect, as it limits the number of cases where a child will be currently at risk.

In addition, the duty of care for interviewers is accommodated by a range of measures (NATSCEV 1 Report; McGee et al., 2002; Radford et al., 2011). Recruitment of high-quality interview staff, who have successfully conducted telephone interviews, with high response rates, on sensitive topics would be recommended. Interviewers would receive random monitoring twice per shift and evaluation of their work during the project (NATSCEV 1 Report p 13); interviewers would work four hours per day to guard wellbeing (SAVI Report p 36). Supervision would involve measures including an operations manager being present during all interviews; weekly supervision sessions; and external support if necessary.

- f) CATI can be used with a governance framework to ensure study completion; administration techniques are publicly available (Hamby et al., 2004; McGee et al., 2002).

Feasibility – The use of the CATI method via RDD of landlines and mobile phones is shown to be feasible and optimal for the Australian context.

- a) The time the study would require is feasible based on the studies using the JVQ and administration by CATI. CATI enables optimal speed of data collection; in the 49 included studies the duration of data collection varied from one month (Dunne et al., 2003, sample size n = 1,784) to 12 months (de Visser et al., 2003, sample size n = 19,307; Richters et al., 2014: n = 20,094). CATI is also time-effective for participants (Bowling, 2005; Ryan, 2001; Smith, 2005). CATI is demonstrated to be suitable for use with both landlines and mobile phones with substantial survey instruments, including the JVQ (Finkelhor et al., 2014; Richters et al., 2014).
- b) The study is quite expensive, but using CATI is substantially cheaper than alternatives; it is cost-effective compared to face-to-face interviewing (Aday & Llewellyn, 2006; de Vaus, 2014). The Finkelhor et al. (2009) study using CATI and the JVQ with 4,503 participants is the only one to report its funding amount (\$2.7 million), although the Australian studies indicate a lower cost and further costings would need to be conducted.
- c) Ensuring access to participants is far more likely using the JVQ by CATI administration, which is far superior for household and school studies.
- d) Ensuring participants complete the survey is far more likely using the JVQ and CATI administration. CATI:
 - i) enables establishment of rapport for research legitimacy and integrity via personal contact while maintaining respondent anonymity (Bowling, 2005; Smith, 2005)
 - ii) is perceived by respondents as less intimidating and more private (Finkelhor et al., 2014) and provides greater comfort levels and more careful responses compared to other methods (Reddy et al., 2006)
 - iii) promotes greater agency for children and minimises power imbalances between adults and children (Vogl, 2013)

- iv) CATI has advantages over postal surveys in reducing missing or incomplete item data (Aday & Llewellyn, 2006; Bowling, 2005) due to more focused communication, fewer distractions and respondents having more control over the process (Vogl, 2013).

Alignment with study objectives – CATI aligns with the Royal Commission’s study objectives.

- a) The CATI method of administration can be used over a relatively short period to gather data.
- b) CATI has been used in repeated studies in the US, enabling tracking of trends in prevalence and incidence.
- c) CATI directly involves children as research participants and is a consistent method for use with both adults and children (Vogl, 2013).
- d) CATI can be used to survey Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse groups; and people with disability (see Section 3.6 below).

3.5 Administration of surveys involving child and adult participants: A single study conducted concurrently with required adaptations to meet the needs of young people and adult participants

The fourth key element in the proposal regards the preferred method of administration of the surveys to ensure involvement of child and adult participants. Informed by the considerations below, as well as for reasons of rigour, feasibility and alignment with the Royal Commission’s study objectives, *the optimal way to achieve this is by concurrent administration of a single study with required adaptations to meet the needs of young people aged 16–17 and adults*. This approach offers extremely significant benefits in terms of feasibility, time efficiency and cost.

Designs: child studies, adult studies and studies with both adults and children – The literature review identified surveys conducted specifically with children, surveys conducted specifically with adults, and a smaller group of surveys conducted with both children and adults. The most notable included the Australian study by de Visser et al. (2003), which included young people aged 16–17 and adults aged up to 59, and the UK study by Radford et al. (2013), which used the JVQ to survey children directly aged 11–17, and young adults aged 18–24.⁷ The predominant approach is to conduct a study with either adults or children, for several reasons:

- There are significant differences in the purpose of the research: surveys with adults can unveil the historical contexts and long-term effects of child abuse on health and

⁷ This study was conducted using face-to-face interviews.

social and economic wellbeing, while surveys with children or young adults only (e.g. aged 18–24) illuminate contemporary or near-contemporary incidence and settings of maltreatment.

- There are differences in the feasibility of population sampling: typically, adults are accessible through landline or mobile phone numbers, electoral rolls, college campuses or randomly selected households, while children or young people are often accessed via school-based or household samples. Children under the age of 16 are surveyed least often, and those under the age of 10 have not been surveyed directly. However, four nationwide studies of children aged under 18 have been conducted using CATI, and the de Visser et al. (2003) Australian study also adopted CATI for participants aged 16–59.
- There can be significant differences in the structure and age appropriate content of interviews for adults and children. However, three factors support our proposed approach in this regard. First, the JVQ has been used previously in a study concurrently involving both children and adult participants (Radford et al., 2013). Second, other studies of sexual victimisation have been conducted concurrently with older children and adults, including in Australia: the study by de Visser et al. (2003) asked young people aged 16–17 identical questions about sexual victimisation. Third, our proposed child participant age range has been developed with this in mind; by limiting the study to children aged 16–17, we have overcome any need to make substantial changes to the survey items.
- There can be practical or ethical constraints on interviewing children, particularly within settings where abuse may have occurred, and especially for younger children. However, older children, especially those aged 16 and over, are clearly capable of providing their own consent to participate in research. By limiting the survey to children aged 16–17, practical and methodological difficulties involved in asking parents about the experience of their younger children are avoided, as are difficulties in obtaining parental consent for children aged under 16 to participate. In addition, this approach overcomes the problem of skewed data from asking child sexual abuse questions of children aged far below the average of onset. Finally, this approach can effectively manage concerns about the ethics of research with children.

The 14 child studies – Of the 49 eligible studies, 14 involved only child participants who were aged under 18. Four studies by Finkelhor et al. (2005, 2009, 2014, 2015), which directly surveyed children aged 10–17 also involved parental participants for a separate age cohort of children (infancy to age nine). Ten of these 15 studies involved nationwide representative samples of children (Ajduković, 2013; Edgardh & Ormstad, 2000; Euser, 2013; Finkelhor, 1994, 2005, 2009, 2014, 2014; Helweg-Larsen & Larsen, 2006; Sariola, 1992). Five studies were both nationwide studies and covered all five maltreatment types (Euser et al., 2013; Finkelhor et al., 2005, 2009, 2014, 2015). There were no Australian studies in this group of 14.

The 14 nationwide studies with adults – Of the 49 eligible studies, 14 involved nationwide samples primarily comprising only adult participants (two studies included

some child participants: de Visser et al., 2003, which surveyed participants aged 16–59; and Radford et al., 2013, which surveyed children aged 11–17 directly, with parents as proxies for children aged under 11; and young adults aged 18–24).⁸ Only one of these 14 studies covered all five maltreatment types (Radford et al., 2013) but four others covered all maltreatment types except exposure to family violence (Christoffersen et al., 2013; Laaksonen et al., 2011; May-Chahal & Cawson 2005; Tsuboi et al., 2015). There are two Australian studies in this group of 14, both of which covered sexual abuse only (de Visser et al., 2003; Dunne et al., 2003).

Significantly, de Visser et al. (2003) conducted a nationwide Australian survey concurrently involving children aged 16–17 and adults aged 18–59, exploring sexual victimisation using the CATI method. Radford et al. (2013) also conducted a concurrent study, using the JVQ, although this was a household study. This concurrent approach offers obvious and strong advantages of feasibility in time and cost, and avoidance of duplication. As well, the use of very similar methods of administration and the same instrument offer further advantages. Our conclusion is that the study can be conducted concurrently and this would only require slight variation in content, which would be required by any separate administration.

The conclusion that the study of child participants and adult participants can be conducted concurrently in a single administration meets the criteria:

Rigour of research design:

- a) Each study can employ the same valid, proven survey instrument (JVQ), with adaptations for each group (Radford et al., 2013).
- b) Each study can be conducted with a sufficiently rigorous sample size (de Visser et al., 2003).
- c) Each study can be conducted with a sample that is representative of the general population (de Visser et al., 2003).
- d) Each study can be conducted with a sufficient participation rate.
- e) Each study can meet ethical standards to protect the specific interests and needs of child and adult participants respectively.
- f) Each study can employ a governance framework designed to the specific needs of children and adults respectively to ensure study completion.

Feasibility:

- a) The study can be conducted in a substantially shorter period of time using this approach.

⁸ van der Kooij is not included in this section despite involving participants aged 12–22 since that study was conducted primarily with children in schools and vocational training settings and the study involved only 246 adults. In addition, cohort studies such as Hussey et al. (2006) and Tsuboi et al. (2015) involved child participants in earlier waves that were not reported.

- b) The cost of the study is substantially minimised.
- c) The likelihood of ensuring access to participants is not compromised.
- d) The likelihood of ensuring participants complete the survey is also not compromised.

Alignment with study objectives – the study aligns with the Royal Commission’s objectives:

- a) The study can be repeated over time to enable tracking of trends in prevalence.
- b) The study can directly involve children as research participants, although we propose that the child participants be restricted to those aged 16–17.
- c) The study can involve three key subpopulations (see Section 3.6 below).

3.6 Preferred approach to surveying three subpopulations: Two models

The fifth key element in the proposal regards the preferred approach to surveying three subpopulations of particular interest to the Royal Commission: Aboriginal and Torres Strait Islander peoples; people from culturally and linguistically diverse groups and people with disability. In addition, there may be other subpopulations of interest to the Royal Commission, such as those who are currently in institutions, those in mental health facilities and children in out-of-home care.

This raises the question of how these subpopulations, which may be difficult to access, can most feasibly be involved as research participants. To address this question, the research team has reviewed international literature on the conduct of studies with subpopulations of both adults and children about child maltreatment and other health issues.⁹ The research team has also considered other Australian reports by academic researchers and government agencies on the results of studies with these groups. The research team has also considered the characteristics of these groups in Australia, and the Australian context itself. Finally, the research team has considered other methodological issues in the measurement of phenomena with subpopulations that may be difficult to access.¹⁰

⁹ For examples of studies of individuals from culturally and linguistically diverse groups, see Futa et al. (2001), Duran et al. (2004). For examples of studies of Aboriginal and Torres Strait Islander peoples, see Adams et al. (2013), Holden et al. (2005). For examples of studies of people with disability or special medical condition, see Ammerman et al. (1994), Kvam (2004), Kvam (2005), Mandell et al. (2005), Manders (2004), Maniglio (2014), Maniglio (2013). For examples of other groups that are traditionally difficult to access, see Sundin & Baguley (2015), Coleman & Stewart (2010), Euser et al. (2013), Euser et al. (2015), Falbo et al. (2004), Hadi (2000), Johnson et al. (2006), Keeshin and Campbell (2011), Mathur et al. (2009), Miller et al. (2011), Sullivan and Knutson (2000).

¹⁰ See for example; Gorey et al. (1997), Runyan (1998), Wynkoop et al. (1995).

Informed by the literature and the considerations below, as well as for reasons of rigour, feasibility and alignment with the Royal Commission's study objectives, *the optimal approach to obtaining the involvement of these subpopulations is:*

- to consult with representatives of the Aboriginal and Torres Strait Islander community about conducting a connected study with a convenience sample of Aboriginal and Torres Strait Islander peoples
- to use the results of the general population survey as a natural indicator of the experiences of individuals with disability (given the sufficient representation of this subpopulation within the population sample the study would recruit)
- to use the results of the general population survey as a natural indicator of the experiences of individuals from culturally and linguistically diverse groups as a whole (given the sufficient representation of this subpopulation within the population sample the study would recruit) and if further subsets of this culturally and linguistically diverse subpopulation are of interest to the Royal Commission, to conduct a connected study with a convenience sample to capture their experience

For the same reasons, any study exploring the experience of other subpopulations, such as those who are currently, or who have been in residential institutions including justice facilities, mental health facilities and children in out-of-home care, would need to be conducted in connected studies with convenience samples because they would not be represented in the general population survey.

General lack of special measures adopted to reach these subpopulations –

Australian studies of personal safety and health have generally not adopted measures to recruit individuals from these subpopulations, both in child and adult studies. In the Australian Bureau of Statistics *Personal Safety Survey*¹¹, for example, there is no information identifying methods used to access these three populations. The demographic characteristics of children, adolescents and families who participated in the study were found to be comparable to the population. However, the study found that while the number of children and adolescents of Indigenous background included in the survey was consistent with that of the general population, it was too small to guarantee the data reflected the characteristics of all Indigenous children and adolescents. It was also acknowledged that an adapted study using culturally sensitive methods may be required to administer the study with this population. In addition, the survey yielded little data about the mental health of children and adolescents living in non-English speaking families. There were several reasons for this: parents who completed the study needed sufficient competence in English; the lack of non-English speaking families in the population meant there were not enough children and adolescents in the survey to provide an accurate picture of the mental health of all children and adolescents living in these families; in addition, many individuals from culturally and linguistically diverse groups tend to be less inclined to participate due to more conservative attitudes. Special measures to access

¹¹ <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>

these populations are not generally reported by other similar studies where participants are children, such as the Longitudinal Surveys of Australian Youth¹², the Australian National Children's Nutrition and Physical Activity Survey¹³, the Australian Health Survey¹⁴, the Australian Child and Adolescent Survey of Mental Health and Wellbeing¹⁵, the Longitudinal Study of Australian Children. The same absence of special approaches is generally evident in adult studies, such as the National Survey of Mental Health and Wellbeing¹⁶, the Household, Income and Labour Dynamics in Australia (HILDA)¹⁷ survey, the Crime Victimization Survey (individuals aged 15 and older)¹⁸, and the Australian Longitudinal Study on Women's Health (ALSWH).¹⁹

Three possible approaches to involvement of subpopulations – Overall, there are three possible approaches a research study could adopt to involve subpopulations:

- 1) Conduct the general population survey and do not adopt a strategy to capture representation of the subpopulation, on the basis that the sample that eventuates will naturally contain sufficient representation of the subpopulation due to its size and likely participation.
- 2) Conduct the general population survey and adopt a strategy to capture representation of the subpopulation by oversampling (this is the method most frequently adopted in prior studies; for example, Finkelhor et al., 2014)
- 3) Conduct the general population survey, do not adopt a strategy to capture representation of these subpopulations by oversampling, and replicate the study with a convenience sample of the subpopulations.

For the Aboriginal and Torres Strait Islander subpopulation, Approach 3 is optimal: replicated study with convenience samples – This conclusion is informed by the literature review of subpopulation studies regarding child maltreatment, the experience of successful studies described below (one of which involved CI Dunne as a co-author), and the low proportion of Aboriginal and Torres Strait Islander peoples in the general population (3 per cent), which makes it unfeasible to ensure their adequate representation in the main study.

¹² Accessed at www.isay.edu.au/aboutisay/faq/survey.html

¹³ Accessed at [www.health.gov.au/internet/main/publishing.nsf/content/8F4516D5FAC0700ACA257BF0001E0109/\\$File/childrens-nut-phys-survey.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/8F4516D5FAC0700ACA257BF0001E0109/$File/childrens-nut-phys-survey.pdf)

¹⁴ Accessed at www.abs.gov.au/ausstats/abs@.nsf/Lookup/4363.0.55.001Chapter2002011-13

¹⁵ See analysis by Reeve and Van Gool from the Centre for Health Economics Research and Evaluation (CHERE) at University of Technology Sydney (2013).

¹⁶ Accessed at www.abs.gov.au/ausstats/abs@.nsf/Products/4326.0~2007~Explanatory+Notes~Explanatory+Notes?OpenDocument#3110231325149955

¹⁷ Accessed at https://www.melbourneinstitute.com/downloads/hilda/Stat_Report/statreport_2015.pdf

¹⁸ Accessed at www.abs.gov.au/Ausstats/abs@.nsf/Latestproducts/4530.0Explanatory%20Notes12013-xx

¹⁹ Accessed at www.alswh.org.au/about/sample

This approach has multiple advantages. First, due to the low proportion of Aboriginal and Torres Strait Islander peoples in the general population (see further analysis below), it is not feasible to ensure adequate representation in a general population study, even using the optimal CATI method of administration and a sample size of 10,000. Second, this approach fulfils two purposes. The general population survey establishes baseline data for the general population and establishes a proven method for conducting the study. The study can be replicated in a feasible way with a convenience sample of the subpopulation, then generate data which stands alone for the subpopulation and can be used as a comparator with the data from the general population survey. This model has been used in studies of health and sensitive topics (see 'Model for the connected study' below). Third, there are a range of social benefits in involving community leaders and members as key supporters of and participants in studies of health and wellbeing. In addition, ethical standards relating to research with Aboriginal and Torres Strait Islander populations require prior consultation with community members and elders, as well as feedback to relevant communities. The involvement of individuals in community settings in the conduct of the study can help create more specific benefits in developing a self-sustaining culture of awareness, inquiry and investment in research into child maltreatment and a commitment to reducing it. The use of replicated studies with the subpopulation is best directed by a partnership approach between academic researchers and community members, which both develops the culture of social research to be more inclusive of the study of violence, and creates an additional legacy of this research and the Royal Commission.

Model for the connected study of Aboriginal and Torres Strait Islander peoples –

Based on 2011 national Census data, Aboriginal and Torres Strait Islander peoples constitute 3 per cent of the population, both as a whole (606,000 people), and for males and females respectively.²⁰ Approximately 35 per cent of Aboriginal Australians live in major cities, 22 per cent live in inner regional locations, 22 per cent in outer regional locations, 8 per cent in remote locations and 14 per cent in very remote locations. Torres Strait Islander peoples form a relatively small number of the total population (38,000) with almost two-thirds concentrated in Queensland (24,000).

Studies of health status have been successful with targeted samples of Aboriginal and Torres Strait Islander peoples, including by this proposal's co-author CI Dunne. The Men in Australia Telephone Survey (MATeS) was conducted with a general population sample of 5,990 Australian men to explore the sensitive topic of reproductive health (Collins et al. 2005).²¹ The general population survey did not adopt any methods for accessing subpopulations including Aboriginal and Torres Strait Islander peoples. Instead, to identify the experience of Aboriginal and Torres Strait Islander men, this study was subsequently replicated by Adams, Collins, Dunne, de Kretser & Holden et al. (2013) with a convenience sample using quota sampling of 293 Aboriginal and Torres Strait Islander men in urban townships, a rural area, and remote communities in Queensland and the Northern Territory

²⁰ Australian Bureau of Statistics (2013a).

²¹ Adams et al. (2013), Holden et al. (2005).

(Darwin, Cairns, Brisbane: urban; the Tiwi Islands and Yarrabah: remote; Caloundra: rural). The conduct of a separate study with this adapted methodology to suit the cultural context and ensure representation of this subpopulation was deemed the optimal method to access these participants, especially for a study into a sensitive topic.

Other targeted studies with convenience samples also provide examples of this approach. The Australian Survey for Kids and Young People recruited 121 children to participate in focus groups, recruiting through disability support services and Aboriginal organisations.²² The Footprints in Time – the Longitudinal Study of Indigenous Children conducted sampling and recruitment based primarily on Centrelink and Medicare information, as well as informal means of contact such as word of mouth, local knowledge and study promotion.²³ The Ward et al. study (2015) surveyed Aboriginal and Torres Strait Islander peoples using convenience samples obtained at targeted unique community events.²⁴

Broader studies have been conducted, such as the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, which generated a response rate in community areas of 77 per cent.²⁵ However, using such a broad sample is not logistically feasible in this context given the time frame required for the proposed study, and the sensitivity of the subject matter.

Therefore, the overall recommendation is that for both children and adults, the subpopulation of Aboriginal and Torres Strait Islander peoples can optimally be involved in the study by using a connected study that replicates the general population study, using a convenience sample and following the model adopted successfully in similar previous studies.

People with disability are likely to be naturally represented in the general population survey – Australian demographic data suggest that the subpopulation of people with disability is likely to be naturally represented in the general population study (Approach 1). According to the 2012 Survey of Disability, Ageing and Carers (SDAC), 4.2 million Australians have a disability, representing 18.5 per cent of the population.²⁶ The concept of ‘disability’ is defined as ‘any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months’. In addition, after removing the effects of different age structures, the age standardised rate was 17.4 per cent. Based on this rate of disability in the general population, it is concluded that

²² Accessed at <http://isia.acu.edu.au/wp-content/uploads/sites/4/2015/05/Taking-Us-Seriously-Children-and-young-people-talk-about-safety-and-institutional-responses-to-their-safety-concerns-.pdf>

²³ More information can be found in the Data User Guide: https://www.dss.gov.au/sites/default/files/documents/04_2015/data_user_guide_-_release_6.0.pdf and more broadly that link is also found on the ‘About’ page for the Study: <https://www.dss.gov.au/about-the-department/publications-articles/research-publications/longitudinal-data-initiatives/footprints-in-time-the-longitudinal-study-of-Indigenous-children-Isic->

²⁴ Ward et al. (2015).

²⁵ Australian Bureau of Statistics. (2013c).

²⁶ Australian Bureau of Statistics. (2013b).

the conduct of a general population survey is highly likely to attract sufficient participation by individuals with disability. This means that, while it will be necessary to ensure the demographic data gathered from participants includes information on their disability status, no separate study of this group would be required.²⁷ Guidance in this regard can also be obtained from dedicated studies of people with disability, such as the Survey of Disability, Ageing and Carers.²⁸

Culturally and linguistically diverse peoples – Similarly, the studies referred to above do not report on methods for recruiting individuals from the broad component of the population which together constitute a single entity that could be classed as people of culturally and linguistically diverse backgrounds. People from culturally and linguistically diverse backgrounds, as a single subpopulation, are not a clear and readily identifiable subset since this subpopulation itself contains dozens of subsets.

However, what is clear is that in its broadest definition – with culturally diverse peoples being defined as those not of Anglo-Saxon heritage, and linguistically diverse peoples being defined as those in which English is not the language primarily spoken at home – the broad entity constituting culturally and linguistically diverse peoples in Australia is a large proportion of the population and would be highly likely to be represented in the general population survey, obviating the need for any separate strategy such as that recommended for the subpopulation of Aboriginal and Torres Strait Islander peoples. The demographic section of the survey could elicit data about the culturally and linguistically diverse status of participants, obtaining information about the experiences of this subpopulation in the same way as for the subpopulation of people with disability described above. This approach was adopted in Radford et al. (2013).

It can be further recommended that if the Royal Commission desires information about specific subsets of the broader culturally and linguistically diverse subpopulation – for example, the Vietnamese community or the Jewish community – a connected study with a convenience sample be conducted in the same way as the recommended study of Aboriginal and Torres Strait Islander peoples. The reasoning underpinning this conclusion is identical to that outlined above in relation to the Aboriginal and Torres Strait Islander peoples. The literature review also shows that studies of child maltreatment and other sensitive topics with populations with a distinct and narrowly-defined cultural or linguistic frame, such as those by Futa et al. (2001) of Asian American families and Duran et al.

²⁷ The exception to this is if the Royal Commission desires a study of a subset of the disabled subpopulation. For example, if the Royal Commission desires a study of deaf children then, for the reasons provided above, we recommend that in our treatment of the Aboriginal and Torres Strait Islander subpopulation, we conduct a connected study with a convenience sample. In addition, the main study would be likely to attract people with physical rather than cognitive/intellectual impairment. If the Royal Commission wanted to include information about this population (who are particularly vulnerable to child sexual abuse) a sub-study or at least oversampling of this group would be required.

²⁸ Accessed at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Explanatory%20Notes5002012?OpenDocument#Chapter2

(2004) of American Indian persons²⁹, adopt different methods to recruit the sample of participants. Rather than recruiting through a general population survey, these studies occur in specialised settings such as targeted communities or clinical convenience samples. This method is also adopted by studies of individuals from other groups who are difficult to access through general population studies, such as the homeless, those in jails or detention centres, and those in out-of-home care.³⁰

In summary, the theoretical range of culturally and linguistically diverse groups is large, embracing groups from multiple cultural and linguistic subsets. Accordingly, an issue to be determined in consultation with the Royal Commission is whether specific culturally and linguistically diverse groups are of interest, or whether it will be sufficient to obtain information about the culturally and linguistically diverse subpopulation as a whole. This determination will influence the final design.

Other subpopulations of interest to the Royal Commission – Other subpopulations of interest whose experience of child sexual abuse, institutional child sexual abuse, and other forms of maltreatment and its nature and context, include those who are in institutions and mental health facilities, and children in out-of-home care. Adopting the same reasoning as outlined above, any study exploring the experiences of these groups would need to be conducted in connected studies with convenience samples because they would not be represented in the general population survey.

It should be noted that these populations are difficult to recruit and many participants will have special needs; for example, low literacy, speech difficulties and poor English. Special efforts will have to be made to recruit them and the survey instrument will have to be adapted for some groups of people with disability.

²⁹ For individuals from culturally and linguistically diverse groups, see Futa et al. (2001), Duran et al. (2004).

³⁰ For examples of studies of individuals who are homeless, see Sundin and Baguley (2015), Keeshin and Campbell (2011), Mathur et al. (2009), Sullivan and Knutson (2000). For examples of studies of individuals in jails or detention, see Coleman and Stewart (2010), Falbo et al. (2004), Johnson et al. (2006). For examples of studies of individuals in out-of-home care, see Euser et al. (2013), Euser et al. (2015), Miller et al. (2011).

4 Review of existing Australian surveys and official data sources

A review was carried out to ascertain the nature of existing Australian national surveys and data collections, and to consider whether existing mechanisms could be used to calculate prevalence or to contribute to a prevalence study. For example, current surveys or national data collections relating to children and young people (e.g. the Australian Early Development Census (AEDC), the National Survey of Child and Adolescent Mental Health and Wellbeing, the Longitudinal Study of Australia's Children (LSAC), the Australian Temperament Project, the Longitudinal Surveys of Australian Youth (LSAY) and the Footprints in Time study) may include or have the potential to include measures of childhood adversity (including childhood maltreatment) and/or poor functioning associated with such experiences, as well as help-seeking experiences. Similarly, national surveys of adults (e.g. the HILDA study, the Personal Safety Survey, the Victims of Crime Survey, the Survey of Disability and Care (SDAC)) may already include or have the potential to include retrospective items that examine abuse in childhood and its impacts. The feasibility of triangulating information from multiple survey methods and data collections is reported in this section.

4.1 Can an existing survey be used to carry out the prevalence study?

There are distinct advantages to conducting a prevalence study that includes questions on child maltreatment in an existing study. There are also some disadvantages. This section sets out the main advantages and challenges before focusing on the studies that could potentially be used for this purpose. The scoping study has concluded that adding questions to existing surveys will *not* be viable for the main prevalence study. However, this approach could be used for supplementary studies that examine maltreatment in particular subpopulations, including Aboriginal and Torres Strait Islander peoples and people in specific circumstances.

4.1.1 Advantages

Cost

It is much less expensive to include items on existing studies than to fund a self-standing prevalence study of child maltreatment. The core costs of developing the study, sample recruitment, governance, data collection and storage infrastructure, etc. have already been incurred and therefore the costs of adding even a significant number of questions would be several orders of magnitude lower than for conducting a new separate study.

Convenience

Similar to the above, all the large-scale studies have existing governance structures, ethics approval, data storage protocols, etc. Thus, a range of very significant tasks which would have to be undertaken for any new survey would be avoided by utilising an existing study.

Data and analysis

Perhaps the most important advantage of this approach would be that the existing large-scale studies, both longitudinal and cross-sectional, include a significant amount of information about participants which could be used to contextualise the information on child maltreatment. Although each of the studies discussed below has a different focus, all of them collect a wealth of demographic and wellbeing information which could be used to better understand the social, health and economic wellbeing of the participants and, in some cases, outcomes such as educational attainment and employment. This is particularly the case with longitudinal studies, which will be able to provide information over several waves. Some designs can even provide prospective data on the precursors and consequences of abuse, thus avoiding the significant problem of recall bias in any retrospective design.

4.1.2 Disadvantages

Quantity of information

Although additional questions on existing surveys will provide a large amount of contextual information, it will be very difficult to include a large number of questions on child maltreatment. First because typically in these studies there is always competition for items on the survey, and the questions on child maltreatment are often tangential to the main focus of the study. Thus the study investigators are very likely to be reluctant to give up more than a few minutes on any specific survey to include these items. Another concern for many investigators is that too many questions on a sensitive topic such as child maltreatment will compromise participant retention, especially in longitudinal studies. Therefore, it is unlikely that a full suite of questions about the nature of abuse, context, disclosure and outcomes can be attached to any existing survey.

Timing

Most of the surveys discussed here are conducted at fixed times and there is no leeway to change the timing of the survey to fit the objectives of the Royal Commission. Further, it typically takes many months and often years to negotiate the addition of new sensitive items on surveys, and similarly it can take several years for the data to be released.

Other issues

Some issues apply only to certain study designs. For example, longitudinal studies such as LSAC will only have two opportunities to ask these questions (for the B and K cohort, in 2018 and 2022) and even if there is another birth cohort, it will be at least 20 years before the survey can be conducted again in the same way (although the follow-up could be a self-standing study). Similarly, some of the cross-sectional studies are only conducted at

long intervals, and therefore will be difficult to use as a baseline for tracking policy outcomes over time.

4.2 Overview of existing national surveys and data collections in Australia

4.2.1 Purpose

Numerous existing data sources provide information about adults, young people and children who have experienced child sexual abuse and other forms of child maltreatment. However, no single data source provides comprehensive evidence on all issues of interest to the Royal Commission and other Australian policymakers.

This component of the scoping study focuses on establishing the potential for existing national surveys and data collections to contribute to a prevalence study. For example, current surveys or national data collections relating to children and young people may include or have the potential to include measures of childhood adversity (including childhood maltreatment) and/or poor functioning associated with such experiences, as well as help-seeking experiences. Similarly, national surveys of adults may already include or have the potential to include retrospective items that examine abuse in childhood and its impacts. The feasibility of triangulating information from multiple survey methods and data collections will also be explored in this component.

This review will illustrate the kinds of information available and the variation across existing survey data sources to provide a context for considering options designed to improve child sexual abuse and child maltreatment data. A brief summary of the review is provided below, and more information can be found in Appendices F, G, H and I; this includes details of the surveys and data collections, and their potential for triangulation and inclusion of additional items relating to child sexual abuse and other forms of child maltreatment.

4.2.2 Method and sources of information

We adapted the audit methodology used by the US Department of Health and Human Services in assessing the need for a national disability survey (Livermore et al., 2011a, b). Selection criteria for surveys and data collections for this component of the scoping study included:

- the survey was federally-sponsored and national in scope
- the survey was fielded in 2005 or later
- if the survey has not been fielded since 2005, it contains significant content relating to child maltreatment or other information particularly relevant to the Royal Commission and Commonwealth Government to assist policymaking and resource allocation.

Twenty-four surveys and collections of data were identified that met the selection criteria of being federally sponsored, national in scope and fielded in 2005 or later. These are

presented alphabetically in Table 5. The information extracted from the 24 surveys and collections of data that met the selection criteria is presented in Table 5.

An additional 16 studies were identified that did not meet the selection criteria, as they related to research and/or data collections that were beyond the date range for this scoping project, they related to state-specific surveys, measured development, and/or were not federally sponsored.

Table 5 Identified national Australian surveys

| Surveys of children |
|---|
| Child/youth report |
| <ol style="list-style-type: none"> 1. Australian Survey for Kids and Young People 2. Longitudinal Surveys of Australian Youth |
| Teacher report |
| <ol style="list-style-type: none"> 1. Australian Early Development Census |
| Combination (child/parent/carer/teacher) |
| <ol style="list-style-type: none"> 1. Australian National Children's Nutrition and Physical Activity Survey (primary caregiver and child) 2. Footprints in Time – the Longitudinal Study of Indigenous Children (child, parent and teacher) 3. Longitudinal Study of Australian Children (child measure, parent report, and teacher or centre-based carer) 4. Australian Child and Adolescent Survey of Mental Health and Wellbeing (parents/carers of all children (aged 4–17 and 11–17)) |
| Administrative data collection |
| <ol style="list-style-type: none"> 1. Child Protection Australia 2. Perinatal data |
| Surveys of adults |
| <ol style="list-style-type: none"> 1. Australian Longitudinal Study on Women's Health 2. Drug Use Monitoring in Australia 3. Personal Safety Survey |
| Surveys that include adult and child report/information |
| Survey data |
| <ol style="list-style-type: none"> 1. Australian Health Survey (one adult and one child from each household) 2. Australian Study of Health and Relationships (16–69 years) 3. Crime Victimization Survey (aged 15+) 4. Household Expenditure Survey (aged 15+) 5. Household, Income and Labour Dynamics in Australia (aged 15+) 6. Identity Crime and Misuse in Australia (aged 15+) 7. Longitudinal Study of Factors Affecting Housing Stability (Journeys Home) (aged 15+) 8. National Drug Strategy Household Survey (aged 12+) 9. National Survey of Adult Mental Health and Wellbeing (aged 16–85) 10. Survey of Disability, Ageing and Carers (aged 15+, proxy for less than 15 years) 11. Survey of Income and Housing (aged 15+) |
| Administrative data collection |
| <ol style="list-style-type: none"> 1. Recorded Crime – Victims, Australia |

For each survey and data source that met the selection criteria, information was extracted from publicly available sources relating to the characteristics of the survey (population of

interest), sampling strategy, design, sample size, administration methods, measures, ethical considerations and potential for providing estimates of the prevalence of all forms of childhood maltreatment and/or for incorporating standardised measures of maltreatment.

4.2.3 Overview of findings

This scoping study identified 24 national surveys and data collections that included information about children and adults. Of these, nine related to information collected to study children's development and wellbeing, three related to studies of the experiences of adults alone, and 12 included the experiences of adults and children. There was substantial variation across surveys in terms of target populations, the measures used, topics covered, frequency and design. None of the surveys included measures of all five child maltreatment types or details of the context of abuse.

A number of nationally representative studies (National Survey of Mental Health and Wellbeing, National Survey of Child and Adolescent Mental Health and Wellbeing, Australian Health Survey, Australian Study of Health and Relationships, the LSAC and the Personal Safety Survey) that involve children and adults as respondents about their own experiences included items that relate to childhood adverse experiences/maltreatment and/or also include highly important data about potential health, mental health, cognitive and social correlates.

Two studies of respondents aged 16 and over included young people's and adults' responses to questions relating to child sexual abuse. The Australian Study of Health and Relationships used Computer Assisted Telephone Interviewing (CATI) to ask respondents about unwanted and forced sexual experiences, frequency, age at onset and help-seeking. The National Survey of Mental Health and Wellbeing asked about sexual and physical abuse, witnessing domestic violence, the age of onset of the abuse, and the frequency of abuse in face-to-face interviews. Similarly, the Personal Safety Survey asks adult respondents about their experiences of sexual and physical abuse in childhood.

While some of these studies (National Survey of Mental Health and Wellbeing, Australian Study of Health and Relationships, National Survey of Child and Adolescent Mental Health and Wellbeing) have been infrequently administered (usually a decade apart) or are longitudinal in nature (the Longitudinal Study of Australia's Children), the potential for including brief standardised measures of child maltreatment experiences in these studies should be explored further as supplements to the main prevalence study.

Other studies have included items or indicators relating to forms of maltreatment other than child sexual abuse. The studies examine narrow forms of abuse or neglect (e.g. experiencing violence as a result of others' alcohol or drug use) using non-standardised measures and/or in narrow population groups (e.g. children in a small age band or subsets of children from larger studies). Together with the studies identified earlier, information from these datasets could be triangulated to provide a picture of specific forms of child maltreatment in specific populations; however, they do not appear suitable for the inclusion of additional standardised measures of child maltreatment.

One administrative data collection (Child Protection Australia) contains information about rates of child sexual abuse and other forms of child maltreatment reported to child protection agencies, but does not provide information about the context, duration, severity or perpetrators of the abuse. This data collection now does collect unit record data and so there exists the ability to study reported rates of child maltreatment for birth cohorts of children, and to potentially link this data with information in other datasets to examine potential impacts of abuse and neglect.

Other surveys of adults and children relate to selected target groups in the population of Australian adults (e.g. female participants from certain birth cohorts; people with disability, police detainees, the Longitudinal Study of Indigenous Children) and do not currently collect detailed information about childhood maltreatment and/or do not include representative samples. However, as these target groups are of specific interest to a prevalence study of childhood maltreatment it may be suitable to explore incorporating maltreatment measures within these surveys.

4.2.4 Surveys and collections relating to children's experiences

Of the 24 surveys and data sources identified, nine related to information collected about children. Data was collected about children from children themselves, teachers, administrative data or a combination of children, parents/carers and teachers. Surveys of adults collected data directly from the adults, and a number of the identified surveys collected information from individuals in a range of ages, including children/youth and adults, asking them about their personal experiences (see Appendix I, Table 27).

None of the surveys and data collections involving children aged under 18 included direct questions for children or their caregivers about experiences of child sexual abuse. One administrative data collection (Child Protection Australia) contains information about rates of child sexual abuse and other forms of child maltreatment reported to child protection agencies, but does not provide information about the context, duration, severity or perpetrators of the abuse. This data collection now does collect unit record data and so there exists the ability to study reported rates of child maltreatment for birth cohorts of children, and to potentially link this data with information in other datasets to examine potential impacts of abuse and neglect.

Another study, the Australian Survey of Kids and Young People, uses vignettes to examine the extent to which children have experienced or have knowledge of scenarios that may indicate child sexual abuse. However, this study does not use representative sampling or a validated tool, does not question children about their direct experience of child sexual abuse or other forms of maltreatment, and currently is only being administered once.

Two surveys of children's experiences included items or indicators relating to forms of maltreatment other than child sexual abuse. The studies examine narrow forms of abuse or neglect (or indicators thereof) using non-standardised measures and/or in narrow population groups (e.g. children in a small age band and subsets of children from larger studies). Of these studies, one is limited to indicators of physical neglect for a very small

age range (the AEDC), and the other includes indicators based on non-standardised interviewer observations of the child and the home and single items about abuse, neglect and violence as reasons for moving/not seeing non-resident parents (the Longitudinal Study of Australia's Children). Together with the studies identified earlier, information from these datasets could be triangulated to provide a picture of specific forms of child maltreatment experiences in specific populations; however, they do not appear suitable for the inclusion of additional standardised measures of child maltreatment.

While no studies of children currently include standardised measures of children's experiences of childhood maltreatment including sexual abuse, three studies (the National Survey of Child and Adolescent Mental Health and Wellbeing, the Longitudinal Study of Australia's Children and the Longitudinal Study of Indigenous Children) include measures of risk factors and/or potential impacts (e.g. mental health, social, behavioural and cognitive development) that could be related to childhood maltreatment in representative samples of Australian children. The possibility of incorporating brief measures of all forms of child maltreatment in such studies is worth further exploration, although it should be noted that one of these surveys, the National Survey of Child and Adolescent Mental Health and Wellbeing, is conducted intermittently and has just been administered in 2014, and the other two studies are following cohorts of children over several years. While prevalence estimates may be obtained in these latter two samples, changes in prevalence estimates for populations over time will not be readily observable unless new cohorts are added to these studies regularly.

4.2.5 Surveys of adults' experiences

Of the 24 identified national Australian surveys, three surveys related to information collected solely about adults and their experiences (see Appendix I, Table 28). All of these surveys collected information directly from adults and included studies examining personal safety, drug use and women's health.

Of the three surveys of adults' experiences, only one study currently collects information from adults relating to physical and sexual abuse in childhood – the Personal Safety Survey. This survey does not include information about other forms of maltreatment and has only been administered intermittently, with the survey most recently being conducted in 2012. However, there may be potential to include additional standardised measures of maltreatment in childhood in this survey.

Of the other two studies involving adult participants relating their own experiences, both relate to selected target groups of Australian adults. The first includes female participants only (Australian Longitudinal Study on Women's Health) in certain birth cohorts, and the second (Drug Use Monitoring in Australia) includes only police detainees in a small number of sites across Australia. Unless these target groups are of specific interest to a prevalence study of childhood maltreatment, it would not be suitable to explore incorporating maltreatment measures within these surveys.

4.2.6 Surveys that detail children's and adults' experiences

Twelve of the 24 surveys and data collections identified as part of this scoping study collect information from children and adults about their own experiences (see Appendix I, Table 29). This includes cross-sectional and longitudinal surveys of representative samples of Australian children and adults, a non-representative longitudinal study and one administrative data collection.

Typically the studies of children's and adults' experiences included samples of participants aged over 15, and in some cases a proxy report was provided for those aged 15–17 where parents did not give consent for their children's participation. In other cases, children were not asked questions from modules relating to child sexual abuse or other reportable experiences.

Three studies (National Survey of Adult Mental Health and Wellbeing, Australian Study of Health and Relationships and the Crime Victimization Survey) and one administrative dataset (Recorded Crime – Victims, Australia) included information relating to child sexual abuse, unwanted or forced sexual experiences and/or adult victimisation. Some of these studies also included details of other forms of harm in childhood, such as physical abuse or assault (National Survey of Adult Mental Health and Wellbeing), as did other surveys (e.g. the National Drugs Strategy Household Survey includes verbal and physical abuse/fear; the Australian Health Survey includes family stressors such as witnessing violence and abuse; and Journeys Home asked about neglect and physical abuse in childhood). Only one study explored help-seeking for unwanted or forced sexual experiences in childhood – the Australian Study of Health and Relationships. These studies all provide useful information that could be collated across studies to provide a picture of adverse childhood experiences; however, no studies include standardised measures of all forms of child maltreatment, nor comprehensive detail of the duration, context, frequency or severity of the abuse.

A number of nationally representative studies (National Survey of Adult Mental Health and Wellbeing, the Australian Health Survey and the Australian Study of Health and Relationships) that involve children and adults as respondents about their own experiences have included items that relate to childhood adverse experiences/maltreatment and also include highly important data about potential health, mental health and social correlates. Some of these studies (National Survey of Adult Mental Health and Wellbeing and the Australian Study of Health and Relationships) have been infrequently administered, but the potential for including brief standardised measures of child maltreatment experiences in these studies should be explored further.

5 Recommendations

5.1 Recommended framework for the prevalence study

The Royal Commission requires a draft research framework for a study of prevalence of child maltreatment and its nature and context, involving child and adult participants, in which we identify the optimal design. The framework provided here is informed by the systematic literature review, other Australian literature, the Australian studies literature review, and the Delphi study, and by the research team's critical analysis of the literature. As stated above, the research team has used three essential criteria to guide the development of the optimal designs: rigour; feasibility; and alignment with the Royal Commission's study objectives. The framework comprises:

- the guiding questions for national prevalence studies with adults, young people and children
- an outline of the recommended research design(s), including justification for the preferred approach(es) after due consideration of alternatives
- the methodology for implementing the research, including:
 - recommendations for survey content (along with appropriate tools and references) in an appendix. In addition, this will have recommendations on including items relating to forms of abuse other than child sexual abuse
 - sampling and recruitment strategies to ensure population representativeness, plus inclusion of specific groups of young people who are particularly vulnerable to abuse
 - guidelines for ethical conduct of research with children around child maltreatment within which the surveys should be framed
 - guidelines for data analysis and preferred formats for presentation of findings to the general community, policymakers and scientific audiences, and recommended time line for completion of the surveys
- cost estimates for the two surveys
- the governance structure required to conduct the research (including an outline of necessary expertise of researchers)
- a detailed list of risks and proposed mitigation strategies to address the key risks.

5.1.1 Guiding questions/principles

The key guiding principle, and the first key element in this proposed framework, regards the recommended scope of these studies. Informed by the literature, and taking into account considerations of rigour, feasibility and alignment with the Royal Commission's study objectives, the optimal scope of the study is to cover the prevalence of all five types of child maltreatment, and their nature and context. This promotes Option 4 as set out by the Royal Commission in its Request for Offer document. Option 1 was the Royal Commission's minimum requirement, namely to explore the prevalence of child sexual abuse only, including institutional child sexual abuse, and the nature and context of

institutional child sexual abuse only. Importantly, Option 1 is included within our proposed framework but for reasons described above and for reasons of rigour and feasibility, Option 1 alone is not deemed preferable or viable. Full reasoning is set out at Section 3.2.

Related to this, the prevalence study will be most able to facilitate meaningful change to child abuse prevention policy and programs in Australia if it also assesses the probable consequences of maltreatment and identifies risk factors so that the social and economic burden can be quantified. Prior Australian research offers useful but limited insight into risks and consequences (Moore et al., 2015). Decisions about inclusion or exclusion of ancillary questions should be guided by international research and ultimately determined through competitive peer review of the guiding conceptual model. In this framework, we propose that the study should include: *Risk factors* (family socio-economic conditions in childhood, cultural and linguistic diversity, disability, family structure, and household drug and alcohol problems) and *Putative consequences* (health and social services utilisation, reports to and contact with child protection services, self-reported depression, anxiety and self-harm, common chronic diseases and subjective physical health status, (un)employment, poor educational attainment, and exposure to violence and stressful life events after the age of 16). Some of these elements are present in the provisional proposed JVQ instrument (see Appendix E), and others can readily be built into the survey instrument by incorporating items from similar Australian studies (e.g. Richters et al., 2014 p 388; de Visser et al., 2003) and other studies (Radford et al., 2013; Briere, 1996; Briere & Runtz, 1989). The results of this study will also complement and underpin the findings from other studies the Royal Commission has funded to examine the nature, impact and consequences of child sexual abuse in institutional contexts.

5.1.2 Outline of recommended research design

Instrument

The second key element in the proposal regards the preferred instrument for conducting these studies. The review has concluded that the JVQ is clearly the optimal instrument (Finkelhor et al., 2009, 2011, 2014, 2015; Radford et al., 2011). This tool has been used successfully in telephone surveys in comparable national populations, such as in the US and the UK, and has recently been adapted for research in China (Chan, 2013). Full reasoning is set out in Section 3.3. The JVQ will have to be adapted to the Australian context and may be supplemented with additional or substitute items from other instruments.

Administration

The third key element in the proposal regards the central question of the preferred method of administration of the study. We recommend that the only feasible and proven manner in which to administer the study is by CATI. Recent Australian studies using CATI obtain high participation rates from landline and mobile numbers, and are conducted in a timely manner. Our further analysis of Australian literature on the use of telephone interviews and CATI support our conclusion. This was shown at pp 10–13. For example, Richters et al. (2014) conducted an Australian study of health and relationships with a nationwide

representative population using the CATI method and obtained an overall participation rate of 66.2 per cent, which comprised participation rates of 63.9 per cent (landline, men); 67.9 per cent (landline, women) and 66.5 per cent (mobile phone user only respondents). Data was collected over 12 months from 20,094 participants using a 20-minute interview. Dunne et al. (2003) obtained data from 1,784 participants over one month using CATI, with a 61 per cent participation rate. De Visser et al. (2003) gathered data from 19,307 participants over 13 months using CATI, with a 73 per cent participation rate. In the US, Finkelhor et al. (2009) obtained participation of 4,549 participants over five months using CATI, with a participation rate of 71 per cent. Full reasoning is set out at Section 3.4.

Concurrent conduct of study with children and adults

The fourth key element regards whether the same prevalence study can involve child and adult participants, or whether it is essential to conduct separate studies. We recommend that the prevalence study should be conducted with a single national sample of people aged 16 to late adulthood. Having a single study (as opposed to two separate child/adolescent and adult studies) would be most the efficient and cost-effective in generating evidence both from individuals who are children (aged 16–17) and people who recently were children (aged 18–24). In addition, it would obtain perspectives on child maltreatment in previous decades and associations with long-term health, social and economic problems by surveying older adults (aged 25 and over).

One of the most critical decisions regarding the optimal framework for research into child maltreatment in Australia has been to set an age threshold for entry. We recommend a minimum age of 16 for several reasons:

- 1) Data on child sexual abuse experiences of young children is of poor quality and quantity. As mentioned earlier, researchers in the US and UK have conducted national household surveys in which parents/guardians were asked to report child sexual abuse and other maltreatment by caregivers and other, non-caregiver adults (Finkelhor et al., 2015; Radford et al., 2011). In both countries, there were negligible reports of child sexual abuse by caregivers and very little data on other sexual abuse of children aged under 11. Among children aged 11–15 inclusive who were interviewed at home, it is also notable that the reports of lifetime sexual abuse are considerably lower than the lifetime estimates for young people aged 16–17. These differences between the cohorts are greater than the reported incidence at ages 16–17, likely reflecting under-reporting of such events when younger adolescents are interviewed at home.
- 2) A high degree of difficulty and ethical challenges are associated with accessing and interviewing children aged 11–15. Research with children younger than 16 would require parental/guardian consent. Also, by limiting the survey to children aged 16–17, the proposed framework minimises the likely number of situations in which an interview reveals a child who is currently in need of protection. Interviewers have a duty to report such a situation to a child protection agency and to adopt other ethical measures to ensure a child participant is safe and has access to support and resources, but this strategic decision reduces the likely incidence of the need to take such action.

- 3) By age 16 in Australia there is a reasonable assumption that young people are able to make decisions about their own participation and to negotiate privacy during the interview.

Full reasoning is set out in Section 3.5.

5.1.3 Methodology

Recommendations for the survey content (also describing appropriate tools and references), including items relating to forms of abuse other than child sexual abuse

The review concluded that a modified version of the JVQ is the optimal instrument (Finkelhor et al., 2009, 2011, 2014, 2015; Radford et al., 2011) and suggests that the survey includes:

- extracted items relating to the five main forms of maltreatment, while excluding JVQ variables such as exposure to crime, civil violence and other social adversities
- follow-up questions on the nature and context of the maltreatment and disclosure (see our proposed provisional instrument in Appendix E)
- the instrument adopted by Radford et al. (2013, p 804) to elicit further information on health outcomes (the *Trauma Symptoms Checklist for Children* (Briere, 1996) and for adults, the *Trauma Symptoms Checklist* (Briere & Runtz, 1989)).

Preparation for a national survey would necessarily require refinement and field testing of the key questions about maltreatment to ensure their suitability in Australian contexts.

Sampling and recruitment strategies to ensure population representativeness, plus inclusion of specific groups of young people who are particularly vulnerable to abuse

The most feasible research design is a cross-sectional, computer-assisted interview-based survey of a random sample of the population aged 16 and over.

Sampling frame – The sampling frame should include people aged 16 and over who are accessible by mobile phones and/or living in households that are accessible by landline. Phone numbers will be selected through random digit dialling. As our literature review showed, this recruitment method has been proven recently to be effective in reaching a broadly representative sample of more than 20,000 Australians aged 16–69 years (The Australian Study of Health and Relationships, Richters et al., 2014). Richters et al. (2014) successfully used a dual frame of landline and mobile numbers, attracting a response rate of 66.2 per cent (comprising 6.5 per cent of mobile only users, 63.9 per cent of male landline users and 67.9 per cent of female landline users). In addition, the method can be piloted in the short time of approximately one month (Richters et al., 2014; de Visser et al., 2003).

The target sample size should be approximately 10,000 individuals. This sample size should be sufficient to include approximately 1,000 child participants aged 16–17 and approximately 1,500 people in each of the following age cohorts: 18–25, 26–35, 36–45, 46–55, 56–65, 66 and over (each age band should have approximately 1,500 participants). Meaningful age categories can be developed in different ways. The Australian Bureau of

Statistics recommends five-year or 10-year groupings for most surveys with cut-off years varying according to survey type and objectives (ABS, 2014).³¹ To meet the Royal Commission's objectives, in a study of children (aged 16–17), young people (aged 18–24 years), and adults (aged 25 and over), the design accommodates the desirability of estimating prevalence across decades: 16–17 year olds (born in the new millennium); 18–25 year olds (born in the 1990s); 26–35 year olds (1980s); 36 to 45 (1970s); 46–55 (1960s); 56–65 (1950s); and 66 and over.

Based on the experience of the ASHR study (Richters et al., 2014) and earlier Australian surveys of health and sexuality (Dunne et al., 2003; de Visser et al., 2003), we expect relatively equal numbers of males and females. The age structure of the respondents should be similar to the general population, although as usual in social survey research of this nature, the sample will include over-representation of somewhat younger, English-speaking, Australian-born, more highly educated people who do not have severe disabilities (particularly intellectual impairment). That said, random sampling in Australian surveys of personally sensitive issues do capture wide socio-economic and cultural diversity (Holden et al., 2005; Purdie et al., 2002; Richters et al., 2014; de Visser et al., 2003).

