



Australian Centre for  
Child Protection

# **Multiagency Investigation & Support Team (MIST) Pilot: Evaluation Report**

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## Glossary of Acronyms and Initialisms

CAC	Child Advocacy Centre (or Children’s Advocacy Centre)
CAI	Child Assessment Interview (WA)
CAIT	Child Assessment and Interview Team (WA)
CAS	Child Abuse Squad (WA & NSW)
CASA	Centres Against Sexual Assault (Vic)
CCFS	Child Centred Family Support (WA)
CPFS	Department of Child Protection & Family Support (WA)
CPS	Child Protection Service (SA)
CPU	Child Protection Unit (WA)
CWS	Child Witness Service (WA)
FACS	Department of Family and Community Services (NSW)
GJCAC	George Jones Child Advocacy Centre (WA)
ICM	Information Coordination Meeting (Qld)
IMS	Incident Management System (WA)
IR	Incident Report (WA)
JIRT	Joint Investigation Response Team (NSW)
JRU	JIRT Referral Unit (NSW)
MDC	Multi-Disciplinary Centres (Vic)
MDT	Multi-Disciplinary Team
MIST	Multiagency Investigation & Response Team (WA)
MoU	Memorandum of Understanding
OMS	Outcome Measurement System
PMH	Princess Margaret Hospital (WA)
POI	Person of Interest
SAS	Sex Assault Squad (WA)
SAPOL	South Australia Police
SAMART	Sexual Assault Management and Referral Tracking System (WA)
SCAN	Suspected Child Abuse & Neglect Teams (Qld)
SOP	Standard Operating Procedure
SPSS	Statistical Package for the Social Sciences
SWA	Safety & Wellbeing Assessment (WA)
SWWS	Safety, Welfare, and Wellbeing Summary (NSW)
TFS	Therapeutic Family Services (WA)
VRI	Visually Recorded Interview (WA)
WAPOL	Western Australian Police

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## EXECUTIVE SUMMARY

This report summarises the findings of the evaluation of the Multiagency Investigation and Support Team (MIST), a pilot response developed by WA Police (Child Abuse Squad); Department for Child Protection & Family Support (Child First, Armadale & Cannington Districts); WA Department of Health (Princess Margaret Hospital); Department of the Attorney General (Child Witness Service); and Parkerville Children and Youth Care Inc.

This report comprises the following:

- A review of key literature;
- What is the Multiagency Investigation & Support Team?
- Comparison of Western Australia to practices in other states/territories;
- A Theory of Change for the MIST
- Methodology;
- Research Findings of the following sub-studies;
  - Qualitative Study of the Perceptions of the MIST pilot;
  - Descriptive Study of the Fidelity of the MIST Pilot to the Standard Operating Procedures;
    - i. Was MIST implemented as intended (e.g. allocation and interview location);
  - Quasi-experimental Comparison;
    - i. Do the MIST and Practice as Usual conditions differ in the criminal justice and child protection response?
    - ii. Do the MIST and Practice as Usual conditions differ in the timeliness of the criminal justice and child protection response?
    - iii. Do the MIST and Practice as Usual conditions differ in the referral and uptake of therapeutic and other supportive services?
- Conclusion.

This report draws on a number of publications resulting from a project looking at effective cross-agency responses to severe abuse. This includes two published systematic searches of the literature (Herbert & Bromfield, 2016b, 2017a), a national survey of directors of Child Advocacy Centres in the United States (Ghan, 2017; Herbert, Walsh, & Bromfield, Under Review), a report comparing cross-agency practices in responding to severe child abuse nationally (Herbert & Bromfield, Under review-a), a draft theory of change for multi-disciplinary teams (Herbert & Bromfield, Under review-b). These articles have also been translated into two reports for the New South Wales Ombudsman's Office and the Joint Investigation Response Team (JIRT) agencies (NSW Police, NSW Health, NSW Family and Community Services) for their review of the JIRT arrangement (Herbert & Bromfield, 2017b, 2017c). This report also references the interim report of the MIST evaluation (Herbert & Bromfield, 2016a).

### **Review of Key Literature**

The studies included in the reviews examined the effect of multi-disciplinary teams on: (a) criminal justice outcomes; (b) receipt of mental health and support services; (c) child protection outcomes; (d) satisfaction with the approach; and (e) mental health symptoms. The studies also provide data on process characteristics; data that suggests the program is operating as intended (e.g. number of interviews, number of joint police/child protection investigations). The studies identified by the searches provided some evidence of the effectiveness for 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. The reviews also highlighted that there is a lack of systematic research and evaluation of approaches; much policy development and practice in responses to abuse occurs without consulting or contributing to existing research and knowledge of effective interventions.

### **What is the Multiagency Investigation & Support Team?**

The MIST pilot involves the co-location of a Child Abuse Squad (CAS) team (WA Police), police and Child Protection and Family Support (CPFS) specialist child interviewers, a CPFS worker (covering two child protection districts), Child and Family Advocates, and therapeutic support services to work as part of an integrated team in Armadale, Western Australia. This team works with cases primarily related to child sexual abuse (and some severe physical abuse cases) by a known offender, and children and families located in or near the Armadale and Cannington communities. Children and families 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 MIST team are co-located in Armadale with the intention that they work closely together on cases. In comparison, cross agency collaboration occurs in “Practice as Usual” cases usually at a senior level prior to being allocated to an interviewer and then a CAS detective. Also, in the MIST pilot, children and families receive advocacy support at the George Jones Child Advocacy Centre (GJCAC), the advocate remains with families while children are interviewed, and works to engage families with supportive services. The advocates also take on the role of liaising between families and other agencies about their case. In the Practice as Usual condition, families generally wait on their own while their children are interviewed, and while services may be suggested to them by interviewers, they do not routinely receive any direct case management or support unless they obtain it themselves or are referred to Child Centred Family Support by CPFS following a Safety & Wellbeing Assessment, or attend the Child Protection Unit at Princess Margaret Hospital<sup>1</sup>.

MIST cases have a different allocation process to Practice as Usual. WAPOL and CPFS MIST team members are responsible for the early processing and assessment of cases, and often receive cases that would have been screened out prior to allocation to a detective in Practice as Usual due to the lack of a disclosure or other evidence to investigate. In Practice as Usual much of the initial screening, information exchange, and allocation to an interviewer is done prior to allocation to a detective by more senior centralised staff.

### **Comparison of Western Australia to Practices in Other Jurisdictions**

Relative to other jurisdictions in Australia, the MIST response is comparable to the Multi-Disciplinary Centres in Victoria, and the co-located Joint Investigation Response Team in New South Wales in terms of the degree of integration of police, child protection, and support service workers. The Child and Family Advocate role was similar to that in the Multi-Disciplinary Centres (Vic), and in the Wraparound (ACT), although the Health Clinicians in the JIRTs (NSW) undertook a similar role but over a shorter period of time.

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<sup>1</sup> We note that since August 2016 CPFS have funded an advocate to provide support and referral from the centralized interview unit at Child Abuse Squad.

Broadly, Western Australia was distinct in terms of having child protection interviewers in lieu of having the assessing child protection worker attend forensic interviews. Only the smaller states (ACT, NT, Tas) still used on the kind of centralised model relied on at CAS/Child FIRST; most other jurisdictions had localised responses, mostly combining the duties of CAS with either family violence more broadly (SA), or adult sexual assault and child abuse (Vic). In all other jurisdictions (except for in some situations in SA), the investigating officer from the specialist squad undertook interviews with children, and all other jurisdictions had provision for child protection to observe the interviews. Practice as Usual in the Perth metropolitan area was quite distinct nationally in not having cross-agency protocols, relying only on directions and procedures within individual agencies.

## **Theory of Change for MIST**

The theory of change outlines the key difference between this evaluation and previous studies of similar approaches; Practice as Usual in the Perth metropolitan area in this context involves elements of inter-agency practice that in other studies have been distinct to the MDT approach being evaluated. This means MIST is being compared against a much higher baseline for inter-agency collaboration, which is less likely to result in a significant difference in outcomes (Wolfteich & Loggins, 2007).

The key points of the theory of change hinge around the increased rate of referral and uptake of services that are assumed to improve children's trauma and wellbeing, and improve family wellbeing more generally. In terms of the criminal justice response, the hypothesised improved collaboration, built in support, and faster response are assumed to have positive effects on the rates of disclosure at a forensic interview, the identification and interview of a person of interest, and the arrest of perpetrators.

The effect of MIST on the child protection response is more unclear, while the existing research suggests that more complete information about cases will result in increased actions by child protection authorities, in the context of MIST there may also be the opposite effect. For some cases where CPFS have relatively fewer concerns, they may be more likely to close the case in the knowledge that the situation in the family will be monitored by the Multi-Disciplinary team at MIST (including the CPFS district worker). The use of the in-house child protection worker is assumed to result in quicker Safety and Wellbeing Assessments.

The theory of change also outlines some of the longer-term measures that the agencies may want to consider monitoring over the longer term.

## **Methodology**

This report comprises findings from three sub-studies:

- A qualitative study of perceptions of the MIST pilot, using interviews with workers involved in and affected by the MIST response, and workers in the Practice as Usual condition;
- A descriptive study of the fidelity of the MIST pilot using administrative data to identify the extent to which MIST was implemented in accordance with the Standard Operating Procedure (SOP) manual;
- A quasi-experimental follow-forward comparison study also drawing on administrative data to compare MIST with the Practice as Usual response;

The qualitative study of perceptions of the MIST pilot involved interviews with staff from the MIST, staff from agencies involved in and affected by the MIST pilot, and equivalent staff from Practice as

Usual. The interviews were undertaken to better understand and contrast the response between MIST and Practice as Usual, and to get a detailed understanding of the implementation of the MIST pilot; the advantages, difficulties, and suggestions for improvement.

The descriptive study draws on administrative data from the WA Police, CPFS, and Parkerville Children and Youth Care Inc. The de-identified data were linked across agencies using a series of administrative codes in order to create a linked database. As data was not able to be accessed directly from the databases, the samples were obtained by providing a data extraction template to Child Abuse Squad, who then included all cases allocated to the MIST CAS team, and all cases that were allocated to a Practice as Usual CAS team, or where a child interview occurred for a CAS charter offence. The process also involved identifying and merging duplicate cases. This resulted in a sample of 180 MIST unique cases and 329 Practice as Usual unique cases. The sample was then matched to the records held by CPFS, and to the sample of cases from Parkerville that received advocacy services.

The quasi-experimental follow-forward study draws on a sub-set of data from the descriptive study, sampled in order to enable an equivalent comparison of the two responses. Cases were restricted to those that included a visually recorded interview, where the allegation fit the CAS charter, and where the incident report and/or the allocation of a detective occurred within the pilot period. To distinguish between these samples the quasi-experimental comparison samples are referred to throughout as MIST-INT ( $n = 126$ ) and Practice as Usual-INT ( $n = 276$ ).

## **Findings Across All Studies**

### **Q1. To what extent has the MIST pilot been implemented as planned among severe child abuse cases referred to the team in the South-East Metropolitan district of Perth?**

Overall, fidelity to the key principles and practices that comprised the MIST Pilot was high. Case allocation was largely consistent with the SOP, however many outside of area cases were investigated by the MIST CAS team and vice versa. The allocation of cases to MIST or Practice as Usual appeared to occur because of logical and purposeful victim/workflow oriented decision-making rather than being a consequence of drift. Advocacy was almost universal for MIST cases and cases interviewed at GJCAC, exceptions were all attributable to circumstances of the individual case. A relatively low proportion of Safety and Wellbeing Assessments were completed by the in-house CPFS worker.

One issue that did emerge was that there may still be differences in the types of cases investigated at MIST in terms of having a disclosure or other avenues for investigation than Practice as Usual even among cases that received a child interview.

### **Q2. What are the weaknesses and strengths of the MIST pilot process compared to standard practices?**

#### *Weaknesses*

There were no significant differences between MIST and Practice as Usual on headline rates of arrests/cautions, or decisions made by CPFS.

The MIST Pilot does not appear to be translating into greater arrests/cautions, which may be due to MIST investigating cases that may have been unlikely to be allocated in Practice as Usual. On the information available to the evaluators no benefits of investigating these cases are apparent in terms of the rate of arrest among priority 3 cases. The investigation of these additional cases may be

contributing unnecessarily to the workload of interviewers and CAS Squad detectives in the MIST pilot.

### *Strengths*

The model is theoretically sound, and aligns with international evidence for best practice; it compares favourably to responses operating within the Australian context.

The MIST response seems to be significantly faster in terms of police investigations and in opening an assessment by CPFS.

The volume of cases being processed by the MIST team appears to be equivalent to if not greater than Practice as Usual even after controlling for the different allocation points.

Practitioners perceived the response to be more victim-centred in terms of being localised and actively incorporating a therapeutic engagement element through the advocates; and to overcome some of the limitations of Practice as Usual in connecting victims and their families to therapeutic services and supports. Caregivers who responded to the survey expressed high levels of satisfaction with the MIST response. Staff involved in the MIST Pilot appeared to feel positive about the Pilot and their work within it.

### **Q3. How effective has the implementation of the MIST pilot been in improving collaboration between professionals involved in the response to severe child abuse?**

Based on the interviews with professionals, the MIST pilot seems to have been successful in improving collaboration between professionals. Participants talked about some of the communication difficulties between police and child protection in Practice as Usual and pointed to the value of not only having a CPFS worker on-site, but also the improved collaboration with interviewers.

The interviews did also identify some gaps in cross-agency collaboration that remain, in particular with the CPFS districts, the Child Protection Unit, and the Child Witness Service. Issues were identified both in terms of the process of consultation and development of the MIST response, and in terms of ongoing case management. Much of the concerns were due to the potentially overlapping role that the advocates played with regards to the work of CPFS districts and the child witness service.

### **Q4. How effective has the implementation of the MIST pilot been in improving the referral to support services to abused children and their (non-abusive) caregivers?**

The evaluators were unable to obtain comparison data in order to address this question. However, among the MIST sample the degree of service delivery and uptake was high, drawing on both the advocates, the in-house therapeutic team, and various external services networked into the MIST response.

### **Q5. How effective has the implementation of the MIST pilot been in decreasing attrition from the investigation of severe child abuse?**

Based on the available data it appears that the MIST pilot has a negligible effect on attrition from the investigation of abuse, although this does not account for the fact that MIST appeared to be responding to cases that may not have received an investigation in Practice as Usual. Interview data showed that professionals perceived MIST, and particularly the advocates, to have enhanced referral and uptake of therapeutic services and the time for this to occur.

## **Q6. How effective has the implementation of the MIST pilot been in increasing the responsiveness of interviews and investigations for severe child abuse?**

Based on the available data it appears that the MIST pilot significantly increases the responsiveness of the policing and child protection response to cases. The MIST response was much quicker from the point of report to each of the key points of the policing response (allocation of a detective, victim interview, POI interview, & police outcome). MIST was also significantly faster in terms of the opening of a Safety and Wellbeing Assessment, but not in terms of the closing of an assessment, or the total number of days an assessment was open.

