Components of Effective Cross-Agency Responses to Abuse – A Report for the NSW Ombudsman's Office

(Report 2 of 2)

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Acronyms & Initialisms

CAC	Child Advocacy Centre (or Children's Advocacy Centre)
CAS	Child Abuse Squad (WA & NSW)
CPFS	Department of Child Protection & Family Support (WA)
CSC	Community Services Centre (NSW)
DOCS	(Formerly) Department of Community Services (NSW)
FACS	Department of Family and Community Services (NSW)
FRS	Family Referral Service (NSW)
JIRT	Joint Investigation Response Team (NSW)
JIR	Joint Investigation Response (NSW)
JIT	Joint Investigation Team (NSW)
JRU	JIRT Referral Unit (NSW)
MASH	Multi-Agency Safeguarding Hub
MDT	Multi-Disciplinary Team
MIST	Multiagency Investigation & Support Team

1. EXECUTIVE SUMMARY

This report aims to provide a synthesis of research information to suggest the most important components of Multi-Disciplinary Team responses in order to inform the ongoing review of the Joint Investigation Response Team (JIRT) model by the NSW Ombudsman's Office. Drawing on recently completed studies of multi-disciplinary teams and new research, this report presents findings on: (a) What is the evidence for the effectiveness of Multi-Disciplinary Teams, and what characteristics are consistent across effective Multi-Disciplinary Teams; (b) What Multi-Disciplinary Team responses to abuse are in use in Australia and comparable international jurisdictions; and (c) The rationale for Multi-Disciplinary Team models. The report ends with a summary of the implications of this information for the current review of the JIRT model.

1.1 Background on the Report

The report is framed around a discussion between JIRT agencies (NSW Police, Family and Community Services, & NSW Health) of the existing structures, processes and resourcing of the JIRTs. From this, a number of key issues were identified:

- Despite a strong history of reform and policy improvement in the New South Wales cross-agency responses, there are some continuing issues around effective referral to often scarce community based family and other victim support services, counselling and therapeutic responses for children and young people who display sexually abusive behaviours, children with complex needs, and children who have not formally disclosed abuse;
- Differences in capacity between the agencies involved in the JIRT model, specifically that of Family and Community Services (FACS) working both as part of the JIRT model and in local Community Services Centres (CSC), as well as capacity limitations in therapeutic services for children and families. The New South Wales child protection system in particular in particular is under-resourced to deliver support services;
- Issues with the JIRT model in the Jonathon Lord case study (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014) around communication between the JIRT agencies and families of victims of institutional abuse, and the preference for a single point of contact for victim/survivors. Some of these issues have been addressed through the implementation of the Local Contact Point Protocol.

These issues directed this report towards exploring the potential for Child and Family Advocacy to enhance the existing JIRT model. Other key issues considered were the police interviewing process under the JIRT model, and some of the challenges of providing a coordinated response in regional and remote areas.

1.2 Evidence for the Effectiveness of Multi-Disciplinary Team Models

Drawing on a series of searches of the literature, the report provides a summary of the evidence for Multi-Disciplinary Team approaches on a number of commonly associated outcomes, and examines the components of approaches that were found to be effective in improving individual outcomes. Broadly, while 63 research articles were identified, only 22 studies included a reference to some kind of comparison or control condition in order to assess the effectiveness of Multi-Disciplinary Team practice.

The literature searches found that Multi-Disciplinary Team responses were consistently associated with improved criminal justice outcomes, mental health service delivery, and medical service delivery. Findings were mixed around increased child protection substantiations, measures of collaboration and the satisfaction of service users and staff.

A review of the effective components of Multi-Disciplinary Teams primarily drew on studies from the United States, which may limit the applicability of some of the findings. Across Multi-Disciplinary Team sites that were found to be effective in improving criminal justice outcomes, almost all involved cross-agency observed interviews of children, with interviews conducted by an independent interviewer supervised by statutory agencies (e.g. police, child protection); this reflects the predominate arrangement for child interviewing in the United States. Most models found to be effective included advocacy for children and non-abusive caregivers. Advocates tended to be independent although there were some examples of advocacy staff provided by child protection authorities and state prosecutors offices. Sites that were effective in improving the receipt of medical services tended to have medical personnel co-located, and other therapeutic and support services on site.

1.3 How are Multi-Disciplinary Teams Structured in Australian and Comparable International Jurisdictions

This report provides an examination of how Australian jurisdictions respond to severe child abuse, an analysis of characteristics of Child Advocacy Centres in the United States, and a summary of other multi-disciplinary models in other international jurisdictions.

The comparison to other Australian and international jurisdictions found that the JIRT model was fairly unique in terms of having a state-wide localised response, with the benefit of centralised and standardised intake assessment involving the three partner agencies. The JIRT model is also fairly distinctive internationally in terms of the degree to which statutory agencies are co-located in the centre; although differing from models such as Child Advocacy Centres and Barnahus (Children's Houses) in not providing on-site therapeutic and medical services. Broadly, the JIRT model is comparable to most models identified in this section, although the approach is distinct in Australia as a state-wide multi-disciplinary centre based model. Comparable models within Australia that had advocacy, the Multi-Disciplinary Centres in Victoria, and the Multiagency Investigation and Support Team, a pilot program in Western Australia, used a strategy around using the initial contact with the family for a child interview to engage them in on-site services.

Australian and international models differed in terms of who is responsible for interviewing children. The CACs in the United States in particular rely heavily on independent interviewers, while other jurisdictions (including Australia) were more likely to have police interviewers; either the investigating officers, or a pool of police interviewers from a specialised interviewing unit.

Most MDT models operated in urban settings. Few directly addressed the challenges of regional/remote service delivery, although the American CACs had a large proportion of rural centres with similar resources and services to their urban and suburban counterparts. The key features on which they varied being the availability of a purpose built and dedicated physical location and the extent of co-location.

1.4 Rationale for Multi-Disciplinary Team Models

The report outlines a theory of change for Multi-Disciplinary Teams, identifying all the activities and their connection to outcomes in the broader field of practice. Compared to the model, a number of key activities are not currently undertaken as part of the JIRT model:

- Longer term case consultation and information sharing on cases;

- Engaging and developing knowledge of available services and supports in community beyond NSW Health resources;
- Due to current demand at the JIRTs, ongoing and flexible support responses beyond the interview and initial referral;
- More comprehensive coordination of services for child and family, and relationship building with community based service providers;
- Broader assessment of needs beyond just counselling and medical examinations, which is limited due to the current demand for service relative to capacity;
- Support to engage with needed services, addressing barriers to engagement, and providing information about the benefits of services;
- Consulting with and acting on the interests of the child and their family, bringing their interests and perspective to meetings with other agencies;
- Ongoing contact with families: A single point of contact for information may be best placed to provide consistent information to the family about the status of their case, and to liaise with other agencies outside of the JIRT model on behalf of children and their non-abusive-families (e.g. education).

1.5 Implications for the JIRT Model

From the information presented in the report, a number of implications have been identified:

1. The agencies operating under the JIRT model might consider re-examining the aims of the model in order to align activities towards the intended outcomes, in particular recognising outcomes around improving child and family wellbeing post-disclosure;
2. Consider incorporating the functions of advocacy into the JIRT model in order to potentially improve existing effectiveness;
3. Develop a clear and agreed theory of change across agencies that distinguishes between the core components of the JIRT model, and additional elements that are theorised to be desirable rather than essential to achieving outcomes;
4. Use the theory of change as a key reference in assessment planning and reform; and
5. Develop a long-term strategy for ensuring the JIRT model is an evidence-based approach.

2. INTRODUCTION

The New South Wales Ombudsman's Office was engaged in June 2016 to conduct an independent review of the state-wide Joint Investigation Response Team (JIRT) response, following a previous independent review in 2002, a review conducted by JIRT partner agencies in 2006, and a high-level review conducted by the New South Wales Ombudsman in 2012 as part of an audit of the *NSW Interagency Plan to Tackle Child Sexual Abuse in Aboriginal Communities.* The Australian Centre for Child Protection was commissioned in October 2016 by the New South Wales Ombudsman's Office on behalf of the NSW JIRT agencies (NSW Police, Family and Community Services NSW, NSW Health) to provide research support for the 2016 review (Report 2). Separately, The Australian Centre for Child Protection was commissioned to conduct a paper comparing multi-agency responses to abuse across Australian and international jurisdictions (Report 1):

- Report 1: A comparison of the features of the JIRT model alongside the features of multi-disciplinary child abuse responses operating in Australian and comparable international jurisdictions.
- Report 2: A synthesis of research information that will suggest the most important components of different multi-disciplinary responses, with a focus on models of child advocacy.

This is Report 2, which aims to synthesise the best available evidence on multi-disciplinary team responses to identify the effect particular components may have on the effectiveness of multi-disciplinary responses. In this context, effectiveness refers to improvements on the intended outcomes for evaluated multi-disciplinary team models.

The brief for this report specifies that it will provide:

> *A summary of available national and international research on the components of effective cross-agency responses to child abuse requiring police investigation, with a particular focus on child advocacy. It is envisaged that this analysis will help to inform the review of JIRT by providing a framework for assessing the components of the current JIRT model against national and international evidence as well as potential options for reform, including whether and how child advocates could be included within JIRT in the future.*
>
> *The components review will draw from existing intellectual property developed by the Australian Centre for Child Protection including a survey of child advocacy centre directors, existing systematic searches of the research literature, and analysis of the logic and underpinning assumptions of different components of multi-disciplinary teams. The project will include the completion of an additional literature review on evaluated components of multi-disciplinary investigative responses for serious child abuse (rather than the models as a whole), with a particular focus on the nature and ways in which child advocates are included in various models and the evaluative evidence regarding child advocacy. The report will also draw from the learnings from Western Australian site visits made by NSW JIRT Agencies and the NSW Ombudsman's Office as part of the JIRT Review. The Australian Centre for Child Protection will also send representatives on this visit.*

The main body of the report will provide the synthesis and analysis of the research and literature

reviews drawn on for this report.

2.1 Background to Cross-Agency Responses

Responding to allegations of child abuse and neglect typically requires the involvement of workers of diverse disciplines from different agencies. Statutory workers such as child protection workers and police have duties outlined in state law, while other types of workers such as social workers, psychologists, counsellors, paediatricians, and other medical specialists have regulated professional duties to children they work with. These workers will all have the best interests of children in mind, but how this is understood will likely differ based on the role and discipline of professionals. Accordingly, many jurisdictions have developed procedural frameworks and approaches to facilitate a more joined up and coordinated response to allegations of child abuse.

Multi-Disciplinary Team (MDT) responses lay out a framework for the effective coordination of responses across agencies and disciplines, typically including mechanisms for discussion, planning and review of cases for workers involved. These frameworks can involve anything from an agreement (e.g. Memorandum of Understanding) between agencies to consult with each other on decision-making, to elaborate centre-based responses with dedicated on-site resources for victims of abuse and their families.

Jurisdictions may seek to develop MDT responses for several reasons, but these typically include:

- Improving the cohesiveness of the response and reducing conflict and confusion between responding workers and agencies;
- Improving forensic interviewing and evidence collecting processes;
- Improving the experiences of suspected child victims of abuse and their non-abusive caregivers;
- Reducing attrition from the criminal justice process;
- Addressing service gaps and improving the rates of children and families receiving needed services.

MDT models and approaches will likely differ depending on the rationale for (or intended effects/outcomes) of the collaboration. This report focuses on advocacy as part of a MDT response and the impact this may have in improving the intended outcomes of a planned response. While a broad definition for advocacy will be provided in Section 2.4, exactly what constitutes advocacy will also differ between models and approaches.

2.2 New South Wales Context

The JIRT model is a state-wide joint response to allegations of child abuse that constitute a criminal offence and meet the JIRT criteria. The team involves representatives of Family and Community Services (FACS); Child Abuse Squad (CAS) of the NSW Police; and NSW Health. According to Cashmore, Taplin and Green (2002), this joint approach was developed in order to:

- Ensure the safety and protection of children;
- Provide a timely and appropriate response;
- Improve the effectiveness of the investigation and prosecution process; and
- Reduce the stress on children and their non-abusive caregivers arising from the investigation and prosecution process.

It is noted that at the outset of the JIRT, there was no specific reference to improving the health – particularly the mental health – of child victims of abuse and their non-abusive caregivers. However activities such as the preparation of safety and wellbeing summaries and referral to sexual assault services suggests that improved health and wellbeing for child victims and their non-abusive family is also now part of the rationale for JIRT process.

The JIRT model commenced in 1997 and currently operates under a 2006 Memorandum of Understanding between the three agencies. The MoU records the responsibilities of the three agencies most directly involved in the response to child abuse that constitutes a criminal offence.

The role of NSW Police as per the MoU is to detect and investigate alleged child abuse and neglect. Where appropriate they initiate legal proceedings against identified offenders.

The role of DOCS (now FACS) as per the MoU is to receive and assess reports of risk of (significant) harm to children and young people. DOCS also ensure the safety of children and their ongoing care. Where appropriate they initiate Children's Court proceedings.

The role of Health as per the MoU is to identify and report risk of (significant) harm to children and young people. They also provide treatment, crisis and ongoing counselling as well as medical examinations.

Matters requiring a response from the JIRT are initially assessed by a centralised process involving the three agencies at what is known as the JIRT Referral Unit (JRU). The JRU provides a centralised decision-making process for accepting and planning initial responses to child abuse reports that may meet the JIRT Referral Criteria. The JRU provides advice to NSW Police Local Area Commands (LACs) and FACS Community Services Centres (CSCs) in relation to matters that are not accepted for a response under the JIRT model.

In accordance with the JIRT Criteria, the JRU accepts referrals for allegations of child sexual abuse where the victim is under 18 (including pursuant to the JIRT, Enhanced Services to Aboriginal Children and Young People procedures); although some matters where the victim is 16 years of age or over may not be accepted (including pursuant to the NSWPF Sexual Assault Victims 16 to 18 Policy or NSWPF Adolescent Peer Sex Guidelines). The JRU also accepts matters of extreme child neglect (e.g. malnutrition/dehydration), and cases of severe or serious physical abuse (e.g. extensive soft tissue injuries, head injuries, fractures, burns).

Referrals accepted for a response under the JIRT model are then assigned a priority rating determined by FACS and referred out to one of 22 JIRT sites[i] across New South Wales (See Table 1), where they are dealt with in accordance with the Local Planning & Response (LPR) procedures with a child or young person's safety, welfare and wellbeing the primary consideration. CAS will make their own determination of priority later, based on factors relevant to the investigation. Matters referred to the JIRT can also be accepted for a police only response.

The local response under the JIRT model consists of seven stages:

1. *Accepted Referrals*: Matters are transferred from the JRU to the respective JIRT unit, which involves transferring referrals through the JIRT Tracking System and across each agency's databases and notifications systems;
2. *Pre-Meeting Briefing on Contact (for high risk matters)*: The three agencies should consult

[i] We note that Child Abuse Squad now operate from 23 locations, including the new Far South Coast site.

prior to any contact with the child, young person and/or non-offending carer/s, except where a police response is required urgently and/or outside of business hours);

3. *Information Gathering, Recording and Sharing*: Each agency reviews their agency's information holdings on the matter and may share with the other agencies at the Briefing Meeting information relevant to the safety, welfare and wellbeing of a child, young person or class of children or young persons pursuant to the Children & Young Persons (Care & Protection) Act 1998;
4. *Briefing Meeting*: Each agency shares relevant information to inform the investigative response regarding the safety, welfare and wellbeing of the child or young persons, which includes developing a Safety Welfare and Wellbeing Summary (SWWS);
5. *Interview Planning*: Police should develop an Interview Plan prior to interviewing the child or young person. The NSWPF is responsible for conducting electronically recorded police interviews with victims and witnesses. This is important for police to properly discharge their functions under the JIRT MoU, and ensure the integrity of any related criminal investigations or prosecutions; however (this) should in no way detract from the equally important, albeit separate functions, that FACS and Health perform in relation to assessing issues of safety, risk, health and wellbeing. FACS and Health are able to electronically monitor (or review) interviews and are able to ask further questions at the conclusion of the interview to clarify any care, protection or clinical issues not already canvassed by police, however this does not need to be electronically recorded;
6. *Debriefing Meeting*: Following the field response, the agencies to discuss and share information on the outcome of their response, and plan ongoing actions; and
7. *Case Meetings:* Allows for agencies operating under the JIRT model still involved with the child, young person or family, to share relevant information that may assist to ensure that future action is appropriate and continues to address the child or young person's needs, including a review of the SWWS.

Outside of business hours Police will generally respond on a single agency basis, with ancillary support provided via the FACS Crisis Response Team (CRT) or relevant Local Health District Sexual Assault Service (SAS) as and if required. More detail on the after-hours response is provided in Section 4.1.1 of the NSW Ombudsman Inquiry into the Operation of the JIRT program (New South Wales Ombudsman, 2017).

The JIRT model involves the coordination of the key roles and responsibilities of the three agencies involved as outlined in the JIRT Memorandum of Understanding. While the response will differ depending on the circumstances of the case, these may include:

- *Medical Examination*: Undertaken to ensure the physical wellbeing of the child/young person, and the collection of any forensic evidence. The Health Clinicians will assist in arranging for medical examinations, these do not occur on site;
- *Interview of the Child/Young Person Alleged Victim*: The Child Abuse Squad conducts all forensic child interviews, with FACS/Health being able to monitor or retrospectively review the interview. The interview is (audio, video or audio & video) recorded for the purpose of being used as a child's evidence in-chief for criminal proceedings. FACS/Health have the ability to ask further questions impacting on care, protection and clinical issues not already canvassed during the electronically recorded Police interview.
- *Witness Intermediary Interviews:* A recent pilot at CAS Bankstown, Kogarah, Chatswood and Newcastle added to the cross-agency interview process by including provision for a witness intermediary to advise police on how best to communicate with the child. A qualified

Witness Intermediary will conduct an assessment of a child sexual assault victim prior to the police interview to determine their communication needs. The Witness Intermediary may then be present during the Police interview to assist the interviewer, if necessary, with any further communication needs of the victim;

- *Health and Counselling Support*: The Health Clinician provides information and support at the time of the interview, and makes referrals for counselling and information for caregivers;
- *Court Proceedings*: JIRT agencies may participate in criminal proceedings and children's court. Witness intermediaries can also play a role in the court process, assisting with communication in court. This is currently being trialled at the Newcastle and Downing Centre (Sydney) District Courts.

While all agencies have their designated role in the local planning response outlined above, each agency's individual roles and responsibilities in relation to the accepted referral follows their individual organisational mandates as per the JIRT MOU:

- *Child Abuse Squad* detectives are responsible for the investigation of abuse that constitutes a criminal offence, and undertake their investigations in coordination with the other agencies involved in the response. Detectives from this squad have special responsibilities distinct from other police in working with child victims and witnesses, primarily keeping children and caregivers appraised of the criminal justice process, minimising distress and uncertainty where possible, and in some cases making referrals to support services. Child Abuse Squad members are responsible for undertaking interviews with children, and follow the case through the criminal justice system to conclusion;
- *Family and Community Services* are responsible for the assessment of child safety, investigation of reports of child abuse and neglect, and undertaking protective intervention when safety cannot be assured. Longer term engagement (where needed) between the child and their family tends to be taken on by the local Community Services Centre (CSC), with JIRT FACS staff more focused on responding to immediate harm. Local CSCs also take responsibility for a case when a child needs to be immediately removed into out-of-home care;
- *NSW Health* staff are responsible for the arrangements for a forensic medical examination, and referrals to therapeutic counselling and ongoing health care e.g. at Sexual Assault Services sites, New Street Services, Child Protection Counselling Services, Mental Health, Drug and Alcohol, Youth Health, Women's Health, Maternity, Child and Family Health.

Currently the stated aims of the JIRT model are separated into the aims of the JRU and the JIRT Local Planning and Response Procedures; both of which are potentially subject to change as a result of the current review of the JIRT model. As per the 2013 JIRT Local Planning and Response Procedures (See JIRT Local Planning and Response Procedures), the JIRT Local Planning and Response procedures aim to:

- Support a comprehensive investigative and assessment process which minimises delay and promotes information exchange between the NSW Police Force, FACS, and Local Health District;
- Enhance timely access to care and support services for the child, young person and non-offending family members/carers throughout, and beyond, the initial joint response;
- Coordinate agency intervention to minimise the number of investigative and assessment interviews conducted.

The JRU (See JIRT Referral Unit Process Guidelines) aims to:

- Maximise outcomes for children, young people and families with the provision of tri-agency information and decision making for all referrals referred to JIRT;
- Maximise operational consistency in the application of acceptance criteria for JIRT referrals;
- Support local JIRT units' capacity to implement the JIRT Local Planning and Response Procedures;
- Provide advice to FACS Community Service Centres, NSW Police Force Local Area Commands and NSW Health services to inform planning for referrals that will not be subject to a JIRT response;
- Increase the capacity of each agency involved in the JIRT for reporting on various data relating to JIRT referrals.

Outline of Current Features of JIRTs

While the process of the JIRT model aims to be consistent state-wide, the 22 JIRTs across New South Wales do vary as to whether all the responding agencies are co-located in the same facility, and in the resources available onsite. Some areas will also receive a satellite service where the JIRT facility is outside the area, but will interface with the relevant agencies in that area.

Table 1. Location of JIRT Responses

Co-Located JIRTs		**Partially Co-Located JIRT Response (Health & FACS Only)**[1]	
JIRT Location	*Catchment Areas*	*JIRT Location*	*Catchment Areas*
Bankstown	Bankstown, Burwood, Central Sydney, Fairfield, Lakemba	Bathurst	Bathurst, Condobolin, Cowra, Lithgow, Mudgee, Orange, Parkes
Chatswood	Chatswood, Pennant Hills	Dubbo	Coonabarabran, Coonamble, Dareton, Dubbo, Nyngan
Kogarah	Central Sydney, Eastern Sydney, St George, Sutherland	Queanbeyan	Batemans Bay, Bega, Bowral, Cooma, Goulburn, Queanbeyan, Yass
Liverpool	Liverpool, Campbelltown, Ingleburn	Wagga Wagga (Satellite Service to Albury and Griffith)	Cootamundra, Wagga Wagga, Albury, Deniliquin, Griffith, Leeton
Newcastle	Cessnock, Charlestown, Maitland, Raymond Terrace, Edgeworth, Mayfield, Muswellbrook		
Parramatta	Auburn, Blacktown, Parramatta		
Penrith	Penrith, Mt Druitt, St Marys, Hawkesbury, Katoomba		
Tamworth (Satellite Service to Inverell)	Armidale, Muswellbrook, Tamworth, Glenn Innes,		

<table>
<tr><td></td><td>Inverell, Moree, Narrabri</td><td></td><td></td></tr>
<tr><td>The Entrance</td><td>Wyong, Gosford, Lakes, Peninsula</td><td></td><td></td></tr>
<tr><td>Wollongong</td><td>Wollongong, Shellharbour, Nowra, Ulladulla</td><td></td><td></td></tr>
<tr><td colspan="4">Non-Co-Located JIRT Response</td></tr>
<tr><td colspan="2">JIRT Location</td><td colspan="2">Catchment Areas</td></tr>
<tr><td colspan="2">Ballina/Northern Rivers JIRT</td><td colspan="2">Ballina, Lismore, Tweed Heads</td></tr>
<tr><td colspan="2">Bourke (Satellite Service to Broken Hill)</td><td colspan="2">Bourke, Brewarrina, Cobar, Walgett, Broken Hill, Dareton, Wilcannia</td></tr>
<tr><td colspan="2">Mid North Coast (Satellite Service to Coffs Harbour)</td><td colspan="2">Kempsey, Port Macquarie, Taree, Clarence Valley, Coffs Harbour</td></tr>
</table>

[1] We also note the establishment of the Far South Coast site, with Child Abuse Squad and a Health Clinician working from this site.

The sites from which CAS, FACS and Health staff operate also vary in terms of the facilities available onsite; while those in the metropolitan area and larger regional areas have police interviewing suites with monitoring rooms, statement rooms, and conference rooms, those based in other locations are much more variable. Some sites also have manager's offices, which are used for private discussions, supervision, debriefs, and in some cases, confidential discussions for a particular agency. Particularly in some of the regional sites, the facilities are quite minimal; in these areas depending on the circumstances of the case (i.e. risk, age, wishes of the child/non-abusive caregiver, location) interviews can occur at the interview suites of the rural CAS units, school, CSCs, homes, hospitals or other community facilities. Police interviewing suites are usually designed to be minimal and reduce potential distractions, but all are set up to be a safe and comfortable space for children.

Table 2. Facilities Available for Partially and Non-Co-Located JIRTs

JIRT Site[1]	Interview Suite	Monitoring Room	Statement Room	Conference Room
Ballina/Northern Rivers				X
Bathurst				X
Bourke	X	X	X	X
Bourke (Broken Hill Satellite)				X
Dubbo	X		X	
Mid North Coast				X
Mid North Coast (Coffs Harbour Satellite)				X
Queanbeyan				
Wagga Wagga				X
Wagga Wagga (Albury Satellite)				X
Wagga Wagga (Griffith Satellite)				X

[1] We also note the establishment of the Far South Coast site, with Child Abuse Squad and a Health Clinician working from this site.

Staffing varied between sites reflecting the volume of cases to which local staff from each agency respond. Table 3 outlines the staff associated with each location. While generally catchment areas between the agencies are aligned, there are some exceptions to this, in particular Health Clinicians who may work across multiple sites (See Table 3).

Table 3. FTE Staffing Across JIRT Agencies

JIRT Site	FACS Staff	Sworn Police Staff	Health Staff
JIRT Referral Unit	7 (1 Manager Client Services, 1 Senior Project Officer, 1 Senior Administrative Officer and 4 Caseworkers)	4 (1 Senior Sergeant level and 3 Team Leaders)	5 (1 Health Service Manager, 1 Senior Health Clinician, 2.5 Health Clinicians, and 0.5 Administrative Assistant)
Albury	3	5 (Including 1 Team Leader)	1.5 (1 Senior Health Clinician & 0.5 Health Clinician)
Ballina	5 (1 Manager)	7 (1 Team Leader)	3 (1 Senior Health Clinician & 2 Health Clinicians)
Bankstown	7 (1 Manager Casework)	9 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)

Bathurst	6 (1 Manager Casework)	7 (1 Team Leader)	2.5 (1 Senior Health Clinician & 1.5 Health Clinicians)
Bourke	2 (1 Manager Casework)	4 (1 Team Leader)	1 (1 Senior Health Clinician)
Broken Hill	1	2	1.5 (1 Senior Health Clinician & 0.5 Health Clinician)
Chatswood	4 (1 Manager Casework)	7 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
Coffs Harbour	2	7 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
Dubbo	4 (1 Manager Casework)	5 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
Far South Coast	0	4 (1 Team Leader)	1 (1 Health Clinician)
Griffith	1	3	1.5 (1 Senior Health Clinician & 0.5 Health Clinician)
Inverell	2	3	1.5 (1 Senior Health Clinician & 0.5 Health Clinician)
Kogarah	5 (1 Manager Casework)	8 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
Liverpool	11 (2 Managers Casework)	14 (2 Team Leaders)	3 (1.5 Senior Health Clinicians & 1.5 Health Clinicians)
Newcastle	12 (2 Managers Casework)	17 (2 Team Leaders)	4 (2 Senior Health Clinician & 2 Health Clinician)
Parramatta	6 (1 Manager Casework)	11 (2 Team Leaders)	2.5 (1.5 Senior Health Clinicians & 1 Health Clinician)
Penrith	8 (1 Manager Casework)	14 (2 Team Leaders)	2.5 (1.5 Senior Health Clinicians & 1 Health Clinician)
Port Macquarie	6 (1 Manager Casework)	8 (1 Team Leader)	3 (2 Senior Health Clinician & 1 Health Clinician)
Queanbeyan	3 (1 Manager Casework)	5 (1 Team Leader)	1 (1 Senior Health Clinician)

Tamworth	5 (1 Manager Casework)	7 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
The Entrance	7 (1 Manager Casework)	11 (2 Team Leaders)	2 (1 Senior Health Clinician & 1 Health Clinician)
Wagga Wagga	3 (1 Manager Casework)	6 (1 Team Leader)	2 (1 Senior Health Clinician & 1 Health Clinician)
Wollongong	7 (1 Manager Casework)	12 (2 Team Leaders)	2 (1 Senior Health Clinician & 1 Health Clinician)

Previous Reviews of the Joint Investigation Response Team Model

The JIRT model has been subject to a number of reviews of policy and practice, with a mix of internal and external reports. These reports provided an important background to the development of the JIRT process and to the present issues that this report is designed to inform. The reviews also highlighted the strong history of responding to recommendations among the agencies involved in the JIRT.

Evaluation of the Joint Investigation Team (JIT)/ Joint Investigation Response (JIR) - 2002

This evaluation examined the antecedent models of the JIRT model, the Joint Investigation Team and the Joint Investigation Response. The distinction between these two responses continues in the difference between co-located JIRTs (predominantly metro and regional centre teams) and partly co-located and non-co-located JIRTs (predominantly in smaller regional areas). Cashmore, Taplin, and Green (2002) reported on their evaluation which set out to assess whether the response reduced trauma for victims, improved investigations, improved safety and family functioning, improved cooperation between agencies, and whether appropriate processes and resources were in place. As noted by the authors (Cashmore et al., 2002) the evaluation had a number of limitations that reduce the extent to which the authors can make conclusions about the benefits of adopting joint responses. The evaluation did not include any comparisons between the JIT/JIR and other practices, or comparisons with data prior to the implementation of the teams. The evaluation was set out as a process or implementation evaluation of the performance of the response against the planned strategy rather than an impact or outcome evaluation. The evaluation was also missing data in a few key areas: delivery of support services, counselling and court preparations support, and reoccurrence of abuse notifications. The evaluation sought the views of children and non-abusive caregivers regarding their experience of the JIT/JIR, however the response rates were very low.

The evaluation relied heavily on worker perceptions of the quality of the response. Broadly, the workers surveyed felt they were well prepared to be able to do their work, and workers from the Office of the Director of Public Prosecutions indicated that briefs from police attached to JIT and JIR tended to be better than briefs produced by Police from other locations. Concerns were identified around:

- Organisational differences that slowed the response down (i.e. regular business hours for FACS workers, shift work for police);
- The lack of availability of experienced medical staff to undertake examinations;
- Lack of referral to NSW Health by the other JIRT agencies to put services in place for families;

- Concern from workers about sexual assault counsellors and the accuracy of information they provided about the police and child protection response;
- Observations that police tended to leave it to the child and family to decide whether to pursue charges, and that in some situations it was perceived that they had talked people out of pursuing charges if the evidence was not strong;
- Excessive workloads and lack of resources for all agencies.

Comparing the JIT and the JIR, the co-located JIT workers reported having higher levels of role clarity, and reported finding it easier to arrange joint briefings than workers in the JIR response.

NSW Joint Investigative Response Team Review (Internal JIRT Review) -2006

In 2006, an internal review by the agencies involved in the JIRT model was conducted to identify potential improvements in the response, with information drawn from consultations with senior staff and aggregate data on the number of referrals and the proportion of referrals accepted into the JIRT program.

In relation to the assessment and intake of cases, the review identified issues with the consistency of referral acceptances between locations, low rates of acceptance of referrals for physical abuse, and delays in conducting interviews with children, forensic medical examinations and counselling services. There were also criticisms about the over-dependence on children having already disclosed abuse in the criteria for acceptance to the JIRT response, and the focus on the most recent incident in intake assessments rather than considering histories of abuse or concerns about abuse. The review also suggested that the quality of the response was affected by NSW Health not being an equal partner and not involved in planning decisions.