Sample size and power analysis – The estimated sample sizes would be the same for Option 1 and Option 4. Sample size estimation is driven by two main factors: the likely proportional size of the subgroups being compared, and the likely estimated prevalence and confidence intervals (based on prior research). In each of the options, we have the same parameters for child sexual abuse. Given the Royal Commission's expansive definition of 'institution' (to mean 'any public or private body, agency, association, club, institution or other entity that provides activities, facilities, programs or services through which adults have contact with children'), almost 100 per cent of people qualify, as almost everyone will have been to school and if they have not, they will have been involved with other institutions. In addition, the Royal Commission's expansive definition of CSA would result in high prevalence for both males and females. The estimates of any form of exposure to child sexual abuse could be taken from Dunne et al., 2003, which found 33.6 per cent of women and 15.9 per cent of men experienced at least non-penetrative child sexual abuse before age 16 (with 12.2 per cent and 4.1 per cent respectively experiencing penetrative child sexual abuse). In addition, Moore et al. (2015) found summative estimates of non-penetrative sexual abuse of 26.8 per cent for females and 10.4 per cent for males; estimates of penetrative child sexual abuse were 6.9 per cent and 5.2 per cent for females and males respectively (see Moore et al. Table 1). We do not have precise estimates for *any type* of exposure, including the many non-contact forms covered in the Royal Commission's expansive definition, but it is reasonable to estimate the lifetime prevalence of child sexual abuse before age 18 will be at least 30 per cent for females and 12 per cent for males.

³¹ Australian Bureau of Statistics (2014).

Total number of participants, and strata – Assuming random sampling, which is the preferred method, stable estimates for an adult sample could be obtained with a relatively small total number of participants. Age strata are important to the Royal Commission in this project to estimate changes in rates over time, and to enable repeated studies to track the impact of policy. Other Australian studies of health and victimisation have successfully used the age strata we have proposed. We have proposed seven age strata (16–17, 18–25, 26–35, 36–45, 46–55, 56–65, 66 and over) with the age band for 16–17 having roughly 1,000 participants, and each adult age band having approximately 1,500 participants. This gives a total sample size of approximately 10,000. The size of the age strata should reflect the relative proportions of age groups in the general population, as closely as possible to ensure that the study represents the general population as far as possible.

Health outcomes – It makes little difference to sample size estimation if the study includes measures of health status. It should be taken as given that a study such as this should include measures of social, psychological and physical wellbeing. However, this will not influence the sample size estimation, as the primary purpose of the study is to estimate the prevalence of abuse. Accordingly, sample size estimates are similar for Option 1 and Option 4, whether or not health status is assessed.

Estimation of optimal sample size and statistical power should be guided by specific hypotheses about various types of abuse and/or theoretically important subgroup analyses. Two bottom-line indicators of statistical power for this proposed study are:

- 1) **Total sample size:** Based on the Australian meta-analyses of Moore et al. (2015), the prevalence of penetrative sexual abuse is 6.4 per cent. For a prevalence survey, this percentage could be estimated with +/- 1 per cent precision with a total sample of 2,302 adults. The minimum sample for estimation of non-penetrative sexual abuse (from Moore et al., it is 21.8 per cent) with the required total sample size of +/- 1 per cent precision with 95 per cent confidence intervals is 6,549 adults, which is well within the projected target of 10,000.
- 2) **Subgroup analyses:** The study should be able to detect differences between key subgroups within each age strata. We suggest the number of participants per adult stratum should be at least 1,500, with approximately 750 males and 750 females. With these subgroup sizes, the study would be able to detect a small gender difference in prevalence of penetrative sexual abuse of 2.6 percentage points, with power >80 per cent. Therefore, the total minimum sample size of 10,000 individuals is necessary to have adequate power to detect fairly small though significant differences in prevalence within the various age strata. The suggested sample supplements this with an increased sample for young people (n = 1,000 in the 16–17 age band, and n = 1,500 in the 18–25 age band), reflecting the importance of this age cohort for setting the baseline for further prevalence studies.

Pilot – Pilot studies can be conducted with sufficient samples over a relatively short period; for example, Holden et al. (2005) conducted a one-month pilot with 433 respondents before implementing the main study in which CATI was used to capture data

over three and a half months from 5,990 participants using a 20-minute interview with a 78 per cent participation rate.

Overall, data collection will take roughly five to six months, but this timing could be shortened if adequate funds were available to support the study and to hire a reasonably large staff to collect data. Our proposed number of participants is approximately 10,000 (see above), which is half the size of de Visser et al. (2003) and Richters et al. (2014), and five times the size of the Dunne et al. (2003) sample. CATI requires sufficient personnel and staff training and supervision, and these elements can be built into the design, in particular being informed by the experience of Finkelhor et al. (2005, 2009, 2014, 2015; Abt SRBI, 2008) and McGee et al. (2011).

This approach is achievable, and because the study participants are aged 16 and older, the time frame for obtaining institutional ethics approval would be the same as that required for a study involving adults only, as the issues to be addressed are similar. In each case, the ethics application would be carefully crafted to accommodate the need to conduct the study in a manner that meets all ethical requirements.

Subpopulations

We have concluded that the optimal approach for obtaining the involvement of the subpopulations is:

- to conduct a connected study with a convenience sample of Aboriginal and Torres Strait Islander peoples
- to use the results of the general population survey as a natural indicator of the experiences of individuals with disability (given the sufficient representation of this subpopulation within the population sample the study would recruit)
- to use the results of the general population survey as a natural indicator of the experiences of individuals from culturally and linguistically diverse groups as a whole (given the sufficient representation of this subpopulation within the population sample the study would recruit) and if there are further subsets of this culturally and linguistically diverse subpopulation that are of interest to the Royal Commission, to conduct a connected study with a convenience sample to capture their experience
- similarly any study exploring the experience of other subpopulations, such as those who have lived in residential institutions and/or out of home care and those currently in mental health facilities would need to be conducted in connected studies with convenience samples because they would not be represented in the general population survey.

Full reasoning is set out in Section 3.6.

5.1.4 Guidelines for ethical conduct of research with children regarding maltreatment

The suggested optimal model for the study would adhere to ethical guidelines for research, as established by the National Health and Medical Research Council. As stated in the NH&MRC *National Statement on Ethical Conduct in Human Research* (NH&MRC 2014), research involving children and young people raises particular ethical concerns about:

- their capacity to understand what the research entails, and therefore whether their consent to participate is sufficient for their participation
- their possible coercion by parents, peers, researchers or others to participate in research
- the conflicting values and interests of parents and children (NH&MRC 2014, p 50).

The appointment of trained researchers and fieldworkers will be critical for maintaining the ethical standards for conducting research of this nature.

Understanding the research, providing consent and ensuring confidentiality

The literature reviews and consultation with stakeholders indicated that 16 year olds are able to provide informed consent to a CATI study without parental consent.

It should be important that participants are not identifiable in any report of the study. Thus the study should not report cell sizes of less than 20 for any specific finding.

Avoiding coercion

Participants should be compensated for their time in taking part in this research. This may be in the form of an iTunes voucher or Coles/Myer voucher (excluding the purchase of alcohol or tobacco).

Interviewers should be appropriately trained and monitored to avoid coercion. Participants should be contacted directly by phone to avoid coercion by third parties.

Distressed participants

It is likely that the survey will cause distress for some participants. Participants who become distressed will be referred to a counselling service that will have a number of trained counsellors available to meet the needs of those participants. This has been included in the costings for the project.

Reports of children at risk

It is possible that participants will report children currently at risk of abuse, for example younger siblings who may still be at risk or children still in an institution where an offender is still working. In such cases, the fieldworker will discuss with the participant their obligation to report abuse. Clear protocols will be developed to ensure that fieldworkers have access to supervisors who can help them with these decisions. This is a risk in any research with young people.

5.1.5 Guidelines for data analysis and format of reporting

One of the key criteria for awarding a contract for the national survey will be the research team's proven capacity for expert data management and analysis and an excellent track record in completing and publishing research. It is unnecessary in this document to specify the statistical models and methods, as they will be assessed through peer review. Findings should be disseminated to the public, to government and community stakeholders, and in scientific papers and at leading conferences for the academic community in Australia and internationally. See also, Section 5.7.

Other implications and considerations for implementing a prevalence study, including costs, governance, timing, risks and mitigation, reporting and limitations, are presented in in this section.

5.2 Governance structure

5.2.1 Governance options

Four possible forms of *governance* are considered for implementing a prevalence study:

- Governance A: an agency conducts the prevalence study wholly in-house
- Governance B: an agency project manages the study in-house (contracting out key elements)
- Governance C: an agency contracts out all elements of the study to an external agency or consortium
- Governance D: an agency funds additional modules in existing surveys.

Table 6 presents the four forms of governance in detail, describing their advantages, disadvantages and risks (and the mitigation strategies that may be needed to minimise these). A broad range of issues have been considered, including cost, workforce specialisation and skills, timing, procurement processes, administrative burden, quality assurance, decision-making processes, flexibility and responsiveness.

Table 6 Forms of governance investigated

| Form of governance | Advantages | Disadvantages | Risk mitigation |
|---|--|---|---|
| <p>A: Conduct the study wholly in-house.</p> <p>This includes:</p> <ul style="list-style-type: none"> ▪ undertaking consultation (expert advice on content; broader stakeholder input) ▪ undertaking content development, refinement and finalisation ▪ seeking ethics approval ▪ seeking instrument approval for instrument use (copyright) ▪ developing fieldwork specifications/protocols ▪ undertaking cognitive pre-testing ▪ undertaking pilot study and refining measures and procedures (with additional submission to Human Research Ethics Committee for approval) ▪ carrying out fieldwork ▪ carrying out data preparation (cleaning; creating variable categories; treating missing data; data dictionary) ▪ releasing data (if the data is to be made available for broader use outside the commissioning agency) ▪ carrying out data analysis ▪ gathering participant feedback ▪ reporting on findings. | <ul style="list-style-type: none"> ▪ Flexibility and control <p>Decision-making around content can be kept close to the end-users. Quality assurance processes could be centralised – consistent methodology could be used to assure high standards across all elements and activities</p> | <ul style="list-style-type: none"> ▪ Insufficient capacity <p>Due to the scale and time frame for conducting the study, a fieldwork agency would need to be used</p> <ul style="list-style-type: none"> ▪ Insufficient skill <p>No previous experience running and managing large-scale population studies</p> <ul style="list-style-type: none"> ▪ Inadequate infrastructure <p>Would need to have infrastructure in place to deal with all elements of the project – including HREC approval, as well as housing and releasing data to potential users, given the study’s national significance</p> <ul style="list-style-type: none"> ▪ High cost <p>Acquiring new staff/skills will be expensive if it is not already available</p> <ul style="list-style-type: none"> ▪ Lack of independence <p>The results may have less credibility as the study is not being conducted independently</p> <ul style="list-style-type: none"> ▪ May impact on main role of the commissioning agency <p>The internal operational project management tasks required for this study may take time and effort away from the focus on content alignment and quality assurance functions</p> <ul style="list-style-type: none"> ▪ Inefficient <p>Specialist skills required to deliver this form of governance will be underutilised; this will significantly drive up the overall cost</p> | <ul style="list-style-type: none"> ▪ Recruit a dedicated project manager <p>The project manager would need the necessary skills (though these are difficult roles to fill, particularly with experienced staff)</p> <ul style="list-style-type: none"> ▪ Establish an advisory process <p>The process would focus on the operational aspects, to complement the content-related advice that is also needed. This would add cost</p> <ul style="list-style-type: none"> ▪ Comprehensive risk management <p>This would ensure the study was completed within the time frame of the commissioning agency</p> |

| Form of governance | Advantages | Disadvantages | Risk mitigation |
|---|--|---|---|
| <p>B: Project manage the study in-house and contract out key elements</p> <p>This includes:</p> <ul style="list-style-type: none"> ▪ overseeing overall project management ▪ contracting out content design, fieldwork, analysis, and reporting. | <ul style="list-style-type: none"> ▪ Flexibility and (potentially) control The commissioning agency would not only have direct visibility of the status of all elements of the study, but would also be responsible for keeping all (subcontracted) activities on time, in order to meet overall project time lines ▪ Relies on external expertise The same level of skill specialisation is not required as for Governance A, but it would require a highly skilled project management team with expertise in conducting large-scale surveys of at-risk populations | <ul style="list-style-type: none"> ▪ Potential delays from attracting and appointing contractors Each element is significant and requires adequate resources to attract and appoint an appropriate contractor, particularly when appointing multiple contractors ▪ Difficulty managing contingent tasks between contractors Contingencies for tasks being subcontracted may come at a cost, particularly where there are dependencies between tasks (e.g. if subcontractors build in penalty clauses for delays in receiving project material that they rely on to complete tasks) ▪ High transaction costs The cost of managing each subcontractor and <i>between</i> subcontractors can be high ▪ Relies on external expertise to resolve problems Expertise may not be available to respond in a timely way to issues that arise ▪ Project manager must manage HREC approval process Many HRECs do not review projects from external bodies that don't have their own staff acting as investigators – and if they do, it usually comes at a cost | <ul style="list-style-type: none"> ▪ High specificity of terms of reference The terms of reference for each element subcontracted out will have high specificity ▪ Extensive controls Strong controls will be need for contracts, project management, risk management and communications to manage risk for each subcontractor (both between the project manager and subcontractors, and <i>between</i> subcontractors) ▪ Project advisory group A group will need to be established and resourced to provide expertise as required |

| Form of governance | Advantages | Disadvantages | Risk mitigation |
|--|---|--|--|
| <p>C: Contract out all elements to an external consortium</p> <p>This includes using existing internal procurement processes to:</p> <ul style="list-style-type: none"> ▪ develop a set of specifications based on the current Scoping Study ▪ go to the market for competitive offers. | <ul style="list-style-type: none"> ▪ Economical A competitive process will ensure that the best expertise, at the best value, can be used to deliver the survey ▪ Access to external expertise This would allow the commissioning agency to leverage expertise from providers, including expertise in sampling, design, project management, data management and delivery ▪ Efficient Providers in the sector are likely to be already running large-scale surveys or panel studies, and have the full range of relevant skills in-house, which would significantly reduce their costs, and provide the commissioning agency with the necessary skill set only when needed for each element of the project ▪ Independent The data will have increased credibility if it's collected independently ▪ Coherent It could provide an end-to-end service, meaning that data is likely to be analysed and released earlier if managed by an entity with both content, design, management, analysis and reporting skills ▪ Transfers risk The risk is transferred to the contracted party | <ul style="list-style-type: none"> ▪ Not as much control as A and B. May not meet the Commission's objectives. ▪ Relies on extensive experience of contractor. ▪ Relies on contractor to work collaboratively with the commissioning agency. Significant risk if relationships break down | <ul style="list-style-type: none"> ▪ High specificity of the terms of reference The terms of reference, reporting, communication, and quality assurance will align with the objectives established by the Royal Commission ▪ Specifications informed by the current Scoping Study The study would be robust, cost effective and ethically sound should it follow these specifications. ▪ Criteria for procurement These include past experience in delivering similar studies on time and as per agreed specifications ▪ Collaborative approach Could procure a service provider that collaborates during the initial stages of planning to ensure the study meets the needs of the commissioning agency |

| Form of governance | Advantages | Disadvantages | Risk mitigation |
|--|---|---|--|
| <p>D: Fund additional modules in existing surveys or panel studies</p> <p>This could include single items, scales or whole modules; for example:</p> <ul style="list-style-type: none"> ▪ LSAC wave 8 (K-cohort), which will be turning 18 or 19 during data collection in 2018 ▪ HILDA ▪ Personal Safety Survey ▪ LSAY ▪ Australian Survey of Mental Health of Children and Adolescents (if repeated) ▪ Any proposed future national surveys of adolescents and/or young adults. | <ul style="list-style-type: none"> ▪ Economical It would be significantly cheaper than a standalone survey ▪ Potential longevity This form has the same potential advantages as either A or B, but allows for the longevity of the project, beyond an initial single-wave study ▪ Potential for previous datasets to identify risk factors Longitudinal information from previous waves can be used to prospectively identify risk factors for CSA/institutional abuse. | <ul style="list-style-type: none"> ▪ Difficult to add sensitive questions to existing surveys Existing surveys are built with a different purpose in mind – so explicit questions may surprise participants. Survey ‘owners’ may be hesitant to include controversial material, particularly if it may affect participation ▪ Requires additional management and responses Examples include the need to respond to ethical issues relating to mandatory reporting ▪ Prevalence It would be harder for the Royal Commission to establish prevalence using later waves of existing longitudinal studies due to attrition that has already occurred across waves ▪ Due to cost and attrition, only small number of items may be added The pressure on existing surveys, in terms of the administration costs (particularly for face-to-face methods) and respondent burden risking drop-out or refusal, means that it is likely that only a very constrained set of items could be included ▪ Very unlikely to be completed in the Royal Commission’s time frame None of the surveys examined will be going into the field soon enough to include relevant questions | <ul style="list-style-type: none"> ▪ Draw on existing research This would draw on research where sensitive material about child maltreatment has been inserted into existing longitudinal studies, such as the Australian Temperament Project, where at wave 14 (when participants were aged 22–23) they reported retrospectively on child abuse and neglect. Based on this, Doidge et al. (2015) concluded that: ‘Close attention must be paid to missing data and non-response in research on adverse childhood experiences as data is unlikely to be missing at random’ (p 2) |

Weighing up the relative advantages and disadvantages, as well as the risks (and the cost or burden of mitigation strategies), our view is that *Governance C provides the most cost-effective strategy to achieve the highest quality outcome*. Governance D is not an alternative, but could be implemented in tandem with C, given that it is likely to achieve savings compared to A and B.

Regardless of which commissioning agency has carriage of the study, there should be an agreed process with other key agencies (e.g. the Attorney General's Department, Department of Social Services and Department of Education) so that the study can align with the policy needs of these other Commonwealth departments, as well as comparable agencies in each of the states and territories (e.g. child protection, education, etc). It will be important to coordinate the conduct of the study and share the findings from ongoing analysis of the data to meet future needs for monitoring trends in maltreatment prevalence, as well as using the methodology and/or the data for comparison purposes when evaluating smaller-scale interventions designed to reduce child maltreatment in particular locations and contexts.

Given the importance of the study nationally, the highest level of scientific and project management capacity is required. Moreover, having an experienced survey provider will limit delays (and costs) that using inexperienced staff could create.

In relation to *Governance B*, the research expertise, capacity and judgment needed to progress such a study is very difficult to obtain through conventional recruitment processes. Some of the difficulties are not easy to foresee. Our experience of such structures has been that they can create significant delays and challenges and very high transaction costs in managing multiple contracts and ensuring that the various work schedules are compatible. There is a high risk of difficulties in communication between the Royal Commission and the various contractors, and even higher risk of communication challenges between the contractors themselves, as they would not have the same overall objective.

5.2.2 Oversight

Role and membership of an advisory group

The best structure for ensuring appropriate and objective expert advice for a survey is to include key decision-makers and relevant experts in one oversight body. While some surveys opt for a separate organisational 'authorisation' or approval body, and another body for technical input, our view is that the issues that tend to be discussed have a lot of overlap, and many of the same people could usefully contribute to both. So a more efficient process is to have a single, overall governance structure, such as that of AIFS during its longitudinal study of humanitarian migrants – *Building a New Life In Australia*.³² The single group structure also deals with potential difficulties in information flows between the two groups, the Royal Commission and the research consortium (this has occurred in other recent projects undertaken by the consortium).

³² See www3.aifs.gov.au/bnla/

A clear purpose for the oversight body should be set out in a *Terms of Reference* document. It should include a range of experts and advisors, including:

- end policy users (within the auspicing departmental/funding agency, as well as other relevant departments)
- survey management experts
- survey design experts
- an expert in epidemiology
- an expert in psychometrics
- content area experts (both research, and professional practice – e.g. child sexual abuse counsellors)

It is important to identify which issues will need to come to the oversight body for a *decision*, as opposed to coming before the body for information only, discussion or feedback, and advice – but with decisions being made either by the organisation running the survey or by the funding body. For example, final decisions that must be made on topics such as survey content, length (that is, timing) and sampling issues have financial and/or contractual implications that need to be considered.

Link to other surveys

It is important for the oversight body to include appropriate representation from other key Australian surveys to ensure that important lessons about implementation are learned, but to also benefit from potential synergies in content, methods, etc. This should include not only other longitudinal surveys, but also key Australian survey collections relevant to child safety (particularly the ABS Personal Safety Survey).

The governance oversight would need to facilitate and expedite the study, in relation to other studies, and it would need to be established and resourced in such a way that it minimises delays.

5.2.3 Stakeholder engagement

It will be important to engage with key stakeholder groups that may have differing expectations of this study so that they are fully aware of the implications of the study. These include survivor groups, victim advocacy groups and the wider community. Aboriginal and Torres Strait Islander representatives must be fully consulted before any specific study focuses on this subpopulation.

Some large-scale studies have stakeholder engagement processes that are separate to the formal governance structures. This is because it might be important to consult with key groups, including advocacy groups representing the interests of affected individuals, such as care leavers, abuse survivors or Aboriginal and Torres Strait Islander peoples.

Such stakeholders could be included within the abovementioned oversight body; however, this is not the recommended option for reasons including:

- many technical or funding-related issues are discussed, which might exclude or frustrate such stakeholders
- the formal, technical nature of the discussion may be inappropriate, or even traumatising for individuals who do not understand the complexity of survey design and management, and the complexity of the processes that underpin actions and decisions taken.

Stakeholders should genuinely feel heard. The study design should include processes for recruiting respondents and disseminating the findings. These steps could be achieved by conducting focus groups with key representatives from subpopulation study stakeholders – or by more formally convening one or multiple stakeholder advisory groups. Again, clear documentation of the *Terms of Reference* is needed so that stakeholders understand their role in relation to the oversight body.

5.2.4 Conducting the research

The survey contract should be awarded through competitive application and rigorous scientific peer review. It is anticipated that the best outcomes for research of this scale and complexity will entail collaboration between academic institutions and public research survey organisations or private companies. It is most cost-effective and time-efficient for data collection to be done using the infrastructure and staff of a survey company (e.g. as was done in the Australian Study of Health and Relationships (Richters et al., 2014) and the Men In Australia Telephone Survey (Holden et al., 2005)). With this approach, universities provide content knowledge and multidisciplinary expertise for research planning, human research ethics, oversight of data collection and quality control, data analysis and reporting, and overall financial auditing.

Random sampling of telephone numbers, recruitment of participants, screening, interviewing, data entry and collation, and financial auditing are provided by the fieldwork agency. Research staff training is jointly managed by the research/academic institution and the survey agency conducting the fieldwork.

A number of similar surveys and longitudinal studies have adopted this model. Some surveys, such as LSAC, are managed as a consortium, whereby the overall project is managed by the funding body (Department of Social Services), with design and data preparation managed by a research institute (AIFS), with content expertise contributed by in-house experts supported by a consortium advisory group of academics from across the country.

In terms of capability and capacity, the appointed consultants should consist of an individual organisation or consortium with skills and expertise including:

- significant knowledge of child maltreatment and measurement of prevalence
- a track record of conducting studies with vulnerable populations on sensitive issues
- strong and proven project management skills
- quantitative analysis skills
- experience of data linkage
- capacity to deliver the project on time.

5.3 Costs

A provisional estimate of costs indicates that this framework is feasible, although detailed costings require further discussion. It is highly advantageous to conduct the study based on an existing instrument (JVQ), a proven and cost-effective method of administration (CATI), and in one combined study. The Richter et al. (2014) study is reported to have had between \$2 million and \$3 million in funding. It is thought that Dunne et al. (2003) (1,784 participants) and de Visser et al. (2003) (19,307 participants) each received about \$100 per participant, although these studies only covered child sexual abuse and these estimations would need to be confirmed. Finkelhor et al. (2009) is the only published study to report its funding quantum (USD 2.7 million).

Conducting the study in a timely way would require substantial and sufficient initial investment. This would enable the appointment of research staff; the appointment and training of data collection personnel; the purchase and modification of the study software program; and the completion of a pilot study.

5.4 Data linkage

A number of responses to the Delphi survey indicated that the study would be strengthened considerably if the participants gave permission for their responses to be linked to administrative data. Increasingly, longitudinal and cross-sectional studies are using data linkage to enhance survey findings. These data could be historic, contemporary or prospective.

Historic data could include contact with the child protection system, educational attainment, involvement in the youth justice system, etc. Current data could include records of welfare payments received and/or access to the Medicare Benefits Scheme. Prospective data linkage will allow researchers to follow up participants and, for example, track whether they receive welfare payments following their participation in the study.

Data linkage can be done with the consent of the participants who will give consent for specific datasets to be linked to their responses. For example, in the prevalence study this could include a request to identify whether they have been involved with the child protection system or whether they have ever received psychiatric treatment or medication.

5.4.1 Risks of data linkage

Data linkage generally takes several months or even years. It would not be possible to return to participants to seek permission to link their data, so this request would have to be done as part of the survey itself.

Datasets are held by a range of Commonwealth and state government departments, and each data custodian will have to be approached to identify the mechanism for releasing the particular dataset for which they are responsible. This is likely to be a fairly resource intensive process, especially in a national study that may involve several departments in each state and territory. Nevertheless, the potential scientific benefits of linking administrative data with survey responses could be very significant. It may also be possible to link administrative data with survey results without consent of the participants through probabilistic matching. However ethical considerations will be far more challenging and this approach may ultimately not be possible or appropriate.

It must be noted that data linkage was not part of the original brief of this review and the systematic review did not identify other prevalence studies that have used data linkage. Data linkage is, however, being used in the National Survey of Child and Adolescent Mental Health and Wellbeing, as well as all the longitudinal studies cited in this report as well as a number of the ABS surveys. Further work will therefore need to be undertaken to examine the feasibility, cost and ethical implications of data linkage to the prevalence study.

5.5 Timing

The estimated time line for conducting the study is presented in Table 7.

Table 7 Estimated time line for Option 4

| | | Low estimate | Medium estimate | High estimate | Dependency /notes |
|----|--|--------------|-----------------|---------------|-------------------|
| 1 | Tender, review tender, contract and start up | 3 months | | | |
| 2 | Design phase (instrument design and programming, recruitment methods) and consultation | 1 month | 2 months | 3 months | [1] |
| 3 | Approval and sign-off | 1 month | 6 months | 12 months | [1], [2] |
| 4 | Ethics | 3 months | 4 months | 12 months | [1], [3] |
| 5 | Piloting/testing (train, program, recruit, test, debrief, retest if necessary) | 3 months | 4 months | 12 months | |
| 6 | Training of interviewers | 1 month | 2 months | 6 months | [1] |
| 7 | Finalise instrument, approval and sign-off | 1 month | 2 months | 4 months | [2] |
| 8 | Ethics | 2 weeks | 4 weeks | 6 weeks | [3] |
| 9 | Fieldwork | 2 months | 4 months | 6 months | [4] |
| 10 | Data cleaning | 3 months | 4 months | 6 months | |
| 11 | Data analysis | 6 weeks | 3 months | 4 months | [5] |
| 12 | Draft report | 1 month | 3 months | 5 months | [6] |
| 13 | Final report | 2 weeks | 4 weeks | 6 weeks | [2] |

[1] Depends on subpopulations, whether it includes specific sub-populations such as Aboriginal or CALD groups, people with disability or people with cognitive impairment.

[2] Depends on governance structure, funding and sign-off process.

[3] Depends on the number of ethics committees involved.

[4] Depends on mode, sample response and number of trained interviewers available (cost of training each one).

[5] Depends on detail of analysis – high-level figures can be provided quickly. Depends on amount of qualitative data provided.

[6] Depends on whether this includes peer/external review.

5.6 Risks and mitigation

This research has identified a number of strategic risks concerning timing, quality and cost of the study. The risks and mitigation measures are described below. If the Royal,

Additional risks and mitigation strategies may be identified depending on the specific approach the commissioning agency takes. The likelihood and impact of the risks are not described as they depend on the chosen design of the study, and the resources and governance structure used.

5.6.1 Timing of the study

Risk: Not spending enough time developing and piloting research instruments leads to problems in implementation and analysis

Spending additional time developing, piloting and refining methodologies overcomes the risk of problems arising during implementation and analysis. While the time lines for the study are relatively short (as described above), additional time could be spent now (while deciding whether and how to proceed, and if the study goes ahead, during the commissioning process) developing and piloting survey instruments.

Stakeholders consulted emphasised that careful planning in the early stages is essential.

Risk: Inadequate or unclear governance structures cause delays or other challenges

A number of stakeholders consulted indicated that when multiple stakeholders are involved in a study decision-making can become difficult and inefficient. In a study such as this, with short time lines, unclear accountability could present a significant risk.

It is important that the research questions and decision-making are clear. Although multiple stakeholders and experts will need to be consulted, the final decisions should rest with the commissioning agency, in collaboration with the chief investigator of the study. There should be clear protocols for decision-making and accountability, including for the timing of each component of the study. The project will need a clear project plan with specific milestones and deliverables, and clear accountability for the deliverables. A risk register for both the governance process and the conduct of the study should also be developed and used as an ongoing 'working document'.

Risk: Delays in obtaining ethics approval

Asking people about their experiences of maltreatment (including sexual abuse) as a child is possibly one of the most difficult ethical challenges in social research.

The ethics of conducting this study are challenging but relatively straightforward. The guidelines for conducting ethical research with vulnerable groups are clear and straightforward; researchers have experience with researching one or more components of this subject, and there have been small studies conducted in Australia that have received ethics approval.

However, depending on the number of ethics committees that would need to approve the study, significant delays could occur.

The potential delay in obtaining ethics approval can be overcome by careful design using proven methods, detailed recruitment and sampling strategies, and the provision of informed consent. This study can be based on similar population studies of sensitive topics such as sexual health, mental health and domestic violence. Early consultation with the ethics committees is advantageous and we strongly recommend that the Royal Commission funds a pilot study as soon as possible to ensure that the sampling, recruitment, consent and duty of care concerns that HRECs is likely to raise are addressed early. This applies particularly to the aged 16–17 cohort.

Delays in ethical approval are likely if the study is deemed to require ethics approval by one or more Aboriginal and Torres Strait Islander ethics committees and/or ethics committees from particular disciplines, such as health or education departments. The recommended study design is highly unlikely to require approval from health, education or justice ethics committees, but it is possible that it will require approval from an Aboriginal and Torres Strait Islander ethics committee, even though we are recommending a separate study of Aboriginal and Torres Strait Islander victims. Piloting will identify any issues and will expedite approval.

5.6.2 Quality of the study

Risk: Survey instruments are inadequate

Although the JVQ is an instrument that has been validated in a number of different contexts, it will have to be adapted to the Australian context and specifically for this study. Thus piloting the survey will be crucial for a robust prevalence study.

Risk: Study does not provide an accurate estimate of the prevalence of institutional child sexual abuse and how this has changed over time

The recommended population study will be one of the largest prevalence studies of child maltreatment ever conducted. Nevertheless, as a population study it would provide limited capacity to facilitate detailed analysis of relatively small subgroups within the population, including victims of institutional child sexual abuse. Findings from the prevalence study will provide an assessment of this prevalence over time, but will not be able to differentiate the experiences of different groups that suffered abuse in institutions such as children in out-of-home care, children in the juvenile justice system, or children with disability living in supported accommodation. Supplementary studies will be able to provide more detail on these populations, together with administrative data.

Risk: The Royal Commission does not recognise the limitations of the study

This risk will be overcome through clear communication of what this study will and will not provide.

Some of the key limitations may be overcome by mapping how this study will complement other sources of data commissioned by the Royal Commission or other agencies (other surveys as well as administrative data).

Risk: Not getting a representative sample

The proposed method has been identified as the most appropriate way to maximising participant recruitment. This approach has been tried with similar studies and typically has a success rate of around 60 per cent or more. No other strategy is as cost-effective as CATI. However, we recommend that a pilot trial of both CATI and face-to-face interviews using the same research instrument be conducted to satisfy the Royal Commission that CATI is indeed the most cost-effective recruitment strategy and mode of delivery.

Risk: Incomplete survey responses

There is a risk that participants drop out of the survey because the survey is too long and/or too stressful to complete. It is inevitable that some difficult decisions will have to be made about what to include and exclude from the survey, and the survey instrument will have to be very carefully designed so that most participants do not have to spend more than an hour responding (unless they have suffered multiple forms of abuse). The JVQ is a well validated instrument that has been used in multiple contexts and with different modes of questioning. The proposed framework also includes options such as splitting the interview into two sessions and allowing participants to respond online if they so wish. These techniques have been used in other studies to reduce respondent burden and will be piloted to see how they affect retention of participants.

With regard to causing stress to participants, there will be safeguards built into the process to ensure that participants are not unduly distressed by their participation and that they are supported if they do become distressed. These include thorough training of interviewers, provision of trained counsellors for those who become distressed, and testing of the instrument so that it is delivered in a way that minimises distress.

5.6.3 Cost of the study

Risk: Cost overrun

A study such as this is very difficult to cost accurately because of its complexity and the potential for unanticipated challenges to occur.

The final costs, which will be provided once the methodology has been refined, will build in contingency funding for the most likely risks, as described above, and will be based on actual costs for similar studies. This will allow some leeway for the project to deal with contingencies such as lower than expected responses or delays from ethics procedures. It should be emphasised that piloting the method will minimise these unexpected contingencies and will also provide a very accurate basis on which to cost the full study.

Risk: Subpopulation studies too expensive

The subpopulation studies may be relatively expensive compared to the main study as the method may have to be adapted (e.g. face-to-face interviews may have to be used for some groups), and ethics approval is likely to take longer and be more complex.

However, the risk of not conducting these studies would be significant as these are populations of particular interest to the Royal Commission and for child protection policy more generally. One way of addressing this would be to use additional questions on existing surveys of these populations. This would reduce costs and provide potentially more robust findings. However, this depends on relevant surveys being available and the willingness to include questions on child abuse. In addition, this approach would encounter the same challenges as described in Section 4.1.2 for the main study.

5.7 Reporting

Different reports will be required from this survey, including:

- summary report to be made available to participants
- summary report for the general population
- summary report for policymakers
- detailed report for policymakers
- academic publications to contribute to the global knowledge on prevalence.

All reports will comply with ethical reporting practices to maintain the confidentiality of participants. All reports must comply with the Web Content Accessibility Guidelines version 2.0 to ensure that the content is fully accessible.

5.8 Limitations

Although the model presented for the main study is optimal in terms of cost, rigour, efficiency and meeting the objectives of the Royal Commission, it has some limitations. The most important of these is that there would be no capacity to undertake analysis of subpopulations such as Aboriginal or Torres Strait Islander peoples and people who have been in residential institutions. In particular, although it would provide a figure for the proportion of children who have been abused in an institutional context, it would not be able to examine any subpopulations of this group (e.g. people in different sorts of institutions, from different demographic backgrounds or those who suffered different forms of abuse).

Like any study this survey will not provide all the information that may be of interest to the Royal Commission. CATI surveys should optimally be relatively short and it is important not to overburden participants. Thus the amount of contextual information the survey will be able to generate will be somewhat limited.

All retrospective studies are limited by recall bias (that is, the tendency for participants to interpret past events in the light of subsequent life events), no matter how well designed. The JVQ is well validated but will not eliminate this issue. Nevertheless, the findings from this study will be comparable to those of similar studies internationally.

6 Conclusion

This report has described the optimal design for a prevalence study of child maltreatment in Australia; the reasons this design is better than the alternatives are set out in Section 5.

6.1 Specific findings

Overall recommendations for optimal design – The review recommends that the optimal and most viable option has the following key features:

- 1) **Scope:** The study should explore all five forms of maltreatment and their nature and context, and, if feasible, should also explore their health outcomes and risk factors. Thus Option 4 is the preferred approach (see Section 3.2).
- 2) **Instrument:** The Juvenile Victimization Questionnaire should be the basis for this study, supplemented by demographic data, questions about current wellbeing and other scales relevant to the research objectives. The instrument should be carefully piloted before being used for the full study (see Section 3.3).
- 3) **Method of administration:** The study should be conducted by computer assisted telephone interview (CATI) using landlines and mobile phones (see Section 3.4).
- 4) **Administration of child and adult studies:** A single study of 10,000 randomly selected Australians should be conducted, using similar methods across the age ranges. The study should involve around 1,000 participants aged 16–17, and adult participants with around 1,500 people in each of these age cohorts: 18–25, 26–35, 36–45, 46–55, 56–65, 66 and over (see Section 3.5).
- 5) **Surveying three subpopulations:** The three subpopulations of particular interest to the Royal Commission have different characteristics; people with disability and culturally and linguistically diverse populations may be accommodated within the general population survey, but Aboriginal and Torres Strait Islander peoples should be surveyed in a connected study with a convenience sample; other subpopulations would need to be treated in the same way (see Section 3.6).
- 6) **Link survey findings with administrative data:** Further consideration should be given to exploring the option of asking participants for permission to link survey findings with administrative data.

The review identifies a number of study limitations, including a need for supplementary studies focused on particular subpopulations that are of interest to the Royal Commission. The main study will act as a benchmark for these supplementary studies.

Further studies could be either self-standing or attached to existing surveys. For example, an Aboriginal subpopulation study could be an extension of the National Aboriginal and Torres Strait Islander Social Survey (NATSISS). However, the limitations of adding questions to existing surveys and the ethical requirements of undertaking research with

Aboriginal and Torres Strait Islander populations (set out in Section 3.6) must be taken into account.

There appear to be no serious ethical impediments to conducting the recommended design for the main study. However, a number of clear procedures have been suggested to ensure the study is conducted to the highest possible ethical standards.

The systematic review of the literature and consultation with key stakeholders both indicated a need for a prevalence study of child maltreatment in Australia. A rigorous study of the prevalence of maltreatment which could be repeated at regular intervals will be an invaluable addition to the evidence base for policy and practice development for many decades.

References

- Abt SRBI Inc 2008, *National Survey on Children's Exposure to Violence: A Survey of Parents and Children Age 0–17, Methods Report*, New York, NY: Abt SRBI Inc.
- Adams, M, Collins, V, Dunne, M, de Kretser, D, Holden, C 2013, 'Male reproductive health disorders among Aboriginal and Torres Strait Islander men: A hidden problem?', *Medical Journal of Australia*, 198(1), pp 33–38.
- Aday, LA, Llewellyn, CJ 2006, *Designing and Conducting Health Surveys: A Comprehensive Guide*, Hoboken, NJ, Wiley.
- Ajduković, M, Sušac, N & Rajter, M 2013, 'Gender and age differences in prevalence and incidence of child sexual abuse in Croatia', *Croatian Medical Journal*, 54(5), pp 469–479.
- Al-Yaman, F, Van Doeland, M, Wallis, M 2006, *Family Violence among Aboriginal and Torres Strait Islander Peoples*, cat no IHW 17, Canberra: AIHW.
- Ammerman, RT, Hersen, M, Van Hasselt, VB, Lubetsky, MJ, Sieck, WR 1994, 'Maltreatment in psychiatrically hospitalized children and adolescents with developmental disabilities: Prevalence and correlates', *Journal of the American Academy of Child and Adolescent Psychiatry*, 33(4), p 567.
- Anda, RF, Butchart, A, Felitti, VJ, Brown, D 2010, 'Building a framework for global surveillance of the public health implications of adverse childhood experiences', *American Journal of Preventive Medicine*, 39(1):93-8.
- Australian Bureau of Statistics 2013a, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011, Cat no 3238.0.55.001*, ABS, Canberra, accessed at www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001
- Australian Bureau of Statistics 2013b, *Disability, Ageing and Carers, Australia: Summary of Findings, 2012*, Cat no 4430.0, ABS, Canberra, accessed at www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features12012?opendocument&tabname=Summary&prodno=4430.0&issue=2012&num=&view=
- Australian Bureau of Statistics 2013c, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012–13*, Cat no 4727.0.55.001, ABS, Canberra, accessed at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4727.0.55.001Explanatory%20Notes12012-13?OpenDocument
- Australian Bureau of Statistics 2012 *Personal Safety, Australia 4906.0*. Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12012?OpenDocument>
- Australian Bureau of Statistics 2014, *Standard output categories: 1200.0.55.006: Age Standard, 2014, Version 1.7*, ABS, Canberra, accessed 8 September 2015 at www.abs.gov.au/ausstats/abs@.nsf/Lookup/1200.0.55.006main+features62014,%20Version%201.7
- Australian Institute of Health and Welfare 2012, *Children and Young People at Risk of Social Exclusion: Links between Homelessness, Child Protection and Juvenile Justice*, Data linkage series no. 13, cat no CSI 13, Canberra: AIHW.
- Bartholomew LK, Parcel GS, Kok G, Gottlieb NH, Fernández ME 2010, *Planning Health Promotion Programs: An Intervention Mapping Approach*. San Francisco: Jossey-Bass.

- Bolen RM, Scannapieco M 1999, 'Prevalence of Child Sexual Abuse: A Corrective Meta-analysis', *Social Services Review*, 73(3), pp 281–313.
- Boney-McCoy, S, Finkelhor, D 1995, 'Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth', *Child Abuse & Neglect*, 19(12), pp 1401–21.
- Bowling, A 2005, 'Mode of questionnaire administration can have a serious effect on data quality', *Journal of Public Health*, 27(3), pp 281–291.
- Briere, J, Runtz, M 1989, 'The trauma symptom checklist (TSC-33): Early data on a new scale', *Journal of Interpersonal Violence*, 4(2), pp 151–163.
- Briere, J, 1996 'Trauma symptom checklist for children', *Odessa, FL: Psychological Assessment Resources*, 00253-8.
- Chan, KL, Yan, E, Brownridge, DA, Ip, P 2013, 'Associating child sexual abuse with child victimization in China', *The Journal of Pediatrics*, 162(5), pp 1028–1034.
- Chen L, Murad H, Paras M, Colbenson K, Sattler A, Goranson E, Elamin M, Seime R, Shinozaki G, Prokop L, Zirakzadeh A 2010, 'Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis', *Mayo Clinic Proceedings*, 85, p 618.
- Christoffersen, MN, Armour, C, Lasgaard, M, Andersen, TE, Elklit, A 2013, 'The prevalence of four types of childhood maltreatment in Denmark', *Clinical Practice & Epidemiology in Mental Health*, 9, pp 149–156.
- Coleman, D, Stewart, LM 2010, 'Prevalence and impact of childhood maltreatment in incarcerated youth', *American Journal of Orthopsychiatry*, 80(3), pp 343–349.
- Curtain, R, Presser, S, Singer, E 2005, 'Changes in telephone survey nonresponse over the past quarter century', *The Public Opinion Quarterly*, 69(1), pp 87–98.
- de Vaus, D 2014, *Surveys in Social Research* (6th ed), London: Routledge.
- de Visser, RO, Smith, AMA, Rissel, CE, Richters, J, Grulich, AE 2003, 'Sex in Australia: Experiences of sexual coercion among a representative sample of adults', *Australian and New Zealand Journal of Public Health*, 27(2), pp 198–203.
- Dinwiddie, S, Heath, M, Dunne, M, Bucholz, K, Madden, P, Slutske, W, et al. 2000, 'Early sexual abuse and lifetime psychopathology: A co-twin control study', *Psychological Medicine*, 30, pp 41–52.
- Doidge, JC, Edwards, B, Higgins, D, Segal, L 2015 'Selection bias and missing data in retrospective self-reports of adverse childhood experiences: Comparison of methods for addressing non-response and loss to follow-up', (Manuscript submitted to *Epidemiology*).
- Dube, S, Miller, J, Brown, D, Giles, W, Felitti, V, Dong, M, Anda, R 2006, 'Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence', *Journal of Adolescent Health*, 38, 444.e1-444.e10.
- Dunne, M, Purdie, D, Cook, M, Boyle, F, Najman, J 2003, 'Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia', *Child Abuse & Neglect*, 27, pp 141–152.
- Dunne, M, Zolotor, A, Runyan, D, et al. 2009, 'ISPCAN Child Abuse Screening Tools – Retrospective version (ICAST-R): Delphi study and field testing in seven countries', *Child Abuse & Neglect*, 33, pp 815–825.
- Duran, B, Malcoe, LH, Sanders, M, Waitzkin, H, et. al. 2004, 'Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care', *Child Abuse & Neglect*, 28(2), pp 131–145.

- Edgardh, K, Ormstad, K 2000, 'Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls', *Acta Paediatrica*, 88, pp 310–19.
- Edwards, B, Hawkins, M, Letcher, P, Little, K, Macdonald, J, Oberklaid, F, et al. 2013, '*The Australian Temperament Project: The First 30 Years*', Australian Institute of Family Studies, Melbourne, Vic.
- Euser, S, Alink, LR, Tharner, A, van IJzendoorn, MH, Bakermans-Kranenburg, MJ 2013, 'The prevalence of child sexual abuse in out-of-home care: A comparison between abuse in residential and in foster care', *Child Maltreatment*, 18(4), pp 221–231.
- Euser, S, Alink, LR, Tharner, A, van IJzendoorn MH, Bakermans-Kranenburg, MJ 2015, 'The prevalence of child sexual abuse in out-of-home care: Increased risk for children with a mild intellectual disability', *Journal of Applied Research in Intellectual Disabilities*.
- Falbo, G, Caminha, F, Aguiar, F, Albuquerque, J, de Chacon Lourdes, M, Miranda, S, Marques, S 2004, 'Incidence of child and adolescent abuse among incarcerated females in the northeast of Brazil', *Journal of Tropical Pediatrics*, 50(5), pp 292–296.
- Fang, X, Fry, DA, Brown, DS, Mercy, JA, Dunne, MP, Butchart, AR, Corso, PS, Maynzyuk, K, Dzhygyr, Y, Chen, Y, McCoy, A, Swales, DM 2015a, 'The burden of child maltreatment in the East Asia and Pacific region', *Child Abuse & Neglect*.
- Fang, X, Fry, DA, Ji, K, Finkelhor, D, Chen, J, Lannen, P, Dunne, MP 2015b, 'The burden of child maltreatment in China. Bulletin of the World Health Organisation', 2015 Mar 1; 93(3): 176–185C.
- Feng, JY, Chang, YT, Chang, HY, Fetzer, S, Wang, JD 2015, 'Prevalence of different forms of child maltreatment among Taiwanese adolescents: a population-based study', *Child Abuse & Neglect*, 42, pp 10–19.
- Fildes, J, Robbins, A, Cave, L, Perrens, B, Wearing, A 2014, *Mission Australia's 2014 Youth Survey Report*, Mission Australia.
- Finkelhor, D, Dziuba-Leatherman, J 1994, 'Children as victims of violence: A national survey', *Pediatrics*, 94, pp 413–420.
- Finkelhor, D, Hamby, S, Ormrod, R, et al. 2005, 'The JVQ: Reliability, validity, and national norms', *Child Abuse & Neglect*, 29, pp 383–412.
- Finkelhor, D, Hotaling, G, Lewis, I, Smith, C 1990, 'Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors', *Child Abuse & Neglect*, 14, pp 19–28.
- Finkelhor, D, Ji, K, Mikton, C, Dunne, M 2013, 'Explaining lower rates of sexual abuse in China', *Child Abuse & Neglect*, 37(10), pp 852–860.
- Finkelhor, D, Ormrod, R, Turner, H, Hamby, S 2005, 'The victimisation of children and youth: A comprehensive, national survey', *Child Maltreatment*, 10(1), pp 5–25.
- Finkelhor, D, Turner, H, Ormrod, R, Hamby, SL 2009, 'Violence, abuse, and crime exposure in a national sample of children and youth', *Pediatrics*, 124(5), pp 1411–1423.
- Finkelhor, D, Turner, H, Ormrod, R, Hamby, S. 2010. Trends in childhood violence and abuse exposure: Evidence from 2 national surveys. *Archives of Pediatric and Adolescent Medicine*, 164(3), 238–242.
- Finkelhor, D, Turner, HA, Shattuck, A, Hamby, SL 2015, 'Prevalence of childhood exposure to violence, crime, and abuse: results from the National Survey of Children's Exposure to Violence', *JAMA Pediatrics* (in press).
- Finkelhor, D, Turner, HA, Shattuck, AM, et al. 2013, 'Violence, crime, and abuse exposure in a national sample of children and youth: An update', *JAMA Pediatrics*, 167:614e21.

- Finkelhor, D, et al. 2014, 'The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence', *Journal of Adolescent Health*, 55, 329e333.
- Fleming, J 1997, 'Prevalence of childhood sexual abuse in a community sample of Australian women', *Medical Journal of Australia*, 166, pp 65–68.
- Futa, KT, Hsu, E, Hansen, D 2001, 'Child sexual abuse in Asian American families: An examination of cultural factors that influence prevalence, identification, and treatment', *Clinical Psychology: Science and Practice*, 8(2), p 189.
- Gadermann, AM, Guhn, M & Zumbo, BD 2012, 'Estimating ordinal reliability for Likert-type and ordinal item response data: A conceptual, empirical, and practical guide', *Practical Assessment, Research and Evaluation*, 17(3), pp. 1–13.
- Ganann, R, Ciliska, D, Thomas, H 2009, 'Expediting systematic reviews: Methods and implications of rapid reviews', *Implementation Science*, 5(1), p 56.
- Giovannono, J, Becerra, R 1979, *Defining Child Abuse*, Free Press: New York.
- Global Health and Wellbeing 2015, *Global Health and Wellbeing Survey*, retrieved from <https://www.globalhwsurvey.com/home/#!overview>
- Goldman, JD, Padaychi, UK 1997, 'The prevalence and nature of child sexual abuse in Queensland, Australia', *Child Abuse & Neglect*, 21(5), pp 489–498.
- Gorey, K, Leslie, D 1997, 'The prevalence of child sexual abuse: Integrative review adjustment for potential response and measurement biases', *Child Abuse & Neglect*, 21(4), pp 391–398.
- Gough, D 1996, 'Defining the problem', *Child Abuse & Neglect*, 20(11), pp 993–1002.
- Grant M, Booth A 2009, 'A typology of reviews: An analysis of 14 review types and associated methodologies', *Health Information & Libraries Journal*, 26(2), pp 91–108.
- Hadi, A 2000, 'Child abuse among working children in rural Bangladesh: prevalence and determinants', *Public Health*, 114(5), pp 380–4.
- Hamby, SL, Finkelhor, D, Ormrod, RK, Turner, HA 2004, *The Juvenile Victimization Questionnaire (JVQ): Administration and Scoring Manual*, Durham, NH: Crimes Against Children Research Center.
- Hasson, F, Keeney, S, McKenna, H 2000, 'Research guidelines for the Delphi survey technique', *Journal of Advanced Nursing*, 32(4), pp 1008–1015.
- Haugaard, J 2000, 'The challenge of defining child sexual abuse', *American Psychologist*, 55(9), p 1036.
- Helweg-Larsen, K, Larsen, HB 2006, 'The prevalence of unwanted and unlawful sexual experiences reported by Danish adolescents: results from a national youth survey in 2002', *Acta Paediatrica*, 95, pp 1270–1276.
- Higgins, JP, Green, S 2008, *Cochrane Handbook for Systematic Reviews of Interventions*, Hoboken, NJ: Wiley-Blackwell.
- Higgins, DJ, McCabe, MP 2001, 'The development of the comprehensive child maltreatment scale', *Journal of Family Studies*, 7, pp 7–28.
- Holden, C, McLachlan, R, Pitts, M, Cumming, R, Wittert, G, Agius, P, Handelsman, D, de Kretser, D 2005, 'Men in Australia Telephone Survey (MATeS): A national survey of the reproductive health and concerns of middle-aged and older Australian men', *Lancet*, 366, pp 218–224.
- Hovdestad, W, Campeau, A, Potter, D, Tonmyr, L 2015, 'A systematic review of childhood maltreatment assessments in population-representative surveys since 1990', *PLOS ONE*, 10(5).