## **Discussion**

On the basis of this report, the evaluators are of the view that there are no efficiency losses, some efficiency gains in terms of response times, and benefits to victims and their non-offending family members as a result of the MIST response, and that there would be benefits to the scale up of MIST to other locations in WA.

While much of the MIST response appears to be neutral in terms of its effect on the investigation process for police and children protection; the more rapid response, improved collaboration across agencies, and more victim centred response suggest the model has the potential to improve the response and outcomes experienced by children and families. We also note that the arrest/caution rates for MIST were slightly higher on Priority 1 and Priority 2 cases, the rate of arrests were only lower on Priority 3 cases. However, the critical element involves children and families receiving support and services they would have otherwise not received. While we can't directly evidence an improvement in the referral and uptake of these services, having clear arrangements for warm referral to services is in line with best practice in other jurisdictions. This however needs to be monitored and evaluated over the long term, including provision to collect a baseline or comparison response.

The undertaking of linking data sources from three agencies highlighted the critical need for a cross-agency data system that both allows for case tracking/monitoring by the agencies involved, and the monitoring of clearly identified and measured outcomes. The evaluation also highlighted the need for a clearer set of cross-agency protocols and procedures, and effective governance of these procedures.

While the advocate role appears to have value, there are broader capacity challenges in the service environment. Part of the value a cross-agency system may be able to provide is to network across services and manage limited resources to ensure services have the greatest impact, and to improve rates of therapeutic service completion by allowing children and family a choice of services. Related to this is the monitoring of the fidelity, quality, and evidence base of treatments that children and families are referred to. A review of effective treatments for target groups is needed to ensure that the limited resources available are spent on effective treatments, and that the right treatment is provided.

As observed in the interviews, it is problematic for Western Australia to remain with a partially decentralised response, including only two districts. Therefore, there are some key decisions to be made about the cross-agency design of responding to child abuse across the Perth metro area.

As discussed in the national comparison paper (Herbert & Bromfield, 2017c), New South Wales, Victoria, Queensland, and South Australia all have decentralised specialist responses, with specialist units distributed across the state. By localising the CAS response there are opportunities to

harmonise better with existing CPFS districts, although for this response to be scaled additional areas of victim centred policing may need to be combined.

The current cross-agency interviewing unit is part of the centralised response, providing dedicated interviewing for children with a team including both police and CPFS interviewers. A potential scale-up of the MIST response may bring up questions of the value of CPFS providing interviewers, as opposed to having the assessing CPFS caseworker attend interviews. Another option may be to adopt a large scale centralised MIST type model in Stirling St, similar to international models such as Boost Child Advocacy Centre in Toronto or Puawaitahi in Auckland.

The descriptive study showed a benefit to centralised oversight of allocation as it facilitated workload redistribution when a squad was at capacity which will be important for maintaining timely investigations. The difference in process for screening in cases between the two conditions illustrate a particular vulnerability of localised responses. Should localised models be scaled up in Western Australia then particular attention will need to be given to these issues.

## INTRODUCTION

An effective response to severe child abuse requires the involvement of many different professionals and agencies working together. These different groups need to balance the need to keep children safe, prosecute offenders, and identify the services needed to ameliorate harm. The interaction of these agencies ideally occurs within a set of agreed processes and procedures. One type of arrangement is to establish multi-disciplinary teams (either virtual or co-located) to facilitate collaboration between the different workers and agencies required for an effective response to abuse, complimented by resources and services for children and their families. The integration of professional support workers into the response may be critical to improving the effectiveness of the response due to the nature of child abuse offences, which overwhelmingly rely on the evidence of children (Cross & Whitcomb, 2017).

Typically, team/centre based approaches are deployed to address a number of perceived issues with individual agency responses that are thought to lead to poor outcomes at the agency, child, and family level:

- Lack of co-ordination and information sharing across agencies;
- Response and service gaps due to the lack of joined up policy between agencies;
- Exposure of children to inappropriate or repetitive interviewing or disclosures;
- Low rates of access and completion of supportive and therapeutic services for children with trauma;
- Lack of consistent support, advice, and advocacy for children and families;
- Low rates of prosecution for child abuse offences.

Multi-disciplinary team approaches aim to develop coordinated/collaborative responses to the investigation of child sexual abuse cases, with a number of processes to help support this response (e.g. joint interviewing, inter-agency case review meetings), and resources in place to enhance the effort of the coordinated/collaborative response (e.g. on site therapy services; child and family advocacy) to achieve desired outcomes (e.g. increased prosecution of child sexual abuse, reduced system trauma imposed upon child victims).

This document reports on the findings from an evaluation of the Multiagency Investigation & Support Team (MIST) pilot, a developing multi-disciplinary approach to responding to children and families affected by abuse in Western Australia in Armadale and Cannington districts.

### **MIST Pilot**

The MIST was established in July 2015 as a pilot project encompassing Child Abuse Squad (Western Australian Police), ChildFIRST (Department for Child Protection and Family Support WA), Cannington and Armadale District Child Protection and Family Support, the Child Protection Unit (Princess Margaret Hospital; Western Australian Department of Health), the Child Witness Service (Department of the Attorney General), and Parkerville Children and Youth Care. This team aims to bring together all of the agencies involved in the investigation of severe child abuse in order to provide a holistic and coordinated response to affected children and their families.

### **MIST Pilot Evaluation**

This report has been prepared by the Australian Centre for Child Protection, a national research centre based at the University of South Australia. The evaluation of the MIST pilot is being undertaken as part of a Post-Doctoral Research Fellowship (post-doc) funded by Parkerville Children

and Youth Care Inc. and supported in-kind by the Australian Centre for Child Protection, and the University of South Australia through the involvement of senior academics from the Centre. The broad scope of the post-doc is to examine multi-disciplinary responses to child abuse with a view to informing service delivery approaches in Western Australia in a manner which also contributes to the international evidence base.

## **MIST Pilot Evaluation Design**

This report represents a summary of the findings of the ongoing evaluation of the MIST pilot; this section will provide a summary of the scope of this evaluation and the data sources drawn upon to develop the findings.

As this pilot is a new and developing intervention, the focus of the evaluation is primarily to examine implementation of the pilot, and gain a better understanding of the processes involved in the pilot. The research questions are:

**Q1. To what extent has the MIST pilot been implemented as planned among severe child abuse cases referred to the team in the South-East Metropolitan district of Perth?**

**Q2. What are the weaknesses and strengths of the MIST pilot process compared to standard practices?**

**Q3. How effective has the implementation of the MIST pilot been in improving collaboration between professionals involved in the response to severe child abuse?**

**Q4. How effective has the implementation of the MIST pilot been in improving the referral to support services to abused children and their (non-abusive) caregivers?**

**Q5. How effective has the implementation of the MIST pilot been in decreasing attrition from the investigation of severe child abuse?**

**Q6. How effective has the implementation of the MIST pilot been in increasing the responsiveness of interviews and investigations for severe child abuse?**

## **Sub-Studies**

This report presents data from three sub-studies:

- A qualitative study of perceptions of the MIST pilot: In this study interviews with MIST staff and staff affected by MIST were analysed to identify their perceptions of the strengths and limitations of MIST. The interviews also included equivalent staff from the Practice as Usual response;
- A descriptive study of the fidelity of the MIST pilot: In this study the administrative data is used to present the case-flow for MIST and Practice as Usual squad cases. This data is then used in order identify the extent to which MIST was implemented in accordance with the Standard Operating Procedure manual (SOP); and
- A quasi-experimental follow-forward comparison study: In this study the administrative data is used to compare a Practice as Usual team with the MIST Team on the police, child protection, and service delivery response to cases.

## **Data Sources**

The evaluation draws on the following sources of data:

1. *Staff Interviews*: Semi-structured interviews with 33 workers and managers; this included 27 staff involved in MIST or directly affected by the pilot, and six of their equivalent Practice as Usual counterparts. Participants were asked a different set of questions depending on if they

were a MIST worker, a Practice as Usual worker, or a service manager (who were mostly responsible across both MIST and Practice as Usual);

2. *Administrative Data*: The evaluation draws on de-identified administrative data for both sub-studies. The data describe the response from the perspective of each of the agencies involved in the MIST pilot ( $n = 180$ ), and data on an equivalent group of cases dealt with by a Practice as Usual response ( $n = 329$ ) over the same time.

A more restrictive sample was used for the quasi-experimental comparison with 126 in the MIST response, and 276 in the Practice as Usual response. These cases included only those where a child interview occurred, the case fit within the CAS charter, and the matter was reported during the pilot period.

The cases included reflect a time period after a CPFS worker was based at the centre, and prior to the implementation of an advocate at CAS, and the beginning of an additional pilot in the Practice as Usual condition. Records were linked using identifying codes across these databases. Data provided by agencies include:

- a. *WA Police Child Abuse Squad Records*: Records from the IMS database of all Child Abuse Squad cases reported between 1<sup>st</sup> October 2015 – 31<sup>st</sup> July 2016. IMS information includes all the particulars of the police response, and characteristics of the victim and offender;
- b. *ASSIST*: Records were retrieved using ASSIST codes linked to the IMS and SAMART databases drawn from cases for the sample identified by Child Abuse Squad. This database contains details of the Department for Child Protection and Family Support response in relation to the assessment and response to abuse at the district level. This includes referrals to supportive services.
- c. *Parkerville's Sharepoint Database*: This database contains all the details of the work of the advocates and therapists at Parkerville including all referrals to supportive services. These records were retrieved separately and then matched back to cases in the samples identified by Child Abuse Squad. Parkerville also conducted a caregiver satisfaction survey to examine the quality of the MIST response from the perspective of caregivers of children interviewed.

## Content in this Report

This report draws on all available data in the evaluation of the MIST Pilot.

- Review of key literature;
- What is the Multiagency Investigation & Support Team?
- Comparison of Western Australia to Practices in Other Australian Jurisdictions;
- Theory of Change;
- Methodology;
- Research Findings of the Following Sub-Studies;
  - Qualitative Study of Perceptions of the MIST pilot drawing on workers involved in, or affected by the MIST pilot, and their equivalent Practice as Usual counterparts;
  - Descriptive Study of the Fidelity of the MIST pilot;
    - i. Was MIST implemented as intended (e.g. allocation and interview location)?
  - Quasi-Experimental Follow Forward Comparison;

- i. Do the MIST and Practice as Usual conditions differ in the criminal justice and child protection response to cases?
  - ii. Do the MIST and Practice as Usual conditions differ in the timeliness of the criminal justice and child protection response?
  - iii. Do the MIST and Practice as Usual conditions differ in the referral and uptake of therapeutic and other supportive services?
- Conclusion.

## SUMMARY OF KEY LITERATURE

This section will briefly summarise some of the key published peer reviewed research on multi-disciplinary approaches to child abuse investigation. As mentioned above several systematic searches of the literature have been undertaken to inform the development of this evaluation. The first focused specifically on the evidence for Child Advocacy Centres (Herbert & Bromfield, 2016b), while the second involved a broad search of evidence for multi-disciplinary teams in general (Herbert & Bromfield, 2017a). An additional review of components of effective cross-agency responses has not yet been completed, but the research has been drawn on in the researchers' commissioned reports on the Joint Investigation Response Teams in New South Wales (Herbert & Bromfield, 2017b, 2017c). A more detailed summary of findings of these searches can be found in these articles/reports.

These reviews were undertaken as a rapid systematic search of the literature. This is a method of undertaking a literature review that addresses several issues with standard literature reviews, principally the selective inclusion of studies that support a particular position.

Many studies identified in these reviews did not include comparison to a control or practice as usual condition. While there may be legitimate reasons why studies were done this way, this research has limited use in informing decision-making around effective practice. The review of literature only draws on studies with a comparison group.

The studies included in the reviews examined the effect of multi-disciplinary teams on: (a) criminal justice outcomes; (b) receipt of mental health and support services; (c) child protection outcomes; (d) satisfaction with the approach; and (e) mental health symptoms. The studies also provide data on process characteristics; data that suggests the program is operating as intended (e.g. number of interviews, number of joint police/child protection investigations). A summary of the findings of the searches can be found in Appendix B, links to the full articles can be found in the reference section.

Broadly, the studies identified by the search provide some evidence for the effectiveness for multi-disciplinary teams on most of the outcomes discussed, particularly in terms of criminal justice outcomes and the increased receipt of supportive/therapeutic services. However, there are gaps in terms of high quality studies amongst a few types of outcomes, particularly around child and family wellbeing. The reviews also highlighted that there is a lack of systematic research and evaluation of approaches; much policy development and practice in responses to abuse occurs without consulting or contributing to existing research and knowledge of effective interventions. As such the research in this field has limited utility to draw conclusions about the effectiveness of MDT approaches relative to others. This issue is particularly important considering in most jurisdictions practice has moved on significantly since the major studies of responses, meaning that most standard practice will have some elements of multi-disciplinary practice.

## WHAT IS THE MULTIAGENCY INVESTIGATION & SUPPORT TEAM?

In July 2015, the MIST pilot launched with the re-location of a WA Police Child Abuse Squad (CAS) team to the George Jones Child Advocacy Centre in Armadale, Western Australia. The MIST CAS team at the beginning of the pilot comprised of two Detective Sergeants, three detectives, and two probationary detectives. One police child interviewer, and two part-time ChildFIRST (CPFS) child interviewers were also brought to the centre. Near the end of October 2015, a Senior Child Protection Case Worker began at the centre, representing both Armadale and Cannington CPFS districts. A team leader from ChildFIRST (the CPFS team responsible for child interviewing) was also based part-time at the centre.

Onsite resources provided by Parkerville Children and Youth Care Inc. at the beginning of the pilot included two Child and Family Advocates, one Clinical Psychologist Consultant and members of their therapy team as needed, the clinical director of the George Jones Child Advocacy Centre, and the administrative team including a receptionist. A part-time paediatrician from the Child Protection Unit at Princess Margaret Hospital also became a member of the pilot, but left around November 2015, with the role partly replaced by the contracting of an external paediatric consulting team holding regular clinics at the centre.

Like many other types of multi-disciplinary teams, the intent of MIST is to set up a framework to support collaboration and communication between workers that respond to abuse cases, and to embed the resources to support abused children and families in the response. This is constituted by some clear structural differences in the way the response occurs compared to Practice as Usual (See Table 1). We have provided a summary of some of the changes to the Practice as Usual process put in place after the evaluation follow-up period.