In response to these identified issues, NSW Health was made a full partner in the JIRT model, the JRU was piloted to help improve the consistency of decision-making and response times, and a protocol for the inclusion of allegations of more serious physical abuse to the JIRT acceptance criteria was adopted. The review also recommended offering counselling to all children referred for a response under the JIRT model, and the completion of comprehensive safety, welfare and wellbeing plans for every child referred. The Safety, Welfare and Wellbeing Summary (SWWS) was introduced as part of the local planning response. The relatively recent inclusion of NSW Health as a full partner, safety and wellbeing aspects and referral to counselling being added into the model following the 2006 internal review likely explain why improved health and wellbeing are not yet included in the rationale or aims of the JIRT process.

The review also outlined broader issues to do with cross-agency communication, governance and cross-agency data. In response to these, the report recommended some clear governance structures across organisations, and improvements to data systems.

Issues with Aboriginal children and families' experiences under the JIRT model were also a key theme in the review, with recommendations for more proactive engagement with Aboriginal communities, Aboriginal involvement in the governance of the program, increased employment of Aboriginal staff in areas with many Aboriginal communities, provision for culturally appropriate support people for interviews, and increased cultural awareness training for staff. The review also recommended introducing increased opportunity for rapport building for interviews, pointing out that Aboriginal children and children from diverse cultural backgrounds may be more responsive to interviewers where they can develop a degree of trust with the worker before the interview

commences.

A significant event in the development of the JIRT model was the development of the JRU. Responding to criticisms from the NSW Ombudsman's Office about the inconsistency of decision-making between the JIRT units, the Executive Officers Group (constituted by representatives from each of the partner agencies) established a trial of joint assessments, intended to improve consistency and to free up staff at local sites from having to undertake assessment work. Following the trial, the JRU was been retained as a key part of the New South Wales state-wide response.

Wood Special Commission of Inquiry into Child Protection Services in NSW - 2008

While having a broader scope of inquiry, the Wood Inquiry reported on the operation of the JIRT model following the implementation of the JRU. The inquiry highlighted the benefits of the JIRT model in the quality and sensitivity of investigation, referral to therapeutic services, and extent of inter-agency information exchange and collaboration. The inquiry endorsed the existing program of reform, while also recommending regular audit and review of the JIRT model, and amending legislation to enable more free exchange of information between agencies.

Responding to Child Sexual Assault in Aboriginal Communities – NSW Ombudsman 2012

The most recent external report that considered the JIRT framework was undertaken by the NSW Ombudsman's Office, focusing specifically on responses to the sexual abuse of Aboriginal children, but with findings that apply across all children that receive a response from the JIRT model.

The report highlighted the benefits from the implementation of the JRU, the JIRT Enhanced Aboriginal Service Protocol, and expansion of the JIRT model to include a new site at Bourke, and of initiatives to improve the accessibility of the court system. Decreases in the rate of cases dismissed or withdrawn were attributed to these initiatives.

The report highlighted key gaps in the capacity of the existing service sector in New South Wales to provide counselling and therapeutic services. While pointing out that the system overall was stretched, this was particularly the case for children with complex needs, children who had not made a formal disclosure of abuse, adult survivors of abuse, and sexual abuse/assault victims that were in custody. Despite some progress, the review highlighted the lack of services in Aboriginal communities as an ongoing gap. Broadly, the report highlighted the patchwork of services that exist, each with different eligibility requirements and suitability for different populations. The report called for a more joined-up approach across services across the government and non-government sector to reduce the potential confusion and distress for children and their families in trying to identify suitable services.

The report was also critical of the data systems across the three agencies, particularly in terms of being able to monitor the referral and use of therapeutic services. Resourcing of the JIRT model was also highlighted as a key issue, particularly following the increases to cases accepted for a response following the implementation of the JRU. The lack of availability of forensic medical examinations in some areas was also raised as an issue, along with the lack of resources to provide a treatment response to children and young people with sexualised and sexually abusive behaviours.

In addition to issues around therapeutic services, the report also focused on the performance of Child Abuse Squad in the context of the JIRT model. The report drew on comprehensive site level workload data, which was subsequently used as part of the review process by JIRT senior managers. The report also highlighted the importance of strengthening accountability across the JIRT

partnership, in part through regular reviews of the JIRT model. The New South Wales Ombudsman's Office also recommended the introduction of the witness intermediary scheme, which is currently being piloted across four CAS sites in New South Wales.

Royal Commission into Institutional Responses to Child Sexual Abuse - 2014

Most recently the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014) highlighted a number of issues in response to Case Study 2 (Jonathan Lord: YMCA) related to the JIRT model. The key issues identified with the response in Case Study 2 included criticisms about:

- JIRT agencies' communication with parents/caregivers who had concerns about their children's previous contact with Jonathan Lord;
- How child interviews were arranged, managed, and how the process was explained to children and caregivers;
- Lack of information provided back to parents/caregivers about the details of the disclosure, with parents/caregivers sometimes left with the perception that the child told the police more than they (parents) were told;
- Parents felt they were poorly informed about the progress of cases in the criminal justice system, and felt unprepared for court with inadequate explanation of both court and preparing a victim impact statement;
- Parents indicated they would like there to be a single point of contact throughout the process.

In response to concerns from the Royal Commission, the JIRT model has implemented a Local Contact Point Protocol to coordinate responses to parents/carers of children/young persons that may have been impacted by institutional child abuse (i.e. where there may be many child victims). Primarily this was to guide communication with parents and concerned community members where there is evidence that additional victims may have been or are at risk of abuse through contact with the person of interest through the institution.

The NSW Ombudsman office have also assisted the NSWPF in the development of standard operating procedures for employment related child abuse allegations.

Background to Review

The JIRT agencies have implemented several reforms to address issues identified in the reviews discussed above. Since 2006, NSW Health has been included as a full partner in the JIRT model, and has expanded their commitment through additional senior personnel. The JIRT Referral Unit (JRU) was established in 2009 to help improve consistency in decision-making responses across NSW with all three agencies involved in the initial assessment of cases on a standardised rubric. Also in 2006, an *Enhanced Services for Aboriginal Children and Young People* was introduced to address concerns about underreporting of abuse, along with this the recruitment of Aboriginal health workers in areas with high Aboriginal populations.

The recent history of review and reform of the JIRT process points to several key underlying issues into which this report will aim to inform decision-making.

While the JIRT Local Contact Point Protocol has been developed to improve the JIRT response to institutional child sexual abuse, issues remain in how best to structure this critically important stage of contact with a child and their family. The review will consider in detail the arrangements that other jurisdictions and models have for communicating with children and their non-abusive

caregivers.

A number of recent reports and submissions to the New South Wales Parliament have highlighted serious concerns about the potential impacts of current resourcing levels within the New South Wales child protection system, and the capacity of that system to fulfil its role in investigating the risk of significant harm to children (New South Wales Ombudsman, 2011, 2013, 2014). In the context of the JIRT model, this limited capacity threatens the capacity of FACS to undertake their part of the response, particularly as a number of additional investigators at the Child Abuse Squad were due to be rolled out in May 2017.

We also note a recent decision in relation to the co-location and distribution of Child Abuse Squad as part of the JIRT model. In December 2016 the JIRT Senior Management Group (SMG) reached agreement that the NSWPF would progressively transition away from all integrated co-located sites; meaning sites with shared office space across agencies. Outside the metropolitan area this will impact existing premises at Newcastle, The Entrance, Tamworth and Wollongong (planned to occur during the 2017-2018 and 2018-2019 financial years respectively). Within the metropolitan area this will also involve the clustering of six existing CAS sites at three central locations: Strawberry Hills (incorporating Chatswood and Kogarah), Liverpool (absorbing Bankstown) and Penrith (absorbing Parramatta). The first of these amalgamations is imminent, with the remaining two expected to follow at some point during the 2017-2018 financial year. At the completion of this process the NSWPF will operate from 20 CAS locations (in addition to the JRU and Child Abuse Response Team at Police Headquarters Parramatta). These will be: Ballina, Coffs Harbour, Port Macquarie, Newcastle (Northern Zone), Gosford and Strawberry Hills (Central Zone), Liverpool & Wollongong (South Western Zone), Penrith & Bathurst (North Western Zone), Narooma, Queanbeyan, Wagga Wagga, Griffith & Albury (Southern Zone), and Inverell, Tamworth, Dubbo, Bourke and Broken Hill (Western Zone).

The most recent review of the JIRT in relation to child sexual abuse in Aboriginal communities highlighted the key challenges for regional/remote service delivery. The recruitment and retention of skilled and qualified workers in the regions, the lack of supportive and therapeutic services, and poor coordination between these services all were thought to impact on the quality of the response. The availability of specialist services such as forensic medical examinations in regional and remote communities also presents as an ongoing challenge. This review will consider how models are adapted to operate in regional/remote settings (e.g. satellite or outreach services).

As identified above in the 2012 NSW Ombudsman's review, in many communities there is a complex patchwork of services with different entry requirements, suitability, and likely different approaches and treatment modalities. These services are in high demand in most communities, often with lengthy waiting lists. There is considerable research evidence about the long-term impact of child abuse and neglect on children (Cashmore & Shackel, 2013), and the effectiveness of therapeutic approaches to ameliorate some of the harms done to children (Macdonald et al., 2012).

There is considerable difficulty in ensuring that children affected by abuse receive needed services, due to a mix of barriers related to the situation of families, and the nature of service delivery. The scarcity of services described above limits the opportunity for children and their families to (a) access any service; and (b) exercise any choice regarding the service(s) or treatment types with which they would prefer to engage. The lack of scope to provide referral and support the delivery of family focused services for families that don't have ongoing cases with FACS also limits the potential

benefits the JIRT could be providing children and families affected by abuse. The Royal Commission Case Study 2 also identified issues in communication with families, both about the interview/investigations process and the progress of the case.

The issues above have prompted interest in models of advocacy and their potential to improve the JIRT response. This report will examine models of advocacy and other methods of providing follow-up care and - acknowledging the existing role of NSW Health Clinicians in referring children and families to therapeutic counselling and ongoing health care, and the role of FACS in providing and monitoring services for families receiving statutory child protection intervention – consider the potential to incorporate advocacy into the existing JIRT process.

2.3 About this Report

This report aims to provide a synthesis of research information that will suggest the most important components of different multi-disciplinary responses. Drawing on the issues identified in previous reviews of the JIRT model, this report will identify effective and promising practices in interviewing, regional/remote service delivery, and in child and family advocacy.

This research inputs upon which this report will draw to inform its synthesis include:

- The available national and international research on the components of effective cross-agency responses;
- A survey of directors of child advocacy centres in the United States completed in March 2016; and
- A conceptual model for how MDT type models are intended to affect a commonly identified set of outcomes.

The report will also aim to draw implications from this research synthesis for NSW JIRT model.

The sections of this report are structured around the following key questions:

What is the evidence for the effectiveness of MDTs, and what characteristics are consistent across effective MDTs?

This section will present the findings of a recent systematic search of the literature for evaluations of MDTs. This section will present the findings of this search including the types of outcomes evaluated, the evidence of effectiveness overall, and a review of the components associated with effective practices.

How are MDT approaches structured in other Australian and Comparable International Jurisdictions?

This section will begin by briefly examining how MDT models are structured in Australian jurisdictions, drawing on another report prepared for the NSW Ombudsman's office (Herbert & Bromfield, 2017c). This will lead into a discussion of practices within the CAC model in the United States, drawing on a survey of the components that these centres have implemented. MDT models from comparable international jurisdictions will then be presented. The section will conclude with a discussion of how the structure of the JIRTs compare across the variety of models presented.

What are the potential impacts for the introduction of advocacy to existing components in place in the NSW JIRTS, and what evidence exists for these benefits?

This section will provide an overall summary of the data and literature review to highlight what the

available evidence suggests about effective components of a cross-agency response to child abuse requiring investigation by police. This will follow with a discussion of the potential impacts of adding advocacy and other additional components to the existing structures of JIRTs, and recommend some indicators for how the implementation of such structures might be monitored. This section will conclude by identifying the key gaps in research and evaluation in the literature, and highlight some of the opportunities for the JIRTs to contribute to the international evidence base for cross-agency interventions.

2.4 Definitions and Concepts

This section will introduce several key concepts pertinent to the rest of this report. These will be brief high-level descriptions as many of them vary considerably in details between models.

Multi-Disciplinary Team (MDT)

An approach to responding to alleged child abuse that requires investigation that involves a team of professionals from different disciplines and agencies. The degree to which teams are integrated, collaborative, or consultative will vary between models, but MDTs will usually have a process of case review or information sharing to coordinate and plan the response across agencies. The purpose of these teams and the types of agencies involved will also vary between models, although for the present review the MDTs will typically involve the police and child protection statutory authorities. The MDT may also involve medical and therapeutic professionals depending on the purpose of the model.

Child/Children's Advocacy Centre (CAC)

Child Advocacy Centres (CAC) will be frequently discussed in this report. CACs are the most prominent type of MDT response internationally, with over 800 centres across the United States (National Children's Alliance, 2016), and centres drawing on the model in Canada (Department of Justice Canada, 2013; Dubov & Goodman, 2017), Europe (Rasmusson, 2011), and Australia (Herbert & Bromfield, 2016a, 2017b). These centres all describe a comprehensive one-stop-shop approach, with the criminal justice, child protection, mental health and medical response all coordinated from the one site (Cross, Jones, Walsh, Simone, & Kolko, 2007a). Much of the existing published research on MDTs for alleged child abuse requiring police investigation refers to CACs.

Accreditation as a CAC in the United States is based on 10 standards (National Children's Alliance, 2011):

- *Multidisciplinary team*: Cases are managed by teams from across different disciplines and agencies that have responsibility for child sexual abuse (e.g. police, child protection, health, district attorney);
- *Forensic interviews*: The use of trained and experienced interviewers with evidence based interview protocols. Members of the multidisciplinary team with investigative responsibility observe interviews through a one-way mirror, allowing for the interviewer to receive feedback and ensure all the information required by each agency is collected;
- *Victim support and advocacy*: The victim advocate serves as the primary contact point for the victim and their family. As well as being the person that greets them when they arrive at the centre, they also represent their interests to the multidisciplinary team;
- *Child focused setting*: CACs are purpose built facilities that aim to reduce any unnecessary stress, discomfort or intimidation for children. Centres aim to replicate features of the home environment, with playrooms, and toys;

- *Mental health services*: Mental health services oriented towards trauma are available onsite or by direct referral;
- *Medical Examinations*: Examinations are available on site or by direct referral;
- *Case review*: Regular case review meetings involving members of the multidisciplinary team are scheduled;
- *Case tracking*: Cases are managed through the centre to ensure appropriate referrals and the progress of cases;
- *Cultural competency and diversity*: Cultural appropriateness is a consideration of all parts of the process;
- *Organisational capacity*: Organisations have the resources to manage the ongoing training and professional development of staff.

As outlined in Section 4, CACs vary considerably in their structure, consistent with the emphasis on the model's adaptability to different socio-legal contexts (Walsh, Jones, & Cross, 2003). The National Children's Alliance implemented a new set of standards for CACs that rolled-out in 2017 (National Children's Alliance, 2017). Much of the standards and criteria for accreditation are the same, but several criteria have been made essential for accreditation.

Advocacy (i.e. Victim Advocacy, Child Advocacy, Child and Family Advocacy)

Advocates within the context of an MDT model typically are workers that are usually independent from statutory agencies (i.e. police & child protection) with a role to listen to and act for children and families affected by abuse. The role of advocates will vary considerably across models, with some taking a shorter-term role in contact with children and families when they attend for an interview, some working with a specific end in mind (i.e. reducing attrition from the criminal justice system, or improving the take-up of therapeutic services), and others providing long-term holistic support towards improved child and family wellbeing across domains.

The provision of child advocacy is a standard for Child Advocacy Centres (National Children's Advocacy Center, 2013), and is a role that involves liaising with all the other agencies in order to be able to advocate on behalf of families (National Children's Alliance, 2011). There are examples of advocacy provided by different agencies including prosecutors (Patterson & Tringali, 2015), child protection agencies (Goldbeck, Laib-Koehnemund, & Fegert, 2007; Turner, 1997), or (more commonly) from an independent not-for profit agency (e.g. Cross et al., 2007a); the role of this worker and their relationships and interactions with other members of a team may differ depending on their employer and their legitimacy from the perspective of other workers. Exactly what can be included in the role of an advocate is extensive and variable, but generally involves the following:

- Assisting victims of crime and their families to navigate the different systems (i.e. legal, child protection, mental health systems);
- Facilitating referral to needed services, working to reduce barriers to accessing services, working to build engagement with services;
- Providing immediate support to families and children throughout the interview and investigative process;
- Acting as a consistent contact point for children and families for information about their case;

- Working to reduce barriers to accessing the justice system (Gains & Wells, 2015; Patterson & Tringali, 2015);
- Empowering children and families to be able to participate in decision-making about their case (Patterson & Tringali, 2015).

Researchers have also conceptualised the role in terms of several behaviours, values, and strategies. Parkerville Children and Youth Care (2013) commissioned a comprehensive review of advocacy roles, standards and training for staff working with victims/survivors of sexual violence. This review identified the following domains of advocacy:

- *Accessible and Known*: Known in the local community and professionals for their work;
- *Client led*: Listens to victims/survivors to identify their views and wishes;
- *Facilitates informed decision-making*: Provides relevant information and provides options for families;
- *Facilitates empowering opportunities*: Find opportunities to re-empower children through their interactions with various systems;
- *Provides emotional and practical supports*: Ensuring that children and families feel understood and welcome at the service, and receive support based on their needs and wishes;
- *Independence*: Ensuring that children and families have their needs and wishes heard and are represented free of agency bias;
- *Support through the criminal justice system*: Provision of end-to-end support through the justice system;
- *Multi-agency collaboration and representation*: The advocate represents the interests of children and their families to other agencies and members of the multi-disciplinary team;
- *Seeks and progresses positive and negative feedback and suggestions*: Openness in receiving feedback about advocacy and the process involved in accessing other services and acting on this to facilitate systems improvement.

Some MDT models will include their own support services resources, usually in addition to connecting families to external services. In environments where supportive services are limited, providing internal capacity for support and mental health care may be vital for teams to have any chance of improving in the wellbeing of children. Other teams may focus more on making appropriate referrals to external services, and assisting children and families to navigate the complexity of these services. Collaborations may also differ in terms of providing and referring children to services, or their non-abusive families, recognising the importance of improving the family environment in order to facilitate recovery for children (e.g. Hochstadt & Harwicke, 1985; Shepler, 2010). Models also may employ strategies around making acute mental health support available at highly distressing times for children and families such as at the point of disclosure (Cole, 2007; Shepler, 2010). These staff may also provide advice and consultations with other staff members about mental health and developmental issues, for example advice on dealing with and interpreting the body language of developmentally delayed children (Bross, Ballo, & Korfmacher, 2000).

3. WHAT IS THE EVIDENCE FOR MULTI-DISCIPLINARY TEAMS?

This section will address the current state of research evidence for MDT models, and the evidence for the effectiveness of components or variations of MDT models. This section includes the findings from two systematic searches of the international research literature.

The first article (Herbert & Bromfield, 2016b) involved a systematic search of the research literature specifically on Child Advocacy Centres. This research identified some significant gaps in the evidence for the approach around child and family outcomes, but found consistent outcomes studied in relation to the benefits of the approach (relative to standard practice of the era) in relation to criminal justice outcomes.

The second article (Herbert & Bromfield, 2017a) expanded on the search in the original article to identify all kinds of MDT responses. This search identified published evaluations of many different types of MDTs, resulting in a much broader set of outcomes investigated, although still lacking control group studies for child and family outcomes.

It should be identified that there is a lack of systematic research on MDTs, particularly research with comparison to non-collaborative responses. Much of the research relied on for evidence of the effectiveness of MDT approaches is also quite old, and considering practices have moved on considerably in many jurisdictions, the age of these studies may lack relevance to the current context.

3.1 What is the Evidence of the Effectiveness of MDT Models (inclusive of Child Advocacy Centres)

The two literature searches set out to examine three key questions:

a) What types of study designs are used to evaluate multi-disciplinary approaches to physical and sexual child abuse;

b) What types of outcomes are measured; and

c) What evidence exists for the effectiveness of multi-disciplinary approaches to physical and sexual child abuse?

A summary of the search strategy and results can be retrieved from the published articles which can be made available by the authors. A table of all the studies identified in the search results has been included as a separate appendix to the report (Appendix A).

Broadly, the search strategy identified studies reporting on a variety of teams (see Table 4) including multi-disciplinary teams within a CAC or a similar kind of community based collaboration (*n* = 29), therapeutically focused teams that are brought in to provide and refer children to needed services (*n* = 8), teams focused on identifying evidence of abuse for investigative purposes (*n* = 5), and hospital based teams that respond to suspected abuse cases as they present (*n* = 7). Nine of the studies included reported on the effect that closer ties or relationships between agencies have on outcomes; these were included as these studies are more or less comparing the degree to which professionals worked collaboratively towards mutual outcomes (e.g. Bai, Wells, & Hillemeier, 2009). Four studies reported on various types of interagency protocols and networks to increase collaboration across agencies (e.g. Webber, McCree, & Angeli, 2013). The research included relatively few Australian studies (*n* = 6), with the majority of the research conducted in the United States.

3.2 Types of Study Designs Used to Evaluate Teams

The studies included in this section fit into four main categories: evaluations of multi-disciplinary teams with a comparison group of some type; evaluations without a comparison group; evaluations involving perceived outcomes; and studies that examine the effect that different levels of collaboration have on various outcomes. This last category is distinct as these designs typically involve examining the effect different elements of collaboration have on case outcomes such as mental health service receipt (e.g. Bai, Wells, & Hillemeier, 2009). While the ultimate focus of this section is on the evidence of effectiveness, these studies were reviewed to be able to present the full body of research that exists for MDT approaches.

Table 4. Design of Studies Examining MDT Responses

Design		n	%
Multi-Disciplinary Teams with a Comparison Group		(*n* = 22)	35%
	Comparison Communities	(*n* = 9)**	14%
	Different Intake (e.g. random assignment)	(*n* = 6)*	10%
	Pre-Implementation of the Team	(*n* = 6)	10%
	Same Case Assessment	(*n* = 1)	2%
Multi-Disciplinary Teams Without a Comparison Group		(*n* = 23)	37%
Perceived Outcomes of Multi-Disciplinary Teams		(*n* = 10)	16%
Degree of Cross-Agency Response		(*n* = 8)	13%

* One study included both Pre-Implementation and Comparison Communities for different variables.

** One study included both Pre-Implementation and Different Intake comparisons for different variables.

3.3 Types of Outcomes Measured by Studies of MDT Approaches

The sixty-three studies reported on a variety of outcomes which the teams were assessed against (See Table 5), primarily criminal justice outcomes (*n* = 26), whether children and their families were referred to and received mental health and other support services (*n* = 17), child protection outcomes (e.g. removal/placement of children in out of home care; *n* = 16), characteristics associated with the response (e.g. number of interviews, involvement of particular agencies in the investigation; *n* = 16), satisfaction with the response provided by the team (*n* = 17), and whether children and their families received medical services (*n* = 5).

The criminal justice outcomes included mostly focused on how far through the criminal justice process particular cases proceeded; the number of cases that resulted in arrests, charges, prosecutions, and convictions (e.g. Miller & Rubin, 2009; Sedlak et al., 2006). Three studies examined the timeliness of these events in the criminal justice process (Turner, 1997; Walsh, Lippert, Cross, Maurice, & Davison, 2008; Wolfteich & Loggins, 2007). Some studies used community level crime rates to compare the effect that the implementation of MDT models had on jurisdictions (Ruggieri, 2011; Shao, 2006).

Table 5. Types of Outcomes Studied[1]

	Multi-Disciplinary Team with Comparisons (*n* = 22)	Multi-Disciplinary Team without Comparisons (*n* = 23)*	Perceived Outcomes of Multi-Disciplinary Teams (*n* = 10)*	Degree of Cross-Agency Response (*n* = 8)*	Totals (*n* = 63)*
Criminal Justice Outcomes	15 (68%)	10 (43%)	1 (10%)	0 (0%)	(*n* = 26)
Receipt of Mental Health and Support Services	3 (14%)	8 (35%)	1 (10%)	5 (62%)	(*n* = 17)
Child Protection Outcomes	3 (14%)	11 (48%)	1 (10%)	1 (12%)	(*n* =19)
Process Characteristics	7 (32%)	2 (9%)	8 (80%)	2 (25%)	(*n* = 19)
Satisfaction with Approach	4 (18%)	6 (26%)	7 (70%)	0 (0%)	(*n* = 17)
Mental Health Symptoms	0 (0%)	5 (22%)	0 (0%)	2 (25%)	(*n* = 7)
Receipt of Medical Services	4 (18%)	1 (4%)	0 (0%)	0 (0%)	(*n* = 5)
Medical Symptoms	0 (0%)	1 (4%)	0 (0%)	0 (0%)	(*n* = 1)

[1] Most studies included more than one category of outcome.

Many studies also examined outcomes related to the referral, uptake and completion of mental health, counselling and other support services for children and families. These figures primarily report the number of identified services children and families are successfully referred to (e.g. Smith, Witte, & Fricker-Elhai, 2006). This included a group of studies that all examined the use of mental health services across large child protection data sets (Bai et al., 2009; Chuang & Lucio, 2011; Chuang & Wells, 2010; Cross, Finklehor, & Ormrod, 2005; Humphreys, 1995; Hurlburt et al., 2004a). In comparison, relatively few studies reported on the outcomes of these services, in terms of trauma symptoms and child behavioural problems (*n* = 7), and no studies involved comparing improvements on mental health measures across types of approaches (e.g. CAC v Separate agency response).

Child protection outcomes related to the actions taken by agencies in responding to child protection concerns (e.g. removal from the home), and longer-term outcomes related to the care of children over the longer term (e.g. achievement of a permanent placement). Some studies reported on the rates at which abuse was substantiated at the team level to the degree that the case needed to be reported to child protection authorities (Chen et al., 2010; Farrell, Billmire, Shamroy, & Hammond, 1981; Oral et al., 2001; Sahin et al., 2009; Wallace, Makoroff, Malott, & Shapiro, 2007a), while others reported on the rates at which cases were substantiated by child protection authorities based on their investigations (Brink, Thackeray, Bridge, Letson, & Scribano, 2015; Carnes, Nelson-Gardell, & Wilson, 2000; Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001; Cross et al., 2005; Jenson, Jacobson, Unrau, & Robinson, 1996; Sedlak et al., 2006; Turner, 1997; Wolfteich & Loggins, 2007). Four studies also looked at the rates of child removals resulting from claims of physical and sexual child abuse (Cross et al., 2005; Hochstadt & Harwicke, 1985; Rivara, 1985; Sahin et al., 2009), while Jenson (1996) similarly looked at whether the living situation of the children had changed three months after the report.

Many studies reported on what we have termed 'process characteristics'; that is parts of the multi-disciplinary response that are assumed to affect outcomes. In evaluation these may be identified as

outputs, variables that suggest the intervention is being delivered as intended (Owen, 2006). In the case of multi-disciplinary teams, these include characteristics like the involvement of police and/or child protection in cases (e.g. Faller & Henry, 2000), the number of interviews or interviewers to whom children are exposed (e.g. Turner, 1997), whether child interviews are conducted in a child friendly environment (e.g. Cross, Jones, Walsh, Simone, & Kolko, 2007b), the degree of cross agency collaboration on a case (Walsh et al., 2008), and the involvement of children and families in the response to abuse (e.g. Goldbeck et al., 2007).

Seventeen studies examined ratings of satisfaction, primarily drawing on staff (*n* = 10), but also caregivers (*n* = 8), and children (*n* = 4) to rate their satisfaction with the response. Staff satisfaction involved interviews that broadly asked workers about their experience in the model (Hebert, Bor, Swenson, & Boyle, 2014a; Klenig, 2007; Onyskiw, Harrison, Spady, & McConnan, 1999; Powell & Wright, 2012), although most studies examined it using survey instruments (Bross et al., 2000; Cole, 1998; Goldbeck et al., 2007; Jenson et al., 1996; Jones, Worthington, Hawks, Mercer, & et al., 1998; Lalayants, Epstein, & Adamy, 2011). Similarly, standardised surveys were more common amongst studies examining satisfaction amongst caregivers (Bonach, Mabry, & Potts-Henry, 2010; Hubel et al., 2014; Jenson et al., 1996; Jones, Cross, Walsh, & Simone, 2007; Walsh, Cross, Jones, Simone, & Kolko, 2007) and children (Hubel et al., 2014; Jenson et al., 1996; Jones et al., 2007).

3.4 Evidence for the Effectiveness of Multi-Disciplinary Teams Responding to Child Abuse

The evidence for the outcomes associated with multi-disciplinary teams are reviewed below in five categories: Criminal justice outcomes; Mental health/support service referral and improvement in trauma symptoms; Child protection outcomes; Satisfaction with response; and Medical referral and improvement in medical symptoms.

Results are grouped by outcome type and presented across the types of teams included in studies that had comparative data. These include CAC type teams – teams that aimed to link the investigative and therapeutic response; Sexual Assault Resource Centre (SARC) Teams – teams assembled around an existing SARC medical response; Investigation focused teams – that are primarily collaborations oriented towards improving the criminal investigation of abuse; therapeutically focused teams – which providing a multi-disciplinary team response separate from the criminal justice response; and what we have termed degrees of cross-agency response – studies of many different cases and responses.

Criminal Justice Outcomes

Studies examining criminal justice outcomes were mixed in terms of finding that MDTs resulted in more arrests, and prosecutions than comparison groups (i.e. pre-post implementation of teams, comparison to other communities without teams, or different intake processes). Some of the earlier studies (e.g. Jaudes & Martone, 1992; Turner, 1997) found significant differences; this may have been due to practices in the comparison group. Many of the practices of multi-disciplinary teams, such as evidence based interviewing techniques and child friendly facilities, have diffused into practice as usual in some jurisdictions (Lippert, Cross, Jones, & Walsh, 2009), which may result in a higher baseline for multi-disciplinary teams in later studies. Table 6 provides a breakdown of positive and null findings amongst studies that examined criminal justice outcomes with comparisons.