- Hussey, J, Chang, J, Kotch, J 2006, 'Child maltreatment in the United States: Prevalence, risk factors, and adolescent health consequences', *Pediatrics*, 118(3), pp 933–942.
- Ji, K, Finkelhor, D, Dunne, M 2013, 'Child sexual abuse in China: A meta-analysis of 27 studies', *Child Abuse & Neglect*, 37(9), pp 613–622.
- John Jay College of Criminal Justice 2004, *The Nature and Scope of Sexual Abuse of Minors by Catholic Priests and Deacons in the United States, 1950–2002*, Washington, DC: United States Conference of Catholic Bishops.
- Johnson, RJ, Ross, MW, Taylor, WC, Williams, ML, Carvajal, RI, Peters, RJ 2006, 'Prevalence of childhood sexual abuse among incarcerated males in county jail', *Child Abuse & Neglect*, 31(1), pp 75–86.
- Keeshin, BR, Campbell, K 2011, 'Screening homeless youth for histories of abuse: Prevalence, enduring effects, and interest in treatment', *Child Abuse & Neglect*, 35(6), pp 401–7.
- Khangura, S, Konnyu, K, Cushman, R, Grimshaw, J, Moher, D 2012, 'Evidence summaries: The evolution of a rapid review approach', *Systematic Reviews*, 1(1), 10-10.
- Kvam, MH 2004, 'Sexual abuse of deaf children. A retrospective analysis of the prevalence and characteristics of childhood sexual abuse among deaf adults in Norway', *Child Abuse & Neglect*, 28(3), pp 241–251.
- Kvam, MH 2005, 'Experiences of childhood sexual abuse among visually impaired adults in Norway: Prevalence and characteristics', *Journal of Visual Impairment & Blindness*, 99(1), pp 5–14.
- Laaksonen, T, Sariola, H, Johansson, A, Jern, P, Varjonen, M, von der Pahlen, B, Sandnabba, K, Santtila, P 2011, 'Changes in the prevalence of child sexual abuse, its risk factors, and their associations as a function of age cohort in a Finnish population sample', *Child Abuse & Neglect*, 35(7), pp 480–490.
- Langeland, W, Hoogendoorn, AW, Mager, D, Smit, JH, Draijer, N 2015, 'Childhood sexual abuse by representatives of the Roman Catholic Church: A prevalence estimate among the Dutch population', *Child Abuse & Neglect*, 46, pp 67–77.
- Laslett, A, et al. 2010, *The Range and Magnitude of Alcohol's Harm to Others*. Canberra: Alcohol Education and Rehabilitation Foundation.
- Livermore, G, Whalen, D, Prenovitz, S, Aggarwal, R, Bardos, M 2011a, *Disability Data in National Survey*, US Department of Health and Human Services, New Jersey.
- Livermore, G, Whalen, D, Stepleton, DC 2011b, *Assessing the Need for a National Disability Survey: Final Report*, US Department of Health and Human Services, New Jersey.
- Mandell, DS, Walrath, CM, Manteuffel, B, Sgro, G, Pinto-Martin, JA 2005, 'The prevalence and correlates of abuse among children with autism served in comprehensive community-based mental health settings', *Child Abuse & Neglect*, 29(12), pp 1359–72.
- Manders, J 2004, 'Abuse and sexual assault against children and adults with disabilities: Current research in prevalence, intervention and prevention and suggestions for future study', *Journal of Intellectual Disability Research*, 48, p 460.
- Maniglio, R 2013, 'Prevalence of child sexual abuse among adults and youths with bipolar disorder: A systematic review', *Clinical Psychology Review*, 33(4), pp 561–573.
- Maniglio, R 2014, 'Prevalence of sexual abuse among children with conduct disorder: a systematic review', *Clinical Child and Family Psychology Review*, 17(3), pp 268–282.

- Martin, J, Anderson, J, Romans, S, Mullen, P, O'Shea, M 1993, 'Asking about child sexual abuse: Methodological implications of a two stage survey', *Child Abuse & Neglect*, 17(3), pp 383–392.
- Martin, G, Bergen, HA, Richardson, AS, Roeger, L, Allison, S 2004, 'Sexual abuse and suicidality: Gender differences in a large community sample of adolescents', *Child Abuse & Neglect*, 28, pp 491–503.
- Mathur, M, Rathore, P, Mathur, M 2009, 'Incidence, type and intensity of abuse in street children in India', *Child Abuse & Neglect*, 33(12), pp 907–913.
- May-Chahal, C, Cawson, P 2005, 'Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect', *Child Abuse & Neglect*, 29(9), pp 969–984.
- Mazza, D, Dennerstein, L, Garamszegi, CV, Dudley, EC 2001, 'The physical, sexual and emotional violence history of middle-aged women: A community-based prevalence study', *Medical Journal of Australia*, 175(4), pp 199–201.
- McGee, H, Garavan, R, Byrne, J, O'Higgins, M, Conroy, R 2011, 'Secular trends in child and adult sexual violence – one decreasing and the other increasing: A population survey in Ireland', *European Journal of Public Health*, 21(1), pp 98–103.
- McGee, H, Garavan, R, de Barra, M, Byrne, J, Conroy, R 2002, *The SAVI Report: Sexual Abuse and Violence in Ireland*. Dublin: Dublin Rape Crisis Centre.
- McLennan, W 1996, *Women's Safety Australia*, Canberra: Australian Bureau of Statistics.
- Miller, EA, Green, AE, Fettes, DL, Aarons, GA 2011, 'Prevalence of maltreatment among youths in public sectors of care', *Child Maltreatment*, 16(3), pp 196–204.
- Moher, D, Liberati, A, Tetzlaff, J, Altman, DG 2009, 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement', *PLoS Medicine*, 6(7), pp 1006–1012.
- Moore, E, Romaniuk, H, Olsson, CA, Jayasinghe T, Carlin, JB, Patton, GC 2010, 'The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in Victoria, Australia', *Child Abuse & Neglect*, 34, pp 379–385.
- Moore, SE, Scott, JG, Ferrari, AJ, Mills, R, Dunne, M, Erskine, HE, et al. 2015, 'Burden attributable to child maltreatment in Australia', *Child Abuse & Neglect – The International Journal* (in press), available at www.sciencedirect.com/science/article/pii/S0145213415001684
- Murphy, JY, Mangan, I, O'Neill, H 2009, *Commission of Investigation – Report into the Catholic Archdiocese of Dublin (July 2009)*. Department of Justice and Equality, Ireland.
- Najman, JM, Dunne, MP, Purdie, DM, Boyle, FM, Coxeter, PD 2005, 'Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study', *Archives of Sexual Behavior*, 34(5), pp 517–526.
- Nelson, EC, Heath, AC, Lynskey, MT, Bucholz, KK, Madden, PA, Statham, DJ, Martion, NG 2006, 'Childhood sexual abuse and risks for licit and illicit drug-related outcomes: A twin study', *Psychological Medicine*, 36(10), pp 1473–1483.
- NH&MRC 2014, *National Statement on Ethical Conduct in Human Research 2007* (updated March 2014), developed jointly by the National Health and Medical Research Council, the Australian Research Council, the Australian Vice-Chancellors' Committee.
- Paolucci, E, Genuis, M, Violato, C 2001, 'A meta-analysis of the published research on the effects of child sexual abuse', *The Journal of Psychology*, 135(1), pp 17–36.

- Pereda, N, Guilera, G, Forns, M, Gomez-Benito, J 2009, 'The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994)', *Child Abuse & Neglect*, 33(6), pp 331–342.
- Purdie, DM, Dunne, MP, Boyle, FM, Cook, MD, Najman, JM 2002, 'Health and demographic characteristics of respondents in an Australian national sexuality survey: Comparison with population norms', *Journal of Epidemiology and Community Health*, 56(10), pp 748–753.
- Radford, L, Corral, S, Bradley, C, Fisher, HL 2013, 'The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults', *Child Abuse & Neglect*, 37(10), pp 801–813.
- Radford, L, Corral, S, Bradley, C, Fisher, H, Bassett, C, et al. 2011, *Child Abuse and Neglect in the UK Today*, London: NSPCC.
- Reddy, MK, Fleming, MT, Howells, NL, Rabenhorst, MM, Casselman, R, Rosenbaum, A 2006, 'Effects of method on participants and disclosure rates in research on sensitive topics', *Violence & Victims*, 21(4), pp 499–506.
- Reeve, R, van Gool Chere, K 2013, 'Modelling the relationship between child abuse and long-term health care costs and wellbeing: Results from an Australian community-based survey', *Economic Record*, 89(286), pp 300–318.
- Richters, J, Badcock, P, Simpson, J, Shellard, D, Rissel, C, de Visser, R, Grulich, A, Smith, A 2014, 'Design and methods of the Second Australian Study of Health and Relationships', *Sexual Health*, 11, pp 383–396.
- Rosenman, S, Rodgers, B 2004, 'Childhood adversity in an Australian population', *Social Psychiatry and Psychiatric Epidemiology*, 39(9), pp 695–702.
- Runyan, DK 1998, 'Prevalence, risk, sensitivity, and specificity: a commentary on the epidemiology of child sexual abuse and the development of a research agenda', *Child Abuse & Neglect*, 22(6), pp 493–502.
- Runyan, DK, Dunne, MP, Zolotor, AJ 2009, 'Introduction to the development of the ISPCAN child abuse screening tools', *Child abuse & neglect*, 33(11), pp 842–845.
- Ryan, M, Scott, DA, Reeves, C, Bate, A, van Teijlingen, ER, Russell, EM, Napper, M, Robb, CM 2001, 'Eliciting public preferences for healthcare: A systematic review of techniques', *Health Technology Assessment*, 5(5), pp 1–194.
- Sariola, H, Uutela, A 1992, 'The prevalence and context of family violence against children in Finland', *Child Abuse & Neglect*, 16(6), pp 823–832.
- Shekelle, PG, Woolf, SH, Eccles, M, Grimshaw, J 1999, 'Developing guidelines', *British Medical Journal*, 318(7183), pp 593–596.
- Smith, EM 2005, 'Telephone interviewing in healthcare research: A summary of the evidence', *Nurse Researcher*, 12(3), pp 32–41.
- Stoltenborgh, M, Bakermans-Kranenburg, MJ, Alink, LRA, van IJzendoorn, MH 2015, 'The prevalence of child maltreatment across the globe: Review of a series of meta-analyses', *Child Abuse Review*, 24(1), pp 37–50.
- Stoltenborgh, M, van IJzendoorn, MH, Euser, E, Bakermans-Kranenburg, M 2011, 'A global perspective on child sexual abuse: Meta-analysis of prevalence around the world', *Child Maltreatment*, 16(2), pp 79–101.
- Sullivan, PM, Knutson, JF 2000, 'The prevalence of disabilities and maltreatment among runaway children', *Child Abuse & Neglect*, 24(1), pp 1275–1288.

- Sundin, EC, Baguley, T 2015, 'Prevalence of childhood abuse among people who are homeless in Western countries: A systematic review and meta-analysis', *Social Psychiatry and Psychiatric Epidemiology*, 50(2), pp 183–94.
- Tourangeau, R 2004, 'Survey research and societal change', *Annual Review of Psychology*, 55(1), pp 775–810.
- Tsuboi, S, Yoshida, H, Ae, R, Kojo, T, Nakamura, Y, Kitamura, K 2015, 'Prevalence and demographic distribution of adult survivors of child abuse in Japan', *Asia Pacific Journal of Public Health*, 27(2), NP2578-NP2586.
- Tucker, C, Lepowski, JM 2008, 'Telephone survey methods: Adapting to change', in JM Lepkowski, C Tucker, JM Brick, ED Leeuw, J Japec, PJ Lavrakas, MW Link, RL Sangster (eds), *Advances in Telephone Survey Methodology*, pp 3–26, Hoboken, NJ: John Wiley & Sons.
- van der Kooij, IW, Nieuwendam, J, Bipat, S, Boer, F, Lindauer, RJL, Graafsma, TLG 2015, 'A national study on the prevalence of child abuse and neglect in Suriname', *Child Abuse & Neglect* (in press).
- Varjonen, M, Santtila, P, Höglund, M, Jern, P, Johansson, A, Wager, I, Witting, K, Ålgars, M, Sandnabba, NK 2007 'Genetic and environmental effects on sexual excitation and sexual inhibition in men' *Journal of Sex Research*, 44 pp. 359–369
- Vogl, S 2013, 'Telephone versus face-to-face interviews: Mode effect on semi-structured interviews with children', *Sociological Methodology*, 43(1), pp 133–177.
- Ward, J, Bryant, J, Wand, H, Kaldor, J, Delaney-Thiele, D, Worth, H, Betts, S, Waples-Crowe, P, Cairnduff, S, Coburn, T, Donovan, B, Pitts, M 2015, 'Methods of a national survey of young Aboriginal and Torres Strait Islander people regarding sexually transmissible infections and bloodborne viruses', *Australian & New Zealand Journal of Public Health*, doi: 10.1111/1753-6405.12427
- Watson, B, Halford, WK 2010, 'Classes of childhood sexual abuse and women's adult couple relationships', *Violence and Victims*, 25(4), pp 518–535.
- Wyatt, GE, Peters, SD 1986, 'Issues in the definition of child sexual abuse in prevalence research', *Child Abuse & Neglect*, 10, pp 231–240.
- Wynkoop, TF, Capps, SC, Priest, BJ 1995, 'Incidence and prevalence of child sexual abuse: A critical review of data collection procedures', *Journal of Child Sexual Abuse*, 4(2), p 49.

Appendix A: Research options

The table below is as presented in the Royal Commission's Request for Quote, Annex 1. Table 1: Research options for consideration given the minimum requirements of the prevalence research.

| Variable set | Minimum requirement | | Other alternatives | |
|-----------------------------------|---|---|--|---|
| | Option One | Option Two | Option Three | Option Four |
| | Ask prevalence questions only about sexual abuse; ask nature and context questions (which identify institutional abuse) about sexual abuse only | Ask prevalence questions about child maltreatment, ask nature and context about sexual abuse only | Ask prevalence questions about child maltreatment, ask nature and context about maltreatment only when they are mentioned in the context of institutional child sexual abuse | Ask prevalence questions about child maltreatment, ask nature and context about child maltreatment regardless of whether they occur in the context of sexual abuse or not |
| Child sexual abuse | | | | |
| Prevalence | ✓ | ✓ | ✓ | ✓ |
| Nature and context | ✓ | ✓ | ✓ | ✓ |
| Physical abuse | | | | |
| Prevalence | ✗ | ✓ | ✓ | ✓ |
| Nature and context | ✗ | ✗ | Only when accompanied by institutional sexual abuse | ✓ |
| Emotional abuse | | | | |
| Prevalence | ✗ | ✓ | ✓ | ✓ |
| Nature and context | ✗ | ✗ | Only when accompanied by institutional sexual abuse | ✓ |
| Neglect | | | | |
| Prevalence | ✗ | ✓ | ✓ | ✓ |
| Nature and context | ✗ | ✗ | Only when accompanied by institutional sexual abuse | ✓ |
| Witnessing family violence | | | | |
| Prevalence | ✗ | ✓ | ✓ | ✓ |
| Nature and context | ✗ | ✗ | Only when accompanied by institutional sexual abuse | ✓ |

| Possible research questions: | | | | |
|---|---|---|---|---|
| What is the prevalence of child sexual abuse? | ✓ | ✓ | ✓ | ✓ |
| What is the prevalence of institutional child sexual abuse? | ✓ | ✓ | ✓ | ✓ |
| How often does sexual abuse occur in institutional contexts compared with all contexts? | ✓ | ✓ | ✓ | ✓ |
| Are disclosure experiences different for children sexually abused in institutional contexts compared with children sexually abused in other contexts? | ✓ | ✓ | ✓ | ✓ |
| What is the prevalence of physical and emotional abuse, neglect and witnessing family violence? | ✗ | ✓ | ✓ | ✓ |
| How prevalent is sexual abuse compared to other kinds of abuse / maltreatment? | ✗ | ✓ | ✓ | ✓ |
| When sexual abuse occurs in institutions, what kind of abuse accompanies it? | ✗ | ✗ | ✓ | ✓ |
| Is it the same perpetrator or different? Does the abuse start as sexual abuse or is there a period of emotional / physical abuse preceding it? | ✗ | ✗ | ✓ | ✓ |
| How have the 'dynamics' of sexual abuse changed over time? | ✗ | ✗ | ✓ | ✓ |
| When abuse occurs in an institution, is it more likely to be physical or sexual? | ✗ | ✗ | ✗ | ✓ |
| Has this changed over time? | ✗ | ✗ | ✗ | ✓ |

Appendix B: Systematic literature review methodology and PRISMA flow diagram

The Royal Commission has commissioned a research project to scope the research design, methodology, cost and governance structure of two separate though related studies investigating the prevalence of child maltreatment in Australia, including the prevalence of institutional child sexual abuse.

- Study One: The prevalence of child maltreatment in a representative community sample of Australian *adults* (with four options as defined by the Royal Commission in Annex 1)
- Study Two: The prevalence of child maltreatment within a representative sample of Australian *young people* (with four options as defined by the Royal Commission in Annex 1) – and with ‘young people’ defined by the Royal Commission as including people aged 18–24, as well as those aged under 18.

As required by the Royal Commission, this scoping study required identification and analysis of prevalence studies for any or all five forms of child maltreatment (physical, sexual, psychological/emotional, neglect, and witnessing of/exposure to domestic violence):

- conducted with adults about their childhood experiences
- conducted with children aged under 18 about their childhood experiences.

To align with the purposes of the Royal Commission, we identified studies of:

- *child sexual abuse* (regardless of the identity of the perpetrator)
- *other forms of maltreatment* (physical, psychological/emotional, neglect and exposure to domestic violence) inflicted by parents, caregivers or institutional authority figures.

Where they did so, we also recorded how these studies explored the nature and context of the abuse, namely:

- perpetrator identity/relationship with victim
- nature, severity, frequency or duration
- disclosure
- health outcomes.

We conducted a systematic literature review (Grant & Booth, 2009) with evidence synthesis (Gannan et al., 2010, Khangura et al., 2012) to identify methodological and ethical approaches to prevalence studies. This type of review approaches the rigour of gold standard systematic reviews exemplified by Cochrane Reviews, while being more time-efficient. Our review included a literature search across multiple databases; screening and selection of studies according to predetermined inclusion/exclusion criteria; information and data extraction using a standardised template; and thematic synthesis of results. The overall

purpose was to identify and describe the key characteristics of prevalence studies. This then informed the critical analysis of the strengths and weaknesses of such characteristics for the scoping of two Australian prevalence studies involving child participants and adult participants.

Databases

- 1) Pubmed (Ovid Medline)
- 2) Embase via embase.com
- 3) EBSCOhost (includes CINAHL, ERIC, PsycINFO, Violence and Abuse Abstracts)
- 4) ProQuest Research Library (ProQuest Psychology, ProQuest Social Science, ProQuest Nursing & Allied Health)
- 5) ScienceDirect

Search approach

As a general strategy, the search approach had three components with search terms and operators designed to capture relevant literature and exclude irrelevant literature. The precise strategies were adapted to suit the different databases (see below for technical detail). This approach was used in PubMed:

- Line 1 prevalence OR incidence
AND
- Line 2 child* OR youth* OR minor* OR student*
AND
- Line 3 maltreatment OR abuse OR neglect
OR
- Line 4 (physical OR sexual OR emotional OR psychological) adj abuse
OR
- Line 5 (family OR domestic) adj violence

Table 8 Systematic literature review – database search strategy

| Database search strategy details | Endnote running total |
|--|-----------------------|
| <p>PubMed</p> <p>((((prevalence[Title] OR incidence[Title])) AND (child*[Title] OR youth*[Title] OR minor*[Title] OR student*[Title])) AND (maltreatment[Title] OR abuse[Title] OR neglect[Title])) OR ((physical[Title] OR sexual[Title] OR emotional[Title] OR psychological) adj abuse[Title])) OR ((family[Title] OR domestic) adj violence[Title]) Filters: Publication date from 1990/01/01</p> <p>n = 239</p> | 239 |
| <p>ProQuest</p> <p>TI(prevalence OR incidence) AND TI(child* OR youth* OR student* OR minor*) TI(maltreatment OR abuse OR neglect) OR TI((physical OR sexual OR emotional OR psychological) adj abuse) OR TI((family OR domestic) adj violence)</p> <p>Limited to 1990 onwards + peer reviewed</p> <p>n = 155 -> 151 when duplicates removed</p> | +151 = 390 |
| <p>EBSCOhost (CINAHL; ERIC; PsycINFO; Violence and Abuse Abstracts)</p> <p>TI (prevalence or incidence) AND TI (child* or youth* or minor* or student*) AND TI (maltreatment or abuse or neglect) OR TI ((physical or sexual or emotional or psychological) adj abuse) OR TI ((family or domestic) adj abuse)</p> <p>Limited to 1990 onwards + peer reviewed</p> <p>n = 365 -> n = 249 when exact duplicates removed.</p> | +249 = 639 |
| <p>Embase</p> <p>#1 - prevalence:ti OR incidence:ti</p> <p>#2 - child*:ti OR youth*:ti OR minor*:ti OR student*:ti</p> <p>#3 - maltreatment:ti OR abuse:ti OR neglect:ti</p> <p>#4 - 'physical abuse':ti OR 'sexual abuse':ti OR 'emotional abuse':ti OR 'psychological abuse':ti OR 'family violence':ti OR 'domestic violence':ti</p> <p>#5 - #1 and #2</p> <p>#6 - #3 or #4</p> <p>#7 - #5 and #6</p> <p>Limited to 1990 onwards.</p> <p>n = 305</p> | +305 = 944 |

| Database search strategy details | Endnote running total |
|--|---------------------------|
| <p>ScienceDirect</p> <p>pub-date > 1990 and TITLE(maltreatment or abuse or neglect) or TITLE(“physical abuse” or “sexual abuse” or “emotional abuse” or “psychological abuse” or “family violence” or “domestic violence”)</p> <p>[All Sources(- All Sciences -)]</p> <p>AND</p> <p>(pub-date > 1990 and TITLE(prevalence or incidence) and TITLE(child* or youth* or minor* or student*)) AND (pub-date > 1990 and TITLE(maltreatment or abuse or neglect) or TITLE(“physical abuse” or “sexual abuse” or “emotional abuse” or “psychological abuse” or “family violence” or “domestic violence”))</p> <p>[All Sources(- All Sciences -)]</p> <p>Limited to 1990 onwards</p> <p>n = 100</p> | <p>+100 = 1044</p> |
| <hr/> <p>OpenGrey</p> <p>Terms: incidence or prevalence and child* OR youth* OR student* OR minor</p> <p>24 results, none relevant.</p> <hr/> | |

Inclusion and exclusion criteria

Inclusion and exclusion criteria to meet the Royal Commission’s requirements were defined and used to determine eligible studies. Based on the two kinds of prevalence studies (with each containing four options) to be subjected to review, analysis and scoping, the criteria were as described in Table 9 below.

Table 9 Systematic literature review: Inclusion and exclusion criteria

| Dimension | Included studies | Excluded studies |
|-----------------------------|--|--|
| Type of research | Original empirical research (primary research) and systematic reviews | Secondary research |
| Publication type | Peer-reviewed research published in scholarly refereed journals | Other publications, reports and grey literature |
| Overall nature of the study | Studies of the prevalence or incidence within and beyond institutions of one or more of the five specified types of maltreatment in childhood (physical abuse, sexual abuse, psychological or emotional abuse, neglect, and exposure to domestic violence) and of the nature and context of the child maltreatment (perpetrator; nature, severity, frequency or duration of child maltreatment) (see <i>Notes</i> below) | <p>Studies of other broader kinds of childhood adversity such as bullying, exposure to community violence (e.g. street crime), exposure to or involvement in civil conflict, trafficking, specific cultural violence (e.g. female genital cutting/mutilation)</p> <p>Studies only of contextual factors (e.g. disclosure, health consequences)</p> |

| Dimension | Included studies | Excluded studies |
|---|--|--|
| Parameters of maltreatment and perpetrator type/responsible agent | Prevalence or incidence studies of relevant forms of maltreatment by relevant perpetrator type, namely, CSA by anyone; other forms of maltreatment by parents, caregivers or institutional authorities | Studies of adversity involving other perpetrators/responsible agents (e.g. bullying or psychological 'abuse' by peers), neglect by government agencies |
| Participant type | Studies using participant self-reporting or parent/caregiver reporting | Studies using informants (i.e. other individuals or agencies) |
| Sample strategy | Quantitative studies using a population-wide representative sample at national or regional level (state, territory or province) | Qualitative studies and small quantitative studies using a convenience sample, clinical sample or an institutional sample |
| Special subsample type | Studies using a clinical or institutional sample to access hard-to-reach population subsets as follows: children in out-of-home care; children in detention centres; children from culturally and linguistically diverse groups; children with disability; homeless children; adults in detention centres; adults from culturally and linguistically diverse groups; adults with disability; homeless adults | Studies using other more generalised clinical or institutional samples |
| Location | Studies conducted in Australia or any other jurisdiction (includes English speaking and non-English speaking) | None |
| Time period | Studies published from 1 January 1990 to 31 July 2015 | Studies published outside this period |

Notes

Four 'groups' of studies included the relevant characteristics. The study's search strategy centred around group 2, which automatically captured studies within groups 1, 2, 3 and 4.

- 1) Studies about the prevalence of institutional child sexual abuse and child sexual abuse only, , including:
 - peer-reviewed nationwide and region-wide studies of child sexual abuse
 - research that didn't cover institutional child sexual abuse
 - research that consider the nature and context of abuse .
 -
- 2) Studies about the prevalence of any of the five forms of institutional child maltreatment or child maltreatment, including d:
 - Peer-reviewed nationwide and region-wide studies of one or more forms of child maltreatment
 - Research that did not cover institutional child maltreatment
 - Research that did not consider nature and context.
- 3) Studies about the nature and context of child sexual abuse/child maltreatment (perpetrator identity/relationship, severity, frequency, duration, disclosure, health outcomes), including:

- All nationwide and region-wide studies of one or more forms of child maltreatment
 - Only peer-reviewed research
 - Research that did not cover the institutional context.
- 4) Studies about special subpopulations (Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities and people with disability), including:
- Extracted information from studies included in No. 1 and No. 3 above
 - Conducting further reviews to identify more information if necessary.

Identification of studies

The literature review identified the studies (1,044). After duplicates were removed using electronic software (Endnote), there were 582 unique records. Chief Investigators (CIs) then identified further duplicates, leaving 289 records, which two CIs screened for eligibility criteria over several phases (first by title, leaving 172 records; then by title and abstract, leaving 55 records; then by full text, which resulted in 32 studies). Additional records were then identified by screening reference lists of included studies focusing on five systematic reviews, which identified 33 potentially eligible studies. These were then screened by abstract and/or full text to identify 17 further eligible studies. Multiple articles about the same study were grouped for analysis but counted as one eligible study (Sariola 1992, 1994), which removed one record. Finally, any other studies researchers knew personally and which hadn't been identified, were added (one article: McGee et al., 2011). This process resulted in identification of 49 eligible studies (see the PRISMA flow diagram below).

Extraction of key information from final list of eligible studies

We used a *standardised template* to extract information about key items from the studies, which are detailed below. Data was extracted by two team members (Kerryann Walsh, Ben Mathews) with discrepancies resolved via discussion and referral to a third team member (Michael Dunne). We tabulated the data in excel format to produce a master file and a summary matrix of key subgroups of studies for consideration in the critical analysis phase. The standardised template is included below.

Key information extracted from eligible studies

Details of eligible study

1. Author names and publication citation
2. Jurisdiction/s

Design

3. CM types studied (SA; PA; E/PA; N; EDV)
4. Study of institutional CM only; non-institutional CM only; or unspecified (institutional; non-institutional; NS)
5. Participant age (children <18; adult age range)
6. Gender (female/male/both)

7. Age range of victimisation (<18; specify if other)
8. Study type (cross-sectional (CS) or longitudinal (L))
9. Study repeated in subsequent year with either same or different cohort (yes/no)
10. Were key terms defined (SA; PA; E/PA; N; EDV; institution)? (yes/no). If yes, detail them.

Instrument

11. Specific instrument used (name)
12. Is the instrument shown by data to possess reliability and validity? (yes/no)
13. **Institutional CSA:** Did instrument contain specific items about ICSA? (yes/no). If no, proceed to next question. If yes:
 - a. How many items? (n =)
 - b. Were there items about perpetrator identity/relationship with victim? (yes/no)
 - c. Were there items about nature, severity, frequency or duration? (yes/no)
 - d. Were there items on disclosure? (yes/no)
 - e. Were there items on health outcomes? (yes/on)
 - f. Detail the specific items as worded
14. **Institutional CM:** Did instrument contain specific items about ICM other than CSA? (y/n). If no, proceed to next question. If yes:
 - a. How many items? (n =)
 - b. Were there items about perpetrator identity/relationship with victim? (yes/no)
 - c. Were there items about the nature, severity, frequency or duration? (yes/no)
 - d. Were there items on disclosure? (yes/no)
 - e. Were there items on health outcomes? (yes/no)
 - f. Detail the specific items as worded
15. **Non-institutional/unspecified CSA:** Did instrument contain specific items about CSA? (y/n). If no, proceed to next question. If yes:
 - a. How many items? (n =)
 - b. Were there items about perpetrator identity/relationship with victim? (yes/no)
 - c. Were there items about nature, severity, frequency or duration? (yes/no)
 - d. Were there items on disclosure? (yes/no)
 - e. Were there items on health outcomes? (yes/no)
 - f. Detail the specific items as worded
16. **Non-institutional/unspecified CM:** Did instrument contain specific items about maltreatment other than CSA? (yes/no). If yes:
 - a. How many items? (n =)
 - b. Were there items about perpetrator identity/relationship with victim? (yes/no)
 - c. Were there items about nature, severity, frequency or duration? (yes/no)
 - d. Were there items on disclosure? (yes/no)
 - e. Were there items on health outcomes? (yes/no)
 - f. Detail the specific items as worded

Procedure

17. Method of data collection (phone, household, public intercept, school, institution): P; H; PI; S; I
18. Type and number of staff used to collect data (academics/research assistants; company; NGO): A; C; NGO
19. Time taken for data collection and analysis (months)
20. Cost of study

Ethics/governance measures

21. Were there measures for reporting of suspected harm or risk of harm to a child? (yes/no)
22. Were there measures to provide assistance to participants? (yes/no)
23. Were there any adverse events reported? (yes/no)

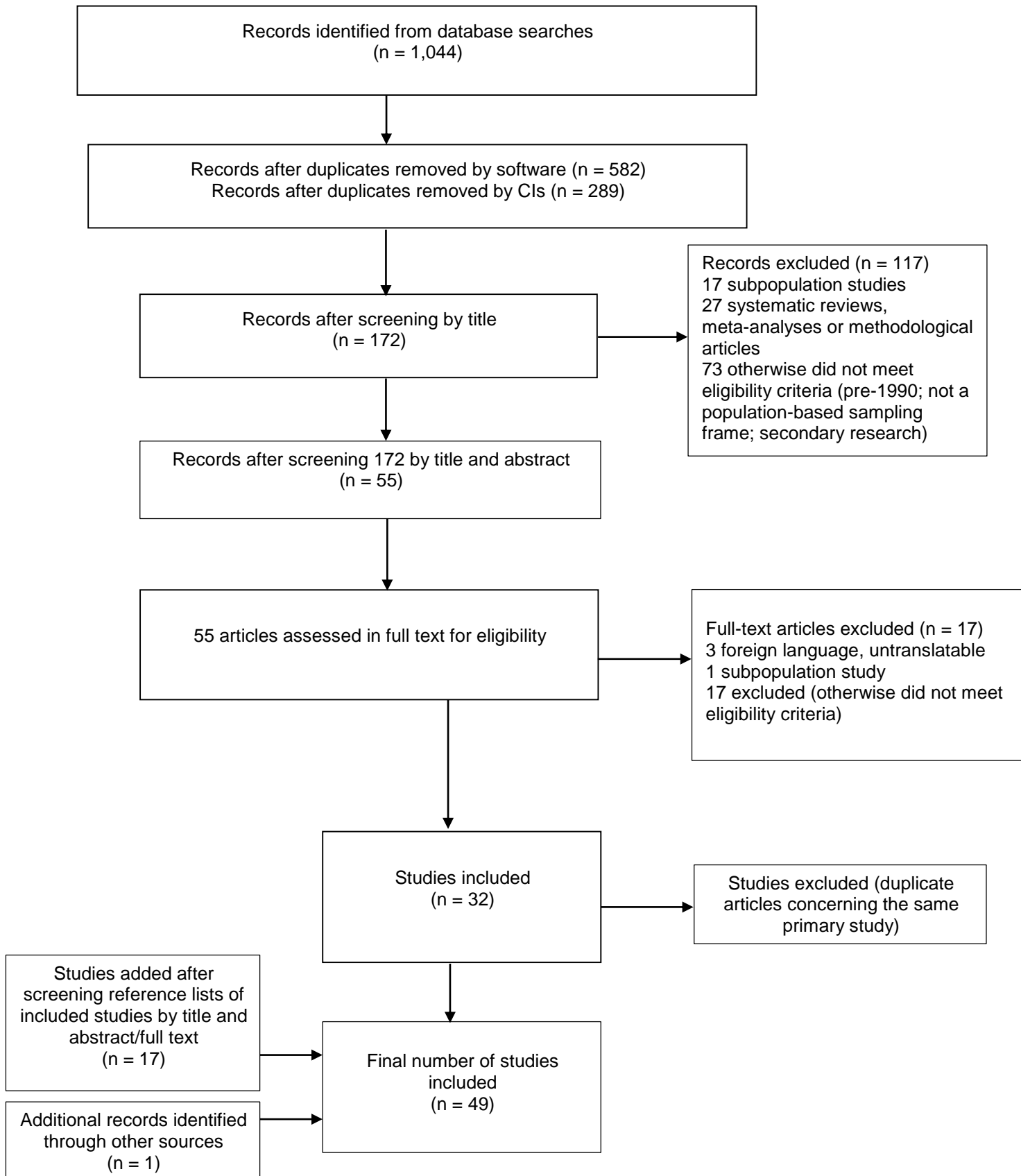
Sampling

24. Method of recruitment (e.g. phone, online, invitation to institution)
25. Were there measures to recruit special subgroups of participants e.g. Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, institutional, disabled participants) (yes/no)
26. Total sample size and response rate (n = ; %)

Data analysis

27. Were there strategies for special subgroups e.g. Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, institutional; for example, by weighting, oversampling, clustering (yes/no)

Figure 1 PRISMA flow diagram



Appendix C: Summary of literature, identification of key features and collation of subgroups of studies

| | |
|---------------|--|
| PART 1 | Table 10 The 49 studies with nine key dimensions |
| <hr/> | |
| PART 2 | Overview of key features of 14 studies with child participants only |
| | Table 11 Studies with child participants only: key features of study design, sample, procedure, ethics and instrument |
| <hr/> | |
| PART 3 | Overview of key features of 14 nationwide studies with adult participants (or adults and children) |
| | Table 12 Nationwide studies with adult participants (with two involving adults and children): key features of study design, sample, procedure, ethics and instrument |
| <hr/> | |
| PART 4 | Overview of key features of 11 studies conducted by telephone interview or computer assisted telephone interview |
| | Table 13 Phone studies: key features of study design, sample, procedure, ethics and instrument |
| <hr/> | |
| PART 5 | Overview of breadth of studies and their key features |
| | Table 14 Studies of all five maltreatment types: key features of study design, sample, procedure, ethics and instrument |

Part 1 – Overview of key features of all 49 studies

The summary below captures key themes from the 49 studies. Table 10 then provides further details about these studies' key dimensions of *design* (prevalence, incidence or both; period; maltreatment types; participant age range; single or repeated; retrospective or prospective); *sample* (sampling frame; sampling strategy; sample size; response rate); *procedure* (recruitment measures; method of administration; data collection personnel; data collection time); *ethics* (whose consent was obtained; measures for reporting suspected risk; measures for providing assistance; adverse events reported); and *instrument* (name; validity and reliability; maltreatment types covered; items about ICSA; and presence and number of items about CSA, PA, E/PA, N and EDV).

Study location

- Europe (including UK) = 15 (predominantly Scandinavian countries)
- US = 11
- Asia = 9
- Middle East = 3
- Australia = 4
- Africa = 2
- Canada = 2
- New Zealand = 2
- South America = 1

Prevalence or incidence

- Prevalence = 30 (lifetime; childhood/before 18)
- Incidence = 11 (typically over past 12 months)
- Both = 8

Child maltreatment items embedded in broader study

- Embedded in broader survey = 13
- Most are broader health studies
- Most ask very few questions relating to maltreatment
- Two are from Australia: Moore et al.'s Victorian Adolescent Health Cohort Study; Rosenman & Rodgers: Path through life project in ACT

Maltreatment subtypes

- Institutional child sexual abuse only = 0
- Child sexual abuse only = 15
- All 5 maltreatment subtypes = 9 (4 were Finkelhor; others were Al Eissa; Euser; Feng; Radford; van der Kooij) (using JVQ + ICAST)
- 4 maltreatment subtypes (not EDV) = 5
- 3 maltreatment subtypes = 7
- Other combinations of maltreatment subtypes = 13 (typically using Conflict Tactics Scale)

Participants

- Adult only (aged 18 and older) = 20
- Child only (aged under 18) = 10 (youngest = 10, in Finkelhor)
- Children and young adults = multiple studies and multiple age ranges (10–19; 15–18; 14–23; 13–19; 12–20; 13–18. Usually dictated by age range of children at school)
- Both = 8, with five by Finkelhor as follows:
 - Finkelhor et al. 1994 (Study 1): direct self-report by children aged 10–16
 - Finkelhor et al. 2005, 2009, 2014, 2015 (Studies 2, 3, 4, 5) cover children aged 2–17 (studies 2 and 3) and 0–17 (Studies 4 and 5)
 - In Studies 2, 3, 4 and 5, children aged 10–17 participated directly by self-report; children aged 2–9 or 0–9 participated indirectly by parent/caregiver report.

Cross-sectional or repeated measures studies

- Typically one-off/cross-sectional
- The study most often repeated is Finkelhor's NATSCEV in US (now every 3 years)

Retrospective or prospective

- Nearly all are retrospective

Key terms defined

- Some papers define abuse types in the article's introduction or upfront
- Some upfront definitions do not align with instrument descriptions of abuse types
- Types of abuse need to be operationalised in the instrument (e.g. use of the 'five-year rule') and this does not occur consistently
- Instrument tends to dictate the definition and description of the abuse type
- Analytic categorisations (e.g. into categories such as contact/non-contact CSA occur post-hoc after data collection to fit analytic approaches; thereby simplifying or dichotomising a spectrum phenomenon)

How study was described to participants

- Generally not reported in studies
- Rare examples include: 'your experiences in childhood', 'your physical and mental health, lifestyle and life experiences', 'study of health and wellbeing'

Sample frame

- Of the samples, 27 of the 49 studies are representative nationwide, including:
 - 10 of 27 conducted with child participants only (in US and UK, by CATI; in continental Europe, generally via schools)
 - 14 of 27 conducted with either adults only, or adults and children (typically by CATI or telephone, or by CASI).

Sampling strategy

- All use a version of stratified random sampling or multistage/stratified random cluster sampling

Sample size

- <2,000 = 12
- 2,000-5,000 = 22
- >5,000 = 15 (most of these were household or broader health surveys, or large cohort studies)

Response rates

- Phone studies – high response rates (60–88% in Finkelhor’s studies)
- Somewhat lower in more recent studies but still reported as sufficient
- School studies – high response rates generally (studies were conducted in systems where children consent for themselves, where no parental consent was necessary and parents were simply informed about the study’s conduct, or where passive parental consent was sufficient)

Recruitment

- Through school = 22
- By phone = 11 (5 of these are Finkelhor)
- Online panel = 1 (Langeland)
- Home address/doorknock = small number

Note: Measures used to recruit special subsamples are generally not described in studies. Of those that were reported, the typical strategy was oversampling by ethnicity.

Administration method

School-based studies

- In school with hard-copy questionnaire = 20
- In school with multimedia handheld device/online = 1 (Helweg-Larsen, Denmark)

Telephone studies

- Either expressly reported as a study using CATI or stating that it was conducted by telephone = 11

Home-based studies

- At home with hard-copy questionnaire = 5
- At home with face-to-face interview = 3
- At home with CASI on laptop = 3 (Hussey, USA; Radford, UK; Rosenman & Rodgers, Australia)

Online panel

- One study

Unclear

- The rest

Data collection personnel

- Research company = 13
- Researchers and/or RAs = 11
- Staff within school or other institution = 4
- Not reported = 21

Data collection time

- Range 1–6 months. Depends on sample size

Adverse events

- No studies reported adverse events

Cost

- Only one study reported cost: Finkelhor's NATSCEV #1 (~USD2.7 million)

Instruments

- JVQ or modified/enhanced JVQ = 6
- Conflict Tactics Scale (CTS) or adapted CTS = 5
- ICAST-CH = 2 (collects data on abuse in the home)
- ICAST-C = 1
- ACES = 1, adapted (this is usually a measure of health consequences rather than experience of maltreatment (also studied with clinical populations)
- Other adapted instruments/new instruments Validity and reliability data
- Very few report this data at all. Rely on original testing/data
- None report on development of measurement models with new populations.
- ICAST has good strategies for validation (focus groups, including with children, and pilot testing with data reported)
- JVQ & CTS have reliability data

Table 10 The 49 studies with nine key dimensions

Key

Child = study with child participants

Adult = study with adult participants

ICSA = institutional child sexual abuse

CSA = child sexual abuse

Number of the 5 forms of maltreatment studied

Administration = mail (M); school hard copy (S); telephone interview (TI); computer assisted telephone interview (CATI); computer assisted self-interview (CASI); household face-to-face interview (H); household hard-copy (HH)

Nationwide

Instrument psychometrics reported

Type of study: cross-sectional (CS) or cohort (C)

| Child | Adult | ICSA | CSA | No. of the 5 forms | Administration | Nationwide | Instrument Psychometrics | Type of study | Study (* = CSA only; ** = all 5 forms) |
|-------|-------|------|-----|--------------------|----------------|------------|--------------------------|---------------|--|
| ✓ | ✗ | ✗ | ✓ | 3 | S | ✓ | ✓ | CS | Ajdković, M, Sušac, N & Rajter, M 2013, 'Gender and age differences in prevalence and incidence of child sexual abuse in Croatia', <i>Croatian Medical Journal</i> , 54(5), pp 469–479. |
| ✓ | ✗ | ✗ | ✓ | 5 | S | ✗ | ✓ | CS | **Al-Eissa, MA, AlBuhairan, FS, Qayad, M, Saleheen, H, Runyan, D & Almuneef, M 2015, 'Determining child maltreatment incidence in Saudi Arabia using the ICAST-CH: a pilot study', <i>Child Abuse & Neglect</i> , 42, pp 174–182. |
| ✓ | ✗ | ✗ | ✓ | 3 | S | ✓ | ✓ | CS | Al-Fayez, GA, Ohaeri, JU & Gado, OM 2012, 'Prevalence of physical, psychological, and sexual abuse among a nationwide sample of Arab high school students: association with family characteristics, anxiety, depression, self-esteem, and quality of life', <i>Social Psychiatry and Psychiatric Epidemiology</i> , 47(1), pp 53–66. |
| ✓ | ✗ | ✓ | ✓ | 2 | S | ✓ | ✗ | CS | Andersson, N & Ho-Foster, A 2008, '13,915 reasons for equity in sexual offences legislation: a national school-based survey in South Africa', <i>International Journal for Equity in Health</i> , 7, p 20. |
| ✓ | ✗ | ✗ | ✗ | 1 | S | ✗ | ✗ | CS | Annerbäck, EM, Wingren, G, Svedin, CG & Gustafsson, PA 2010, 'Prevalence and characteristics of child physical abuse in Sweden – Findings from a population-based youth survey', <i>Acta Paediatrica</i> , 99(8), pp 1229–1236. |
| ✗ | ✓ | ✗ | ✓ | 2 | M | ✓ | ✗ | CS | Briere, J & Elliott, DM 2003, 'Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women', <i>Child Abuse & Neglect</i> , 27(10), pp 1205–1222. |
| ✗ | ✓ | ✗ | ✓ | 4 | TI + H | ✓ | ✗ | CS | Christoffersen, MN, Armour, C, Lasgaard, M, Andersen, TE & Elklit, A 2013, 'The prevalence of four types of childhood maltreatment in Denmark', <i>Clinical Practice & Epidemiology in Mental Health</i> , 9, pp 149–156. |

| Child | Adult | ICSA | CSA | No. of the 5 forms | Administration | Nation wide | Instrument | Psychometrics | Type of study | Study (* = CSA only; ** = all 5 forms) |
|-------|-------|------|-----|--------------------|----------------|-------------|------------|---------------|---------------|---|
| ✓ | ✓ | ✗ | ✓ | 1 | CATI | ✓ | ✓ | ✓ | CS | *de Visser, RO, Smith, AMA, Rissel, CE, Richters, J & Grulich, AE 2003, 'Sex in Australia: Experiences of sexual coercion among a representative sample of adults', <i>Australian & New Zealand Journal of Public Health</i> , 27(2), pp 198–203. |
| ✗ | ✓ | ✗ | ✓ | 1 | CATI | ✓ | ✓ | ✓ | CS | *Dunne, M, Purdie, D, Cook, M, Boyle, F & Najman, J 2003, 'Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia', <i>Child Abuse & Neglect</i> , 27, pp 141–152. |
| ✓ | ✗ | ✗ | ✓ | 1 | S | ✓ | ✗ | ✗ | CS | *Edgardh, K & Ormstad, K 2000, 'Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls', <i>Acta Paediatrica</i> , 88, pp 310–319. |
| ✓ | ✗ | ✗ | ✓ | 5 | S | ✓ | ✗ | ✗ | CS | **Euser, S, Alink, LR, Pannebakker, F, Vogels, T, Bakermans-Kranenburg, MJ, van IJzendoorn, MH 2013, 'The prevalence of child maltreatment in the Netherlands across a 5-year period', <i>Child Abuse & Neglect</i> , 37(10), pp 841–851. |
| ✗ | ✓ | ✗ | ✓ | 1 | H | ✗ | ✓ | ✓ | CS | *Fanslow, JL, Robinson, EM, Crengle, S & Perese, L 2007, 'Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand woman', <i>Child Abuse & Neglect</i> , 31(9), pp 935–945. |
| ✓ | ✗ | ✗ | ✓ | 5 | S | ✓ | ✓ | ✓ | CS | **Feng, JY, Chang, YT, Chang, HY, Fetzer, S & Wang, JD 2015, 'Prevalence of different forms of child maltreatment among Taiwanese adolescents: a population-based study', <i>Child Abuse & Neglect</i> , 42, pp 10–19. |
| ✗ | ✓ | ✗ | ✗ | 1 | H | ✓ | ✓ | ✓ | C | Ferguson, DM & Horwood, LJ 1998, 'Exposure to interparental violence in childhood and psychological adjustment in young adulthood', <i>Child Abuse & Neglect</i> , 22(5), pp 339–357. |
| ✗ | ✓ | ✗ | ✓ | 2 | S | ✗ | ✗ | ✗ | CS | Figueiredo, B, Bifulco, A, Paiva, C, Maia, A, Fernandes, E & Matos, R 2004, 'History of childhood abuse in Portuguese parents', <i>Child Abuse & Neglect</i> , 28, pp 669–682. |
| ✓ | ✗ | ✗ | ✓ | 2 | TI | ✓ | ✗ | ✗ | CS | Finkelhor, D & Dziuba-Leatherman, J 1994, 'Children as victims of violence: a national survey', <i>Pediatrics</i> , 94(4), pp 413–420. |
| ✓ | ✗ | ✗ | ✓ | 5 | CATI | ✓ | ✓ | ✓ | CS | **Finkelhor, D, Ormrod, R, Turner, H & Hamby, SL 2005, 'The victimization of children and youth: a comprehensive, national survey', <i>Child Maltreatment</i> , 10(1), pp 5–25. |
| ✓ | ✗ | ✗ | ✓ | 5 | CATI | ✓ | ✓ | ✓ | CS | **Finkelhor, D, Turner, H, Ormrod, R & Hamby, SL 2009, 'Violence, abuse, and crime exposure in a national sample of children and youth', <i>Pediatrics</i> , 124(5), pp 1411–1423. |
| ✓ | ✗ | ✗ | ✓ | 5 | CATI | ✓ | ✓ | ✓ | CS | **Finkelhor, D, Vanderminden, J, Turner, H, Hamby, S & Shattuck, A 2014, 'Child maltreatment rates assessed in a national household survey of caregivers and youth', <i>Child Abuse & Neglect</i> , 38, pp 1421–1435. |

| Child | Adult | ICSA | CSA | No. of the 5 forms | Administration | Nation wide | Instrument Psychometrics | Type of study | Study (* = CSA only; ** = all 5 forms) |
|-------|-------|------|-----|--------------------|---------------------|-------------|-----------------------------|---------------|---|
| ✓ | ✗ | ✗ | ✓ | 5 | CATI | ✓ | ✓ | CS | **Finkelhor, D, Turner, HA, Shattuck, A & Hamby, SL 2015, 'Prevalence of childhood exposure to violence, crime, and abuse: results from the National Survey of Children's Exposure to Violence', <i>JAMA Pediatrics</i> (in press). |
| ✗ | ✓ | ✗ | ✓ | 1 | TI | ✗ | ✗ | CS | *Hébert, M, Tourigny, M, Cyr, M, McDuff, P & Joly, J 2009, 'Prevalence of childhood sexual abuse and timing of disclosure in a representative sample of adults from Quebec', <i>The Canadian Journal of Psychiatry</i> , 54(9), pp 631–636. |
| ✓ | ✗ | ✗ | ✓ | 1 | S + CASI | ✓ | ✗ | CS | *Helweg-Larsen, K & Larsen, HB 2006, 'The prevalence of unwanted and unlawful sexual experiences reported by Danish adolescents: results from a national youth survey in 2002', <i>Acta Paediatrica</i> , 95, pp 1270–1276. |
| ✗ | ✓ | ✗ | ✗ | 1 | TI | ✓ | ✗ | CS | Hemenway, D, Solnick, S & Carter, J 1994, 'Child-rearing violence', <i>Child Abuse & Neglect</i> , 18(12), pp 1011–1020. |
| ✗ | ✓ | ✗ | ✓ | 3 | H + CASI | ✓ | ✗ | CS | Hussey, JM, Chang, JJ & Kotch, JB 2006, 'Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences', <i>Pediatrics</i> , 118(3), pp 933–942. |
| ✓ | ✗ | ✗ | ✓ | 1 | S | ✓ | ✓ | CS | *Kim, Hyun-Sil & Kim, Hun-Soo 2005, 'Incestuous experience among Korean adolescents: prevalence, family problems, perceived family dynamics, and psychological characteristics', <i>Public Health Nursing</i> , 22(6), pp 472–482. |
| ✗ | ✓ | ✗ | ✓ | 4 | M | ✓ | ✓ | CS | Laaksonen, T, Sariola, H, Johansson, A, Jern, P, Varjonen, M, von der Pahlen, B, Sandnabba, K & Santtila, P 2011, 'Changes in the prevalence of child sexual abuse, its risk factors, and their associations as a function of age cohort in a Finnish population sample', <i>Child Abuse & Neglect</i> , 35(7), pp 480–490. |
| ✗ | ✓ | ✓ | ✓ | 1 | Online survey panel | ✗ | ✗ | CS | *Langeland, W, Hoogendoorn, AW, Mager, D, Smit, JH & Draijer, N 2015, 'Childhood sexual abuse by representatives of the Roman Catholic Church: a prevalence estimate among the Dutch population', <i>Child Abuse & Neglect</i> , 46, pp 67–77. |
| ✓ | ✗ | ✗ | ✗ | 2 | S | ✗ | ✗ | CS | Lau, JTF, Liu, JL & Cheung, JCK 1999, 'Prevalence and correlates of physical abuse in Hong Kong Chinese adolescents: a population-based approach', <i>Child Abuse & Neglect</i> , 23(6), pp 549–557. |
| ✓ | ✗ | ✓ | ✗ | 2 | S | ✗ | ✗ | CS | Lee, JH 2015, 'Prevalence and predictors of self-reported student maltreatment by teachers in South Korea', <i>Child Abuse & Neglect</i> , 46, pp 113–120. |
| ✓ | ✗ | ✗ | ✓ | 3 | S | ✗ | ✓ | CS | Leung, PW, Wong, WC, Chen, WQ & Tang, CS 2008, 'Prevalence and determinants of child maltreatment among high school students in Southern China: a large scale school based survey', <i>Child and Adolescent Psychiatry and Mental Health</i> , 2(1), p 27. |
| ✗ | ✓ | ✗ | ✗ | 2 | NR | ✗ | ✓ | CS | Machado, C, Goncalves, M, Matos, M & Dias, AR 2007, 'Child and partner abuse: self-reported prevalence and attitudes in the north of Portugal', <i>Child Abuse & Neglect</i> , 31(6), pp 657–70. |

| Child | Adult | ICSA | CSA | No. of the 5 forms | Administration | Nation wide | Instrument | Psychometrics | Type of study | Study (* = CSA only; ** = all 5 forms) |
|-------|-------|------|-----|--------------------|----------------|-------------|------------|---------------|---------------|--|
| ✓ | ✓ | ✗ | ✓ | 2 | H | ✗ | ✗ | ✗ | CS | MacMillan, HL, Fleming, JE, Trocmé, N, Boyle, MH, Wong, M, Racine, YA, Beardslee, WR & Offord, DR 1997, 'Prevalence of child physical and sexual abuse in the community: results from the Ontario Supplement', <i>JAMA</i> , 278(2), p 131. |
| ✗ | ✓ | ✗ | ✓ | 4 | H | ✓ | ✗ | ✗ | CS | May-Chahal, C & Cawson, P 2005, 'Measuring child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect', <i>Child Abuse & Neglect</i> , 29(9), pp 969–984. |
| ✗ | ✓ | ✗ | ✓ | 1 | CATI | ✓ | ✗ | ✗ | CS | *McGee, H, Garavan, R, Byrne, J, O'Higgins, M & Conroy, R 2011, 'Secular trends in child and adult sexual violence – one decreasing and the other increasing: a population survey in Ireland', <i>European Journal of Public Health</i> , 21(1), pp 98–103. |
| ✗ | ✓ | ✗ | ✓ | 1 | S | ✗ | ✓ | ✓ | C | *Moore, EE, Romaniuk, H, Olsson, CA, Jayasinghe, Y, Carlin, JB & Patton, GC 2010, 'The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in Victoria, Australia', <i>Child Abuse & Neglect</i> , 34(5), pp 379–385. |
| ✓ | ✗ | ✗ | ✓ | 1 | S | ✗ | ✗ | ✗ | CS | *Nelson, DE, Higginson, GK & Grant-Worley, JA 1994, 'Using the youth risk behaviour survey to estimate prevalence of sexual abuse among Oregon high school students', <i>Journal of School Health</i> , 64(10), pp 413–416. |
| ✗ | ✓ | ✗ | ✓ | 1 | S | ✗ | ✓ | ✓ | CS | *Perera, B & Ostbye, T 2009, 'Prevalence and correlates of sexual abuse reported by late adolescent school children in Sri Lanka', <i>International Journal of Adolescent Mental Health</i> , 21(2), pp 203–211. |
| ✗ | ✓ | ✗ | ✓ | 1 | H | ✓ | ✓ | ✓ | CS | *Perez-Fuentes, G, Olsson, M, Villegas, L, Morcillo, C, Wang, S & Blanco, C 2013, 'Prevalence and correlates of child sexual abuse: a national study', <i>Comprehensive Psychiatry</i> , 54(1), pp 16–27. |
| ✓ | ✓ | ✗ | ✓ | 5 | CASI | ✓ | ✓ | ✓ | CS | **Radford, L, Corral, S, Bradley, C & Fisher, HL 2013, 'The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults', <i>Child Abuse & Neglect</i> , 37(10), pp 801–813. |
| ✗ | ✓ | ✗ | ✗ | 4 | CASI | ✗ | ✗ | ✗ | CS | Rosenman, S & Rodgers, B 2004, 'Childhood adversity in an Australian population,' <i>Journal of Social Psychiatry and Psychiatric Epidemiology</i> , 39, pp 695–702. |
| ✓ | ✗ | ✗ | ✓ | 2 | S | ✓ | ✗ | ✗ | CS | Sariola, H & Uutela, A 1992, 'The prevalence and context of family violence against children in Finland', <i>Child Abuse & Neglect</i> , 16(6), pp 823–832. Sariola, H & Uutela, A 1994, 'The prevalence of child sexual abuse in Finland', <i>Child Abuse & Neglect</i> , 18(10), pp 827–835 |
| ✗ | ✓ | ✗ | ✓ | 3 | M | ✗ | ✓ | ✓ | C | Sørbø, MF, Grimstad, H, Bjørngaard, JH, Schei, B & Lukasse, M 2013, 'Prevalence of sexual, physical and emotional abuse in the Norwegian mother and child cohort study', <i>BMC Public Health</i> , 13, p 186. |

| Child | Adult | ICSA | CSA | No. of the 5 forms | Administration | Nation wide | Instrument Psychometrics | Type of study | Study (* = CSA only; ** = all 5 forms) |
|-------|-------|------|-----|--------------------|----------------|-------------|-----------------------------|---------------|--|
| ✓ | ✗ | ✗ | ✗ | 3 | S | ✗ | ✓ | CS | Stephenson, R, Sheikhattari, P, Assasi, N, Eftekhari, H, Zamani, Q, Maleki, B & Kiabayan, H 2006, 'Child maltreatment among school children in the Kurdistan Province, Iran', <i>Child Abuse & Neglect</i> , 30, pp 231–245. |
| ✗ | ✓ | ✗ | ✓ | 4 | HH | ✓ | ✗ | CS | Tsuboi, S, Yoshida, H, Ae, R, Kojo, T, Nakamura, Y & Kitamura, K 2015, 'Prevalence and demographic distribution of adult survivors of child abuse in Japan', <i>Asia Pacific Journal of Public Health</i> , 27(2), NP2578-NP2586. |
| ✓ | ✓ | ✗ | ✓ | 5 | S | ✓ | ✓ | CS | **van der Kooij, IW, Nieuwendam, J, Bipat, S, Boer, F, Lindauer, RJL & Graafsma, TLG 2015, 'A national study on the prevalence of child abuse and neglect in Suriname', <i>Child Abuse & Neglect</i> (in press). |
| ✗ | ✓ | ✗ | ✓ | 1 | H | ✓ | ✓ | C | *Vogeltanz, ND, Wilsnack, SC, Harris, TR, Wilsnack, RW, et al. 1999, 'Prevalence and risk factors for childhood sexual abuse in women: National survey findings', <i>Child Abuse & Neglect</i> , 23(6), pp 579–592. |
| ✓ | ✗ | ✗ | ✓ | 3 | S | ✗ | ✓ | CS | Wong, WC, Leung, PW, Tang, CS, Chen, WQ, Lee, A & Ling, DC 2009, 'To unfold a hidden epidemic: prevalence of child maltreatment and its health implications among high school students in Guangzhou, China', <i>Child Abuse & Neglect</i> , 33(7), pp 441–450. |
| ✓ | ✗ | ✗ | ✓ | 1 | S | ✗ | ✓ | CS | *Worku, D, Gebremariam, A & Jayalakshi, S 2006, 'Child sexual abuse and its outcomes among high school students in southwest Ethiopia', <i>Tropical Doctor</i> , 36, pp 137–140. |
| ✓ | ✗ | ✗ | ✓ | 2 | S | ✗ | ✓ | CS | Yen, CF, Yang, MS, Yang, MJ, Su, YC, Wang, MH & Lan, CM 2008, 'Childhood physical and sexual abuse: prevalence and correlates among adolescents living in rural Taiwan', <i>Child Abuse & Neglect</i> , 32(3), pp 429–438. |

Part 2 – Overview of key features of 14 studies with child participants only (aged under 18)

Of the 49 eligible studies, 14 involved only child participants who were aged under 18. Four studies by Finkelhor et al. (2005, 2009, 2014, 2015), which directly surveyed children aged 10–17, are included in this section despite also involving parental participants for a separate age cohort of children (infancy to age nine). Ten of these 14 studies involved nationwide representative samples of children (Ajduković et al., 2013; Edgardh & Ormstad, 2000; Euser, 2013; Finkelhor, 1994, 2005, 2009, 2014, 2014; Helweg-Larsen, 2006; Sariola, 1992). Five studies were both nationwide and covered all five maltreatment types (Euser et al., 2013; Finkelhor et al., 2005, 2009, 2014, 2015). None of the 14 studies is Australian.