**Table 1 Differences between MIST and Practice as Usual Response**

	<b>MIST</b>	<b>Practice as Usual</b>
<b>Intake/Allocation</b>	<ul style="list-style-type: none"> <li>• Cases allocated to MIST based on CAS charter, area of offence and residence of child;</li> <li>• After initial intake screening cases are assessed by the CAS team;</li> <li>• Typically, the investigating detective is allocated prior to an interview and strategy meeting.</li> </ul>	<ul style="list-style-type: none"> <li>• Cases allocated based on CAS charter and CAS squad capacity;</li> <li>• Centralised group assess cases;</li> <li>• Typically, the investigating detective is allocated after the interview.</li> </ul>
<b>Strategy Meetings</b>	<ul style="list-style-type: none"> <li>• Strategy meeting typically includes the investigating detective, in-house CPFS worker, team leader from CPFS districts along with interviewers, and other agencies as needed;</li> <li>• Information from the strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Strategy meeting includes team leaders and Detective Sergeants from Child First and Child Abuse Squad, team leaders from CPFS districts, and other agencies as needed.</li> </ul>

	meeting is passed on to the advocate.	
<b>Interview</b>	<ul style="list-style-type: none"> <li>• Interview occurs at GJCAC in Armadale;</li> <li>• Child and family greeted by the interviewer and advocate;</li> <li>• Advocate remains with family in waiting room while child is interviewed to provide support and to discuss the MIST process;</li> <li>• Advocate and Psychologist available to provide support to child and family or to assess mental health concerns;</li> <li>• Interview typically observed by investigating detective, in-house CPFS worker, and another interviewer;</li> <li>• Interviewer, detective, CPFS worker able to debrief family and talk to them about what will happen next;</li> <li>• Family able to remain and receive support from the advocate as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Interview occurs at CAS/Child First in Perth;</li> <li>• Child and family greeted by the interviewer;</li> <li>• Family remains in waiting room while child is interviewed;</li> <li>• No capacity for in-house support or assessment of mental health concerns;</li> <li>• Interview typically observed only by the other interviewer;</li> <li>• Interview typically provides debrief to family about disclosure and can provide a list of services they could access.</li> </ul>
<b>Follow-Up</b>	<ul style="list-style-type: none"> <li>• Advocate will make contact with the family to provide follow-up support and to arrange for an assessment;</li> <li>• Some families will receive more extensive advocate follow up for support;</li> <li>• Cases are discussed at the MDT meeting to determine the most suitable services;</li> <li>• Advocate works to engage families in needed services;</li> <li>• Dedicated in-house therapy resources with no session limit;</li> <li>• Advocates provide ongoing updates about the status of the case;</li> <li>• Safety &amp; Wellbeing Assessment completed by in-house CPFS</li> </ul>	<ul style="list-style-type: none"> <li>• Degree of support following the interview will depend on family's capacity to individually engage with services, ongoing involvement of CPFS, or involvement of the Child Protection Unit at Princess Margaret Hospital;</li> <li>• Information about the status of the case from the investigating detective or allocated CPFS worker;</li> <li>• Safety and Wellbeing Assessment will be completed by the allocated CPFS district worker.</li> </ul>

	worker, who then hands over the case if needed to another CPFS worker. Advocates will liaise with CPFS if both are working on a particular case.	
<b>Court Preparation</b>	<ul style="list-style-type: none"> <li>• If advocate is still providing support as the matter comes to court, the advocate will liaise with the Child Witness Service;</li> <li>• The Child Witness Service will make contact with the family and provide support and court preparation services.</li> </ul>	<ul style="list-style-type: none"> <li>• The Child Witness Service will make contact with the family and provide support and court preparation services.</li> </ul>

## Intake/Allocation

The MIST SOPs manual outlines two conditions for allocation to MIST:

- The victim’s residence occurs within Armadale and Cannington CPFS boundaries; and
- The alleged offence fits within the Child Abuse Squad Charter.

While the place where the offence occurred was originally part of the conditions for inclusion this has not been used as part of the criteria for the allocation of cases to MIST. As will be discussed further, this criterion was not strictly adhered to, with both conditions responding to cases outside of their intended catchment area.

Setting intended suburb boundaries differs from the Practice as Usual condition as cases are allocated by capacity rather than geography, meaning that CAS squads will be responding to offences across the Perth metro area (and some offences in regional areas), and dealing with different CPFS districts for joint responses.

For most Practice as Usual cases, much of the initial response is undertaken in parts; a senior group of CAS and ChildFIRST staff will undertake the initial desktop assessment of information about the case, undertake a strategy/planning meeting, then allocate the case to an interviewer, which will then be allocated to a detective after the interview. For MIST referrals while some initial screening is still done at intake, much of the initial work on a case is now done by the MIST team. This includes obtaining background information about the family and person of interest from CPFS and Police databases.

## Strategy Meetings

Undertaking a strategy meeting is a key stage for both MIST and Practice as Usual cases to facilitate the sharing of information across agencies and to plan the response. For MIST cases, strategy meetings are chaired by the CPFS child interviewers, and typically include the investigating detective and the in-house child protection worker, as well as team leaders from the relevant district CPFS. Strategy meetings for Practice as Usual cases involve team leaders from ChildFIRST, and the relevant District CPFS, along with senior CAS police (but generally not the detectives that will investigate the matter). For MIST cases, following the strategy meeting either the CPFS worker or detectives will provide information about the case to the advocate in anticipation of a child interview.

## **Interview**

Most of the differences between MIST and Practice as Usual case flow occur at the point of interview. For MIST cases, children and families will be invited to attend an interview at the George Jones Child Advocacy Centre. When they arrive they will be greeted by an interviewer and the Child and Family Advocate and taken upstairs to a family room. The interviewer will bring the child into the interviewing suites, while the advocate remains with the family to build rapport and begin to discuss the services that are available. The advocate and the duty psychologist are also available to provide any support or counselling to the child or family during the interview. The interview will typically be observed by a second interviewer who will write notes during the interview, the investigating detective, and the in-house CPFS worker. Following the interview, the interviewer will debrief the family, and typically the detective and in-house CPFS worker will also talk to the family about any disclosures. The family then can remain at the centre and receive any additional support from the advocate as needed.

By comparison, in Practice as Usual cases, families will be greeted by an interviewer, the family will remain in an open waiting room during the interview. The interview is typically observed only by another interviewer. Following the interview, the interviewer may debrief the family about the disclosure during the interview, and may suggest some supportive services the family may want to access, and have a pamphlet of suggested services available. Once an interview has occurred, and a disclosure obtained the matter will then proceed to be allocated to a detective.

Over the period included in this evaluation, there was no Child and Family Advocate in the Practice as Usual condition, although since then CPFS have created an advocate role at the CAS/ChildFIRST interview suites. This role primary extends to providing support to the child/family on the day of the interview.

## **Follow-Up**

In the MIST Pilot, following the interview, the Child and Family Advocate makes contact with the family to provide support over the phone and to arrange for the family to come in for an assessment in order to identify appropriate services to refer the family to. Some children and their families may receive more intensive follow up, with individual and group sessions, provision of supportive counselling, protective behaviours training, psycho-educational and general supports. The advocate will bring cases to the Multi-Disciplinary Team case review meeting (attended by the in-house CPFS worker, Parkerville staff, and occasionally CAS Detectives), where the situation of the family, appropriate services, and the status of the case will be discussed. The advocate works with families to ensure a successful referral to services, and to provide updates to the family on the status of the case.

The Therapeutic Family Services team within the George Jones Child Advocacy Centre has capacity to receive referrals from the MIST team, and to provide as many sessions as needed on top of the regular 10 sessions that can be obtained under a mental health care plan. A similar service is provided centrally by the Child Protection Unit at Princess Margaret Hospital.

Typically for MIST cases, when the family requires a Safety and Wellbeing Assessment this will be completed by the in-house CPFS worker. Prior to the in-house worker being deployed, these would have been undertaken by the intake/assessment team for the appropriate CPFS district. If the family require further attention from CPFS as a result of issues identified in the SWA, this worker will arrange a handover to a different team in either Cannington or Armadale CPFS. The advocates work

to coordinate with CPFS where both a CPFS District and the advocates are actively involved in a case. In comparison, the degree of follow up for Practice as Usual cases is not well known. Some families with active cases with CPFS may receive referrals to supportive services or trauma counselling, or may identify and access these services themselves. Interviewers sometimes may provide a referral to services, and a list of services are provided to the family in a post-interview handbook. Information about the progress of their case will generally come from the detective assigned to the case, or the CPFS worker. Families can obtain a mental health care plan for children affected by trauma from a GP, which will entitle them to ten free sessions of therapy, though there is typically a considerable waiting list for free and Medicare supported services (6-8 months). Alternatively, families may attend the therapy service at the Child Protection Unit of Princess Margaret Hospital, which is similar to the therapy service at MIST in that children can receive as many sessions as they need.

In both MIST and Practice as Usual cases, the Child Witness Service will provide support to the child in preparation for the court process. In MIST cases, the advocate may liaise with workers from the Child Witness Service to provide an introduction to the worker that will provide the child preparation for court. In Practice as Usual this is often the point at which arrangements are made for the child and family to receive counselling and support.

### **Changes to Practice as Usual**

While outside the scope of the data obtained for this evaluation, a number of changes have occurred within Practice as Usual, which in part helped to determine the date limits for the sample.

Since August 2016, CPFS has employed an advocate working at the CAS/ChildFIRST interviewing suites. This role primarily focuses on providing support to families when they attend for an interview. Partly due to the volume of cases this worker is unable to provide much follow-up support or service coordination in the way that the Child and Family Advocates currently do for cases in the MIST condition. As outlined in the methodology section, the sample was drawn from October 2015 – July 2016 in order to best provide a distinct comparison between Practice as Usual and MIST, without the presence of an advocate at the interview suite.

In addition since late 2016, Child Abuse Squad has undertaken a trial of a new arrangement for one of their teams, more or less adopting some of the processes of MIST in the centralised model. This involves removing some police interviewers from the joint CAS/ChildFIRST floor, and co-locating them with a team of CAS detectives. Along with this closer connection between the interviewers and investigators, the allocation process has changed in order to allow for an earlier allocation of detectives to cases to allow them to attend strategy meetings, and forensic interviews with children. This change means that CPFS interviewers do not conduct interviews for this team and only observe interviews, although they are able to ask additional questions after the evidentiary interview has concluded. This change still does not involve the assessing child protection worker attending the interview, as they routinely do in the MIST response. This arrangement has since been adopted across all non-MIST CAS cases since mid-2017.

## COMPARISON TO PRACTICES IN OTHER AUSTRALIAN JURISDICTIONS

This section has been included to provide some context around the current arrangements between agencies in Western Australia, comparing policies and procedures in Western Australia to those in other Australian jurisdictions. From undertaking the national review project (Herbert & Bromfield, 2017c) the researchers have observed that many jurisdictions lack knowledge of the practices of their interstate colleagues. The comparison is intended to be informative about the context of arrangements in Western Australia, and identify some of the solutions other states/territories have employed towards potentially common problems.

The information in this section is drawn from a national comparison of cross-agency responses to abuse undertaken by the authors for the NSW Ombudsman, NSW Police, NSW Health, and Family and Community Services NSW (Herbert & Bromfield, 2017c).

The national comparison report (Herbert & Bromfield, 2017c) was undertaken in order to better understand the cross-agency responses in place in every state/territory; with a particular focus on cross-agency models of practice. The approach to the report involved drawing on publicly available documentation describing the response to severe child abuse in each jurisdiction, and providing state/territory summaries back to policing and child protection agencies in those jurisdictions for review.

This section will begin with a summary of arrangements in each Australian jurisdiction, followed by a discussion of how policy/procedures in Western Australia compare to other jurisdictions.

### **Western Australia**

In Western Australia, the report describes three distinct responses, acknowledging a new trial of a different arrangement for interviewing and investigation in the standard response (Herbert & Bromfield, 2017c), and the introduction of an advocate to the centralised interviewing suites.

In the regular, or as referred to in the rest of this report, Practice as Usual response, for the Perth Metro area more severe child abuse offences are dealt with by centralised specialist policing teams (Child Abuse Squad & Sex Assault Squad), with interviewing conducted by a mixed team of police and CPFS staff. A strategy meeting is used to help WAPOL, CPFS, and the Child Protection Unit at Princess Margaret Hospital plan their initial response to a case. Until recently the investigating detectives did not typically attend interviews, although interviews involved an interviewer from both Police and Child Protection. Referral to supportive and therapeutic services more or less occurs informally, although a CPFS employed advocate now provides support to families at the point of interview.

As mentioned above, some of the processes around Practice as Usual has recently changed. As a trial, police has withdrawn some of their interviewers from the shared floor and co-located them with their investigators. The allocation process has also changed in order to enable detectives to observe and provide direct feedback on interviews. While the CPFS interviewers are able to observe these interviews and ask child safety related questions after, the CPFS worker who ultimately undertakes the assessment of the child still does not typically attend interviews, although we note that CPFS now employs an advocate who provides support to families during interviews.

As discussed in detail earlier, the MIST pilot involves the co-location of the CAS 3 team, with a police and child protection interviewer, a CPFS worker who conducts assessments for the CPFS districts in the MIST catchment, two Child and Family Advocates, and a team of therapeutic staff. The team

receives cases from their local area, as opposed to the other teams who receive cases from across the Perth metro area. Strategy meetings occur as normal, however with the involvement of the investigating detective and the CPFS worker that will be undertaking the assessment. All of these workers are able to observe and provide feedback on the interview. The Child and Family Advocate initially engages and provides support to the family during the interview, and then has a role that extends until the family decides they do not need the service any longer. The GJCAC facility is similar to the CAS interviewing facility except for the location, and that families are provided with a private room instead of an open reception area.

In regional/remote Western Australia, the procedure is similar to Practice as Usual, however with detectives and interviewers from the local policing district, as opposed to the specialist units in the Perth metro area; although some offences will be forwarded to Child Abuse Squad or Sex Assault Squad in Perth for a response, particularly those from the Peel area. Strategy meetings occur, similar to the responses in the Perth metro area, with local police and child protection authorities, and usually members of the Child Protection Unit at Princess Margaret Hospital meeting by phone. Much of the follow-up and ongoing discussion and feedback about practice occurs informally.

## **New South Wales**

Most serious child abuse offences in New South Wales are handled by a specialist tri-agency team called the Joint Investigation Response Team (JIRT). The JIRT is 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 areas providing a JIRT response (all Sydney metropolitan and major regional centres) are fully co-located with all three agencies based in a shared building and workspace. All co-located and non-co-located sites include access to specialist interview suites with observation rooms; although some interviews occur at Community Services Centres, in the home, schools, hospitals or other community facilities. Interviewing suites used in New South Wales are designed to reduce potential distractions to the child, and to be a safe and comfortable space for children.

Cases for the JIRTs come through a shared central reporting system (Family & Community Services Helpline); cases are then assessed and triaged by all three agencies at the JIRT Referral Unit (JRU). Referrals are then sent out to the local planning response, which includes a seven-stage process:

1. *Accepted Referrals*: Matters are transferred from the JRU to the respective JIRT team, 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 essential 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 Family and Community Services and Health perform in relation to assessing issues of safety, risk, health and wellbeing. Family and Community Services 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 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 arrangement still involved in the 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.

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

## **Victoria**

The Multi-Disciplinary Centres (MDC pilots) are a centre-based response inclusive of a specialist policing team (Sexual Offences and Child Abuse Investigation Teams), child protection statutory workers, a not-for-profit support agency (Centres Against Sexual Assault), and a specialist unit that undertakes forensic medical examinations in Victoria (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). At these centres all agencies are co-located except the specialist forensic medical unit. In Victoria the cross-agency response encompasses the sexual abuse/assault of both children and adults.