Table 6. Significant and Non-Significant Findings on Criminal Justice Outcomes between Teams and Comparisons (*n* = 15)

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings (Negative Findings Where Indicated)
CAC Based Team (or similar)					
Bradford (2005)	717	Comparison to Pre-Team	Child Sexual Abuse	Criminal charges Convictions (where cases are filed)	
Edinburgh, Sawyc, & Levitt (2008)	256	Different Intake	Child Sexual Abuse		Criminal charges Criminal convictions Sentence length
Joa & Goldberg-Edelson (2004)	101	Different Intake	Child Sexual Abuse	Criminal charges Number of criminal charges Guilty pleas	Guilty verdicts (where cases go to court) Sentence type (where convicted) Sentence length (where convicted)
Lippert, Cross, Jones, & Walsh (2009)	987	Comparison to Other Community	Child Sexual Abuse		Disclosure in forensic interview
Miller & Rubin (2009)	Pop*	Comparison to Other Community	Child Sexual Abuse	Felony prosecutions for CSA	
Ruggieri (2005)	Pop*	Comparison to Other Community	Child Sexual Abuse	Substantiation of CSA Prior victimisation	CSA Rates
Shao (2009)	Pop*	Comparison to Other Community	Child Sexual Abuse	CSA Rates	Physical, emotional abuse, and neglect rates
Shepler (2010)	370	Different Intake	Child Sexual Abuse		Re-victimisation Time to re-victimisation
Smith, Witte, & Fricker (2006)	76	Different Intake	Physical and Sexual Abuse	Substantiations	
Wolfteich & Loggins (2007)**	184	Comparison to Pre-Team Different Intake (Child Protection Team MDT)	All Types of Abuse All Types of Abuse	Substantiation (CAC v MDT v standard practice)	Substantiation (CAC v MDT) Arrest (CAC v MDT) Criminal charges (CAC v MDT) Re-victimisation (CAC v MDT
Walsh et al. (2008)	160	Comparison to Other Community	Child Sexual Abuse	Time to charging decision	Case resolution time Total case processing time

Sexual Assault Resource Team					
Campbell et al. (2012)	392	Comparison to Other Community	Child Sexual Abuse		Referred for prosecution Accepted for prosecution Dropped or Acquitted Plea or Trial Conviction
Investigation Focused Team					
Jaudes & Martone (1992)	264	Comparison to Pre-Team	Child Sexual Abuse	Substantiation of abuse Identification of Perpetrator Criminal Charge (where perpetrator is identified)	
Turner (1997)	155	Comparison to Pre-Team	Child Sexual Abuse	Time from report to referral to police Time from child protection receipt of report to police involvement Overall length of investigation Arrest Criminal Charges Criminal Convictions	Identification of the perpetrator
Therapeutically Focused Team					
Goldbeck et al. (2007)	80	Different Intake	All Types of Abuse		Prosecution (significantly higher rates in the control condition)

*Study involved population data e.g. number of prosecutions across the entire population of a city.
**Study involves the comparison of three conditions on some variables; a CAC, a child protection MDT lead by law enforcement, and practice before either initiative was implemented.

The studies included examined many different types of criminal justice variables, under different types of conditions. While most of these variables are self-explanatory, some studies include substantiation by police and/or child protection agencies; in the context of criminal justice outcomes this refers to police obtaining enough evidence in order to move forward with a matter to arrest. Outcomes earlier in the criminal justice process (i.e. police substantiations) were more likely to be significantly different between teams and their comparisons (Jaudes & Martone, 1992; Ruggieri, 2011; Smith et al., 2006; Wolfteich & Loggins, 2007) than not (Wolfteich & Loggins, 2007). Across studies, the results were less consistent for outcomes like criminal charges filed/prosecutions for abuse with some studies finding a significant difference (Bradford, 2005; Joa & Edelson, 2004; Miller & Rubin, 2009; Turner, 1997), and some finding no difference between teams and their comparisons (Campbell, Greeson, Bybee, & Fehler-cabral, 2012; Edinburgh, Saewyc, & Levitt, 2008; Goldbeck et al., 2007; Wolfteich & Loggins, 2007). Similarly the results were mixed in terms of convictions, though with more studies suggesting a significant difference (Bradford, 2005; Joa & Edelson, 2004; Turner, 1997), than studies that did not (Edinburgh et al., 2008; Joa & Edelson, 2004).

Key Messages:

- Most studies found a positive effect of team approaches in terms of criminal justice outcomes, but some studies also found no difference;
- Older studies tended to be more likely to find a difference, potentially as standards have improved in comparison conditions over time;
- Outcomes earlier in the criminal justice process were more likely to be found as significantly different.

Components of an Effective MDT Response on Criminal Justice Outcomes

As discussed in the previous section, much of the research into the effect of MDTs is on criminal justice outcomes, but only fifteen individual sites have been evaluated on improvements in criminal justice outcomes (Table 7). From the fifteen studies identified in the review that examined criminal justice outcomes in an MDT against a non-MDT response, eleven found that MDT responses were beneficial. This eleven includes three studies (Miller & Rubin, 2009; Ruggieri, 2011; Shao, 2006) that involve comparison between state or district level responses and could not be included in the components review. This left eight studies, which reported on eleven individual sites; four studies found no difference between the MDT and comparison condition. Four studies that found no significant effect or a negative significant effect in terms of criminal justice outcomes were also reported on.

Among sites/studies that found a positive significant difference, sites differed in terms of the types of cases they received; most MDTs dealt with sexual abuse and severe physical abuse (n = 5), or just sexual abuse (n = 4). Only two sites dealt with all kinds of abuse and neglect. Among sites with no significant effect or a negative significant effect two dealt with all kinds of abuse and neglect, one dealt with physical and sexual abuse, and one with sexual abuse only.

All the MDTs had police and child protection involved in the response, but only three sites had police co-located, and four sites had child protection authorities co-located[ii]. Many MDTs had prosecutors as part of their response (n = 8), with four sites having prosecutors co-located. Eight sites had an explicit advocate role as part of their response, most of which were employed by the entity running the MDT site. One advocate was employed by the district attorney's office, and one was employed by the child protection statutory service. Where an advocate was part of the response they were mostly co-located (n =5)[iii]. In most cases, medical personnel were also part of the response (n = 9), and they were also mostly co-located (n = 6). For sites with no significant effect or a negative significant effect, only one had a full complement of CAC agencies involved in their MDTs, two had combinations of medical/mental health supports, while the other one had police, prosecutors, medical and rape crisis services involved as the service was targeting adolescent victims of sexual assault.

Most of the articles contained limited details of their case review and consultation process. Four sites had a weekly case review meeting to share information and plan their response, and two reported meeting as needed when cases came in. Across all sites very limited details were available of the components that may have been included in the control conditions which the interventions were compared against.

[ii] From 9 sites where the agencies co-located was reported.
[iii] For site the article did not state whether the advocate was co-located or not.

Joint or multi-disciplinary interviews were part of almost every site, with provision for agencies to observe and provide feedback to the interviewer, and ensure that all the information required from the child was obtained to reduce the need for additional interviewing. For one site the study did not specify whether there were arrangements for multi-disciplinary interviews. For most of the sites, an independent interviewer was used (n = 8), with a police interviewer, and a child protection interviewer at one site each. At one site, there was no designated interviewer, the group of professionals conferred on who was best placed to conduct the interview. Among sites with no significant effect or a negative significant effect three did not involve forensic interviewing, and it was unclear which agency did the interviewing in the other site.

Key Messages:

- Relatively few sites had police and child protection authorities co-located;
- Prosecutors are a common part of the response for MDTs aimed at the criminal justice response;
- Most sites had independent advocacy, which was usually one of the co-located workers;
- Medical staff are also commonly co-located;
- Almost all sites had provision for cross-agency observed child interviews, which were usually conducted by an independent interviewer supervised by statutory agencies.

Table 7. Characteristics of MDTs Effective at Improving Criminal Justice Outcomes

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Bradford (2005)	Child Sexual Abuse	CAC	Police CAC Interviewer Child Protection Prosecutors Advocate	None	Frequency Unknown	Independent CAC Interviewer Joint Interviewing	External Referral	Victim's Services Officer Employed by the District Attorney's Office	CPS or Police Interview (No standard interview process) Included MDT case review
Lippert, Cross, Jones, & Walsh (2009); Walsh et al. (2008) **Site 1 (Charleston, South Carolina)**	All Abuse & Neglect	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Site 2 (Pittsburgh, Pennsylvania)	All Abuse & Neglect	Hospital Based CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	As Needed	Independent CAC Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 3 (Huntsville, Alabama)	Sexual Abuse and Severe Physical Abuse	CAC	Police (Police conduct Interviews) Child Protection Prosecutors Advocacy Mental Health Medical	Police Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Police Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations

Site 4 (Dallas, Texas)	Sexual Abuse and Severe Physical Abuse	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Jaudes & Martone (1992)	Sexual Abuse with a Known Offender	Investigative Interview Team	Police Medical/Social Worker (Interviewer) Child Protection Mental Health Prosecutor	Unknown	The professionals meet before and after each interview	Independent Interviewer Joint Interviewing	Unknown	No	Pre-Standardised Victim Sensitive Protocol – Hospital Based Assessment
Joa & Goldburg, & Edelson (2004)	Sexual Abuse	Investigative Interview Team	Police Child Protection Interviewer Medical	Interviewer Medical	Unknown	Independent Interviewer Unknown	Unknown	No	Matched Cases Not Interviewed at a Child Abuse Assessment Centre
Smith, Witte, & Fricker (2006)	Sexual Abuse and Severe Physical Abuse	CAC	Police Child Protection Medical Mental Health Prosecutor Advocate	Unknown	Unknown	Independent Interviewer Joint Interviewing	Unknown	CAC Advocate	Non-CAC CPS Cases
Turner (1997)	Intra-Familial Sexual Abuse	Multi-Agency Team	Police Child Protection Prosecutors Advocate	No	Weekly	No Designated interviewer; Group Confer on Professional Best Placed to Interview Joint Interviewing	Referral to external services	CPS Advocate	Pre-Multi-Agency Team
Wolfteich & Loggins (2007) **Site 1 – Joint Team**	Physical & Sexual Abuse	Child Protection Team	Police Child Protection Medical	Police Child Protection Medical	Unknown	Child Protection Interviewer Joint Interviewing	Referral to external services	No	Traditional CPS Investigation
Site 2 - CAC	Physical & Sexual Abuse	CAC	Police Child Protection Interviewer Medical Mental Health Advocacy	Child Protection Advocates	Unknown	Independent Interviewer Joint Interviewing	Referral In-House Services	CAC Advocate	Traditional CPS Investigation

Studies with No Significant Effect or A Negative Significant Effect									
	Types of Cases	**MDT Type**	**Roles Involved**	**Co-Location of Staff**	**Case Review**	**Child Interviewing**	**Referral to Support Services**	**Advocacy Role**	**Comparison Condition**
Edinburgh, Saewyc, & Levitt (2008)	Physical and Sexual Abuse	Hospital Based CAC	Mental Health Medical Advocacy	Mental Health Medical Advocacy	Unknown	Medical/Mental Assessment – No Forensic Interviewing	In-House Services	CAC Advocate	Non-CAC Police Investigation
Shepler (2010)	All Abuse	CAC	Police Child Protection Prosecutors Interviewer Medical Mental Health Advocacy	Unknown	Unknown	Unknown	In-House Services	CAC Advocate	Traditional Model of Care
Campbell et al. (2012)	Sexual Abuse	MDT at a Sexual Assault Resource Team	Police Prosecutors Medical Rape Crisis Service	Medical Rape Crisis Service	Yes	No	External Services	Unknown	Less Formal Integration of Response
Goldbeck et al. (2007)	Sexual, Physical and Emotional Abuse, and Neglect	Expert Assisted Case Management	Child Protection Mental Health Medical	None	Multiple Case Conferences – First within 4 Weeks of a report	None	External Referral	No	Practice as Usual Without Consultation with a Multi-Disciplinary Team

Mental Health/Support Service Referral and Improvement in Trauma Symptoms

Studies examining the effect of multi-disciplinary teams in increasing the uptake of needed services predominately found a significant difference compared to different types of individual agency responses (Table 8). Only three studies compared the extent of service referral and the use of services, and all found that outcomes related to service use were significantly greater than the comparison condition (Edinburgh et al., 2008; Smith et al., 2006; Turner, 1997). The five studies that examined a multi-disciplinary response found mostly significant results for the effect of increased collaboration or ties between service agencies (Bai et al., 2009; Cross et al., 2005; Hurlburt et al., 2004a) including collaborative characteristics that would suggest that there is a multi-disciplinary team (e.g. co-location, presence of a case review coordinator). Cross, Finkelhor and Omrod (2005) had mixed findings for the effect of multi-disciplinary teams in increasing service receipt, with results different between children with different types of abuse (See Table 8). One study found that having a single agency responsible for care resulted in an increased likelihood that clients would receive a service (Chuang & Wells, 2010).

Table 8. Significant and Non-Significant Findings on Mental Health/Support Service Outcomes between Teams and Comparisons (*n* = 9)

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings (Negative Findings Where Indicated)
CAC Based Team (or Similar)					
Edinburgh, Sawyc, & Levitt (2008)	256	Different Intake	Child Sexual Abuse	Mental health screening Referral to counselling	
Smith, Witte, & Fricker (2006)	76	Different Intake	Physical and Sexual Abuse	Mental health referral (where cases were substantiated)[1]	
Investigation Focused Team					
Turner (1997)	155	Comparison to Pre-Team	Child Sexual Abuse	Involvement of mental health professional in interviews	
Multi-Disciplinary Response					
Bai, Wells, & Hillemeier (2009)	1613	Different levels of collaboration factors across teams	All Types of Abuse	Mental health service use Mental health improvement	
Chuang & Lucio (2011)	491	Different levels of collaboration factors across teams	All Types of Abuse	School based mental health service use (Positive findings associated with person centred collaborative practices)[4]	School based mental health service use (Negative findings associated with co-location)

				Outpatient mental health service use (Positive findings associated with person centred collaborative practices)	Outpatient mental health service use (Negative findings associated with co-location)
Chuang & Wells (2010)	178	Different levels of collaboration factors across teams	All Types of Abuse	Inpatient mental health service use (attributed to linked databases)	Outpatient mental health service use (Collaboration and linked databases)[2] Inpatient mental health service use (Collaboration)[2]
Cross, Finklehor, & Omrod (2005)[3]	3842	Different levels of collaboration factors across teams	All Types of Abuse	Any service provision or referral (physical, sexual abuse, & neglect) Receipt of services for parents (sexual abuse & neglect) Receipt of services for children (physical & sexual abuse)	Receipt of services for parents (physical abuse) Receipt of services for children (neglect)
Glisson & Hemmelgarn (1998)	250	Different levels of collaboration factors across teams	All Types of Abuse		Mental health service outcomes (i.e. measures of children's psychosocial functioning)
Hurlburt et al. (2004)	2823	Different levels of collaboration factors across teams	All Types of Abuse	Mental health service use	

[1] Samples were not large enough to enable a meaningful chi-square comparison; however, the rates were 100% for the CAC condition, and 71.4% for the comparison condition.
[2] Increased interagency collaboration was related to lower use of services; the authors suggest this was due to clearer individual agency accountability for follow-up on referrals; linked databases had a null effect on outpatient services.
[3] Study examined conditions for both joint investigations and joint planning between police and child protection, as well as multi-disciplinary teams. The analysis included compared multi-disciplinary teams versus child protection alone.
[4] For example use of a care coordinator, or cross-training of staff.

From the studies that did not include a comparison group the rates of referral to services were fairly similar to each other, most studies reported referral of children to psychological, psychiatric and counselling services at a rate of around 70% or higher (Dale & Davies, 1985; Gragg, Cronin, & Schultz, 2006; Jenson et al., 1996; Sahin et al., 2009). Most of these studies had limited details about the uptake of these services over the medium to long term. Hochstadt and Harwicke (1985) found that amongst recommended services by the multi-disciplinary team, child psychotherapy was only obtained by 35% of cases, family therapy in 44% of cases, and additional psychological assessment in 29% of cases.

Key Messages:

- Cross-agency teams were mostly consistently associated with higher rates of mental health service receipt;
- Most studies examining differences were of multi-disciplinary responses – typically involving national samples of cases that received various degrees of an MDT responses (i.e. case coordinator;
- Only two studies examined the effects of the response on mental health outcomes for children, one study found improved mental health outcomes for MDTs, one found no difference.

Components of an Effective MDT for Mental Health/Support Referral

Very few studies identified MDT sites that were individually evaluated to have a positive effect on outcomes related to mental health and support services; most of the studies supporting the idea of collaborative practice improving rates of service access and engagement were national/state/county level studies. From the nine studies identified in the review that examined mental health/support referral in an MDT against a non-MDT response, all but one found that MDT responses were beneficial. This nine includes six studies (Bai et al., 2009; Chuang & Lucio, 2011; Chuang & Wells, 2010; Cross et al., 2005; Glisson & Hemmelgarn, 1998; Hurlburt, Leslie, Landsverk, & et al., 2004b) that involve comparison between many responses at the state or national level and could not be included in the components review. This left three studies. The details of how these interventions were delivered and the conditions they were compared against were limited in these studies (See Table 10), although all sites had medical, mental health and independent advocacy services as part of their response. Two studies found that the MDT response resulted in higher rates of mental health referral, one found that the response resulted in increased mental health professionals involvement in the case.

Child Protection Outcomes

As shown in Table 9, most of the studies examining child protection related measures found that the use of multi-disciplinary teams was associated with increased child protection related responses, although the number of studies with comparison data were very limited (*n* = 4).

Table 9. Significant and Non-Significant Findings on Child Protection Outcomes between Teams and Comparisons (*n* = 4)

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings (Negative findings Where Indicated)
CAC Based Team (or Similar)					
Wolfteich & Loggins (2007)*	184	Comparison to Pre-Team	All Types of Abuse	Increased Substantiation (CAC v MDT v standard practice) Time to substantiation (CAC v standard practice)	Increased Substantiation (CAC v MDT) Time to substantiation (CAC v MDT)**

Brink et al. (2015)	1422	Same Case Assessment	Child Sexual Abuse	Agreement between MDT assessment and child protection investigation outcomes	
Investigation Focused Team					
Turner (1997)	155	Comparison to Pre-Team	Child Sexual Abuse	Time from child protection receipt of report to police involvement	Increased Case substantiated by child protection Increased Family court petition
Multi-Disciplinary Response					
Cross, Finkelhor & Omrod (2005)***	3842	Different levels of collaboration factors across teams	All Types of Abuse	Increased out of home placement (neglect)	Increased out of home placement (physical, sexual abuse)

*Study involves the comparison of three conditions on some variables; a CAC, a child protection MDT led by law enforcement, and practice before either initiative was implemented.

** MDT was significantly faster than the CAC condition.

*** Study examined conditions for both joint investigations and joint planning between police and child protection, as well as multi-disciplinary teams.

Many more studies reported on child protection outcomes without reference to a comparison (*n* = 11), primarily reporting on the percentage of cases that were substantiated by the team and passed on to child protection authorities. These team substantiation rates varied between around 40% (Carnes et al., 2000; Carnes et al., 2001; Jenson et al., 1996), around 50% (Chen et al., 2010), to around 60% (Sahin et al., 2009). In terms of longer term outcomes Jenson et al. (1996) found that at 3 months after the initial report, 60% of children remained in their home, and 29% returned to their home after a removal. At follow-up (average of 30 months) Rivara (1985) found that 41% of children under two with suspected physical abuse remained in their homes.

Key Messages:

- Studies found mixed results on increased rates of child protection substantiation;
- Studies mostly found quicker responses from statutory child protection agencies (i.e. time until a substantiation is made from the point of initial report & time from child protection receipt of a matter to referral to police).

Components of an Effective MDT for Child Protection Outcomes

A limited number of studies (*n* = 4) which both described the components of the MDT and had significant findings in the hypothesised direction reported on child protection outcomes, primarily related to child protection substantiation of acts of abuse. From the four studies identified in the review that examined child protection outcomes in an MDT against a non-MDT response, all studies found that MDT responses were beneficial on some outcome. This four includes one study (Cross et al., 2005) that involve comparison between state or district level responses and could not be included in the components review. This left three studies, and four individual intervention sites. All sites had police and child protection involved in the response, and child protection was co-located in three of the four sites; police were co-located in two of the sites. Three of the four sites had an advocate. One site had a combined mental health worker/advocate, and it was unclear from the

article which agency they were employed by. One other site had an advocate provided by the statutory child protection service, and another had an independent advocate.

All but one site had joint interviewing, with a mix of independent interviewers, a child protection interviewer, and one site with no designated interviewer. The sites had a mix of in-house support services and referral to external support services.

Table 10. Characteristics of MDTs Effective at Improving Mental Health Outcomes

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Edinburgh, Saewyc, & Levitt (2008)	Physical and Sexual Abuse	Hospital Based CAC	Mental Health Medical Advocacy	Mental Health Medical Advocacy	Unknown	Medical/Mental Assessment – No Forensic Interviewing	In-House Services	CAC Advocate	Non-CAC Police Investigation
Smith, Witte, & Fricker (2006)	Sexual Abuse and Severe Physical Abuse	CAC	Police Child Protection Medical Mental Health Prosecutor Advocate	Unknown	Unknown	Independent Interviewer Joint Interviewing	Unknown	CAC Advocate	Non-CAC CPS Cases
Turner (1997)	Intra-Familial Sexual Abuse	Multi-Agency Team	Police Child Protection Prosecutors Advocate	No	Weekly	No Designated interviewer; Group Confer on Professional Best Placed to Interview Joint Interviewing	Referral to external services	CPS Advocate	Pre-Multi-Agency Team

Table 11. Characteristics of MDTs Effective at Improving Child Protection Outcomes

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Brink (2015)	Child Sexual Abuse	CAC	Police Interviewer Child Protection Medical Mental Health/ Advocate	Police Interviewer Child Protection Medical Mental Health/Advocate	Frequency Unknown	Unknown Joint Interviewing	In-House Services (Hospital Based CAC)	Mental Health Advocate Unknown	Child Protection Decision-Making
Turner (1997)	Intra-Familial Sexual Abuse	Multi-Agency Team	Police Child Protection Prosecutors Advocate	No	Weekly	No Designated interviewer Group Confer on Professional Best Placed to Interview Joint Interviewing	Referral to external services	CPS Advocate	Pre-Multi-Agency Team

Wolfteich & Loggins (2007) **Site 1 – Joint Team**	Physical & Sexual Abuse	Child Protection Team	Police Child Protection Medical	Police Child Protection Medical	Unknown	Child Protection Interviewer	Referral to external services	No	Traditional CPS Investigation
Site 2 - CAC	Physical & Sexual Abuse	CAC	Police Child Protection Interviewer Medical Mental Health Advocacy	Child Protection Advocates	Unknown	Independent Interviewer Joint Interviewing	Referral In-House Services	CAC Advocate	Traditional CPS Investigation

Process Related Measures

Quite a few studies reported variables that were outputs rather than outcomes, or variables that suggest the approach is being delivered as intended, such as the number of interviews or the involvement of particular agencies in the response. Some of the older studies found that multi-disciplinary teams were able to reduce the number of interviews and interviewers children were subjected to compared with the comparison condition (Jaudes & Martone, 1992; Turner, 1997), however the most current studies found no difference across conditions (Cross et al., 2007b). All studies found that teams increased police involvement and joint investigations (Cross et al., 2007a; Smith et al., 2006), along with a number of other characteristics which are part of the CAC model (Cross et al., 2007b).

A small number of studies reported on collaboration quality with comparison to standard practice in order to see how measures to implement multi-disciplinary teams affect practice level behaviours. The findings were mixed, with Cross et al. (2007b) concluding that having a CAC resulted in increased formal collaboration between agencies, while Goldbeck et al. (2007) found that inter-organizational communication did not increase with additional disciplines involved in the management of the case. Altshuler (2005) found no difference in survey ratings of collaboration over the course of the implementation of a community based multi-disciplinary team, although workers rated their collaboration at quite a high level from the start of the program.

Table 12. Significant Findings on Process Related Measures between Teams and Comparisons

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings (Negative Findings Where Indicated)
CAC Based Team (Or Similar)					
Cross et al. (2007)	1069	Comparison Community	All Types of Abuse	Police involvement in cases Multi-Disciplinary interviews Case reviews Joint Police/Child Protection investigations Video/audiotaping of interviews Interviews at child friendly facilities Formal coordination between agencies	Number of interviews
Smith, Witte, & Fricker (2006)	76	Different Intake	Physical and Sexual Abuse	Involvement of police in cases	
Investigation Focused Team					
Jaudes & Martone (1992)	264	Comparison to Pre-Team	Child Sexual Abuse	Number of interviews Number of interviewers	

Turner (1997)	155	Comparison to Pre-Team	Child Sexual Abuse	Number of interviews Number of interviewers Number of interview settings	
Therapeutically Focused Team					
Lalayants et al. (2011)	500	Different Intake	All Types of Abuse	Family focused interventions	Child centred consultations (Negative finding) Strengths based interventions Culturally sensitive interventions (Negative finding) Internal & External Collaborative Approach (Negative finding)
Goldbeck et al. (2007)	80	Different Intake	All Types of Abuse		Certainty in intervention planning Involvement of children and families (Negative finding) Inter-institutional communication
Altshuler (2005)	74	Comparison to Pre-Team	All Types of Abuse		Ratings of collaboration
Multi-Disciplinary Response					
Glisson & Hemmelgarn (1998)	250	Different levels of collaboration factors across teams	All Types of Abuse		Service quality (Increased service coordination decreased service quality)

Key Messages:

- Many studies included variables as outcomes that are more like outputs, measures that suggest the intervention is being delivered as intended (i.e. number of interviews);
- Older studies tended to find reductions in the number of interviews children were exposed to, while newer studies tended to not find any difference between the MDT and standard practice;
- Results were mixed in terms of MDTs improving the quality of collaboration. In one of the studies the effect of having an MDT couldn't be compared as the initial collaboration score was very high.

Components of an Effective MDT for Process Measures

As discussed above, process variables refer to characteristics that are not necessarily outcomes in terms of improvements to the lives of children and families, but intermediate variables that more suggest that the model is being implemented as intended. This includes measures of collaboration between workers, the number of interviews, and the location of interviews; these are variables which may conceivably result in positive outcomes (e.g. increased charges, increased uptake of therapeutic services, improved child health), but are not outcomes in and of themselves. From the eight studies identified in the review that examined process measures in an MDT against a non-MDT response, all but three studies found that MDT responses were beneficial on some outcome. This eight includes one study (Glisson & Hemmelgarn, 1998) that involve comparison between state or district level responses and could not be included in the components review. This left five studies with seven individual intervention sites.

Seven sites demonstrated improvements on process variables relative to their comparison groups, five of which were CACs. All sites had police, child protection, advocates, and prosecutors as part of the response, and all but one had mental health and medical professionals as part of the response. Co-location details were missing for two of the sites; of the remaining five, one had no agencies co-located, and only two sites had police and child protection co-located. Four had prosecutors, mental health, and medical personnel co-located. Among sites with no significant effect or a negative significant effect, two had the full complement of CAC agencies involved in case review, while one had only child protection, mental health, and medical services involved. Two sites had no co-location, and for one site it was not clear whether the team was co-located.

Four of the sites had weekly case review meetings, two had meetings as needed, and one site did not have information about the frequency of case meetings. Three of the seven sites referred to external support services, two had their own in-house services, and two did not provide information about whether services were provided on site. For the three sites with no significant effect or a negative significant effect, in two of the sites case reviews were held as needed, while one held monthly meetings.

Five of the sites had an independent interviewer, at one site police conducted the child interviews, and in another the group of professionals conferred to determine who was the most appropriate interviewer. The same five sites also had an independent advocate, with one site having an advocate from a child protection authority, and another having no advocate. Interviewing was no part of the response for two of the sites with no significant effect or a negative significant effect, and it was unclear whether interview was included in one of the sites.

Key Messages:

- Most sites that found differences in process measures were CACs with independent interviewers, and independent advocates. Only two sites had police and child protection co-located.

Table 13. Characteristics of MDTs Effective at Changing Process Measures

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Cross et al (2007); **Site 1 (Charleston, South Carolina)**	Physical, Sexual Abuse, and Neglect	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Site 2 (Pittsburgh, Pennsylvania)	All Abuse & Neglect	Hospital Based CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	As Needed	Independent CAC Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 3 (Huntsville, Alabama)	Sexual Abuse and Severe Physical Abuse	CAC	Police (Police conduct Interviews) CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Police Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 4 (Dallas, Texas)	Sexual Abuse and Severe Physical Abuse	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations

Jaudes & Martone (1992)	Sexual Abuse with a Known Offender	Investigative Interview Team	Police Medical/Social Worker (Interviewer) Child Protection Mental Health Prosecutor	Unknown	The professionals meet before and after each interview	Independent Interviewer Joint Interviewing	Unknown	No	Pre-Standardised Victim Sensitive Protocol – Hospital Based Assessment
Smith, Witte, & Fricker (2006)	Sexual Abuse and Severe Physical Abuse	CAC	Police Child Protection Medical Mental Health Prosecutor Advocate	Unknown	Unknown	Independent Interviewer Joint Interviewing	Unknown	CAC Advocate	Non-CAC CPS Cases
Turner (1997)	Intra-Familial Sexual Abuse	Multi-Agency Team	Police Child Protection Prosecutors Advocate	No	Weekly	No Designated interviewer Group Confer on Professional Best Placed to Interview Joint Interviewing	External Referral	CPS Advocate	Pre-Multi-Agency Team
Studies with No Significant Effect or A Negative Significant Effect									
	Types of Cases	**MDT Type**	**Roles Involved**	**Co-Location of Staff**	**Case Review**	**Child Interviewing**	**Referral to Support Services**	**Advocacy Role**	**Comparison Condition**
Lalayants et al. (2011)	All Abuse & Neglect	Multi-Disciplinary Consultation with a CPS Team	Child Protection Mental Health Medical Domestic Violence Counsellors Substance Abuse Councillor	Unknown (Varies across 12 teams)	As needed	None	Unknown	No	Practice as Usual Without Consultation with a Multi-Disciplinary Team
Goldbeck et al. (2007)	Sexual, physical and emotional abuse, and neglect	Expert Assisted Case Management	Child Protection Mental Health Medical	None	Multiple Case Conferences – First within 4 Weeks of a report	None	External Referral	No	Practice as Usual Without Consultation with a Multi-Disciplinary Team

Altshuler (2005)	Drug Endangered Children	Drug Endangered Child Team	Police Child Protection Mental Health Prosecutors Advocates	None	Monthly	Unknown	Unknown	Social Service Agencies	Pre-Post Implementation

Satisfaction with the Response

Few studies provided a comparison of satisfaction with the multi-disciplinary team response compared with a standard response (See Table 14). Jones et al. (2007) found that caregivers were significantly more satisfied with an investigation undertaken at a CAC as opposed to the standard investigative response, but found that satisfaction did not differ between conditions for children. The researchers attributed the lack of difference in satisfaction for children to improvements in the child friendliness of investigations in non-CAC communities (i.e. a ceiling effect on satisfaction with the response), along with difficulties obtaining valid quantitative measures of satisfaction from children (Jones et al., 2007).

Table 14. Significant Findings on Satisfaction Outcomes between Teams and Comparisons

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings (Negative Findings Where Indicated)
CAC Based Teams (Or Similar)					
Jones, Cross, Walsh, & Simone (2007)	284	Comparison to Other Communities	Child Sexual Abuse	Caregiver satisfaction with the investigation	Children's satisfaction with the investigation
Walsh et al. (2007)	143	Comparison to Other Communities	Child Sexual Abuse		Caregiver Satisfaction with a medical examination
Therapeutically Focused Teams					
Lalayants et al. (2011)	500	Different Intake	All Types of Abuse	Staff satisfaction with multi-disciplinary consultations	
Goldbeck et al. (2007)	80	Different Intake	All types of Abuse	Staff satisfaction with the degree of child protection	

Walsh et al. (2007) found that caregivers were not any more satisfied with medical examinations at a CAC than at a standard response, primarily as both samples were highly satisfied with the exam. Both Lalayants et al. (2011), and Goldbeck et al. (2007) found that workers were significantly more satisfied with multi-disciplinary responses, both from the perspective of the workers who consulted with teams, and the team members themselves.