The 14 studies are:

- 1) Ajduković, M, Sušac, N & Rajter, M 2013, 'Gender and age differences in prevalence and incidence of child sexual abuse in Croatia', *Croatian Medical Journal*, 54(5), pp 469–479.
- 2) Annerbäck, EM, Wingren, G, Svedin, CG & Gustafsson, PA 2010, 'Prevalence and characteristics of child physical abuse in Sweden – Findings from a population-based youth survey', *Acta Paediatrica*, 99(8), pp 1229–1236.
- 3) Edgardh, K & Ormstad, K 2000, 'Prevalence and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls,' *Acta Paediatrica*, 88, pp 310–19.
- 4) Euser, S, Alink, LR, Pannebakker, F, Vogels, T, Bakermans-Kranenburg, MJ, van IJzendoorn MH 2013, 'The prevalence of child maltreatment in the Netherlands across a 5-year period', *Child Abuse & Neglect*, 37(10), pp 841–851.
- 5) Finkelhor, D & Dziuba-Leatherman, J 1994, 'Children as victims of violence: a national survey', *Pediatrics*, 94(4), pp 413–20.
- 6) Finkelhor, D, Ormrod, R, Turner, H & Hamby, SL 2005, 'The victimization of children and youth: a comprehensive, national survey', *Child Maltreatment*, 10(1), pp 5–25.
- 7) Finkelhor, D, Turner, H, Ormrod, R & Hamby, SL 2009, 'Violence, abuse, and crime exposure in a national sample of children and youth', *Pediatrics*, 124(5), pp 1411–1423.
- 8) Finkelhor, D, Vanderminden, J, Turner, H, Hamby, S & Shattuck, A 2014, 'Child maltreatment rates assessed in a national household survey of caregivers and youth', *Child Abuse & Neglect*, 38, pp 1421–1435.
- 9) Finkelhor, D, Turner, HA, Shattuck, A & Hamby, SL 2015, 'Prevalence of childhood exposure to violence, crime, and abuse: results from the National Survey of Children's Exposure to Violence', *JAMA Pediatrics* (in press).
- 10) Helweg-Larsen, K & Larsen, HB 2006, 'The prevalence of unwanted and unlawful sexual experiences reported by Danish adolescents: results from a national youth survey in 2002', *Acta Paediatrica*, 95, pp 1270–1276.

- 11) Lee, JH 2015, 'Prevalence and predictors of self-reported student maltreatment by teachers in South Korea', *Child Abuse & Neglect*, 46, pp 113–120.
- 12) Leung, PW, Wong, WC, Chen, WQ & Tang, CS 2008, 'Prevalence and determinants of child maltreatment among high school students in Southern China: a large scale school based survey', *Child and Adolescent Psychiatry and Mental Health*, 2(1), p 27.
- 13) Sariola, H & Uutela, A 1992, 'The prevalence and context of family violence against children in Finland', *Child Abuse & Neglect*, 16(6), pp 823–832; Sariola, H, Uutela, A 1994, 'The prevalence of child sexual abuse in Finland', *Child Abuse & Neglect*, 18(10), pp 827–835.
- 14) Wong, WC, Leung, PW, Tang, CS, Chen, WQ, Lee, A & Ling, DC 2009, 'To unfold a hidden epidemic: prevalence of child maltreatment and its health implications among high school students in Guangzhou, China', *Child Abuse & Neglect*, 33(7), pp 441–450.

The summary below captures key themes. Table 11 then provides further details about these studies' key dimensions of *design* (prevalence, incidence or both; period; maltreatment types; participant age range; single or repeated; retrospective or prospective); *sample* (sampling frame; sampling strategy; sample size; response rate); *procedure* (recruitment measures; method of administration; data collection personnel; data collection time); *ethics* (whose consent was obtained; measures for reporting suspected risk; measures for providing assistance; adverse events reported); and *instrument* (name; validity and reliability; maltreatment types covered; items about ICSEA; and presence and number of items about CSA, PA, E/PA, N and EDV).

Study location

- Europe (including UK) = 6
- US = 5
- Asia = 3
- Australia = 0

Prevalence or incidence

- Both prevalence and incidence = 6
- Prevalence only (childhood/before 18) = 3
- Incidence only (typically over past 12 months) = 5

Maltreatment subtypes

- five studies covered all five maltreatment types (Euser 2013; Finkelhor x 4: 2005, 2009, 2014, 2015)
- two studies covered CSA only
- five studies covered other combinations of maltreatment subtypes
- two studies did not elicit data on CSA (Annerback; Lee)
- zero studies covered ICSEA

Participants

- Children only (under 18 years) = 14 studies³³
- The youngest children were aged 10 – Finkelhor’s five studies as follows³⁴:
 - Finkelhor et al. 1994: children aged 10–16
 - Finkelhor et al. 2005, 2009, 2014, 2015 all cover children aged either 2–17 or 0–17; in each study, children aged 10–17 were direct participants (self-report) and children aged under 10 were indirect participants via parent/caregiver reporting
- Several studies were conducted either with children of a specific age, or over a narrower age range:
 - Ajduković: aged 11–16
 - Annerback: aged 13–17
 - Edgardh: aged 17
 - Euser: aged 12–17
 - Helweg-Larsen: aged 15–16
 - Sariola: aged 15–16
 - Wong: aged 12–16.

Cross-sectional or repeated measures studies

- Typically one-off/cross-sectional
- The study that has been repeated most often is Finkelhor’s NATSCEV in US (now every three years).

Key terms defined

- Some papers define abuse types in the article’s introduction or upfront
- Some definitions do not align with instrument descriptions of abuse types
- Instrument tends to dictate the definition and description of the abuse type

SAMPLE

Sample frame

- 10 of the 15 are nation-wide representative samples of children (Ajduković et al., 2013; Edgardh & Ormstad, 2000; Euser, 2013; Finkelhor, 1994, 2005, 2009, 2014, 2014; Helweg-Larsen, 2006; Sariola, 1994)

Sampling strategy

- All use a version of stratified random sampling or multistage/stratified random cluster sampling

³³ Note: This is usually dictated by the age range of children at school, but a number of studies involved participants who were ‘children’ but whose age exceeded 17 (10–19; 15–18; 14–23; 13–19; 12–20; 13–18).

³⁴ Note: In two studies involving both children and adults, Radford’s study involved children aged 11–17 who participated directly, and de Visser’s study involved child participants aged 16–17.

Sample size

- Of the 10 nationwide studies:
 - 1,500–2,500 = 7 (Finkelhor x 5; Edgardh; Euser)
 - 2,500–3,000 = 1 (Ajduković)
 - >5,000 = 2 (Helweg-Larsen; Sariola)

Response rates

- Phone studies – High response rates (60–88% in Finkelhor’s studies). The response rate is somewhat lower in more recent studies but is still reported as sufficient.
- School studies – High response rates generally (studies were conducted in systems where children consent for themselves, where no parental consent was necessary and parents were simply informed about the study’s conduct, or where passive parental consent was sufficient).

PROCEDURE

Recruitment

- Through school = 9
- By phone = 5 (Finkelhor x 5)
- Measures used to recruit special subsamples were generally not described in studies. Of those that did report measures, the typical strategy was oversampling by ethnicity.

Administration method

- In school with hard-copy questionnaire = 9
- In school with multimedia handheld device/online = 1
- CATI = 3
- Phone interview = 1

Data collection time

- The range is generally 1–6 months, depending on method of administration and number of personnel

Adverse events

- No studies reported adverse events for child participants

INSTRUMENT

Instruments

- JVQ or modified/enhanced JVQ = 5 (Finkelhor x 4; Helweg-Larsen)
- Conflict Tactics Scale (CTS) or adapted CTS = 3
- ICAST-C = 1
- Other adapted instruments/new instruments = 5

Validity and reliability data

- JVQ and CTS have reliability data, and ICAST has good strategies for validation (focus groups, including with children and pilot testing with data reported)
- Few report this data
- None report on development of measurement models with new populations

Table 11 Studies with child participants only: key features of study design, sample, procedure, ethics and instrument

| Study details | | Design | | | | | | Sample | | | |
|--------------------------------------|-----------------------------|-----------------------------|---------------------|---------------------|-----------------------------|-----------------------------------|----------------------------------|---|--|---|--|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Child participant age range | Single/ repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Ajduković et al. (2013) | Croatia | Both | Lifetime; past year | SA | 11–16 years | Single | Retrospective | General population of children aged 11, 13, 16 | Nationally representative probabilistic 2-stage stratified cluster sample of students in Croatia | n = 3,175 | NR |
| Annerback et al. (2010) | Sweden; Sodermanland County | Prevalence | Lifetime | PA | 13–17 years | Single | Retrospective | Students in Sodermanland County, Sweden | All students in Grades 7, 9 and upper secondary school Grade 2 | n = 8,494 | NR |
| Edgardh & Ormstad (2000) | Sweden | Prevalence | Lifetime | SA | 17 years | Single | Retrospective | Nationally representative sample of 17 year olds from schools and youth centres | National representative sample of 17 year olds: random sample of students from 100 of the nation's 500 upper secondary schools and 30 youth centres for non-school attendees | n = 1,943 (students from 93/100 schools) and n = 210 (non-school) | 92.2% (students) and 44.2% (non-school) |
| Euser et al. (2013) | Netherlands | Incidence | Past year | SA, PA E/PA, N, EDV | 12–17 years | Single | Retrospective | National – students 12–17 years | Random selection of 42 high schools, each with 4 randomly selected classes | n = 1,920 (from 29/42 schools) | NR |
| Finkelhor & Dziuba-Leatherman (1994) | US | Both | Lifetime; past year | SA, PA | 10–16 years | Single | Retrospective | Nationally representative sample of households | Random digit dialling | n = 2,000 | 88% (adults) and 82% (eligible children) |

| Study details | | Design | | | | | | Sample | | | |
|---|----------|-----------------------------|---------------------|----------------------|---|-----------------------------------|----------------------------------|--|--|--|--|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Child participant age range | Single/ repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Finkelhor et al. (2005) Developmental Victimization Survey | US | Incidence | 12 months | SA, PA, E/PA, N, EDV | 2–17 years (children aged 10–17; parents/care givers of children aged 2–9) | Repeated 5 years | Retrospective | Nationally representative sample of children aged 2–17 | Random digit dialling | n = 2,030 (including n = 1,000 children aged 10–17 and n = 1,030 parents/ caregivers of children aged 2–9) | 79.5% (of eligible persons contacted) |
| Finkelhor et al. (2009) NATSCEV 1 | US | Both | Lifetime; past year | SA, PA, E/PA, N, EDV | 2–17 years (children aged 10–17; parents/care givers of children aged 2–9) | Repeated 3 years | Retrospective | Cross-sectional national sample of children aged 2–17 | National landline residential telephone survey | n = 4,549 (n = 3,053 national cross-section and n = 1,496 oversample 'Hispanic, African-American, low-income'); n = 2,095 aged 10–17 | 71% (cross-section) and 63% (oversample) |
| Finkelhor et al. (2014) NATSCEV 2 | US | Both | Lifetime; past year | SA, PA, E/PA, N, EDV | 1 month to 17 years (children aged 10–17; parents/care givers of children aged infant to 9) | Repeated 3 years | Retrospective | Nationwide sampling frame of residential phone numbers | Random digit dialling and to capture those without landlines 2 samples were added, 1 of mobile phone numbers (n = 31; abandoned due to low yield) and address sample (n = 750) | Total n = 4,503 n aged 10–17 not reported but ~2,000 | 60% (of eligible respondents) |

| Study details | | Design | | | | | | Sample | | | |
|--|---------------------------|-----------------------------|---|----------------------|--|-----------------------------------|----------------------------------|-----------------------------------|---|---|--|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Child participant age range | Single/ repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Finkelhor et al. (2015) NATSCEV 3 | US | Both | Lifetime; past year | SA, PA, E/PA, N, EDV | 0–17 years (children aged 10–17; parents/care givers of children aged infant to 9) | Repeated | Retrospective | National sample | Nationally representative sample of phone numbers via 4 methods | n = 4,000 n = 1,949 aged 10–17 | (differed across 4 sample frames) |
| Helweg-Larsen et al. (2006) | Denmark | Prevalence | Before age 15 | SA | 15–16 years | Single | Retrospective | Ninth grade students in Denmark | Random sample of 183 schools representing all regions in Denmark | n = 7,241 | 86% |
| Lee (2015) | South Korea | Incidence | Past year | PA, E/PA | Year 7–9 of school | Single | Retrospective | Seoul and province of Gyeonggi-do | Random sample of middle schools, 5 or 6 from province divided into NWES; 1 class randomly selected in each school | n = 1,777 | NR |
| Leung et al. (2008) | China, Guangzhou province | Incidence | Past 6 months | SA, PA, E/PA | 13–15 years, (m = 14.68 years) | Single | Retrospective | Aged 13–15 in Guangzhou province | 24 high schools out of 192 schools in the region via stratified random sample using districts (8 districts) and banding (province/city) | n = 6,592 | 99.70% |
| Sariola & Uutela (1992, 1994) | Finland | Both | Pre-14th birthday; in the year before study | PA | 15–16 years | Single | Retrospective | 9th grade students in Finland | 409 of 2,770 9th grade classes randomly selected | n = 7,349 | 96% (average individual student response rate) |
| Wong et al. (2009) | Guangzhou province, China | Incidence | Past 6 months | SA, PA, E/PA | 12–16 years (m = 14.2 years) | Single | Retrospective | High school students | 27 high schools out of 192 schools randomly selected from 8 districts; 2 classes from each school randomly selected | n = 6,593 (144 classes from 24 schools) | 89% (school response rate) |

| Study | Procedure | | | | Ethics | | | |
|--------------------------------------|------------------------------------|----------------------|---|---------------------------|--|----------------------------|--|-------------------------|
| | Study citation | Recruitment measures | Method of administration | Data collection personnel | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance |
| Ajduković et al. (2013) | Through school | In school | Researchers | 4 months | Both; parents' consent for children <14 years; child's consent older than 14 | Y | Y (helpline number) | N |
| Annerback et al. (2010) | Through school | In school | Staff in organisation (school nurses and teachers, p 1,230) | 2 months | Both; parents' passive consent for children ≤14 years; child's consent older than 15 years | N | Y (information about counselling services) | N |
| Edgardh & Ormstad (2000) | Through school, other organisation | In school | Staff in organisation | NR | Child | N | Y | N |
| Euser et al. (2013) | NR | In school | NR | NR | Both parent and child | NR | NR | N |
| Finkelhor & Dziuba-Leatherman (1994) | Phone | Phone | Research company | NR | Both parent and child | Y | Y | N |
| Finkelhor et al. (2005) DVS | Phone | CATI | Research company | Dec 2002 to Feb 2003 | Both parent and child | Y | NR | N |
| Finkelhor et al. (2009) NATSCEV 1 | Phone | CATI | Research company | Jan–May 2008 | Both parent and child | Y | Y | N |
| Finkelhor et al. (2014) NATSCEV 2 | Phone | CATI | Research company | Aug 2013 to Aug 2014 | Both parent and child | Y | N | N |
| Finkelhor et al. (2015) NATSCEV3 | Phone | CATI | NR | Aug 2013 to Apr 2014 | Both parent and child | Y | NR | N |

| Study | Procedure | | | | Ethics | | | |
|-------------------------------|---------------------------|--|---|----------------------------|---|---------------------------------------|--|-------------------------|
| Study citation | Recruitment measures | Method of administration | Data collection personnel | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance | Adverse events reported |
| Helweg-Larsen et al. (2006) | Through school | In school (multi-media CASI with laptop) | Research company (trained interviewers) | 2002 (months not reported) | Both (parent passive consent, child active consent on laptop) | NR | Y (information about free counselling) | N |
| Lee (2015) | Through school, principal | In school | NR | 5 weeks Oct-Nov 2012 | Child (parent representative on school council) | NR | NR | N |
| Leung et al. (2008) | Through school, principal | In school | NR | NR | Child | N | N | N |
| Sariola & Uutela (1992, 1994) | Through school | In school | Nurses (school nurses) | NR | NR | NR | Y (directed to school nurse, psychologist) | N |
| Wong et al. (2009) | Through school | In school | NR | 4 months | Child | NR | NR | N |

| Study | Instrument | | | | | | | | | |
|-------------------------|--|--------------------------|-------------|------------------|------------------|--------------------------------|---|---------------------------------|------------------------------|--------------------------------|
| Study citation | Instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (no. of items) | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (no. of items) | Items about EDV (no. of items) |
| Ajdković et al. (2013) | ICAST-C (modified – longer/shorter versions) | Yes; focus groups; pilot | Yes | N | SA | Y 5 | Y NR | Y NR | N | N |
| Annerback et al. (2010) | Based on Swedish studies | NR | NR | N | PA | N | Y Year 7: 68; Year 9: 87; Senior, 98 | N | N | N |

| Study | Instrument | | | | | | | | | |
|--------------------------------------|--|---------------------------------------|--------------------------------------|------------------|----------------------|---|---|--|---|--------------------------------|
| Study citation | Instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (no. of items) | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (no. of items) | Items about EDV (no. of items) |
| Edgardh & Ormstad (2000) | NR | NR | NR | N | SA | Y 6 | N | N | N | N |
| Euser et al. (2013) | Combined several tools (p 844) | NR | NR | N | SA, PA, E/PA, N, EDV | Y 24 across all types | Y 24 across all types | Y 24 across all types | Y 24 across all types | N |
| Finkelhor & Dziuba-Leatherman (1994) | NR | NR | NR | N | SA, PA | Y 6 | Y 6 | N | N | N |
| Finkelhor et al. (2005) DVS | Juvenile Victimization Questionnaire (JVQ) | Yes, previous paper (2005, 'The JVQ') | Yes, previous paper (2005 'The JVQ') | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 2 | Y 1 | Y 2 |
| Finkelhor et al. (2009) NATSCEV 1 | Enhanced version of JVQ | 2005, 'The JVQ' | 2005 'The JVQ' | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 1 | Y 1 | Y 8 |
| Finkelhor et al. (2014) NATSCEV 2 | Enhanced version of JVQ | NR | NR | N | SA, PA, E/PA, N, EDV | Y 4 screener items (S1–S4) + 14 nature and context items | Y 1 screener item (M1) + 12 nature and context items | Y 1 screener item (M2) + 8 nature and context items | Y 5 screener items (M3, 5, 6, 8, 9) + 8 nature and context items | Y NR |
| Finkelhor et al. (2015) NATSCEV 3 | JVQ | 2005, 'The JVQ' | 2005, 'The JVQ' | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 1 | Y 5 | Y 6 |

| Study | Instrument | | | | | | | | | |
|-------------------------------|---|--------------------------------|--------------------------------|------------------|------------------|--------------------------------|-------------------------------|---------------------------------|------------------------------|--------------------------------|
| Study citation | Instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (no. of items) | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (no. of items) | Items about EDV (no. of items) |
| Helweg-Larsen et al. (2006) | Modified JVQ | NR | NR | N | SA | Y 14 | N | N | N | N |
| Lee (2015) | NR | NR | NR | N | PA, E/PA | N | Y 3 | Y 2 | N | N |
| Leung et al. (2008) | Conflict Tactics Scale, Parent-child version (CTSPC) | Yes, previous paper | N | N | SA, PA, E/PA | Y 2 | Y 15 | Y 5 | N | N |
| Sariola & Uutela (1992, 1994) | Based on CTS (Straus, 1980) | NR | NR | N | SA, PA | Y | PA 10 SA not reported | N | N | N |
| Wong et al. (2009) | CTS: Straus 1979; CTS parent-child version: Straus 1998 | Yes, previous paper: Chan 2005 | Yes, previous paper: Chan 2005 | N | SA, PA, E/PA | Y 2 | Y 14 | Y 7 | N | N |

Part 3 – Overview of key features of 14 nationwide studies with adult participants (or adults and children)

Of the 49 eligible studies, 14 involved nationwide samples primarily comprising only adult participants (two studies included some child participants: de Visser; Radford).³⁵ Only one of these 14 studies covered all five maltreatment types (Radford et al., 2013), but four others covered all maltreatment types except exposure to family violence (Christoffersen et al., 2013; Laaksonen et al., 2011; May-Chahal & Cawson, 2005; Tsuboi et al., 2015). Two Australian studies are included in this group, both of which covered sexual abuse only (de Visser et al., 2003; Dunne et al., 2003).

The 14 studies are:

- 1) Briere, J & Elliott, DM 2003, 'Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women', *Child Abuse & Neglect*, 27(10), pp 1205–1222.
- 2) Christoffersen, MN, Armour, C, Lasgaard, M, Andersen, TE & Elklit, A 2013, 'The prevalence of four types of childhood maltreatment in Denmark', *Clinical Practice & Epidemiology in Mental Health*, 9, pp 149–156.
- 3) de Visser, RO, Smith, AMA, Rissel, CE, Richters, J & Grulich, AE 2003, 'Sex in Australia: Experiences of sexual coercion among a representative sample of adults', *Australian & New Zealand Journal of Public Health*, 27(2), pp 198–203.
- 4) Dunne, M, Purdie, D, Cook, M, Boyle, F & Najman, J 2003, 'Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia', *Child Abuse & Neglect*, 27, pp 141–152.
- 5) Ferguson, DM & Horwood, LJ 1998, 'Exposure to interparental violence in childhood and psychological adjustment in young adulthood', *Child Abuse & Neglect*, 22(5), pp 339–357.
- 6) Hemenway, D, Solnick, S & Carter, J 1994, 'Child-rearing violence', *Child Abuse & Neglect*, 18(12), pp 1011–1020.
- 7) Hussey, JM, Chang, JJ & Kotch, JB 2006, 'Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences', *Pediatrics*, 118(3), pp 933–942.
- 8) Laaksonen, T, Sariola, H, Johansson, A, Jern, P, Varjonen, M, von der Pahlen, B, Sandnabba, K & Santtila, P 2011, 'Changes in the prevalence of child sexual abuse, its risk factors, and their associations as a function of age cohort in a Finnish population sample', *Child Abuse & Neglect*, 35(7), pp 480–490.

³⁵ Note: van der Kooij is not included in this section despite involving participants aged 12–22 since that study was conducted primarily of children in schools and vocational training settings and involved only 246 adults. In addition, cohort studies such as Hussey et al., 2006 and Tsuboi et al. involved child participants in earlier waves, which were not reported.

- 9) May-Chahal, C & Cawson, P 2005, 'Measuring child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect', *Child Abuse & Neglect*, 29(9), pp 969–984.
- 10) McGee, H, Garavan, R, Byrne, J, O'Higgins, M & Conroy, R 2011, 'Secular trends in child and adult sexual violence – one decreasing and the other increasing: a population survey in Ireland', *European Journal of Public Health*, 21(1), pp 98–103.
- 11) Perez-Fuentes, G, Olfson, M, Villegas, L, Morcillo, C, Wang, S & Blanco, C 2013, 'Prevalence and correlates of child sexual abuse: a national study', *Comprehensive Psychiatry*, 54(1), pp 16–27.
- 12) Radford, L, Corral, S, Bradley, C & Fisher, HL 2013, 'The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults', *Child Abuse & Neglect*, 37(10), pp 801–813.
- 13) Tsuboi, S, Yoshida, H, Ae, R, Kojo, T, Nakamura, Y & Kitamura, K 2015, 'Prevalence and demographic distribution of adult survivors of child abuse in Japan', *Asia Pacific Journal of Public Health*, 27(2), NP2578-NP2586.
- 14) Vogeltanz, ND, Wilsnack, SC, Harris, TR, Wilsnack, RW, et al. 1999, 'Prevalence and risk factors for childhood sexual abuse in women: National survey findings', *Child Abuse & Neglect*, 23(6), pp 579–592.

The summary below captures key themes. Table 12 then provides further details about these studies' key dimensions of *design* (prevalence, incidence or both; period; maltreatment types; participant age range; single or repeated; retrospective or prospective); *sample* (sampling frame; sampling strategy; sample size; response rate); *procedure* (recruitment measures; method of administration; data collection personnel; data collection time); *ethics* (whose consent was obtained; measures for reporting suspected risk; measures for providing assistance; adverse events reported); and *instrument* (name; validity and reliability; maltreatment types covered; items about ICSEA; and presence and number of items about CSA, PA, E/PA, N and EDV).

DESIGN

Study location

- Europe (including UK) = 5
- US = 5
- Asia = 1
- Australia = 2
- New Zealand = 1

Maltreatment subtypes

- 1 study covered all five maltreatment types (Radford, 2013, involved three groups of participants: young adults aged 18–24; children aged 11–17 as direct participants; and parents/caregivers responding for children aged under 11)

- 4 studies covered four maltreatment types
- 5 studies covered CSA only
- 4 studies covered other combinations of maltreatment subtypes
- 2 studies did not elicit data on CSA
- zero studies covered ICSEA

Participants

- These 14 studies were directed primarily at adults only (age range 18–90). Two studies involved adults and children, as follows:
 - de Visser et al., 2003: age range 16–59
 - Radford et al., 2013, involved three groups of participants: young adults aged 18–24; children aged 11–17 as direct participants; and parents/caregivers responding for children aged under 11

Cross-sectional or repeated measures studies

- Typically one-off/cross-sectional; five are repeated

SAMPLE

Sample frame

- All are nationwide representative samples of adults

Sampling strategy

- All use a version of stratified random sampling or multistage/stratified random cluster sampling

Sample size/number of participants

- Of the 13 studies:
 - <1,500 = 4
 - 1,500–2,500 = 2 (Dunne: 1,784; Radford: 1,761 adults aged 18–24)
 - 2,500–3,500 = 4
 - >3,500 = 4

Response rates

- 9 are between 57–77%
- 1 over 90%
- 4 not reported or not identifiable

PROCEDURE

Recruitment

- By phone = 4
- Home = 5
- Other (e.g. cohort) = 5

Administration method

- CATI = 2 (de Visser, Dunne)
- Phone interview = 2
- Phone and home = 1
- Home only = 5
- Other/NR = 4

Data collection time

- Range of 1–10 months = 4 (most are not reported)

Adverse events

- No studies reported adverse events

Instruments

- A range of instruments have been used, and other studies have created new instruments

Table 12 Nationwide studies with adult participants (with two involving adults and children): key features of study design, sample, procedure, ethics and instrument

| Study details | | Design | | | | | Sample | | | |
|------------------------------|-------------|-----------------------------------|--|-----------------|-------------------------|---|--|--|----------------------------------|---------------|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Participant age range | Single/ repeated study (interval) | Sampling frame | Sampling strategy | Sample size | Response rate |
| Briere & Elliott (2003) | US | Prevalence | Younger than 18 | SA, PA | 18–90 years (m = 46yrs) | Single | National | Geographically stratified random sample of general population | n = 935/1,442 | 64.80% |
| Christoffersen et al. (2013) | Denmark | Prevalence | Age <12 (PA, E/PA, N); age <24 for SA | SA, PA, E/PA, N | 24 | Single | Total birth cohort of all children born in 1984 | Stratified random sample of 24 year olds | n = 2,980/4,718 | 63% |
| de Visser et al. (2003) | Australia | Prevalence | <9; 9–12; 13–16; 17–20; 21–24; 25+ | SA | 16–59 | Single | National representative sample of men and women | Representative sample of men and women, modified random digital dial | n = 19,307 | 73% |
| Dunne et al. (2003) | Australia | Prevalence | Younger than 16 | SA | 18–59 | Single | Nationally representative sample of men and women aged 18–59 | Names of 4,449 adults drawn randomly from electoral roll – search for phone numbers for each name using White Pages and Desktop Marketing System | n = 4,449; participant n = 1,784 | 61% |
| Ferguson & Horwood (1998) | New Zealand | Prevalence | Childhood | EDV | 18 | Repeated | National | Longitudinal birth cohort study | n = 1,265 | 92% |
| Hemenway et al. (1994) | US | Prevalence | Childhood | PA | NR | Single | Adult American men and women | National random digit dialling telephone survey | n = 801 | NR |

| Study details | | Design | | | | | Sample | | | |
|-----------------------------|----------|-----------------------------------|--|----------------------|--|---|---|---|---|---|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Participant age range | Single/ repeated study (interval) | Sampling frame | Sampling strategy | Sample size | Response rate |
| Hussey et al. (2006) | US | Prevalence | Lifetime prevalence before 6th grade | PA, SA, N | 18–26 | Repeated | US Adolescents/ Young Adults | Nationally representative probability sample of adolescents in grades 7–12 in 1994–95 school year | n = 15,197 | 77% |
| Laaksonen et al. (2011) | Finland | Prevalence | Younger than 16 | SA, PA, E/PA, N | 18–49, separated by cohorts: 18–23; 24–29; 30–35; 36–41; 42–49 | Single | National | Via twin study | n = 4,561 (male) and n = 8,361 (female) | NR |
| May-Chahal & Cawson (2005) | UK | Prevalence | Childhood | SA, PA, E/PA, N | 18–24 | Single | Aged 18–24 in the UK | Random probability sample of general population based on postcode address file – 633 postcode sectors with probability proportional to population aged 18–24 after stratification | n = 90 addresses in each postcode; n = 56,979 addresses; n = 2,869 interviews | 69% |
| McGee et al. (2011) | Ireland | Prevalence | Childhood and adulthood | SA | 18–90 | Single | Representative sample of adult population | National cluster-randomised telephone interview study via random digit dialling | 3,120 participants | 71% |
| Perez-Fuentes et al. (2013) | US | Prevalence | Younger than 18 | SA | Over 18 | Repeated (wave 1 and wave 2 – CSA) | Population aged over 18 | NR | n = 34,653 | NR |
| Radford et al. (2013) | UK | Prevalence | Younger than 18, and also in the past year | SA, PA, E/PA, N, EDV | Parents of children aged 2 months to 10 years; children aged 11–17; young people aged 18–24 (m = 20.6 years) | Single | Children and young people in the UK aged under 25 | Random probability sampling of households from UK Postcode Address File (50,000 by mail), and eligibility determined by visits to check persons aged under 25 years | n = 2,160 (parents of children 2 months to 10 years); n = 2,275 (children 11–17 years); n = 1,761 (young adults aged 18–24) | 60.4% (no. of interviews completed as a proportion of all eligible households approached/ visited to check eligibility) |

| Study details | | Design | | | | | Sample | | | |
|-------------------------|----------|-----------------------------------|-----------------|--------------------------|-----------------------|---|----------------------------|--|-------------|---------------|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Participant age range | Single/ repeated study (interval) | Sampling frame | Sampling strategy | Sample size | Response rate |
| Tsuboi et al. (2015) | Japan | Prevalence | Younger than 18 | SA, PA, E/PA, N | 20–49 | Repeated | Japanese adults aged 20–49 | Multistage randomised cluster sampling; 44 clusters from 11 geographical units | n = 2,693 | 57.2% |
| Vogeltanz et al. (1999) | US | Prevalence | NR | SA | NR | Repeated (cohort) | US women aged 18 and over | National probability sample and nationally representative | n = 1,099 | NR |

| Study | Procedure | | | | | Ethics | | | |
|------------------------------|---|--------------------------|--|-----------------------------------|----------------------------|---------------------------------------|-------------------------|-------------------------|--|
| Study citation | Recruitment measures | Method of administration | Data collection personnel | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance | Adverse events reported | |
| Briere & Elliott (2003) | Direct to individual via mail (car and phone records) | Household, hard copy | NR | NR | Adult | NR | NR | NR | |
| Christoffersen et al. (2013) | NR | CATI | Researchers/RAs | NR | Adult | N | Y | N | |
| de Visser et al. (2003) | Phone | CATI | Research company ('with added training') | 12 months (May 2001 to June 2002) | Adult | NR | NR | N | |
| Dunne et al. (2003) | Phone | CATI | NR | 1 month (April 2000) | Adult | N | NR | N | |
| Ferguson & Horwood (1998) | NR | Household interview | NR | NR | Adult | NR | NR | N | |
| Hemenway et al. (1994) | Phone | Telephone interview | Research company | NR | NR | NR | NR | N | |

| Study | Procedure | | | | Ethics | | | |
|-----------------------------|--|--|--|-------------------------------------|---|---|---------------------------------------|-------------------------|
| | Study citation | Recruitment measures | Method of administration | Data collection personnel | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance |
| Hussey et al. (2006) | NR | Household CASI at home | Research company | 12 months (2001–2002) | Both (at start, for this component adult only, written) | NR | NR | N |
| Laaksonen et al. (2011) | Reported in Varjonen et al 2007 | Mail (Reported in Varjonen et al 2007) | NR | NR | Adult | NR | NR | N |
| May-Chahal & Cawson (2005) | Direct to individual | Household, computer assisted personal interview (CAPI) | Fieldwork company (trained interviewers in British Market Research Bureau and training by research team) | 5 months (7 Sep 1998 to 8 Feb 1999) | Adult | N | Y | N |
| McGee et al. (2011) | Phone | CATI | Specially trained researchers | NR | Adult | N | Y | N |
| Perez-Fuentes et al. (2013) | NR | Household, face-to-face interview | Experienced interviewers with training and supervision (p 17) – 5 years' experience, 5 days training | 2 years | Adult | NR | NR | N |
| Radford et al. (2013) | Direct to individual via mail, doorknock | Household, hard copy as well as CASI | Research company | 10 months (Mar–Dec 2009) | Parent for aged <18; both for children aged 11–17; self for young people aged 18–24 | Y (automatic red flag items triggered response) | Y (reminders, service details) | N |
| Tsuboi et al. (2015) | Direct to individual, doorknock | Hard copy to home address | RAs | 1 month | NR | NR | NR | N |
| Vogeltanz et al. (1999) | Direct to individual via mail | Household face-to-face personal interview | Research company ('highly trained' p 581) | NR | NR | NR | NR | N |

| Study | | Instrument | | | | | | | | |
|------------------------------|--|--------------------------------|--------------------------------|------------------|------------------|--------------------------------------|-------------------------------|---------------------------------|------------------------------|--------------------------------|
| Study citation | Name of instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (no. of items) | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (no. of items) | Items about EDV (no. of items) |
| Briere & Elliott (2003) | Traumatic Events Survey and Trauma Symptom Inventory | NR | NR | N | SA, PA | Y (pp 1,208–9) | Y (pp 1,208–9) | N | N | N |
| Christoffersen et al. (2013) | NR | NR | NR | N | SA, PA, E/PA, N | Y (4 items, pp 152–3) | Y (7 items, pp 152–3) | Y (6 items, pp 152–3) | Y (7 items, pp 152–3) | N |
| de Visser et al. (2003) | Australian Study of Health and Relationships | PP | PP | N | SA | Y (1 item) | N | N | N | N |
| Dunne et al. 2003 | CSA items adapted from Fleming, 1997. Used other validated instruments for health items | Prior paper Purdie et al. 2002 | Prior paper Purdie et al. 2002 | N | SA | Y (9 items) p 144 | N | N | N | N |
| Ferguson & Horwood (1998) | Based on Conflict Tactics Scales | Prior paper | Prior paper | N | EDV | N | N | N | N | Y (8 items, p 346) |
| Hemenway et al. (1994) | NR | NR | NR | N | PA | N | Y | N | N | N |
| Hussey et al. (2006) | Based on Finkelhor and Dzuiba-Leatherman (1994), Gallup Organisation (1995) and Straus et al. (2004) | NR | NR | N | SA, PA, N | Y (items not fully reported) | Y (items not fully reported) | N | Y (items not fully reported) | N |
| Laaksonen et al. (2011) | Childhood Trauma Questionnaire (separated by age cohort) | NR | Y | N | SA, PA, E/PA, N | Y (5 items, p 483) | (p 483) | (p 483) | (p 483) | (p 483) |
| May-Chahal and Cawson (2005) | NR | NR | NR | N | SA, PA, E/PA, N | Y (14 items p 975) | Y (9 items, p 973) | Y (7 items p 973) | Y (8 items p 974) | N |
| McGee et al. (2011) | NR | NR | NR | N | SA | Y (12 items) reported on EURPUB site | N | N | N | N |

| Study | | Instrument | | | | | | | | |
|-----------------------------|---|---|-------------------------------|------------------|----------------------|--------------------------------|-------------------------------|---------------------------------|------------------------------|--------------------------------|
| Study citation | Name of instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (no. of items) | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (no. of items) | Items about EDV (no. of items) |
| Perez-Fuentes et al. (2013) | Alcohol Use Disorder and Associated Disabilities Interview Schedule. SA elements adapted from ACEs, CTS, CTQ | Prior paper (Ref #58-9) | Prior paper | N | SA | Y (p 18) | N | N | N | N |
| Radford et al. (2013) | Modified JVQ (Hamby et al., 2004) self-report version p 803. JVQ caregiver version for children 2 months to 10 years (Hamby et al., 2004) | Prior paper (Finkelhor, 2005) | Prior paper (Finkelhor, 2005) | N | SA, PA, E/PA, N, EDV | Y (7 items, pp 811–13) | Y (1 item, pp 811–13) | Y (1 item, pp 811–13) | Y (14 items, pp 811–13) | Y (1 item, pp 811–13) |
| Tsuboi et al. (2015) | Lifestyle and attitudes towards sexual behaviour survey | NR | NR | N | SA, PA, E/PA, N | Y/NR | Y/NR | Y/NR | Y/NR | N |
| Vogeltanz et al. (1999) | NR | Prior paper (Wilsnack et al.1991, 1995) | Prior paper | N | SA | Y (8 items) | N | N | N | N |

Part 4 – Overview of key features of 11 studies conducted by telephone interview or computer assisted telephone interview

Of the 49 eligible studies, 11 involved data collection by phone. Of these 11 studies, four covered all five maltreatment types and each of these involved nationwide representative samples of child participants in the US (Finkelhor x 4: 2005, 2009, 2014, 2015). A further four studies were conducted solely about child sexual abuse (but not identifying institutional abuse), all in Western jurisdictions (Ireland, Canada, Australia). Ten of these 11 studies involved nationwide representative samples, with six involving adult participants. Two Australian studies are in this group of 11, both of which covered sexual abuse only (de Visser et al., 2003; Dunne et al., 2003); de Visser et al., 2003 involved participants aged 16–59 and Dunne et al., 2003 involved adult participants aged 18–59.

The studies are:

- 1) Christoffersen, MN, Armour, C, Lasgaard, M, Andersen, TE & Elklit, A 2013, 'The prevalence of four types of childhood maltreatment in Denmark', *Clinical Practice & Epidemiology in Mental Health*, 9, pp 149–156.
- 2) de Visser, RO, Smith, AMA, Rissel, CE, Richters, J & Grulich, AE 2003, 'Sex in Australia: Experiences of sexual coercion among a representative sample of adults', *Australian and New Zealand Journal of Public Health*, 27(2), pp 198–203.
- 3) Dunne, M, Purdie, D, Cook, M, Boyle, F & Najman, J 2003, 'Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia', *Child Abuse & Neglect*, 27, pp 141–152.
- 4) Finkelhor, D & Dziuba-Leatherman, J 1994, 'Children as victims of violence: a national survey', *Pediatrics*, 94(4), pp 413–420.
- 5) Finkelhor, D, Ormrod, R, Turner, H & Hamby, SL 2005, 'The victimization of children and youth: a comprehensive, national survey', *Child Maltreatment*, 10(1), pp 5–25.
- 6) Finkelhor, D, Turner, H, Ormrod, R & Hamby, SL 2009, 'Violence, abuse, and crime exposure in a national sample of children and youth', *Pediatrics*, 124(5), pp 1411–1423.
- 7) Finkelhor, D, Vanderminden, J, Turner, H, Hamby, S & Shattuck, A 2014, 'Child maltreatment rates assessed in a national household survey of caregivers and youth', *Child Abuse & Neglect*, 38, 1421–1435.
- 8) Finkelhor, D, Turner, H A, Shattuck, A & Hamby, SL 2015, 'Prevalence of childhood exposure to violence, crime, and abuse: results from the National Survey of Children's Exposure to Violence', *JAMA Pediatrics* (in press).
- 9) Hébert, M, Tourigny, M, Cyr, M, McDuff, P & Joly, J 2009, 'Prevalence of childhood sexual abuse and timing of disclosure in a representative sample of adults from Quebec', *The Canadian Journal of Psychiatry*, 54(9), pp 631–636.
- 10) Hemenway, D, Solnick, S & Carter, J 1994, 'Child-rearing violence', *Child Abuse & Neglect*, 18(12), pp 1011–1020.

- 11) McGee, H, Garavan, R, Byrne, J, O'Higgins, M & Conroy, R 2011, 'Secular trends in child and adult sexual violence – one decreasing and the other increasing: a population survey in Ireland', *European Journal of Public Health*, 21(1), pp 98–103.

The summary below captures key themes. Table 13 then provides further details about these studies' key dimensions of *design* (prevalence, incidence or both; period; maltreatment types; participant age range; single or repeated; retrospective or prospective); *sample* (sampling frame; sampling strategy; sample size; response rate); *procedure* (recruitment measures; method of administration; data collection personnel; data collection time); *ethics* (whose consent was obtained; measures for reporting suspected risk; measures for providing assistance; adverse events reported); and *instrument* (name; validity and reliability; maltreatment types covered; items about ICSEA; and presence and number of items about CSA, PA, E/PA, N and EDV).