The MDC response links the support and therapeutic requirements of children and their families, primarily through co-location. Each agency works in their own area, but there is an understanding that each is available for consultations and discussions as needed. Police and child protection investigators undertake joint interviews and investigations on-site, with Centres Against Sexual Assault (CASA) workers available to provide acute support and counselling during interviews.

The MDCs deal with cases that have come in through police or child protection referral, but also cases without a referral or a disclosure. These cases are managed by Centres Against Sexual Assault workers, until they can be referred to statutory agencies where a child/young person and their family wants to formally report abuse. The MDC pilots include a counsellor/advocate role who works

to engage the child and family with in-house services.

Outside of areas where a MDC exists the same interagency protocol operates, however with each agency working from separate offices. Police are required to contact their local CASA office within two hours of a report to facilitate support; immediate counselling and support can be arranged either at the interview site or at the closest CASA.

## **Queensland**

The state-wide Queensland response involves inter-agency information sharing and communication at two levels. Suspected Child Abuse and Neglect (SCAN) teams deal specifically with matters that are notifications by Child Safety Services, or where 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.

The SCAN response is aimed at sharing information 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 exist 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 SCAN 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 and Child Safety Services will also identify and refer to appropriate services as part of their participation in the SCAN 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 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 for Child Protection), and the Child Protection Service within SA Health (Flinders Medical Centre & Adelaide Women and Children's Hospital<sup>2</sup>). 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 strategy discussions about alleged intra-familial abuse, while SAPOL convene discussions about alleged extra-familial abuse.

The Child Protection Service (CPS) provides a specialist response for cases involving children under seven, with the CPS conducting psychosocial forensic assessments from Flinders Medical Centre, 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 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 therapeutic 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. 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 ensuring the level of care is monitored, unless CPS, the Child & Adolescent Mental Health Service, or a non-government agency assumes responsibility.

## **Tasmania**

Tasmania operates an inter-agency response relying on informal communication between police and child protection workers, and victim support groups. The state does not have a specialist policing group for child abuse offences, but do run interview training for police from the Central Investigations Branch to undertake interviews with children. Provision is in place for Child Safety Services to observe the interview and contribute to interview planning.

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<sup>2</sup> Note: The SA government have committed to establishing an additional Child Protection Service unit at Lyell McEwin Hospital.

## **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.

## **Northern Territory**

The Child Abuse Taskforce is a co-located response including a territory specialist policing unit (Sex Crimes Unit), federal police, and child protection agencies. There are two centres responding to matters across the Northern Territory in Darwin and Alice Springs. The taskforce deals specifically with serious and complex matters requiring joint investigation (i.e. intra-familial child abuse), with referrals received from the Central Intake Team (Territory Families).

The Child Abuse Taskforce management team meet daily to conduct case management discussions and to assess cases referred to the taskforce by the Central Intake Team. Matters accepted by the Child Abuse Taskforce can be streamed into a joint investigation, or a police only investigation within the taskforce. Child interviews are conducted either in co-located interview suites, or off-site in a safe and non-distracting environment by the investigating officer.

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.

Part of the role of the taskforce is community engagement, developing a sustained presence in Aboriginal communities to build confidence in reporting child abuse and neglect.

## **Comparison of Western Australia with Other Australian Jurisdictions**

As discussed in Herbert and Bromfield (2017c) cross-agency responses are used in different ways and at different stages in the case process across Australia. We have made several key observations about the Western Australian responses compared with other Australian jurisdictions.

### **MIST in Line with JIRT and MDC Models**

The MIST response compares well with established Australian responses like the Joint Investigation Response Teams (NSW) and the Multi-Disciplinary Centres (Victoria). Like MIST, the MDCs have the co-location of key localised police and child protection workers, and an on-site advocate role along with on-site support services. While most of the JIRT sites have a similar degree of co-location, the response is limited in terms of the continued involvement of the onsite health clinician. A recent review of the JIRT has recommended the adoption of a child and family advocate role similar to that at MIST and the MDCs (New South Wales Ombudsman, 2017).

### **Child & Family Advocacy Role in MIST**

MIST is distinctive in providing an independent Child and Family Advocate role as part of the in-house response, which is only matched by the Multi-Disciplinary Centres in Victoria. While New South Wales uses Health Clinicians in a similar supportive role, their involvement on a case is more limited in terms of timespan and scope. The ACT uses similar workers in their wraparound response, however this occurs after the interview process as part of an aftercare response.

### **No Involvement of Child Protection Worker at Interview in Practice as Usual**

Compared to other jurisdictions, Practice as Usual in Western Australia was distinct in not involving the child protection worker who undertakes the safety assessment in the interview of children, instead CPFS contribute staff to a pool of specialist child interviewers alongside Child Abuse Squad interviewers. In comparison, most other jurisdictions had policy recommending that the child protection worker responsible for the child/children either *should* be present at interviews (NSW, Vic, Qld), or the procedures acknowledge that child protection workers *can* be at interviews (Qld, SA-Under Seven Year Olds, Tas, ACT, NT). The only other jurisdiction that did not routinely include the assessing child protection worker in observing forensic interviews was South Australia in some situations, namely where children were *not* interviewed by the Child Protection Service (i.e. children over seven years with no complex communication needs). Workers from the Department for Child Protection (SA) could however request to obtain a copy of these interviews after they occurred.

### **Centralisation of Key Resources**

Practice as Usual in Western Australia had strong centralisation of key resources, with specialist interviewing facilities and forensic medical facilities based in Perth city. While not unusual amongst the smaller population states (i.e. NT, ACT, Tas), this also extended to the investigation of cases, with all Child Abuse Squad teams (other than the MIST team) based in Perth. Only the MIST CAS team responded to cases within their local area. New South Wales, Queensland, Victoria, and South Australia all had de-centralised specialist policing teams that operate in their local districts, although many of their remits extended to either adult sexual assault or family violence. This arrangement in Western Australia is different among CPFS, where workers operate within local districts, although the specialist interviewers are centralised. The centralisation of CAS teams (other than MIST) mean that the teams work across many different CPFS districts, with different workers, processes and practices.

### **Interviewing**

Interviewing practices were also quite distinct in Western Australia with interviewing undertaken by a joint team of police and child protection specialist child interviewers. This contrasts with most other jurisdictions where the investigating detective undertakes the interview. The only exception to this is in South Australia, where children under seven and children with communication difficulties can be interviewed at the Child Protection Units at Flinders Medical Centre or Adelaide Women and Children's Hospital. In South Australia, for older children with communication difficulties, each Family Violence Section has a Victim Management Unit with specialist interviewers, otherwise interviews will be conducted by the investigating officer if they have received the required training.

### **Inter-Agency Protocol, Governance & Training**

Western Australia was also quite distinct in not having an inter-agency protocol for Practice as Usual, with processes outlined in each agency's policy and processes rather than in a protocol or manual

across agencies. Most other jurisdictions had detailed processes and procedures for the cross-agency response to cases (NSW, Vic, Qld, SA, NT), with the process document in many cases available to the public. Similarly, Practice as Usual was distinct in having limited cross-agency governance and not having cross-agency training for workers, with both occurring within individual agencies. Although we do note that the individual agency inductions for workers often include leaders from other agencies, and that interview training is currently cross-agency between police and CPFS. Most jurisdictions had groups for senior executives that met regularly to discuss and review practices (NSW, Vic, Qld, SA, ACT, NT), and cross agency training in the policy and procedures that apply across the agencies involved in the response (NSW, Vic-MDC, SA, ACT). MIST had much more governance and review around its operation due to it being a pilot project.

## **Conclusion of Comparison Section**

This section outlined some of the equivalent responses operating in other Australian jurisdictions, highlighting the Joint Investigation Response Teams (NSW), and the Multi-Disciplinary Centres (Vic) as equivalent responses to the MIST in most aspects. Both have clear state-wide interagency procedures that apply across both co-located and non-co-located sites in the responses. The Multi-Disciplinary Centres had a similar counsellor/advocate role to the Child and Family Advocate.

Broadly, Western Australia was distinct from the other jurisdictions in terms of having interviewers employed by child protection in lieu of having the assessing child protection worker attend forensic interviews. Only the smaller states (ACT, NT, Tas) still had the kind of centralised model relied on at CAS/Child FIRST; most other jurisdictions had localised responses, mostly combining the duties of CAS with either family violence more broadly (SA), or both adult sexual assault and child abuse (Vic). In all other jurisdictions, the investigating officer from the specialist squad undertook interviews with children, and had provision for child protection to observe the interviews. Practice as Usual was quite distinct nationally in not having cross-agency protocols, relying only on directions and procedures within individual agencies.

## THEORY OF CHANGE FOR MIST

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.

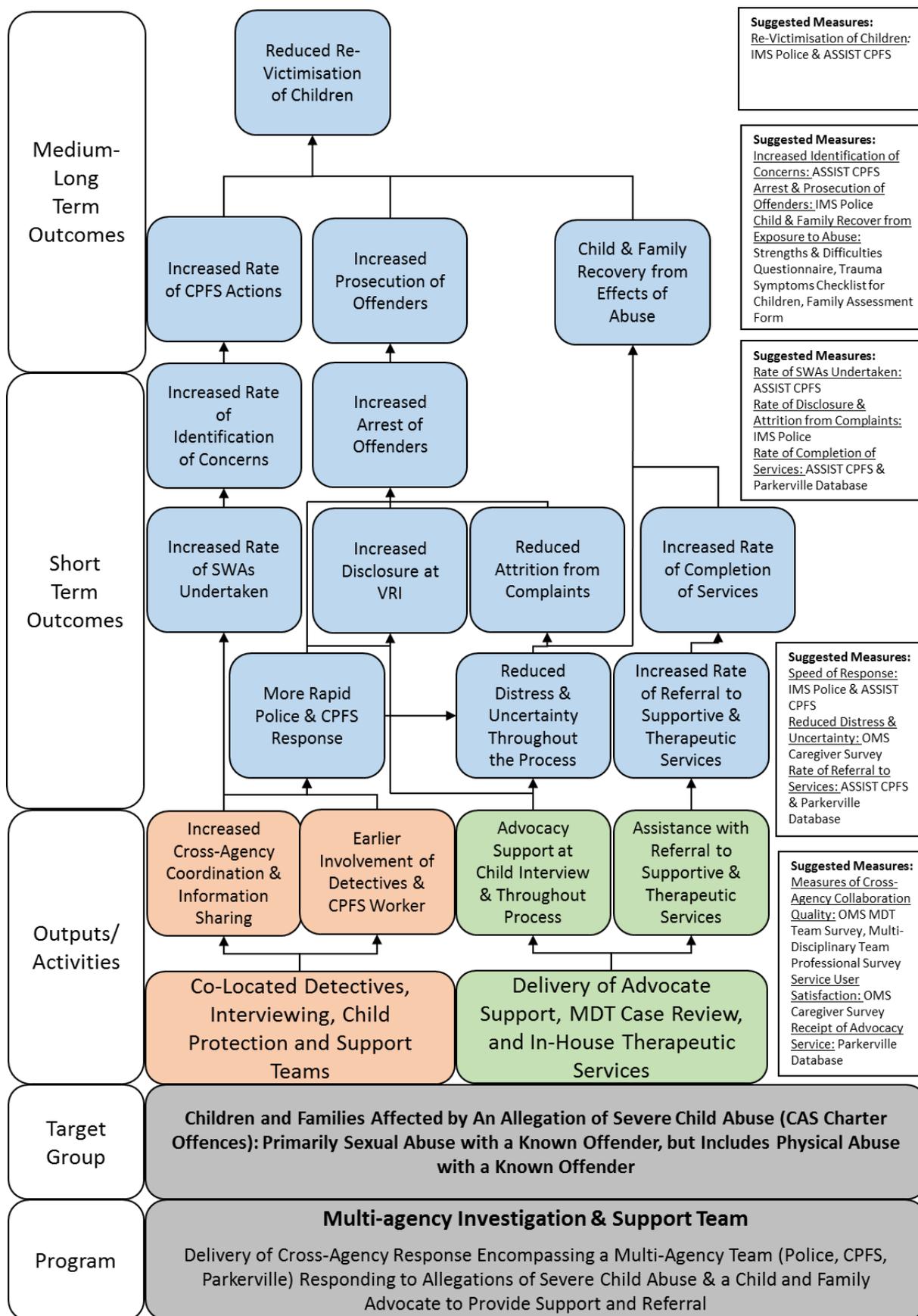
### **MIST Assumptions**

The literature review section suggests that implementation of a multi-disciplinary team is associated with improvement on several outcomes (e.g. arrests & receipt of supportive services), however the present context is more complicated. Most studies compared multi-disciplinary teams to ‘usual’ or individual agency responses in the United States or Europe. Compared to these jurisdictions, what counts as Practice as Usual in Perth involves many of the elements of multi-disciplinary practice, with specialist workers undertaking strategy meetings with their peers from other agencies. This means that MIST is being compared to a much higher quality standard of response as opposed to in the key Child Advocacy Centre studies in the United States (e.g. Walsh, Cross, Jones, Simone, & Kolko, 2007).

The following initialisms appear in Figure 1:

- *IMS*: Incident Management System;
- *OMS*: Outcome Measurement System;
- *MDT*: Multi-Disciplinary Team;
- *SWA*: Safety & Wellbeing Assessment;
- *VRI*: Visually Recorded Interview;

Figure 1 Theory of Change for MIST Pilot (Read from Bottom to Top)



The key assumptions of MIST, recognising that Practice as Usual has some of the characteristics of multi-disciplinary response are:

- Earlier allocation of detectives and their increased role in assessing, participating in strategy meetings, observing interviews, and contact with families, and integration with team members from other agencies will result in **an increase in the arrest and prosecution of child sexual abuse offences and a more rapid police response to the disclosure of child sexual abuse offences;**
- Providing supportive services during the interview process will increase the **disclosure of child sexual abuse offences by children having difficulty disclosing in an interview;**
- Providing ongoing support and updates throughout the interview and investigation process will result in will reduce **distress and uncertainty associated with the investigation of abuse, and reduced attrition from complaints of child sexual abuse;**
- Earlier allocation of the in-house CPFS worker, and their increased role in assessing, participating in strategy meetings, observing interviews, and contact with families, and integration with team members from other agencies will result in **increased rates of SWAs being undertaken, reduced rates of cases referred to support teams within CPFS due to the MDT response and a more rapid response to cases by child protection authorities;**
- The early involvement of the advocate during the interview process, ongoing contact, and support for children and families, and integration with team members from other agencies will result in **increased referral and uptake of needed services for children and families affected by abuse;**
- The increased uptake of needed services will result in **improved child and family wellbeing, reduced attrition from the prosecution of child sexual abuse offences, and reduced re-victimisation of children affected by child sexual abuse.** This assumption depends on the quality, fidelity and appropriateness of the services children and families are referred to, along with many factors external to the response.

These are presented in Figure 1, while it is beyond the scope and timeframe of this evaluation to examine all of these assumptions, the evaluation will compare the MIST and Practice as Usual response in terms of characteristics that suggest the MIST response is being delivered as planned, and examine the early impacts of this on criminal justice, child protection, and service delivery outcomes.

### Design

The detailed evaluation methodology is contained in a separate technical appendix (available on request), this section provides a brief overview of the data collection, data treatment, and process of analysis for the three sub-studies.