Key Messages:

- Few studies have directly compared rates of satisfaction with the response. Staff were more satisfied across two studies, caregivers were mixed in terms of satisfaction over two studies, children weren't more satisfied with MDT based responses in the one study that provided a comparison. This may be attributable to a ceiling effect in satisfaction with the response.

Components of an Effective MDT for Satisfaction Measures

Four studies identified in the review examined satisfaction measures in an MDT against a non-MDT response, all but one study found that MDT responses were beneficial on some outcome. This left three studies with six sites were found to be effective in improving satisfaction relative to comparison conditions, this included caregiver satisfaction and staff satisfaction with the quality of

the response (See Table 13). Two of the studies did not appear to involve interviewing children and caregivers directly; the studies were of the satisfaction of child protection workers' consultation with a multi-disciplinary team. These teams involved a mix of social work, medical and mental health professionals; none were co-located and none involved advocacy or interviewing. The one site with no significant effect or a negative significant effect had the full complement of CAC agencies, a high level of co-location, and interviewing by a CAC specialist interviewer.

The four sites that identified improvements in caregiver satisfaction were all CACs compared to demographically equivalent counties in the same state (Cross et al., 2008). All sites had police, child protection, prosecutors, advocates, mental health, and medical personnel as part of the response; most of the other agencies/workers were co-located at all sites, but police and child protection were only co-located in two sites. Three of the four sites held a weekly MDT, with the other holding MDTs as needed. All had joint interviewing, with three relying on independent interviewers, and one using a police interviewer. The sites were evenly split in terms of providing services on site, and providing services through external referral. All sites had an independent advocate.

Key Messages:

- The finding of improved caregiver satisfaction included only one study with four different CAC sites.

Table 15. Characteristics of MDTs Effective at Satisfaction Measures

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Jones, Cross, Walsh, & Simone (2007); **Site 1 (Charleston, South Carolina)**	Physical, Sexual Abuse, and Neglect	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Site 2 (Pittsburgh, Pennsylvania)	All Abuse & Neglect	Hospital Based CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	As Needed	Independent CAC Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 3 (Huntsville, Alabama)	Sexual Abuse and Severe Physical Abuse	CAC	Police (Police conduct Interviews) Child Protection Prosecutors Advocacy Mental Health Medical	Police Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Police Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 4 (Dallas, Texas)	Sexual Abuse and Severe Physical Abuse	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations

Goldbeck et al. (2007)	Sexual, physical and emotional abuse, and neglect.	Expert Assisted Case Management	Child Protection Mental Health Medical	None	Multiple Case Conferences – First within 4 Weeks of a report	None	External Referral	No	Practice as Usual Without Consultation with a Multi-Disciplinary Team
Lalayants et al. (2011)	All Abuse & Neglect	Multi-Disciplinary Consultation with a CPS Team	Child Protection Mental Health Medical Domestic Violence Counsellors Substance Abuse Councillor	Unknown (Varies across 12 teams)	As needed	None	Unknown	No	Practice as Usual Without Consultation with a Multi-Disciplinary Team
Studies with No Significant Effect or A Negative Significant Effect									
Walsh et al. (2007)	Physical, Sexual Abuse, and Neglect	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations

Medical Referral and Improvement in Medical Symptoms

Again, very few studies examined outcomes related to medical referral and improvement in symptoms, but all those that did found MDTs compared to practice as usual were significantly more likely to result in the receipt of medical services.

Table 16. Significant Findings on Medical Referral between Teams and Comparisons

	N	Comparison Group	Types of Abuse in Study	Significant Findings	Null Findings
CAC Based Team (Or Similar)					
Edinburgh, Saewyc, & Levitt (2008)	256	Different Intake	Child Sexual Abuse	Receipt of physical exam, genital exam (when indicated), and receipt of Post-Exposure Prophylaxis Positive genital trauma findings	
Smith, Witte, & Fricker (2006)	76	Different Intake	Physical and Sexual Abuse	Receipt of medical examination	
Walsh et al. (2007)	143	Comparison Community	Child Sexual Abuse	Receipt of medical examination	
Hospital Based Team					
Chomba et al. (2010)	2863	Comparison to Pre-Team	Child Sexual Abuse	Completion of Post-Exposure Prophylaxis	

Components of an Effective MDT for Medical Service Outcomes

From the four studies identified in the review that examined medical referrals in an MDT against a non-MDT response, all studies found that MDT responses were beneficial on some outcome. This left five studies with seven individual intervention sites. Seven sites identified improvements in medical services, primarily related to the receipt of forensic medical examinations, and the receipt of needed medical care following sexual assault/abuse). Three of the sites were hospital based, and all but one were CACs.

These sites had a large proportion of other agencies co-located. All seven of the sites had medical personnel involved in the response, and six had medical personnel co-located[4]. All but one site also had mental health services involved in the response, and these workers were usually co-located. Most of the sites had in-house support services (*n* = 4), and all but one site had an independent advocate. Four sites had independent interviewers, with two sites where medical professionals conducted interviews, and one where police interviewed children.

Key Messages:

- Sites that were effective in improving the receipt of medical services tended to have medical personnel co-located, and other therapeutic and support services on site.

[4] For one study the article was not clear on which agencies were co-located.

Table 17. Characteristics of MDTs Effective at Improving Medical Referral Outcomes

	Types of Cases	MDT Type	Roles Involved	Co-Location of Staff	Case Review	Child Interviewing	Referral to Support Services	Advocacy Role	Comparison Condition
Studies with a Positive Significant Effect									
Chomba et al. (2010)	Child Sexual Abuse	One-Stop Centre in a Paediatric Hospital	Police (Victim Support Unit) Advocate (Hospital Social Worker) Medical (Clinical Officer, Nurses) Lawyer	Police (Victim Support Unit) Advocate (Hospital Social Worker) Medical (Clinical Officer, Nurses)	Frequency Unknown	Interview by Medical Professional Joint Interviewing	In-House (Hospital Based MDT)	No	Pre-Implementation of a Joint Team
Walsh et al. (2007) **Site 1 (Charleston, South Carolina)**	Physical, Sexual Abuse, and Neglect	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Site 2 (Pittsburgh, Pennsylvania)	All Abuse & Neglect	Hospital Based CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	CAC Interviewer Prosecutors Advocacy Mental Health Medical	As Needed	Independent CAC Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations
Site 3 (Huntsville, Alabama)	Sexual Abuse and Severe Physical Abuse	CAC	Police (Police conduct Interviews) Child Protection Prosecutors Advocacy Mental Health Medical	Police Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Police Interviewer Joint Interviewing	In-House Therapeutic Services	CAC Advocate	CPS Investigations

Site 4 (Dallas, Texas)	Sexual Abuse and Severe Physical Abuse	CAC	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Police CAC Interviewer Child Protection Prosecutors Advocacy Mental Health Medical	Weekly	Independent CAC Interviewer Joint Interviewing	External Referral	CAC Advocate	CPS and Police Investigations
Edinburgh, Saewyc, & Levitt (2008)	Physical and Sexual Abuse	Hospital Based CAC	Mental Health Medical Advocacy	Mental Health Medical Advocacy	Unknown	Medical/Mental Assessment – No Forensic Interviewing	In-House Services	CAC Advocate	Non-CAC Police Investigation
Smith, Witte, & Fricker (2006)	Sexual Abuse and Severe Physical Abuse	CAC	Police Child Protection Medical Mental Health Prosecutor Advocate	Unknown	Unknown	Independent Interviewer Joint Interviewing	Unknown	CAC Advocate	Non-CAC CPS Cases

Studies Examining the Effect of Degrees of Multi-Disciplinary Responses on Outcomes

Eight studies found that increasing the degree of collaboration between various agencies results in improved outcomes (e.g. increased mental health service use). For five of these studies this involved large data sets across states and counties in the United States to examine the effect of collaboration on mental health service use. These studies used various factors to rate the degree of collaboration associated with a case; factors which reflect the operation of an MDT model (See Table 18).

Table 18. Studies of Effective Multi-Disciplinary Responses Across Areas

	Types of Cases	Significant Outcomes	Null & Negative Outcomes	Collaborative Factors
Bai, Wells, & Hillemeier (2009)	Children with Mental Health Problems and Contact with CPS	Mental Health Service Use Improvements in Mental Health		Number of inter-organisational relationships, defined as: Joint budgeting or resource allocation; cross-training of staff, working with the agency on child welfare cases, development of interagency agreement and memoranda of understanding; joint planning/police formulation for service delivery; discussion and information sharing
Chuang & Lucio (2011)	Children with Mental Health Problems and Contact with CPS where information on school support staff was available	School based mental health service use Outpatient mental health service use	School based mental health service use (Negative findings associated with co-location) Outpatient mental health service use (Negative findings associated with co-location)	Different levels of ties between agencies defined as: Having a care coordinator position or committee to ensure coordination; cross-training of staff, co-location of staff, sharing records, sharing management information systems or access to management information systems.
Chuang & Wells (2010)	Children involved with Child Welfare, with mental health symptoms, and involvement with juvenile justice.	Inpatient mental health service use	Outpatient mental health service use (Collaboration and linked databases) Inpatient mental health service use (Collaboration)	Differing levels of inter-organisation relationships defined as: Designation of agencies accountability (whether care for youth was under joint, child welfare, or juvenile justice control); whether shared information arrangements exist; number of ties between agencies (discussion and information sharing), development of interagency agreements and MOU; joint planning or policy formation for service delivery; cross training of staff; joint budgeting or resource allocation.
Cross, Finklehor & Omrod (2005)	Physical, Sexual, and neglect cases	Any service provision or referral (physical, sexual abuse, & neglect)	Receipt of services for parents (physical abuse) Receipt of services for children (neglect) Increased out of home placement (physical, sexual abuse)	Differing levels of inter-organisation relationships defined as: Police involvement in child protection investigation; Police involvement in placement

		Receipt of services for parents (sexual abuse & neglect) Receipt of services for children (physical & sexual abuse) Out of home placement (neglect)		decisions for the safety of children.
Hurlburt et al. (2004)	Children that have had contact with statutory child welfare	Mental health service use		Degree of coordination between local child welfare and mental health agencies: Colocation of child welfare and mental health services, existence of a formal child welfare committee that reviews mental health service use on a case-by-case basis, shared office space, joint service provision at the caseworker level, and joint training.
Miller & Rubin (2009)	Suspected Child Sexual Abuse (Although the CACs varied in terms of accepting referrals for child abuse and neglect)	Felony prosecutions for CSA		Districts with high and low CAC concentrations.
Ruggieri (2005)	Allegations of Child Sexual Abuse (State Level)	Substantiation of CSA Prior Victimisation		States with a high number of CACs compared to states with a low number of CACs.

Three other studies explored the effect of CAC concentration on criminal justice outcomes. Miller & Rubin (2009) explored whether more CACs were associated with more prosecutions, while Ruggieri (2011) found that higher concentrations of CACs were associated with higher rates of substantiation of child sexual abuse, which was attributed to improved reporting and investigation of incidents. Ruggieri (2011) also examined prior victimisation for child victims between states, examining whether prior responses in high CAC states were more likely to reduce repeated victimisation.

Key Messages:

- Having increased characteristics of an MDT response (i.e. discussion and information sharing sessions, having a care coordinator) was found to increase rates of mental health service use, and the police substantiation and prosecution of abuse;
- These studies did not examine the relative contribution of the different factors to effectiveness, all studies treated these different factors as cumulative (e.g. the more factors the greater the number of inter-organisational ties);

- High concentrations of CACs were found to be associated with improved criminal justice outcomes; however these studies don't provide any analysis of the characteristics of these centres, only their concentration within that state/district.

3.5 Section Summary

This section provides an overview of the existing research evidence for MDT responses. It needs to be acknowledged that there is a lack of systematic research and evaluation of approaches; much policy development and practice occurs without consulting or contributing to existing research and knowledge of effective interventions. Much of the research in this field has limited utility in order to draw conclusions about the effectiveness of approaches relative to others. In particular, the lack of description of comparison conditions limits the degree to which particular mechanisms can be identified as being essential for particular outcomes. As discussed above, much of the research identified in the review was either qualitative (and lacked a comparison to other practice), or provided outcomes data with no comparison group. Also problematic is the lack of research reporting on the characteristics of interventions.

Broadly, the studies identified by the search provide some evidence for the effectiveness of multi-disciplinary teams on most of the outcomes discussed, although there are gaps in terms of high quality studies amongst a few types of outcomes, particularly around child and family wellbeing.

While the review suggests that broadly MDTs are effective at improving a variety of outcomes, the review highlighted that there is a lack of evidence for specific components of the MDT response. Across outcome types, most MDTs that have a positive effect on outcomes had police, child protection, prosecutors, medical and mental health workers as part of the response, with most sites having medical and mental health workers co-located; it was less usual to have government agency workers co-located. Most of the effective sites had independent interviewers and independent advocacy. There was a mix in terms of whether medical and therapeutic services were provided on-site.

Key Messages:

- Most studies found a positive effect of MDT approaches in terms of criminal justice outcomes. Older studies tended to be more likely to find differences and outcomes were more likely to be significantly different earlier in the criminal justice process;
- The review was limited by the lack of description in studies for the conditions MDT interventions were compared against;
- Older studies tended to find reductions in the number of interviews children were exposed to, while newer studies tended to not find any difference between the MDT and standard practice. This may be attributable to greater awareness of child victim needs and/or evidence-based interviewing protocols being adopted in standard practice;
- Most studies found a positive effect of MDT approaches in increasing mental health service outcomes;
- Studies were mixed in terms of finding increased rates of child protection substantiation and action. Most studies which included child protection outcomes found faster child protection responses;
- Many studies included variables that were more like outputs (e.g. number of interviews) than outcomes (e.g. charges). Results were mixed in terms of measures of collaboration;

- An MDT response was consistently associated with increased staff satisfaction. Results were mixed for caregiver satisfaction. One study found no difference in satisfaction for children. The authors of this report would suggest client satisfaction measures relating to MDTs be interpreted with caution due to concerns about the validity of these measures.
- Many studies included did not evaluate individual MDTs, they evaluated thousands of cases from different types of multi-disciplinary responses – finding in particular that increased elements of MDT practice (e.g. having a care coordinator, co-location of agencies) was associated with increased mental health service receipt;
- Two studies found that states and districts with high concentrations of CACs were found to be associated with improved criminal justice outcomes;
- Across sites of MDTs found to be effective in improving criminal justice outcomes almost all had provision for cross-agency observed interviews of children, which were usually conducted by an independent interviewer supervised by statutory agencies (e.g. Police, child protection).
- Most models found to be effective included advocacy, advocates tended to be independent although there were some examples of advocacy staff provided by child protection authorities and state prosecutors offices;
- Advocates tended to be located on-site. The majority of effective MDTs also included co-located medical and therapeutic services. Relatively few sites had police and child protection agencies co-located.
- Sites that were effective in improving the receipt of medical services tended to have medical personnel co-located, and other therapeutic and support services on site.

4. HOW ARE MULTI-DISCIPLINARY TEAMS STRUCTURED IN AUSTRALIAN AND COMPARABLE INTERNATIONAL JURISTICTIONS?

MDT models are diverse, with structures adopted for different purposes and to reflect the socio-legal, demographic and historical conditions of the jurisdiction. This section will begin by briefly summarising cross agency practices in Australian jurisdictions, focusing on jurisdictions that have clearly identified formal arrangements for collaborative practices (i.e. cross-agency teams or centres). Following this, the section will discuss variations within the Child Advocacy Centre (CAC) model in the United States, drawing on the results of a survey of CAC directors. The section will then examine models in other comparable jurisdictions including New Zealand, Canada, the United Kingdom and Europe. Finally, the section will position the JIRT model within the context of the structure of other models internationally.

4.1 Multi-Disciplinary Teams/Centres in Australian Jurisdictions

Report 1 to the NSW Ombudsman provides a more detailed summary of cross-agency practices across all Australian jurisdictions (Herbert & Bromfield, 2017c). This - Report 2 to the NSW Ombudsman – focuses on summarising approaches that involve a structured team or centre based response. Both reports attempt to distinguish between types of responses that we have termed:

(a) Informal Collaboration – Information sharing and collaboration between organisations involved in the response is informal and relies on individual workers to build trust and rapport;

(b) Inter-Agency Agreements – Agreements across agencies to a protocol or process for information sharing and response planning, but agencies still work and operate individually;

(c) Multi-Disciplinary Teams/Centres – Agreements across agencies to operate as an integrated cross-agency team, which can operate virtually (e.g. by phone), in a shared professional space, or victim focused space.

This section will focus on multi-disciplinary teams/centres, while recognising that often there is a fine line between inter-agency agreements, and integrated team based approaches. Moreover, there is often a difference between the stated models and how models operate in practice, particularly for state-wide approaches that may vary from place to place (i.e. between urban, regional and remote areas).

In terms of MDT models in use in Australian jurisdictions (Table 19), the main examples included in this discussion are: The Multiagency Investigation & Support Team (MIST) in Western Australia; the Multi-Disciplinary Centres in Victoria; Child Abuse Squad/ChildFIRST in Western Australia; the Child Abuse Taskforce in the Northern Territory; the Suspected Child Abuse & Neglect (SCAN) Teams in Queensland; the State-Wide South Australia response; and the Wraparound response in the ACT. These responses differ on a number of characteristics, but particularly in terms of the types of cases that receive a cross-agency responses, and the stage at which the response occurs.

Table 19. Summary of Response Types in Australia Jurisdictions

State	Specialist Police Team	Agencies Involved in Response	Centre Based Approach[1]	Memorandum of Understanding	Specialist MDT Response Name
New South Wales	**Yes** Child Abuse Squad	Police Child Protection Health	**Yes**[2]	**Yes**	Joint Investigation Response Team Model
Victoria	**Yes** Sexual Offences and Child Abuse Investigation Teams	Police Child Protection Health NGO Support Service (For MDC Sites)	**Yes** (For areas with an MDC)	**Yes**	Multi-Disciplinary Centres (MDC)
Queensland	**Yes** Child Protection & Investigation Units Child Safety & Sexual Crime Group	Police Child Protection Health Education	**No**	**Yes**	Suspected Child Abuse and Neglect (SCAN) Teams
Western Australia	**Yes**[3] Child Abuse Squad & Sex Assault Squad	Police Child Protection Health NGO Support Services (For Pilot Site)	**Yes** (For single pilot site)[4]	**Yes**	Child Abuse Squad/ChildFIRST Multiagency Investigation & Support Team (MIST)
South Australia	**Yes** Special Crimes Investigation Branch	Police Child Protection Health	**No**	**Yes**	
Tasmania	**No** Criminal Investigation Branch	Police Child Protection	**No**	**Yes**	
Australian Capital Territory	**Yes** Sexual Assault and Child Abuse Team	Police (Territory & Federal) Child Protection Health Public Prosecutions NGO Support Services	**No**	**Yes**	Wraparound
Northern Territory	**Yes** Child Abuse Taskforce	Police (Territory & Federal) Child Protection	**Yes**	**Yes**	Child Abuse Taskforce

[1] Cross-agency team operating out of a single centre, which also has facilities for interviews with children.
[2] Note: 11 of 22 JIRTs are fully co-located.
[3] Regional/Remote responses are conducted by the local detective team rather than a specialist squad.
[4] Child Protection and Police are co-located in the metro response, but this does not include the statutory child protection workers who have responsibility for the case. Child Protection workers only undertake interviews of children in this model.

Cross-Agency/Inter-Agency Responses in Australian Jurisdictions

Table 20 provides a brief comparison of the core characteristics of MDT teams/centres in Australian jurisdictions, focusing on the structures and processes built into these arrangements designed to enable cross-agency working, and coordinated responses and follow-ups for children and their families affected by abuse.

Table 20. Summary of Characteristics of Cross-Agency/Inter-Agency Responses

	Target Group	Co-Location of Agencies	Joint-Interviewing	Connection to (Non-Statutory) Support Services	Advocacy and Follow-Up	Localised Regional/Remote Response
JIRTs (NSW) State-Wide Response	Allegation of severe child abuse[1]	Child Abuse Squad FACS NSW Health 11/22 JIRTs are in shared office spaces, the remainder have separate offices in close proximity (NSW Police and NSW Health are now also based at an additional site in the Far South Coast)	Police, FACS, and NSW Health participate in Joint Interview Planning as Part of the Local Planning Response FACS and NSW Health Agencies able to observe interviews and provide feedback about any care and protection or clinical issues that may have arisen via an earpiece, where not present in the interview room, or during a break in the interview, unless there are valid reasons for a break not to occur in a particular case	Health Clinicians provide referral to Sexual Assault Centres and other health services (NSW Health)	Some support and follow up provided by Health Clinician	**Yes** State-wide response Including regional/remote. Some regional sites receive a fly-in response from another nearby JIRT where NSW Health or FACS are not already based there
MDCs (Victoria) 6 Pilot Sites	Allegation of severe child abuse in six Pilot sites: Dandenong, Seaford, Mildura, Barwon, Bendigo, Latrobe Valley[2] Centres also provide services for adult victims of sexual assault within the Pilot sites	SOCIT (Victoria Police) Victorian Department of Health and Human Services Centres Against Sexual Assault	Both police and child protection agencies should be present for an interview, Child Protection primarily to observe. CASA Counsellors/Advocates do not usually attend the interview, but are available to provide support if a child becomes distressed	In-House Sexual Assault Workers (Counsellors/ Advocates) provide counselling services and other support work	Counsellors/Advocates undertake a dual role in providing counselling services, and information and advocacy on legal, medical, and social issues	**Yes** MDCs are a Pilot and four of the six Pilot sites are in regional centres: Mildura, Barwon, Bendigo, Latrobe Valley

State-Wide Response Queensland	Ongoing Child Safety Services action and determination is made by Child Safety Services that coordination is required to assess and respond to protection needs	None	Where a joint interview occurs (police & child protection) Child Safety Services workers can participate in interview planning, and to an extent in the interview A corroborating officer from the Child Safety & Sexual Crime group, and a representative from Child Safety Services (if child is in need of protecting) are recommended to be present	Facilitated referral through the Police Referrals System Queensland Health to identify and refer to appropriate support services for children and young people. Child Safety Services, Education, Recognised Entities, and NGOs can also make these referrals	Follow up depends on ongoing engagement with Child Safety Services	**Yes** State-wide response including regional/remote
MIST (WA) Pilot Site	Intra-Familial (and person in position of authority) Sexual and Severe Physical Abuse Offences against a child under 13 in the Cannington/Armadale Catchment Area (the Pilot site)	Child Abuse Squad Detectives and Interviewers (WAPOL) ChildFIRST Interviewers (CPFS) District Worker (CPFS) Child & Family Advocates (NGO) Therapeutic Services Staff (NGO)	Interview planning occurs between the interviewers (police & CPFS), the investigating officer, and the in-house child protection worker. The other interviewer (police or CPFS), investigating officer, and child protection worker are able to observe the interview and provide feedback during a scheduled break	Child and Family Advocates connect children and families to in-house and local services	Child and Family Advocates provide a comprehensive support service from the point of interview until the service is no longer needed. Inclusive of cases that don't continue through the criminal justice system	**No** MIST is a Pilot and only applies to Cannington/Armadale Police/CPFS districts of the Perth metro area
CAS/ChildFIRST (WA) Perth Metro Response	All Perth metro cases of suspected sexual abuse and physical abuse above the threshold of grievous bodily harm (with the exclusion of cases within the MIST Pilot site)	Child Abuse Squad/Sex Assault Squad (WA Police) ChildFIRST (CPFS) Child Protection Service	Interview planning occurs between the Police and CPFS interviewers An interviewer from the other agency (police or CPFS) observes the interview and is able to provide feedback during a scheduled break	Suggested referral to WA Health and NGO Services (including CPFS Funded Child Sexual Abuse Therapeutic Services)	Follow up dependent on Police and CPFS involvement in case	**No** Some priority regional cases will require attendance at CAS/ChildFIRST in Perth. Otherwise a separate local response applies with general CPFS and Police staff
State-Wide South Australian Response	Interagency code of practice applies to all types of abuse and neglect; Families SA will refer to SAPOL for sexual abuse, serious neglect or	None	(Under 7 year olds) – Interview by Child Protection Service (SA Health) Investigating Officer and Worker from the Department of Child	Facilitated referral by CPS – Other agencies should routinely refer to CPS to coordinate services. In-house services at	Follow up depends on ongoing engagement with the SA Department for Child Protection	**Yes** CPS interviewing and services limited to two sites in Adelaide metropolitan area In regional/remote areas investigations are undertaken by district detectives rather than the SCIB

	physical abuse – The responding police group will vary based on the nature of the concern/risk		Protection are able to observe the interview (7-14 year olds) – Interview by investigating officer or by the Victim Management Unit (SAPOL) The Recording of the interview can be made available to other agencies with permission from the Investigating Officer. (Children over 14) – Interview in the form of a written statement verified by declaration (conducted by investigating officer)	Adelaide Women and Children's Hospital Suggested referral by SAPOL; In some cases a victim contact officer will make facilitated referrals		
Wraparound (ACT) State-Wide Response (Opt-In by Families)	Sexual offences (both adult and child offences) in the ACT in which families were offered and consented to Wraparound.	None – Mobile counselling and support service offered at police interviews	Investigators conduct their own interview planning however they often seek information and input from CYPS where appropriate. In some instances, CYPS are able to view interviews in real time from an external monitoring room.	Support agencies part of the wraparound case review process	Follow up provided to children and families that consent to the wraparound response	**Yes** Territory-Wide Response
Child Abuse Taskforce (NT) State-Wide Response	Complex Abuse, Sexual Abuse, Severe Physical Abuse and Neglect – Harm involving multiple abusers and or victims in the NT	NT Police Australian Federal Police Territory Families	Investigating officer conducts the child interview in a safe place for the child	Suggested Referral to Sexual Assault Referral Centres (NT Health) & NGO Providers	Follow up depends on ongoing engagement with Territory Families	**Yes** Two sites cover the state (North & South) Mobile Child Protection teams are used for regional/remote responses

[1] Alleged child sexual abuse, extreme neglect (e.g. malnutrition/dehydration), and severe or serious alleged physical abuse (e.g. extensive soft tissue injuries, head injuries, fractures, burns).

[2] Rapes of children (suspect known), rapes of adults strangers/ known persons) and indecent acts (including sexual penetrations) upon children, elderly and disabled persons that involves high level of violence or unusual modus operandi; Rape/attempt/assault with intent to rape by a stranger; All allegations of child abuse where the offending occurs in intra-familial environment (family violence); Joint investigations with Child Protection and other stakeholders in respect to child abuse.

Based on MDT components identified in Table 20, New South Wales has the most comprehensive state-wide MDT type response, inclusive of police, child protection and health. Pilot sites operating in Western Australia and Victoria at the time of writing provided equivalent centre based responses, with the addition of built in support services provided by the not for profit sector. The Northern Territory also has two co-located centres with integrated Police and Territory Families teams that provide a territory wide response. Some other jurisdictions have state-wide team-based approaches with processes to support the coordination of responding agencies (i.e. Queensland), but without the use of cross-agency centres for the response. South Australia and the Australian Capital Territory have a specialist response for cases within parameters (i.e. under seven years old; families that consent to the wraparound response).

Joint Investigation Response Team (JIRT) Model – New South Wales

The Joint Investigation Response Team (JIRT) model provides for a state-wide centre based response, including specialist police (Child Abuse Squad; CAS), child protection (Family and Community Services), and health agencies (NSW Health). Around half of the 22 JIRTs[5] (all Sydney metropolitan and major regional centres) are fully co-located with all three agencies based on site. Most sites also include police interview suites with observation rooms either on-site or nearby at the local Child Abuse Squad building; where such suites are unavailable or it is not practical that they be used these interviews also occur at schools, Community Services Centres, homes, hospitals or other community facilities. Dedicated interview suites are usually designed to reduce potential distractions to the child, but all are set up to be a safe and comfortable space for children.

Matters considered for a JIRT response come through a mandatory reporting system for children or young people at risk of significant harm (Family & Community Services Helpline); matters are assessed and triaged by all three agencies at the JIRT Referral Unit (JRU) as to whether the matter meets the JIRT Referral Criteria. Referrals are then sent out to the local JIRT Unit (where the victim resides) within care & protection timelines and a response (in line with JIRT Local Planning & Response Procedures) is provided, the response includes a seven stage process:

1. *Accepted Referrals*: Matters are transferred from the JRU to the JIRT unit, which involves transferring referrals through the JIRT Tracking System and across each agency's databases and notifications systems;
2. *Pre-Meeting Briefing on Contact (for high risk matters)*: The three agencies should consult prior to any contact with the child, young person and/or non-offending carer/s, except where a police response is required urgently and/or outside of business hours);
3. *Information Gathering, Recording and Sharing*: Each agency reviews their agency's information holdings on the matter and may share with the other agencies at the Briefing Meeting information relevant to the safety, welfare and wellbeing of a child, young person or class of children or young persons pursuant to the Children & Young Persons (Care & Protection) Act 1998;.
4. *Briefing Meeting*: Each agency shares relevant information to inform the investigative response regarding the safety, welfare and wellbeing of the child or young persons, which includes developing a Safety Welfare and Wellbeing Summary (SWWS);
5. *Interview Planning*: Police should develop an Interview Plan prior to interviewing the child or young person. The NSWPF is responsible for conducting electronically recorded police interviews with victims and witnesses. This is important for police to be able to discharge

[5] We note that NSW Police and NSW Health now operate from an additional Far South Coast site.

their functions under the JIRT MoU, and ensure the integrity of any related criminal investigations or prosecutions; however (this) should in no way detract from the equally important, albeit separate functions, that FACS and Health perform in relation to assessing issues of safety, risk, health and wellbeing. FACS and Health are able to electronically monitor (or review) interviews and are able to ask further questions at the conclusion of the interview to clarify any care, protection or clinical issues not already canvassed by police however this does not need to be electronically recorded;

6. *Debriefing Meeting*: Following the field response, the agencies are to discuss and share information on the outcome of their response, and plan ongoing actions; and
7. *Case Meetings:* Allows for agencies operating under the JIRT model still involved with the child, young person or family, to share relevant information that may assist to ensure that future action is appropriate and continues to address the child or young person's needs, including a review of the SWWS.

Health Clinicians from NSW Health provide referrals to forensic medical services, as well as to counselling and therapeutic services and other NSW Health resources services in the community. These clinicians also provide a supportive role for victims and their families when they attend police interviewing, and advice about the mental health and wellbeing of the client to Police and FACS in order to promote a trauma informed process where victims are engaged and willing to participate in the investigation.

Multi-Disciplinary Centres – Victoria

The Multi-Disciplinary Centres (MDCs) are a pilot centre-based response inclusive of the Sexual Offences and Child Abuse Investigation Teams (SOCIT; Victoria Police), Victorian Department of Health and Human Services, Centres Against Sexual Assault (NGO), and the Victorian Institute of Forensic Medicine. At the time of writing, the centres were operating as pilot sites in six areas: (Barwon, Dandenong, Melbourne Metro, Frankston, Tamar Valley, La Trobe Valley). The MDCs work with children who have and have not disclosed abuse, meaning different responses are available depending on if the case will be criminal justice focused, or where there is suspected abuse and counselling needs and the initial aim is to have services in place to improve the potential for the disclosure of abuse. The service is also focused on non-offending family members.