DESIGN

Study location

- US = 6
- Europe (including UK) = 2
- Australia = 2
- Canada = 1

Prevalence or incidence

- Both prevalence and incidence (typically lifetime and 12 months) = 4 (all Finkelhor studies)
- Prevalence only (childhood/before aged 16 or 18) = 5
- Incidence only (past 12 months) = 1 (Finkelhor et al., 2005, although unclear if broader study also included prevalence as his studies typically include both)
- Not reported = 1

Maltreatment subtypes

- 4 studies covered all five maltreatment types (Finkelhor x 4: 2005, 2009, 2014, 2015)
- 4 studies covered CSA only
- 2 studies covered other combinations of maltreatment subtypes
- 1 study covered PA only (that is, no CSA)

Participants

- Adults only = 5 studies
- Children only (aged 10–16) = 1 study (Finkelhor & Dziuba-Leatherman, 1994)
- Children and parents as informants = 4 studies (Finkelhor, 2005, 2009, 2014, 2015)
- Both adults and children = 1 study

Cross-sectional or repeated measures studies

- All one-off/cross-sectional

- Study that has been repeated most often is Finkelhor's NATSCEV in US (every 5 and 3 years) but with different cohorts
- No cohort studies

Key terms defined

- Some papers define abuse types in the article's introduction or upfront
- Some definitions do not align with instrument descriptions of abuse types
- Instrument tends to dictate or operationalise the definition and description of the abuse type

SAMPLE

Sample frame

- All individuals born 1984 = 1 study (Christoffersen, Denmark)
- National samples = 10
- State sample = 1 (Hebert, Canada)

Sampling strategy

- Random digit dialling = 8 (includes 5 Finkelhor studies)
- Cluster randomised random digit dialling = 1
- Stratified random sample = 1 study (Christoffersen, Denmark)
- Random sample from electoral roll = 1 study (Dunne, Australia)

Sample size

- Ranges from 800–19,000
- 0–2,000 = 3 studies
- 2,000–3,000 = 3 studies
- 3,000–4,000 = 1 study
- 4,000–5,000 = 3 studies
- 19,307 = 1 study (de Visser et al., 2003 – Australian study of health and relationships)

Response rates

- Approximately 60–80% (cannot discern that rates are lower over time; Australian studies 61% and 73%)

PROCEDURE

Recruitment

- All via phone = 11 studies
- 2 studies report oversampling
- From geographic areas (de Visser et al., 2003)
- For ethnicity and socio-economic status (Finkelhor et al., 2009)

Administration method

- Phone interview = 7
- CATI = 4

Data collection time

- The collection times were between one and 13 months; studies with larger sample sizes took longer

Adverse events

- No studies reported adverse events

INSTRUMENT

Instruments

- Not reported = 5 studies
- JVQ or modified/enhanced JVQ = 4 studies
- Australian Health and Relationships Survey = 1 study
- Adapted from Fleming 1997 = 1 study

Validity and reliability data

- JVQ: reliability and validity data reported in other papers
- Australian Health and Relationships Survey: reliability and validity data reported in other papers
- Dunne et al.'s measure: reliability and validity data reported in Fleming 1997

Table 13 Phone studies: key features of study design, sample, procedure, ethics and instrument

| Study details | | Design | | | | | | Sample | | | |
|--|-----------|-----------------------------|---------------------------------|----------------------|--|-------------------------------------|----------------------------------|--|--|--|--|
| Study ID (citation) | Location | Prevalence/ incidence/ both | Period | CM types | Child/adult/ both Age range | Single or repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Christoffersen et al. (2013) | Denmark | Prevalence | NR | SA, PA, E/PA, N | Adult 24 years | Single | Retrospective | Total birth cohort of all children born 1984 | Stratified random sample of 24 year olds | 2,980 | 63% |
| de Visser et al. (2003) | Australia | Prevalence | Lifetime (through to adulthood) | SA | Both 16–59 | Single | Retrospective | Men and women from all states and territories | Modified random digit dialling Oversampling some geographical areas | 19,307 | 73.1% |
| Dunne et al. (2003) | Australia | Prevalence | Younger than 16 | SA | Adult 18–59 | Single | Retrospective | Nationally representative sample of men and women aged 18–59 | Drawn randomly from electoral roll with search for telephone numbers | 1,784 | 61% |
| Finkelhor and Dziuba-Leatherman (1994) | US | Both | Lifetime 12 months | SA, PA | Child 10–16 | Single | Retrospective | Nationally representative sample of households | Random digit dialling | 2,000 | 88% (adults) 82% (of eligible children) |
| Finkelhor et al. (2005) | US | Incidence | 12 months | SA, PA, E/PA, N, EDV | Child 2–17 (parent informant for children aged 2–9) | Repeated NR | Retrospective | Nationally representative sample of children aged 2–17 | Random digit dialling | 2,030 (1,000 children and 1,030 parents/caregivers) | 79.5% (of eligible persons contacted) |

| Study details | | Design | | | | | | Sample | | | |
|-------------------------|----------|---------------------------|-----------------------|----------------------|---|-------------------------------------|--------------------------------|--|--|-------------|---------------------------------------|
| Study ID (citation) | Location | Prevalence/incidence/both | Period | CM types | Child/adult/both Age range | Single or repeated study (interval) | Retrospective/prospective/both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Finkelhor et al. (2009) | US | Both | Lifetime 12 months | SA, PA, E/PA, N, EDV | Child 2–17 (parent informant for children aged 2–9) | Repeated 5 years | Retrospective | National sample of children aged 2–17 | National landline residential telephone survey Oversampling ethnic groups and low SES | 4,549 | 71% cross-sectional 63% oversample |
| Finkelhor et al. (2014) | US | Both | Lifetime 12 months | SA, PA, E/PA, N, EDV | Child 1 month to 17 years (parent informant for children aged 0–9) | Repeated 3 years | Retrospective | Nationwide sampling of residential phone numbers | Random digit dialling of landlines, mobile phone numbers (n = 31; abandoned due to low yield), and address (n = 750) | 4,503 | 60% (of eligible respondents) |
| Finkelhor et al. (2015) | US | Both | Lifetime 12 months | SA, PA, E/PA, N, EDV | Child 0–17 years (parent informant for children aged 0–9) | Repeated 3 years | Retrospective | National sample | Nationally representative sample of telephone numbers via 4 methods | 4,000 | 9.7–67% across 4 sampling methods |
| Hebert et al. (2009) | Quebec | Prevalence | Younger than 18 | SA | Adult NR | Single | Retrospective | Adults from Quebec | Random digit dialling | 1,002 | 30% |
| Hemenway et al. (1994) | US | Prevalence | Childhood | PA | Adult NR | Single | Retrospective | Adult American men and women | National random digit dialling telephone survey | 801 | NR |

| Study details | | Design | | | | | | Sample | | | |
|---------------------|----------|-----------------------------|------------------------|----------|--------------------------------|-------------------------------------|----------------------------------|---|---|-------------|---------------|
| Study ID (citation) | Location | Prevalence/ incidence/ both | Period | CM types | Child/adult/ both Age range | Single or repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| McGee et al. (2011) | Ireland | Prevalence | Childhood Adulthood | SA | Adult 18–90 years | Single | Retrospective | Representative sample of adult population | National cluster-randomized telephone interview study via random digit dialling | 3,120 | 71% |

| Study | Procedure | | | | Ethics | | | |
|--------------------------------------|----------------------|---|---------------------------------|----------------------|----------------------------|---------------------------------------|-------------------------|-------------------------|
| Study ID (citation) | Recruitment measures | Method of administration | Data collection personnel (n =) | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance | Adverse events reported |
| Christoffersen et al. (2013) | Phone/residential | Telephone interview (also involved household study) | NR | NR | NR | N | Y | N |
| de Visser et al. (2003) | Phone | CATI | NR | 11 months | NR | NR | NR | N |
| Dunne et al. (2003) | Phone | CATI | NR | 1 month | Adult | N | Y | N |
| Finkelhor & Dziuba-Leatherman (1994) | Phone | Telephone interview | NR | NR | Parent Child | Y | Y | N |
| Finkelhor et al. (2005) | Phone | CATI | NR | 3 months | Parent Child | Y | NR | N |
| Finkelhor et al. (2009) | Phone | CATI | NR | 5 months | Parent Child | Y | Y | N |

| Study | Procedure | | | | Ethics | | | |
|-------------------------|---------------------|----------------------|--------------------------|----------------------------------|----------------------|----------------------------|---------------------------------------|-------------------------|
| | Study ID (citation) | Recruitment measures | Method of administration | Data collection personnel (n =) | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance |
| Finkelhor et al. (2014) | Phone | CATI | NR | 12 months | Parent Child | Y | NR | N |
| Finkelhor et al. (2015) | Phone | CATI | NR | NR | Parent Child | Y | NR | N |
| Hebert et al. (2009) | Phone | Telephone interview | NR | NR | Adult | NR | NR | N |
| Hemenway et al. (1994) | Phone | Telephone interview | NR | NR | NR | NR | NR | N |
| McGee et al. (2011) | Phone | CATI | NR | NR | Adult | N | Y | N |

| Study | Instrument | | | | | | | | | |
|------------------------------|--|--------------------|-------------------|-------------|------------------|--------------------------------|----------------------|-------------------------------|---------------------------------|-----------------------------|
| | Study ID (citation) | Name of instrument | Validity | Reliability | Items about ICSA | Items about CSA (no. of items) | Items about CM types | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (No of items) |
| Christoffersen et al. (2013) | NR | | NR | NR | N | Y 4 | SA, PA, E/PA, N 7 | Y 6 | Y 7 | N |
| de Visser et al. (2003) | Australian Health and Relationships Survey | In previous paper | In previous paper | N | Y 1 | SA | N | N | N | N |

| Study | Instrument | | | | | | | | | |
|--------------------------------------|--|-------------------|-------------------|------------------|---|----------------------|--|---|--|-------------------------------|
| Study ID (citation) | Name of instrument | Validity | Reliability | Items about ICSA | Items about CSA (no. of items) | Items about CM types | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (No of items) | Items about EDV (No of items) |
| Dunne et al. 2003 | CSA items adapted from Fleming 1997 | In previous paper | In previous paper | N | Y 9 | SA | N | N | N | N |
| Finkelhor & Dziuba-Leatherman (1994) | NR | NR | NR | N | Y 6 | SA, PA | Y 6 | N | N | N |
| Finkelhor et al. (2005) | Juvenile Victimization Questionnaire (JVQ) | In previous paper | In previous paper | N | Y 7 | SA, PA, E/PA, N, EDV | Y 1 | Y 2 | Y 1 | Y 2 |
| Finkelhor et al. (2009) | Enhanced version of JVQ | In previous paper | In previous paper | N | Y 7 | SA, PA, E/PA, N, EDV | Y 1 | Y 1 | Y 1 | Y 8 |
| Finkelhor et al. (2014) | Enhanced version of JVQ | NR | N | N | Y 4 items (S1-4) + 14 items about nature and context | SA, PA, E/PA, N, EDV | Y 1 item (M1) + 12 items about nature and context | Y 1 item (M2) + 8 items about nature and context | Y 5 items (M3, 5, 6, 8, 9) + 8 items about nature and context | Y NR |
| Finkelhor et al. (2015) | JVQ | In previous paper | In previous paper | N | Y 7 | SA, PA, E/PA, N, EDV | Y 1 | Y 1 | Y 5 | Y 6 |
| Hebert et al. (2009) | NR | NR | NR | N | Y | SA | N | N | N | N |

| Study | Instrument | | | | | | | | | |
|------------------------|--------------------|----------|-------------|------------------|--------------------------------|----------------------|-------------------------------|---------------------------------|-----------------------------|-------------------------------|
| Study ID (citation) | Name of instrument | Validity | Reliability | Items about ICSA | Items about CSA (no. of items) | Items about CM types | Items about PA (no. of items) | Items about E/PA (no. of items) | Items about N (No of items) | Items about EDV (No of items) |
| Hemenway et al. (1994) | NR | NR | NR | N | N | PA | Y NR | N | N | N |
| McGee et al. (2011) | NR | NR | NR | N | Y 12 | SA | N | N | N | N |

Part 5 – Overview of breadth of studies and their key features

Of the 49 eligible studies, 9 covered all five forms of maltreatment (but without identifying institutional abuse). Of these nine studies, eight involved nationwide representative samples of participants. Seven of the nine studies involved children participating directly and two studies also involved young adults aged up to the early 20s. None of these studies were conducted in Australia.

The studies are:

- 1) Al-Eissa, MA, AlBuhairan, FS, Qayad, M, Saleheen, H, Runyan, D & Almuneef, M 2015, 'Determining child maltreatment incidence in Saudi Arabia using the ICAST-CH: a pilot study', *Child Abuse & Neglect*, 42, pp 174–182.
- 2) Euser, S, Alink, LR, Pannebakker, F, Vogels, T, Bakermans-Kranenburg, MJ, van IJzendoorn MH 2013, 'The prevalence of child maltreatment in the Netherlands across a 5-year period', *Child Abuse & Neglect*, 37(10), pp 841–851.
- 3) Feng, JY, Chang, YT, Chang, HY, Fetzer, S & Wang, JD 2015, 'Prevalence of different forms of child maltreatment among Taiwanese adolescents: a population-based study', *Child Abuse & Neglect*, 42, pp 10–19.
- 4) Finkelhor, D, Ormrod, R, Turner, H & Hamby, SL 2005, 'The victimization of children and youth: a comprehensive, national survey', *Child Maltreatment*, 10(1), pp 5–25.
- 5) Finkelhor, D, Turner, H, Ormrod, R & Hamby, SL 2009, 'Violence, abuse, and crime exposure in a national sample of children and youth', *Pediatrics*, 124(5), pp 1411–1423.
- 6) Finkelhor, D, Vanderminden, J, Turner, H, Hamby, S & Shattuck, A 2014, 'Child maltreatment rates assessed in a national household survey of caregivers and youth', *Child Abuse & Neglect*, 38, pp 1421–1435.
- 7) Finkelhor, D, Turner, HA, Shattuck, A & Hamby, SL 2015, 'Prevalence of childhood exposure to violence, crime, and abuse: results from the National Survey of Children's Exposure to Violence', *JAMA Pediatrics* (in press).
- 8) Radford, L, Corral, S, Bradley, C & Fisher, HL 2013, 'The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults', *Child Abuse & Neglect*, 37(10), pp 801–813.
- 9) van der Kooij, IW, Nieuwendam, J, Bipat, S, Boer, F, Lindauer, RJJ & Graafsma, TLG 2015, 'A national study on the prevalence of child abuse and neglect in Suriname', *Child Abuse & Neglect*, (in press).

A further five studies out of the 49 eligible studies covered *four forms of maltreatment* (physical, sexual and emotional abuse, and neglect, and excluded exposure to family violence). These were: Christoffersen et al., 2013; Laaksonen et al., 2011; May-Chahal & Cawson, 2005; Rosenman & Rodgers, 2004; Tsuboi et al., 2015. A further seven studies covered *three forms of maltreatment* (all except two covered sexual abuse, physical abuse

and emotional abuse): Ajduković et al., 2013; Al-Fayez et al., 2012; Hussey et al., 2006; Leung et al., 2008; Sørbø et al., 2013; Stephenson et al., 2006; Wong et al., 2009. Fifteen studies covered *child sexual abuse only*, with these tending to be conducted in the earlier years of the period: de Visser et al., 2003; Dunne et al., 2003; Edgardh et al., 2000; Fanslow, 2007; Hébert et al., 2009; Helweg-Larsen & Larsen, 2006; Kim et al., 2005; Langeland et al., 2015; McGee et al., 2011; Moore et al., 2010; Nelson et al., 1994; Perera et al., 2009; Perez-Fuentes et al., 2013; Vogeltanz et al., 1999; Worku et al., 2006.

The summary below captures key themes. Table 14 then provides further details about these studies' key dimensions of *design* (prevalence, incidence or both; period; maltreatment types; participant age range; single or repeated; retrospective or prospective); *sample* (sampling frame; sampling strategy; sample size; response rate); *procedure* (recruitment measures; method of administration; data collection personnel; data collection time); *ethics* (whose consent was obtained; measures for reporting suspected risk; measures for providing assistance; adverse events reported); and *instrument* (name; validity and reliability; maltreatment types covered; items about ICSEA; and presence and number of items about CSA, PA, E/PA, N and EDV).

DESIGN

Study location

- US = 4 (all Finkelhor)
- Europe (including UK) = 2
- Asia = 2
- South America = 1 (Suriname)

Prevalence or incidence

- Both prevalence and incidence (typically childhood aged younger than 18 and older than 12 months) = 6
- Incidence only (past 12 months) = 3
- Prevalence only (childhood/before aged 16 or 18) = 0

Maltreatment subtypes

- Five maltreatment subtypes = 9

Participants

- Children under 18 years (11–17), and parents as informants for children aged under 11, and young adults aged up to early 20s = 1 study (Radford et al., 2013)
- Children aged under 18 (10–17) and parents as informants for children aged under 10 = 4 studies (Finkelhor)
- Children only, including 18 year olds = 2 studies (Al-Eissa et al., 2015; Feng et al., 2015)
- Children only (aged 17 and under) = 1 study (Euser et al., 2013)
- Children aged under 18 and young adults aged up to early 20s = 2 studies (Radford et al., 2013; van der Kooij et al., 2015)

Cross-sectional or repeated measures studies

- All cross-sectional, no cohort studies
- The only studies to be repeated are those by Finkelhor (NATSCEV)

Key terms defined

- Some papers define abuse types in the article's introduction or upfront
- Some definitions do not align with instrument descriptions of abuse types
- Instrument tends to dictate/operationalise the definition and description of the abuse type

SAMPLE

Sample frame

- All are national population-based studies except Al-Eissa et al.

Sampling strategy

- Random digit dialling = 4 (Finkelhor)
- Stratified random sample of schools = 4 (Al-Eissa; Euser; Feng; van der Kooij)
- Random probability sample of households = 1 (Radford)

Sample size

- Range for studies with either children aged under 18 only, or components of studies with child cohorts aged under 18, is 1,000–2,275. The breakdown is:
 - Euser (aged 12–17) – 1,920
 - van der Kooij (aged 12–17) – 1,072
 - Finkelhor, (2005) (aged 10–17) – 1,000
 - Finkelhor, (2009) (aged 10–17) – 2,095
 - Finkelhor, (2014) (aged 10–17) – approx. 2,000
 - Finkelhor, (2015) (aged 10–17) – 1,949
 - Radford (aged 11–17) – 2,275.
- Range for five studies with components involving parents responding for children aged under 10 or under 11 is 1,030–2,454. The breakdown is:
 - Finkelhor, (2005) (aged 2–9) – 1,030
 - Finkelhor, (2009) (aged 2–9) – 2,454
 - Finkelhor, (2014) (aged one month to nine years) – approx. 2,500
 - Finkelhor, (2015) (aged 0–9) – 2,051
 - Radford, (aged two months to 10 years) – 2,160.
- Range for two studies involving children under 18 and 18 year olds only is 2,043 (Al-Eissa) to 5,236 (Feng).
- Range for two studies with components involving cohorts aged over 18 is 239 (van der Kooij: aged 18–22) to 1,761 (Radford: aged 18–24)

Response rates

- The response rate is approximately 60–99% (Feng has 99%)

PROCEDURE

Recruitment

- Via phone = 4 studies
- Via school = 4 studies
- Via household = 1 study

Administration method

- Phone or CATI = 4 studies (all Finkelhor)
- In school, hard copy = 4 studies
- Household, hard copy + CASI = 1 study (Radford)

Data collection time

- The data collection time is 3–12 months (missing data – 4 not reported)

Adverse events

- No studies reported adverse events

INSTRUMENT

Instruments

- JVQ or modified/enhanced JVQ = 5 studies
- ICAST-CH = 2 studies
- Combined several tools = 2 studies

Validity and reliability data

- JVQ: reliability and validity data reported in other papers = 5 studies
- ICAST-CH: reliability and validity data reported in other papers = 2 studies
- Euser et al. not reported; van der Kooij et al. based on Euser.

Table 14 Studies of all five maltreatment types: key features of study design, sample, procedure, ethics and instrument

| Study details | | Design | | | | | | Sample | | | |
|---|--------------|-----------------------------|----------------------------|----------------------|--|-----------------------------------|----------------------------------|--|--|--|--|
| Study citation | Location | Prevalence/ incidence/ both | Period | CM types | Child participant age range | Single/ repeated study (interval) | Retrospective/ prospective/ both | Sampling frame | Sampling strategy | Sample size | Response rate |
| Al-Eissa et al. (2015) | Saudi Arabia | Incidence | Past year | SA, PA, E/PA, N, EDV | 15–18 | Single | Retrospective | Adolescents aged 15–18 | Stratified multistage random cluster sample of 5 zones (boys' and girls' schools, public/private, middle/high) | n = 2,043 | 76% ('consent rate') |
| Euser et al. (2013) | Netherlands | Incidence | Past year | SA, PA, E/PA, N, EDV | 12–17 | Single | Retrospective | National – students aged 12–17 | Random selection of 42 high schools, each with 4 randomly selected classes | 1,920 | NR |
| Feng et al. (2015) | Taiwan | Both | Younger than 18; Past year | SA, PA, E/PA, N, EDV | 12–18 | Single | Retrospective | Taiwanese adolescents aged 12–18 | Stratified random sample of schools in 5 regions Disproportionate random sampling in offshore islands | 5,236 | 99.4% |
| Finkelhor et al. (2005) Developmental Victimization Survey | US | Incidence | 12 months | SA, PA, E/PA, N, EDV | 2–17 (children aged 10–17; parents/ caregivers of children aged 2–9) | Repeated 5 years | Retrospective | Nationally representative sample of children aged 2–17 | Random digit dialling | n = 2,030 (including n = 1,000 children aged 10–17 and n = 1,030 parents/caregivers of children aged 2–9) | 79.5% (of eligible persons contacted) |
| Finkelhor et al. (2009) NATSCEV 1 | US | Both | Lifetime Past year | SA, PA, E/PA, N, EDV | 2–17 years (children aged 10–17; parents/ caregivers of children aged 2–9) | Repeated 3 years | Retrospective | Cross-sectional national sample of children aged 2–17 | National landline residential telephone survey | n = 4,549 (n = 3,053 national cross-section and n = 1,496 oversample 'Hispanic, African-American, low-income') n = 2,095 aged 10–17 | 71% (cross-section) and 63% (oversample) |

| Study details | | Design | | | | | | Sample | | | | |
|--------------------------------------|----------|---------------------------|--|----------------------|--|----------------------------------|--|---|---|--|---|--|
| Study citation | Location | Prevalence/incidence/both | Period | CM types | Child participant age range | Single/repeated study (interval) | Retrospective/prospective/both | Sampling frame | Sampling strategy | Sample size | Response rate | |
| Finkelhor et al. (2014) NATSCEV 2 | US | Both | Lifetime Past year | SA, PA, E/PA, N, EDV | One month to 17 years (children aged 10–17; parents/caregivers of children aged infant to 9) | Repeated 3 years | Retrospective | Nationwide sampling frame of residential phone numbers | Random digit dialling, and to capture those without landlines 2 samples were added, 1 of mobile phone numbers (n = 31; abandoned due to low yield) and address sample (n = 750) | Total n = 4,503 n aged 10–17 not reported but ~2000 | 60% (of eligible respondents) | |
| Finkelhor et al. (2015) NATSCEV 3 | US | Both | Lifetime Past year | SA, PA, E/PA, N, EDV | 0–17 years (children aged 10–17; parents/caregivers of children aged infant to 9) | Repeated | Retrospective | National sample | Nationally representative sample of phone numbers via 4 methods | n = 4,000 n = 1,949 aged 10–17 | (differed across 4 sample frames) | |
| Radford et al. (2013) | UK | Prevalence | Younger than 18, and also in past year | SA, PA, E/PA, N, EDV | Parents of children aged 2 months to 10 years; children aged 11–17; young adults aged 18–24 (m = 20.6 years) | Single | Both (aged younger than 18; and past year) | Children and young people in the UK aged under 25 years | Random probability sampling of households from UK Postcode Address File (50,000 by mail), and eligibility determined by visits to check persons aged under 25 | n = 2,160 (parents of children 2 months to 10 years); n = 2,275 (children aged 11–17); n = 1,761 (young adults aged 18–24) | 60.4% (No of interviews completed as a proportion of all eligible households approached/visited to check eligibility) | |
| van der Kooij et al. (2015) | Suriname | Both | Lifetime Past year | SA, PA, E/PA, N, EDV | 12–17 years (m = 15.04) and 18–22 years (m = 18.53) | Single | Retrospective | National sample of students in Suriname | Stratified national random sample of students from high schools and vocational education classes in 5 districts | 1,391 (n = 1,072 children aged 12–17; n = 239 young adults aged 18–22) | NR | |

| Study | Procedure | | | | Ethics | | | |
|-----------------------------------|--|--------------------------------------|----------------------------------|----------------------------------|--|--|---------------------------------------|-------------------------|
| | Study citation | Recruitment measures | Method of administration | Data collection personnel | Data collection time | Whose consent was obtained | Measures for reporting suspected risk | Measures for assistance |
| Al-Eissa et al. (2015) | Via school | In school, hard copy | NR | 3 months (Dec 2011 to Feb 2012) | Both parent and child | Y (encouraged students to talk with parents, teachers or someone they trusted if they had had an adverse experience) | NR | N |
| Euser et al. (2013) | NR | In school, hard copy | NR | NR | Both parent and child | NR | NR | N |
| Feng et al. (2015) | Via school | In school, hard copy | Staff in organisation (teachers) | NR | Child (not parents) | NR | Y | N |
| Finkelhor et al. (2005) DVS | Phone | CATI | Research company | Dec 2002 to Feb 2003 | Both parent and child | Y | NR | N |
| Finkelhor et al. (2009) NATSCEV 1 | Phone | CATI | Research company | 5 months (Jan–May 2008) | Both parent and child | Y | Y | N |
| Finkelhor et al. (2014) NATSCEV 2 | Phone | CATI | Research company | 12 months (Aug 2013 to Aug 2014) | Both parent and child | Y | N | N |
| Finkelhor et al. (2015) NATSCEV3 | Phone | CATI | NR | 8 months (Aug 201 to Apr 2014) | Both parent and child | Y | NR | N |
| Radford et al. (2013) | Direct to individual via mail, doorknock | Household CASI + household hard copy | Research company | 10 months (Mar–Dec 2009) | Parent for <18 years, both for children aged 11–17; self for 18–24 | Y (automatic red flag items triggered response) | Y (reminders, service details) | N |
| van der Kooij et al. (2015) | Via school | In school, hard copy | NR | NR | Child only (verbal consent); parent (info + passive consent) | NR | Y | N |

| Study | Instrument | | | | | | | | | |
|--------------------------------------|--|--------------------------------------|---------------------------------------|------------------|----------------------|---|---|--|---|-------------------------------|
| Study citation | Instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (No of items) | Items about PA (No of items) | Items about E/PA (No of items) | Items about N (No of items) | Items about EDV (No of items) |
| Al-Eissa et al. (2015) | ICAST-CH | PP (ICAST-CH) | PP (ICAST-CH) | N | SA, PA, E/PA, N, EDV | Y 6 | Y 10 | Y 8 | Y 6 | Y 6 |
| Euseret et al. (2013) | Combined several tools | NR | NR | N | SA, PA, E/PA, N, EDV | Y 24 items across all types | Y 24 items across all types | Y 24 items across all types | Y 24 items across all types | N |
| Feng et al. (2015) | ICAST-CH | In previous papers | NR | N | SA, PA, E/PA, N, EDV | Y 6 | Y 9 | Y 8 | Y 6 | Y 7 |
| Finkelhor et al. (2005) DVS | Juvenile Victimization Questionnaire (JVQ) | Yes, previous paper (2005 'The JVQ') | Yes, previous paper (2005, 'The JVQ') | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 2 | Y 1 | Y 2 |
| Finkelhor et al. (2009) NATSCEV 1 | Enhanced version of JVQ | 2005, 'The JVQ' | 2005, 'The JVQ' | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 1 | Y 1 | Y 8 |
| Finkelhor et al. (2014) NATSCEV 2 | Enhanced version of JVQ | NR | NR | N | SA, PA, E/PA, N, EDV | Y 4 screener items (S1-S4) + 14 nature and context | Y 1 screener item (M1) + 12 nature and context items | Y 1 screener item (M2) + 8 nature and context items | Y 5 screener items (M3, 5, 6, 8, 9) + 8 nature and context items | Y NR |
| Finkelhor et al. (2015) NATSCEV 3 | JVQ | 2005, 'The JVQ' | 2005, 'The JVQ' | N | SA, PA, E/PA, N, EDV | Y 7 | Y 1 | Y 1 | Y 5 | Y 6 |

| Study | Instrument | | | | | | | | | |
|-----------------------------|--|-------------------------------|-------------------------------|------------------|----------------------|-------------------------------|------------------------------|--------------------------------|-----------------------------|-------------------------------|
| Study citation | Instrument | Validity | Reliability | Items about ICSA | CM types covered | Items about CSA (No of items) | Items about PA (No of items) | Items about E/PA (No of items) | Items about N (No of items) | Items about EDV (No of items) |
| Al-Eissa et al. (2015) | ICAST-CH | PP (ICAST-CH) | PP (ICAST-CH) | N | SA, PA, E/PA, N, EDV | Y 6 | Y 10 | Y 8 | Y 6 | Y 6 |
| Radford et al. (2013) | Modified JVQ (Hamby et al., 2004) self-report version p 803. JVQ caregiver version for children aged 2 months to 10 years (Hamby et al., 2004) | Prior paper (Finkelhor, 2005) | Prior paper (Finkelhor, 2005) | N | SA, PA, E/PA, N, EDV | Y (7 items, pp 811–13) | Y (1 item, pp 811–13) | Y (1 item, pp 811–13) | Y (14 items, pp 811–13) | Y (1 item, pp 811–13) |
| van der Kooij et al. (2015) | Combined several tools (based on Euser et al., 2013) | In previous paper (Euser) | In previous paper (Euser) | N | SA, PA, E/PA, N, EDV | Y 7 | Y 8 | Y 1 | Y 8 | Y 7 |

Appendix D: Instrument analysis

Juvenile Victimization Questionnaire

The Juvenile Victimization Questionnaire (JVQ) is used with children aged 0–17.

The latest version of the JVQ can be found in Finkelhor et al., 2015 (*JAMA Pediatrics*) (screening items only) and Finkelhor et al., 2014 (includes follow-up items about nature and context).

The JVQ is used in:

- **Developmental Victimization Survey (DVS)** is a longitudinal study assessing a comprehensive range of childhood victimisations across gender, race and developmental stage. Data was collected in two phases: Phase 1 (December 2002 to February 2003) was a nationally representative sample of 2,030 children aged 2–17. Phone interviews with parents and youth were conducted by employees of an experienced survey research firm specially trained to talk with children and parents; Phase 2 (December 2003 to May 2004) was conducted one year after the baseline interview. Repeated Phase 1 with re-interviewing of 1,467 respondents (72.3 per cent of the baseline sample). Seventeen papers report on these datasets (see Crimes Against Children Research Centre website at www.unh.edu/ccrc/papers/DVS_papers.html). Datasets are publicly available via the National Data Archive on Child Abuse and Neglect at www.ndacan.cornell.edu/. Reliability, validity and national norms were published in a 2005 paper.
- **National Survey of Children’s Exposure to Violence (NATSCEV)** is a cross-sectional survey designed to obtain lifetime and one-year incidence estimates of a comprehensive range of childhood victimisations across gender, race and developmental stage. It is for children aged up to 17. Violence types covered include conventional crime, child maltreatment, peer and sibling victimisation, sexual assault, and witnessing and indirect victimisation. A nationally representative sample of households was surveyed via phone (using random digit dialling) by interviewers from a professional interviewing firm. One target child was randomly selected from each eligible household. First, caregivers were interviewed for demographic information, and then the target child was interviewed. For children younger than 10, proxy interviews were conducted with the adult in the household most familiar with the child and her/his activities. Interviews were offered in English and Spanish.
- **NATSCEV 1** (December 2007 to July 2008). The final report is available at <https://www.ncjrs.gov/pdffiles1/ojdp/grants/248444.pdf>
- **NATSCEV 2** (2011)
- **NATSCEV 3** (August 2013 to April 2014).

NATSCEV is part of the broader Safe Start Initiative sponsored by the USA Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Centers for Disease Control and Prevention (CDC).

The Methods report is available at www.unh.edu/ccrc/pdf/NATSCEV_methods_report.pdf.

The JVQ administration and scoring manual is available at www.unh.edu/ccrc/pdf/jvq/CV55newedition04.pdf

Datasets are publicly available via the US National Archive of Criminal Justice Data at <http://www.icpsr.umich.edu/icpsrweb/NACJD/support/announcements/2014/08/nacid-releases-natscev-data> .

ISPCAN Child Abuse Screening Tool

There are four different versions of the ISPCAN Child Abuse Screening Tool (ICAST):

- **ICAST-C (Child)** – for use with children aged 11–17, and has home and institutional modules. The home module covers: PA, SA, E/PA, N, Discipline. The institutional module covers: PA, SA, E/PA. The internal consistency (fair to very good for different scales) is reported in Zolotor et al. (2009).
- **ICAST-R (Retrospective)** – for use with young adults to assess experiences that may have occurred before age 18 (that is, prevalence prior to age 18). It is limited to CSA, PA, E/PA. It includes 15 behaviourally specific primary questions (also known as ‘stem’ items) about potentially abusive physical, sexual and emotional events (CSA, PA, E/PA, N), with follow-up questions about perpetrator characteristics, frequency of acts and periods in childhood when the recalled abuse occurred (also known as ‘leaf’ items). The internal consistency (high) is reported in Dunne et al. (2009).
- **ICAST-P (Parent)** – for use with parents of children younger than 18 to assess disciplinary practices over the last year and during the child’s lifetime. It addresses CSA, PA, E/PA, N. The internal consistency is very good for PA and E/PA, but poor for CSA and N, as reported in Runyan et al. (2009).
- **ICAST-CH (Child Home)** – for use with children aged 11–17. It collects information about experiences of violence at home only. It is intended to be administered in group settings. Its internal consistency (fair to very good for different scales) is reported in Zolotor et al. (2009).

The tool was developed by ISPCAN expert working groups, based on the Parent Child Conflict Tactics Scale (Straus et al., 1998); World SAFE survey (Sadowski et al., 2004); Juvenile Victimization Survey (Finkelhor et al., 2005); and LONGSCAN Youth Self-Report measure (Amaya-Jackson et al., 2000). It is designed to complement existing retrospective measures.

ICAST is used in:

- Al-Eissa et al. (2015) (Saudi Arabia)
- Ajudovic et al. (2013) (Croatia). It is part of the larger Balkan Epidemiological Study on Child Abuse and Neglect (BECAN). Information is available at www.becan.eu/.
- Feng et al. (2015) (Taiwan).

Questionnaires can be requested from ISPCAN. Permission to use the tool must be obtained in writing from ISPCAN.

Administration and scoring manuals are also available.

Revised Conflict Tactics Scale, Parent-Child version

There are different versions of the Conflict Tactics Scale that have been developed and modified over time; initially it was developed to examine adult partner relationships and was used in the International Dating Violence Study. The most relevant version used for child maltreatment research is the Conflict Tactics Scale, Parent-Child version (CTSPC).

The CTSPC is completed as a self-report questionnaire, but is also used in face-to-face and telephone interviews. It includes scales to measure behaviour of parents towards each other, sibling violence, discipline, physical abuse and psychological aggression. There are supplemental scales for neglect, corporal punishment and CSA.

- **Child respondents (CTSPC-CA)** asks children to report on what happened in the past year, but can be customised to any period (e.g. last 6 months, since you started the program). It can be used for either parent or both parents together. There are weekly discipline supplemental questions, and a supplemental neglect scale.
- **Adult respondents** asks adults to report on what happened 'during the year when you were about 13 years old' or 'during the year you last lived at home with your parents', but can be customised to any period.

Its reliability is moderate for most scales except for neglect and severe physical assault; its construct validity is good; and discriminant validity is fair, as reported in Bennett et al., 2006; Caliso & Milner, 1992; Jouriles & Norwood, 1995; Straus et al., 1998.

Questionnaires, suggested ethical considerations, and a scoring manual are available on Murray Straus' homepage at <http://pubpages.unh.edu/~mas2/>.

Adverse Childhood Experiences International Questionnaire

The Adverse Childhood Experiences International Questionnaire (ACE-IQ) was originally used with adults (aged 18 and over). More recently it has been adapted for use with schoolchildren, parents of children aged 17 and under, and juvenile offenders.

The latest versions of the questionnaires can be found on the World Health Organization's Violence & Injury Prevention (VIP) website at www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/.

The ACE-IQ is used in:

- **CDC-Kaiser Permanente Adverse Childhood Experiences Study** recruited 17,421 participants who completed a standardised physical examination and biopsychosocial questionnaire, and trauma items, in 1995–1997 in San Diego. Initially there were eight ACEs: three for abuse (sexual, verbal, physical abuse) and five for family dysfunction (parent who's mentally ill or alcoholic, a mother who's a domestic violence victim, a family member who's been incarcerated, a loss of a parent through divorce or abandonment). Two further abuse types were added later (emotional and physical neglect). Participants were followed longitudinally since that time to establish a link between childhood trauma and adult onset of chronic disease.
- **ACE questionnaire used** in 29 US states in 2009–14 as cross-sectional studies; a large study of 64,329 juvenile offenders was conducted in Florida.
- 8 ACE domains added to **National Survey of Children's Health** (NSCH, 2012–2013), which polled parents directly for information on ACE rates.
- **WHO's ACE International Questionnaire (ACE-IQ) Version 1** is being field-tested in China, the Former Yugoslav Republic of Macedonia, the Philippines, Saudi Arabia, South Africa, Thailand and Vietnam.

It is used in retrospective reporting of adversities; cross-sectional ascertainment of health and social problems; prospective assessment of outcomes (disease, health care and pharmacy utilisation, and mortality).

It is unclear whether it is currently being field-tested for use with children.

WHO recommends that ACE-IQ is always used as part of broader health surveys.

The original ACE questionnaire used the '5-year rule' for CSA.

The number of items: original 10 items; ACE-IQ = 43 items

The response scale: original yes/no; ACE-IQ = 5-point or 6-point scales

Sexual Abuse and Violence in Ireland

The Health Services Research Centre, Department of Psychology at the Royal College of Surgeons in Ireland (RCSI), conducted research work for Sexual Abuse and Violence in Ireland (SAVI) in 2001 (and was presented before the Irish Inquiry).

- **Sexual abuse and violence in Ireland (SAVI)** study, which assessed prevalence of sexual violence in anonymous telephone interviews conducted with randomly selected participants from the general population in Ireland. The purpose was to estimate the prevalence of various forms of sexual violence among Irish women and men across the lifespan from childhood through adulthood (n = 3,120).

It was one cross-sectional study and was not repeated.

It contained 12 items about sexual experiences in childhood plus 10 items about sexual experiences in adulthood.

A detailed 392-page report is available at www.oneinfour.ie/content/resources/savi.pdf and a 15-page Executive Summary is available at <http://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1014&context=psycholrep>

Instrument tables

Note: The following tables (Tables 16–18) should be read in conjunction with the statement on reliability and validity that follows after the tables.

Table 15 Rigour criteria

| Instrument | Reliability (internal consistency) | Reliability (test-retest reliability) | Validity |
|--|---|---|--|
| Juvenile Victimization Questionnaire (JVQ) | Child version: 0.35–0.64 for different subscales (Finkelhor et al., 2005, p 401) Adult adaptation (Radford et al., 2011, 2013): data not reported | Child version: 0.59 (0.22–1.00) (Finkelhor et al., 2005, p 399) Adult adaptation (Radford et al., 2011, 2013): data not reported | Reported in (Finkelhor et al., 2005, pp 396–99): Moderate, significant convergent validity established with Trauma Symptom Checklist for Young Children (Briere et al., 2001) and Trauma Symptom Checklist for Children (Briere, 1996) Adult adaptation (Radford et al., 2011, 2013): data not reported |
| ISPCAN Child Abuse Screening Tool (ICAST) | ICAST-Child: 0.69–0.86 for home subscales (Zolotor et al., 2009, p 837) ICAST-Child: 0.78–0.86 for institutional subscales (Zolotor et al., 2009, p 837) ICAST-Retrospective: 0.61–0.82 for different subscales (Dunne et al., 2009, p 821) | ICAST-Child: not reported ICAST-Retrospective: not reported | ICAST-Child: construct validity via extensive pilot testing (Zolotor et al., 2009, p 837) ICAST-Retrospective: not reported, but extensive field testing was conducted (Dunne et al., 2009, pp 819–820) |
| Adverse Childhood Experiences International Questionnaire (ACE-IQ) | Field testing underway as part of broader health surveys in 6–8 countries | N/A | N/A |
| Sexual Abuse and Violence in Ireland Survey (SAVI Survey) | Not reported | Not reported | Not reported |

Table 16 Feasibility criteria

| Instrument | Number of items | Administration method and time | Administration and scoring manual | Ethical clearance package | Interviewer training material |
|--|---|--|---|---|---|
| Juvenile Victimization Questionnaire (JVQ) | Modularised Screening items (up to 52) Follow-up items (up to 18) | CATI (average 55 mins) | Yes only for child version JVQ Administration and Scoring Manual (Hamby et al., 2005); NatSCEV 1 Methods Report (Finkelhor & Turner, 2008); NatSCEV 1 Codebook (Finkelhor & Hamby, 2008, 1,500 pages) | Yes Child version (Turner et al., 2005; Finkelhor & Turner, 2008) Adult adaptation (Radford et al., 2011, Appendix C, pp 169–176) | Yes Child version (Hamby et al., 2005; Finkelhor & Turner, 2008) Adult adaptation brief details (Radford et al., 2011, p 166) |
| ISPCAN Child Abuse Screening Tool (ICAST) | Modularised Stem items (15) Leaf items (4) | Paper and pencil in school settings (time not reported) | Yes, available via application to ISPCAN | Yes, available via application to ISPCAN | No |
| Adverse Childhood Experiences International Questionnaire (ACE-IQ) | Not modularised Screening items only (10) | Face-to-face interview in clinic setting Currently being tested in schools (time not reported) | Yes, Data Management Guide (WHO, undated, available at www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/) | No | Yes, Interviewer Guide (WHO, undated, available at www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/) |
| Sexual Abuse and Violence in Ireland Survey (SAVI Survey) | Not modularised Screening items only (12) | CATI (Approx. 35 mins) | No | Yes, ethical and safety considerations (McGee et al., 2002, pp 30–35) | Yes, interviewer training and support (McGee et al., 2002, pp 35–37) |

Table 17 Alignment with Royal Commission’s research objectives (Option 1; Option 4)

| Instrument | Studies using the instrument | Country of origin | Versions available | Age range | Types of child maltreatment covered | Collects data on prevalence, nature and context | Number of items | Administration method and time |
|--|--|--|---|---|--|---|---|--|
| Juvenile Victimization Questionnaire (JVQ) | 7 of the 49 Finkelhor x 5 Helweg-Larsen Radford | Child version US Adult version UK | Child (parent proxy report) Child self-report Adult self-report (adapted by Radford et al., 2011, 2013) | 1 month to 9 years 10-17 18 years and older | Child sexual abuse Physical abuse Emotional/psychological abuse Neglect Witnessing family violence Other victimisations | Prevalence Nature Context | Modularised Screening items (up to 52) Follow-up items (up to 18) | CATI (Average 55 mins) |
| ISPCAN Child Abuse Screening Tool (ICAST) | 3 of the 49 Al-Eissa Ajduković Feng | Multi-country | ICAST-C (child self-report) ICAST-R V3.0 2014 (adult self-report) | 12–17 18 years and older | Child sexual abuse Physical abuse Emotional/psychological abuse Neglect | Prevalence Nature Context | Modularised Stem items (15) Leaf items (4) | Paper and pencil in school settings (time not reported) |
| Adverse Childhood Experiences International Questionnaire (ACE-IQ) | 0 of the 49 | Multi-country | Adult self-report | 18 years and older | 10 adverse childhood experiences | Prevalence only | Not modularised Screening items only (10) | Face-to-face interview in clinic setting Currently being tested in schools (time not reported) |
| Sexual Abuse and Violence in Ireland Survey (SAVI Survey) | 1 of the 49 | Ireland | Adult self-report | 18 years and older | CSA only | Prevalence Nature Context | Not modularised Screening items only (12) | CATI (Approx. 35 mins) |

Reliability and validity of the major instruments for measuring the prevalence of child abuse and neglect

This section explores in more detail the reliability data for the JVQ and ICAST-C (Home and Institutional modules used with children), and ICAST-R (Retrospective used with adults). No reliability data are publicly available for the other measures discussed in this report (ACE-IQ and SAVI surveys).

Internal consistency

Cronbach's alpha is one of the most commonly used statistics to establish the internal consistency of an instrument, and is usually used to examine whether items deemed to measure the same latent construct correlate with each other. If the average of those correlations is high, the items are thought to measure the same underlying construct.

- Because alpha calculations use correlation coefficients (r), the data need to be measured on a continuous scale (e.g. 1–5).
- Alphas are typically lower when a subscale or scale has few items.
- The validity of using alphas to assess the reliability of subscales and scales measuring the extent and nature of different forms of abuse in childhood is questionable as the items relate to factual data about events, contexts and perpetrators **which may or may not be expected to correlate with one another**, as opposed to items measuring a latent construct (such as anxiety or depression) which **would** be expected to correlate with each other.

JVQ

- The JVQ internal consistency data come from the article by Finkelhor et al. (2005) and were established with samples ranging from 779 caregivers/youth to 2,023 caregivers/youth. The sample sizes vary widely due to the selected age range for the administration of some screener items.
- It should be noted that the internal consistency is not reported separately for the youth ($n = 1,000$) and caregiver versions ($n = 1,030$) of the measure and presumably they have been aggregated into a single sample despite the informant type – this is a significant flaw in reliability calculations as the two measures may perform differently.
- Domains (that is, victimisation types) with 3, 4 and 5 items showed the lowest alphas (0.35–0.39) while domains with higher numbers of items (e.g. 8, 9, 10 items) showed higher alphas (0.55–0.64) and the total JVQ showed an alpha of 0.80.
- The description of the method for establishing internal consistency of the JVQ does not describe whether both the screener items and/or the follow-up questions were used, or if only screener items were used. Based on the sample sizes included in the table reporting the alphas (Table 8, p 401) it appears that only the single item screener questions were used for calculating the alphas for the combined caregiver/youth samples.
- The results section states that the JVQ aggregates, which have been used to establish internal consistency, tally whether the child had any of the events included in the domain and are scored the same whether the child reported had one or

multiple events – as a yes/no/not sure measure – hence the data are categorical and not suitable for alpha calculations (Gadermann, 2012, p 1637).

ICAST-C Home and ICAST-C Institutional

- The internal consistency information for the Home and Institutional versions of the ICAST-C came from the paper by Zolotor et al. (2009) and were established with a subset of a sample of 571 children and adolescents aged 11–18 from three countries – due to changes in the scale piloted in one country, it was not possible to pool reliability information for that site. It is also unclear if the same group of children completed both the Home and the Institutional items – the Icelandic sample is slightly different in the numbers for the two scales.
- It should be noted that the internal consistency is reported for the total sample across countries (with the exception of the fourth country as noted above), which may obscure reliability variation across contexts.
- The ICAST-C Home includes 5 item subsets (ranging from 6 to 9 items each) and the Institutional version includes three item subsets (ranging from 10–17 items each).
- The internal consistency was calculated for the item subsets – Home ranged from 0.69–0.83 and Institutional ranged from 0.78–0.85. There was no relationship between the number of items on the subscale and the size of the alpha.
- It isn't clear from the paper whether internal consistency was calculated using the stem (categorical) and/or leaf questions (frequency and other measures). If categorical, then Cronbach's alpha is not appropriate.

ICAST-R

- The ICAST-R internal consistency information came from the paper by Dunne et al. (2009) and was established with a sample of 842 young people aged 18–26 in 7 countries.
- It should be noted that the internal consistency is reported for the total sample across the 7 countries, which may obscure reliability variation across contexts.
- The ICAST-R includes three item subsets (for sexual, physical and emotional abuse) and each subset contains 5 items.
- The internal consistency was calculated for the three item subsets – sexual abuse (alpha = 0.824), physical abuse (alpha = 0.610) and emotional abuse (alpha = 0.626).
- It isn't clear from the paper whether internal consistency was calculated using the stem (categorical) and/or leaf questions (frequency and other measures). If categorical, then Cronbach's alpha would not be appropriate.

General conclusions about comparability of measures of internal consistency

It is unclear from both papers whether the stem/screener questions were the only questions included in the internal consistency analyses, but based on the numbers and other information presented in the published papers, we would assume this to be the case. Given the screeners/stems are measured categorically (that is, yes/no/not sure) and are designed to capture actual experiences rather than to measure a latent construct (such as anxiety or depression with items measured on a scale), we suggest that internal consistency calculations are an inappropriate measure of the reliability of these measures. As a general note, the JVQ measure includes more severe (and presumably less frequent) events than the ICAST-C and in some respects the ICAST-R and this may also explain some of the differences in internal consistency, given that data on these items will be highly skewed towards the 'no' response.

Test-retest reliability

- Test-retest reliability is established through re-administering the measure with the same informant after a specified period – the period used is usually long enough to increase the likelihood that informants are basing their recall on actual events/feelings rather than their recall of their responses to the first administration of the measure, and the period is not long enough to have enabled scores to have varied by a large amount (e.g. for more events to have occurred or for beliefs or attitudes to have changed).
- Test-retest reliability can be tested in different ways, including through correlation and related samples t-tests (or non-parametric equivalent) for continuous data and kappa coefficients or percentage agreement for categorical data. Kappa coefficients take into account the level of agreement occurring by chance – but note that values for kappa coefficients are lower when there are fewer items in a scale.

JVQ

- The JVQ test-retest reliability data come from the article by Finkelhor et al. (2005) and were established with a subsample of 100 caregiver respondents and 100 youth respondents over a 3–4 week period.
- Percentage agreement ranged from 79–100% for the total sample, 81–100 % for caregivers and 73–100% for youth. Using kappa's for test-retest reliability should be viewed with caution in this instance, as some kappas could not be calculated for items on which there was 100% agreement (e.g. exposure to war or ethnic conflict, witness to murder). Kappa coefficients varied widely across items on which there was perfect agreement. This is likely an artefact of low numbers of items on some domains.
- Rates of agreement were lowest on bullying and assault items, including peer/sibling assault and victimisation – these events may have re-occurred during the retest period and/or may be items that were classed as assault/victimisation at one administration of the measure, but were not considered so at the alternate administration. Percent agreements on the sexual violence items ranged from 97–100%.

ICAST-C and ICAST-R

Test-retest not reported

The test-retest reliability of the ICAST tools has not been established.

Validity

Validity is as important as reliability as a psychometric dimension. Validity refers to the extent to which the instrument or scale measures the construct it is intended to measure. The various components of validity include:

- concurrent or predictive validity (that is, demonstrating expected dose-response associations between poly-victimisation and adverse health and social outcomes). This has been demonstrated convincingly for all main tools in multiple countries and languages
- construct validity (the extent to which the instrument measures the underlying constructs it sets out to assess), which is now being determined through factor analyses for ICAST and the ACE-IQ questionnaires, but to date results have not been published and none of these papers were identified in our literature search.
- face validity across cultures (the extent to which the instrument appears to be measuring the right construct), which is quite strong for the JVQ and is one of the reasons it has been adopted quite often outside the US (e.g. the Optimus Studies). Face and content validity for the ICAST-Child's questionnaires are also good; the ICAST-C tool has been adopted in about 15 countries. However, both the ICAST-CH and ICAST-CI offer limited insight into the contexts in which sexual abuse and other forms of maltreatment occur.

The final study should use a hybrid tool based on the core elements of JVQ but adapted to the Royal Commission's requirements, refined for Australian culture and vernacular, and within constraints imposed by feasible survey methods and mode(s).

Summary of instrument reliability and validity

- The JVQ is the only instrument that fully meets the Royal Commission's objectives of measuring the prevalence of child sexual abuse (in the general population and in institutional contexts) with the potential also to measure prevalence of other child maltreatment subtypes, including physical and emotional abuse, neglect, and exposure to family violence.
- Although the JVQ has some weaknesses, it is one of only two instruments for which validity and reliability data are available. The data show that the JVQ is overall both a valid and reliable instrument, and in particular it has shown adequate test-retest reliability.
- Psychometric testing has identified low rates of internal consistency for the JVQ (as presented in the table); however, Cronbach alphas for all measures were calculated on categorical data, and in the case of the JVQ for subscales with a small number of

items, which at times measured highly infrequent events. The authors of both measures have identified that calculating internal consistency for a scale that is assessing whether events did or did not occur, rather than examining various components of an underlying construct, may be inappropriate.

- The report strongly recommends piloting the preferred instrument as the final version will likely be a hybrid that includes scales from other instruments and will have to be adapted for the Australian context. It may be advantageous to pilot two or three hybrid instruments so that the optimal instrument for this study can be empirically tested in the field. This would also add new knowledge to the field in terms of empirical measurement of maltreatment and victimisation.
- It is not feasible to create a new instrument, nor is it advisable, since the currently available instruments, especially the JVQ, are sufficiently robust to provide the information the Royal Commission requires. Any new instrument would take more than two years to develop and test, and there is no guarantee that it would be more valid or reliable than the JVQ. In addition, any new scale will not have an international benchmark.
- The instruments reviewed in this scoping study are being used continuously throughout the world and new evidence of the psychometric properties of these scales will emerge over time. When the piloting takes place it should take into account recent developments. Unfortunately the psychometric properties of instruments used for prevalence studies are reported rarely at present. Research teams should be encouraged to report on these technical aspects of surveys used in the field.

Appendix E: Juvenile Victimization Questionnaire – provisional instrument

Explanatory Note: The JVQ collects information on a wide range of maltreatment and other victimisations, including exposure to conventional crime (robbery, theft, vandalism) and peer victimisation (gang violence, bullying, dating violence).

To develop this provisional instrument and meet the Royal Commission’s research objectives, we extracted the most relevant items from successive versions of the JVQ used in the NATSCEV study series in 2014 and 2015 (that is, the JVQ-R2 Full interview: youth (Finkelhor et al., 2008, 2014, 2015)). We were also informed by linguistic adaptations Radford et al. made to the JVQ for the UK study (Radford, Corral, Bradley, Fisher, Bassett, Howat & Collishaw, 2011).

This process meets the Royal Commission’s research objectives to provide a provisional abridged set of items from the JVQ (both **screeners** and **follow-up items** about nature and context, including disclosure). A long list of follow-up items is possible with the JVQ. We extracted the items most appropriate for the relevant screeners, and not all follow-up items are asked for each screener. **Screeners** collect data on prevalence only (yes/no). **Follow-up items** collect more detailed data on prevalence (e.g. frequency), nature (e.g. severity), and context (e.g. relationship of perpetrator to victim).

The JVQ includes some follow-up items on health outcomes, but a more developed exploration of health outcomes can and will be explored with the method Radford et al. (2011, 2013) adopted using the *Trauma Symptom Checklist for Children* (Briere, 1996) for 16–17 year olds, and the *Trauma Symptom Checklist* (Briere & Runtz, 1989) for adults.