The report comprises findings from three sub-studies:

- A qualitative study drawing on interviews with workers involved in and affected by the implementation of MIST and equivalent workers from the Practice as Usual response;
- A descriptive study of the fidelity of the MIST pilot using administrative data to identify the extent to which MIST was implemented in accordance with the Standard Operating Procedures;
- A quasi-experimental follow-forward comparison study also drawing on administrative data to compare a Practice as Usual Child Abuse Squad with the MIST Team.

### Ethics

The research has been approved by the University of South Australia Human Research Ethics Committee, with permission to undertake the research granted by the Academic Research Unit of the Western Australian Police, and the Research and Evaluation Unit of the Department for Child Protection and Family Support. Ethics approval was also obtained from the Princess Margaret Hospital Human Research Ethics Committee, and approval was obtained from the Child and Adolescent Health Service Research Governance Office for staff from the Child Protection Unit to participate in interviews was also obtained.

### Staff Perception Qualitative Study

As part of a study reporting on staff perceptions of the MIST model, interviews were undertaken with workers and line managers involved in the MIST pilot and equivalent workers from the Practice as Usual response. The interviews were undertaken between 4th February – 5th April 2016 and thus focus on the early implementation of MIST. A requirement to obtain additional ethics review from a separate Human Research Ethics Committee meant that several additional interviews were completed on the 13th September 2016.

The analysis of the interviews draws on Thomas' (2006) principles of general inductive analysis for evaluation data, with coding based on content analysis of interview data. The coding process within this approach is similar to Cresswell (2002) with the following stages:

1. Initial reading of text data;
2. Identify specific text segments related to objectives;
3. Label the segments of text to create categories;
4. Reduce overlap and redundancy among the categories;
5. Create a model incorporating the most important categories

The analysis began with the interview records, which were transcribed and summarised into individual documents. Working in Nvivo 11, the researcher read through the transcripts and coded all text related to the advantages, disadvantages, and suggestions from participants. The text that was coded into each of these categories was then labelled and sorted into specific themes and ideas. These were then amalgamated and merged using the Nvivo 11 mind map feature (attached in technical appendix), allowing the researcher to identify and merge similar and overlapping themes.

The result was the identification of the themes included in this report. An analysis of the early interviews were provided to the participants and to a group of managers responsible for MIST in the form of an interim report (Herbert & Bromfield, 2016a) and various dissemination workshops. This information was primarily collected in order to provide information about how MIST was performing at an early point in its implementation, and in particular provide information actionable by practitioners (Herbert, 2015). Early dissemination and engagement of end users is an important tactic in order to create the conditions for the influence of the evaluation (Herbert, 2014; Mark & Henry, 2004).

Due to the small teams associated with MIST and the non-MIST interview participants, and the potential for identifiability of respondents, we have not identified the roles or employer of participants or attributed quotes to specific participants.

## **Administrative Data**

Data for both the descriptive study and the quasi-experimental comparison study was provided by the WA Police, CPFS, and Parkerville Children and Youth Care. The samples include all cases that came through the Child Abuse Squad intake desk between 1<sup>st</sup> October 2015 and 31<sup>st</sup> July 2016, case outcomes were followed to the point of case closure, or otherwise through to 17<sup>th</sup> February 2017.

### **Rationale for the Date Range**

The date range 1<sup>st</sup> October 2015 to 31<sup>st</sup> July 2016 was selected to control for a number of changes to the CAS/Child First response that may have affected the comparison. The start date identifies a time by which the MIST Pilot was thought to be fully operational, with the in-house CPFS worker in place. An end date needed to be selected that would enable sufficient time for Policing responses to occur during the follow up period. Additionally, the end date of 31 July 2016 enabled the evaluation to avoid being impacted by changes within the Practice as Usual condition which commenced in the second half of 2016<sup>3</sup>.

The time period was also selected in order to provide a reasonable follow-up period for cases held by each of the agencies to conclude. The follow-up period for the most part was up until case closure; however, some the cases were open at the time of extraction. For cases that remained open, the follow-up depends on the date the case was reported; the follow-up period is between seven to sixteen months, which was the latest point at which the cases could be extracted within the scope of the project.

WA Police data were not readily extractable from existing police databases. Data extraction templates were provided to the Senior Sergeant in charge of Child Abuse Squad to extract data pertaining to Practice as Usual, and the Detective Sergeant of the MIST CAS squad to extract data

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<sup>3</sup> In August 2016, a CPFS employed Child and Family Advocate began at Child Abuse Squad in Stirling Street. While this role is limited primarily to providing support to families on the day of interview, this role reduces the distinctiveness between the two responses. In late 2016, Child Abuse Squad began a pilot to remove Police Specialist Child Interviewers from the shared workspace with their CPFS colleagues and to co-locate them with CAS investigators. This change also included the earlier allocation of CAS detectives to enable them to more routinely attend forensic interviews. CPFS Interviewers can observe these interviews in this pilot, and are able to ask child safety questions following the conclusion of the interview. This approach has since been adopted across all non-MIST CAS cases since mid-2017. Again, this development includes the adoption of characteristics of the MIST response, which further reduce the distinction between the two responses.

pertaining to MIST. The two data sets were provided to the research team as an excel file, with incident report and SAMART numbers in order to link the cases.

An additional search was completed in the police database for cases that received a visually recorded interview, with allegations that fit the CAS charter, but did not go on to be allocated through the CAS intake desk. An additional 36 cases were identified, extracted and added to the sample from 1343 records in the IMS database with a child interview, that met the following criteria:

- Date range of 01/10/2015 - 31/07/2016 (Reported date range).
- A child interview was conducted and attached to the case record.
- The incident involved a child abuse allegation.
- The matter was assigned to the Child Assessment and Interview Team (CAIT).
- The incident would have been investigated by the Child Abuse Squad if it progressed past CAIT.

CPFS data was drawn from ASSIST, the main database used to record interactions between CPFS and families. The ASSIST case numbers of the samples identified from the police intake process were sent to CPFS Statistics, who retrieved the requested data. ASSIST case numbers were obtained through the co-operation of the Team Leader of interviewing at ChildFIRST who had access to both SAMART and ASSIST databases. This enabled the researchers to link cases without needing to obtain any identifying details of the cases.

Parkerville data was drawn independently and was matched back to cases in the CAS sample. This process identified that a considerable number of cases dealt with by the Parkerville advocacy and therapy team were not part of the evaluation sample; that the support and therapeutic end of the MIST team provided services for many more cases than those that came in through the process described in the Standard Operating Procedure Manual. Limited detail is available on these cases that were not matched back to cases included in the CAS/ChildFIRST sample, only the response and services provided by the advocates. The interviewers at MIST also worked cases outside of the CAS charter as the joint agency interview team provide specialist child interviews for many different police units (i.e. sex assault squad, district detectives, regional detectives), so it seems likely that the additional advocacy services were provided to these cases.

### **Overlap between CAS/ChildFIRST Cases & Parkerville Service Delivery Data**

The sets of data retrieved involved matching the samples identified through Child Abuse Squad back to cases that had received support services by the Parkerville Child and Family Advocates. Parkerville provided advocacy support to many children and families outside the scope of the MIST pilot, cases that may be investigated by Sex Assault Squad, District Detectives, cases that were investigated prior to the beginning of the pilot, or even cases that were not being investigated by police at all. Some cases dealt with by the MIST team did not include the advocates. By necessity some interviews occurred out of hours and/or off-site, in most situations the advocates were either able to attend, or the advocates successfully made contact following the interview. All MIST cases where there was no advocacy record were double checked with both Police and Parkerville and to identify why a MIST case did not have a record of advocacy occurring.

When duplicate screening was applied, the Parkerville database identified 289 unique cases from 416 records (which included services for children, services for their siblings, witnesses, caregivers, and child offenders).

Table 2 presents the cross-over of the samples, which included the degree to which cases in the Parkerville sample appeared in the CAS sample. For some cases a corresponding CPFS record could not be identified, or the record for that child on the ASSIST system was blank.

**Table 2 Sample Overlap between CAS/CPFS Samples, and the Parkerville Sample**

	CAS Sample	CPFS Record Matched to CAS Sample	Parkerville Sample	Parkerville Sample Matched to CAS Sample
<b>Practice as Usual</b>	329	315	0	0
<b>MIST</b>	180	164	289	140

As the cases retrieved by CPFS were selected from the cases identified by CAS, the only difference in the number of cases is from where the a CPFS record could not be found or was missing from the data.

Of the unique cases identified by Parkerville, 149 did not have a corresponding CAS record. Primarily this was because the list of Parkerville cases included cases from July – September 2015, prior to the start of the sampling period ( $n = 63$ ). Of the remaining 86 cases, enough details were in the case records to identify that 17 cases were not allocated to the CAS 3 team (i.e. case was investigated by local detectives, or Sex Assault Squad), in 14 cases advocacy support was not provided to the victim of the abuse (sometimes services were provided just to siblings or parents of victims), six cases did not include a police incident report number, and one case involved a vulnerable adult. There were 48 remaining cases where there was not enough detail to determine why the matter was not included in the MIST CAS 3 sheet. The most probable explanation is that the matters were not CAS cases and were assigned to the MIST interviewers to help with the load of cases managed across all the interviewers.

### **Creating the Administrative Data Sets**

Two linked administrative data sets were created using the information requested from the WA Police, Department for Child Protection and Family Support, and Parkerville Children and Youth Care: one for the descriptive study of fidelity and a second for the quasi-experimental comparison (described below). The data sets pertained to the MIST Pilot and a Practice as Usual comparison group.

De-identified records were linked using the Incident Report, SAMART, and ASSIST numbers and combined into a single database in Microsoft Excel. These records were cleaned, coded where necessary (see technical appendix for more details) and duplicate records were identified. All cases were reviewed where the same Incident Report number appeared multiple times in the database or the same ASSIST numbers appeared in the database. In some instances, the same case had been entered in multiple times, in other cases inter-related offences had been given different Incident Response numbers; in part this is because of practices in creating records in the Police IMS system that provides both a general IR number and a Child Abuse related IR number for cases where child abuse was later detected. In some cases additional IR numbers may be generated with additional disclosures of abuse; for example there were some cases with the same child and same alleged offender with several IR numbers all within 5 minutes of each other (IR codes are based on date,

time, and the badge number of the officer receiving the report). The technical appendix provides a summary of all cases that were combined and the rationale for decisions – the general principle was to combine cases where the offences were inter-related (e.g. husband and wife accomplices).

The database was set up so that information could be retrieved for both case level data and individual victim/perpetrator data, although some of the detail for individual victims/perpetrators was limited, so case level details were used for most variables (e.g. not enough data existed to determine which offences were associated with individual children where there are multiple victims in the record. The data were copied into SPSS 17.0 where all statistical procedures were completed.

The obtained data has a number of inherent limitations. Firstly, organisational records may not be accurate, and while due diligence was taken with the data, and all organisations double checked and reviewed their data, factual errors may exist. Secondly, the method of linking records relied on unique child identifiers codes, and for incident report numbers that were either the same or close together (IR numbers begin with a date and time stamp). This was to correct for differences in the raw data, where in some cases different children had been entered in multiple times under the same incident report number, but in others multiple children were reported under the same record. Separate cases were also found that reported on the same child and the same perpetrator on the same day. While a rationale is provided in the technical appendix for each decision, these represent judgements made by the researcher on the basis of the available data as to if the offences were related and the response associated with two IR numbers constituted the same response. Finally, some difficulty was had working with individual child/victim records, as many were missing key details for second and third children associated with an incident report (i.e. what abuse was inflicted on whom, which child disclosed, which child was the victim associated with a charge). Much of the report relies on reporting case level data as this was the most consistent and reliable form of information.

### **Descriptive Study of the Fidelity of MIST**

The descriptive study includes a summary of the case-flow between the cases that were allocated to the MIST CAS team with all cases that came through the CAS intake desk or received an interview and would have been allocated to a CAS team (Practice as Usual). These samples are not provided for the purposes of a comparison, rather for the purposes of describing the different processes and decision-making for each condition. This study also more fully describes the volume of cases dealt with by each of the conditions.

The data included in this study cover the decision flow for each of the conditions leading from intake to a child interview occurring, to the point of closure for both police and child protection. This study also describes the attrition process for cases from the arrest of alleged perpetrators. The study also includes detail about the staffing and relative workload across the two conditions. Finally, the study includes caregiver feedback about the MIST condition.

#### *Caregiver Satisfaction Survey*

The Outcome Measurement System (OMS) is a survey developed by the Children's Advocacy Centres of Texas and adopted by the National Children's Alliance (National Children's Alliance, 2014) to measure caregiver satisfaction with the response of a Child Advocacy Centre. The system also includes a survey of satisfaction within the MDT. The OMS is provided as an online platform for Child Advocacy Centres to collect data on their service delivery, with 681 CACs using the OMS in 2016 (National Children's Alliance, 2016). Parkerville Children and Youth Care Inc. were given permission

to use the OMS by the National Children's Alliance, with some minor alterations in order to make the language and categories relevant to the Australian context. The survey was not administered to caregivers in the Practice as Usual condition/service, primarily as there was no workers who consistently had contact with these families following the interview.

While called the Outcome Measurement System, the survey is limited in terms of providing data on outcomes. The measure is completed by the caregiver either online, in paper form, or on the phone with a worker from the CAC. The questions in the OMS covers the caregiver's own perceptions, and perceptions of their child's feelings about various parts of the service received at the centre. The measure is more of an indicator of whether the response was delivered as intended rather than reflecting outcomes of the response. The absence of genuine child or family outcome data and the availability of this data solely for the MIST condition led to the decision to include this data in the descriptive study of the implementation of the MIST pilot.

It is important to note some of the differences between the MIST and CACs, which may affect the responses on the OMS. The majority of CACs (and MDT models nationally and internationally) involve an interviewer employed by the CAC (Herbert et al., Under Review), whereas in MIST interviews are undertaken by either Police or CPFS specialist child interviewers. Some of the questions in the OMS ask if participants would recommend the service to anyone dealing with a similar situation; the context is slightly different in that often cases are referred to CACs in jurisdictions in the United States, rather than allocated as part of the statutory response. In MIST cases within the catchment area were sent to the centre, so this question may be less relevant in this context.

The OMS was administered by Parkerville Children and Youth Care staff between the 18th November 2015 to 29th July 2016. The majority of the surveys were completed over the phone (75%), with a worker not involved in the advocacy or therapeutic support of MIST clients filling in the survey based on the participant's responses. A worker contacted the caregiver to complete the survey around 4-6 weeks after the interview. The survey responses were not linked to the other administrative data, so the response rate is estimated based on the total number of cases the advocates had contact with. Sixty-two surveys were completed between November 2015 and July 2016, compared to 289 unique cases/caregivers the advocates had contact with over that time. This equates to an approximate response rate of 21%.