The MDCs are a co-located centre based response inclusive of the criminal justice, child protection, and mental health response. MDCs work with both adult and child victims of child sexual abuse, with separate processes that operate for child based offences inclusive of child protection statutory authorities. The centres host joint child interviews, which are then used to help build engagement with families toward putting supportive services in place, which are available in-house. While dealing with both adults and children, the centres are set up to provide a child friendly environment for interviews and consultations. The Victorian Institute of Forensic Medicine provide forensic medicals to MDC cases, but are not currently on site. The NGO Centres against Sexual Assault provide counsellor/advocates who serve a dual role in providing direct support and in helping to arrange other support services as needed.

SOCIT and Child Protection (DHHS) undertake joint investigations and interviewing of children, with an assumption of continuous communication, information sharing and case planning through the process. Interviews can be conducted by either SOCIT, or Child Protection, but are generally conducted by police.

The role of the counsellor/advocate will vary depending on the circumstances of the case. As the MDCs deal with cases pre-disclosure, the counsellor/advocate can provide an 'options talk', and introduce some of the on-site police and child protection workers, which may facilitate disclosure. In the forensic response, the counsellor/advocate plays a role alongside the police and child protection workers to facilitate referrals to therapeutic services, provide information about what will happen, advocate for the interests of clients, and provide a holistic follow up service.

Key Features:

- Aimed at providing a comprehensive police, child protection and care response to cases;
- The MDC works with cases prior to the disclosure of abuse and involvement of statutory authorities. The aim of this is to help provide children and young people with options, or otherwise to put services in place to help children and young people get to the point of being able to disclose and provide for safety;
- In working with these pre-disclosure cases, statutory authorities can have an independent NGO do the initial work with children and families, while also being able to monitor and track any child safety concerns;
- Independent (Non-Government Employed) Advocate following the case from start to finish and for many different types of scenarios;
- Dual role of the counsellor/advocate;
- Referral to on-site or local support services, with ongoing support to address barriers to engaging with therapeutic services;
- Co-location and integration of SOCIT, Child Protection and CASA workers, with links to agencies that provide forensic medical examinations.

Child Abuse Squad/ChildFIRST - Western Australia

CAS/ChildFIRST (Formerly the Child Assessment and Interview team) is a joint response including the WA Police and the Department of Child Protection and Family Support (CPFS). Cases are received by a police intake team from several different streams (i.e. mandatory report, CPFS, Police districts, Department of Health) and brought to a duty team who then conduct a strategy meeting consisting of representatives from CAS and ChildFIRST (CPFS), the relevant Child Protection District staff (CPFS), and representatives from the Child Protection Unit at Princess Margaret Hospital. These meetings are typically scheduled once a week for each CAS team, but more immediate meetings can be scheduled if needed. While the investigating detectives and specialist child interviewers are co-located, the child protection worker and the Child Protection Unit are all based off-site and generally do not attend interviews with child witnesses.

If a child has not yet disclosed, the process will typically begin with a Child Assessment Interview, which is conducted by CPFS. If a child has already disclosed, or discloses during the Child Assessment Interview, then the matter would typically lead into a Visually Recorded interview. The interviews are conducted at a specialised facility in Perth, by an integrated team of specialist child interviewers from both Police and CPFS. The interview is typically conducted by two interviewers, one from each agency. In most circumstances the investigating officer and the assigned child protection worker will not attend the interview, but receive the recorded interview, and a summary of child protection issues respectively. Questions relevant to child safety and wellbeing are typically asked off-camera.

Child protection and police are co-located in the same building as the interview suites, however their

work is mainly integrated in terms of the interviewing teams; interviewers can be from either agency. Investigators are based on a separate floor, and the child protection workers who have responsibility for the cases are not on site. Interviews occur on the ground floor of the building, with entry to a child friendly common area, leading into the interview suites that are similarly child friendly and also aimed at minimising distraction.

Previously, referrals to support services were tasked to the interviewers who would provide a list of sexual assault support services. If involved in the case, district CPFS workers and sometimes also the investigating officer from CAS make referrals to supportive and therapeutic services. For children that require an acute forensic medical examination, these would occur at the Child Protection Unit at Princess Margaret Hospital. The CPU also offers a free comprehensive child sexual abuse counselling service at a child friendly office near the hospital. For cases going through the court system, the Child Witness Service will also arrange referrals to counselling services in addition to their court preparation and support role. Recently CPFS has introduced an advocate to the common area of the interview unit to provide support to families attending for an interview.

The CAS/ChildFIRST response includes only cases in the Perth metro area, the regional/remote response in Western Australia, is similar in terms of process (e.g. strategy meetings) but operates at a local level. In some situations children may be flown to Perth for an interview, or in some cases interviewers and CAS detectives may be sent to a regional area to provide a response. In most cases the regional response involves district police and CPFS.

An additional pilot (as well as MIST) is currently underway in Child Abuse Squad. Responding to complaints about the quality of interviewing and from senior staff observations of practice in New South Wales, some police specialist child interviewers have been moved from the shared space at Child Abuse Squad, to share space with one of the Child Abuse Squad teams (CAS1). This co-location along with changing the detective allocation process to allow for CAS detectives to be involved in cases earlier, is hoped to improve the connection between interviewing and investigation, and improve response times. CPFS specialist child interviewers are currently permitted to observe these interviews, but not conduct them. CPFS district workers, who have responsibility for assessing the safety and wellbeing of children, still do not attend these interviews.

Key Features:

- Specialised child interview staff trained and managed within an integrated unit;
- Joint response involves CAS and ChildFIRST, and a strategy meeting with the CPFS worker that has responsibility for the case;
- Strategy meetings involving WA Police, CPFS, and Child Protection;
- Family support provided in common area of the interviewing unit by a child protection worker;
- Direct connection to child sexual abuse services for children that receive forensic medical examinations;
- Informal process of providing cold referrals to support, with responsibility across many workers, agencies and stages in the process and no return point of contact for families seeking advice on therapeutic services and supports.

Multiagency Investigation & Support Team (MIST) - Western Australia

The MIST pilot involves the co-location of a Child Abuse Squad (CAS) team (WA Police), police and

Child Protection and Family Support (CPFS) child interviewers, a CPFS worker (Working across two child protection districts), Child and Family Advocates (employed by Parkerville Children and Youth Care Inc.), and therapeutic support services at the same site in Armadale, Western Australia (Herbert & Bromfield, 2016a, 2017b). Working with cases primarily related to child sexual abuse (and some severe physical abuse cases), children and families located in or near the Armadale and Cannington (both in metropolitan Perth) communities receive what is intended to be a holistic response to abuse by a cross-agency, cross-disciplinary team tasked with undertaking criminal and child protection investigations, while also facilitating health services for the child, and therapeutic treatment and support for the child and their family.

The main structures for collaboration include *co-location* in a purpose built, locally situated, child friendly building with interviewing facilities on site. *Strategy meetings*, which take place after the initial intake processing[6] has occurred. Strategy meetings involve the investigating detective, the interviewer, the child protection worker, the Child Protection Unit at Princess Margaret Hospital, and team leaders at CAS/ChildFIRST, and are used to plan the response including the arrangements for undertaking an interview. The *interview process* then involves the interviewers greeting the child and family when they arrive at the centre, and bringing them up to a private family room. Once the child is comfortable with the surroundings, one of the interviewers will bring the child into an interviewing suite. The Child and Family Advocate will provide support and work to engage with the family, while the investigating officer and the in-house CPFS worker will observe the interview by closed circuit camera with the second interviewer. The co-location of these workers is designed to allow for easy cross-agency interview planning, post-interview discussion, and information sharing about the response.

A separate *multi-disciplinary care team meeting* occurs weekly to discuss the long-term care response needed for cases that have come in through the MIST process. This involves the advocates, the director of Therapeutic Services at Parkerville, and the CPFS worker. Police and other CPFS workers will occasionally attend these meetings. This meeting aims to develop plans to refer and engage children and families into needed services.

The role of the *advocate* extends from the point of greeting and providing support to the family at the interview, to following up with them and attempting to facilitate their engagement with therapeutic services, providing information on the investigation process, and potentially following the case through the court process.

While not in-house, the Child Protection Unit of Princess Margaret Hospital (PMH) is typically included in strategy meetings, particularly if a forensic medical examination is required. The CPU also has a counselling service on-site, which would be referred to if the MIST team have contact with cases where the child and family attending PMH (Perth City) would be more convenient for them. While the in-house CPFS worker represents the local child protection districts, this person's role is limited to undertaking Safety & Wellbeing Assessments. All other parts of the child protection process (e.g. if ongoing protective intervention is required) would typically be taken on by teams within those districts. Finally, the Child Witness Service (CWS) provides court support and preparation for children that are required to be cross-examined (by closed circuit camera) on their

[6] Initial intake occurs centrally as part of metro wide response and allocation processing. This initial processing concerns whether the alleged offence fits into the CAS charter, and whether the child resides within the MIST catchment area (Armadale & Cannington CPFS districts).

recorded testimony. The CWS is included as one of the agencies linked to MIST, but is operationally quite separate.

Key Features:

- Aimed at providing a comprehensive police, child protection and care response to cases;
- Independent (Non-Government Employed) Advocate following the case from start to finish;
- Referral to on-site or local support services, with ongoing support to address barriers to engaging with therapeutic services;
- Co-location and integration of investigating officers, CPFS workers, interviewers, and advocates as part of the initial response when cases are brought in for interview;
- Localised response, enabling the building of trust and rapport amongst police, CPFS, and community workers within a district;
- Two points of response planning: Strategy Meeting with government agencies for immediate investigation/child protection response planning; and a Multi-Disciplinary Team meeting for planning regarding longer-term safety, health and wellbeing needs.

Child Abuse Taskforce – Northern Territory

The Child Abuse Taskforce is a partnership between the NT Police, Territory Families, and the Australian Federal Police, with the co-location of police and child protection investigators, a centralised intake service, and an Aboriginal Community Resource Team. The intake process directs complex matters to the taskforce, and directs simpler matters to the police districts. The response operates out of two sites across the territory, with a mobile team operating in regional and remote communities.

Part of the role of the taskforce is community engagement, developing a sustained presence in communities to build confidence in reporting child abuse and neglect. Officers from the Child Abuse Taskforce meet daily with investigators from Territory Families to discuss intakes from the past 24 hours. While the support services are not directly part of the response, children and families are referred to specialist crisis services funded under the Victims of Crime Assistance Act.

Key Features:

- Aimed at improving case coordination and collaboration between statutory agencies;
- Proactive engagement with communities to help improve the reporting of child abuse and neglect;
- Joint investigations and information sharing between investigative agencies.

State-Wide Queensland Response

The State-Wide Queensland response involves inter-agency information sharing and communication at two levels. SCAN teams deal specifically with matters that are notifications by Child Safety Services, or Child Safety have responsibility for ongoing intervention, and that require coordination across agencies. The response primarily consists of SCAN team meetings, which are used to discuss the case, share information, and allow the team to plan their interventions. For matters that don’t reach the threshold of notification and receive a Child Concern Report, an Information Coordination Meeting (ICM) can be arranged to share information and discuss the case which may result in the matter being sent back through the Child Safety intake if there is an ongoing concern.

Suspected Child Abuse & Neglect (SCAN) teams differ from the responses described above in terms of not being co-located, and not being primarily designed around police investigation and interviewing of children in suspected/alleged criminal abuse cases. The SCAN response is aimed at sharing and coordination in complex child protection cases, rather than a process for joint investigations; agencies undertake their assessment and investigation independently. The SCAN team response is just one part of the cross-agency response in Queensland; policies existing for cross agency investigations between Child Protection & Investigation Units (Queensland Police Service), and Child Safety Services outside of the SCAN team framework.

SCAN teams involve specialist police (Child Protection & Investigation Units, & Child Safety & Sexual Crime Group), child protection (Child Safety Services), health and education agencies in their state-wide response; across Queensland 30 SCAN teams operate from 21 team coordination points. The Queensland Aboriginal and Torres Strait Islander Child Protection Peak can also be included in the response when an Aboriginal or Torres Strait Islander child is discussed.

In the State-Wide Queensland response, interviews are conducted by officers from the Child Protection and Investigation Units (Queensland Police Service), which are normally observed by a representative from Child Safety Services. Interviews occur in places as free of interruption and distractions as possible for the child, which include specialist interview suites in most major police stations. Outside of the SCAN system, Child Protection and Investigation units may work collaboratively with Child Safety Services through more informal arrangements.

Referrals to supportive services are managed by the Police Referrals System, this system creates a prompt for an external supportive service to directly contact children and families about services. Queensland Health will also identify and refer to appropriate services as part of their participation in the SCAN response.

Key Features:

- Aimed at improving communication and information sharing between agencies involved in responding to abuse;
- Information sharing and coordination process for cases that don’t meet the threshold to obtain more informed assessment of risk;
- Involvement of Aboriginal peak organisations and education in the SCAN team meetings;
- Information sharing and response coordination, with individual agency response.

State-Wide Response - South Australia

The response between agencies in South Australia is outlined in the Inter-Agency Code of Practice, primarily this provides a framework for case planning and information exchange between agencies and the specialist units within agencies. The process and investigating groups involved will depend on the nature of the offence and of the characteristics of the victim. These agencies/groups can include the police (Special Crime Investigation Branch, Local Service Area investigators and the Family Violence Investigation Groups within those LSAs), child protection (Department of Child Protection), and the Child Protection Service (Flinders Medical Centre & Adelaide Women and Children’s Hospital). The response occurs through structured strategy discussions which are used to exchange intelligence about a case, and plan the response across agencies; Department for Child Protection are responsible for convening intra-familial strategy discussions, while SAPOL convene extra-familial discussions.

The Child Protection Service (CPS) provides a specialist response for cases involving children under seven, with the Child Protection Service conducting forensic or therapeutic interviews psychosocial forensic assessments from Flinders Medical, and Adelaide Women and Children's Hospital. These assessments will also be conducted with older children with complex communication needs on request from either the Department for Child Protection or SAPOL, and Aboriginal children in rural/remote communities up to the age of 12. Assessment includes the appropriateness of interviewing children, which can also be conducted by the CPS worker This response involves a trained Child Protection Service worker conducting the interview, which is observed by members of the Special Crime Investigation Branch (SAPOL) and Department for Child Protection. Both CPS sites will provide referrals to supportive and therapeutic services, however Adelaide Women and Children's Hospital has services integrated into their unit. The CPS will usually undertake a caregiver interview prior to interviewing a child to better understand the context of the family and the allegation, and then conduct a child interview and parenting assessment with representatives from SAPOL and Department for Child Protection present.

For children 7-12 years old identified as having communication difficulties, interviews are undertaken by specialist police from the Victim Management Section within the Special Crime Investigation Branch of SAPOL. Otherwise children in this age group will be interviewed by the investigator (as long as the officer has completed the interview training). The Child Protection Service, Special Crimes Investigation Branch, and the Victim Management Section of SAPOL all operate from purpose built child interviewing facilities. Older children and young people will generally be interviewed by the investigating officer.

The investigating group from police will differ depending on the area and case characteristics. Local detectives will be response for investigations in rural areas, but can consult with police from the Special Crime Investigation Branch or Family Violence Investigation Section. The Special Crime Investigation Branch are a specialist service for sexually related crimes and serious offences against the person; this group will investigate tier 2 cases (primarily at risk of significant harm), while the Local Service Areas will respond to tier 1 cases (immediate danger).

Department for Child Protection will have ongoing case management responsibility, coordinating service delivery and ensuing the level of care is monitored, unless CPS, the Child & Adolescent Mental Health Service, or a non-government agency assumes responsibility.

Key Features:

- Aimed at providing a process for information sharing, and a specialised interview response for children and young people;
- Independent interviewer for under seven years old, specialist police interviewer from Victim Management section for 7-12 years olds where a communication difficulty is identified;
- Parent/Caregiver interview prior to child interview to better plan interview around the family context and specifics of the allegation;
- Comprehensive information sharing arrangements, including not for profit agencies and any other body that may have information.

Wraparound – Australian Capital Territory

The wraparound response is part of the Sexual Assault Reform Program in the ACT, and involves improving linkages between the agencies responding to sexual assault, inclusive of both adult and

child sexual offences. The reform process includes a mobile counselling service for adult and child victims who disclose abuse, and the wraparound process of information exchange between agencies. The wraparound response provides a process for information sharing and collaboration between agencies, as well as helping to build connection between the agencies involved in supporting victims. This response is primarily aimed at improving inter-agency practice in terms of support, rather than enhancing collaboration around interviewing and investigation.

The monthly wraparound meetings involve a comprehensive list of agencies including specialist police (Sexual Assault and Child Abuse Team & Federal Police), child protection (Care and Protection Services), health/medical services (Children at Risk Health Unit & Forensic and Medical Sexual Assault Care), supportive and therapeutic services (Canberra Rape Crisis Centre; Service Assisting Male Survivors of Sexual Assault), and prosecutors (Office of the Director of Public Prosecutions). The wraparound response is voluntary, and requires specific consent from victim/survivors.

Key Features:

- Aimed at improving information sharing, and coordinating the service response to sexual assault cases;
- Information sharing and collaboration with not for profit agencies involved in supporting victims;
- Reform package involved funding for additional support staff and an ongoing evaluation of reforms.

Summary of Cross-Agency Australian Jurisdictions

Broadly, Australia has a variety of cross-agency responses in place to respond to severe child abuse. The JIRT model in NSW is particularly noteworthy as a state-wide localised response with standard intake assessment through the JRU, and joint information sharing, and planning of responses at the local planning level.

The Multi-Disciplinary Centres in Victoria provide a comprehensive forensic response inclusive of supportive and therapeutic services within centres. These centres also provide a response for children that have not yet disclosed abuse, working to provide them with information about their options and to put services in place. The MIST pilot in Western Australia also provides a similar centre based response, with advocacy and support services on-site. The standard WA response, the Child Abuse Taskforce in the NT, SCAN teams in Queensland, wraparound in the ACT, and the state response in South Australia have elements of MDT responses that are built around processes of information sharing and response planning between statutory and government agencies. These responses differed in the degree to which agencies undertake joint investigation and assessment, the degree to which support agencies were involved in the information exchange, planning, and interviewing process.

4.2 Child Advocacy Centres in the United States

This report has drawn heavily on material related to CACs as these are the most established, researched and on the published literature, and appear to be the most common MDT model in use. A recent census of National Children's Alliance (NCA) members in the United States identified around 800 CACs (National Children's Alliance, 2016). This model has also been adapted for use in other countries; these will be discussed separately in section 4.3 as the model has been implemented differently in other countries.

CACs are based on 10 standards developed by the NCA as required to obtain the best result for children from the inter-agency response to child abuse (discussed in Section 2.4). CACs are generally aimed at improving forensic interviewing processes, and reducing the distress and uncertainty for children and families associated with the investigation of severe child abuse (Walsh et al., 2003). Many CACs also host therapeutic services or provide referrals to these services.

A survey was conducted in March 2016 to get a better understanding of the diversity of characteristics of CACs that exist in practice (Herbert, Walsh, & Bromfield, Under Review), recognising that much of the existing evidence base for this type of intervention reflects the full-scale 'one-stop shop' type CAC. Drawing on preliminary planning for a review of components associated with the quality of collaborations at CACs (reported on in section 3), directors of CACs were surveyed to find out what structures or processes they had in place to support effective collaborations. 796 directors of CACs on the National Children's Alliance's register were asked to participate in the survey between January-March 2016. 361 directors completed the survey (response rate = 45%).

Background of Respondents

The survey was sent to the directors of each of the CACs registered with the NCA. Directors of CACs are typically in charge of practice within the entity running the CAC, and in managing the relationships with the partner agencies associated with the CAC. The role may differ depending on the size and type of CAC, but directors were thought to be important respondents due to their central role in the day-to-day operations of the centre.

Participants reported working in the child abuse field for an average of 15 years, and had worked at their CAC for an average of 8 years. Participants most commonly had a background in social work (36%), with many others having a background in not-for profit management (18%), mental health (15%), law enforcement (5%), legal/public defender/public prosecutor (5%), and medicine (4%). Some directors indicated they were from other disciplinary backgrounds (17%) including education, journalism, community health, and financial services.

CAC Demographics

Most of the CACs in the sample had operated for more than ten years, with an average of 14 years. However, the mean or average can be somewhat misleading, when broken down further, most CACs had been operating for between 11-19 years (37%), or more than 20 years (27%). The respondents were well distributed across the United States with the highest proportions of CACs in the South (30%) and Mid-West (28%) regions of the United States. Many CACs in the sample were from a rural area (45%). Most CACs were set up as an NGO (52%) or operated as a program within an existing NGO (24%). Relatively fewer CACs were government run (14%) or were hospital based (9%).

Directors reported on both the number of children seen at the CAC per year, and the number of full-time equivalent staff members working at the centre. On average, centres saw 487 children per year, more than half of the CACs dealt with relatively small numbers of children from their community (i.e. less than 300 per year). A large proportion of CACs had relatively low numbers of staff (i.e. less than 4), while a smaller group of CACs had very high numbers of staff (e.g. more than 12).

Co-Location & Workers Involved in MDT Case Review Meetings

Participants were asked which multi-disciplinary team members were co-located at the CAC (see Table 21). Most CACs indicated that they had a forensic interviewer and victim advocate co-located at the CAC. A lower proportion of mental health professionals were co-located at the CAC (50%), and even fewer medical professionals/examiners were co-located (34%). Surprisingly, very few CACs had police (18%), child protective services (18%), or prosecutors (14%) co-located at the CAC, despite these groups being part of almost all CAC's MDT case reviews. The largest proportion of CACs reported having: 2-3 agencies co-located (43%), with similar proportions having 4-5 agencies co-located (20%), just one agency co-located (16%), or more than six agencies co-located (14%). Seven percent of CACs had no partner agencies co-located with them.

Table 21. MDT Workers & their Co-Location (N = 349)

	Are Co-Located[1,2] %	Routinely Attend MDT Case Review Meetings[3] %
Forensic Interviewer	71	95
Victim/Witness/Advocate Assistant	70	95
Mental Health Professional	50	90
Medical Professional/ Medical Examiner	34	79
Police	18	96
Child Protective Services	18	98
Prosecutors/ District Attorney	14	94
Rape Crisis Counsellor/ Advocate	12	30
Domestic Violence Counsellor/ Advocate	12	25
Other Agencies	8	26
Juvenile Court	1	35

[1]Note: 7% of participants indicated no agencies were co-located at their CAC.
[2] No response from 12 participants.
[3] No response from 15 participants.

Unsurprisingly, the main types of professionals associated with the CAC model (police, child protective services, forensic interviewer, victim advocate, prosecutors, & medical professionals) regularly attended most MDTs (see Table 21). Notable proportions of CACs included representatives of juvenile court (35%), rape crisis counsellors (31%), and domestic violence counsellors (25%). Directors also listed other types of workers that routinely attended their MDT (26%) including tribal liaison, substance abuse providers, school representatives, probation services, representative of a children's shelter, the Federal Bureau of Investigation, Guardian ad-litum, foster care services, public health, and Court Appointed Special Advisors (CASA).

Most CACs held case review meetings monthly (64%), smaller proportions held meetings every other week (22%), or weekly (12%). A small proportion indicated they held case review meetings less than monthly or just as needed (3%).

Agency of MDT Workers and Service Site

Separate from the issue of whether agencies were co-located, participants were asked about what services were provided on-site at the CAC (see Table 22). What this means in practice is that in some cases services were provided on site, but the agency/workers were not co-located at the CAC (i.e. the worker will travel from their office to the CAC to provide services). Across the CACs in the sample, most provided the key services of CACs on-site (i.e. forensic interview, and advocacy support). Almost all CACs provided on-site forensic interviews (90%), or provided both on and off site interviewing (9%). Similarly, most CACs provided advocacy services on-site (76%), or on and off site (16%), although 7% only provided the service off-site and 1% did not provide victim advocacy. The site of delivery of mental health services was much more mixed: on-site only (45%); on and off site (13%); and off-site only (36%). Similarly, for medical services about half of CACs delivered services on-site (43%) or on and off site (9%), but 43% provided services only off-site. This is significant due to some of the challenges in providing appropriate clinical governance for external services.

Table 22 Availability of Services (N = 349)

	Service Provided Only On-Site (%)	Service Provided Only Off-Site (%)	Service Provided On & Off-Site (%)	Not A Service Provided as Part of the CAC (%)
Forensic Interviewing	90	1	9	< 1
Victim/Witness/ Advocate/ Assistant	76	7	16	1
Mental Health Services	45	36	13	5
Rape Crisis Services	17	35	5	43
Domestic Violence Services	11	37	4	48
Medical Services/Examinations	43	43	9	5
Other (e.g. prevention, education, outreach)	26	10	5	59

The directors were asked about the proportion of services provided through their centre that involved staff of the CAC (see Table 23). In terms of forensic interviewing, most CACs used their own staff to conduct interviews with children (80%), although some also used representatives of partner agencies (36%). A high number of CACs indicated that they had victim advocates as CAC staff (78%), but most medical services and examinations were conducted by partner agencies (60%). Contractor services were most common for mental health services (18%) and medical services (22%). Similarly, most rape crisis, domestic violence, and 'other' services provided at CACs were delivered by partner agency staff.

Table 23 Service Agency (N =349)[1]

	CAC Staff Member (%)	Contractor (%)	Partner Agency (%)	Not part of the CAC (%)
Forensic Interviewing	80	6	36	< 1
Victim/Witness/ Advocate/ Assistant	78	2	38	1
Mental Health Services	38	18	56	5
Rape Crisis Services	13	2	45	42
Domestic Violence Services	9	2	46	45
Medical Services/Examinations	20	22	60	5
Other (e.g. prevention, education, outreach)	28	3	11	62

[1] Note: Participants were able to endorse more than one response, so totals do not add to 100%.

Forums to Address Interagency Conflict

CAC directors indicated that most often informal processes were used to address conflicts, namely the use of informal discussion between workers (67%). Case review meetings were also often used to resolve conflicts, either as an item at a regular case review meeting (54%), or as a separate case review meeting for discussing any difficulties (51%). CACs also used steering committees/advisory boards (40%), and CAC boards (21%) to address any difficulties. Some directors indicated that they used other (19%) forums to address issues, such as professional advisory committees, MDT department heads meetings, annual surveys, full-time partner relations staff, process improvement meetings, protocol committees, and policy and oversight committees. Most directors reported that forums to resolve inter-agency conflict were relatively infrequent, occurring less than monthly, or only as needed (70%).

Structural Characteristics Supporting Collaboration

CACs may have several different characteristics in place to support inter-agency collaboration. Only 35% of directors indicated that their CAC had a shared case tracking/data system to help them monitor the progress of cases across agencies. However, most CACs had a cross-agency steering group (60%), had state legislation in place to support cross-agency work (i.e. information sharing; 64%), and had joint performance measurement or evaluation of practice in place (70%). Most CACs indicated that they had a written protocol or interagency agreement on processes and practices (97%), an MDT Coordinator or a person that fits this description (91%), had regular informal contact and personal relationships amongst MDT members (93%), and engaged in joint training and professional development for multi-agency work (91%).

How do CACs Vary Across Urban/Suburban/Rural Settings?

Some differences in CAC characteristics emerged across area types (i.e. urban, suburban, & rural). Urban CACs were significantly more likely to have mental health services provided by a CAC staff member. Rural CACs were significantly less likely than other area types to have mental health

services provided by a CAC staff member, had fewer agencies co-located, and were less likely to have a cross-agency steering group. Surprisingly all other characteristics did not differ across area types suggesting that many rural CACs provide concentrations of services and workers like their urban and suburban counterparts.

Table 24. Crosstabs of CAC Characteristics by Area Type

		Urban	Suburban	Rural
Forensic Interviewing	On-Site vs. Off site	100%	98%	99%
	CAC Staff vs. not	83%	79%	78%
Victim Advocacy	On-Site vs. Off site	90%	92%	93%
	CAC Staff Member vs. not	71%	79%	80%
Mental Health Services	On-Site vs. not	65%	58%	50%
	CAC Staff Member vs. not	**49%**	**37%**	**32%**
Medical Services/ Examination	On-Site vs. not	55%	48%	48%
	CAC Staff Member vs. not	27%	21%	20%
Number of Co-Located Agencies		**0 Agencies (4%) 1 Agency (12%) 2-3 Agencies (32%) 4-5 Agencies (27%) 6+ Agencies (26%)**	**0 Agencies (9%) 1 Agency (10%) 2-3 Agencies (46%) 4-5 Agencies (20%) 6+ Agencies (14%)**	**0 Agencies (8%) 1 Agency (22%) 2-3 Agencies (47%) 4-5 Agencies (16%) 6+ Agencies (7%)**
Shared Data System		39%	35%	33%
Cross Agency Steering Group		**76%**	**70%**	**43%**
Joint Performance Measurement & Evaluation		66%	70%	72%

Summary of Child Advocacy Centres in the United States

The survey of CAC directors found that CACs were incredibly varied, and many differed significantly from the full-service flagship models featured in much of the evidence base of the approach (See section 2). That said, some of the core features of CACs (interviewing & victim advocacy), and features around supporting and fostering cross-agency work are almost universal. There were clear differences across CACs in terms of whether services were provided on-site at the CAC (mental health services, medical services/examinations, & other support services), the number of agencies co-located at the CAC, and whether services were provided by CAC staff members (mental health services, medical examinations, other support services).

Almost all CACs had several governance features including joint training and professional development, informal contact/personal relationships, an MDT coordinator, and a protocol or inter-agency agreement. The presence of shared data/tracking systems, cross-agency steering groups, and joint performance measurement and evaluation were much more variable. The lack of these governance features suggest that some CACs may have limited capacity to undertake effective

practice review, and may limit opportunities to discuss and action changes across agencies. Most CACs indicated that state legislation existed that supported their cross-agency work.

Observing these variations, there seems to be at least three types of CACs within the sample:

- *Basic CACs*: Providing core interviewing and advocacy functions and a framework and site for core agencies (i.e. law enforcement, child protection, prosecutors) to meet and collaborate on cases. While some staff operate from a centre, most of the partner agencies attend only for interviews and case review meetings. These centres may have limited capacity to provide follow-up support for attending children and families and primarily provide support on the day and referral to local services.
- *Aggregator CACs*: Centres that provide the core services, but also have the internal resources and infrastructure to connect children and families to external services in the community. These CACs are more likely to have some key roles undertaken by CAC staff members, have more agencies involved in the response, are more likely to have services on site, and have more formalized arrangements for collaboration (e.g. cross-agency steering groups).
- *Centralised Full-Service CACs*: Talked about as 'one-stop shops' for children and families affected by abuse. These CACs are most likely to have CAC staff providing mental health and medical services, have services provided on site, have many diverse partner agencies, many of them co-located, and is likely to have all the formal systems to support collaboration.

Relatively few CACs in the sample fit into the full-service category. For example, only 18% of CACs had police and child protective services co-located in the centre, only 38% of CAC staff provided mental health services, and only 52% of CACs had medical services/examinations on-site. It is possible that population density, service demand and/or availability of professionals impact on the extent to which a CAC is suitable for or implementable within different geographic areas; issues of relevance within the Australian context.

4.3 Multi-Disciplinary Teams/Centres in Comparable International Jurisdictions

While the CAC is certainly the largest body of practice organised under a practice model/approach, other similar models are in use in other jurisdictions. This section will briefly summarise some of the most prominent models in other jurisdictions.

Multi-Agency Safeguarding Hub (MASH) – United Kingdom

Compared to some of the approaches described above MASH are more broadly aimed at preventing harm to children, using the multi-disciplinary team approach to address child protection issues across different levels. While some of the CACs will also work with a broad set of cases where children may not have disclosed abuse, or there are early indicators of harm, these and much of the other models discussed above are oriented towards the forensic response to child abuse, and primarily child sexual abuse. MASH deal with cases in level 2-3 of the London continuum; meaning children showing early signs of abuse and neglect, and children with complex multiple needs.