Table 18 JVQ screener items

| |
|---|
| Sexual abuse |
| S1+S2 combined. At any time in your life/before you were 18, did a grown-up ... touch your private parts when they SHOULD'N'T have or MAKE you touch their private parts, or did a grown-up FORCE you to have sex? |
| S3. Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. At any time in your life/before you were 18, did another child or teenager make you do sexual things? |
| S4. At any time in your life, did anyone TRY to force you to have sex, that is sexual intercourse of any kind, even if it didn't happen? |
| S5. At any time in your life, did anyone make you look at their private parts by using force, or surprise, or by 'flashing' you? |
| Physical abuse |
| M1. Not including spanking on your bottom/smacking, at any time in your life/before you were 18 did a grown-up in your life hit, beat, kick or physically hurt you in any way? |
| Emotional abuse |
| M2. At any time in your life/before you were 18, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you? |
| Neglect |
| M3. When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick/ill, or make sure they have a safe place to stay. At any time in your life/before you were 18, were you neglected? |
| Witnessing family violence |
| W1. At any time in your life/before you were 18, did you SEE a/your parent get pushed, slapped, hit, punched or beat up by another/your other parent or their boyfriend or girlfriend? |
| W2. At any time in your life/before you were 18, did you SEE a/your parent hit, beat, kick or physically hurt your brothers or sisters, not including (a spanking on the bottom/smacking)? |

Table 19 JVQ follow-up items

| Item | SA | PA | EA | N | WFV |
|------|----|----|----|---|-----|
|------|----|----|----|---|-----|

| | | | | | |
|---|---|---|---|---|---|
| <p>1. [Lifetime prevalence] How many times did this happen to you in your whole life? _____ times [Range: 1-96; 97 = 97 or more; 98 = Not sure; 99 = Refused] [Interviewer: If respondent is unsure, say "Would you say it was closer to 10 times, closer to 50 times, or more than that?" Assist respondent in pinpointing number of times. If more than one time, say "Answer the next questions about the last time this happened."]</p> | ✓ | ✓ | ✓ | ✓ | ✓ |
| <p>2. [Incidence in past year] Thinking of (the last time/when) this happened to you...did it happen within the last year? By the last year we mean between (current month) when you were (current age – 1) and now?" [Interviewer: Read definition of "year" when this question is asked the first time and then as many times as needed] 1 Yes 2 No 3 (VOL) Not sure 4 (VOL) Refused</p> | ✓ | ✓ | ✓ | ✓ | ✓ |
| <p>3. How old were you (the last time/when) this happened? [Interviewer: Use grade/age chart to assist respondent.] _____ years old</p> | ✓ | ✓ | ✓ | ✓ | ✓ |
| <p>4. Were you physically hurt when this happened? [Interviewer: Read definition when this question is asked the first time and then as many times as needed]: "Hurt means you could still feel pain in your body the next day. You are also hurt when you have a bruise, a cut that bleeds, or a broken bone." Yes / No / Not sure / Refused</p> | ✓ | ✓ | ✓ | ✓ | |
| <p>5. What kind of an injury was it? Read if needed, multiple record. Small bruise, scrape, or cut Large bruise, major cut, black eye, or bloody nose Sprain, broken bone, or broken teeth Injury inside your body Knocked-out or hit unconscious Felt other pain that lasted until next day Other (specify): _____ (VOL) Not sure (VOL) Refused</p> | ✓ | ✓ | ✓ | ✓ | |
| <p>6. Did you go to the hospital, a doctor's office, or some kind of health clinic to get treated for this injury? Yes / No / Not sure / Refused</p> | ✓ | ✓ | ✓ | ✓ | |
| <p>7. Who did this? [Interviewer: Try to categorize from open-ended responses. Read categories only if respondent needs help.] Brother, sister, or other child who lives with (your child/you) (cousin, foster sibling, etc.) Biological or adoptive father Step-father or live-in boyfriend Biological or adoptive mother Step-mother or live-in girlfriend Foster parent A relative who <u>lives in your home</u> (uncle, grandparent, etc.) A relative who <u>does not live with you</u> A parent's boyfriend, girlfriend, date, or ex-boyfriend or girlfriend who <u>does not live with you</u>. Grown-up you know(s) from some organization, such as a teacher, coach, or youth group leader Anyone else you know(s) such as a friend or neighbour Stranger (a stranger is someone you don't know) Boyfriend/girlfriend</p> | ✓ | ✓ | ✓ | ✓ | |

| | | | | | |
|---|---|---|---|---|---|
| Other _____ (write in who it was) (VOL) Not sure (VOL) Refused | | | | | |
| 8. Was this person a man, woman, boy, or girl? [Interviewer: Ask only for perpetrators when gender is not clear but always code gender but <u>always</u> code gender.] [CATI - IF j=2 or 3, autopunch 1 here, if j=4 or 5, autopunch 2 here and do not show question] Man Woman Boy Girl (VOL) Not sure (VOL) Refused | ✓ | ✓ | ✓ | ✓ | |
| 9. Where were you when this happened? At or near home At school (inside, in school yard, or on bus) At day care or an after school program Somewhere else (VOL) Not sure (VOL) Refused | ✓ | ✓ | ✓ | ✓ | |
| 10. Thinking back to when it happened, how afraid did you feel? Would you say you felt... Not at all afraid A little afraid Very afraid (VOL) Not sure (VOL) Refused | ✓ | ✓ | ✓ | ✓ | ✓ |
| 11. Did you miss any days of school, or were you unable to complete your schoolwork, because of what happened? Yes / No / Not sure / Refused | ✓ | ✓ | ✓ | ✓ | ✓ |
| 12. Do any of these people know about what happened? [Interviewer: Read each response and code all that apply.] A parent (or ANOTHER parent if one parent did this) Yes / No / Not sure / Refused A teacher, counselor, or other adult at your school or day care Yes / No / Not sure / Refused A police officer or some other law official Yes / No / Not sure / Refused | ✓ | ✓ | ✓ | ✓ | ✓ |
| 13. Did you talk with someone other than friends or family about what happened --- someone like a counsellor or minister who tried to help you deal with it? Counsellor, psychologist, social worker, therapist of any type Minister or clergy of any type Other professional None of these (VOL) Not sure (VOL) Refused | ✓ | ✓ | ✓ | ✓ | ✓ |
| 14. Did the person who did this use any of these? Gun Knife Stick, rock, bottle, pipe, or tool such as a hammer or wrench Other (Specify _____) (VOL) No weapon used (VOL) Not sure | ✓ | ✓ | | | |

| | | | | | |
|---|---|---|---|---|---|
| (VOL) Refused | | | | | |
| 15. How old was the person(s) who did this? [Interviewer: If the respondent doesn't know, ask him/her to guess. At a minimum determine whether the person was 18 or older.] [Interviewer: If the respondent doesn't know or guess, ask what grade the person was in] _____ years old | ✓ | ✓ | ✓ | ✓ | |
| 16. Did you get sick when this happened? Yes / No / Not sure / Refused | | | | ✓ | |
| 17. Did this person(s) put any part of her/his body inside you? Yes / No / Not sure / Refused | ✓ | | | | |
| 18. Did this person (these persons) try to do that? Yes / No / Not sure / Refused | ✓ | | | | |
| 19. When this (last) happened did someone actually use physical force by pushing, grabbing, hitting or threatening you with a weapon? Yes / No / Not sure / Refused | ✓ | | | | |
| 20. We've been talking about the last time this happened. Now, I want you to think about the VERY FIRST TIME this happened. How old were you the very first time this happened? _____ years old (VOL) Not sure (VOL) Refused | ✓ | ✓ | ✓ | ✓ | ✓ |

Appendix F: Overview of existing national surveys

There are numerous data sources with information about children, young people and adults who have experienced child sexual abuse and other forms of child maltreatment. However, *no single data source provides comprehensive evidence on all issues of interest to the Royal Commission and other Australian policymakers.*

This component of the scoping study focuses on establishing the potential for existing national surveys and data collections to contribute to a prevalence study. For example, current surveys or national data collections relating to children and young people may include or have the potential to include measures of childhood adversity (including childhood maltreatment) and/or poor functioning associated with such experiences, as well as help-seeking experiences. Similarly, national surveys of adults may already include or have the potential to include retrospective items that examine abuse in childhood and its impacts. This component also explores the feasibility of triangulating information from multiple survey methods and data collections.

This review will illustrate the kinds of information available and the variation across existing survey data sources to provide a context for considering options designed to improve child sexual abuse and child maltreatment data.

Method and sources of information

To develop an understanding of existing data relating to child maltreatment, a systematic search was conducted to identify national Australian surveys and national data collections. These were then examined for measures and indicators relating to child sexual abuse and child maltreatment, and their impacts, and the potential for including such measures (see Appendix G). We adapted the audit methodology used by the US Department of Health and Human Services in assessing the need for a national disability survey (Livermore et al., 2011a, b).

In selecting the surveys and data collections to be reviewed, we used the following selection criteria:

- The survey was federally-sponsored and *national in scope*.
- The survey was fielded in 2005 or later.
- If the survey has not been fielded since 2005, it contains significant content relating to child maltreatment or other information particularly relevant to the Royal Commission and Commonwealth Government to assist policymaking and resource allocation.

For each survey/data source meeting the selection criteria, the following information was extracted from publicly available sources:

- name of the survey/data collection
- purpose
- auspicing agency
- population of interest – age range of participants
- sampling strategy/universe
- sample size
- regional and state level estimates
- longitudinal data
- frequency of data collection and year(s) fielded
- methods/mode of administration
- child sexual abuse and child maltreatment measures/items/indicators
- risk/protective factor and other abuse context measures
- impact measures
- demographic and other measures
- links to administrative data
- potential uses for child sexual abuse/institutional child sexual abuse/child maltreatment research
- ethical considerations
- governance model
- other notable features
- publications/web resources detailing the survey/data collection.

Twenty-four surveys and data collections were identified that met the selection criteria of being federally sponsored, national in scope and fielded in 2005 or later. These are presented alphabetically in Table 18. The information extracted for the 24 surveys and data collections that met the selection criteria is presented in Appendix H.

An additional 16 studies were identified that did not meet the selection criteria, as they related to research and/or data collections that were beyond the date range for this scoping project (Dunne et al., 2003; Najman et al., 2005; Women’s Safety Australia³⁶; National Aboriginal and Torres Strait Islander Social Survey³⁷) and/or they related to state-specific surveys (Goldman & Padaychi, 1997; Martin et al., 2004; Mazza et al., 2001; Moore et al., 2010; the Australian Temperament Project³⁸; and data linkage³⁹) and/or measure development (Higgins & McCabe, 2001; Watson & Halford, 2010) and/or were not federally

³⁶ The Australian Bureau of Statistics’ Women’s Safety Australia survey, available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4128.01996?OpenDocument

³⁷ The National Aboriginal and Torres Strait Islander Social Survey is available at www.aihw.gov.au/publication-detail/?id=6442467912

³⁸ The Australian Temperament Project (Victoria only) is available at www3.aifs.gov.au/atp/

³⁹ Administrative data from Tasmania and Victoria (children and young people at risk of social exclusion: links between homelessness, child protection and juvenile justice).

sponsored (Nelson et al., 2006; the Global Health and Wellbeing Survey⁴⁰; Fildes et al., 2014; Laslett, 2010).

⁴⁰ Global Health and Wellbeing Survey, commissioned by the Movember Foundation.

Table 20 Identified national Australian surveys

| Surveys of children |
|--|
| Child/youth report |
| <ol style="list-style-type: none"> 1. Australian Survey for Kids and Young People (ASK-YP) 2. Longitudinal Survey of Australian Youth (LSAY) |
| Teacher report |
| <ol style="list-style-type: none"> 1. Australian Early Development Census (AEDC) |
| Combination (child/parent/carer/teacher) |
| <ol style="list-style-type: none"> 1. Australian National Children's Nutrition and Physical Activity Survey (primary caregiver and child) 2. Footprints in Time – the Longitudinal Study of Indigenous Children (child, parent and teacher) 3. Longitudinal Study of Australian Children (LSAC) – child measure, parent report, and teacher or centre-based carer 4. National Survey of Child and Adolescent Mental Health and Wellbeing (parents/carers of children (aged 4–17) and children aged 11–17) |
| Administrative data collection |
| <ol style="list-style-type: none"> 1. Child Protection Australia 2. Perinatal Data |
| Surveys of adults |
| <ol style="list-style-type: none"> 1. Australian Longitudinal Study on Women's Health (ALSWH) 2. Drug Use Monitoring in Australia 3. Personal Safety Survey |
| Surveys that include adult and child report/information |
| Survey data |
| <ol style="list-style-type: none"> 1. Australian Health Survey (one adult and one child from each household) 2. Australian Study of Health and Relationships (aged 16–69) 3. Crime Victimization Survey (aged 15+) 4. Household Expenditure Survey (aged 15+) 5. Household, Income and Labour Dynamics in Australia (HILDA) (Aged 15+) 6. Identity Crime and Misuse in Australia (aged 15+) 7. Longitudinal Study of Factors Affecting Housing Stability (Journeys Home) (aged 15+) 8. National Drugs Strategy Household Survey (aged 12+) 9. National Survey of Adult Mental Health and Wellbeing (aged 16–85) 10. Survey of Disability, Ageing and Carers (aged 15+, proxy for younger than 15) 11. Survey of Income and Housing (aged 15+) |
| Administrative data collection |
| <ol style="list-style-type: none"> 1. Recorded Crime – Victims, Australia |

Findings

The degree of information collected about childhood adversity (child maltreatment), poor functioning associated with adverse experiences, and help-seeking experiences, varied between the 24 surveys that met the inclusion criteria, as did their potential suitability for incorporating measures relating to child sexual abuse and other forms of maltreatment.

The 24 studies are categorised in Table 20 by survey participants and who provided the information (more detail can be found in Appendix H). The following sections are structured to describe nationally representative, non-nationally representative and administrative data collections relating to the experiences of children, adults as children, and children and adults, respectively. They incorporate a review of the information these studies collect, if any, in relation to child maltreatment, including retrospective adult reports, poor functioning associated with adverse experiences and help-seeking.

Surveys relating to children's experiences

Of the 24 surveys and data sources identified, nine related to information collected about children. Data were collected about children from children themselves and teachers, or a combination of children/parents/carers and teachers. Surveys of adults collected data directly from the adults. A number of the surveys collected information from individuals in a range of ages, including children/youth and adults, asking them about their personal experiences (see Appendix I, Table 27).

Nationally representative surveys

Of the surveys that relate to the experiences of children, five are nationally representative samples including the Longitudinal Study of Australia's Children, the Longitudinal Study of Australian Youth, the National Survey of Child and Adolescent Mental Health and Wellbeing, the Australian National Children's Nutrition and Physical Activity Survey, and the Australian Early Development Census.

Two nationally representative studies were identified that followed children's experiences longitudinally. The *Longitudinal Study of Australia's Children* (LSAC) began data collection in 2004 for two cohorts of children, aged 0–1 and 4–5. The children and their families are followed up every two years, and sometimes more frequently (e.g. questionnaires are mailed out between waves). LSAC provides details about whether the child does not see a parent due to abuse/neglect or violence; why the family may not have a permanent place to live and whether it is due to abuse or neglect; detailed information about the condition of the home and whether it is hazardous for the child; and whether the child is unkempt (as a sign of neglect). This survey also collects a range of information relating to child outcomes (e.g. academic performance, child violence, behavioural and emotional functioning, and health) and potential risk and protective factors (e.g. parental stress and parental mental health).

Data are next being collected for LSAC in 2016, when children will be aged 12–13 and 17–18. Given this is a large-scale study that has longitudinally and consistently tracked children every two years, this survey has the potential to include retrospective items asking about the children's experiences of abuse and neglect. This study already contains details about child outcomes relating to education, socio-emotional wellbeing, violence and health, as well as detailing parental risk and protective factors.

There are plans for LSAC to collect data on child maltreatment when the two cohorts reach adulthood. However, the Department of Social Services, which is responsible for LSAC content, has not decided how many questions will be devoted to child maltreatment and has not fully formulated these surveys.

As LSAC follows two cohorts it will provide two opportunities to survey participants about abuse. But, unless there is another cohort study, this will not be repeatable after each cohort has been surveyed. Even if another cohort study begins in the next few years, it will be another 20 years before the follow-up can be conducted.

The **Longitudinal Study of Australian Youth** (LSAY) includes samples from schoolchildren aged 15 in 1995, 1998, 2003, 2006 and 2009, and collects data annually from these

samples for 10 years. Currently, this survey contains no details relating to child maltreatment; however, it does collect information relating to outcomes for children, including education, employment, study, work and social indicators. Retrospective maltreatment items could be added into the next waves of data collection or incorporated into the first wave of the next cohort; however, the samples are now drawn from the Programme for International Student Assessment⁴¹ rather than directly from schools.

Three of the studies of children's experiences that include nationally representative sampling are cross-sectional surveys. The **National Survey of Child and Adolescent Mental Health and Wellbeing** and the **Australian National Children's Nutrition and Physical Activity Survey** do not contain information relating to maltreatment and these surveys are not collected frequently or regularly. The National Survey of Child and Adolescent Mental Health and Wellbeing has only been conducted twice (in 1998 and 2013) and the Australian National Children's Nutrition and Physical Activity Survey has only had one data collection (in 2007). However, the National Survey of Child and Adolescent Mental Health and Wellbeing collects important information about the potential impacts of child maltreatment on children's psychosocial functioning and their help-seeking behaviour.

The **Australian Early Development Census** (AEDC) data is collected every 3 years (it has so far been collected from 2009–15) and is representative as it relates to all children who are attending their first year of full-time school. The AEDC includes items relating to potential child maltreatment, including the state in which the child has come to school (for example, too tired, sick or hungry to do school work, or overdressed or underdressed) and the child's overall physical and emotional development. The AEDC contains a range of child impact measures; for example, aggressive, anxious and fearful behaviour; literacy and numeracy skills; and overall social competence. This survey is regularly fielded, generally about children aged 4–7; however, this is a teacher report and teacher observations alone may not capture enough detail to accurately report maltreatment.

Studies with non-representative samples

Of the nine surveys relating to children's experiences, two may not be nationally representative, including Footprints in Time, the Longitudinal Study of Indigenous Children (LSIC), and the Australian Survey for Kids and Young People (ASK-YP).

The **Longitudinal Study of Indigenous Children** (LSIC) has two cohorts of children, aged 6–18 months and 3.5–5 years when recruited in 2008, and data is collected every 12 months where possible. This study does not include a representative sample of Australian Aboriginal and Torres Strait Islander children. Eligible families living in 11 sites, selected to reflect a range of socio-economic and community environments where Aboriginal and Torres Strait Islander children live, were approached to be included in the study, and this sample was a non-representative purposive sample. The survey contains no information relating to child maltreatment. It does contain information that could relate to risk and protective factors (e.g.

⁴¹ The Programme for International Student Assessment (PISA) is a triennial international survey, which aims to evaluate education systems worldwide by testing the skills and knowledge of 15-year-old students. To date, students representing more than [70 economies](#) have participated in the assessment.

maternal health care, parental health, child and family functioning, and financial stress) and impact measures (e.g. child social and emotional development, and the strengths and difficulties questionnaire).

The **Australian Survey for Kids and Young People** (ASK-YP) is a newly developed study commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse. The ASK-YP has been developed through focus groups with children and young people interacting with a variety of institutions, including early learning centres, schools, sporting groups, holiday camps, church groups, out-of-home care agencies and hospitals. The study is currently recruiting children and young people using convenience sampling, including children in institutions. ASK-YP covers children's and young people's experiences of how well organisations are keeping them safe; how children and young people understand, perceive and respond to safety issues in the institutions with which they interact; and asks them to reflect on the extent to which they believe institutions respond to their safety needs. Currently, it is expected that ASK-YP will be conducted once only and it does not include direct questioning of children about their experience of maltreatment.

Administrative data

Two state and territory administrative data collections were identified that relate to children. The Perinatal data collection appears annually in the Australia's Mothers and Babies report and contains information relating to all births in a 12-month period from January to December. This data collection doesn't contain child maltreatment indicators, and provides little useful detail on impact measures or risk factors, although indicators for alcohol use in pregnancy are under development. The second data collection is administrative data from child protection services relating to all notifications, investigations, substantiations, care and protection orders and out-of-home care placements in a one-year period between July and June. It is reported on in the annual *Child Protection Australia* report.

The administrative data collections are limited to the fields that are available in the state and territory data systems. Child Protection Australia provides details of instances of reported abuse and neglect, which can contribute to an estimate of child adverse experiences. However, this data is limited to the instances of adverse child experiences that are reported, and therefore is likely to be an underestimate because it does not account for unreported adverse experiences. This data is limited to that collected by agencies responsible for child protection and data that can be easily extracted from administrative systems. However, now that data collected by child protection units is being collected nationally, there is the potential to examine the data of birth cohorts of children, and to link child protection administrative data to other data sources to examine impacts of reported adverse experiences and other risk factors.

Summary

No existing survey or data collection involving children aged under 18 obtains population-wide prevalence data about children's experiences of sexual abuse, institutional sexual abuse, or other forms of maltreatment, their nature and context, or health outcomes. No surveys align with the Royal Commission's research objectives, and none can be adapted to do so. In addition, the most developed surveys are conducted intermittently and

will not meet the Royal Commission's timing requirements. It is highly unlikely that any of the methods detailed previously could capture the necessary data, even if other major obstacles were overcome. The biggest obstacle is that the survey would have to include a large additional component even if the narrowest option was chosen (Royal Commission Option 1); and the additional components would be far more extensive if Option 4 was preferred.

None of the surveys and data collections involving children aged under 18 included direct questions for children or their caregivers about experiences of child sexual abuse. One administrative data collection (Child Protection Australia) contains information about rates of child sexual abuse and other forms of child maltreatment reported to child protection agencies, but it does not provide information about the context, duration, severity or perpetrators of the abuse. This data collection now includes unit record data, which makes it possible to study reported rates of child maltreatment for birth cohorts of children, and potentially to link this data with information in other datasets to examine potential impacts of abuse and neglect.

The ASK-YP uses vignettes to examine the extent to which children have experienced or have knowledge of scenarios that may indicate child sexual abuse. However, this study does not use representative sampling or a validated tool, does not question children about their direct experience of child sexual abuse or other forms of maltreatment, and currently is only being administered once.

Two surveys of children's experiences included items or indicators relating to forms of maltreatment other than child sexual abuse. The studies examine narrow forms of abuse or neglect (or indicators thereof) using non-standardised measures and/or in narrow population groups (for example, children in a small age band or subsets of children from larger studies). Of these studies, one is limited to indicators of physical neglect for a very small age range (the AEDC), and one includes indicators based on non-standardised interviewer observations of child and home, and single items about abuse, neglect and violence as reasons for moving/not seeing non-resident parents (the Longitudinal Study of Australia's Children). Together with the studies identified earlier, information from these datasets could be triangulated with a prevalence study to provide a picture of specific forms of child maltreatment in specific populations; however, they do not appear suitable for the inclusion of additional standardised measures of child maltreatment.

While no studies of children currently include standardised measures of children's experiences of childhood maltreatment, including sexual abuse, three studies (the National Survey of Child and Adolescent Mental Health and Wellbeing, the Longitudinal Study of Australia's Children and the Longitudinal Study of Indigenous Children) include measures of risk factors and/or potential impacts (for example, mental health, and social, behavioural and cognitive development) that could be related to childhood maltreatment in representative samples of Australian children. The possibility of incorporating brief measures of all forms of child maltreatment in such studies is worth further exploration, although it should be noted that one of these surveys, the National Survey of Child and Adolescent Mental Health and Wellbeing, is conducted intermittently and was administered in 2014, and the other two studies are following cohorts of children over several years. While prevalence estimates may

be obtained in these latter two samples, changes in prevalence estimates for populations over time will not be readily observable unless new cohorts are added to these studies regularly.

Surveys of adults' experiences

Of the 24 identified national Australian surveys, three surveys related to information collected solely about adults and their experiences (see Appendix I, Table 28). All of these surveys collected information directly from adults and included studies examining personal safety, drug use and women's health.

Nationally representative studies

The only nationally representative study of adult's experiences was the **Personal Safety Survey**. This survey collects information from men and women aged over 18 about the nature and extent of their experience of violence. This survey asks details experiences of violence and abuse retrospectively by asking for experience in the previous 12 months and since the age of 15. The survey collects information about physical and sexual abuse as a child (before age 15); however, experiences of emotional abuse and neglect are excluded. The survey asks whether abuse has been experienced more than once, and the age at which abuse first occurred, and the relationship to the perpetrator/s of the first incident of abuse. It includes details about abuse (before age 15), stalking, nature and extent of violence experienced (since age 15), including partner violence and partner emotional abuse (since age 15).

This survey provides details of abuse experiences, and may provide an indicator of types of abuse; however, there is no information on when the abuse occurred and who inflicted the abuse. There could be scope to add additional questions more specific to adverse childhood experiences; however, it should be noted that the survey has not been frequently or regularly used to collect data. Data has only been collected and reported twice, once in 2005 and once in 2012. There is no indication that this survey will be administered within the timescales of the Royal Commission and therefore it cannot be used as the primary vehicle for the prevalence study.

Studies with non-representative samples

Two surveys of adult experiences were identified that were not nationally representative: **Drug Use Monitoring in Australia** and the **Australian Longitudinal Study on Women's Health** (ALSWH). Drug Use Monitoring in Australia collects data quarterly relating to all police detainees in six sites across Australia. This survey contains no measures of child maltreatment and no risk factors; however it does contain details relating to housing, employment, criminal history, offending details and charges, drug use and self-reported alcohol use. This survey is conducted frequently and regularly but only for police detainees at six sites in Australia (including Adelaide, Bankstown, Brisbane, East Perth, Kings Cross and Surry Hills). Therefore it may not be an appropriate survey in which to include retrospective reports of child maltreatment, unless this specific population is of great interest, or in order to examine links between child maltreatment and the potential adult impacts (for example, drug use or criminal charges).

The ALSWH began collecting data in 1996 from three groups of women aged 18–23 (born 1973–78), aged 45–50 (born 1946–51) and aged 70–75 (born 1921–26). Data was collected every three years in 1996–2011. In 2012, a new cohort of young women born in 1989–95 began. This survey contains no specific child maltreatment items. The survey is regularly fielded and contains longitudinal data relating to women only within specific age ranges. Retrospective reports of child maltreatment could be added but this will only capture the experiences of this sample of women within the age ranges that were purposefully sampled.

Summary

No existing survey or data collection involving adults obtains population-wide prevalence data about their childhood experiences of sexual abuse, institutional sexual abuse, or other forms of maltreatment, their nature and context, or their health outcomes. No surveys align with the Royal Commission’s research objectives, and none can be adapted to do so. In addition, the most developed surveys are conducted intermittently and can’t meet the Royal Commission’s timing requirement. It is highly unlikely that any of the methods detailed above could capture the necessary data, even if other major obstacles were overcome. The biggest obstacle is that the survey would have to include a large additional component, even if the narrowest option was chosen (Royal Commission Option 1); and the additional components would be far more extensive if Option 4 was preferred.

Of the three surveys of adults’ experiences, only one study currently collects information from adults relating to physical and sexual abuse in childhood – the Personal Safety Survey. This survey does not include information about other forms of maltreatment and has only been administered intermittently, most recently in 2012. However, there may be potential to include additional standardised measures of maltreatment in childhood in this survey.

Of the other two studies involving adult participants relating their own experiences, both relate to selected target groups in the population of Australian adults. The first includes female participants only (the Australian Longitudinal Study on Women’s Health) in certain birth cohorts, and the second (Drug Use Monitoring in Australia) includes only police detainees in a small number of sites across Australia. Unless these target groups are of specific interest to a prevalence study of childhood maltreatment, exploring incorporating maltreatment measures within these surveys is not recommended.

Surveys of children’s and adults’ experiences

Twelve of the 24 surveys and data collections identified in this scoping study collect information from children and adults about their own experiences (see Appendix I, Table 29). This includes cross-sectional and longitudinal surveys of representative samples of Australian children and adults, a non-representative longitudinal study, together with one administrative data collection.

Representative samples

Nine of the 12 studies included cross-sectional studies using random sampling to obtain representative samples. These studies included studies of drug and alcohol use, health,

disability, aging and wellbeing, as well as crime, housing, income and expenditure. More detail is provided below.

The **National Drugs Strategy Household Survey** is administered every two to three years with random samples of Australians aged 12 and over. The study is designed to examine alcohol and tobacco consumption and illicit drug use in Australia, and people's attitudes towards tobacco, alcohol and drug use. The sample size has grown from 3,500 respondents in 1993 to 23,855 in 2013. The survey does not ask about child sexual abuse specifically, but does ask respondents whether a person(s) under the influence of alcohol or illicit drugs has verbally or physically abused them or cause them to feel fearful in the past 12 months. The survey also asks about risk and impact factors such as the respondent's own illicit drug use, and smoking and alcohol use, including in pregnancy. It may be possible to triangulate data from these surveys with other data sources to provide a more comprehensive picture of harms to children. As the items specifically relate to harms caused by people under the influence of alcohol or illicit drugs, it may not be possible to include a broader set of items relating to childhood maltreatment.

The **Australian Health Survey** is a large survey administered cross-sectionally every three to six years, recruiting one adult, and where appropriate, one child per randomly selected household. The survey is designed to provide information about health-related issues, including health status, risk factors, socio-economic circumstances, health-related actions and use of medical services. Respondents aged 15 and over were asked if they, a family member, or someone close to them had experienced family stressors in the preceding 12 months – this included witnessing violence, and abuse or violent crime. While family violence and child physical abuse may be covered by these items, no specific child maltreatment items are apparent. The potential exists to include additional brief standardised measures of maltreatment in childhood, as the survey is administered regularly, includes information about harm to young people, and provides extensive information about health and wellbeing.

The **National Survey of Mental Health and Wellbeing** examines the psychosocial functioning of Australians, including the prevalence of and impairment caused by selected lifetime and 12-month mental disorders. It is a cross-sectional survey that has been administered twice (once in 1997 with a sample of 10,600 Australians aged 18 and over, and again in 2007 with a younger sample, including more than 8,800 16–85 year olds). Participants are randomly selected and complete measures relating to mental health and wellbeing. The survey includes items relating to sexual abuse, physical abuse and witnessing domestic violence in childhood, including the age at which abuse first occurred and the frequency of abuse. The surveys are infrequent, but provide nationally comparable information about abuse in childhood and mental health and wellbeing in late adolescence and adulthood. If administered more frequently, it may be possible to include measures relating to maltreatment in childhood, although extensive measures, including details of context and perpetrators, may not be appropriate.

The **Survey of Disability, Ageing and Carers** is a national survey that aims to capture the experiences of Australians with a disability, aging Australians (those aged over 65) and carers. It is conducted every three to seven years with a random sample of Australian's living

in private dwellings and a targeted sample of Australian's in non-private dwellings and cared accommodation. A computer assisted personal interview (CAPI) methodology is used and proxy reports are obtained for children younger than 15, children aged 15–17 where parent/guardian consent has not been given, and those incapable of answering for themselves due to illness, impairment, injury or language problems. The survey includes an item relating to homelessness as a result of violence, abuse or neglect, but does not ask further questions about maltreatment in childhood. The potential for including a brief standardised measure of child maltreatment could be explored, as this study targets Australians with disability, a population of interest to the Royal Commission.

The **Australian Study of Health and Relationships** is a cross-sectional CATI survey of a large representative sample of Australians aged 16–69. The study is designed to examine the sexual and reproductive health of Australians, including older Australians. The study includes a measure of unwanted and/or forced sexual experiences, their frequency, the age of the respondent at onset, and any help sought and from whom. Existing data from the study could be triangulated with other data sources to provide information about unwanted childhood sexual experiences, although the survey does not provide detail of the context in which the abuse occurred, nor of the relationship to the perpetrator. The study has been infrequently administered (twice in the past decade and most recently in 2012–13), but if conducted again, it has the potential to include additional items about child maltreatment.

The **Crime Victimisation Survey** is cross-sectional and is conducted as part of the **Multi-purpose Household Survey** (MPHS) by the Australian Bureau of Statistics. The survey collects via telephone or personal interview information about people's experiences of crime victimisation, whether these incidents were reported to police, and details of the most recent incident. The Crime Victimisation Survey is administered to randomly selected respondents aged 15 and over who have completed the Labour Force Survey in full. Adults complete all modules of the Crime Victimisation Survey, and parents can provide proxy reports for 15–17 year olds for whom consent is not given to respond. Questions relating to sexual assault, alcohol or substances contributing to the most recent physical or face-to-face threatened assault were not asked of proxy respondents. Those aged 15–17 who do self-report are not asked questions relating to sexual assault. This survey may be suitable for including additional child maltreatment items, however it not clear whether adult reports include lifetime prevalence and/or reports of intra-familial abuse.

The **Identity Crime and Misuse Survey** is a cross-sectional study conducted in 2013. The study aimed to examine the extent and impact of identity crime and misuse in Australia using a sample 5,000 respondents randomly selected from registrants with an online survey panel provider. The study did not include items or measures associated with child maltreatment or its impacts, and is designed to examine identity theft and other crimes. Therefore it is unsuitable for data triangulation or incorporation of maltreatment measures.

The **Survey of Income and Housing** is cross-sectional and conducted biennially with a random sample of households in Australia to understand household income, wealth and housing costs across the population. The related **Household Expenditure Survey** is also cross-sectional and conducted every six years with a subsample of the households from the

2009–10 Survey of Income and Housing, and includes households with inhabitants aged 15 and over. The survey examines broad patterns of expenditure and is used to update the weighting pattern of the consumer price index. These surveys are not suitable for child maltreatment research as they focus on current patterns of household income, borrowing and expenditure, and it would be inappropriate to incorporate current or retrospective reports of child maltreatment.

The **Household, Income and Labour Dynamics in Australia** (HILDA) study is a longitudinal survey that included a randomly selected sample of Australian households with respondents aged 15 and over. The households were recruited in 2001, and the sample in wave 11 was topped up. The study follows up family members annually across generations, and as families form and re-form over time. The survey examines aspects of life in Australia, including household and family relationships, child care, employment, education, income, expenditure, health and wellbeing, attitudes and values on a variety of subjects, and various life events and experiences. While the survey does not include measures of child sexual abuse or other forms of child maltreatment, incorporating measures into the HILDA study would make it possible to study the impacts of abuse and neglect on multiple family members and across generations.

Studies with non-representative samples

The **Longitudinal Study of Factors Affecting Housing Stability** (Journeys Home) surveys a sample of 1,682 Australians aged 15 and over who were identified by Centrelink data as homeless or at risk of homelessness. The study aims to explore factors associated with journeys into and out of homelessness and service usage patterns of people experiencing homelessness. Information is collected face-to-face biannually, and the interview includes information about respondents' childhood experiences of being left without food, experiencing physical violence and threats of harm to themselves and others, as well as current experiences of abuse. Details of context, duration and relationship to perpetrator, and exploration of child sexual abuse, specifically, are not provided. The survey includes a wide range of factors that could demonstrate a link to abuse in childhood, including relationship status and marital history, schooling, employment, income and financial stress, housing and living arrangements, support services and networks, health and wellbeing, psychological resources, cognitive ability, diet and food security, and contact with the justice system. This study has completed its sixth and final wave of biannual data collection, but the information in this study could be triangulated with other sources of data to provide an overview of adverse experiences in childhood for this population group.

Administrative data

Recorded Crime – Victims, Australia, 2014, is an administrative data collection that provided information about reported crimes against children and adults. The Victims Australia report collates statistics about crime victimisation for a selected range of offences that came to the attention of, and were recorded by, police within a calendar year. Data is derived from administrative systems maintained by state and territory police agencies. Data relating to sexual assault is provided, along with details of the gender and age of the victim, relationship to offender, incident location and incident type. Reports are recorded by

reporting date, and not the date of the alleged offence/s, and therefore this dataset doesn't distinguish between recent and historical events. This dataset could be used to triangulate information with other sources of data to describe sexual assault of minors, but cannot be used to distinguish recent or historical events.

Summary

Typically the studies of children's and adults' experiences included samples of those aged 15 and over, and in some cases a proxy report was provided for 15–17 year olds where parents did not give consent for their children's participation. In other cases, children were not asked questions from modules relating to child sexual abuse or other reportable experiences.

Three studies (the National Survey of Adult Mental Health and Wellbeing, the Australian Study of Health and Relationships, and the Crime Victimization Survey) and one administrative dataset (Recorded Crime – Victims, Australia) included information that relating to child sexual abuse, unwanted or forced sexual experiences and/or adult victimisation. Some of these studies also included details of other forms of harm in childhood, such as physical abuse or assault (the National Survey of Adult Mental Health and Wellbeing), as did other surveys (for example, the National Drugs Strategy Household Survey includes verbal and physical abuse/fear; the Australian Health Survey includes family stressors such as witnessing violence and abuse; and Journeys Home asked about neglect and physical abuse in childhood). Only one study explored help-seeking for unwanted or forced sexual experiences in childhood – the Australian Study of Health and Relationships. These studies all provide useful information that could be collated across studies to provide a picture of adverse childhood experiences; however, no studies include standardised measures of all forms of child maltreatment, nor comprehensive detail of the duration, context, frequency or severity of the abuse.

A number of nationally representative studies (the National Survey of Adult Mental Health and Wellbeing, the Australian Health Survey and the Australian Study of Health and Relationships) that involve children and adults as respondents about their own experiences have included items that relate to childhood adverse experiences/maltreatment and also include highly important data about potential health, mental health and social correlates. Some of these studies (the National Survey of Adult Mental Health and Wellbeing and the Australian Study of Health and Relationships) have been infrequently administered, but the potential for including brief standardised measures of child maltreatment experiences in should be explored.

Overview of findings

This scoping study identified 24 national surveys and data collections that included information about children and adults. Of these 24 studies, nine related to information collected to study children's development and wellbeing, three related to studies of the experiences of adults alone, and 12 included the experiences of adults and children. There was substantial variation across surveys in terms of target populations, the measures used,

topics covered, frequency and design. None of the surveys included measures of all five child maltreatment types or details of the context of abuse.

A number of nationally representative studies (the National Survey of Adult Mental Health and Wellbeing, the National Survey of Child and Adolescent Mental Health and Wellbeing, the Australian Health Survey, the Australian Study of Health and Relationships, the Longitudinal Study of Australia's Children and the Personal Safety Survey) that involve children and adults as respondents about their own experiences have included items that relate to childhood adverse experiences/maltreatment and/or also include highly important data about potential health, mental health, cognitive and social correlates.

Two studies of respondents aged 16 and over included young people's and adults' responses to questions relating to child sexual abuse. The Australian Study of Health and Relationships used CATI to ask respondents about unwanted and forced sexual experiences, frequency, age at onset and help-seeking. The National Survey of Adult Mental Health and Wellbeing asked about sexual and physical abuse, witnessing intimate partner violence, and the age of onset of the abuse in face-to-face interviews. Similarly, the Personal Safety Survey asks adult respondents about their experiences of sexual and physical abuse in childhood.

While some of these studies (the National Survey of Adult Mental Health and Wellbeing, the Australian Study of Health and Relationships and the National Survey of Child and Adolescent Mental Health and Wellbeing) have been infrequently administered (usually a decade apart) or are longitudinal in nature (the Longitudinal Study of Australia's Children), the potential for including brief standardised measures of child maltreatment experiences in these studies should be explored.

Other studies have included items or indicators relating to forms of maltreatment other than child sexual abuse. The studies examine narrow forms of abuse or neglect (e.g. experiencing violence as a result of others' alcohol or drug use) using non-standardised measures and/or in narrow population groups (e.g. children in a small age band and subsets of children from larger studies). Together with the studies identified earlier, information from these datasets could be triangulated to provide a picture of specific forms of child maltreatment in specific populations; however, they do not appear suitable for the inclusion of additional standardised measures of child maltreatment.

One administrative data collection (Child Protection Australia) contains information about rates of child sexual abuse and other forms of child maltreatment reported to child protection agencies, but does not provide information about the context, duration, severity or perpetrators of the abuse. This data collection does collect unit record data and so there is the ability to study reported rates of child maltreatment for birth cohorts of children, and to possibly link this data with information in other datasets to examine impacts of abuse and neglect.

Other surveys of adults and children relate to selected target groups (e.g. female participants from certain birth cohorts, people with disability, police detainees and the Longitudinal Study of Indigenous Children) and do not currently collect detailed information about childhood

maltreatment and/or do not include representative samples. However, as these target groups are of interest to a prevalence study of childhood maltreatment, it may be suitable to explore incorporating maltreatment measures into these surveys.

Appendix G: Potential suitability of surveys for including additional items

Table 21 Potential suitability of including items about children's experiences in Australian studies*

| Survey/data collection | Potential for triangulation | | | | Potential for including items |
|---|--|---|---|--|--|
| | Option 1 Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional sexual abuse) about sexual abuse only | Option 2 Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only | Option 3 Ask prevalence questions about child maltreatment; ask nature and context about maltreatment only when mentioned in the context of institutional sexual abuse | Option 4 Ask prevalence questions about child maltreatment; ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse | |
| Australian Early Development Census | Does not meet criteria – only asks questions about some aspects of neglect | Does not meet criteria – only asks questions about some aspects of neglect | Does not meet criteria – only asks questions about some aspects of neglect | Does not meet criteria – only asks questions about some aspects of potential neglect | This survey is teacher report and only asks about part of one subtype of maltreatment (neglect), and is not representative of the broader population of children as it only includes a very limited age range. The survey is cross-sectional and administered every 3 years with the next due in 2018, therefore offering limited capacity to add items. |
| Australian National Children's Nutrition and Physical Activity Survey | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | This survey is not suitable as it does not include measures of risk or maltreatment factors. It was administered to a randomly selected cross-sectional sample as a once-off with no information about intended re-administration |
| Australian Survey for Kids and Young People | Does not meet criteria – does not directly ask about sexual abuse | Does not meet criteria – does not directly ask about sexual abuse | Does not meet criteria – does not directly ask about maltreatment | Does not meet criteria – does not directly ask about maltreatment | This survey is not suitable because it does not ask children directly about maltreatment. It is seeking a cross-sectional cohort and is currently only planned to have a single administration (taking place now). The representative nature of the sample is unknown, and it only targets children aged 10–19 recruited through institutional settings |

| Survey/data collection | Potential for triangulation | | | | Potential for including items |
|--|--|---|---|--|---|
| | Option 1 Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional sexual abuse) about sexual abuse only | Option 2 Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only | Option 3 Ask prevalence questions about child maltreatment; ask nature and context about maltreatment only when mentioned in the context of institutional sexual abuse | Option 4 Ask prevalence questions about child maltreatment; ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse | |
| Child Protection Australia | Does not meet criteria – does not distinguish institutional abuse | Does not meet criteria – does not capture details of the nature and context of sexual abuse | Does not meet criteria – does not capture details of the nature and context of maltreatment and whether it occurred in an institutional context | Does not meet criteria – contains details of the incidence of emotional abuse, neglect, physical and sexual abuse | Data collection only contains details of reported abuse and neglect. This data is collected and reported on annually with the next data extraction (July 2015 to June 2016) occurring after 30 June 2016. The collected data is unit record, which means that birth cohorts of children can be studied, and further items and details examined by linking the data with other datasets within the Royal Commission time frame |
| Footprints in Time – the Longitudinal Study of Indigenous Children | Does not meet criteria – no maltreatment items included | Does not meet criteria – no maltreatment items included | Does not meet criteria – no maltreatment items included | Does not meet criteria – no maltreatment items included | No maltreatment items were included in the survey. The sample is not representative but is a longitudinal study collecting data every 12 months. Wave 8 began collecting data in February 2015. It may be suitable for adding maltreatment items, as it contains a broad range of correlates, with the next planned data collection beginning in 2016 and therefore there is no opportunity to add items until the following round. |
| Longitudinal Study of Australia's Children | Does not meet criteria – no specific maltreatment items | Does not meet criteria – no specific maltreatment items | Does not meet criteria – no specific maltreatment items | Does not meet criteria – alludes to abuse/neglect in some questions but not enough to determine nature, prevalence and context | This study does not contain specific maltreatment items. It may be suitable for adding more detailed maltreatment items, as it contains broad correlates. Data is longitudinal, with collections every 2 years and the next occurs in 2018. A randomly selected sample is representative. It would need additional cohorts to study prevalence changes over time Note: The cohort will be adults when they are surveyed about child maltreatment |

| Survey/data collection | Potential for triangulation | | | | Potential for including items |
|---|--|---|---|--|---|
| | Option 1 Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional sexual abuse) about sexual abuse only | Option 2 Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only | Option 3 Ask prevalence questions about child maltreatment; ask nature and context about maltreatment only when mentioned in the context of institutional sexual abuse | Option 4 Ask prevalence questions about child maltreatment; ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse | |
| Longitudinal Surveys of Australian Youth | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | No maltreatment items are included in the survey. Longitudinal data is collected annually for 10 years for multiple cohorts of children aged 15 and over. The next data collection is in 2016 for the Y06 and Y09 cohorts. It is not suitable for including items as the sample is not representative of the population of interest, which is inconsistent with the current content |
| National Survey of Child and Adolescent Mental Health and Wellbeing | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | No information relating to maltreatment is collected. This survey is administered infrequently and has only been administered twice (in 1998 and in 2013–14). Apparently, no future administrations are planned and, therefore, it could not meet the Royal Commission's time frame. However, if this survey was administered more frequently, it may be suitable for adding items as it includes measures of impact and covers a representative community sample |
| Perinatal Data | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | Does not meet criteria – no maltreatment information collected | This data collection does not include any information relating to maltreatment. It is a cross-sectional sample that is collected annually for all women who give birth in Australia. The last data extraction occurred in early 2016 for data between January and December 2015. It would meet the Royal Commission's time frames, however it is not suitable for including items as it is administrative data relating to pregnancy, birth and early infancy |

*Note: Red = not feasible; green = feasible; amber = possibly feasible or feasible for a subpopulation; black = administrative data, not a survey

Table 22 Potential suitability of Australian studies of adults' experiences*

| Survey/data collection | Potential for triangulation | | | | Potential for inclusion of items |
|---|---|---|--|---|---|
| | Option 1 <i>Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional abuse) about sexual abuse only</i> | Option 2 <i>Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only</i> | Option 3 <i>Ask prevalence questions about child maltreatment; ask nature and context questions about maltreatment only when it is mentioned in the context of institutional sexual abuse</i> | Option 4 <i>Ask prevalence questions about child maltreatment; ask nature and context questions about child maltreatment regardless of whether or not it occurred in the context of sexual abuse</i> | |
| Australian Longitudinal Study on Women's Health | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | <i>This survey does not collect information relating to maltreatment. It collects longitudinal data on women in 4 age groups. It is currently collecting data annually for women born in the new cohort (born 1989–95) or 6 monthly for the older cohort (born 1921–26). This survey is not suitable for including items as it examines women's experiences only, and only certain birth cohorts, therefore it is not representative of Australian children</i> |
| Drug Use Monitoring in Australia | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | Does not meet criteria – no child maltreatment items | <i>This survey does not contain information relating to maltreatment. Data is collected quarterly and the last collection occurred in the first quarter of 2016, therefore it could meet the Royal Commission's time frame. But it is not suitable for including items as it examines experiences of police detainees from a very small non-representative sample of detention sites</i> |
| Personal Safety Survey | Does not meet criteria – does contain questions about the relationship to the perpetrator and type of abuse (for example, sexual) but it does not specify institutional abuse | Does not meet criteria – does contain questions about the relationship to the perpetrator and type of abuse (for example, sexual) | Does not meet criteria – does contain questions about the relationship to the perpetrator and type of abuse (for example, sexual) but it does not specify institutional abuse | Partially meets criteria – includes questions about retrospective physical and sexual abuse (before age 15), but doesn't ask about emotional abuse or neglect. Includes details of age at which abuse occurred, frequency of abuse and the relationship of the perpetrator(s) to the victim | <i>This survey contains some information about maltreatment (sexual and physical abuse) but does not cover emotional abuse or neglect. It is administered infrequently and only two data collections have taken place (2005 and 2012). Apparently no future administrations are planned and therefore it won't meet the Royal Commission's time frame. It may be suitable for including additional items to capture a representative sample of adults/young people's retrospective reports although not currently administered regularly.</i> |

*Note: Red = not feasible; green = feasible; amber = possibly feasible or feasible for a subpopulation; black = administrative data, not a survey

Table 23 Potential suitability of Australian studies of children’s and adults’ experiences*

| Survey/data collection | Potential for triangulation | | | | Potential for inclusion of items |
|--|---|---|--|---|---|
| | Option 1 <i>Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional abuse) about sexual abuse only</i> | Option 2 <i>Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only</i> | Option 3 <i>Ask prevalence questions about child maltreatment, ask nature and context questions about maltreatment only when it is mentioned in the context of institutional sexual abuse</i> | Option 4 <i>Ask prevalence questions about child maltreatment, ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse</i> | |
| Australian Health Survey | Does not meet criteria – asks about abuse only, but does not detail the type, context or nature of the abuse or whether it was in an institutional context | Does not meet criteria – asks about abuse only, but does not detail the type, context or nature of the abuse | Does not meet criteria – asks about abuse only, but does not detail the type, context or nature of the abuse | Does not meet criteria – asks about abuse only, but does detail the type, context or nature of the abuse | This survey does not contain detailed maltreatment information. It may be suitable for adding brief standardised measures of maltreatment in childhood, as the survey is administered regularly (every 3 to 6 years), includes information about harm to young people, and provides extensive information about health and wellbeing of a representative sample. The next administration is currently unknown. |
| Australian Study of Health and Relationships | Does not meet criteria – contains items about sexual abuse only, frequency, age it occurred and whether the person sought help, but doesn't mention institutional context | Partially meets criteria – contains items about sexual abuse only and details frequency, age it occurred and whether the person sought help | Does not meet criteria – contains items about sexual abuse only and details frequency, age it occurred and whether the person sought help, but doesn't mention institutional context | Does not meet criteria – contains items about sexual abuse only and details frequency, age it occurred and whether the person sought help, but doesn't mention institutional context | This study does not include details of maltreatment other than sexual abuse. Data is collected once a decade for a representative sample of 16–69 year olds, with the last administration in 2012–13. The next administration is potentially in 2021. It may be suitable for including broader maltreatment types |
| Crime Victimization Survey | Does not meet criteria – no specific questions about child maltreatment or institutional context | Does not meet criteria – no specific questions about child maltreatment, but it may detect some child maltreatment as it includes people aged 15 and over | Does not meet criteria – no specific questions about child maltreatment, but it may detect some child maltreatment as survey includes people aged 15 and over | Does not meet criteria – no specific questions about child maltreatment, but it may detect some child maltreatment as survey includes people aged 15 and over. No details of the nature or context of abuse | This survey doesn't include information relating to maltreatment, but asks adults about sexual assault. Other forms of child maltreatment are not explored specifically and it is not clear whether it includes lifetime prevalence and/or intra-familial abuse. Data is collected annually with the 2014–15 data expected to be available in early 2016. A collection is likely in mid- to late-2016, potentially meeting the Royal Commission's time frame. |
| Household Expenditure Survey | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | This survey doesn't include information on maltreatment. Data is collected every 6 years, with the next |

| Survey/data collection | Potential for triangulation | | | | Potential for inclusion of items |
|---|--|--|--|---|---|
| | Option 1 <i>Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional abuse) about sexual abuse only</i> | Option 2 <i>Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only</i> | Option 3 <i>Ask prevalence questions about child maltreatment, ask nature and context questions about maltreatment only when it is mentioned in the context of institutional sexual abuse</i> | Option 4 <i>Ask prevalence questions about child maltreatment, ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse</i> | |
| | | | | | administration in 2016–17; therefore it may not meet the Royal Commission's time frame. It is not suitable for including items as the content is inappropriate for this type of survey, which focuses on household expenditure, not health or welfare |
| Household Income and Labour Dynamics in Australia | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | No information about maltreatment is included in the survey. This annual survey has collected longitudinal data on families since 2001, with the next data collection to occur in 2016, potentially meeting the Royal Commission's time frame. While the survey does not include measures of child sexual abuse or other forms of child maltreatment, if measures were incorporated it would be possible to study the impacts of abuse and neglect on multiple family members and across generations for representative sample households |
| Identity Crime and Misuse in Australia | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | This survey does not include information on maltreatment. It was a one-off administration in 2013 with no future data collections planned. The sample was nationally representative of the population aged older than 15. The survey is not suitable for including items. |
| Longitudinal Study of Factors Affecting Housing Stability (Journeys Home) | Does not meet criteria – no questions specifically about sexual abuse or institutional context | Does not meet criteria – no questions specifically about sexual abuse | Does not meet criteria – no questions specifically about sexual abuse or institutional context. Includes items about emotional and physical abuse, and neglect | Does not meet criteria – no questions specifically about sexual abuse or the context or nature of abuse. Includes items about emotional and physical abuse, and neglect | Some information is included about emotional and physical abuse, and neglect, but there are no items about sexual abuse. Data was collected biannually, however no new collections are planned, making this unsuitable for inclusion of items |

| Survey/data collection | Potential for triangulation | | | | Potential for inclusion of items |
|--|---|---|---|--|--|
| | Option 1 | Option 2 | Option 3 | Option 4 | |
| | <i>Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional abuse) about sexual abuse only</i> | <i>Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only</i> | <i>Ask prevalence questions about child maltreatment, ask nature and context questions about maltreatment only when it is mentioned in the context of institutional sexual abuse</i> | <i>Ask prevalence questions about child maltreatment, ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse</i> | |
| National Drug Strategy Household Surveys | Does not meet criteria – no indication of sexual abuse or institutional context. Items only relate to verbal or physical abuse perpetrated by someone under the influence of alcohol or other drugs | Does not meet criteria – no indication of sexual abuse or institutional context. Items only relate to verbal or physical abuse perpetrated by someone under the influence of alcohol or other drugs | Does not meet criteria – no indication of sexual abuse or institutional context. Items only relate to verbal or physical abuse perpetrated by someone under the influence of alcohol or other drugs | Partially meets criteria – items only relate to verbal or physical abuse perpetrated by someone under the influence of alcohol or other drugs. No further details about the context or nature of maltreatment are included | This survey contains items that relate to verbal and physical abuse perpetrated by someone under the influence of alcohol or other drugs. No other maltreatment information is collected, but there is potential to include questions about broader maltreatment. Data is collected every 2 to 3 years, and the next administration is likely occurring in 2016. |
| National Survey of Mental Health and Wellbeing | Does not meet criteria – contains questions about abuse, age at occurrence and frequency but does not mention institutional context | Does not meet criteria – contains questions about abuse, age at occurrence and frequency | Does not meet criteria – contains questions about abuse, age at occurrence and frequency but does not mention institutional context | Does not meet criteria – contains questions about abuse, age at occurrence and frequency but there are no items relating to neglect | Items relating to physical and sexual abuse are included, but there are no items relating to neglect and emotional abuse. There is potential to include brief measures relating to maltreatment in childhood, however this survey is infrequently administered – it was first administered in 1991 and again in 2007. But the next administration is unknown. |
| Recorded Crime – Victims, Australia | Does not meet criteria – contains details of sexual assault, including incident location and relationship to offender, but does not distinguish between recent and historical events, making the victim's age unclear | Does not meet criteria – contains details of sexual assault, including incident location and relationship to offender, but does not distinguish between recent and historical events, making the victim's age unclear | Does not meet criteria – contains details of sexual assault, including incident location and relationship to offender, but does not distinguish between recent and historical events, making the victim's age unclear | Does not meet criteria – contains details of sexual assault, including incident location and relationship to offender, but does not distinguish between recent and historical events, making the victim's age unclear. Does not include other maltreatment types | This data collection only contains sexual assault of minors, with no other child maltreatment information collected. Data is extracted annually for a calendar year with the next extraction occurring in early 2016, therefore making it available within the Royal Commission's time frame. This dataset could be used to triangulate information with other data sources to describe sexual assault of minors, but it cannot be used to distinguish recent or historical events |

| Survey/data collection | Potential for triangulation | | | | Potential for inclusion of items |
|---|---|---|--|---|---|
| | Option 1 | Option 2 | Option 3 | Option 4 | |
| | <i>Ask prevalence questions about sexual abuse only; ask nature and context questions (which identify institutional abuse) about sexual abuse only</i> | <i>Ask prevalence questions about child maltreatment; ask nature and context questions about sexual abuse only</i> | <i>Ask prevalence questions about child maltreatment, ask nature and context questions about maltreatment only when it is mentioned in the context of institutional sexual abuse</i> | <i>Ask prevalence questions about child maltreatment, ask nature and context questions about child maltreatment regardless of whether or not it occurs in the context of sexual abuse</i> | |
| Survey of Disability, Ageing and Carers | Does not meet criteria – abuse and neglect used as an option for why a person is experiencing homelessness, but it contains no other maltreatment items | Does not meet criteria – abuse and neglect used as an option for why a person is experiencing homelessness, but it contains no other maltreatment items | Does not meet criteria – abuse and neglect used as an option for why a person is experiencing homelessness, but it contains no other maltreatment items | Does not meet criteria – abuse and neglect used as an option for why a person is experiencing homelessness, but it contains no other maltreatment items | This survey contains only a single item relating to maltreatment and whether homelessness is a result of violence, abuse or neglect. It occurs every 3 to 7 years with the most recent administration in 2009. The date of the next study is not known; therefore it is unclear whether it can meet the Royal Commission's time frame. There is potential to include a brief standardised measure to capture maltreatment information, however the study sample is limited as it targets people with disability |
| Survey of Income and Housing | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | Does not meet criteria – no maltreatment items | This survey contains no information relating to maltreatment. It is administered biennially, with the next survey likely between July 2015 and June 2016. However this survey is not suitable as its content focuses on household income and housing, not health or welfare |