While not being used as an outcome, and not compared across samples a number of limitations of the OMS need to be acknowledged. Firstly, despite the use of a staff member not involved in the MIST pilot, caregivers may have been unwilling to express dissatisfaction with the response, particularly considering the police and child protection are closely associated with the response, and for some the matter will be still proceeding through the justice system. Secondly, external factors may be more important to satisfaction than the actual quality of the service delivery. For example, aspects of satisfaction will likely be affected by determinations made by CPFS to remove children or to seek a parenting order. Similarly, decisions to not proceed with the arrest of offenders due to insufficient evidence may also reduce satisfaction. Thirdly, the survey includes many items that rely on perceptions that are obtained retrospectively. While the OMS as delivered in the CACs seeks initial feedback on the day of the interview, Parkerville Children and Youth Care Inc. identified that this was problematic in the context of MIST. Providing feedback on past events and impressions of the response are highly likely to be biased by subsequent contact and external events. Finally, the

survey received a low response rate, meaning there is likely to be a strong response bias. Typically surveys with low response rates tend to include participants that are either very satisfied or very dissatisfied. Similarly, the survey may also be biased in favour of clients who are returning to relatively stable situations who are able to be contacted. Response bias is inherent in most surveys to do with child abuse and neglect.

### **Quasi-Experimental Follow-Forward Comparison Study**

In the quasi-experimental comparison study, a follow forward design was used to examine differences in response times and response characteristics between the MIST and Practice as Usual conditions. It was determined that these comparisons would be more meaningful if it only pertained to those cases which received an interview (excluding cases reported but screened out for various reason prior to interview).

The two groups in the quasi-experimental comparison study were:

- MIST-INT: Cases allocated to CAS 3 (MIST), which were reported during the study period, and received a visually recorded interview;
- Practice as Usual INT – Cases allocated to CAS 1, CAS 2, CAS 4 during the study period (or which would have been allocated if there was a disclosure<sup>4</sup>), which were reported during the pilot period, and received a visually recorded interview.

The quantitative analysis primarily involved the Chi-Square test of independence for the categorical variables unless the number of cases in a square were less than five, in which case Fisher's Exact Test was used (Tabachnick & Fidell, 2013). T-Tests were used for the continuous variables (Tabachnick & Fidell, 2013), except when the samples were not normally distributed and could not be easily transformed by the exclusion of outliers, in which case Mann-Whitney *U* was used (Tabachnick & Fidell, 2013). As the measure of central tendency most relevant to Mann-Whitney *U* is median, the median and range is reported rather than the mean and standard deviation where this test was used (Tabachnick & Fidell, 2013).

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<sup>4</sup> During the study period MIST cases were allocated to a Detective prior to interview, whereas PAU cases were allocated to a Detective post interview.

## ANALYSIS OF STAFF INTERVIEWS ON PERCEPTIONS OF THE MIST PILOT

Semi-structured interviews with staff involved in the MIST pilot, staff working in equivalent positions in Practice as Usual staff, and staff working across both conditions that were likely to be affected by the MIST pilot. The study aimed to address the research question: What are the weaknesses and strengths of the MIST pilot process compared to standard practices?

Participants were asked about the advantages and disadvantages of this approach from their perspective as a worker or line manager involved in the response to child abuse, and suggestions for improvement to the response. Interviews were also obtained with workers not directly involved in the response, but who may be affected by the MIST process. Interviews were also undertaken with workers from the Practice as Usual condition to better understand the contrast between MIST and Practice as Usual. Initial interviews were undertaken between 4<sup>th</sup> February – 5<sup>th</sup> April 2016 and thus focus on the early implementation of MIST. A requirement to obtain additional ethics review from a separate Human Research Ethics Committee meant that a number of additional interviews were completed on the 13<sup>th</sup> September 2016.

**Table 3 Number and Agency of Interviews Included in Report**

Agency	Number of Interviews
WA Police (Including CAS detectives, interviews and line managers)	9
Department for Child Protection & Family Support (Including ChildFIRST, CPFS Districts, and Line Managers)	11
Parkerville Children and Youth Care Inc.	6
Support Service Providers	4
Child Protection Unit – Princess Margaret Hospital	3

Due to the small number of respondents and the potential for identifiability of respondents, we have not identified the roles or employer of participants or attributed quotes to specific participants.

### Advantages

Interviews with staff identified six broad themes in terms of advantages of the MIST pilot process. The overwhelming theme was about *improvements to collaboration and communication across agencies*, which had several key sub-themes. Other themes included *the provision of consistent support throughout the process, improved referral to supportive services alongside the investigation, improved convenience for families, minimising child and family distress, and opportunities to divert families from CPFS*.

**Table 4 Themes Relating to Advantages of the MIST Model**

Main Theme	Sub Themes
Communication & Collaboration	<ul style="list-style-type: none"> <li>• Case communication</li> <li>• Access to workers from other agencies</li> <li>• Knowledge of other workers and agency processes</li> <li>• Earlier allocation of detectives</li> <li>• Response planning</li> <li>• Mutual support from other workers</li> <li>• Flexibility</li> <li>• Trust</li> </ul>
Consistent Support Throughout the Process	<ul style="list-style-type: none"> <li>• Support for families during interviewing</li> <li>• Support for families and children through the investigation process</li> </ul>
Referral to Supportive Services Alongside the Investigation	<ul style="list-style-type: none"> <li>• Availability of in-house therapy services</li> <li>• Service quality</li> <li>• Input from family on support needs</li> </ul>
Improved Convenience for Families	<ul style="list-style-type: none"> <li>• Services all in the one building</li> <li>• Location</li> <li>• On-site Child Assessment Interviews</li> </ul>
Minimising Child and Family Distress	<ul style="list-style-type: none"> <li>• Child friendliness of building</li> <li>• Reducing need to repeat disclosures</li> </ul>
Opportunities to Divert Families from CPFS	<ul style="list-style-type: none"> <li>• Earlier CPFS assessment</li> <li>• Opportunity for the MDT to manage lower risk cases</li> </ul>

**Improvements to Communication and Collaboration**

The most prominent theme in the interviews was the perceived improvements to communication and collaboration that comes from having a cross-agency team, combined with some of the perceived advantages of having additional workers involved in the interviewing that would otherwise not be part of the response in the Practice as Usual condition.

A key perceived advantage to the MIST process discussed by workers was the improved accessibility of workers from other agencies. Workers discussed the difficulties they had experienced in Practice as Usual getting workers from other agencies on the phone:

“...we’ve had times before when it’s been a few months before we could get a hold of say a detective, and it might just be that we’re playing phone tag... sometimes people are on shifts differently or there have been changes in case managers”.

“...it can be hard to get access to these forms and details, sometimes it feels like you are butting heads, sometimes it seems like people are forgetting the purpose of things”.

Workers thought that by having representatives from all agencies in the same team, and working consistently with the same people from different agencies, the accessibility of other workers for discussions, consultations, and information sharing had improved:

“...although we work on a regular basis with CPFS, it’s by remote, we don’t do that face to face interaction, even having the CPFS district worker has been hugely beneficial because we

are able to communicate exactly from each point of view, and try to come to some resolution, whereas dealing with district CPFS, and lots of different districts, you don't always get that same consistency there...".

In most cases, the workers required were on-site and able to be consulted immediately; otherwise there was a sense that off-site members of the MIST team could be more easily contacted due to the increased familiarity. The implications of this for the handling of a case can be significant, one of the participants pointed out the impact of the inability to contact workers from other agencies in slowing down the ability to take action in a case:

"Easy access to this entire team is really the crux of the issue here... outside of the MIST project one of the big things is trying to coordinate that response... it really takes away some of those cases where we have them sitting on our list unable to be touched for a couple of weeks... it [the MIST process] prevents a lot of that case drift".

Related to improved access is potential improvements in case communication, that working more closely together meant that workers had more information about a case, and are able to make better decisions as a result "*...there's a lot of extra information that might not otherwise be known about a family*". Workers provided examples of several serious gaps in communication between police, child protection, and therapy providers in Practice as Usual:

"we get the CAIT completion forms [a summary of the content of the forensic interview provided to District CPFS], sometimes we have to chase them up when the file goes to Child Abuse Squad or Sex Assault Squad or whatever, police take [too] long, I've got a case with substantiated sexual harm that has been sitting there for one year... they haven't started investigating".

Participants primarily referred to improved communication of information about the context of the family, but also information about how each agency is responding to the case "*... they can do their safety planning knowing what the police are going to be doing, if the offender will be out of the house it is easier to deal with the safety planning*".

This improved communication about a case was also connected to a sense that having more complete information about the child and family resulted in better response planning "*here we've got a pretty good rapport with CPFS... if there's information we need [CPFS Worker] to know about child safety we are able to relay it to [CPFS Worker] in real time... information flows a lot quicker*". Having the responding detective, CPFS worker and interviewer as part of the strategy meeting was put forward as a particular strength of the response; workers were able to become familiar with the case straight away, and observe and contribute to forensic interviews "*[Sharing information before the interview means] we have all the information before the interview, whereas if you don't share that information... I didn't know that, I should have asked this, this, and this...*".

Having the responding workers work on the early processing of the case rather than a centralised team, was also seen as a potential advantage as the team was more invested in the outcome:

"...at Stirling St [where jobs are processed centrally] the parties that are involved in that have no interest in the job, they're just people that have to tick the box for the strat [Strategy] meeting, compared to the strat [Strategy] meeting here, it's [MIST CPFS Worker] who has ownership of that family, because [MIST CPFS Worker] is the one who is going to follow it through...".

The earlier allocation of detectives to cases was seen as a huge advantage to cross-agency communication and collaboration on cases:

“...the speed in which we receive the file, in Stirling St there is the process where the file goes to CAIT [Child Assessment & Interview Team], at the completion of the interview it will go to their supervisors for review, which is then forwarded down to Child Abuse... allocated to a team, at that time a supervisor would then allocate it to one of the investigators. Here it is allocated straight to us, we’ve had the interview and we’re involved from the beginning, we’re generally involved in the strat [strategy] meeting, we’re involved in the interview, we’re involved from the ground floor which primarily doesn’t happen at CAS...”

“Again, I think what I have seen is the times between charges being laid and court is happening a lot quicker now, and I think that’s happening because everything is happening in live time, so we’re not waiting four weeks for a detective to be allocated to reviewing the process, they’re allocated straight away, so we’ve taken away four weeks wait so everything is kicking into gear that little bit faster for families, so all of that stuff has really helped”.

In particular, detectives being able to attend strategy meetings about the case, attend the forensic interview, and undertake rapid investigation of matters where required was identified as an advantage “...I mean they are taking action straight away, if there is any evidence it gets collected there and then, before, you know I might find out an interview has happened and get rid of things”. Particularly in terms of the forensic interview, the attendance of the investigating officer at the child interview, and being able to prompt the interviewer during breaks to pursue particular lines of questioning was seen as particularly advantageous “...it’s helpful having the detective there with monitoring the interview... if they need to do feedback or if they need to get statements or any forensic detail from the family that’s all followed up”.

In the Practice as Usual response, participants observed that if particular questions or lines of inquiry had not been pursued, then potentially additional interviews would be required “... having all those people involved we’re really aware of what we need to find out there... and we reduce the risk of that child coming back for a subsequent interview”. While for some high priority matters in the Practice as Usual condition a detective would be allocated early in order for them to attend the interview, having either the investigating detective or a member of the team of detectives present at all interviews was thought to be a particularly important advantage of the MIST pilot process. Having detectives and the in-house child protection worker meet the family following the interview was also thought to be beneficial as families are able to put a face to the people that will be managing and responding to their case “Police are a bit more visible, and it helps to break down ideas that police are scary, breaking down barriers, it’s probably more comforting for children”. The presence of a detective as part of the response was also thought to reinforce the seriousness with which disclosures were taken “...because it is acted on quicker, families feel like they’re being taken seriously, whereas... if there’s a delay families are left wondering”.

Participants also described perceived improvements in the knowledge of the roles of other workers, and better understanding of different agency processes through more direct interaction with other members of the team. Being able to better understand decision-making and the processes and constraints of other workers was seen as helpful in improving responses “informal and short consults that help to clarify what is happening behind the scenes”. Similarly, participants reported the building of trust between workers across agencies as a result of working more closely together over

time, which was important to the quality of the team response to cases *“Trust has been built up between personnel, so they all trust each other’s opinion and ability to liaise with families and each other”*. The closeness of this team was also perceived as an important support for workers, who all work closely together to respond to highly distressing incidents *“...the added supports of people working alongside of each other”*. Having the additional workers, and trust across the team also meant that the team were thought to be able to respond in a flexible manner to cases, in particular for child interviews *“The team is able to work creatively. That’s an advantage, getting disclosures on cases that you might not otherwise”*.

### **Consistent Support throughout the Process**

The most obvious difference between MIST and Practice as Usual cases is the degree of built-in support for children and families, primarily in the form of the advocate. Having this person as a consistent point of contact and having intimate knowledge of the cases was seen as a key advantage, particularly compared to referral to other support services that may not know much about the matter:

*“Giving families a space to talk. Not leaving parents holding all those thoughts and feelings without having someone to talk to. Police and CPFS are too busy to do this role. They can’t be everything to everyone, but someone needs to do it or families just can’t cope”*.

The support for family members as well as direct victims of abuse was highlighted as a key advantage and a gap in existing support systems:

*“The advantage is that clients know that everyone is receiving support, and that it is a safe place for all of them. Able to deal with trauma as a family, children don’t have to worry about other members of the family being in distress as much”*.

Separate from the referrals for services, the perceived advantages of the direct support provided by the advocates and on-duty therapeutic staff were discussed in terms of the value to the interview process, and in terms of the value of consistent support throughout the process *“Support to the family is obvious, it is amazing... The advocate bridges a gap, which is really needed”*.

All workers identified the perceived value of having advocates work with families during the child interviews, and were critical of standard practice at the time:

*“... I think we need an advocate... we do this interview and just kick the family out and off you go. A lot of the time they’re shattered, it’s all fresh... they’ve just found out that something has happened, the only thing we can offer is for them to go to a GP and ask for a mental health plan so they can get a referral to a counsellor... you do feel bad about kicking these people out with no support, because their life has been shattered”*.

The availability of the advocate to talk to the family, to work to understand the context of that family, and to start to build rapport in order facilitate referrals to needed services was seen as a valuable addition to the interviewing process *“It must cause a lot of distress and anxiety for parents. Having the advocates there helps to manage that, and provide all the follow up that isn’t possible for interviewers to do”*. In some situations the advocates also provided important information to other workers about the demeanour of the family and child *“Being able to stay with the children while a strat [Strategy Meeting] was being held, to be able to build rapport with the children, listening to them reading body language and reporting this back to interviewers before they go in”*.

The advocate as a consistent point of contact throughout the investigation process was also seen as valuable, particularly where workers change or, additional workers are introduced to the family *“One child in particular was struggling to engage with Child Witness Services so [the Child and Family Advocate is] actually doing a piece of work with the child and the Child Witness Worker to ensure that that will go smoothly for the child”*. Beyond the role entailing direct support, the advocates also helped to explain the processes, provide updates on what is happening on their case, and were perceived to often help families come to terms with the results of these processes:

*“the advocates are able to hold the family... and look at this and say, okay we can understand where the investigation is going, CPFS you have a different investigation going because who is protected in this family but also the family have needs who need to be looked at as well...”*

### **Referral to Supportive Services alongside the Investigation**

Along with providing direct support and updates on cases, the advocates also worked to refer children and families to needed services, in particular mental health services for symptoms related to trauma. Having the role of the advocate embedded within the interview process was perceived to improve not only the provision of direct support, but an opportunity to refer children and families to appropriate services:

*“Not just leaving children and families that disclose abuse, particularly for protective parents; a few months later the trauma hits the child and parents are then left not knowing what to do and have to deal with the waitlist; or started a service but the child doesn’t want to go because the service doesn’t really gel with them. The advocate support means that families have the support down the track when the impact hits them”*.