The MASH model was developed as a single point of entry to the assessment of child abuse across agencies, providing a framework for agencies to share information and develop comprehensive plans for investigations and responses to abuse. This approach developed out of criticism of existing responses from the Munro report (Munro, 2011), that statutory child protection agencies were involved in the lives of many children and families that needed support, but not intrusive statutory

intervention. MASH provides care and support and oversight of families and attempts to prevent them from further escalation into higher risks of harm to children. While assessment processes vary between hubs, generally the response is separated into the following levels:

1. Referral to universal services;
2. Early help for coordination of service provision and/or advice between family and professionals;
3. Statutory assessment; and
4. Child protection investigation.

Like the CACs, there is considerable diversity in how these hubs operate, but they are all oriented towards providing an improved response to safeguarding children through facilitating information exchange between agencies. Generally, hubs require or encourage co-location between the core partners (child protection, police, health & education), but can involve a broad variety of agencies in information sharing and response planning.

Key Features:

- A central point of contact and referral with a cross agency response for cases at all levels of risk of harm;
- Planning and responses to reduce the severity of the situation for children prior to serious harm occurring;
- Diverts cases from the statutory child protection system while still providing services and care with oversight;
- Draws on information from all types of agencies that may be involved with the family to more accurately understand the context of the family, the risks and the protective factors that exist for children.

Canadian Child Advocacy Centres

The Canadian CACs are relatively new compared to centres in the United States with the first established in 1997; although many have developed from antecedent victim support models. In 2015, a report to the Canadian Department of Justice identified fourteen active CACs across Canada, with an additional eight in development and three at the stage of a feasibility study. The Canadian CACs follow similar principles to the CACs in the United States, but with a few key differences reflecting the different context they operate within. Many more of the Canadian CACs are government led, with federal funding to support the development of new CACs and the development of evaluation resources for the broader body of practice. In particular the Canadian Department of Justice is undertaking a long term multi-site study of CACs, and a study of how areas with no CAC fulfil the role of the advocate (McDonald, Scrim, & Rooney, 2016).

While currently not accredited by the NCA, the Canadian centres have been established with an aim for centres to be in line with the same standards as the United States. A recent internal report examined the degree to which a subset of facilities fit the NCA standards, and much like the CACs in the US found that CACs varied in terms of the degree of co-location and onsite services (Proactive Information Services, 2015). Different from the United States, police undertake most of the interviews onsite at the CAC, and most CACs do not yet have on-site medical and therapeutic services, although some of the Canadian CACs that have existed a long time do have these facilities on-site (e.g. Dubov & Goodman, 2017).

Key Features:

- Established later, but for similar reasons of improving the cross-agency response to abuse;
- Some adaption of the NCA standards to the Canadian context, but operate with the same standards in mind, though Canadian CACs are currently not accredited;
- Canadian CACs tend to be government run and led;
- Interviewing mostly still responsibility of police, rather than an independent interviewer like at the American CACs.

Joint Child Abuse Investigation Teams – Scotland

Joint Child Abuse Investigation Teams present as quite similar to MASH (albeit working with cases at a higher level of risk), with a focus on response planning and information sharing across a wide range of agencies. An initial referral decision is made by police and social work as to whether a case requires further investigation; if there is a significant risk of harm to a child, a case conference with all people in contact with the child is arranged. Information is gathered from relevant agencies via the child protection register (a confidential list for children at risk within a local area, allowing authorised people to check the list to see if a child is a known risk). The initial contact (the 'Lead Professional') gathers further information from any other relevant agencies. The case conference aims to determine nature of risk and plan for safety and protection.

A pre-interview briefing is held to consider all aspects of the investigation and prepare a plan for the interview. Following the interview, a debriefing with all involved parties to fully explore all of the information gained from the interview. If a child is at risk, they are added to the child protection register and a child protection plan is developed. Case conferences occur at regular intervals until the child is deemed safe or taken into care.

Key Features:

- Central point of response and coordination for child abuse cases with police involvement;
- Ongoing contact and monitoring of risk to the child;
- Use of a Child Protection Register to flag ongoing child protection concerns with other agencies that may be working with the child.

Barnahus (Children's Houses) – Sweden, Denmark, Finland, Greenland, & Iceland

Children's Houses or Barnahus developed from the American CAC model, modified to fit the welfare tradition of the Nordic countries that adopted this approach (Guobrandsson, 2014). Nordic countries have an inquisitorial civil law system, which allows the participation of the judiciary in the investigative process. This is very different from common law jurisdictions such as Australia where such an approach would not be possible.

While joint interviewing is a key part of the CAC model, particularly the use of independent, specially trained interviewers working from an evidence based protocol (Cross, Jones, Walsh, Simone, & Kolko, 2007), Children's Houses involve an interview under the supervision of a court judge, that is observed by each of the agencies involved in responding to the case (Guobrandsson, 2014). This interview is considered equivalent to court testimony for any future court proceedings, meaning the child does not need to testify again (Rasmusson, 2011). The interviewer from the Barnahus takes the child's statement under the direction of the judge, with police, child protection, prosecutors,

defence attorney and the advocate in a separate room. Interviewers can be a psychologist, social worker or a criminologist. Medical examinations and therapeutic supports tend to be in-house.

Local child protection services are responsible for handling cases, and can request the services of the children's house. Children and their families by referral can receive comprehensive services under one roof and free of charge.

Key Features:

- Comprehensive one-stop shop response including interviewing under the supervision of a judge;
- In-house therapeutic support and medical services co-located with the forensic response;
- Independent interviewer working under the direction of statutory agencies, and legal professionals;
- Advocacy support for all cases (sometimes called the case coordinator).

Puawaitahi (Auckland, New Zealand)

Puawaitahi (Blossoming from Within) is a comprehensive one-stop shop service for investigating and responding to the alleged abuse of children, like the flagship CAC models (i.e. National Child Advocacy Centre, Huntsville Alabama), and is closely aligned to the Child Advocacy Centre standards It operates as a single service centre based in Auckland, near Starship Children's Hospital, with around 60 staff on-site. The response is primarily investigative, but was also established to help victims of abuse access services. Like MASH, the response aims to be a single entry point to all different types of specialised child assessment/investigation services for children, youth, and family, health services, police response, mental health/therapeutic services, and prosecution.

- The following services are offered at Puawaitahi:
    - Detailed diagnostic assessment/therapeutic needs assessment by the local Department of Child, Youth, and Family services with intervention measures to ensure a child's safety where required;
    - Assessment of the health needs of a child with follow up treatment by the staff of Te Puaruruhau Starship Children's Hospital where required;
    - Assessment of the mental health of a child, limited crisis support, and referral back to appropriate community services is provided;
    - Investigation and possible prosecution conducted by the Auckland City District Police Child Protection Team; and
    - Formal evidential video interviews conducted by police and child, youth, and family interviewers on site in the joint evidential video unit. Children can use these evidential video interviews in their court case thereby only requiring them to have to recount the details of their victimisation once.

The Centre aims to provide a coordinated case management response across the different levels of responses that may be needed, improve communication and cooperation, provide linkages to community providers of therapeutic services, and reduce inefficiencies, duplications and omissions in service provision for abused and neglected children and young people.

Key Features:

- Comprehensive response for all types of cases and situations including treatment and supportive services;
- All agencies and resources co-located including Child Protection and Police;
- One-stop shop approach while also providing an adaptable response for matters not requiring police investigation;

4.4. Section Summary

This section reviewed a variety of MDT models from Australian and international jurisdictions to better understand existing practices. While the way the information is presented may privilege full-scale comprehensive models, we caution the assumption that 'more is better' in terms of MDT responses. Some jurisdictions may not operate at a scale that can support a sustainable 'one-stop shop' type model, in any case as discussed in section 2, there is a lack of evidence comparing degrees of MDT models against each other; most MDT models are compared against individualised or informal collaborative practices in research.

That said in terms of a comprehensive response the JIRT model is comparable to the international body of practice of MDT responses. The JIRTs have well-established intake processes, with centralised and consistent state-wide intake through the JRU. We do note however that the collaborative efforts of the JIRT response is limited by the scope of involvement of NSW Health and FACS staff; that they are responsible for the more immediate response while handing over longer term responsibility to others in their agency. While the JIRT process may have many commonalities with models like MASH and Puawaitahi, these responses have a different and more expansive purposes than in NSW. While some matters that do not meet the JIRT Referral Criteria may be referred by the JRU for a local CSC and/or police response; MASH in particular respond to a broad spectrum of cases with an MDT response, aiming to reduce the risk of harm to children across the spectrum of the London continuum and to reduce the necessity for statutory child protection involvement in most cases (Munro, 2011). In Victoria, the MDCs operate a response that extends to children and young people that have not yet disclosed, otherwise known as 'the options talk'. These comprehensive responses have attempted to establish systems to respond to all kinds of cases, and to put in place services and support for children and young people that may not be ready to disclose abuse, and may require some time to develop the trust and rapport to be able to disclose in a forensic interview. These models also provide services for children and young people who may decide not to officially report their abuse, or whose complaint is not proceeding through the criminal justice system.

Many of the models differ in terms of who from the MDT undertakes interviews with children. In CACs the predominant model is to have a trained forensic interviewer employed by the CAC (itself generally an NGO or a government worker in Canada); an arrangement not used in Australia except in South Australia. Like the JIRT, most Australian jurisdictions had interviews undertaken either by police, the investigating officer or from a pool of forensic interviewers. Many jurisdictions had provisions for statutory child protection workers to undertake interviews, but in practice most interviews were done by police.

The JIRT model also compares favourably internationally in terms of the co-location of key agencies, particularly police and child protection statutory authorities. They compare less favourably in terms of co-location and integration with the supportive and therapeutic end of cases. Despite the long

history of the CACs, relatively few of them have statutory agencies based on site in integrated teams, and are primarily based around providing information sharing and case planning between statutory workers and workers providing advocacy and community based therapeutic services. MIST and the MDCs are also exceptions within Australia for having statutory professionals co-located as part of the response, but also for their on-site advocacy and therapeutic services. Internationally the Barnahus, Puawaitahi, and a small number of centralised full service CACs have full co-location and integration of the investigation and supportive responses.

Few of the models described specifically addressed the issue of regional and remote service delivery, most full service models were based in metro areas or large regional centres. That said the survey of CACs included a large proportion of rural centres, responding over large geographical areas, with often-limited community resources. Many of these rural CACs may include just the basic services of interviewing and advocacy, without a standalone facility. While the degree of co-location might vary, rural CACs were more similar than different in terms of the services and supports provided to children and their families.

Key Messages:

- The JIRT model is comparable to the broader range of models that exist in practice nationally and internationally with the exceptions noted above (e.g. Barnahus);
- New South Wales, Victoria and Queensland all had de-centralised state-wide responses, with specialist resources distributed across the state. New South Wales operates a de-centralised response, with a centralised intake and initial assessment. Other jurisdictions had a much more centralised response with specialist resources centred around capital cities;
- Models like MASH and Puawaitahi were established with a different/broader intent than the JIRT model - to respond to all forms of child maltreatment across different levels of risk - this includes using a multi-disciplinary team approach to case conceptualisation and planning for vulnerable children whose circumstances fall below the statutory threshold for intervention.
- Of comparable MDT responses for serious child abuse investigations within Australia, the MDCs in Victoria provide a response called the 'options talk' to children and young people that have not yet disclosed; MIST in WA includes independent child advocates consistent with the US CACs model; both MDC and MIST have therapeutic services co-located on site.
- Australian and international models differ in terms of who is responsible for interviewing children. The CACs in the United States in particular rely heavily on independent interviewers, while other jurisdictions (including Australia) were more likely to have police interviewers; either the investigating officers, or a pool of police interviewers from a specialised unit;
- The CACs and Barnahus (Children's Houses) had prosecutors, legal professionals and magistrates as part of the core staff at their MDTS;
- Internationally, few models had police and child protection authorities co-located onsite, the JIRTs and other comparable comprehensive MDT responses within Australia (i.e. CDC and MIST) were different in terms of having co-located cross-agency teams. The provision of onsite medical, particularly forensic examinations was mixed both internationally and within Australia;
- Internationally, most models did have onsite therapeutic services as part of the response, as did the MDCs and MIST within Australia. The JIRT model does not include on-site ongoing therapeutic or support services and medical resources;

- Most MDT models operated in urban settings, few directly addressed the challenges of regional/remote service delivery, although the American CACs had a large proportion of rural centres with similar resources and services to their urban and suburban counterparts. The key features on which they varied being the availability of a purpose built and dedicated physical location and the extent of co-location.

5. RATIONALE FOR MULTI-DISCIPLINARY TEAM (MDT) MODELS

The research evidence examined in the previous chapter points to some of the benefits of MDT models over practice as usual, noting that older studies were much more likely to find MDTs to be beneficial. The comparison between practice as usual and MDT models becomes more complex when considering changes to standard practices over time, and in comparing standard practices in different jurisdictions.

Not only do the characteristics of MDT responses differ in the evidence base and the purpose of the model, but the comparison condition that MDT models are compared against may also have changed over time. Older studies compared the effect of MDT models against jurisdictions without proper protocols for evidence based interviewing, arrangements for information exchange between agencies, or processes for referral to supportive services; much of what would have constituted a specialised response in the past is now more or less standard practice in most jurisdictions. Accordingly, more recent studies were less likely to find differences between MDT responses, and practice as usual across a number of outcomes. Applying this evidence base to international jurisdictions becomes even more complicated considering the research base is heavily weighted towards jurisdictions in the United States. Jurisdictions with more universal services may need to re-examine the underlying assumptions of MDT models to determine if the approach will logically result in benefit considering the local context.

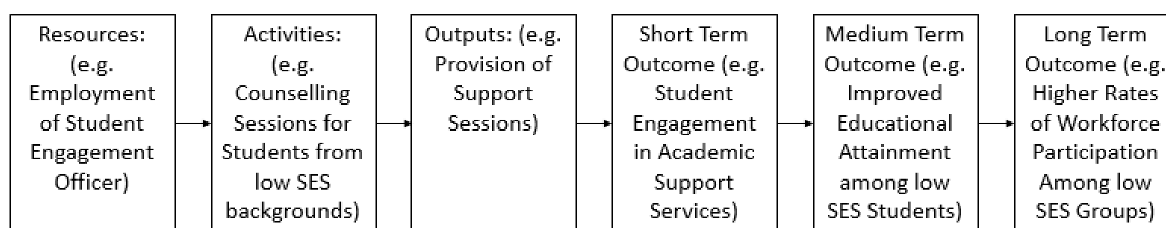
As MDTs vary dramatically in terms of the structure of their response, developing a theory of change can help to develop a better understanding of whether a particular model makes sense in terms of the connection between activities and outcomes. By plotting out models, this can point to inconsistencies or gaps in the logic of the approach; the logic can also be used as the basis to measure whether an intervention is being delivered as intended, and whether the program activities are having their intended effect.

This section will present a summary of what a theory of change is (the terms program logic and theory of change have been used interchangeably in this section) and its importance in policy, program planning, and evaluation, followed by a discussion of the types of system issues that MDTs are typically aimed at resolving. The section will present a broad model of multi-disciplinary teams. This generic theory of change will be discussed in relation to the context of the JIRT model, particularly highlighting where the process does not include some of the program elements included in the logic. Overall, the JIRT model had most of the program elements identified in the theory of change, with the differences primarily being in terms of the scope of follow up and advocacy support following the initial investigation of matters by the joint agency team.

5.1 Description of a Theory of Change

The term 'theory of change' refers to a theoretical or conceptual explanation of how a particular program works, which aims to go beyond generalities to identifying the mechanisms of change assumed within a program. McLaughlin and Jordan (2004) describe this as developing a '…plausible and sensible model of how the program will work under certain environment conditions to solve identified problems' (p. 8). This typically takes the form of a map or logic model that explains the relationship between the program resources, activities, and their intended effect on a specific group of service users (See Figure 1 for a limited example).

Figure 1. Example of a Partial Program Logic for a University Support Program



Having a clearly articulated plan showing the connection between activities and outcomes is important for a number of reasons. Having an agreed program logic helps to clarify the scope and purpose of a particular program; particularly what types of clients are suitable, and what outcomes can be realistically expected. This is particularly important for MDT models, which operate across agencies where the outcomes may be more relevant to some agencies in the collaboration, or where different agencies may have different outcomes as their primary interest. An agreed program logic across agencies may help to focus attention on the holistic nature of the response, rather than outcomes relevant to specific agencies. A program logic or theory of change assists each partner agency to clearly understand why each of the activities are included within the model, and the intended short, medium and long-term impacts that ought be observable if the model is operating as intended. A clearly articulated program logic can also be helpful in preventing model drift over time and in providing a framework for assessing model reform or adaptation.

A program logic is also essential for effective performance measurement and evaluation of an intervention (Owen, 2006). The logic helps to guide stakeholders towards a shared understanding of the effect of the program across stakeholders, and direct efforts towards obtaining the relevant data needed to assess the impact of the program.

5.2 What Problems are MDTs Directed towards Addressing?

This section aims to summarise the types of issues that teams are assumed to address, and connect these to the types of strategies used across models. Table 25 summarises how multi-disciplinary teams are described in the literature in terms of the types of issues they address in responding to child sexual abuse. Each of these outcome areas are discussed in more detail below.

Table 25. Problems/Issues Addressed through Multi-Disciplinary Models

Issue	Strategy	Assumed Outcomes
Poor coordination and information sharing across agencies	Use of joint/multi-disciplinary interviewing, and interview planning Use of case review meetings and consultation between team members Co-location of team members Joint databases and case management systems Increase critical discussion, undertake case joint planning, and information sharing across agencies	More coherent case responses Increased substantiation of harm and responses to the risk of harm from more complete information about cases Faster response to cases Improved child and non-abusive caregiver engagement in the response Improved child and non-abusive caregiver engagement in supportive services

Service gaps and confusion about services for some children and families	Use of case review meetings and consultation between team members Joint databases and case management systems Increase critical discussion, undertake case joint planning, and information sharing across agencies	More coherent case responses Improved child and non-abusive caregiver engagement in supportive services
Exposure of children to inappropriate or unnecessary repetitive interviews	Implementation of Evidence Based Interview Protocols Use of skilled and trained child interviewers Use of child friendly environments Use of joint/multi-disciplinary interviewing approaches and information sharing	Reduced systemic trauma for children Improved quality child testimony Reduced number of unnecessary interviews and assessments Improved child and non-abusive caregiver engagement in the response
Poor rates of access and completion of support services for abused children and families	Resourcing of local services and increased connection to local services Co-location of supportive services on-site Involvement of supportive services in case planning Involvement of supportive services as part of the initial contact with families Use of advocate/supportive worker to address barriers to service use	Increased assessment, referral and completion of needed services Improvements in family functioning Improvements in child trauma symptoms Successful completion of child protection orders Reduced re-victimisation of children
Lack of consistent support, advice, and advocacy for children and families	Involvement of supportive services as part of the initial contact with families Use of advocate/supportive worker to provide information about the status of cases and advice about navigating systems	Improved child and non-abusive caregiver engagement in the response Improved child and non-abusive caregiver engagement in supportive services Increased assessment, referral and completion of needed services Successful completion of requirements of child protection orders Reduced attrition from the criminal justice process
High attrition rates/low conviction rates from the criminal justice process	Use of joint/multi-disciplinary interviewing, and interview planning Use of case review meetings and consultation between team members Increase critical discussion, undertake case joint planning, and information sharing across agencies Use of advocate/supportive worker to provide information about the status of cases and advice about navigating systems	Reduced systemic trauma for children Improved quality child testimony Reduced number of unnecessary interviews and assessments Improved child and non-abusive caregiver engagement in the response Faster response to cases Increased substantiation of abuse Increased arrest of offenders Decreased rate of attrition due to unwillingness to testify or withdrawal of complaint

Difficulties in Coordination and Information Sharing between the Different Agencies

Team based approaches tend to be primarily used to address issues related to difficulties in coordination and information sharing between the different agencies involved in the response to abuse. While this can refer to issues at an individual case level, resulting in service gaps, or agencies not acting on the fullest information (Chen et al., 2010; Tjaden & Anhalt, 1994), this can also refer to siloing in relation to specific knowledge and expertise (Bross et al., 2000; Newman, Dannenfelser, & Pendleton, 2005), making it difficult for workers to achieve a consensus in the type of outcomes that are important for all agencies to work towards (Bertram, 2008).

Service Gaps and Confusion about Services for some Children and Families

One of the assumed benefits of team-based approaches is that collaboration and information sharing between agencies can help identify and address service gaps (Humphreys, 1995; Leslie et al., 2005), where children do not receive needed services or receive an inadequate response from one or more agency. Poor responses may be due to confusion about which agency has responsibility for the case (Bell, 2001; Darlington, Feeney, & Rixon, 2004), difficulty identifying available services in a fragmented environment (Cheung & Boutte-Queen, 2010; Hebert et al., 2014a), or failure on the part of individual workers/agencies to follow up due to resource limitations (Darlington et al., 2004). Equally, teams may be able to address confusion about services through promoting cross-agency case planning for treatment and support services (Goldbeck et al., 2007).

Exposure of Children to Inappropriate or Unnecessary Repetitive Interviews

Child Advocacy Centres in particular have their history being created to reduce systemic trauma related to the inappropriate and repetitive interviewing of children (Chandler, 2006), requiring evidence based interview protocols delivered by skilled specialist interviewers in child friendly facilities (Pipe, Orbach, Lamb, Abbott, & Stewart, 2012; Walsh et al., 2003). Bringing agencies together around the child for the interview also reduces the need for multiple agencies to obtain additional disclosures from children, whether as part of an interview or otherwise (Jones et al., 2007). The model assumes that the use of specialist interviewers working with all the other agencies involved in the response, will contribute to improved testimony from children (Ceci & Bruck, 1993), and that the reduced distress and uncertainty associated with the interview and immediate criminal justice response will improve the willingness of children and families to pursue justice (Walsh et al., 2008), potentially resulting in reduced attrition from the criminal justice process (Parkinson, Shrimpton, Swanston, O'Toole, & Oates, 2002).

Poor Rates of Access and Completion of Support Services for Abused Children and Families

It is recognised that for a variety of reasons children and families in most need of services, are also the least likely to receive or complete these services (Burns et al., 2004). Many multi-disciplinary teams include support service providers as part of the response, using the initial contact between children and caregivers with the centre/team to build rapport in order to more effectively refer to services (Kemp, Marcenko, Hoagwood, & Vesneski, 2009), and to work with families to address some of the barriers to accessing services they may have (Owens et al., 2002).

Lack of Consistent Support, Advice, and Advocacy for Children and Families

Related to the above, many centres/teams will have a designated support person who works alongside the other agencies from the outset in order to provide support, advice, and advocacy for

children and families (e.g. Ayoub & Jacewitz, 1982; Wolfteich & Loggins, 2007). This person works to try reduce any distress and confusion, and to help represent the needs and wishes of children and families to other agencies (National Children's Alliance, 2011). Particularly in the CAC model, these workers will become an important point of contact for information about the progress of the case and having a role in helping children and their families understand the process (Jackson, 2004).

High Attrition Rates/Low Conviction Rates from the Criminal Justice Process

Finally, most teams involved in responding to child sexual abuse are oriented towards a criminal justice response (Cross, 2001), working to address the relatively low rates of convictions compared to other types of offences (Cross, Walsh, Simone, & Jones, 2003). There are no additional strategies that are designed to directly improve criminal justice outcomes, rather it appears that the model operates under the assumption that if the afore mentioned activities and outcomes are attained, then this will in turn have a positive effect on criminal justice outcomes. Specifically that improved quality of child interviewing, better coordination and information sharing across agencies, and ensuring that children and families are referred to needed services (Newman et al., 2005) will result in more timely responses, more families pursuing and remaining in the justice system, children as better witnesses, and higher quality evidence which in turn are expected to improve criminal justice outcomes such as convictions.

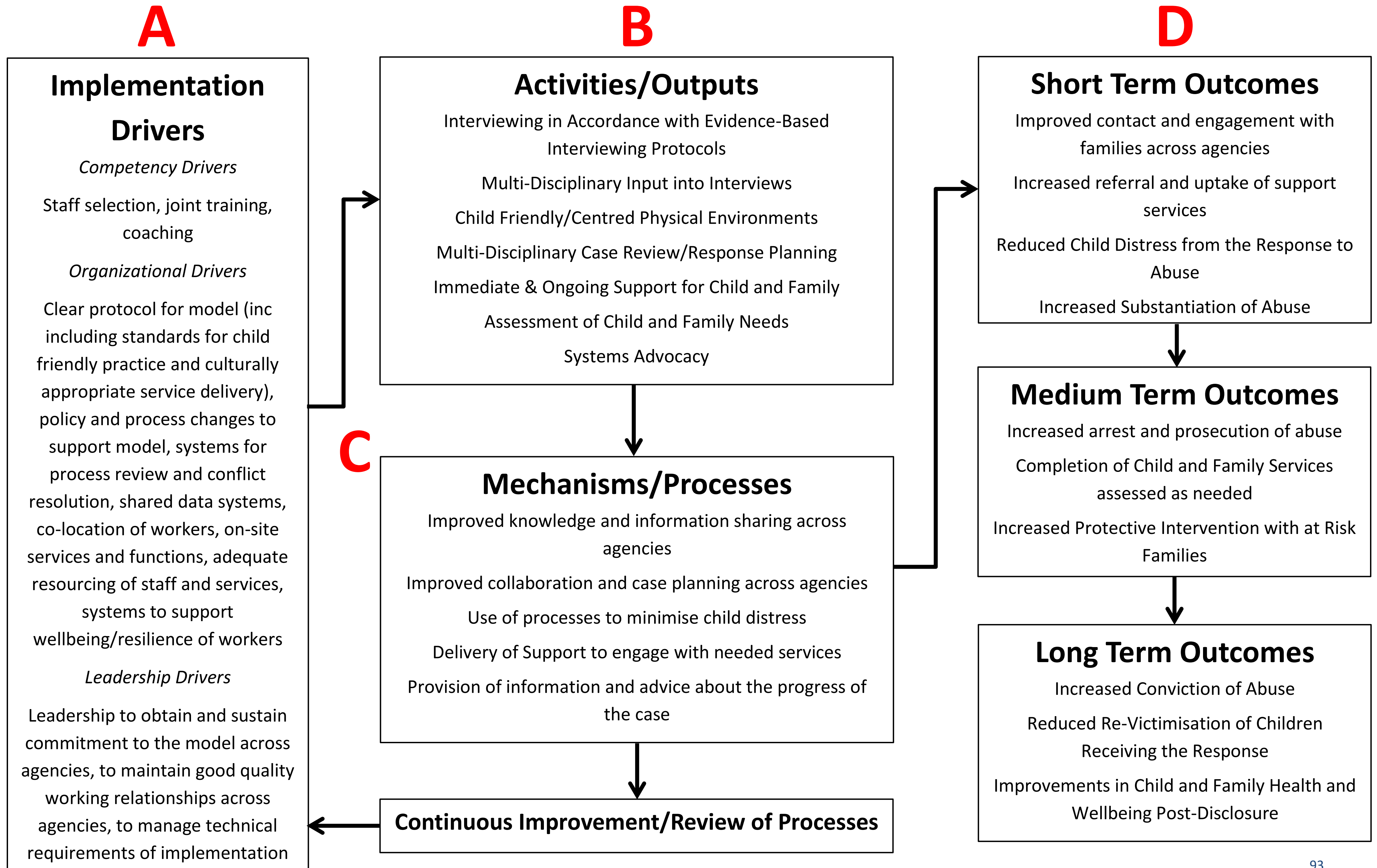
5.3 Simplified Program Logic

MDT models are assumed to improve outcomes relative to individualised or informal processes of collaboration by implementing processes that address some of the problems identified in the previous section. While MDT models are diverse, they generally rely on a few general underlying mechanisms and a common set of assumptions.

Figure 2 details a simple program logic for multi-disciplinary teams, linking a series of factors that reflects the assumed connection between the factors that enable the delivery of elements of the program (A), the activities that constitute the program (B), the direct effect the activities are intended to have (C), and the expected outcomes over the short, medium, and long term (D). Note that this model is theoretical, drawing on the logic implicit across the models reviewed for this report. This logic will lead into the more detailed hierarchy of outcomes presented in section 5.4.

A detailed breakdown of the activities of MDTs and their assumed connection to mechanisms and outcomes are presented in Table 26 - Table 30.

Figure 2. A Simple Program Logic of Multi-Disciplinary Teams



(A) Enablers of Multi-Disciplinary Teams

Enablers include efforts to implement the program, along with a number of other factors that represent important implementation drivers (Fixsen, Blase, Naoom, & Duda, 2013). Implementation drivers refer to the systems and processes in place to turn the program plan into action (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005), and to ensure the program is delivered with fidelity (Carroll et al., 2007). Fixsen et al. (2013) describes three categories of implementation drivers: competency drivers (i.e. staff selection, training, coaching), organisational drivers (i.e. systems intervention, facilitative administration, and decision support data system), and leadership drivers (technical and adaptive). Figure A includes factors within these categories that have been identified from reviews of the literature as relevant to the implementation of MDTs.

(B) Activities of Multi-Disciplinary Teams

This section describes the key activities that constitute the delivery of a multi-disciplinary team response to abuse, enabled by the implementation drivers discussed above. The types of activities associated with multi-disciplinary teams include: (1) Multi-disciplinary interviews[7]; (2) Multi-disciplinary case review/response planning; (3) Provision of immediate and ongoing emotional support for children and families alongside team processes; (4) Assessment and referral of children and families to needed services; (5) Systems advocacy. Each of these activities are broadly descriptive of the processes that occur in responding to abuse across the different agencies involved. While not exhaustive, the rest of this section will aim to describe these processes and the mechanisms by which they are assumed to result in improved outcomes.

(C) Mechanisms/Processes of Multi-Disciplinary Teams

This section describes the mechanisms or processes of multi-disciplinary teams; the underlying assumptions that explain how the program activities will result in particular outcomes (Rycroft-Malone et al., 2012). These can be thought about as the process by which MDTs influence change, which are important to measure in order to be able to determine if the program activities are being delivered as intended, and if the assumptions underpinning the model are correct.

Defining Key Activities Mechanisms, and Processes of Multi-Disciplinary teams

Definitions of the terms used in Table 25 – Table 29 are included below:

1. Knowledge and information sharing across agencies

- *Information sharing*: Systems enable the exchange of information about cases across agencies and workers, enabling teams to make decisions and undertake planning based on the full information and context of a case;
- *Knowledge exchange*: Interactions and discussion across agencies and disciplines result in the exchange of knowledge and perspectives, providing workers with a broader understanding of the response to abuse, and understanding of the motives and values of other workers. This allows them to more effectively reflect on their place in this system;
- *Knowledge transfer*: The involvement of different agencies, disciplines and specialties brings additional knowledge and perspectives on a case, and contributes to the depth of deliberations across the team;
- *Values exchange*: Working in a cross-agency environment as well as resulting in the

[7] Encompassing Interviewing in Accordance with Evidence-Based Interviewing Protocols; Multi-Disciplinary Input into Interviews; Child Friendly/Centred Physical Environments.

exchange of knowledge and information may change the values of inter-agency staff as they are exposed to the broader response to abuse. This may be indicative of the development of a team view of the response (Bertam, 2008), where there is a convergence of priorities where previously individuals were oriented to their particular organisational outcomes (Frost, 2005);

- *Resource identification*: Deliberations and discussions across agencies may enable the identification of needed resources (e.g. services) and knowledge of how to access these resources.