*Note: Red= not feasible. Green=Feasible, Amber=possibly feasible or feasible for a subpopulation Black= administrative data, not a survey

Appendix H: Data extraction tables for surveys

Table 24 Surveys of children

| Survey/data collection | Australian Early Development Census (previously the Australian Early Development Index) |
|---|---|
| Purpose | This is a national progress measure of early childhood development that collects data relating to physical health and wellbeing, social competence, emotional maturity, language and communication skills, cognitive skills and general knowledge. It highlights what is working well and what needs to be improved or developed to support children and their families by providing evidence to support health, education and community policy and planning. |
| Auspecting agency | Australian Government Department of Education |
| Population of interest – age range of participants | All children who are attending their first year of full-time formal schooling in Australia (could range from 4–7 years) |
| Sampling strategy/universe | All children who are attending their first year of full-time formal schooling in Australia |
| Sample size | 289,973 children in 2012 |
| Regional and state-level estimates | National, state and territory, and regional, and has the capacity to go to school and community level |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | Undertaken every 3 years – 2009, 2012, 2015 |
| Methods/mode of administration | Teachers complete checklists on a secure web-based data-entry system based on their knowledge and observation of the children in their class, along with demographic information from school enrolment forms. |
| Child sexual abuse and child maltreatment measures/items | ‘Since the start of the school year, has this child sometimes (more than once) arrived: Over or under-dressed for school-related activities Too tired and/or sick to do school work Too tired to do school work Too sick to do school work Hungry’ ‘How would you rate this child’s: Overall physical development, daily personal hygiene’ |
| Risk/protective factor and other abuse context measures | No |
| Impact measure | Basic literacy, numeracy and memory Communication skills Anxious and fearful behaviour Aggressive behaviour Pro-social and helping behaviour Overall social competence, responsibility and respect Readiness to explore new things Physical readiness for the day Physical independence Fine and gross motor skills |

| | |
|--|--|
| | School absences |
| Demographic and other measures | Socioeconomic Status (SES) Area remoteness Sex Indigenous status Language diversity State and territory Special needs Country born Language spoken at home |
| Links to administrative data | Has been linked in specific studies |
| Potential uses for CSA/ICSA/child maltreatment research | Could be triangulated with other data sources and measure change over time, but very limited age range and only part of one subtype |
| Ethical considerations | None stated |
| Governance model | None stated |
| Publications/web resources detailing survey/data collection | 2012 report can be found at https://www.aedc.gov.au/resources/detail/national-report-2012 |
| Copies of measures | Complete survey saved in file |

| Survey/data collection | Australian National Children's Nutrition and Physical Activity Survey |
|---|--|
| Purpose | This survey was undertaken in recognition of the need to have national data on children's weight status, dietary intake and activity levels for monitoring purposes. This information is also important for assessing the nutritional adequacy and physical activity of the children surveyed. |
| Auspic agency | Department of Health Department of Agriculture and Water Resources Australian Food and Grocery Council CSIRO Preventative Health National Research Flagship University of South Australia I-view Pty Ltd |
| Population of interest – age range of participants | Children aged 2–16 |
| Sampling strategy/universe | The survey sample was randomly selected first by postcode (stratified by state/territory and capital city/rest of state), and then by households within selected postcodes using random digit dialling of telephone numbers. Eligible households with children aged 2–16 were identified and asked to participate in the survey. One child from each selected household was the designated a 'study child'. There was an agreed quota of 1,000 children (50 per cent boys and 50 per cent girls) for the following age groups: 2–3, 4–8, 9–13 and 14–16. The base national sample in South Australia was supplemented by 400 to allow more detailed estimates for that state. A total of 4,487 children completed the entire survey. The sampling, selection and recruitment methodology are comprehensively reported in the User Guide and should be considered when interpreting data. |
| Sample size | 4,487 |
| Regional and state-level estimates | SA only |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | One data collection between 22 February 2007 and 30 August 2007 |
| Methods/mode of administration | CAPI Follow-up CATI 21 days after first interview |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | None identified |
| Impact measure | Physical measurements, food and nutrient intake, food habits |
| Demographic and other measures | Postcode, state of residence, number of adults (>16) and children (<16) in household, household type (collected for each participant and their household) age, gender, Aboriginal and Torres Strait Islander status, country of birth, language spoken, school and higher education, parent/child relationship, income and occupation Food and nutrient intake Food habits questions |

| | |
|--|--|
| | Physical activity recall – Multimedia Activity Recall for Children and Adolescents (Ridley et al., 2006) Physical measurements |
| Links to administrative data | Potential – commissioned the CSIRO to conduct additional analysis of the 2007 Australian National Children’s Nutrition and Physical Activity Survey to enable comparisons between past, present and future data, and to identify additional areas for health promotion with this age group |
| Potential uses for CSA/ICSA/child maltreatment research | Not suitable, currently no measures of risk factors and no information about intended re-administration |
| Ethical considerations | None stated besides having been approved |
| Governance model | Steering group |
| Publications/web resources detailing survey/data collection | available at www.health.gov.au/nutritionmonitoring |
| Copies of measures | User guide with questionnaire saved in folder |

| Survey/data collection | Australian Survey for Kids and Young People |
|---|--|
| Purpose | This survey is an attempt to learn more about how children understand, perceive and respond to safety issues in the institutions with which they interact. It aims to gauge children's and young people's experiences of safety in a variety of institutional contexts, and determine how well they believe institutions are responding to their needs. It also attempts to understand children's and young people's experiences and ideas about how well organisations are performing in terms of keeping them safe. |
| Auspicing agency | Institute of Child Protection Studies, ACU Griffith University Queensland University of Technology Commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse |
| Population of interest – age range of participants | Children aged 10–19 for the survey Focus groups contained children aged 4–18 (it was used to help develop the survey) |
| Sampling strategy/universe | The survey is undertaken on an online platform and children and young people can opt in via the website. A sample of convenience is being sought using youth organisations, networks and schools to advertise the survey on social media, newsletters, bulletins, fliers and other communications. |
| Sample size | 121 children and young people aged 4–18 participated in the focus groups to develop the survey content (focus group data was used to assist with the development of survey items) Survey sample size is to be determined (currently collecting data) |
| Regional and state-level estimates | Unknown |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | 2015 – one administration currently being undertaken |
| Methods/mode of administration | The study uses a mixed-methods design to secure data from a broad variety of children within a diversity of institutional contexts and locations across the nation. Focus group data was collected and used to inform the survey development. Survey data is being collected via an online survey |
| Child sexual abuse and child maltreatment measures/items | The survey does not directly ask about child sexual abuse, but seeks the reflections of children and young people on the extent to which they believe institutions respond to their safety needs. |
| Risk/protective factor and other abuse context measures | Not available online |
| Impact measure | Not available online |
| Demographic and other measures | Not available online |
| Links to administrative data | None stated |

| | |
|--|--|
| Potential uses for CSA/ICSA/child maltreatment research | Not suitable. It is a single administration, non-representative sample, and is not asking children and young people about direct experiences. |
| Ethical considerations | <p>Prior to commencing the project, guidelines were developed that articulated the way researchers would respond to safety concerns.</p> <p>The focus groups and surveys were developed in such a way that children are not asked about their direct experience but are asked, instead, to comment on the safety of children and young people generally.</p> <p>Parental consent is required for children aged under 15, but not for 15–17 year olds</p> |
| Governance model | <p>Reference groups with children aged 9–11, 14–15 and 15–17</p> <p>Adult's advisory group</p> |
| Other notable features | The research project's methodology purposefully seeks to gain the views of children and young people in relation to safety, and safety in institutions broadly, but also provided opportunities for children and young people to specifically discuss safety from child sexual abuse, where appropriate. |
| Publications/web resources | available at http://isia.acu.edu.au/ask-yp/more-information/ |
| Copies of measures | Could not access copy of the measure |

| | |
|---|---|
| Survey/data collection | Child Protection Australia |
| Purpose | This study provides an annual report on detailed statistical information for every state and territory relating to child protection and support services and some of the characteristics of the children receiving these services. |
| Auspecting agency | Australian Institute of Health and Welfare (AIHW) |
| Population of interest – age range of participants | Children aged 0–17 who have been reported to child protection in Australia |
| Sampling strategy/universe | Administrative data for all children who have been reported to child protection in their respective state or territory in a one-year period |
| Sample size | Depends on the year 2013–14: 198,966 children were reported. 143,023 children received child protection services (99,210 were the subject of an investigation, 55,067 were on care and protection orders, and 51,539 were in out-of-home care) |
| Regional and state-level estimates | Provides details at national and state levels |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | Data collected and reported on annually |
| Methods/mode of administration | Administrative data extracted from state and territory departments and given to AIHW for analysis and reporting |
| Child sexual abuse and child maltreatment measures/items | Details notifications, investigations, substantiations and type of harm for each state and territory |
| Risk/protective factor, and other abuse context measures | None noted |
| Impact measure | Care and protection orders Out-of-home care Foster carers Relative/kinship carers Intensive family support services National standards for out-of-home care |
| Demographic and other measures | Age, gender, family socio-economic status (based on postcode), family type (eg, single parent or dual-parent families), Aboriginal and Torres Strait Islander status |
| Links to administrative data | Data collection is administrative data |
| Potential uses for CSA/ICSA/child maltreatment research | Only reported abuse/neglect, but unit record means that birth cohorts of children can be studied and data linked with other datasets |
| Ethical considerations | No ethical considerations noted |
| Governance model | None noted, although linked to National Framework for Protecting Australia’s Children |
| Publications/web resources | www.aihw.gov.au/publication-detail/?id=60129550762 |
| Copies of measures | Administrative data collection, not measure |

| Survey/data collection | Footprints in Time – the Longitudinal Study of Indigenous Children |
|---|--|
| Purpose | Footprints in Time aims to improve the understanding of, and policy response to, the diverse circumstances faced by Aboriginal and Torres Strait Islander children, their families and communities. |
| Auspic ing agency | Department of Social Services Roy Morgan Research |
| Population of interest – age range of participants | When the study was launched in 2008, it included two groups of Aboriginal and/or Torres Strait Islander children aged 6–18 months (B cohort) and 3.5–5 years (K cohort). Aboriginal and Torres Strait Islander children born between December 2006 and November 2007 (B cohort) and December 2003 and November 2004 (K cohort) are the sample units in the study. |
| Sampling strategy/universe | Footprints in Time employs an accelerated cross-sequential design, involving two cohorts of Indigenous children aged from 6 months to 2 years (baby cohort or B cohort) and from 3 years 6 months to 5 years (child cohort or K cohort) in wave 1. The design allows the data covering the first nine or 10 years of Aboriginal and Torres Strait Islander children’s lives to be collected in six years. The probability of being selected for participation in the study was not random across the total Indigenous population of Australia, but was clustered within 11 sites selected for sampling. Neither were families and children selected randomly from within a cluster. The majority of families in the study were recruited using addresses provided by Centrelink and Medicare Australia. Other informal means of contact, such as word of mouth, local knowledge and study promotion, were also used to supplement the number of children in the study. |
| Sample size | Wave 1: 1,687 Wave 2: 1,436 Wave 3: 1,404 Wave 4: 1,283 Wave 5: 1,258 |
| Regional and state-level estimates | None stated |
| Longitudinal data | Yes |
| Frequency of data collection and year(s) fielded | Although the study aims to interview participants at 12-month intervals, this is not always possible because of the availability of respondents and the logistics of interviewers’ travel arrangements and scheduling. Nonetheless, the average time between waves 5 and 6 interviews was 11.7 months. Wave 1: Apr 2008 to Feb 2009 Wave 2: Mar–Dec 2009 Wave 3: Mar–Dec 2010 Wave 4: Mar–Dec 2011 Wave 5: Mar–Dec 2012 Wave 6: Feb–Dec 2013 Wave 7: Feb–Dec 2014 Wave 8: interviews commenced in February 2015 |

| | |
|--|---|
| Methods/mode of administration | Face-to-face interviews Collects data from teachers using the teacher/carer questionnaire – similar to parent survey |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | Maternal health and care – alcohol, tobacco and substance use in pregnancy and birth Parental health – ongoing health conditions, resilience, social and emotional wellbeing, smoking habits and exposure, gambling, parents relationship Child and family functioning – including parental warmth, monitoring, consistency, parenting empowerment and efficacy Financial stress and income, housing and mobility Possibly other factors |
| Impact measure | Early diet and feeding, nutrition, dental health, health conditions, injury, hospitalisation and child's sleeping patterns Child's social and emotional development, temperament, sleep, dental health, injury, school attendance |
| Demographic and other measures | Household demographics, sex, age, Indigenous status, relationship to parent 1, relationship to study child, dwelling type and street traffic, child health, parent education, employment and income Strengths and Difficulties Questionnaire (Goodman) |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | Not a representative sample. Potentially suitable for addition of maltreatment items, as it contains a broad range of correlates, but it would need additional cohorts to study prevalence changes over time. |
| Ethical considerations | Prior to being interviewed for the first time, parents were given an introductory letter and a DVD describing the study and the consent process. At the interview, Research Administrative Officers went through each consent form with the participant(s) and explained what permission was being sought. This enabled parents to make informed consent about their participation in the study. A plain language statement was also available for parents who preferred to read about the study. Parents gave consent on behalf of the study child. As well as seeking permission to take part in the study, participants were separately asked for consent to: <ul style="list-style-type: none"> • voice record the interview • contact the other parent or another carer • contact the child's teacher or childcare worker • photograph the study child. |
| Governance model | LSIC Steering Committee Longitudinal Studies Advisory Group |
| Publications/web resources detailing survey/data collection | Available at https://www.dss.gov.au/about-the-department/publications-articles/research-publications/longitudinal-data-initiatives/footprints-in-time-the-longitudinal-study-of-indigenous-children-lsic |
| Copies of measures | https://www.dss.gov.au/sites/default/files/documents/04_2015/data_user_guide_-_release_6.0.pdf |

| Survey/data collection | The Longitudinal Study of Australia's Children |
|---|--|
| Purpose | This study examines the impact of Australia's unique social and cultural environment on the next generation. It aims to gain further understanding of child development, inform social policy debate, and is used to identify opportunities for intervention and prevention strategies in policy areas concerning children and their families. |
| Auspecting agency | Department of Social Services Australian Institute of Family Studies Australian Bureau of Statistics |
| Population of interest – age range of participants | At wave 1 (in 2004) children were aged: 0–1: born between Mar 2003 and Feb 2004 (B cohort) 4–5: born between Mar 1999 and Feb 2000 (K cohort) |
| Sampling strategy/universe | Recruitment occurred between March and November 2004. The sample was selected from Medicare Australia's enrolment database. Within the selected postcodes, the population was ordered by date of birth and then a random 'start and skip' was applied to select the children. The actual number of children selected depended on the postcode's stratum, but the aim was to recruit about 20 children per cohort for most postcodes. |
| Sample size | Wave 1: 10,090 (B cohort = 5,107; K cohort = 4,983) Wave 2: (B cohort = 4,606; K cohort = 4,464) Wave 3: (B cohort = 4,386; K cohort = 4,331) Wave 4: (B cohort = 4,242; K Cohort = 4,169) |
| Regional and state-level estimates | No |
| Longitudinal data | Yes |
| Frequency of data collection and year(s) fielded | Families have been interviewed every 2 years since 2004. In addition, between each wave, questionnaires were posted to families in 2005, 2007 and 2009. |
| Methods/mode of administration | Interview (child and parent) Mailed pen and paper questionnaire Information is being collected from each child (physical measurements, and cognitive testing and interviews, depending on the age of the child); the parents who live with the child (biological, adoptive or step-parents); home-based and centre-based carers (for preschool children who are regularly in non-parental care); and teachers (for school-aged children). From wave 2, information has also been sought from parents who live apart from the child but who have contact with them (parent living elsewhere). |
| Child sexual abuse and child maltreatment measures/items | 'What is the main reason why child has (never/in the last month) seen his/her other parent?' 1. Not known who other parent is; 2. Other parent doesn't know about child; 3. Child result of rape; 4. Respondent does not want other parent to see child; 5. Other parent does not want to see child; 6. Other parent is in prison; 7. Other parent lives too far away; 8. Other parent is overseas; 9. Other parent is sick/disabled (include mental illness); 10. Other parent does not have enough time to see child; 11. Travel is too expensive; 12. Other parent has a new partner or family; 13. Other parent does not have suitable living arrangements for a child to visit; 14. Supervision or restraint order; 15. Drug, alcohol or violence problems; 16. Other reason' 'What led to you being without a permanent place to live?' Violence/Abuse/Neglect Alcohol or drug use |

| | |
|--|--|
| | <p>Mental Illness'</p> <p>'Condition of Home. All visible rooms of the household are reasonably clean and uncluttered. This is an indication of conditions that might pose a health hazard to the child or that give the sense of a very chaotic household. If conditions in the home are clearly unsanitary (piled up rubbish, multiple days' worth of stacked up dishes, clothes or newspapers strewn across the floor or left piled etc then this would score "No". General untidiness or a lived-in appearance is not considered clutter</p> <p>'Child was unkempt (allowing for recent messy play). Looking for signs of neglect such as extreme poor hygiene – not the usual messy play or circumstantial condition'</p> |
| Risk/protective factor and other abuse context measures | <p>Parental stress Alcohol consumption while pregnant Parental mental health Mental Illness Gambling</p> |
| Impact measure | <p>Child functioning including behavioural, emotional, temperament, self-regulation, motor and physical development, social competence Child education – language and cognitive development, readiness to learn Academic performance (reading and numeracy – National Assessment Program – Literacy and Numeracy (NAPLAN)) Socio-emotional wellbeing Health – illness/disability, immunisation, health weight, diet, activity level (sport, computer use) Child violence (carrying weapon, fighting, used force or threats etc)</p> |
| Demographic and other measures | <p>Family structure, child and parental sex and age, family transitions Parental work arrangements, parents' income, parents' education, ethnic background, religious identity Characteristics of the home – location, type, condition, overcrowding Family functioning – beliefs, goals, parental consistency, parenting stress, parenting self-efficacy, stressful life events, parenting education, family relationships School transition Strengths and Difficulties Questionnaire</p> |
| Links to administrative data | <p>It asks for consent for biological measures and data linkage (wave 1), so if there is consent, data should be able to be linked to administrative data</p> |
| Potential uses for CSA/ICSA/child maltreatment research | <p>It is potentially suitable for addition of maltreatment items, as it contains a broad range of correlates. The study will need additional cohorts to study prevalence changes over time.</p> |
| Ethical considerations | <p>None stated</p> |
| Governance model | <p>The institute is supported by Professor Ann Sanson as Principal Scientific Advisor, and the Consortium Advisory Group (CAG), which includes members of each of the consortium partners</p> |
| Publications/web resources detailing survey/data collection | <p>Annual reports, research papers and technical reports are available from www.growingupinaustralia.gov.au/pubs/index.html</p> |
| Copies of measures | <p>Measure questions are available at www.growingupinaustralia.gov.au/studyqns/wave5qns/index.html (and saved in file)</p> |

| Survey/data collection | The Longitudinal Surveys of Australian Youth |
|---|---|
| Purpose | <p>The Longitudinal Surveys of Australian Youth (LSAY) tracks young people as they move from school into further study, work and other destinations.</p> <p>LSAY is designed to examine major transition points in young people's lives, including completing school and transitioning to work or further training and education, as well as other aspects of their lives.</p> <p>The survey aims to help better understand young people and their transitions from school to post-school destinations, as well as exploring social outcomes, such as wellbeing.</p> |
| Auspicing agency | <p>Commonwealth Department of Education and Training (DET) Wallis Consulting Group – data collection National Centre for Vocational Education Research provides – analytical + reporting services 1995–2007 – analytical and reporting services previously supplied by Australian Council for Educational Research (ACER) and Department of Education and Training</p> |
| Population of interest – age range of participants | <p>Survey participants (collectively known as a 'cohort') enter the study when they turn 15, or in Year 9 (prior to 2003). Studies began in 1995 (Y95 cohort), 1998 (Y98 cohort), 2003 (Y03 cohort), 2006 (Y06 cohort) and 2009 (Y09 cohort). More than 10,000 students begin in each cohort.</p> |
| Sampling strategy/universe | <p>The initial sample was drawn from Australian Year 9 students.</p> <p>Students first completed a two-hour test at school, followed by a mailed survey the following year. Subsequently, telephone interviews took place annually. From 2003 onwards, the sample for LSAY has been drawn from students who have undertaken the Organisation for Economic Co-operation and Development's (OECD's) Programme for International Student Assessment (PISA).</p> |
| Sample size | <p>1995 (Y95) – 13,613 1998 (Y98) – 14,117 2003 (Y03) – 10,370 2006 (Y06) – 14,710 2009 (Y09) – 14,251</p> <p>Wave/cohort (up until the 2014 data collection) Y03, Y06, Y09</p> <ol style="list-style-type: none"> 1. 10,370; 14,170; 14,251 2. 9,378; 9,353; 8,759 3. 8,691; 8,380; 7,626 4. 7,721; 7,299; 6,541 5. 6,658; 6,316; 6,541 6. 6,074; 5,420; 5,787 7. 5,475; 4,670; 5,082 8. 4,903; 4,223 9. 4,429; 3,839 10. 3,945 11. 3,741 |
| Regional and state-level estimates | Yes |
| Longitudinal data | Yes |
| Frequency of data collection and year(s) fielded | <p>Survey participants (collectively known as a 'cohort') enter the study when they turn 15 or are in Year 9 (prior to 2003). Individuals are contacted once a year for 10 years.</p> <p>Studies began in 1995 (Y95 cohort), 1998 (Y98 cohort), 2003 (Y03 cohort), 2006 (Y06</p> |

| | |
|--|---|
| | cohort) and 2009 (Y09 cohort). Since 2003, the initial survey wave has been integrated with PISA. More than 10,000 students start out in each cohort. |
| Methods/mode of administration | Survey completed in school Follow-up telephone interviews – annual CATI Can also complete interviews online |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | None identified |
| Impact measure | Mathematics, reading and science achievement, education and employment indicators, study and work indicators, social indicators |
| Demographic and other measures | State/territory, sex, Indigenous status, geographic region, country of birth, school sector |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | Not suitable – inconsistent with current content and representativeness of sample are considerations |
| Ethical considerations | National Centre for Vocational Educational Research (NCVER) staff are bound by protocols covering the privacy and confidentiality of data and the release of information. On appointment, staff are required to sign an undertaking which gives effect to these protocols. External data users are also required to show how they will comply with the protocols before access to unit record data is granted. The purpose of the privacy and confidentiality protocols is to allow statistical analysis using NCVER data holdings – LSAY – in a way that protects the privacy of persons and organisations about which information is held. Separate protocols cover the release of information. In principle, the data should be fully accessible to all users and information provided in a way that suits a variety of user needs, so long as access is consistent with the privacy and confidentiality protocols. External users are also bound by protocols covering data restrictions on the use of LSAY data. |
| Governance model | LSAY strategic advisory committee LSAY Questionnaire Development Reference Group |
| Publications/web resources detailing survey/data collection | Available at www.lsay.edu.au/publications/index.html Login required to access publications (free) – Username: ChildProtection@unisa.edu.au Password: ACCP2015 |
| Copies of measures | Questionnaires for each wave of each cohort are available at www.lsay.edu.au/data/21070.html |
| Survey identified from | http://www.lsay.edu.au/index.html |

| Survey/data collection | National Survey of Child and Adolescent Mental Health and Wellbeing |
|---|--|
| Purpose | This survey was designed to provide current information about the mental health and wellbeing of children and adolescents in Australia and the extent to which they use health and education services to obtain help with problems. It is designed to determine: <ol style="list-style-type: none"> 1. How many children and adolescents had which mental health problems and disorders 2. Their nature and impact 3. How many children and adolescents had used services for mental health problems 4. The role of the education sector in providing these services. |
| Auspecting agency | The Commonwealth Department of Health funded Young Minds Matter and commissioned The University of Western Australia to undertake the second administration of the survey through the Telethon Kids Institute in partnership with Roy Morgan Research. The survey was first administered by the Women's and Children's Hospital in partnership with the Australian Bureau of Statistics. |
| Population of interest – age range of participants | Parents and carers of children aged 4–17 in the general population and children aged 11–17 themselves |
| Sampling strategy/universe | Area-based sampling was used to select both samples, and where there was more than one child in a household, a child was selected at random by a computer. Households were approached and visited up to 6 times each between June 2013 and April 2014. |
| Sample size | 6,310 families (Aug 15 report; June 13 to April 14 data) 4,500 children (Oct 2000 report; 1998 data) |
| Regional and state-level estimates | No |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | The most recent data collection was in 2013–14, and prior to this was in 1998. |
| Methods/mode of administration | Information was obtained from the parents/carers of all participants and also from adolescents aged 11–17. Face-to-face interviews were conducted with the parent and the adolescent completed a self-report questionnaire on a tablet. |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor, and other abuse context measures | None stated |
| Impact measure | Sexual behaviour Mental health problems Self-harm and suicidal behaviours Substance use (alcohol and other drugs) Problem eating Service use |
| Demographic and other measures | The parent interview included: <ul style="list-style-type: none"> • family structure and socio-demographics • general health of child and disabilities • DISC-IV modules and functional impairment |

| | |
|--|--|
| | <ul style="list-style-type: none"> • Strengths and Difficulties Questionnaire • service use in past 12 months and perceived need for help • school attendance and performance • family characteristics, life stressor events, and parent/carer mental health measures. <p>The young people questionnaire included:</p> <ul style="list-style-type: none"> • DISC-IV major depressive disorder module • Strengths and Difficulties Questionnaire • Kessler Psychological Distress Scale • service use in past 12 months and perceived need for help • use of internet and informal supports • self-harm and suicidal behaviours • experience of bullying • health-risk behaviours, including substance use and problem eating behaviours. |
| Links to administrative data | No links noted |
| Potential uses for CSA/ICSA/child maltreatment research | It is currently administered infrequently, however if it was administered more frequently it might have potential to include measures of impact. It is a representative community sample. |
| Ethical considerations | None stated |
| Governance model | The survey was developed and conducted with advice from the Survey Reference Group. |
| Publications/web resources detailing survey/data collection | A link to PDF of the 2015 report is available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-child2 |
| Copies of measures | Unable to find the survey/interview schedule |

| Survey/data collection | Perinatal data |
|--|---|
| Purpose | This data collection provides national information on births, the women who gave birth and the babies born in Australia. |
| Auspecting agency | Australian Institute of Health and Welfare |
| Population of interest – age range of participants | Mothers who give birth in a 1-year period between 1 January and 31 December, including births in hospitals, in birthing centres and in the community. |
| Sampling strategy/universe | Perinatal data is collected after each birth by midwives or other staff from clinical and administrative records and information systems, including records of antenatal care, the care provided during labour, and the delivery and care provided after birth. Each state and territory has its own form and/or electronic system for collecting data, which is forwarded to the relevant state or territory health department to form the state's or territory's perinatal data collection. |
| Sample size | In 2012, 307,474 women gave birth to 312,153 babies |
| Regional and state-level estimates | Yes – state-level data is available |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | Data has been collected and reported on annually since 1990–91. |
| Methods/mode of administration | Administrative data is collected for all births in the year period. |
| Child sexual abuse and child maltreatment measures /items | None identified |
| Risk/protective factor and other abuse context measures | Indicators for alcohol use in pregnancy are under development |
| Impact measure | None stated |
| Demographic and other measures | Maternal age, Aboriginal and Torres Strait Islander status, geographical location, area remoteness, maternal country of birth, woman's previous pregnancies, type of birth, assisted reproductive technology, antenatal period, duration of pregnancy, smoking during pregnancy, body mass index, place of birth, multiple pregnancies, onset and types of labour, birth status (live or stillborn), child sex, birth weight, resuscitation at birth |
| Links to administrative data | No |
| Potential uses for CSA/ICSA/child maltreatment research | Not suitable – administrative data relating to pregnancy, birth and early infancy |
| Ethical considerations | None stated |
| Governance model | None stated |
| Publications/web resources detailing survey/data collection | Australia's Mothers and Babies Report is available at www.aihw.gov.au/publication-detail/?id=60129550033 |
| Copies of measures | Administrative data collection is not a measure |

Table 25 Surveys of adults' experiences

| Survey/data collection | Australian Longitudinal Study on Women's Health |
|--|---|
| <p>Purpose</p> | <p>This study provides scientifically valid information based on current, accurate data that is relevant to the development of health policy and practice in women's health.</p> <p>By looking at the factors contributing to the physical and emotional health of individual women in Australia, the study particularly aims to provide information that will assist state and federal governments to plan for the future and develop policies that are most appropriate to Australians of all ages in the 21st century.</p> <p>In addition, the project aims to clarify cause-and-effect relationships between women's health and a range of biological, psychological, social and lifestyle factors, and to assess the effects of changes in health policy and practice.</p> |
| <p>Auspecting agency</p> | <p>Commonwealth Department of Health University of Newcastle University of Queensland</p> |
| <p>Population of interest – age range of participants</p> | <p>In April 1996, women in three age groups: aged 18–23 (born 1973–78), 45–50 (born 1946–51), and 70–75 years (born 1921–26) were selected</p> |
| <p>Sampling strategy/universe</p> | <p>The women in the three age groups above were selected from the Medicare database, which contains the name and address details of all Australian citizens and permanent residents. These women were sent an invitation to participate in the Australian Longitudinal Study on Women's Health (ALSWH), and more than 40,000 responded and agreed to participate in the project for 20 years.</p> <p>Sampling from the population was random within each age group, except that women from rural and remote areas were sampled at twice the rate of women in urban areas. This was done so that the numbers of women living outside major urban areas were large enough to allow statistical comparisons of the circumstances and health of city and country women, an important issue for Australia now and in the future.</p> |
| <p>Sample size</p> | <p>Baseline – 41,638 (14,762 aged 18–23; 14,072 aged 45–50; 12,804 aged 70–75)</p> <p>Enrolled in longitudinal component: 18–23 (1973–78 cohort) – 14,247 45–50 (1946–51 cohort) – 13,716 70–75 (1921–26 cohort) – 12,432 18–23 (89–95 cohort – added in 2012–13) – 17,069</p> <p>Cohort: 1973–78, 1946–51, 1921–26, 1989–95 S1: 14,247; 13,716; 12,432; 17,069 S2: 9,688; 12,338; 10,434; 11,448 (+) S3: 9,081; 11,226; 8,647 S4: 9,145; 10,905; 7,158 S5: 8,200; 10,638; 5,560 S6: 8,010; 10,011; 4,055 (+data collection ongoing)</p> <p>6-month follow-ups of 1921–26 cohort May 2012 – 3,431 Nov 2012 – 3,299 May 2013 – 2,853 Nov 2013 – 2,478 May 2014 – 2,107</p> |

| | |
|---|---|
| Regional and state-level estimates | Possible |
| Longitudinal data | Yes |
| Frequency of data collection and year(s) fielded | From 1996 to 2011, each age cohort was surveyed once every 3 years via surveys sent in the mail. In 2011, the older cohort began receiving a shortened survey every 6 months and in 2012, ALSWH began annual surveys of a new cohort of young women born 1989–95. |
| Methods/mode of administration | Mail surveys |
| Child sexual abuse and child maltreatment measures/items | No specific child maltreatment items |
| Risk/protective factor and other abuse context measures | Abuse item – ‘have you ever been in a violent relationship with a partner/spouse?’ |
| Impact measure | Marital status and housing |
| Demographic and other measures | Age, main current employment status, highest qualification completed, Indigenous status, country of birth, present marital status, present housing situation, state/territory, area of residence (city, regional etc), income |
| Links to administrative data | Yes – Australian Census |
| Potential uses for CSA/ICSA/child maltreatment research | No. Examines women’s experiences only and certain birth cohorts |
| Ethical considerations | None stated |
| Governance model | Steering committee |
| Other notable features | As well as the main surveys, women are occasionally invited to participate in a variety of sub-studies targeting particular areas of health. A wide range of topics have been covered including: <ul style="list-style-type: none"> • sleeping difficulties and disturbances • domestic violence • menopausal problems • urinary incontinence • leisure and time use • diabetes • caring • future plans of young women. <p>ALSWH aims to help shape the future of women’s health in Australia by:</p> <ul style="list-style-type: none"> • identifying the social, psychological, physical and environmental factors that determine good health, and those that cause ill health in women throughout adult life • identifying when, if and how the health system meets the health needs of women and helping to guide future policy and planning of women’s health care services • providing information on the long-term health effects of events in women’s lives and on the factors that modify these effects |

| | |
|--|--|
| | <ul style="list-style-type: none"> • giving women an opportunity to have a say about their health and health services • providing a national research resource on women's health issues • providing data that will help motivate women to participate in decision-making on health. |
| Publications/web resources detailing survey/data collection | Publications and other resources available at www.alsw.org.au/ |
| Copies of measures | Not available online |

| Survey/data collection | Drug Use Monitoring in Australia |
|---|--|
| Purpose | <p>The ongoing aim of Drug Use Monitoring in Australia (DUMA) is to provide timely and accurate information about trends in alcohol and drug use among Australian detainees to support and inform policy, evaluations and strategic planning. The program examines the relationship between drugs and crime, and monitors local drug markets and drug use patterns by detainees across time.</p> <p>Data from DUMA is used to examine issues such as the relationship between drugs and property and violent crime, monitor patterns of drug use across time, and help assess the need for drug treatment among the offender population.</p> |
| Auspic agency | Australian Institute of Criminology (AIC) State Police services |
| Population of interest – age range of participants | All police detainees in six sites across Australia |
| Sampling strategy/universe | <p>Trained local staff interview detainees who have been arrested in the previous 48 hours and are being held in custody.</p> <p>Key elements include:</p> <ul style="list-style-type: none"> • voluntary and confidential participation • anonymity -names and addresses are not kept • data that is presented in aggregate form only • urine specimens that are tested by an independent laboratory • interviewers cannot be police officers. |
| Sample size | Total – 3,456 M – 2,812 F – 644 |
| Regional and state-level estimates | Yes |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | Quarterly |
| Methods/mode of administration | Face-to-face interviews and urine samples |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | Nil |
| Impact measure | Education, housing, employment, criminal history, prison history, offending details/charges, drug use, self-reported alcohol use |
| Demographic and other measures | Age, gender |
| Links to administrative data | None stated |

| | |
|--|--|
| Potential uses for CSA/ICSA/child maltreatment research | No. Examines experiences of police detainees from a very small non-representative sample of detention sites |
| Ethical considerations | None stated |
| Governance model | Each site has a local steering committee comprised of representatives from the AIC, independent researchers, local law enforcement and other major stakeholders. |
| Other notable features | The US has been successfully conducting surveys of offenders (including urinalysis) since the mid-1980s through its Arrestee Drug Abuse Monitoring (ADAM) program. DUMA is affiliated with the International Arrestee Drug Abuse Monitoring Program (I-ADAM) that ensures comparable data is being collected in a range of countries, including the US, England, Scotland and South Africa. Such data will enable comparisons of local illicit drugs markets at an international level for the first time. |
| Publications/web resources detailing survey/data collection | Available at www.aic.gov.au/about_aic/research_programs/nmp/duma.html |
| Copies of measures | Not available online |

| Survey/data collection | Personal Safety Survey |
|---|--|
| Purpose | The Personal Safety Survey (PSS) collected information about the nature and extent of violence men and women had experienced since age 15, including their experience of violence in the 12 months prior to the survey. It also collected detailed information about men's and women's experiences of current and previous partner violence, lifetime experience of stalking, physical and sexual abuse before age 15 and general feelings of safety. |
| Auspicing agency | Australian Bureau of Statistics |
| Population of interest – age range of participants | Men and women aged over 18 living in private dwellings in Australia |
| Sampling strategy/universe | <p>Personal face-to-face interviews were conducted with one randomly selected person aged 18 and over who was a usual resident of the selected household. Interviews were conducted from February to December 2012.</p> <p>Dwellings included in the survey in each state and territory were selected at random using a stratified, multistage area sample design. This sample included only private dwellings from the geographic areas covered by the survey. Dwellings were assigned as either male (where an interview with a male was required) or female (where an interview with a female was required). The sample for women was allocated roughly equally in each state and territory to provide sufficiently reliable state, territory and national-level estimates for women. The sample for men was allocated to states and territories roughly in proportion to their respective population size to provide sufficiently reliable national-level estimates for men.</p> |
| Sample size | Total: 17,050 Female – 13,307 Male – 3,743 |
| Regional and state-level estimates | Not reported. Results only split by gender |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | This survey has been conducted twice and was last run in 2005. |
| Methods/Mode of administration | Random selection of households Random selection of participants Face-to-face interviews |
| Child sexual abuse and child maltreatment measures/items | <p>Includes questions on physical and sexual abuse as a child (before age 15) and emotional abuse is excluded.</p> <p>Type of abuse experienced before age 15 Whether experienced abuse >once Age abuse first occurred Relationship to perpetrator(s) of first incident of abuse</p> <p>Also collects characteristics of violence aged over 15 – child abuse would be evident by participant's responses about age when most recent incident occurred</p> |
| Risk/protective factor and other abuse context measures | None stated |
| Impact measure | General feelings of safety, health |

| | |
|---|--|
| Demographic and other measures | <p>State or territory of usual residence, capital city or balance of state, remoteness of area, index of advantage/disadvantage, age, sex, country of birth, year of arrival, first language spoken as a child, main language spoken at home, registered and social marital status, family type, household type, family composition, current partner, partner demographics (as above); education, employment, and income (respondent and partner), household income, household financial stress, social connectedness, health, disability, general feelings of safety</p> <p>Abuse (before age 15), stalking, nature and extent of violence (including partner violence) experienced (since age 15), partner emotional abuse (since age 15)</p> |
| Links to administrative data | Not stated |
| Potential uses for CSA/ICSA/child maltreatment research | Potentially suitable for adult/young person retrospective report although not administered regularly |
| Ethical considerations | <p>Due to the sensitive nature of the information being collected, special procedures were used to ensure the safety of those participating and the reliability of the data provided. This ensured the complete confidentiality of any information collected and the security of both the respondent and the interviewer, where the respondent may have been living in the same household as a perpetrator. If preferred by the respondent, the option of conducting the interview at an alternate location or by telephone was also available. Once the questions regarding a person's experience of violence were reached in the interview, respondents were informed of the sensitive nature of the upcoming questions and were asked for their permission to continue with the interview.</p> <p>In addition, no proxy interviews were conducted. Interpreters or other family members were not used</p> <p>To further ensure respondent and interviewer safety, persons in selected dwellings were not advised in advance of their selection in the survey, as would normally be the case for ABS household surveys. Instead, interviewers were cold calling.</p> |
| Governance model | 2012 PSS Survey Advisory Group |
| Publications/web resources detailing survey/data collection | The ABS publication is available at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4906.0Main+Features12012?OpenDocument |
| Copies of measures | 2012 Personal Safety Survey Australia Data Items list is saved in the folder |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> |

Table 26 Surveys that include adult and child report information

| Survey/data collection | Australian Health Survey |
|---|--|
| Purpose | The Australian Health Survey (AHS) is designed to collect a range of information from Australians about health-related issues, including health status, risk factors, socio-economic circumstances, health-related actions and use of medical services. |
| Auspicing agency | Australian Bureau of Statistics Commonwealth Department of Health National Heart Foundation of Australia |
| Population of interest – age range of participants | (One adult and one child (where applicable) per household) AHS core sample (NHS/NNPAS) – aged 2+ ABS National Health Survey (NHS) – aged 0+ National Nutrition and Physical Activity Survey (NNPAS) – aged 2+ National Health Measures Survey (NHMS) – aged 5+ (selected from NHS/NNPAS respondents) |
| Sampling strategy/universe | The 2011–12 NHS and NNPAS were conducted using a stratified multistage area sample of private dwellings. Within selected dwellings, a random subsample of residents was selected as follows: <ul style="list-style-type: none"> • one adult (aged 18 and over), and (where applicable) • one child aged 0–17 (NHS) • one child aged 2–17 (NNPAS). <p>For NNPAS, the random sample selection code in the survey instrument was designed to give adults aged 65 and over a double chance of being selected in the sample to improve estimates for this older age group.</p> <p>All selected persons aged 5 and over were also invited to participate in the voluntary biomedical component of the surveys.</p> |
| Sample size | AHS core sample (NHS/NNPAS) – Total: 31,837 (6,927 aged 2–17; 19,664 aged 18–64; 5,246 aged 65+) NHS – Total 20,426 (12,332 adults 18–64, 3,413 aged 65+; 4,951 children 0–17). Collected Mar 2011 to March 2012 Previous surveys in the NHS series: 1989–90, 1995, 2001, 2004–05, 2007–08 NNPAS – Total 12,153 (2,718 aged 2–17; 7,332 aged 18–64; 2,103 aged 65+) Collected May 2011 to June 2012 NHMS (drawn from NHS and NNPAS) – Total 11,246 (843 aged 5–11; 839 aged 12–17; 7,164 aged 18–64; 2,397 aged 65+) Collected March 2011 to September 2012 |
| Regional and state-level estimates | Reports regional and state-level sample counts and weighted estimates of some regional and state-level findings, and is also split by age and gender. |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | The AHS 2011–13 survey appears to be a one-off as it is reported that the NHS will return to its normal format in 2014–15. See www.health.gov.au/nutritionmonitoring Previous surveys in the NHS series: 1989–90, 1995, 2001, 2004–05, 2007–08 |
| Methods/mode of administration | Random selection of households Random selection of participants |

| | |
|--|---|
| | <p>Face-to-face interviews</p> <p>Computer assisted personal interview</p> <p>Computer assisted telephone interview</p> |
| Child sexual abuse and child maltreatment measures/items | <p>NHS respondents aged 15+ were asked if they, a family member, or someone close to them had experienced any family stressors in the preceding 12 months. This included witnessing violence, and abuse or violent crime.</p> <p>Family violence and child physical abuse may be covered by these items, but no specific items are apparent.</p> |
| Risk/protective factor and other abuse context measures | <p>NHS – alcohol consumption, drug/drug-related problems (family stressors and long-term conditions sections), mental health and wellbeing</p> |
| Impact measure | <p>NHS (when interviewing children) – alcohol consumption, drug/drug-related problems (family stressors and long-term conditions sections), mental health and wellbeing</p> |
| Demographic and other measures | <p>AHS 2011–13 is a combination of:</p> <ul style="list-style-type: none"> • ABS National Health Survey (NHS) • National Nutrition and Physical Activity Survey (NNPAS) • National Health Measures Survey (NHMS) <p>The survey also collects age, sex, marital status, country of birth, year arrived in Australia, Indigenous status, education, employment, income, financial stress, housing, household and family characteristics, geographical classification and health cards information.</p> |
| Links to administrative data | <p>None stated</p> |
| Potential uses for CSA/ICSA/child maltreatment research | <p>Potential for including additional brief standardised measures of maltreatment in childhood, as the survey is administered regularly, includes information about harm to young people, and provides extensive information about health and wellbeing.</p> |
| Ethical considerations | <p>None stated</p> |
| Governance model | <p>None stated</p> |
| Publications/web resources detailing survey/data collection | <p>Publications and full questionnaires can be found on the ABS website at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4363.0.55.0012011-13?OpenDocument or at www.abs.gov.au/australianhealthsurvey</p> |
| Copies of measures | <p>Full questionnaires can be found on the ABS website at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4363.0.55.0012011-13?OpenDocument</p> |
| Legal provisions (for example, ABS surveys undertaken under the Census and Statistics Act 1905) | <p>Undertaken under the <i>Census and Statistics Act 1905</i></p> |

| Survey/data collection | Australian Study of Health and Relationships |
|---|---|
| Purpose | <p>The Australian Study of Health and Relationships (ASHR) provides a snapshot of the sexual health and wellbeing of Australians, as well as information essential for developing policy and delivering sexual and reproductive health programs across the country.</p> <p>The aims of ASHR2 were to:</p> <ul style="list-style-type: none"> • provide a representative national population-based study of the sexual and reproductive health of Australian adults aged 16–69 • describe changes in the sexual and reproductive health of Australian adults aged 16–59 between 2001–02 and 2012–13 by comparing the ASHR1 data with current patterns • provide the first large-scale national dataset addressing the sexual health of Australian men and women aged 60–69. |
| Auspicing agency | NHMRC grant 1002174 UNSW, University of Sydney, University of Sussex, La Trobe University Hunter Research Foundation Social Research Centre |
| Population of interest – age range of participants | Men and women aged 16–69 in Australia |
| Sampling strategy/universe | A representative sample of the Australian population was contacted by landline and mobile phone modified random digit dialling in 2012–13 |
| Sample size | Total – 20,094 Men – 9,963 Women – 10,131 |
| Regional and state-level estimates | Not stated – although state and region of residence is collected among demographics so it may be possible to group data at both state and regional levels |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | Conducted once a decade ASHR 1 – May 2001 to June 2002 ASHR 2 – October 2012 to November 2013 |
| Methods/mode of administration | Computer assisted telephone interviews |
| Child sexual abuse and child maltreatment measures/items | <p>‘The next section is about sexual situations that both women and men have encountered. We understand that sometimes these are difficult issues to discuss. Have you ever had a sexual experience with a male or a female when you didn’t want to because you were too drunk or high at the time? Have you ever been forced or frightened by a male or a female into doing something sexually that you did not want to do? [if yes] How many times has this happened to you? How old were you when it started? (or How old were you the first time? or How old were you at the time? as appropriate.) Did you talk to someone else about it or seek help? [if yes] Who did you talk to?’</p> |
| Risk/protective factor, and other abuse context measures | Not identified |

| | |
|--|--|
| Impact measure | Education, labour force status, educational attainment, household income, occupation |
| Demographic and other measures | State, sex, age group, legal marital status, birthplace, Indigenous status, relationship in household, smoking status, language spoken at home, region |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | It has potential for triangulation with other data sources. Administration is infrequent but it has potential for including broader maltreatment types. |
| Ethical considerations | <p>Respondents who indicate they have experienced unwanted or forced sexual experiences are asked if they would like the phone number of someone to talk to about this and these details are provided if requested.</p> <p>The study protocol was approved by the Human Ethics Committees of La Trobe University (HEC 11-040) and ratified by the committees at UNSW, the University of Sydney and the University of Sussex.</p> |
| Governance model | None stated |
| Publications/web resources | These are available at www.ashr.edu.au/publications-from-ashr2 |
| Copies of measures | Not available online |

| Survey/data collection | Crime Victimization Survey |
|---|--|
| Purpose | This release presents results from the Australian Bureau of Statistics (ABS) national Crime Victimization Survey, conducted from July 2013 to June 2014 as part of the ABS Multi-Purpose Household Survey (MPHS). The survey collected data, via personal interview, about people's experiences of crime victimisation for a selected range of personal and household crimes. The survey also collected data about whether persons experiencing crime reported these incidents to police, selected characteristics of persons experiencing crime, and selected characteristics of the most recent incident they experienced. |
| Auspic agency | ABS |
| Population of interest – age range of participants | Australians aged 15 and over |
| Sampling strategy/universe | <p>The MPHS supplemented the monthly Labour Force Survey (LFS). Each month one-eighth of the dwellings in the LFS sample were rotated out of the survey. In 2013–14, all of those dwellings were selected to respond to the MPHS each month. After each person in these dwellings had completed the LFS, in scope and coverage, a person aged 15 and over was selected at random (based on a computer algorithm) and asked the various MPHS topic questions in a personal interview. If the randomly selected person was aged 15–17, permission was sought from a parent or guardian before conducting the interview. If permission was not given, the parent or guardian was asked the crime questions on behalf of the 15–17 year old. Questions relating to sexual assault, alcohol or substances contributing to the most recent physical or face-to-face threatened assault were not asked of proxy respondents. Only those persons aged 18 and over were asked questions on sexual assault. Data was collected using computer assisted interviewing, whereby responses were recorded directly onto an electronic questionnaire in a notebook computer, usually during a telephone interview.</p> <p>For the 2013–14 MPHS, the sample was accumulated over a 12-month period from July 2013 to June 2014.</p> |
| Sample size | Total – 27,327 |
| Regional and state-level estimates | State and territory spotlight data is available. No regional-level data is reported |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | This is the sixth annual Crime Victimization Survey the ABS has conducted since the survey was redesigned in 2008–09. |
| Methods/mode of administration | <ul style="list-style-type: none"> Random selection of households Random selection of participants Mostly telephone interviews Computer assisted personal interview |
| Child sexual abuse and child maltreatment measures/items | There were no specific questions about child maltreatment although, as the population of interest is aged 15 and over, items regarding physical and sexual assault may capture some child abuse. |
| Risk/protective factor and other abuse context measures | Employment |
| Impact measure | Employment, education, sexual assault or physical assault victim |

| | |
|---|--|
| Demographic and other measures | <p>Age, sex, social marital status, country of birth, year of arrival in Australia, family relationship, month of MPHS interview, family composition of household, number of usual household residents, Indigenous status, interview or proxy, state or territory of usual residence, remoteness, employment, education, income</p> <p>Assault and physical assault, threatened assault, robbery, sexual assault, personal crime summary, break-ins, attempted break-ins, motor vehicle theft, theft from a motor vehicle, malicious property damage, other theft, household crime summary</p> |
| Links to administrative data | No |
| Potential uses for CSA/ICSA/child maltreatment research | It may be possible to use the survey because it includes items relating to sexual assault that are asked of adults. Other forms of child maltreatment are not explored specifically and it is not clear whether it includes lifetime prevalence and/or intra-familial abuse. |
| Ethical considerations | Cell values are randomly adjusted via perturbation to minimise the risk of identifying individuals in aggregate statistics. |
| Governance model | None stated |
| Other notable features | The statistics were compiled from data collected in the ABS's 2013–14 MPHS, which is conducted each financial year throughout Australia as a supplement to the ABS's monthly LFS and is designed to provide annual statistics for a number of small, self-contained topics. |
| Publications/web resources detailing survey/data collection | The publication is available at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4530.0Main+Features12013-14?OpenDocument |
| Copies of measures | Data items list saved in folder |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> |