While to an extent this is also the role of the CPFS Child Centred Family Support/Intensive Family Support Teams (see difficulties section), the advocate was thought to be able to immediately and in person build trust and rapport with families in order to discuss the types of services they may need *“...with the advocates being here I’ve found that it is easier to get families into support, because they’ve been connected from the very beginning in terms of emotional support and getting the process explained”*.

Participants that provided supportive services reported that cases they saw outside of the MIST response tended to come at the end of the criminal justice process *“In a normal process you won’t see the client until like 3 months after they’ve disclosed and already had the interview”*. Being able to work with children and families earlier in the process, and when they may have additional stress and difficulties due to criminal justice and child protection processes was seen as particularly advantageous:

*“Having therapeutic services involved earlier, even if it isn’t directly with the child but with the family, the hope is not seeing full PTSD, it might just be an acute stress disorder, but they resolve quickly without too much intervention because the families and the systems around them can cope”*.

Referring within a known and local network of services was also seen as an advantage as advocates were thought to have direct knowledge of the content and nature of services in the area, and were able to make referrals with the full knowledge of what the service involves:

“Usually the advocates have a better understanding of what's out there in services as well which is not to say CPFS are not good at their job, but [the advocates] have a better understanding of community services because [the advocates] work a lot with community services and [the advocates] will refer out”.

This seemed to have the effect of engaging families with services earlier *“I think the greatest advantage I’m seeing, for Armadale cases... is that shorter time lag of getting support services in place”*. Participants that were support staff also highlighted being able to ensure that the family had input into the services they’d like, and which goals they’d like to be working towards *“Making sure you’re working on the goals that are most important to the family”*.

### **Improved Convenience for Families**

The participants identified significant perceived advantages in providing all parts of the response to cases from one location. In addition, the benefits to collaboration and communication between workers, it was perceived to be easier for families to attend the same site for interviews, for support and updates on their case, and for many for therapy and other supportive services *“...that it’s all in the one building, they’re familiar with the building... they may have seen their therapist in the building before being introduced”*.

It was pointed out that outside of MIST, families may be subjected to having to attend appointments at many different locations, that having most services on site improved convenience for already vulnerable families *“...they don’t have to go to lots of different places, it’s all at the one place”*. The location of the service was also seen as advantageous, with less difficulty and travel for families *“as a lot of the time distance and people getting to the city really does cause a lot of issues in terms getting those interviews done”*. Participants from the police also perceived working within an area as advantageous, that they were able to quickly interview other family members and execute search warrants where needed due to the proximity of the centre *“proximity to offence locations, victims, and POIs, they are quite often living in our area, so that’s a bonus in terms of the time it takes to get to places”*.

A number of participants discussed the use of the centre for Child Assessment Interviews (CAI), interviews that are typically done off-site, by child protection workers from the districts:

“If the case is open to CPFS, and there isn’t a direct disclosure, they might do a CAI, if it is likely to go to forensic, if a child hasn’t disclosed but the information has come from somewhere else, they prefer to do the CAI at GJCAC”.

Participants indicated that most Child Assessment Interviews were done on-site at the George Jones Child Advocacy Centre, which facilitates the transition from an assessment interview to a visually recorded interview when a disclosure occurs *“...if it’s likely to go to forensic... we prefer to do the CAI here [GJCAC]”*. For disclosures that occur during an assessment interview the worker needs to stop the interview, and arrange for the child to be interviewed by a specialist child interviewer. Having these interviews on-site, particularly those that workers suspect will result in a disclosure was thought to result in a smoother process *“so it goes on camera and it is a really streamlined response, if it was done by a district worker they have to go back to the office and type up the notes and send them through. Much more streamlined”*.

### **Minimising Child & Family Distress**

Participants identified the George Jones Child Advocacy Centre building as having some advantages

over Stirling St in terms of reducing the potential for child and family distress, while acknowledging that the facilities at Stirling St were generally good:

*"I guess in term of child friendly this centre is a lot more child friendly than Stirling St... the waiting room is sealed off, its colourful it's got toys and things like that in there... just that sort of big open space [at Stirling St] for some children might be really overwhelming and there are a few police logos in the foyer so I guess coming here and having that sort of smaller warmer environment would be a lot more child friendly".*

In particular, having a private waiting room was seen as beneficial *"giving them that assurance that it's just going to be them in that environment just gets them a little bit more comfortable"*, along with having someone available to sit and talk with families while their child is being interviewed and the capacity to provide debriefing following the interview *"...the environment and knowing that someone will be with them the whole time"*. Participants also talked about some of the physical characteristics of the building and staff behaviours resulting in a friendlier atmosphere *"it's a less intimidating environment for families and children"*, in particular having a receptionist that initially greets families when they arrive *"the most salient thing in their memory was how warm and nice the reception staff were"*.

Participants also thought that one of the advantages of the earlier allocation of detectives and the presence of an in-house child protection worker at the interview was the reduced need for additional potentially distressing interviews with children *"being part of the interview process helps to cover extra areas and reduce the need for additional interviews"*. Similarly, with psychologists involved in the MDT there is a reduced need for repeated disclosures *"not having to have children repeat the disclosure, it helps that children know that the psychologist already knows"*.

### **Diversion from CPFS**

While the overlap between parts of the service response presents some difficulties (see difficulties section), overall, participants identified the opportunity to divert families from the child protection system as a positive *"It's made a difference more for the intake team; the CCFS [Child Centred Family Support Team] are getting the riskier cases, they aren't getting some of those lower end cases that can be managed and requires less intensive support"*. By knowing the cases that were lower on the scale of risk and concern for Child Protection were being managed and responded to by the Multi-Disciplinary Team (with representation by CPFS), matters that may have remained open to the department were seen as able to be diverted, with any new concerns able to be monitored and reported.

Part of the potential for early diversion from CPFS, was through the in-house capacity to undertake immediate Safety and Wellbeing Assessments *"part of doing the SWAs is to make sure the families have support, with the advocates it is a lot easier to get families into support quicker"*. Having these assessments done quickly, rather than waiting for the case to be allocated to a CPFS district worker in order to be written off, or diverted to supportive services was seen as particularly advantageous *"MIST are catching a lot of cases that the duty team would have caught and able to manage them and close them off, it is saving work"*.

### **Difficulties**

While participants were asked about perceived disadvantages of the MIST process, participants identified difficulties with the adoption of this new process rather than any inherent disadvantages

in the approach. Primarily these difficulties related to collaboration, in particular the difficulties of making the response work across agencies. Other difficulties included capacity and resource issues, uncertainty about the continuation of the pilot, differences between CPFS districts, and lack of awareness of the pilot across agencies.

**Table 5 Themes Related to Difficulties with the MIST Model**

Theme	Sub-Theme
Collaboration Difficulties	<ul style="list-style-type: none"> <li>• Complexity of working across agencies</li> <li>• Interview process</li> <li>• Isolation</li> <li>• Problems with Information Sharing</li> <li>• Continuity among police</li> <li>• Concern about referrals being too Parkerville centric</li> <li>• Relationship between Parkerville and clients</li> </ul>
Capacity & Resource Issues	<ul style="list-style-type: none"> <li>• IT Issues</li> <li>• Limited ability to do home visits</li> </ul>
Uncertainty about Pilot	
Interagency Politics Around the Establishment of the Pilot	
Lack of Clarity Around the Purpose of the Pilot	
Setting Up an In-House Medical Response	
Differences between CPFS Districts	
Lack of Awareness of MIST Across Broader Agencies	

### **Collaboration Difficulties**

Just as the main perceived advantage of the MIST process was improvements to collaboration, most of the difficulties described by participants were also related to collaboration with team members and across agencies. Particularly in the early stages of the pilot, attempts were made to directly resolve some of these disagreements “...So all those little things, the niggly things that were - they're all ironed out. Yeah I think so anyway. I think that was for the better that we got the chance to iron those out...”. A few lingering difficulties in collaboration were identified, with suggestions for how these could be resolved.

Broadly most of the difficulties described by participants could be summarised as being related to the complexity of working across agencies, which have different processes, roles, and viewpoints on cases “[There were] some difficulties at first, teething problems and working at different speeds with police and CPFS”. While participants thought that for most workers, their particular roles were distinct and clear, there was some overlap between CPFS district workers, and the advocates. Depending on the circumstances of the case, the CPFS worker may have responsibility for referring children to particular services, or ensuring that particular services are completed by families as part of a safety plan:

“[Difficulties are related to] the ongoing stuff around the interplay between [advocacy and therapeutic services] and the Department of Child Protection and Family Support. The detectives, CAS, they're very clear and very easy to work with in terms of this, because they don't have that psychological or social work component”.

While participants identified the advantages of having advocates involved and working on referring families into services, there was some confusion about roles and responsibilities “...*families do need the support; need the right agencies and the right workers. Making sure we work together but that the boundaries and roles are clear and maintained*”.

“...MIST advocates have tried to take on board the work that [CPFS Worker] should be doing... while case managing, we need to be managing the service and supports that families are engaging with, through negotiation and consultation with the MIST advocates as well, but it is our primary responsibility”.

Related to the above, participants indicated that collaboration within the building was very good, but that there were some issues with collaborating with workers outside the building “*Easy to collaborate with everyone in the building, collaboration with people outside the building is more difficult*”. While the in-house CPFS worker takes on the early assessment of cases for CPFS, before this worker started at the centre these assessments were done at the CPFS district offices, who may not have been aware of the MIST process beyond the Team Leaders that had been involved in some of the induction and training sessions (see Lack of Awareness of MIST across agencies). Participants indicated that there were some difficulties with collaboration between the on-site MIST team and the district offices prior to the in-house worker beginning in late October “*the first few months were difficult because of the lack of engagement by CPFS; there was no one here, so it was very nice when [the on-site CPFS Worker] came*”.

The interviews however identified some major gaps between MIST and both the Child Witness Service, and the Child Protection Unit at Princess Margaret Hospital. Some participants were critical of both the degree to which both these agencies were involved in the establishment of MIST, and the lack of ongoing contact between MIST and these agencies:

“...[Development of the SOPs manual ] the Child Witness Service seem to have a very minor part in it, they weren't consulted in the way I would have expected them to be, PMH were not consulted in the way I would have expected them to be, even though their roles are minor in the sense of the actual immediate responsibilities of the MIST”.

“Even the worker they had there has never had a formal induction about child witness, or training about child witness, well I find that really unusual in terms of our cooperation and working together with them... but we still we still need to interact with them and cooperate with them for the best of the family”.

While the MIST process involved relatively little change to either the Child Protection Unit, or the Child Witness Service, both agencies more or less had no way to identify whether a case was MIST or not:

“Generally, we don't know if they're MIST or not until we have contact with MIST, often parents don't know if they've had contact with MIST workers or not, because often they've had so many people interacting with them they don't know who comes from where”.

These agencies each had their own concerns about the impact of the lack of ongoing discussion and input into the MIST response:

“...[CPU are] not really getting referrals back this way, so it’s interesting... that they’re seeing a lot of sexual abuse, are they historical cases where children are not needing a medical, or who’s doing the medicals?”

“...it’s great having the advocates to be able to be supporting the parents and to be providing extra services for the child... but just don’t get involved in the legal process because it’s just too complex, and I guess it’s those two things that make me really concerned about their role”.

While the availability of workers in-house to discuss and plan the response to cases was seen as an advantage, some participants were concerned that some decision-making was occurring prior to strategy meetings, with the absence of input from the districts “...*some conversations seem to have already happened; which can be good in some ways, but not so good in others. Sometimes there’s already a plan, but sometimes these plans don’t involve what the [CPFS] district want*”. This issue was thought to be partially resolved with the in-house CPFS worker attending these meetings. However, some participants indicated there was a tendency for police to proceed immediately with their part of the response, when the purpose of strategy meetings was to plan the response, and ensure agencies were working in concert “*before [the CPFS Worker was in place]... because there was no real representative of the department... the police went ahead and just interviewed the kid... that was a bit of an ongoing issue*”.

Difficulties with information sharing arrangements were also raised by most participants; while arrangements were thought to be serviceable they were thought to be quite clunky and difficult in some situations. Participants identified that while statutory agencies had a legislative base for their information sharing, the sharing of information with Parkerville relied on the signing of a consent form to exchange information “*the legislation doesn’t support anyone outside of those government agencies actually sharing information, so we have had to rely on you know the old fashion of consent to exchange information basically*”. This was thought to cause some difficulties as advocates in particular had very little knowledge about a case until it arrived “*Beyond the basics, the real information sharing doesn’t happen until the family is in the building and the consent has been signed*”. Similarly, advocates did not attend strategy meetings, and relied mostly on informal information exchange in order to know that an interview is coming in, and what some of the concerns around the family might be “*[Information exchange] relies on advocates coming up to get the details and chasing details*”. In terms of information sharing, there was also an example where participants were concerned the Parkerville staff did not pass on information about a family, and that the issue was only identified from the CPFS worker attending the Multi-Disciplinary Team meeting “*there have been a couple of issues... information was maybe not shared with CPFS when it could’ve been and it significantly impacted the work that we were able to do with the family*”.

While mainly related to one incident, a few participants identified issues related to collaboration with Parkerville staff related to their closeness with service users. The main example given was where a safety meeting was held at the George Jones Child Advocacy Centre and Parkerville staff participated. The perception was that Parkerville staff were minimising concerns that CPFS staff had wanted to raise through the meeting, because of this another meeting had to occur at a district CPFS office in order to have the concerns properly addressed:

“...we were just so concerned about these kids... we were looking to take the kids into care, we were looking for these meetings to be quite strong, and I guess having that balance of more Parkerville staff than CPFS staff, and they have to have that relationship with the family, and we’re saying these things that are quite harsh, it didn’t land with the family at all, we had to have a subsequent meeting at a DCP office for them to say wow the state government is so concerned about our kids... the outcome of the meeting was for them to know that if they don’t work with us there will be consequences, it’s not all happy families”.

This combined with a perception from some workers that sometimes clients were able to play the advocates against the workers from government agencies *“there’s been a couple of times that it’s niggled me that I know families are playing an advocate against [staff from government agencies]”*. Similarly, Parkerville staff raised the difficulty of working in close connection with government agencies as clients may not feel as free to talk to therapists and advocates because of the presence of CPFS and police in the building *“the investigation can mean people are quite secretive about things, which can make them hesitant to engage with the centre and with services”*.