2. Improved collaboration and case planning across agencies

- *Case Coordination/Case Planning*: Development of a cross-agency response through discussions with all the relevant agencies involved, identification of priorities, and agreement to a plan or approach for a particular case. Deliberations enable rapid decision-making while still consulting with all relevant agencies. Planning occurs with the full knowledge of each agency's processes and requirements. The response may be broken into two components that may be managed separately or together: (a) the investigatory/intervention response; (b) the care/therapeutic responses.
- *Use of Flexibility and Problem Solving Approaches*: The team based environment and planning around cases allows for workers to exercise discretion, flexibility and problem solving in relation to the circumstances of individual cases in the context of the requirements of the process;
- *Consultation with Child and Family*: The principal support person is able to provide the perspective of the child and family as part of cross-agency deliberations.

3. Minimisation of child and family distress

- *Child Friendly Environment*: Interviews and services occur in a child friendly space, an environment that is relaxing, natural, and comfortable for children, such as spaces that resemble a home environment;
- *Child Friendly Staff Behaviour*: All staff that interact with children exhibit a high standard of child friendly behaviour and practice. While this may differ depending on the work role, a standard of behaviour is agreed to and complied with;
- *Availability/Provision of Support during Acute Distress*: Psychologists and/or the primary support person provide direct support during stressful situations such as disclosures at the interview stage, or during stressful situations throughout the investigation process.

4. Delivery of support to engage with needed services

- *Assessment of Needs by Principal Support Person*: The initial assessment is undertaken by a person with an established rapport with the child and family, and with an existing knowledge of the case, any disclosures, and the context of the family;
- *Response Planning to Engage Children and Families with Support Services*: Identification of potential barriers and difficulties and the development of a plan in order to address these, this plan may involve additional support agencies and identifying the role each will play in the response;
- *Builds Motivation and Engagement in Services*: In accordance with the plan, worker/s build the motivation of children and parents to engage with services, identifying the potential benefits of services;
- *Coordination of Support Response*: Worker/s manages referrals in order to minimise any difficulties for the child and family. This may include delivering emotional support or other

more practical support in order to engage with services, facilitating introductions to additional support people, and passing on relevant information in order to minimise the need for additional disclosures.

5. Provision of information, support, and advice to child and family about the response

- *Provision of Information about the Response to Child and Family*: The principal support person contacts families about updates on the status of their case, and ensures that they understand the information. This same person has a consistent role in providing independent information to help child and family understood the process and the possible outcomes;
- *Provision of Support and Advice in Relation to their Case*: The principal support person is able to respond to any distress or confusion with direct support and advice about options;
- *Acts for and Empowers Child & Family Where Possible*: The principal support person identifies opportunities for child and family to talk about their needs and interests in the response, and works to express these other workers. The principal support person acts for victims and works to identify opportunities to empower child and family in the context of the response.

6. Feedback & Program Fidelity

- Staff Engage in Critical Discussion about Appropriate Practice & Processes: Working as part of a team enables an increased visibility across members of the team. Effective team discussion and deliberation results in ongoing critical discussion about practice and policy, and an increased tendency to complete required work. This contributes to continuous improvement processes, and potentially improve adherence to policies.

Table 26. Detailed View of Activities, Mechanisms/Processes, and Outcomes for Multi-Disciplinary Interviews

Activities	Mechanisms/Processes	Hypothesised Direct Outcomes
Cross agency interview planning	• Sharing of information ensures agencies undertake planning with the most complete information and context of cases • Workers with different knowledge, skills, and perspectives on a case involved in interview planning • Planning occurs with acknowledgements of each agency's process requirements and information needs	• Reduced need for additional interviews and assessments • Improved quality of disclosure/recorded testimony • Improved admissibility of disclosure/ recorded testimony
Team observation of interviews	• Workers with different knowledge, skills, and perspectives on a case observe the interview • Observers provide feedback on the interview from their discipline/agency perspective	• Reduced need for additional interviews • Improved quality of disclosure/recorded testimony • Improved admissibility of disclosure/recorded testimony
Information sharing about the content of the interview	• Agencies share information about the content of disclosures/recorded testimony	• Reduced need for additional interviews and assessments
Delivery of interviews based on evidence based protocol	• Interviewers and other workers that interact with child and families use child friendly practices • Interviewers and other workers that interact with child and families use culturally appropriate practices where relevant • Interviewers and other workers that interact with child and families adhere to the accepted process for the interview	• Reduced need for additional interviews • Improved quality of disclosure/recorded testimony • Reduced child distress from the response to abuse • Improved quality of disclosure/recorded testimony
Interviews occur in child friendly space	• The building and interview space are child friendly (are relaxing and comfortable spaces for children) • Interviewers and other workers that interact with child and families use child friendly practices	• Reduced child distress from the response to abuse • Improved quality of disclosure/recorded testimony
Direct feedback to interviewers from across agencies	• Continuous improvement in interviewing practices from different discipline/agency perspectives	
Availability of Support Person for Interviewing	• Psychologist/support person available to provide direct support for children distressed from the interview • Psychologist/support person available to provide professional advice to team/interviewer on interpreting child behaviour based on developmental knowledge	• Reduced child distress from the response to abuse • Improved quality of disclosure/ recorded testimony

Table 27. Detailed View of Activities, Mechanisms/Processes, and Outcomes for Multi-Disciplinary Case Review/Response Planning

Activities	Mechanisms/Processes	Hypothesised Direct Outcomes
Case Coordination & Planning	• Response planning for immediate interventions and investigations • Response planning for engaging children and families with supportive services	• Reduced child and family distress and uncertainty resulting from the response to abuse • Faster response to cases requiring immediate intervention • Increased referral to and engagement with needed services
Information Sharing Between Agencies	• More complete information about the case informs the investigatory/protection response • More complete information about the case informs the care/support needs of child and family	• Increased substantiation of harm • Increased referral to and engagement with needed services • Improved quality of interviewing • Improved quality of disclosure/recorded testimony
Critical Discussion of Appropriate Practice	• Continuous improvement in practices discussed at case review • Identification of areas for improvement or process change • Visibility across disciplines and agencies assures that workers complete their part of the response	
Resource Identification	• Members across the team are able to share knowledge of particular resources and services to help with a case	• Increased referral to needed services
Flexibility & Problem-Solving in the Response	• Members across the team are able to exercise flexibility in responses to cases depending on the circumstances of children or families • Members across the team are able to engage in problem solving in response to any issues that come up in responding to a case	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased referral to needed services • Increased engagement in the response
Involvement of Child and Family in Decision-Making	• The teams are able to receive information about the wishes and needs of the child and family and consider these as part of their response planning	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased engagement in the response • Increased referral to needed services
Knowledge Exchange between Workers Across Disciplines	• Workers develop knowledge over time about the work of different agencies and workers in the response	

Table 28. Detailed View of Activities, Mechanisms/Processes, and Outcomes for Immediate & Ongoing Support for Child & Family

Activities	Mechanisms/Processes	Hypothesised Direct Outcomes
Involvement of Primary Support Person (i.e. advocate) in Initial Contact and Interview Process	• Delivery of support during the interview and investigation process	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased engagement in the response
Ongoing support as needed	• Delivery of support beyond the interview and investigation process as needed	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased engagement in the response
Ongoing contact with family to update them on the case	• Delivery of information about the progress of the case to families • Helping child and family understand the information about their case • Providing support in case of distress from updates about the case	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased engagement in the response
Coordination/Collaboration with other Support Providers	• Discusses and plans the care response with other relevant supporters/agencies • Facilitates introductions and establishment of rapport for additional support people • Able to pass on relevant information to other support providers to minimize need for repeated disclosure	• Reduced child and family distress and uncertainty resulting from the response to abuse • Increased engagement in the response

Table 29. Detailed View of Activities, Mechanisms/Processes, and Outcomes for Assessment of Child & Family Needs

Activities	Mechanisms/Processes	Hypothesised Direct Outcomes
Assessment of broad psycho-social needs	• Assessment of support needs undertaken by worker with established rapport with family and understanding of the case (i.e. Primary Support Person) • Assessment occurs as soon as the child and family are ready to discuss their needs	• Increased referral to needed services • Reduced child and family confusion and distress resulting from the response to abuse • Reduced need for additional interviews and assessments
Referral to needed services and more specific assessment	• Referral to services undertaken by worker with established rapport with family • Facilitates introductions and establishment of rapport for additional support people • Builds motivation and engagement with child and family through discussing the benefits of services • Able to pass on relevant information to other support providers to minimize need for repeated disclosure	• Increased engagement in needed services • Reduced child and family confusion and distress resulting from the response to abuse

Coordination of services	• Manages referrals to minimise any difficulties for child and family • Discusses and plans the assessment & care response with other relevant supporters/agencies	• Increased engagement in needed services • Reduced child and family confusion and distress resulting from the response to abuse
Support to engage with needed services	• Delivery of emotional or other types of support or assistance to engage with services	• Increased engagement in needed services

Table 30. Detailed View of Activities, Mechanisms/Processes, and Outcomes for Systems Advocacy

Activities	Mechanisms/Processes	Hypothesised Direct Outcomes
Consults with and acts on the interests of child and family	• Identifies opportunities for children and family to talk about their needs and interests in the response • Informs other members and acts of the needs and interests of children and families	• Reduced child and family confusion and distress resulting from the response to abuse • Increased engagement in the response • Improved feelings of empowerment for child and family • Increased referral to needed services
Involvement of Primary Support Person at Case Review	• Input from child and family about what they'd like from the response	• Reduced child and family confusion and distress resulting from the response to abuse • Increased engagement in the response • Increased referral to needed services • Increased substantiation of harm
Works to empower child and family	• Identifies opportunities for empowering child and family	• Improved feelings of empowerment for child and family • Reduced child and family confusion and distress resulting from the response to abuse • Increased engagement in the response
Ongoing contact with family to update them on the case	• Delivery of information about the progress of the case to families • Helping child and family understand the information about their case • Providing support in case of distress from updates about the case	• Reduced child and family confusion and distress resulting from the response to abuse • Increased engagement in the response
Support to engage with needed services	• Delivery of emotional or other types of support or assistance to engage with services	• Increased engagement in the response

5.4 What Outcomes are Linked to What Components?

MDTs rely on a complex series of assumptions about how the intervention will improve outcomes, while the initial outcomes are relatively simple, the interaction between these are more complex, indirect, and subject to external influences over the longer term. The interaction with outcomes are also complicated by multiple activities that are all assumed to influence a relatively small set of core outcomes, and individual activities which are expected to influence multiple outcomes. Figure 3 presents an outline of the assumptions inherent in the connection between the typical program activities of MDTs, their immediate outcomes, and their relationship to the high level outcomes that MDTs typically aspire to such as improved child wellbeing post-disclosure, reduced re-victimisation and increased conviction of abusers of children (Cross, 2001).

While there are clear connections between the typical activities of MDTs and some of these outcomes, outcomes further up the chain become more difficult to demonstrate and are subject to many more factors. For example, while systems advocacy may plausibly have an effect on increasing referral and uptake of needed services, to have the intended effect of improved child wellbeing this assumes that the therapeutic service is effective and delivered with fidelity. The connection between completing these services and achieving improvements in child wellbeing is also subject to the situation in which the child is living, responses to their disclosure within their family and community context, the type of parenting they experience, and any additional trauma or events that may affect their wellbeing and the level of trauma they have experienced.

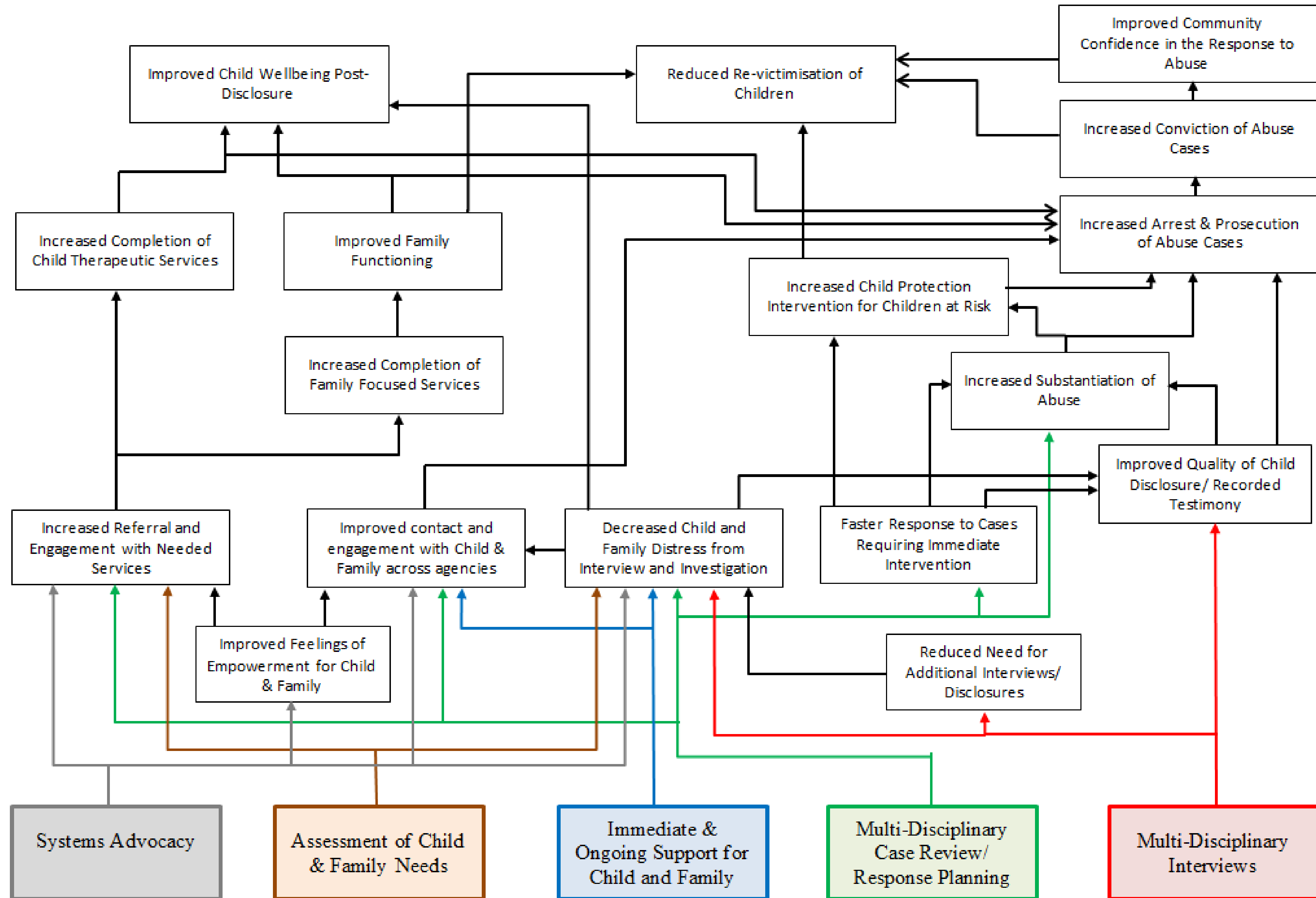
The connection between these outcomes is also subject to numerous other factors in the chain of outcomes towards increased conviction of abusers of children. Most models with onsite support services assume that providing acute counselling and support at the interview can decrease child and family distress resulting in increases in disclosure at interviews. It is implicit in most models that the use of a principal contact person to help engage and support children and families through the criminal justice process is also assumed to reduce attrition. As was the case with child wellbeing above, the further up the chain in criminal justice outcomes, the more factors outside of the MDT there are that may have a more direct impact on case attrition/non-prosecution.

As shown in section 2, much of the research evidence is for immediate outcomes, with much more mixed evidence for the impact of MDTs on outcomes further up the chain. Many of the assumptions within this hierarchy of outcomes have not been explicitly researched; while there is a strong body of research about MDT models, there are limits of knowledge about the interaction of some of these assumptions.

Reading Figure 3

Figure 3 presents a program logic diagram for the theoretical theory of change of MDTs. The diagram is read from bottom to top. The bottom row are the activities of MDT, these correspond with and were described in detail in Tables 25-29 in section 5.3 above. Each of the domains of activity have been colour coded to assist in reading the diagram. The top row reflects the long-term outcomes. The boxes in the middle of the diagram show the mechanisms or assumptions for how these activities are thought to lead to the intended outcomes (as stated previously, many of these assumptions are purely theoretical and have not yet been tested). Coloured arrows corresponding with the colour of one of the activities in the bottom row are used to show the pathway for each of the activities to the intended outcome.

Figure 3. Interaction of MDT Program Elements and Hierarchy of Outcomes.



5.5. Differences between the Generic Logic and the JIRT Model

The generic MDT model corresponds closely to the structure of the JIRTs, but with some minor differences relevant to the aim of this review. This section will identify some of the elements missing from the JIRT response and the outcomes associated with these activities and the outcomes that theoretically could be influenced by the inclusion of these additional activities.

Implementation Drivers

Figure 2 presents a number of implementation drivers for MDTs; within this model these factors are assumed to support the delivery of the program activities. Many of these factors are outside the scope of this review to make observations about (e.g. quality of staff selection processes, leadership to obtain and sustain commitment to the model). However, the JIRT model does have some of the following in place to support their program activities:

- *Joint Training*: The JIRT model incorporates a joint training course to bring workers from each of the agencies involved into the program, helping them to understand the process and the expectations on them as part of their role in a joint agency response;
- *Clear Protocol for Model*: The JIRT model has a developing set of protocols and processes (and templates) that outline the operation of the model.;
- *Systems for Process Review*: Leaders from each of the JIRT agencies meet regularly to discuss arrangements and discuss process improvements;
- *Shared Data Systems*: The JIRT Tracking System is in place to track the referral and assessment phase at the JIRT Referral Unit and the Local Planning & Response Procedure at individual sites;
- *Co-Location of Workers*: As discussed in the introduction, 11 of the JIRTS are co-located, with some of the others having Health and FACS together, and others having agencies work from each of their separate sites. Although as noted, CAS are moving away from a shared office model, to a proximal co-location model, where the relevant JIRT agencies are based nearby, sometimes on different floors in the same building;
- *On-Site Services*: The model for JIRT doesn't extend to direct on-site service delivery beyond the investigative interview, the Local Planning & Response Procedure, and referral to appropriate counselling services. Additional services are currently coordinated by the local CSC if the family has ongoing contact with the statutory child protection system, and counselling and medical services are arranged by the Health Clinician through a process of 'warm' referral.

In terms of program activities the JIRT model also aligns very closely with the generic model presented in this section.

Multi-Disciplinary Interviews

In terms of the activities associated with Multi-Disciplinary Interviews (Table 26) the JIRT model has in place all of the elements described under the generic model. Cross-agency planning and information sharing is built into their response model occurring over a number of stages in the process (sharing of information, briefing meeting, de-briefing meeting, & case meetings). The JIRT model, at least as it is written, enables cross-agency team planning, observation and input into interviews; however in practice the other agencies do not participate in interview planning. The electronically recorded interview captures the evidence for criminal proceedings and also care and protection issues. FACS and/or Health staff may however ask further questions at the conclusion of

the electronically recorded interviews to clarify any care, protection or clinical issues not already canvassed in the interviews. While facilities vary, the JIRT sites generally aim to provide a child friendly environment, and a space that is welcoming and comfortable to children. Health Clinicians are all Sexual Assault Social Workers, and are able to provide direct support to children and families for distress during the interview. These primary support persons establish the initial rapport with children and families through their contact with the JIRT, although currently their involvement in cases is mostly short term, partly due to the volume of cases coming through the JIRT model and the capacity challenges facing the NSW counselling sector.

Multi-Disciplinary Case Review/Response Planning

The JIRT model also has all of the elements described in the generic model associated with multi-disciplinary case review/response planning, although the scope of the resource identification resulting from the case review process is limited to counselling and medical referrals (Table 27). Workers engage in cross-agency case coordination and planning, and information sharing through the various local planning and response procedures. The frequent interaction on the response to cases provides opportunities for critical discussion of practice and knowledge exchange between workers, along with the framework to make flexible decisions based on more complete knowledge about the context of the family. Considering the high demand for counselling services, identification of community resources and services is critical for the role of the Health Clinician. While this role is responsible for referrals to the local Sexual Assault Services and other NSW Health services (e.g. Child Protection Counselling Services, mental health, drug and alcohol, sexual health, youth health, child and family health), and to arrange medical examinations (if needed), scope to build and development networks of community based services may enhance their capacity to direct children and family to needed services.

Immediate and Ongoing Support for Child and Family

The JIRT model differs from the generic model (Table 28) on some elements in relation to the degree of immediate and ongoing support for the child and family. While the JIRT model does provide a primary support person during interviewing, the role of this person is relatively short following referral to the local Sexual Assault Services and other NSW Health services. JIRTs currently lack a primary support person who can provide ongoing support as needed, who can be the primary contact for information for their child/family about their case over the extended period of interaction with the criminal justice and child protection systems, and who can independently advocate for the child and family’s perspective within the system response. While the Health Clinicians do provide coordination of services, or a warm referral into sexual assault counselling, this does not extend to the broad range of services that may be needed, and is limited in terms of follow up, case monitoring, and other work that may be necessary to enable families to be in a place to commit to therapeutic services for themselves and their children.

Assessment of Child & Family Needs

Similar to the previous section, the JIRT model in part fits within some of the activities in the generic logic, but with a limited scope on the types of services, and in terms of engagement with families. All agencies are involved in the development of a Safety Welfare and Wellbeing Summary; however, this is focused on the child’s immediate safety and threats to their wellbeing. The Health Clinician will arrange a referral to the local Sexual Assault Service, where they may also be assessed and referred on to other services; however, adding in holistic assessment of psychosocial needs may

enhance the JIRT response. The role of the Health Clinician is limited in terms of longer-term coordination of services, and providing support to engage with services. Some complex families may have significant barriers to accessing services, and may need a longer term view to addressing other difficulties they may have prior to engaging in counselling. Some children and/or their families may not be ready to accept a referral to counselling services immediately following disclosure (Tidmarsh, Powell, & Darwinkel, 2012). Without a point of contact to reconnect with in the ensuing time, if children and families subsequently decide they need counselling and support they will likely have to navigate finding and accessing this for themselves.

Systems Advocacy

The component where the JIRTs most differ from the generic model is in terms of systems advocacy. While certainly the Health Clinician will work closely with families to coordinate the health response, there is a lack of opportunity for input from the child and family about the response and the services/supports they need. While this input may happen for some cases, particularly in relation to the decision to charge children/young people for sexual offences, and the work of FACS staff with families, a clear advocate for children and families across systems is not currently part of the response. This person would have the role of understanding and conveying the needs of children and families to the other professionals involved in the case. There is also a role in identifying opportunities to empower children and their non-offending family members in the context of the response, helping them to understand the system response and to help support them to make decisions within that response. This may include helping a child and family to work with government agencies, for example helping them understand why a case is not proceeding to prosecution or why evidence about other alleged victims might be excluded from a trial. Rather than have a primary contact person who provides information and updates on the status of the case throughout the process, the response provided under the JIRT model more or less depends on individual agencies to provide updates on the status of a case to the family. Finally, while NSW Health staff at the JRU can make referrals for matters accepted into the program[8], these children and families may have significant barriers to engaging with support services. The uptake of these referrals could be enhanced with ongoing monitoring and support for children with suspected abuse who have not yet disclosed. This additional follow-up may also be important where children and families initially do not want counselling, or want support and assistance beyond counselling.

5.6 Section Summary

Section 5 presented a detailed theory of change for MDTs, recognising the connection between the activities involved in MDTs, and their connection to outcomes. The implications of this conceptual framework to the JIRT are discussed.

The section first presents a discussion of the importance of theory of change in the design of program and systems, reflecting that much of the effectiveness of interventions depend on the degree to which interventions are designed with a reasonable theory of change informed by the best available evidence (Segal, Opie, & Dalziel, 2012).

A key issue in the effective design of a theory of change is problem identification; understanding the issue that the intervention is aimed at, and having clearly identified target groups for an intervention

[8] Note: NSW Health staff at the JIRT may also make referrals for matters not accepted by the JIRT (e.g. referral for a sexual health check in adolescent peer sex matters).

(Dalziel & Segal, 2012; McLaughlin & Jordan, 2004). MDT type interventions are generally aimed at a broad swath of problems in the interaction between the criminal justice, child protection, and mental/medical health systems. Many MDT type models (e.g. Child Advocacy Centres) have been primarily aimed at problems in the criminal justice system, particularly poor forensic interviewing practices, and unnecessary distress to children from repeated and inappropriate interviewing (Walsh et al., 2003). Poor information sharing and collaboration between agencies is often also the impetus for developing an MDT response (Cross et al., 2008). Improved coordination of care and improving the rates of receipt and completion of needed services, particularly among complex families that may not easily engage with supportive services is also a key problem that collaborative responses are aimed at addressing (Chuang & Lucio, 2011; Cross et al., 2008).

This section presented a detailed breakdown of MDT program elements and change mechanisms, identifying the elements of a full MDT response. This discussion breaks the response into: multi-disciplinary interviews; multi-disciplinary case review/response planning; immediate and ongoing support for child and family; assessment of child and family needs; and systems advocacy. Within each of these program elements are a list of activities that each potentially contribute to the effectiveness of the response. As discussed in section 3, to date there has been limited research into which components are essential for improved outcomes, and which are merely part of the typical package of an MDT response.

The section then presented a brief discussion of the hierarchy of outcomes for MDTs, identifying how each program component may contribute to improved outcomes. Importantly this presents the difference between the types of direct outcomes that the intervention can conceivably be thought to influence, with more diffuse outcomes that may be influenced by many other factors outside of the control of an intervention. Expectations for affecting these large-scale longer-term outcomes should be tempered given the complexity of factors influencing these outcomes.

Finally, the section ended with a discussion of how the model relates to the JIRT model, particularly areas of difference between the typical MDT model that appears in the research literature and the JIRTs. Most of the key differences are around the use of a primary support person (i.e. child and family advocate) who coordinates the care of children and families over the medium to long term, separate from the activities of statutory authorities. The NSW JIRT model currently excludes or limits the following functions/activities which are typically performed by child advocates:

- The length and extent of case consultation and information sharing on cases;
- Engaging with and developing knowledge of available services and supports in community;
- Ongoing and flexible support response beyond the interview and initial referral;
- More comprehensive coordination of services for child and family, and relationship building with community based service providers;
- Broader assessment of needs beyond just counselling and medical examinations;
- Support to engage with needed services, addressing barriers to engagement, and providing information about the benefits of services;
- Consults with and acts on the interests of the child and their family, bringing their interests and perspective to meetings with other agencies;

- Ongoing contact with families: As the advocates would have an extended role with families, they may be best placed to provide consistent information to the family about the status of their case.

6 REPORT SUMMARY

The report began with an outline of the current structure of the JIRT model and how it differs across the existing 22 sites (noting the new site, and the JRU). The JIRT model provides a single point of intake, assessment and decision making across agencies (through the JRU), those referrals that are accepted and meet the JIRT Referral unit and are then sent to the local area concerned where a planned response takes place (LPR Procedure). While most CAS sites in the Sydney metro area, larger regional centres (e.g. Newcastle, Wollongong), and some country centres (e.g. Tamworth and Bourke) are located in the same building as the other two agencies, many of the smaller regional sites have Police, NSW Health and FACS, working from separate sites (albeit still with relative close proximity of each other). For many of these regional JIRT units, their work is across a number of different districts working with different operational groups, potentially limiting the benefits of being closely located to each other.

A review of the JIRT model identified a strong history of cross agency review and reform stretching back to the antecedent models of the program. The introduction of the JRU to help improve the consistency in assessment and decision-making, and the inclusion of NSW Health as an equal partner stand as particularly important developments in the history of the JIRT model. However, some issues have remained fairly consistent in the ongoing development of the related response, and are reflected in the current issues this report is framed around. The increased volume of cases resulting from the introduction of the JRU has also introduced new issues around adequate resourcing and accountability of agencies in the context of the JIRT model (New South Wales Ombudsman, 2012).

A key issue is the fragmentation of the service delivery environment, particularly in terms of sexual assault counselling have remained over a number of reviews, reflected in high demand and high dropout rates from the Sexual Assault Service (NSW Health) which children and their families are commonly referred to as part of the JIRT response. This would seem to be particularly an issue for complex cases, and aboriginal children and families.

Interviewing was previously raised as an issue of contention within the JIRT model, with the present review by the New South Wales Ombudman’s Office examining this issue with each of the agencies concerned. Currently all child interviewing is undertaken by the investigating officer from Child Abuse Squad, with FACS and NSW Health workers able to electronically monitor what takes place and ask further questions to clarify any care, protection or clinical issues not canvassed by police once it has been concluded. This is mostly consistent with practices in other Australian jurisdictions, although many have units of police trained in interviewing, but is quite different from MDTs in other jurisdictions and in the effective models identified in section 2. This does not necessarily suggest that independent interviewing is more effective (this was not tested directly in the literature). It is more likely to reflect the different context in other international jurisdictions. There may be some advantages and disadvantages in having a pool of interviewers who are able to train, build and maintain skill in interviewing children (relative to interviewing by the investigating officer), however this needs to occur with consideration to the investigation; ideally with the investigating officer observing the interview and having opportunities to direct the interviewer towards questions that need to be covered for the purposes of their investigation. Potentially more important than which professional undertakes the interview is the opportunity for the relevant agencies to discuss and plan the approach to the interview and the information they may need, and the degree of training and oversight of interviewing.

Limited information was identified about service delivery in regional and remote contexts. Most of the models discussed operated in the metro area or regional hubs, and there is limited research evidence on effectiveness in the regional/remote context. While the study of CAC directors found a large proportion identifying as operating in a regional area, these CACs were not significantly different from metro or suburban CACs on many variables, only in terms of mental health and medical services on site, and in the number of agencies co-located. This emphasises the importance of identifying the core elements of the JIRT model, allowing for adaption of the regional/remote response based on scale/demand for services. The Bourke JIRT in Western New South Wales seems to be a positive example of this adaption with the centre taking more of an opportunity to engage with community groups and service providers in raising community awareness of child sexual abuse (New South Wales Ombudsman, 2012). As the JIRT model is unique within Australia as a state-wide MDT response, there are unique opportunities to develop an evidence base on regional and remote responses.

6.1 Evidence for the Effectiveness of MDTs

The analysis of research evidence found some evidence for MDTs resulting in improved outcomes, but also some serious deficiencies in the evidence base, particularly around the relative importance of particular components of MDTs in contributing to improved outcomes. Much of the research identified in the review was either qualitative (and lacked a comparison to other practice), or provided outcomes data with no comparison group. Many studies also lacked basic description of the nature of the intervention being delivered.