| | |
|---|---|
| Survey/data collection | Household Expenditure Survey – a subsample of the households comprising the 2009–10 survey of income and housing |
| Purpose | The Household Expenditure Survey (HES) identifies the levels and patterns of household spending on a wide range of goods and services. The HES also shows how expenditure varies according to income levels and other characteristics of households, such as size, location and main source of income. One of the most important uses for the HES is updating the weighting pattern of the consumer price index. This cycle of the HES will select households between 28 June 2015 and 25 June 2016. The ABS collects the HES over a full financial year because income and spending vary over the course of a year, due to holidays and seasonal work patterns. |
| Auspic agency | ABS |
| Population of interest – age range of participants | Households in Australia with people aged 15 and over |
| Sampling strategy/universe | Households are selected at random in each state and territory, and each dwelling has an equal chance of being selected. Each participating household will receive a guide explaining that the household has been selected for the survey. The guide provides background information about the survey and contact information. It also lets the household know that a survey invitation letter will arrive within the week to request that they register their contact details online or via phone. A reminder letter will also be sent encouraging selected households to register their contact details. When the household's contact details are registered, an ABS interviewer will contact the household to arrange a time to conduct the survey. If contact details are not registered, an ABS interviewer will visit the address to arrange a time to conduct the survey. |
| Sample size | 10,900 households across Australia |
| Regional and state-level estimates | Reports some details by state level |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | First run in June 1974 and is currently conducted every six years. The most recent one was in 2009–10. |
| Methods/mode of administration | This information is collected through group and individual interviews. Each person in the household aged 15 and over is asked to complete personal expenditure diaries covering two weeks. All persons aged 15 and over are also asked to participate in a group interview to collect information about household expenses, loans and housing circumstances. An individual interview is then used to collect information on employment and income from each person aged 15 and over. |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | None Identified |
| Impact measure | None Identified |
| Demographic and other measures | Age, birthplace, cultural background, employment, education, disability |

| | |
|---|---|
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | This survey is not suitable for child maltreatment research as it focuses on current patterns of household spending and it would be inappropriate to incorporate current or retrospective reports of child maltreatment. |
| Ethical considerations | None stated |
| Governance model | None stated |
| Publications/web resources detailing survey/data collection | Data from SIH and HES is reported together and is available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6530.02009-10?OpenDocument |
| Copies of measures | The full questionnaire is available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6503.02009-10?OpenDocument |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> . |

| Survey/data collection | Household, Income and Labour Dynamics in Australia |
|---|---|
| Purpose | The Household, Income and Labour Dynamics in Australia (HILDA) survey seeks to provide longitudinal data on the lives of Australian residents. It annually collects information on a wide range of aspects of life in Australia, including household and family relationships, child care, employment, education, income, expenditure, health and wellbeing, attitudes and values on a variety of subjects, and various life events and experiences. Information is also collected at less frequent intervals on various topics, including household wealth, fertility-related behaviour and plans, relationships with non-resident family members and non-resident partners, health care utilisation, eating habits and retirement. |
| Auspic agency | Department of Social Services Melbourne Institute of Applied Economic and Social Research (University of Melbourne) Roy Morgan Research |
| Population of interest – age range of participants | <p>These were persons aged 15 and over living in private dwellings in Australia. While all members of the selected households are defined as members of the sample, individual interviews are only conducted with those aged 15 and over on 30 June in the year of the survey. Some limited information about people aged under 15, however, is collected from an appropriate adult member of the household.</p> <p>The reference population for wave 1 was all members of private dwellings in Australia, with exceptions, which were:</p> <ul style="list-style-type: none"> • certain diplomatic personnel of overseas governments, customarily excluded from censuses and surveys • overseas residents in Australia (that is, persons who had stayed or intended to stay in Australia less than one year) • members of non-Australian defence forces (and their dependents) stationed in Australia • residents of institutions (such as hospitals and other healthcare institutions, military and police installations, correctional and penal institutions, convents and monasteries) and other non-private dwellings (such as hotels and motels) • people living in remote and sparsely populated areas. |
| Sampling strategy/universe | <p>HILDA respondents are sent a primary approach letter and brochure/newsletter prior to their initial contact for each wave. Some people are followed up later in the wave if they could not be interviewed earlier, and are then sent a follow-up newsletter. People new to the survey are given a new entrants' brochure.</p> <p>The important distinguishing feature of the HILDA survey is that the same households and individuals are interviewed every year, allowing the ABS to see how their lives are changing over time. As households grow and change – for example, more respondents are added when someone splits from one family and starts another – all 'new' family members are involved.</p> <p>The households were selected using a multistaged approach. First, a sample of 488 Census Collection Districts (CDs) (each consists of about 200 to 250 households) was selected from across Australia. Second, within each CD, a sample of 22 to 34 dwellings was selected, depending on the expected response and occupancy rates of the area. The selections were made after all dwellings within each CD were fully listed. Finally, within each dwelling, up to three people were selected to be part of the sample (Watson and Wooden (2002b) provides further details of the sampling methodology).</p> <p>To retain cross-sectional representativeness in the sample, an additional 2,153 households were added to the sample as part of a general top-up in wave 11. The top-up sample was selected using the same methodology as the original HILDA sample. See Watson (2011) for further information.</p> |

| | |
|---|--|
| Sample size | Wave 1: 13,969 (4,787 children aged under 15) Wave 2: 13,041 (4,276 children aged under 15) Wave 3: 12,728 (4,089 children aged under 15) Wave 4: 12,408 (3,888 children aged under 15) Wave 5: 12,759 (3,897 children aged under 15) Wave 6: 12,905 (3,756 children aged under 15) Wave 7: 12,789 (3,691 children aged under 15) Wave 8: 12,785 (3,574 children aged under 15) Wave 9: 13,301 (3,623 children aged under 15) Wave 10: 13,526 (3,600 children aged under 15) Wave 11: 13,603 (3,601 children aged under 15) (continuing) Wave 11: 4,009 (1,171 children aged under 15) (top-up sample) Wave 12: 13,537 (3,607 children aged under 15) (continuing) Wave 12: 3,939 (1,088 children aged under 15) (top-up sample) No further wave sample details are currently available. |
| Regional and state-level estimates | Some regional-level data is available, but not state-level data. |
| Longitudinal data | Yes – following families across generations annually since 2001 |
| Frequency of data collection and year(s) fielded | Annually since 2001 |
| Methods/mode of administration | Face-to-face interviews or collected via telephone with all eligible household members |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | Alcohol consumption |
| Impact measure | None stated |
| Demographic and other measures | Age, sex, history, geography, current education, current marital status/defacto relationships, children, child care, occupation and industry, other employment, education, family relationships, health, time use, personality, religion, cognitive ability, physical activity, sleep, death, income, wealth |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | While the survey does not currently include measures of child sexual abuse or other forms of child maltreatment, if measures were incorporated into the HILDA study, it would be possible to study the impacts of abuse and neglect on multiple family members and across generations. |
| Ethical considerations | None stated |
| Governance model | Survey design and management by University of Melbourne, which has a survey management support group. Roy Morgan Research collected external reference group data. |
| Other notable features | This survey's sampling methodology can follow individuals, their children and subsequent generations for an indefinite period. |

| | |
|--|--|
| Publications/web resources detailing survey/data collection | Publications relating to HILDA are available at https://www.melbourneinstitute.com/hilda/biblio/ |
| Copies of measures | Wave 15 questionnaires are saved in a folder. Questionnaires for all previous waves available at https://www.melbourneinstitute.com/hilda/doc/questionnaires/default.html |

| Survey/data collection | Identity Crime and Misuse in Australia |
|---|---|
| Purpose | This survey determines the extent and impact of identity crime and misuse in Australia. |
| Auspicing agency | Australian Institute of Criminology was commissioned by the Commonwealth Attorney-General's Department |
| Population of interest – age range of participants | Australians aged 15 and over with internet access and who had registered with the online survey panel provider |
| Sampling strategy/universe | Participants were randomly selected and invited to participate in the survey, which used quotas for location, age and gender. Respondents were stratified across location, so there was an oversampling in smaller states and territories, and undersampling of the larger states compared with their representation in the Australian population aged 15 and over. Age and gender were used as qualifying variables so that the respondents were nationally representative according to ABS (2013) Census data. Sampling was completed once the quotas had been met and a sample size of 5,000 participants had been obtained. |
| Sample size | 5,000 |
| Regional and state-level estimates | Collected at place of residence so it was possible to organise by state |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | One-off in 2013 |
| Methods/mode of administration | Online survey run by i-Link Research Solutions, an external provider |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | None identified |
| Impact measure | None identified |
| Demographic and other measures | Age, gender, normal place of residence, language most often spoken at home, Aboriginal and Torres Strait Islander status, income, computer usage Perceptions of the seriousness of misuse of personal information; experience of misuse of personal information; methods of victimisation in respect of the most serious occasion in the preceding 12 months; actual financial losses; funds recovered and other consequences of victimisation; awareness of the availability of court victimisation certificates; reporting misuse of personal information; behavioural changes arising from misuse of personal information |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | Not suitable – single study that did not obtain information relating to childhood maltreatment or risk and impact factors |
| Ethical considerations | Ethical considerations taken into account throughout the survey included: <ul style="list-style-type: none"> the need for anonymity of research participants (no information that could be used to identify the participants was collected; results are presented in an |

| | |
|--|--|
| | <p>aggregate format and as responses are anonymous, they cannot be matched to specific individuals)</p> <ul style="list-style-type: none"> • the requirement for informed consent (to ensure that participants provided informed consent, a plain language statement was provided with the survey) • the ability of participants to withdraw (the opt-out option allowed respondents completing the survey to contact the external provider to have the responses they had already provided withdrawn from the dataset) • the potential for the research questions to cause psychological discomfort, particularly as they related to victimisation experiences (telephone and website details for Lifeline crisis support were also provided in the plain language statement). <p>Once these concerns were addressed, the project presented a low risk to participants and the research was approved by the AIC's Human Research Ethics Committee.</p> |
| Governance model | This report was funded by the Commonwealth Attorney-General's Department as part the National Identity Security Strategy to develop a national identity crime measurement framework. |
| Publications/web resources detailing survey/data collection | Identity crime and misuse in Australia: Results of the 2013 online survey can be found at www.aic.gov.au/publications/current%20series/rpp/121-140/rpp128.html |
| Copies of measures | No copy found |

| Survey/data collection | Longitudinal Study of Factors Affecting Housing Stability (Journeys Home) |
|---|---|
| Purpose | The Journeys Home data series has been designed to examine: <ul style="list-style-type: none"> • the risk and protective factors associated with homelessness • the characteristics that distinguish those entering homelessness from those who do not • the factors that are important in the road out of homelessness • the length of time that people experience homelessness • the risk factors for persistent homelessness • the role geographic factors play on pathways into and out of homelessness • the service usage patterns of people experiencing homelessness. |
| Auspicing agency | Melbourne Institute of Applied Economic and Social Research, University of Melbourne Roy Morgan Research Funded by the Department of Social Services |
| Population of interest – age range of participants | The target population for Journeys Home was initially restricted to recipients of an income support payment who had been flagged by Centrelink as either 'homeless' or 'at-risk of homelessness' and who were aged 15 and over (n = 42,336). |
| Sampling strategy/universe | The Journeys Home sample was drawn from the Research Evaluation Database (RED) developed by the Department of Education, Employment and Workplace Relations. RED, in turn, is drawn from Centrelink's customer database and contains payment records and a range of personal details for all Centrelink income support customers since 1 July 2002. |
| Sample size | 1,682 |
| Regional and state-level estimates | None stated |
| Longitudinal data | Yes |
| Frequency of data collection and year(s) fielded | Data collected biannually Wave 1: (September–November 2011) Wave 2: (March–May 2012) Wave 3: (September–November 2013) Wave 4: (March–May 2013) Wave 5: (September– November 2013) Wave 6: (March–May 2014) |
| Methods/mode of administration | Face-to-face interviews |
| Child sexual abuse and child maltreatment measures/items | Frequency observed parents/carers physically fighting 1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Often; 5 = Very often Based on Australian Housing and Urban Research Institute Intergenerational Homelessness Survey 2009 – As a child someone living with you left you without adequate food or shelter 0 = No; 1 = Yes Influenced by questions in Adverse Childhood Adversity Study and ABS Personal Safety Survey, ABS (2005) – As a child someone living with you threatened to harm you (but without physically hurting you) 0 = No; 1 = Yes – As a child someone living with you used physical violence or force against you |

| | |
|--|---|
| | <p>0 = No; 1 = Yes</p> <p>– As a child someone living with you threatened to harm family or friends</p> <p>0 = No; 1 = Yes</p> <p>– As a child someone living with you harmed (or threatened to) any of your pets 0 = No; 1 = Yes</p> <p>– As a child someone else threatened to harm you (but without physically hurting)</p> <p>0 = No; 1 = Yes</p> <p>– As a child someone else used physical violence or force</p> <p>0 = No; 1 = Yes</p> <p>– Experienced physical violence as an adult</p> <p>0 = No; 1 = Yes</p> |
| Risk/protective factor and other abuse context measures | It includes current experience of physical and sexual violence, thus it could capture child abuse in children aged under 18. |
| Impact measure | Relationship status, education and schooling, marital history, parent relationships, employment and voluntary work, housing and living arrangements, support services and networks, health and wellbeing, psychological resources, cognitive ability, diet and food security, contact with the justice system, exposure to violence, income and financial stress |
| Demographic and other measures | Family history, relationships, children's education and care, demographic background, age, gender, Indigenous status, country of birth, dependent children |
| Links to administrative data | No |
| Potential uses for CSA/ICSA/Child maltreatment research | This study has completed its sixth and final wave of biannual data collection, but the information could be triangulated with other data sources to provide an overview of adverse experiences in childhood for this specific population group. |
| Ethical considerations | The Exposure to Violence section has several questions that explicitly ask the respondent for consent to ask questions about physical violence, threats of violence and sexual assault. Where the respondent did not wish to answer the questions they have been coded as -4 (opt out). |
| Governance model | None stated |
| Publications/web resources detailing survey/data collection | http://melbourneinstitute.com/journeys_home/research/whatisjourneyshomeabout.html |
| Copies of measures | http://melbourneinstitute.com/journeys_home/assets/JourneysHome_User_Manual_201412_1.pdf |

| Survey/data collection | National Drug Strategy Household Survey |
|---|--|
| Purpose | The National Drug Strategy Household Survey collects information about alcohol and tobacco consumption and illicit drug use in Australia and about people's attitudes towards tobacco, alcohol and drug use. These findings are used to develop policies for Australia's response to drug-related issues. |
| Auspecting agency | Australian Institute of Health and Welfare: commissioned and funded by the Commonwealth Department of Health Roy Morgan Research conducted the fieldwork component of this project |
| Population of interest – age range of participants | Australian residential population aged 12 and over |
| Sampling strategy/universe | Households were selected by a multistage, stratified area random sample design. The sample was based on private dwelling households, so some people (such as homeless and institutionalised people) were not included in the survey (consistent with the approach in previous years). The respondent was the household member aged 12 or older at the next birthday. Most results are based on the population aged 14 or older (unless specified), as this allows consistent comparison with earlier survey results. |
| Sample size | 2013 – 23,855 2010 – 26,648 2007 – 23,356 2004 – 29,445 2001 – 26,744 1998 – 10,030 1995 – 3,850 1993 – 3,500 |
| Regional and state-level estimates | Collected state/territory information as well as major city/remote/very remote information. Currently only reports victims of harms at a national level |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | This survey is conducted every 2 to 3 years and the AIHW has been collating and reporting on these surveys since 1998. This survey has been undertaken in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2007, 2010, 2013 |
| Methods/mode of administration | The 2013 survey was conducted using a self-completion drop-and-collect questionnaire method |
| Child sexual abuse and child maltreatment measures/items | Respondents were asked if they had been verbally or physically abused, or put in fear, in the past 12 months, by persons affected or under the influence of alcohol. Respondents were asked if they had been verbally or physically abused, or put in fear, in the past 12 months, by persons affected or under the influence of illicit drugs |
| Risk/protective factor and other abuse context measures | Alcohol and drug use Smoking in a home with dependent children Drinking during pregnancy |
| Impact measure | Drinking, smoking and drug use by children as young as 12 |
| Demographic and other measures | Age, remoteness area, sex, Aboriginal and Torres Strait Islander status, employment status, pregnant women, sexual orientation, mental illness |
| Links to administrative data | None stated |

| | |
|--|--|
| Potential uses for CSA/ICSA/child maltreatment research | There is potential for data from these surveys for respondents aged 18 to be triangulated with other data sources to provide a more comprehensive picture of harms to children. As the items relate specifically to harms caused by persons under the influence of alcohol or illicit drugs, there may not be potential for including a broader set of items relating to childhood maltreatment. |
| Ethical considerations | None stated |
| Governance model | 2013 National Drug Strategy Household Survey Technical Advisory Group, comprising experts in tobacco, alcohol and other drug data collection and research |
| Publications/web resources detailing survey/data collection | Details of the 2013 report are available at www.aihw.gov.au/alcohol-and-other-drugs/ndshs-2013/ |
| Copies of measures | Could not find a copy |

| Survey/data collection | National Survey of Mental Health and Wellbeing |
|---|---|
| Purpose | The survey provides information on the prevalence of selected lifetime and 12-month mental disorders by 3 major disorder groups: anxiety disorders (for example, social phobia), affective disorders (for example, depression) and substance use disorders (for example, alcohol harmful use). It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, and social networks and caregiving, as well as demographic and socio-economic characteristics. |
| Auspecting agency | Australian Bureau of Statistics Commonwealth Department of Health |
| Population of interest – age range of participants | In 1997 – Australians aged 18 and over In 2007 – Australians aged 16–85 |
| Sampling strategy/universe | Recruitment occurred between August and December 2007. Selected households were posted an information package and contacted to make interview arrangements. The first interview collected household characteristics, demographics, and financial and housing information. Using this information, one member of the household was selected to be interviewed for this study. Does not specify how households were selected. |
| Sample size | 2007 – 8,841 (August to December 2007) 1997 – 10,600 (May to August 1997) |
| Regional and state-level estimates | No |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | This was the second national mental health survey conducted (the first was in 1997); however, as a result of differences in data collection, data from the two surveys is not directly comparable. |
| Methods/mode of administration | Random selection of households Initial contact via post Random selection of participant Face-to-face interviews |
| Child sexual abuse and child maltreatment measures/items | Survey has questions on physical and sexual abuse, including age first abused. Items below are in the post-traumatic stress disorder measure: <ul style="list-style-type: none"> • As a child, were you ever badly beaten up by your parents or the people who raised you? • Were you ever badly beaten up by a spouse or romantic partner? • Were you ever badly beaten up by anyone else? • Were you ever mugged, held up, or threatened with a weapon? • The next two questions are about sexual assault. The first is about rape. We define this as someone either having sexual intercourse with you or penetrating your body with a finger or object when you did not want them to, either by threatening you or using force, or when you were so young that you didn't know what was happening. Did this ever happen to you? • Other than rape, were you ever sexually assaulted where someone touched you inappropriately, or when you did not want them to? • Has someone ever stalked you – that is, followed you or kept track of your activities in a way that made you feel you were in serious danger? • Did anyone very close to you ever have an extremely traumatic experience, like being kidnapped, tortured or raped? |

| | |
|--|---|
| | <ul style="list-style-type: none"> • When you were a child, did you ever witness serious physical fights at home, like when one parent beat up the other parent? • Did you ever on purpose either seriously injure, torture, or kill another person? <p>Responses to above are Yes, No, Don't know, Refused.</p> <p>Follow-up questions include:</p> <ul style="list-style-type: none"> • How old were you the first time? __years old, Don't know, Refused • How many times (did that happen in your life)? __ number, Don't know, Refused • Did you ever experience any other extremely traumatic or life-threatening event that I haven't asked about yet? Yes, No, Don't know, Refused. <p>Follow-up questions include:</p> <ul style="list-style-type: none"> • Briefly, what was the one most traumatic event that you have not told me about? • Was this a one-time event or was it ongoing over a period of days, weeks, months, or even years? • How old where you when this happened/How old were you when you first learned about it? • For how long were you in this situation/for how long did this continue? • Did this event involve threat of death or serious injury to you or to a close loved one? • Sometimes people have experiences they don't want to talk about in interviews. I won't ask you to describe anything like this, but, without telling me what it was, did you ever have a traumatic event that you didn't tell me about because you didn't want to talk about it? Yes, No, Don't know, Refused. <p>Follow-up questions:</p> <ul style="list-style-type: none"> • How old were you when your most upsetting event like this happened? • Or if it was an ongoing event, how older were you when it started and for how long were you in this situation? <p>See Reeve, van Gool & Gu for impact of child abuse on adult health https://www.business.unsw.edu.au/research-site/centreforappliedeconomicresearch-site/Documents/R.%20Reeve,%20K.%20van%20Gool%20and%20Y.%20Gu%20-%20Modelling%20Long%20Run%20Costs%20of%20Child%20Abuse.pdf</p> |
| Risk/protective factor and other abuse context measures | Alcohol and drug use, mental health |
| Impact measure | WMH-CIDI 3.0 diagnoses (ICD-10 and DSM-IV) Kessler Psychological Distress Scale (K10) Severity measure Delighted-Terrible Scale Self-assessed health rating Main problem Psychosis screener Suicidal behaviour Mini-Mental State Examination (MMSE), homelessness, incarceration, education, employment, personal income |
| Demographic and other measures | Household characteristics (details, demographic characteristics, tenure type, geography, household income, financial stress) Demographics (sex, age, country of birth, year of arrival, social marital status, sexual orientation, mother/father country of birth, main language spoken at home, Australian Defence Force service, Department of Veteran's Affairs benefit recipient) |

| | |
|---|---|
| Links to administrative data | No links noted |
| Potential uses for CSA/ICSA/child maltreatment research | The surveys are infrequent, but do provide nationally comparable information about abuse in childhood and mental health and wellbeing in late adolescence and adulthood. If administered more frequently, the surveys could provide potential for including measures relating to maltreatment in childhood, although extensive measures including details of context and perpetrators may not be appropriate. |
| Ethical considerations | <p>Sensitivity awareness training was provided by the OSA Group (counselling services). The interactive session included:</p> <ul style="list-style-type: none"> • understanding the impacts of mental illness and how people may deal with this • asking difficult and/or sensitive questions • anticipating responses and/or reactions to the survey questions, both from the respondent and the interviewer • self-management and self-care • available support options, including trained counsellors. <p>Due to the sensitive nature of the survey questions, it was suggested that interviews be conducted in private. The sensitive nature of the questions made them unsuitable for use with proxies or interpreters, thus proxy, interpreted or foreign-language interviews were not conducted.</p> |
| Governance model | Survey reference group |
| Publications/web resources detailing survey/data collection | Details of data collection, survey and publications are available at www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4327.0Main%20Features12007?opendocument&tabname=Summary&prodno=4327.0&issue=2007&num=&view= |
| Copies of measures | The full interview schedule is available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4327.02007?OpenDocument |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> |

| Survey/data collection | Recorded Crime – Victims, Australia, 2014 |
|---|--|
| Purpose | This publication presents national statistics relating to victims of crime for selected offences as recorded by police. These offences may have been reported by a victim, witness or other person, or they may have been detected by police. |
| Auspicing agency | ABS |
| Population of interest – age range of participants | Victims of crime in Australia |
| Sampling strategy/universe | <p>Statistics about crime victimisation for a selected range of offences recorded by police between 1 January and 31 December 2014. Data is derived from administrative systems maintained by state and territory police agencies, and has been compiled according to national standards to maximise consistency.</p> <p>This collection does not count the number of unique person or organisation victims. As a single person or organisation can appear in multiple offence categories, it is not meaningful to aggregate the number of victims across each offence type. Therefore, it is only meaningful to look at victim counts within each offence category.</p> |
| Sample size | None stated |
| Regional and state-level estimates | Yes – state level |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | National crime statistics are produced annually on a calendar year basis. The reference period for this publication relates to offences reported to police between 1 January and 31 December 2014. |
| Methods/mode of administration | Statistics in this publication are derived from information held in administrative systems, which is collected and maintained by police agencies in each state and territory. This information is collected by the ABS and has been compiled according to the National Crime Recording Standard (NCRS) to maximise consistency between states and territories. |
| Child sexual abuse and child maltreatment measures/items | It includes data on sexual assault but it is compiled by the date of reporting, not the incident date – thus not distinguishing between recent and historical events. |
| Risk/protective factor and other abuse context measures | None stated |
| Impact measure | None stated |
| Demographic and other measures | Sex, relationship to offender, incident location, age, incident type |
| Links to administrative data | Yes, this is administrative data |
| Potential uses for CSA/ICSA/child maltreatment research | This data can be used to triangulate information with other sources of data to describe sexual assault of minors, but it cannot be used to distinguish recent or historical events. |
| Ethical considerations | None stated |
| Governance model | Board of Management of the National Crime Statistics Unit, National Crime Statistics Advisory Group |

| | |
|--|---|
| Publications/web resources detailing survey/data collection | It is available at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4510.0Main+Features12014?OpenDocument |
| Copies of measures | Not available |

| Survey/data collection | Survey of Disability, Ageing and Carers |
|---|---|
| Purpose | <p>The survey aimed to:</p> <ul style="list-style-type: none"> • measure the prevalence of disability in Australia • measure the need for support of older people and those with disability • provide a demographic and socio-economic profile of people with disability, older people and carers compared with the general population • estimate the number of people, and provide information about them, who care for a person with disability, a long-term health condition or an older person. |
| Auspicing agency | ABS |
| Population of interest – age range of participants | <p>The survey collected information from 3 target populations:</p> <ul style="list-style-type: none"> • people with disability • older people (that is, those aged 65 and over) • people who care for a person with disability, long-term health condition or an older person. <p>The survey also collected a small amount of information about people not in the target populations, allowing for comparison of demographic and socio-economic characteristics of the target populations with the general population.</p> <p>The survey included individuals in both urban and rural areas in all states and territories, living in both private and non-private dwellings, but excluded diplomatic personnel of overseas governments, people who usually live outside Australia, members of non-Australian Defence Forces and their dependents stationed in Australia, persons living in very remote areas, and households in Indigenous community frame collection districts.</p> |
| Sampling strategy/universe | <p>Multistage sampling techniques were used to select the sample for the survey.</p> <p>The private dwelling sample was chosen using an area-based selection methodology to ensure that all sections of the population living within the geographic scope of the survey were represented.</p> <p>The sample of non-private dwellings (excluding cared-accommodation establishments) was chosen separately from the sample of private dwellings, and was based on a list containing all non-private dwellings in Australia.</p> <p>The sample of non-private dwellings within cared-accommodation establishments was chosen separately from the sample of households.</p> |
| Sample size | <p>Private dwellings – 27,410 Non-private dwellings – 518 Cared accommodation – 999</p> |
| Regional and state-level estimates | Yes |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | <p>This publication presents first results from the 2012 survey conducted from 5 August 2012 to 2 March 2013. This is the seventh comprehensive national survey conducted by the ABS to measure disability, following similar surveys in 1981, 1988, 1993, 1998, 2003 and 2009.</p> |

| | |
|---|--|
| Methods/mode of administration | Face-to-face computer-assisted personal interviews Proxy interviews for children younger than 15, children aged 15–17 where parent/guardian consent was not given, those incapable of answering for themselves due to illness, impairment, injury, or language problems. |
| Child sexual abuse and child maltreatment measures/items | Household questionnaire – homelessness item. 'What led to [name] being without a permanent place to live?' One response option is 'violence/abuse/neglect'. |
| Risk/protective factor and other abuse context measures | Education, income/employment |
| Impact measure | Education, income/employment |
| Demographic and other measures | Family characteristics, age, income, employment/labour force status, household characteristics, disability items |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | It has potential to include a brief standardised measure because the study targets people with disability. |
| Ethical considerations | Cell values are randomly adjusted via perturbation to minimise the risk of identifying individuals in aggregate statistics. |
| Governance model | None stated |
| Publications/web resources detailing survey/data collection | Publications are available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02012?OpenDocument and at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Explanatory%20Notes5002012?OpenDocument |
| Copies of measures | These are available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02012?OpenDocument |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> |

| Survey/data collection | Survey of Income and Housing |
|---|--|
| Purpose | The Survey of Income and Housing is used to understand the household income, wealth and housing costs across the Australian population. |
| Auspic agency | ABS |
| Population of interest – age range of participants | A household spokesperson aged 18 and over answers questions about loans and housing on behalf of the household. For each person aged 15 years and over, individual interviews then collect information on their employment and income. The consent of a parent or guardian is sought for household members aged 15–17. |
| Sampling strategy/universe | <p>Households are selected at random in each state and territory, and each dwelling has an equal chance of being selected. The information collected from each household is used to represent others like it in terms of key characteristics, housing circumstances and financial situation.</p> <p>Each participating household will receive a guide explaining that the household has been selected for the survey. The guide provides background information about the survey and contact information. It also lets the household know that a survey invitation letter will arrive within the week to request that they register their contact details online or via phone. A reminder letter will also be sent encouraging selected households to register their contact details.</p> <p>When the household's contact details are registered, an ABS interviewer will contact the household to arrange a time to conduct the survey. If contact details are not registered, an ABS interviewer will visit the address to arrange a time to conduct the survey.</p> |
| Sample size | 8,000 households |
| Regional and state-level estimates | None stated |
| Longitudinal data | No |
| Frequency of data collection and year(s) fielded | From 1994–95 to 2003–04, the survey was conducted in most years. (No surveys were run in 1998–99 and 2001–02). Since 2003–04, it is being conducted biennially. |
| Methods/mode of administration | Telephone interview |
| Child sexual abuse and child maltreatment measures/items | None identified |
| Risk/protective factor and other abuse context measures | None identified |
| Impact measure | None Identified |
| Demographic and other measures | Age, birthplace, cultural background, employment, education and disability |
| Links to administrative data | None stated |
| Potential uses for CSA/ICSA/child maltreatment research | This survey is not suitable for child maltreatment research as it focuses on current patterns of household income and housing and it would be inappropriate to incorporate current or retrospective reports of child maltreatment. |

| | |
|---|---|
| Ethical considerations | None stated |
| Governance model | None stated |
| Publications/web resources | Available at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6530.02009-10?OpenDocument |
| Copies of measures | The full questionnaire is available on the ABS website at www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6503.02009-10?OpenDocument It is also saved in a folder. |
| Legal provisions (for example, ABS surveys undertaken under the <i>Census and Statistics Act 1905</i>) | Undertaken under the <i>Census and Statistics Act 1905</i> |

Appendix I: Summary characteristics of Australian studies

Table 27 Summary of characteristics of Australian studies of children's experiences

| Survey/data collection | Auspic agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/other maltreatment? | Risk/impact factors? |
|--|---|---------------------------|--|--|---|------------------------------------|--|--|---|
| <i>Australian Early Development Census</i> Progress measure of early childhood development, collecting details about physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication and general knowledge | Commonwealth Department of Education | 4–7 | 289,973 children in 2012 | Population survey, teacher report | All children enrolled and attending first year of school | Secure web-based data-entry system | Every 3 years; 2009, 2012, 2015. Next administration in 2018 | Indicators of aspects of neglect | Impacts: Literacy, numeracy, memory Communication Anxious/fearful Aggressive Pro-social Social competence Readiness to explore Physical readiness Physical independence Fine/gross motor School absences |
| <i>Australian National Children's Nutrition and Physical Activity Survey</i> Collects information about children's weight status, dietary intake and activity levels | Commonwealth Department of Health Commonwealth Department of Agriculture, Fisheries and Forestry | 2–16 | 4,487 | Cross-sectional CAPI of child or caregiver followed up by a CATI | Random digit dialing of telephone numbers to identify eligible households until quota was met | Initial CAPI, followed by a CATI | Collected once only, in 2007 | No | Physical measurements, food and nutrient intake, food habits |
| <i>Australian Survey for Kids and Young People</i> Examines peoples' experiences of safety in a variety of institutional contexts and determines how well institutions are responding to their needs | Royal Commission into Institutional Responses to Child Sexual Abuse | 10–19 | 121 in focus groups, survey currently being administered | Cross-sectional, self-report | Purposive for focus group, convenience for survey | Focus groups Online survey | Single study | No | Not identified |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/other maltreatment? | Risk/impact factors? |
|---|--|--|--|---|--|--|---|--|---|
| <i>Child Protection Australia</i> Administrative data collection containing child protection data for notifications, investigations, substantiations, intensive family support, and out-of-home care | Australian Institute of Health and Welfare | 0–17 | 2013–14: 198,966 children reported to child protection | Administrative unit record for population | All data on child protection involvement for children aged 0–17 | Data is provided by all state and territory child protection agencies from their administrative data systems | Annual Last extraction occurred after 30 June 2015 | All forms of child maltreatment | Service outcomes but not wellbeing outcomes |
| <i>Footprints in Time – the Longitudinal Study of Indigenous Children</i> Collects information about maternal health and care, parental health, child and family functioning, financial stress, housing and mobility of Aboriginal and Torres Strait Islander families | Department of Social Services | Aboriginal and/or Torres Strait Islander children aged 6–18 months (B cohort) and 3.5–5 years (K cohort) | Wave 1 = 1,687 Wave 2 = 1,436 Wave 3 = 1,404 Wave 4 = 1,283 Wave 5 = 1,258 | Longitudinal, multiple cohort self-report study, caregiver, teacher and child self-report, observational assessments and physical measurement | Sampling via Centrelink and Medicare Australia, supplemented by informal means of contact such as word of mouth, local knowledge and study promotion within 11 sites | Face-to-face CAPI interview (child and parent) Mail-back pen and paper survey Physical measurement, cognitive testing and interviews, teachers | Approx. every 12 months Currently collecting data | No | <ul style="list-style-type: none"> Alcohol, tobacco and substance use in pregnancy and birth Parental health and wellbeing Parenting behaviours, empowerment and efficacy Financial stress and income, housing and mobility |
| <i>National Survey of Child and Adolescent Mental Health and Wellbeing</i> Collects information about the mental health and wellbeing of children and adolescents and the extent to which they use health and education services to assist them with problems | Commonwealth Department of Health | 4–17 | 6,310 families in 2013–14 and 4,500 children in 1998 | Cross-sectional, parent report for children aged 4–17 and self-report for 11–17 year olds | Area-based household sampling | Face-to-face interviews with parents and self-report on tablet for adolescents | Infrequent: 1998 and 2013–14 Next administration unknown | No | <ul style="list-style-type: none"> Sexual behaviour Mental health problems Self-harm and suicidal behaviours Substance use (alcohol and other drugs) Problem eating Service use |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/other maltreatment? | Risk/impact factors? |
|--|---|--|---|--|--|---|---|--|--|
| <p><i>Longitudinal Study of Australia's Children</i></p> <p>Collects information about family's social and cultural environment and child development, child education, child wellbeing, health and violence</p> | <p>Department of Social Services</p> <p>Australian Bureau of statistics</p> <p>Australian Institute of Family Studies</p> | <p>Two cohorts 0–1 years (B cohort) and 4–5 years (K cohort)</p> | <p>Wave 1 = 10,090 (B cohort = 5,107; K cohort= 4,983)</p> <p>Wave 2 (B cohort = 4,606; K cohort = 4,464)</p> <p>Wave 3 (B cohort = 4,386; K cohort = 4,331)</p> <p>Wave 4 (B cohort = 4,242; K cohort = 4,169)</p> | <p>Longitudinal, multiple cohort study, caregiver, teacher and child self-report, observational assessments and physical measurement</p> | <p>Random selection within selected postcodes from Medicare Australia's enrolment database</p> | <p>Interview (child and parent)</p> <p>Mail-back pen and paper survey</p> <p>Physical measurement, cognitive testing and interviews, teachers</p> | <p>Every 2 years since 2004, and between wave mail-outs in 2005, 2007 and 2009</p> <p>Anticipated next administration is 2016</p> | <p>Interviewer observation of child and home</p> <p>Reasons for not having permanent place to live include abuse/neglect and violence</p> <p>Reasons for not seeing other parent</p> | <p>Risk factors:</p> <ul style="list-style-type: none"> • Parental stress • Alcohol consumption while pregnant • Parental mental health • Mental Illness • Gambling <p>Impact factors:</p> <ul style="list-style-type: none"> • Child functioning including behavioural, emotional, temperament, self-regulation, motor and physical development, social competence • Language and cognitive development, readiness to learn • Academic performance • Socio-emotional wellbeing • Health • Child violence |
| <p><i>Longitudinal Surveys of Australian Youth</i></p> <p>Examines major transition points for young people as they move from school to post-school activities (for example, employment, further raining/education) and explores social outcomes such as wellbeing</p> | <p>Commonwealth Department of Education and Training</p> | <p>15</p> | <p>More than 10,000 students in each cohort</p> | <p>Longitudinal, multiple cohort study, assessment and self-report</p> | <p>Initial sample drawn from year 9 students</p> | <p>School-based assessment, mail-out survey and telephone surveys</p> | <p>Annual follow up</p> <p>Next administration for year 6 and year 9 is 2015 and then 2016</p> | <p>No</p> | <p>Impacts:</p> <ul style="list-style-type: none"> • Mathematics • Reading • Science achievement • Education and employment indicators • Study and work indicators • Social indicators |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/other maltreatment? | Risk/impact factors? |
|--|--|------------------------------------|---|--------------------------------|--------------------|---|--|--|---|
| <i>Perinatal Data</i> Administrative data collection on women who gave birth and the babies born in Australia | Australian Institute of Health and Welfare | Pregnancy, birth and early infancy | In 2012, 307,474 women gave birth to 312,153 babies | Administrative data collection | All available data | Perinatal data is collected after each birth from clinical and administrative records | Annual for the period 1 January to 31 December | No | Indicators for alcohol use in pregnancy are under development |

Table 28 Summary of characteristics of Australian studies of adults' experiences

| Survey/data collection | Auspic agency | Age range of target group | Sample size | Study type | Sampling method | Administrati on | Frequency | Child sexual abuse/ other maltreatment? | Risk/impact factors? |
|--|---|--|--------------------|---|--|--|--|--|--|
| <p><i>Australian Longitudinal Study on Women's Health (ALSWH)</i></p> <p>Collects information about physical and emotional health of women in Australia</p> | <p>Commonwealth Department of Health</p> <p>University of Newcastle</p> <p>University of Queensland</p> | <p>In April 1996, women in 3 age groups were selected:</p> <p>18–23 (born 1973–78)</p> <p>45–50 (born 1946–51)</p> <p>70–75 years (born 1921–26)</p> | 57,464 at baseline | <p>Multiple cohort, longitudinal study</p> <p>Self-report</p> | Women in 3 age groups were randomly selected from the Medicare database. Women from rural and remote areas were sampled at twice the rate of women in urban areas | Mail surveys | <p>Six monthly/annually depending on cohort</p> <p>Depending on the cohort, future data collections will continue every 6 or 12 months</p> | None | <p>Abuse item: 'Have you ever been in a violent relationship with a partner/spouse?'</p> <p>Impacts: Marital status and housing</p> <p>Participants may be invited to participate in sub-studies about other aspects of wellbeing and health</p> |
| <p><i>Drug Use Monitoring in Australia</i></p> <p>Collects information about trends of alcohol and drug use among Australian detainees</p> | <p>Australian Institute of Criminology</p> <p>State police services</p> | Adult police detainees | 3,456 | Cross-sectional, interview and physical measures | All police detainees in a 48-hour period in 6 sites across Australia | Face-to-face interview and urine samples | Quarterly | None | <p>Impacts:</p> <ul style="list-style-type: none"> • Education • Housing • Employment • Criminal history • Prison history • Offending details/charges • Drug use • Self-reported alcohol use |
| <p><i>Personal Safety Survey</i></p> <p>Collects information about the nature and extent of violence experienced by men and women since age 15 (for example, intimate partner violence, stalking, physical and sexual abuse, general feelings of safety)</p> | Australian Bureau of Statistics | 18 and over | 17,050 | Cross-sectional survey, self-report | <p>Random selection of private dwellings using stratified, multistage area sample design.</p> <p>Sampling intended to sample men proportionally and equal groups of women across jurisdictions</p> | Face-to-face interviews | Administered twice, in 2005 and 2012. Next data collection not known | <p>Includes questions on physical and sexual abuse as a child (before age 15).</p> <p>Emotional abuse and neglect are excluded</p> | <p>Impact:</p> <ul style="list-style-type: none"> • General feelings of safety • Health • Employment • Social connectedness |

Table 29 Summary of characteristics of Australian studies of children's and adults' experiences*

| Survey/data collection | Auspic agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/ other maltreatment? | Risk/impact factors? |
|---|--|------------------------------|---|--|--|--|--|--|--|
| <p><i>Australian Health Survey</i> Collects information about health-related issues, including health status, risk factors, socio-economic circumstances, health-related actions and use of medical services</p> | <p>Australian Bureau of Statistics Commonwealth Department of Health National Heart Foundation of Australia</p> | Australians aged 2 and over | Total 31,837 (6,927 aged 2–17; 19,664 aged 18–64; 5,246 aged 65 and over) | Cross-sectional, self-report and proxy-report | Stratified multistage area sample of private dwellings, designed to give adults aged 65 and over a double chance of being selected in the sample | <p>Face-to-face interviews CAPI CATI</p> | <p>Every 3 to 6 years Next administration unknown</p> | Not specifically – respondents aged 15 and over were asked if they, a family member, or someone close to them had experienced any family stressors in the preceding 12 months, including witnessing violence, and abuse or violent crime | <p>Impacts:</p> <ul style="list-style-type: none"> Alcohol consumption Drug/drug-related problems (family stressors and long-term conditions) Mental health and wellbeing |
| <p><i>Australian Study of Health and Relationships</i> Collects information about sexual and reproductive health and wellbeing</p> | <p>National Health and Medical Research Council UNSW University of Sydney University of Sussex La Trobe University Hunter Research Foundation Social Research Centre</p> | Australians aged 16–69 | 20,094 | Cross-sectional, self-report | Landline and mobile phone, modified random digit dialling | CATI | <p>Once a decade, 2001–2 and 2012–13 Next administration may be in 2021</p> | Asks about unwanted and forced sexual experiences, frequency, age at onset, help-seeking | <p>Risk: None identified</p> <p>Impact:</p> <ul style="list-style-type: none"> Education Labour force status Educational attainment Household income Occupation |
| <p><i>Crime Victimization Survey</i> Collects information about experiences of crime victimisation for personal and household crimes, whether the incidents were reported to police and characteristics of the victim</p> | Australian Bureau of Statistics | Australians aged 15 and over | 27,327 | Cross-sectional, self-report and proxy report for 15–17 year olds where parents do not give consent (items modified) | Personal interview | <p>Mostly telephone interviews Some CAPI</p> | <p>Annual Anticipated next data collection is between July 2015 and June 2016</p> | Only adults are asked questions relating to sexual assault. Items relating to physical assault asked of 15–17 year olds may indicate physical abuse | <p>Risk: Employment</p> <p>Impact:</p> <ul style="list-style-type: none"> Employment Education Sexual or physical assault victim |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/ other maltreatment? | Risk/impact factors? |
|--|---|--|--|--|--|---|--|---|----------------------|
| <i>Household Expenditure Survey</i> Collects information about levels and patterns of household spending, income levels and characteristics of households (size, location, main source of income) | Australian Bureau of Statistics | Australians aged 15 and over | 10,900 | Cross-sectional, group and individual interviews | Random household sampling | Personal expenditure diary Group interview Individual interview | Every 6 years Potential next administration 2016–17 | None | None |
| <i>Household Income and Labour Dynamics in Australia</i> Collects information about household and family relationships, child care, employment, education, income, expenditure, health and wellbeing, attitudes and values, and various life events | Department of Social Services Melbourne Institute of Applied Economic and Social Research Roy Morgan Research | All occupants in Australian households | Initial sample 13,969 (including 4,787 children under 15) In Wave 12 – 17,476 (including 4,695 children under 15) | Longitudinal, with top-up sampling, self-report | Households selected by multistage, stratified area random sample design | Face-to-face or telephone interview with people aged 15 and older (limited information about people aged under 15 is collected through adult interview) | Initial recruitment 2001 Annual follow-up and top-up for wave 11 Anticipated next administration in 2016 | None identified | Alcohol consumption |
| <i>Identity Crime and Misuse in Australia</i> Collects information about the extent and impact of identity crime and misuse | Commonwealth Attorney-General's Department | Australians aged 15 and over | 5,000 | Cross-sectional, self-report | Random stratified sampling of individuals registered with online survey panel provider | Online survey | Conducted once only, in 2013 No future administrations planned | No | No |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/ other maltreatment? | Risk/impact factors? |
|--|--|--|----------------|------------------------------|--|--|--|---|--|
| <p><i>Longitudinal Study of Factors Affecting Housing Stability (Journeys Home)</i></p> <p>Collects information about homelessness including risk and protective factors, length of homelessness, service usage patterns of people experiencing homelessness</p> | Department of Social Services | Australians aged 15 and over who are homeless or at risk of homelessness | 1,682 | Longitudinal, self-report | Selected from a database of more than 40,000 Australians identified as being homeless or at risk of homelessness on the basis of Centrelink payment data | Face-to-face interview | <p>Biannual follow up</p> <p>Data collection has now concluded</p> | Respondents' childhood experiences of being left without food, experiencing physical violence and threats of harm to themselves and others, as well as current experiences of abuse | <p>Impacts:</p> <ul style="list-style-type: none"> Relationship status and marital history Schooling Employment Income and financial stress Housing and living arrangements Support services and networks Health and wellbeing Psychological resources Cognitive ability Contact with the justice system |
| <p><i>National Drug Strategy Household Surveys</i></p> <p>Collecting information about alcohol and tobacco consumption and drug use</p> | <p>Australian Institute of Health and Welfare</p> <p>Commonwealth Department of Health</p> | Australians aged 12 and over | 23,855 in 2013 | Cross-sectional, self-report | Households selected by multistage, stratified area random sample design | Self-completion drop-and-collect questionnaire method | <p>Every 2 to 3 years</p> <p>Last administered in 2013</p> | Has the respondent been verbally or physically abused, or put in fear, in the past 12 months, by persons affected or under the influence of alcohol or illicit drugs | Respondent's own illicit drug use, smoking and alcohol use, including in pregnancy |
| <p><i>National Survey of Mental Health and Wellbeing</i></p> <p>Collects information on the prevalence of mental health disorders, including anxiety, affective and substance use disorders</p> | <p>Australian Bureau of Statistics</p> <p>Commonwealth Department of Health</p> | Australians aged 16–85 | 8,841 | Cross-sectional, self-report | Randomly selected (method of selection not stated) | <p>Initial contact via post</p> <p>Face-to-face interviews</p> | <p>Conducted twice, 10 years apart (in 1997 and 2007)</p> <p>Next administration not known</p> | Includes questions on physical and sexual abuse, witnessing domestic violence, including age of first abused and frequency | <p>Measures of mental health and wellbeing including psychological disorders</p> <p>Also:</p> <ul style="list-style-type: none"> Homelessness Incarceration Education Employment Personal income |

| Survey/data collection | Auspicing agency | Age range of target group | Sample size | Study type | Sampling method | Administration | Frequency | Child sexual abuse/ other maltreatment? | Risk/impact factors? |
|---|---------------------------------|--|---|--|---|--|--|---|--|
| <i>Recorded Crime – Victims, Australia</i> Collection of data about victims of crime for selected offences (for example, sexual assault) | Australian Bureau of Statistics | Victims of crime of all ages | Not stated, data cannot be aggregated across offence categories | Cross-sectional, administrative data | All crime statistics | Administrative police data reported annually | Annual, reports on each calendar year | Sexual assault | None |
| <i>Survey of Income and Housing</i> Collects information about household income, wealth and housing costs | Australian Bureau of Statistics | Australians aged 15 and over | 8,000 | Cross-sectional Telephone interview | Random household sampling | Individual interview, parental consent for 15–17 year olds | Biennially Anticipated potential next administration July 2015 to June 2016 | None | None |
| <i>Survey of Disability, Ageing and Carers</i> Collects information on socio-economic and demographic profile of people with disability, older people and carers | Australian Bureau of Statistics | Australians aged 15 and over and proxy report for younger participants | Private – 27,410 Non-private – 518 Cared – 999 | Cross-sectional, self-report and proxy-report as appropriate | Area-based selection methodology of private and non-private dwellings | CAPI | Every 3 to 7 years The last administrative was in 2009 | Single item related to homelessness as a result of violence, abuse or neglect | Impacts: <ul style="list-style-type: none"> • Education • Income • Employment |

Appendix J: Stakeholders invited to participate

Stakeholders were identified based on their expertise in:

- content (child maltreatment prevalence study experts identified via the systematic review of international literature)
- conducting research (Australian researchers identified in the systematic review of Australian population-based studies in analogous areas)
- policymaking (for example, AIHW, Commonwealth Department of Social Services, state and territory child safety/protection/communities departments).

Appendix K: Delphi instrument

'Delphi' Survey for scoping of a prevalence study of child maltreatment in Australia

Involvement with child maltreatment prevalence studies

As indicated in the information sheet accompanying this survey, the Royal Commission is interested in exploring the optimal designs for prevalence studies of child maltreatment in Australia.

Briefly indicate your involvement with child maltreatment prevalence studies (or similar studies), including your role/s, and the number and type of studies you have been involved with.

| |
|--|
| |
|--|

Most relevant study

The following questions relate to one specific study. Please choose the study that is most relevant to this questionnaire; i.e. the project that is closest in methodology to a population level child maltreatment prevalence study. If you have conducted a number of such studies, choose the most recent of these.

Briefly describe the most relevant study:

| | |
|---|--|
| Title | |
| Date completed | |
| Brief description | |
| Publication(s) (peer reviewed and or grey) | |
| Data collection mode | |
| Sample size | |
| Sample age | |

Governance

What was the size of the research team (include chief/principal investigators, research associates/assistants, consultants)?

- (a) Was the team a consortium or collaboration, or were all the investigators from the same organisation?

- (b) Was there one Chief/Principal Investigator who made all the decisions or was decision-making collaborative?

- (c) Was a separate agency sub-contracted to undertake the fieldwork, or was this done by the research team? If another agency, what type of agency?

- (d) What was the governance/accountability structure? (Include accountability of Investigators to funders, any advisory or steering groups, etc.)

Funding

We are aware that these questions may be sensitive, but would appreciate a response if this is appropriate.

What was the overall cost of the study?

(a) How was the research funded (tick all that apply and indicate approximate % funding)?

| Funding source type | Funder | Approximate % funding |
|--|--------|-----------------------|
| Government contract | | |
| Research Council (ARC, NHMRC, ESRC, SSHRC, etc.) | | |
| Non-government agency | | |
| International agency (e.g. WHO, World Bank) | | |
| Philanthropic organisation | | |
| Private sector | | |
| Other | | |

(b) How were the Chief/Principal Investigators funded? Was any of their time provided in kind?

Timescales

With regard to the timescales of the most relevant project:

(a) How long did it take from when project was funded to

| Task | Approximate months |
|--|--------------------|
| Preparation (e.g. instrument piloting, stakeholder engagement and consultation) If possible please specify timescales for each task. | |
| Obtaining ethical clearances | |
| Beginning data collection | |
| Completing data collection | |
| Completing data analysis | |
| Submitting a draft report | |

(b) In total, roughly how many months/years did the project take from inception to the first report?

(c) Looking back, could the project timeline have been shortened in any way? If so how?

Research design issues

What were the most challenging issues for the research team to address?

| Issue | Describe most challenging issue | How was the issue addressed? |
|---------------------------|---------------------------------|------------------------------|
| Conceptual/methodological | | |
| Practical | | |
| Ethical | | |
| Other | | |

- (a) What was the single most challenging decision which had to be made in terms of the study design?

- (b) What were the specific words used to describe the survey to participants at the point of recruitment (e.g. a study of adolescent health, mental health and lifestyle)

- (c) Did the research team consider gathering data on participant satisfaction with the survey e.g. their perceptions of (i) the usefulness of the survey, and (ii) the extent of distress they experienced during survey completion? If so how was this done?

- (d) How did the research team ensure that the survey instrument was age-appropriate and/or appropriate for participants with disabilities, limited literacy, and linguistic abilities?

- (e) Overall if you were to do this study again, how would you improve it – what lessons have been learned?

Proposed study

As indicated above, the Royal Commission is interested in exploring the optimal design for a prevalence study of child maltreatment in Australia.

Thinking about the possible designs for such a study, please score the following options according to the domains at the top of the table, with:

1= Not at all significant

2= Not very significant

3= Significant

4= Very significant

| | Policy impact | Academic contribution | Feasibility/ practicability | Cost | Implementation Timescales | Ethical complexity |
|---|---------------|-----------------------|-----------------------------|------|---------------------------|--------------------|
| National population-based study of adolescents aged 15-17 years asking about past experiences of all forms of child maltreatment (including child sexual abuse) | | | | | | |
| National population-based study of 18-24 year olds asking about past experiences of all forms of child maltreatment (including child sexual abuse) | | | | | | |
| National population-based study of adults aged 25 and above, asking about past experiences of all forms of child maltreatment (including child sexual abuse) | | | | | | |
| Other design (please describe) | | | | | | |

(a) The Royal Commission would like a study which examines the prevalence of child sexual abuse in institutional contexts within the context of a general population-based study of all forms of child maltreatment. How best could this be achieved?

(b) What design would best measure the impact of policy changes on prevalence over time?

(c) Any other comments or recommendations on the proposed studies.