Key Messages:

- Most studies found a positive effect of MDT approaches in terms of criminal justice outcomes. Older studies tended to be more likely to find differences and outcomes were more likely to be significantly different earlier in the criminal justice process;
- The review was limited by the lack of description in studies for the conditions MDT interventions were compared against;
- Older studies tended to find reductions in the number of interviews children were exposed to, while newer studies tended to not find any difference between the MDT and standard practice. This may be attributable to greater awareness of child sexual abuse victim needs and/or evidence-based interviewing protocols being adopted in standard practice;
- Most studies found a positive effect of MDT approaches in increasing mental health service outcomes;
- Studies were mixed in terms of finding increased rates of child protection substantiation and action. Most studies which included child protection outcomes found faster child protection responses;
- Many studies included variables that were more like outputs (e.g. number of interviews) than outcomes (e.g. charges). Results were mixed in terms of measures of collaboration;
- A MDT response was consistently associated with increased staff satisfaction.
- Results were mixed for caregiver satisfaction. One study found no difference in satisfaction for children. The authors of this report would suggest client satisfaction measures relating to MDTs be interpreted with caution due to concerns about the validity of these measures.
- Many studies included did not evaluate individual MDTs, they evaluated thousands of cases from different types of multi-disciplinary responses – finding in particular that increased

elements of MDT practice (e.g. having a care coordinator, co-location of agencies) was associated with increased mental health service receipt;

- Two studies found that states and districts with high concentrations of CACs were found to be associated with improved criminal justice outcomes;
- Across sites of MDTs found to be effective in improving criminal justice outcomes almost all had provision for cross-agency observed interviews of children, which were usually conducted by an independent interviewer supervised by statutory agencies (e.g. Police, child protection).
- Most models found to be effective included advocacy, advocates tended to be independent although there were some examples of advocacy staff provided by child protection authorities and state prosecutors offices;
- Advocates tended to be located on-site. The majority of effective MDTs also included co-located medical and therapeutic services. Relatively few sites had police and child protection agencies co-located.
- Sites that were effective in improving the receipt of medical services tended to have medical personnel co-located, and other therapeutic and support services on site.

6.2 Comparisons to Other Jurisdictions

The comparisons found that the JIRT model is comparable to much of the body of practice on MDT responses, and are particularly unique within Australia for being a state-wide MDT response. While some of the other MDTs discussed deal more broadly with reducing the risks of harm for children (MASH & Puawaitahi), or have a more comprehensive in-house therapeutic and advocacy service (MDCs, MIST & Full Scale CACs), these may be difficult to implement at a state-wide level. A key advantage of some of these broader focused MDT services is the management and oversight of cases that may escalate over time, and potentially the management of cases pre-disclosure that may allow children to be in a position to disclose abuse.

Key Messages:

- The JIRT model is comparable to the broader range of models that exist in practice nationally and internationally;
- New South Wales, Victoria and Queensland all had de-centralised state-wide responses, with specialist resources distributed across the state. New South Wales operates a de-centralised response, with a centralised intake and initial assessment. Other jurisdictions had a much more centralised response with specialist resources centred around capital cities;
- Models like MASH and Puawaitahi were established with a different/broader intent than JIRT - to respond to all forms of child maltreatment across different levels of risk - this includes using a multi-disciplinary team approach to case conceptualisation and planning for vulnerable children whose circumstances fall below the statutory threshold for intervention.
- Of comparable MDT responses for serious child abuse within Australia, the MDCs in Victoria provide a response called the 'options talk' to children and young people that have not yet disclosed; MIST in WA includes independent child advocates consistent with the US CACs model; both MDC and MIST have therapeutic services co-located on site.
- Australian and international models differ in terms of who is responsible for interviewing children. The CACs in the United States in particular rely heavily on independent interviewers, while other jurisdictions (including Australia) were more likely to have police

interviewers; either the investigating officers, or a pool of police interviewers from a specialised unit;

- The CACs and Barnahus (Children's Houses) had prosecutors and legal professionals as part of the core staff at their MDTS;
- Internationally, few models had police and child protection authorities co-located onsite, the JIRTs and other comparable comprehensive MDT responses within Australia (i.e. CDC and MIST) were different in terms of having co-located cross-agency teams. The provision of onsite medical, particularly forensic examinations was mixed both internationally and within Australia;
- Internationally, most models did have onsite therapeutic services as part of the response, as did the MDCs and MIST within Australia. The JIRT model does not include on-site ongoing therapeutic or support services and medical resources;
- Most MDT models operated in urban settings, few directly addressed the challenges of regional/remote service delivery. Although the American CACs had a large proportion of rural centres with similar resources and services to their urban and suburban counterparts; The key features on which they varied being the availability of a purpose built and dedicated physical location and the extent of co-location.

6.3 A Theory of Change for MDTs

Drawing on a generic theory of change developed from the literature by the report authors, section 5 provided an overview of all the activities, mechanisms, and outcomes typically associated with MDT models, and examined the differences between this generic model and the JIRT model in order to identify some of the additional activities, and what the effect of these activities may be based on the logic underlying comprehensive MDT models.

In terms of differences, comparison between the JIRT and the theory of change identified the following differences:

- The length and extent of case consultation and information sharing on cases;
- More engagement with and development of knowledge of available services and supports in community;
- Ongoing and flexible support response beyond the interview and initial referral;
- More comprehensive coordination of services for child and family, and relationship building with community based service providers;
- Broader assessment of needs beyond just counselling and medical examinations;
- Support to engage with needed services, addressing barriers to engagement, and providing information about the benefits of services;
- Consults with and acts on the interests of the child and their family, bringing their interests and perspective to meetings with other agencies;
- Ongoing contact with families: As the advocates would have an extended role with families, they may be best placed to provide consistent information to the family about the status of their case.

6.4 Implications for the JIRT Model

In light of the analysis from the previous sections, there are some clear implications for the JIRT model:

1. Re-examine and potentially change the intended outcomes of the JIRT model to better reflect the model as it currently operates;
2. Consider incorporating the functions of advocates into the JIRT program;
3. Develop a clear theory of change for the JIRTs, distinguishing between core elements, and adaptive elements;
4. Use the theory of change as a key reference in assessment, planning and reform;
5. Develop a long-term strategy for ensuring the JIRT process is an evidence-based approach.

These implications are explained in further detail below.

1. Re-Examine and Potentially Change the Intended Outcomes of the JIRT Model to Better Reflect the Model as it Currently Operates

As discussed in chapter 2 and 3, MDT models vary in terms of their scope and aims. While the JIRT model started with a clear focus on protecting children and enhancing the criminal justice response to severe child abuse cases, it is clear that providing services to address harm from abuse, and to reduce the potential for future harm is now part of the aim of the JIRT. The elevation of NSW Health to an equal partner and the investment in Health Clinicians reflects this, along with the current interest in developing an advocacy response to assist with the response. The service response extends well beyond children and families with ongoing involvement with FACS, referrals are made even for children that do not meet the criteria for a response as part of the JIRT program, and for cases that are not substantiated.

Currently the intended outcomes of the JIRT model are layered between the different structures and policies in place. The JIRT process are a mix of the original aims, merged into the aims of the local planning response, the aims of the JRU, and the aims of the various worthy processes/protocols adopted into the existing structure of the JIRT (i.e. Aboriginal Consultation Protocol; Local Contact Point Protocol; Enhanced Access to the JIRT Program for Aboriginal Children and Young People; and the Witness Intermediary Scheme). There clearly is a logical consistency across the activities of the JIRT model; however, its activities may be more clearly aligned under some overarching outcomes that reflect and consolidate the aims of existing practices.

A re-examination of the purpose and aims of the JIRT model may help to frame reform efforts around some overarching outcomes its activities are aimed at. In particular, it is clear that the JIRT process has an aim to ameliorate harm done to children affected by abuse through supported referral to therapeutic services, and seem to aim towards improving the wellbeing of families by referring to a wide variety of NSW health services. For both children and families these referrals are made for cases that do not reach the threshold for FACS intervention, and even for cases that do not meet the threshold for a response as part of the JIRT program. Having better recognition that the 'back of house' response to cases provided by FACS and NSW Health supports the intended aims of the JIRT model may be helpful in future development and reform efforts.

2. Consider Incorporating the Functions of Advocates into the JIRT Model

The main proposal currently considered by the three agencies that operate under the JIRT model is the inclusion of an advocacy component to complement the existing structure of the program. In the Australian context, advocates are used as part of the MDCs and the MIST models, although in the MDCs this person has a dual role as counsellor/advocate. Similar to most international models, both of these Australian responses involve advocates employed by the not for profit sector so the role is

independent, or is seen as independent from police and child protection statutory agencies. This may be particularly important for communities that may have negative perceptions of police and child protection statutory agencies.

Recognising that the existing resources of the JIRT model fulfil many of the activities in the generic MDT model, the introduction of advocacy may help to enhance the performance of the program on outcomes related to child and family wellbeing across domains (see Implications Part 1). Particularly noting that the strategy of the JIRT model to enhance collaboration, may be compromised by the relatively short involvement of NSW Health and FACS staff on a case compared to CAS detectives.

While all the links in the generic MDT model require future research in order to validate, the model provides a comprehensive summary of the logic implicit in the most comprehensive MDT response. While additional work is needed to better understand the relative importance of components in this model, further adding to the capacity of the JIRT to deliver systems advocacy may contribute to some of the outcomes associated with the 'full service' MDT models.

The inclusion of advocacy is theorised to improve the referral, uptake, engagement, and completion of needed services for children and families, while also assisting/supporting communication between families and statutory services. Advocates may also play an important role in linking the JIRT program to other local service providers, developing local knowledge of capacity, quality/fidelity of treatment models, eligibility criteria, as well as warm referrals to a broad spectrum of services that may benefit children and families. This enhanced knowledge of local services, may help to spread demand across the sector, while not necessarily compromising the quality of services. There may also be a role for advocates to provide a more systematised approach to the issue of improving access and quality of mental health services, such as in Example 1. The role of the advocate in working to empower and represent the interests and perspective of family may also enhance the case review process.

Example 1.

Providing Access Toward Hope & Healing – Chicago CAC

Chicago CAC's PATHH initiative aimed to improve access to children's mental health services, using a system of triage (severity of symptoms & motivation to engage in services), a centralised waitlist of vetted service providers, a Hope and Healing drop-in group for children and families on the waitlist for services, and an enhanced family advocacy service including motivational interviewing and the use of a comprehensive family screening tool. Monitoring systems were also put in place in order to get immediate feedback on children's engagement in services.

The centralised waitlist enabled a system of matching children with service providers, and allowing children and families to try different services without losing their place in the waitlist.

By setting up the centralised waitlist, the CAC was able to monitor and evaluate engagement with counselling services. They were also able to monitor the quality and modality of services, and identify service gaps within the city.

Acknowledging the existing resources in place for referral therapeutic and support services, three options present in terms of blending advocacy into the existing JIRT model, each of which have their own advantages and disadvantages:

a. Introduce a new role of 'Child and Family Advocate' as per the MIST and CAC models operating alongside the existing resources within the JIRT model;
b. Incorporate the core functions of advocacy work into the roles of professionals already working as part of the JIRTs;
c. A combination of both, with advocacy work taken on by existing staff, but with some new functions for the new role.

While it is beyond the scope of this report to identify the best option for NSW, we can identify the following core activities associated with advocacy that may enhance the effectiveness of the JIRT model.

- Case consultation and information sharing with the other involved agencies over the longer term of the child and family's involvement in services. This information sharing may enable the worker to identify the most suitable services given the context of the family;
- Resource identification: Developing knowledge of available services and supports in community including NSW Health resources, but extending to other sources of support and services families may need;
- Ongoing Support as Needed: While the Health Clinicians provide immediate support for when children and families attend the interview, the advocates could provide a source of flexible ongoing support as needed by the family. This flexibility needs to reflect the fact that these families may have ongoing criminal justice matters, ongoing involvement with FACS, or have no on-going involvement from either.
- Coordination of Services: While the Health Clinicians coordinate forensic medical examinations and referrals to the Sexual Assault Centres and other NSW Health services, the advocates may be able to take on the coordination of other types of services (e.g. financial and housing support) for both the child and their family. Part of this role may also be to develop connections and working relationships with these services in order to make supported referrals.
- Assessment of Broad Psychosocial Needs: This may extend the role of the Health Clinician to conduct a broad assessment to identify needs that the advocate may be able to assist with. This may also form part of the triage process to ensure the advocacy response is directed to appropriate cases that are most likely to benefit from the service.
- Support to engage with needed services: Part of the ongoing support provided by the advocate could be focused on addressing barriers to service use. These may include emotional, physical and economic barriers to services. In particular, the advocate may be well placed to provide information about the benefits of engaging with services through motivational interviewing approaches. This may also extend to identifying opportunities to empower children and families through understanding their options.
- Consults with and acts on the interests of child and family: The advocate ideally would undertake work informed by their consultation and understanding of the interests of the child and their non-abusive family members, particularly in relation to their support/service needs. The worker would ideally provide this perspective back to the other agencies still involved in the case through de-briefing meetings and case meetings.
- Ongoing contact with families: As the advocates would have an extended role with families, they would be well placed to provide information to the family about the status of their case.

Much of the evidence base emphasises independent advocates employed by the not for profit sector providing an 'end-to-end' type service, with advocates working from the point of contact with the child and family coming in for an interview. Currently the Health Clinicians take on the role of providing immediate support to children and families during the interview, and the referral to medical services and counselling. If a separate advocate role was to be established, then this person would have to interface with the Health Clinician, meaning some of the benefit of the initial contact and rapport building with families when they attend for an interview may be lost through a handover, particularly if the advocate is not part of the initial response.

Without comprehensive data systems, it is difficult to identify the characteristics of children and families at risk of disengaging or not engaging in therapeutic services and other social supports. This makes it difficult to target services towards these groups. Advocacy may particularly benefit cases that are rejected for a JIRT response and are referred to CSCs; similar to cases in the lower levels of risk for MASH advocates may be able to play a role in reducing the risk level of cases and reducing the need for the involvement of statutory agencies:

There are particular groups that may benefit from the inclusion of an advocacy component into the JIRT process, a policy of targeted universalism (Eisenstadt, 2012) may be the best way to consider the benefit advocacy services can provide. Rather than putting in processes to triage and restrict the use of the service, universalising the service means that the response can match the need, while benefiting the broader population of service users.

Along with needs analysis in the design and development of the advocacy component, the scheme will need to feed in to a theory of change (see Implications Part 3 below) reflecting the fact that positive outcomes are dependent on the nature and quality of services that advocates are assisting children and families to engage with. Ultimately, improving outcomes of child wellbeing post-disclosure and family functioning depend on referral to effective programs that are delivered with fidelity. While changing these may be outside of the remit of the advocacy service, greater connection between the JIRT model and these services may justify a broader plan to monitor and support quality standards for all services referred to by Health Clinicians and advocates.

3. Develop a Clear Theory of Change for the JIRT Model, Distinguishing between Core Elements, and Adaptive Elements

As discussed above (See Implications Part 1) the JIRT model has changed rapidly, and despite efforts to introduce some standardised elements to the response (e.g. JRU), the local JIRT sites do differ in terms of their resourcing, co-location, and in elements of their response; which are reflective of demand within that jurisdiction. For the most part the adaptability of the response to local conditions is beneficial (e.g. Bourke JIRT – New South Wales Ombudsman, 2012). Along with re-examining the outcomes that the JIRT program is aligned towards, the development of a specific program logic for the JIRT model may be helpful, distinguishing between core parts of the response, and differentiating between the different elements, and approaches for the different type of responses that occur across NSW.

This theory of change (similar to the generic one presented in section 5) would identify the core elements of the JIRT program, the activities that must occur in order for the response to be a valid response. Layered on top of this would be the additional activities, protocols and processes thought to enhance the core response. Aligning all the variations in activities and responses to their

corresponding outcomes may help in longer term planning, and create opportunities to more closely evaluate the effect particular initiatives have had on the functioning of the JIRT model.

4. Use the Theory of Change as a Key Reference in Assessment, Planning and Reform;

Developing a theory of change for the state-wide service presents as an opportunity to direct future planning and reform efforts towards a clear set of objectives. Large multi-site programs in particular can suffer from 'mission drift' (Australian Law Reform Commission, 2010). Having an underlying theory of change will help to keep the focus on the specific difference that the JIRT model aims to achieve, and provide criteria for monitoring both the fidelity of the response, and the effect it is having on intended outcomes.

Acknowledging the challenges of service delivery in regional and remote settings, most of the models and components of models discussed previously may not scale well to these types of sites. Having a theory of change may help ensure that these responses purposefully retain all the core elements required to have the intended effect, and allow for decisions to be made about introducing elements that may support core practices, but are not essential elements of the response. Similarly, recognising the core elements of the response will allow for proper assessment of whether responses for Aboriginal children and families have been designed to provide a more culturally appropriate response while retaining the core elements of the model.

As discussed above, a clear and agreed theory of change will be an important resource for future reform efforts, particularly in directing change towards improving targeted outcomes without losing the core benefits of the JIRT response. Future reviews may benefit from a clear statement of the core activities and objectives of the JIRT model, which could be used as a tool to examine the fidelity of implementation; the degree to which the model is delivered consistent with the activities that are thought to result in improved outcomes. Having a clear logic for the process may also help to prevent future reform efforts from removing what are understood to be core elements of the response.

5. Develop a Long-Term Strategy for Ensuring the JIRT Model is an Evidence-Based Approach

As acknowledged in section three there is a lack of evidence for the MDT model, in particular evidence for the effect of all the components in use in different approaches. As such much of the theory of change presented in chapter four is based on assumptions in practice, and requires ongoing evaluation and research in order to develop an understanding of their effects. As a state-wide practice, there are considerable opportunities for the JIRT model to add to internal knowledge of effective practices, but also broader knowledge of effective practices across models. The ongoing work to identify the resources and different responses used in different areas, and to evaluate area specific pilots (i.e. Witness Intermediaries currently being used at CAS Bankstown, Kogarah, Chatswood & Newcastle) and examination of outcomes on the JIRT track system all present as opportunities to develop an improved evidence base for the approach. Along with ensuring that children in NSW affected by abuse and neglect are receiving the best possible response, demonstrated social impact is important for the sustainability of the JIRT model in an ever-changing environment for social services. Building in evaluation and data systems to track the impact of new initiatives, such as advocacy, may help in directing resources towards effective change, and in particular allow for long term modelling of the social and economic impacts.

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APPENDIX A

Studies of Multi-Disciplinary Teams with a Comparison Group (n = 22)

Reference	Cited	Outcomes Included	Comparison Groups	Place
Altshuler (2005)	Child Welfare	• Ratings of quality of collaboration; • Observer ratings of collaboration	Pre-Post Implementation	Washington; United States
Bradford (2005)	Thesis	• Charges, guilty pleas, trial convictions	Cases before CAC implementation	Alabama; United States
Brink et al. (2015)	Child Abuse & Neglect	• Agreement between a multi-disciplinary team's initial findings and Child Protection eventual findings of the substantiation of sexual abuse.	Child Protection Investigation Findings	Mid-West; United States
Campbell et al. (2012)	American Journal of Community Psychology	• Criminal case progression outcomes	Equivalent community Sexual Assault Resource Team without regular meetings	Unspecified; United States
Chomba et al. (2010)	Journal of Tropical Medicine	• Completion of Post-Exposure Prophylaxis among children with suspected sexual abuse.	Cases before MDT implementation	Zambia
Cross et al. (2007a)	Child Abuse & Neglect	• Degree of interagency coordination (i.e. multi-disciplinary team interviews; joint CPS-police investigations; interagency case reviews); • Number of child interviews and number of forensic interviewers; • Interview Setting.	Equivalent within state communities without CAC	Texas, South Carolina, Alabama, Philadelphia; United States
Edinburgh, Saewyc, & Levitt (2008)	Child Abuse & Neglect	• Receipt of medical examination and STI testing; • Receipt of mental health assessment and history; • Referral for counselling; • Charges, prosecutions, sentences, sentence length	Matched cases referred to standards service delivery	Mid-West; United States
Goldbeck et al. (2007)	Child Abuse & Neglect	• Satisfaction with the degree of child protection; • Estimation of suspected child abuse; • Certainty in intervention planning; • Inter-institutional communication; • Reported legal prosecutions;	Randomised: Casework as usual	Germany

		• Involvement of children in planning interventions.		
Jaudes & Martone (1992)	Pediatrics	• Number of interviews and interviewers; • Disclosures/initiated cases of sexual abuse; • Identification of perpetrator and investigative outcomes.	Cases before MDT implementation; Equivalent within state community without MDT	Chicago; United States
Joa & Goldberg-Edelson (2004)	Child Maltreatment	• Decision to prosecute, number and types of abuse charges, number of charges pursued by the District Attorney, number of counts no actioned, dismissed or acquitted, grand jury outcome, case outcome, type of sentence, and sentence length	Matched cases referred to traditional services	West; United States
Jones, Cross, Walsh, & Simone (2007)	Child Abuse & Neglect	• Caregivers and children's satisfaction with investigation.	Equivalent communities without CACs	Texas, South Carolina, Alabama, Philadelphia; United States
Lalayants et al. (2011)	International Journal of Social Welfare	• Child centred assessments and interventions, family focused assessments and interventions, external collaborative approach, internal collaborative approach, both internally and externally collaborative approaches. • Satisfaction with consultations.	Single discipline consultation (domestic violence, mental health, substance abuse)	New York; United States
Lippert, Cross, Jones, & Walsh (2009)	Child Maltreatment	• Denied, disclosed fully or partially, or recanted allegations of abuse	Equivalent communities without a CAC	Texas, South Carolina, Alabama, Philadelphia; United States
Miller & Rubin (2009)	Child Abuse & Neglect	• Felony prosecutions for child sexual abuse	Community with low CAC concentration	Not specified; United States
Ruggieri (2011)	Thesis	• Substantiations of abuse • Prior victimisation for sexual abuse allegations	States with a high concentration of CACs v a state with a low concentration	Kansas, Utah, New Mexico, Nebraska, Nevada; United States

Shao (2006)	Thesis	• Number of substantiated child victims per 1,000 children	Comparison communities	Alabama; United States
Shepler (2010)	Thesis	• Re-victimisation • Time to re-victimisation	Same jurisdiction, different intake cohorts	National; United States
Smith, Witte, & Fricker (2006)	Child Maltreatment	• Involvement of police in investigations; • Number of victim interviews; • Receipt of mental health referral; • Receipt of medical examination; • Substantiations of abuse; • Referral for prosecution, conviction rates	Separate intake cohort	South; United States
Turner (1997)	Thesis	• Number of interviews and interviewers; • Interview settings; • Time from initial report to law enforcement contact, overall length of investigation; • Time from initial report to first counselling contact; • Time from initial report to medical examination; • Identification of perpetrator, arrests and indictments; • Child Protection substantiations and family court petitions.	Cases before MDT implementation	New York; United States
Walsh et al. (2007)	Child Abuse & Neglect	• Receipt of forensic medical examinations; • Time between first report and medical examination; • Caregiver satisfaction with the medical examination	Equivalent communities without CACs	Texas, South Carolina, Alabama, Philadelphia; United States
Walsh et al. (2008)	Child Maltreatment	• Time from initial report to charging decision and case resolution • Total case processing time;	Equivalent communities without CACs	Texas; United States
Wolfteich & Loggins (2007)	Child and Adolescent Social Work Journal	• Substantiation of abuse; • Arrest and prosecution of abuse; • Time from initial report to substantiation; • Re-victimisation (at 24 months)	Cases before CAC implementation; Child Protection Team (medically focused responses in collaboration with Police & Child Protection)	Florida; United States

Studies of Multi-Disciplinary Teams Without a Comparison Group (*n* = 23)

Reference	Cited	Outcomes Included	Comparison Groups	Place
Bonach, Mabry, & Potts-Henry (2010)	Thesis	• Satisfaction with CACs (including the MDT response)	None	North-East; United States
Brown (2007)	Thesis	• Trauma symptoms, anxiety, depression, anger, post-traumatic stress, dissociation, and sexual concerns	Pre-Post Therapy	South-East: United States
Carman (2004)	Thesis	• Family empowerment, use of community resources, and satisfaction with service; • Experiences with the program.	Pre-Post; None	Georgia; United States
Carnes, Nelson-Gardell, Wilson, & Orgassa (2000)	Journal of Aggression, Maltreatment & Trauma	• Number of credible disclosures, number of credible non-disclosures, number of non-credible disclosures, and number of unclear disclosures.	None	Alabama; United States
Carnes, Nelson-Gardell, Wilson, & Orgassa (2001)	Child Maltreatment	• Number of abuse likely cases, number of abuse unlikely cases, number of cases unclear.	None	Western, Midwest, North-East, South-East; United States
Chen et al. (2010)	Children and Youth Services Review	• Cases of suspected abuse reported to authorities; • Reasons for abuse cases reported to authorities.	None	Israel
Dale & Davies (1985)	Child Abuse & Neglect	• Families engaged in rehabilitation services.	None	England
Faller & Henry (2000)	Child Abuse & Neglect	• Involvement of police in investigations; • Involvement of child protection in investigations; • Child disclosure of abuse; • Caretaker response to abuse; • Offender confession, offender pleas, trial and child testimony, and sentences.	Comparison to figures from a number of different studies	Mid-West; United States
Farrell et al. (1981)	Pediatrics	• Identification of the source of gonorrhoea; • Identification of gonorrhoea cases through sexual abuse.	None	Ohio; United States
Glassner (2011)	Thesis	• Incarceration of alleged offender and length of sentence.	None	Texas; United States

Hochstadt & Harwicke (1985)	Child Abuse & Neglect	• Number of recommended services received; • Legal status and residence of child at discharge and follow up (at 12 months)	Comparison to service receipt figures from a previous study	Chicago; United States
Hubel et al. (2014)	Journal of Child Sexual Abuse	• Depression, anxiety, loneliness, trauma, fears about victimisation, caregiver reports of behavioural problems, family adaptability and cohesion, family coping, parenting stress; • Child and parent satisfaction with treatment;	Pre-Post for treatment	Mid-West; United States
Humpheries (1995)	Child Abuse & Neglect	• Referral, attendance, and completion of counselling services	None	Sydney; Australia
Jenson et al. (1996)	Child and Adolescent Social Work Journal	• Child and parent satisfaction; • CAC member satisfaction; • Child behavioural and emotional measures; • Investigation and substantiation by child protection; • Investigation by police, arrests, criminal filings; • Children's living situation (3 months); • Referrals to counselling	None; Pre-Post for behavioural and emotional measures	Utah; United States
McKeown (2012)	Journal of Children's Services	• Receipt of services • Collaboration	None	Ireland
Oral et al. (2001)	Child Abuse & Neglect	• Child mortality, physical/emotional handicaps, lost to follow-up, healthy/free of re-abuse; • Report to social affairs bureau, social affairs bureau follow-up; • Removal from family; • Report to law enforcement	None	Turkey
Powell & Cauchi (2013)	Police Practice and Research: An International Journal	• Victim satisfaction with the response	None	Victoria
Rasmusson (2011)	Child Indicators Research	• Children's experience of the investigation; • Parent's experience of the investigation.	None	Sweden
Rivara (1985)	Child Abuse & Neglect	• Compliance with treatment recommendations; • Re-victimisation; • Abuse and neglect of siblings; • Removal from home	None	Tennessee; United States

Sahin et al. (2009)	The Turkish Journal of Pediatrics	• Substantiation of abuse; • Receipt of medical care; • Receipt of mental health care; • Receipt of social support; • Reports to social services; • Removal from home; • Arrest and charging of perpetrators	None	Turkey
Sedlak et al. (2006)	Child Abuse & Neglect	• Child protection substantiation, dependency court filings; • Referrals to police, investigations, arrests, prosecutions, criminal filings, completion of criminal proceedings, pleadings and findings of guilt	None	Unknown; United States
Stefanovics et al. (2014)	Child Abuse & Neglect	• Improvements on Children's Global Assessment Scale at entry, 3 months, and/or 6 months	None	Brazil
Wallace et al. (2007b)	Child Abuse & Neglect	• Decision to report alleged abuse;	None	Ohio; United States

Studies of Perceived Outcomes of Multi-Disciplinary Teams[9] (*n* = 10)

Reference	Cited	Outcomes Included	Research Approach	Place
Bross, Ballo, & Korfmacher (2000)	Child Abuse & Neglect	• Professional's evaluation of the benefits of the team; • Satisfaction with team (survey)	Interview & Survey	Alaska, Colorado, Idaho, Wyoming; United States
Cole (1998)	Thesis	• Perceptions of achievement of goals of culturally sensitive practice, development of guidelines, and clearly define procedures, equal access to services and treatment, individual understanding of roles, access to information in agencies; • Perception of improvements in services to respond to and resolve cases; • Community awareness of the service, and of child abuse generally; • Perceptions of strengths, weaknesses/limitations of program	Survey	California; United States

[9] This includes outcomes reported by participants that were not specifically researched, and not directly involving the participant.

Doss & Idleman (1994)	Child Welfare	• Familiarity with collaborative protocol; • Use of a case management review team; • Frequency of meetings; • Perceived improvements to interagency cooperation and interaction.	Survey	Georgia; United States
Hebert et al. (2014b)	Australasian Psychiatry	• Perceived strengths and weakness of collaboration; • Practitioner perceptions of patients; • Changes in treatment approach; • Changes in case management practices.	Interview	Queensland; Australia
Jones et al. (1998)	Child Abuse & Neglect	• Perceived usefulness; • Perceived value for determining the safety of child, evaluation of witnesses, information discovery, and whether it determined the outcomes of cases;		Arkansas; United States
Klenig (2007)	Thesis	• Perceived satisfaction with the service, satisfaction with implementation and integration, level of support.	Interviews	Western Australia; Australia
Onyskiw et al. (1999)	Child Abuse & Neglect	• Perceived benefits of the approach	Interviews	Canada
Powell & Wright (2012)	Current Issues in Criminal Justice	• Strengths and difficulties; • Perceived impact; • Experience of co-location; • Future concerns, considerations, and support for expansion	Interviews	Victoria; Australia
Untz (2006)	Thesis	• Perceived effectiveness in serving their communities, addressing cultural needs, and providing follow-up support	Surveys	California; United States
Webber, McCree, & Angeli (2013)	Child & Family Social Work	• Exposure to protocol; • Inter-agency relationships; • Perceived effect on practice; • Perceived effect on safeguarding children; • Perceived Effect on criminal justice outcomes.	Surveys	England

Studies of Multi-Disciplinary Responses (n = 8)

Reference	Cited	Outcomes Included	Comparison Variable	Place

Bai, Wells, & Hillemeier (2009)	Child Abuse & Neglect	• Mental health service use • Mental health outcomes	Degree of ties between child welfare and mental health agencies	National; United States
Chuang & Lucio (2011)	Advances in School Mental Health Promotion	• Mental health service use	Degree of coordination between child welfare, schools, and mental health agencies	National; United States
Chuang & Wells (2010)	Children and Youth Services Review	• Mental health service use	Degree of collaboration between child welfare and juvenile justice agencies	National; United States
Cross, Finklehor, & Omrod (2005)	Child Maltreatment	• Substantiation of abuse; • Removal of children from home; • Service referrals for child and/or family	Degree of collaboration between Police and Child Protection	National; United States
Darlington, Feeney, & Rixon (2004)	Children and Youth Services Review	• Experiences and difficulties with working together	Degree of collaboration between child protection and mental health services	Queensland; Australia
Fryer et al. (1988)	Child Abuse & Neglect	• Worker satisfaction; • Worker confidence in skills	Differing levels of access to and use of MDTs	National; United States
Glisson & Hemmelgarn (1998)	Child Abuse & Neglect	• Service quality; • Service outcomes.	Degree of coordination between children's service agencies	Tennessee; United States
Hurlburt et al. (2004)	Archives of General Psychiatry	• Mental health service use	Degree of coordination between child welfare and mental health agencies	National; United States