Some difficulties with the interview process were raised, although most participants thought that the issue had been resolved through the MIST review process. The issue was related to who greets the children and families when they first arrive *“...some issues with the advocates greeting the family without the interviewer knowing the family were there.... lack of understanding from the Parkerville staff about how the interview needs to be done”*. While the SOPs manual outlined that the interviewer should greet the family and introduce the advocate, there were some instances where the advocate was greeting the family and bringing them into the building *“There were some issues with who meets the family at the start; it had been that an interviewer had to be down to greet the family, and sometimes interviewers weren’t available, and it’s not good to have the families waiting there”*. This was thought to primarily occur when interviewers were busy either planning, or completing another interview. Similarly, there were some perceived early issues with children being provided food and drink, or being distracted by toys before the interview *“... like the hot chocolate thing; or the issue about too many toys being in the room and children not wanting to go into the interview because they just wanted to play”*, which was thought to be problematic for their attention span during the interview.

Some of the participants discussed perceived difficulties around isolation, partly related to the building, partly related to distance from their main office. As part of the MIST team is based upstairs at the George Jones Child Advocacy Centre, they sometimes felt a bit out of place downstairs *“Like I always feel when I’m coming down here I’m intruding a little bit”*. Also, due to the workload they were sometimes not able to participate in some of the informal socialising that happens downstairs *“things like the birthday... sort of feel a bit bad that I didn’t get involved in that... I don’t know whether that reflects on their opinion of us”*.

Constant changes in police working at the centre was also raised as a difficulty:

“One thing that’s possibly a little bit frustrating is the change in Police. So for example...[a case] that has gone to court the policeman has already been moved out of the building and so that’s a bit frustrating... Thankfully all the ones that have come in like they’ve all really slotted in really well but that is a frustration...”.

Some participants raised concerns about the perceived preference for internal referral of services by

the advocates rather than services outside of Parkerville *“sometimes they seem to be pushing towards a Parkerville service which may not be the most appropriate service”*. While participants felt that this generally didn’t occur often *“haven’t really had too many issues like that, but the feedback from the districts is different because they haven’t had the personal discussion”*, some identified instances where they thought children and families would have been serviced better by a different service, particularly families that live some distance from Armadale *“there might be better services for those Cannington cases outside of the [Armadale] district and outside of Parkerville that might be easier for families to engage with”*.

### **Capacity & Resource Issues**

Broadly, participants talked about perceived difficulties related to resourcing, including the perception that the team at MIST did not receive proportionate resourcing in relation to the number of cases they were responding to *“...because it is only a project it hasn’t been staffed properly; 30% of the workload but not 30% of the staff has been to the detriment of the workers here”*. Some participants were concerned that resources allocated for the pilot were detrimental to the rest of the response *“my concern was whether that would cause less of a service for other children in the metropolitan area because resources had been quarantined for Armadale”*. Some aspects of the MIST response required additional work, with the team at MIST doing some of the initial processing of cases that would normally be done separately from a Child Abuse Squad *“At MIST the file will be in-taken without assessment and sent to [Detective Sergeants] and they will assess and triage the case and arrange the interview and picking up the front end work... there’s a bit more work for [Police in MIST]”*. Capacity was also an issue in de-centralising parts of CAS in order to undertake the pilot:

*“there’s also an impost [at CAS], because you don’t have that other team sitting with you where you can go... we’ve got four priority 1 jobs to deal with, we need a couple of your guys to swing on to this job. The effect of decentralisation is that you have that team down at Armadale, and you can’t use them”*.

Undertaking strategy meetings and attending interviews at MIST were perceived to be advantageous, however this required additional work compared to the Practice as Usual condition *“In the city they [Strategy Meetings] are done by the team leaders, here they are done by the interviewers, which puts a hell of a workload on the interviewers here”*. Also raised was the many additional Practice as Usual matters that were being sent through the centre *“The city keeps sending other jobs down, other non-MIST jobs are coming in, lots of them, and they don’t count in the stats”*. Having just the one child protection worker also limited their ability to do home visits, as CPFS generally requires workers to do home visits in pairs *“Client contact is mostly over the phone, whereas for [CPFS District] they would go out to the homes”*. This worker also did a lot of additional work in providing information to police on cases not allocated to her:

*“... it’s taking longer to complete SWAs than if [CPFS worker] was sitting here, but that’s about the infrastructure and the expectations within that project, and that’s about getting the infrastructure so [CPFS worker] can do [their] job as efficiently as she can, processing reports etc. And get the police to understand that [CPFS Worker] can’t spend [their] time answering for every case that comes through the MIST project, only the cases [they’re] allocated”*.

Other examples of capacity and resourcing issues were around IT; some workers were not properly

set up in the building and worked from spare laptops “[Planning for]...*the role or providing desk space or a computer or printer access hasn’t really been thought through*”. Some workers also had difficulty working across multiple databases from the centre, with delays in workflow due to the computer logging out of databases “... *it just takes so much time, it’s consistently shutting down, the IT system needs to be reviewed*”.

### **Interagency Politics Around the Establishment of the Pilot**

The interviews highlighted the substantial and long history of interagency politics on the issue of developing a localised interagency response in Western Australia. Most relevant to difficulties associated with the MIST pilot was the legacy of how the GJCAC centre was established:

“...agencies felt resentful that this was an imposed structure rather than we all acknowledge that working together has a better outcome, or could improve outcomes for kids... we’re going to have it in the purest form of how we think it should exist and you guys need to come on board”.

With natural staff turnover, the organisational memories of interagency politics associated with establishment appear to have diminished, and were a feature of only a small number of interviews.

### **Lack of Clarity Around the Purpose of the Pilot**

Some of the participants were critical of the broad and open-ended nature of what the pilot was intended to achieve, pointing out that the SOPs in particular failed to articulate clear outcomes:

“I think what is clear is nobody knows what the outcome is supposed to look like, I don’t know what the outcome is supposed to look like, what are we trying to measure and how are we trying to measure that”.

“...for the advocates to show that the resources that have been put into that place are worth it, they have to show that they are actually doing something above and beyond what is already happening, I’m not sure that they can do that.. what extra value are they adding to the system, that’s what they’ve got to show I think, which to my mind is about support to families, support for parents”.

### **Setting Up an In-House Medical Response**

The MIST response began with a part-time in-house paediatrician managed by the Child Protection Unit at PMH, but this worker left in late 2015. The effort to attempt to have MIST be a full integrated response (including medical services) was marked with significant difficulties. Despite initial reservations about having forensic medical services conducted outside of the Child Protection Unit, managers at the CPU created a document outlining the procedures they would approve an off-site doctor conducting, and reached an agreement about the funding of an in-house paediatrician. However, the paediatrician hired did not have the skills to undertake forensic medical examinations:

“... unfortunately the person recruited didn’t come with the experience to provide a forensic medical service, so the first 12-18 months he was basically trained up to the registrar level”.

“the doctor involved wasn’t hugely experienced in child protection when he started so there was a period where he had to be trained up to do these things because he’s on his own, there’s no one else to kind of discuss with, so he did get trained up but, but then there was the second issue, which was not enough cases to maintain a level of expertise”.

The paediatrician eventually resigned, primarily as only a very small number of cases were being referred:

“...non-acute child sexual abuse cases you can see those and [PMH paediatrician] got trained up... but [they] just didn’t get the referrals, there were hardly any... there just weren’t many cases”.

Broadly, a number of participants talked about the difficulty of implementing a forensic medical service outside of an established hospital:

“[acute sexual assault cases] those types of cases are always in the middle of the night they’re teenage girls, they’re suicidal, they’re not great to be doing in a community setting”.

“...we’ve always said to Armadale, you really cannot see these cases, these acute cases because they really don’t have the links out there. We also have equipment like colposcopes, and I know they’ve purchased one, but you need to be trained in using them to keep your skills up, in order to be able to interpret the images”.

### **Uncertainty about Pilot**

A consistent issue brought up by participants was around the uncertainty involved in the pilot, with the end of the initial pilot timeline fast approaching “*Generally, there was quite a bit of uncertainty about things, emotionally that has been difficult*”. Participants indicated that it was difficult not knowing whether the pilot would continue “*it’s been very uncertain, no one knows how long it’s going to go, it could be pulled next month, so that side of it is always going to change people’s outlook*”.

### **Differences across CPFS Districts**

Primarily an issue for the in-house CPFS worker, differences across CPFS districts was raised as a difficulty. Mostly this involved some difficulty for the worker in completing their paperwork, as things were done differently in each of the two MIST districts “*we write our assessment reports differently [from the other district], so [CPFS Worker] wrote it and then had to re-write it because we weren’t happy with the assessment according to how we do things...*”. There is also the unusual situation of a CPFS worker being supervised across districts; while having a line manager in Armadale district, the in-house worker also was managed by team leaders at Cannington “*one CPFS worker working across two districts has probably been the big thing [disadvantage]... having three different team leaders that work quite differently... for [CPFS Worker] there’s probably a lot of pressure on [CPFS Worker] around that*”. While this presented some difficulties, participants indicated that this was more or less manageable, but had some suggestions for how this might best be managed (see Suggestions for Improvements). Participants also identified that districts differed in their focus, which may present some problems for a worker operating across two districts:

“...areas with massive growth in intakes and interactions which leads to different thresholds; so for districts that have a lot of intakes to respond to they can only respond to the most serious ones; districts with less intakes around the same level, the response is likely to be different. [MIST CPFS Worker] is in a unique position taking direction from team leaders from two districts; there are differences in how districts approach things”.

### **Lack of Awareness of MIST across Agencies**

Participants indicated that there were varying levels of awareness of the pilot across their agencies

“...for some of those other districts such as Rockingham and Peel, they may know that there are Child First interviewers at the centre, but they probably won’t understand the entirety of the [reason they are based there]”. Particularly across Cannington CPFS district workers, there was limited awareness of the pilot, which made collaboration difficult “A lot of workers don’t know or understand MIST and what the process looks like”.

## Suggestions for Improvement

While broadly satisfied with the current process, participants provided some suggestions for improvements to MIST as it functioned at the time of interviews. Primarily this involved additional workers being added to the response to better cope with workload, changes to information sharing arrangements, additional detail in the SOP, more certainty around continuation, a regular team meeting involving just practice staff, and more involvement in the pilot from CPFS districts.

**Table 6 Themes Related to Suggestions to Improve the MIST Model**

Theme	Sub-Theme
Need for Additional Workers	<ul style="list-style-type: none"> <li>• More Advocates</li> <li>• More CPFS Capacity</li> <li>• Additional Police</li> </ul>
Changes to Information Sharing	<ul style="list-style-type: none"> <li>• Advocate at Strategy Meeting</li> <li>• Police at MDT</li> <li>• More contact with Department of Public Prosecutions</li> </ul>
More Detailed Standard Operating Procedure	<ul style="list-style-type: none"> <li>• Improved Clarity of Roles in SOP</li> <li>• Have the SOP reflect the distinction in the types of cases appropriate to be managed by the MDT</li> </ul>
Continue Discussion about Interagency Responses	
Regular Team Meeting for Practice Staff	
Expansion to Other Types of Cases	
Certainty Around Continuation	
More Input from CPFS Districts	

Since the interim report some of these suggestions have been addressed. While directly following the interim report a number of meetings occurred at different levels of practice and management, these have since not occurred regularly. These meetings made a point of including district representatives from CPFS for their feedback. While the pilot was extended until June 2017 following a meeting between the Director General of CPFS and Deputy Commissioner of Police, uncertainty in the future of the pilot remains.

### Need for Additional Workers

The most common suggestion across the participants was for additional workers to help manage the workload of the team. In particular, the perceived need for additional advocates was highlighted, but also additional capacity for the in-house CPFS worker, and additional detectives. There was considerable concern about the workload of the advocates, who were seen as carrying significant active caseloads “The case load is very high for the advocates”. Improved integration of case

management services within Parkerville were suggested as a way to support the advocates *“integration internally in Parkerville, do all of those families need an advocate service or do they need other family support services within community, and longer term supports”*. More stringent criteria around the services provided by the advocates was also suggested in order to make the service more sustainable: *“I think we do need to look at criteria for how much support is going to be provided to each family, because we’re not going to have this wonderful service for families if we carry on providing support for every single person.*

Participants thought that the benefit of the in-house CPFS worker had reduced due to the worker reaching active caseload limits *“[CPFS Worker] has been full all the time, we got real benefit from [CPFS Worker] from the start, but we haven’t really had the same benefit because [CPFS Worker is] trying to catch up”*. Adding capacity to undertake Safety & Wellbeing Assessments in-house was suggested as an important improvement, with some suggestions that there might be need for an additional worker from Cannington *“Another CPFS worker; particularly from Cannington”*. Having a team leader based at the centre in a specialised role that involved supervising interviewers and the in-house CPFS worker was also suggested:

*“...it would probably work better long term if we have a team leader based here; I guess just in terms of hierarchy like we have Detective Sergeants here who are like the boss of a team... where as I guess for the [CPFS staff] both of our team leaders are off site.*

Extra capacity within the co-located CAS squad was also suggested, although it was thought that because of capacity issues across the squads, extra resources would be unlikely to help manage the workload *“I have a feeling like even if we got another body in, the workload isn’t going to change much, there’ll be a brief respite, and it’ll start building up again”*. In particular, having extra capacity for the police interviewer, as currently there is difficulty replacing this worker in the event of absence *“... when they get very busy... they only have x amount of capacity... it’s again I’m talking about that correct resourcing, if [Interviewer] went on leave we’d be down to one interviewer”*.

### **Changes to Information Sharing**

Suggestions to improve information sharing centred on finding a way to streamline the information exchange process, particularly between the workers from government agencies, and the advocates. Some of the difficulties around information exchange were related to the lack of specific legislation allowing workers from the not-for-profit sector to receive information without specific written consent *“Clearer agreement on information sharing that doesn’t rely on families on the day”*. Some participants suggested that a solution to this would be for the advocates to attend strategy meetings to avoid information from these meetings having to be repeated and relayed verbally *“for some limited matters it might be useful to have the advocate at the strat [Strategy Meetings] meeting to prevent going in blind to support a family because there isn’t the time to do it.* Similarly, some participants thought there might be some benefit in having police attend the multi-disciplinary team case review meeting on a more regular basis *“interviewers or police sitting in on MDTs would be good”*. The involvement of the Department of Public Prosecution was also raised as a way to improve access to information about cases once police have closed *“more contact with DPP to obtain information about court appearances and such”*.

### **More Detailed SOP**

While the SOP has remained more or less unchanged over the course of the pilot *“once we started*

*there was a good SOP, it's hardly changed"*, participants suggested that some additional detail might assist with clarifying processes. Providing clarity around roles within the team, particularly in terms of review processes were suggested *"it doesn't talk much about how the team works together, what processes support the team working together"*. As discussed above, participants thought that there were some advantages in the Multi-Disciplinary Team (a case review meeting including Parkerville staff, the CPFS worker, and occasionally police) taking on responsibility for responding to some cases; having this reflected in the SOP, particularly with more clarity about what cases are appropriate for the Multi-Disciplinary Team to manage at GJCAC, and when the team need to take their lead from the allocated CPFS district worker:

*"if we could in that... mandatory reporting process... we can kind of get more quickly that a parent is protective, that they have the ability to be protective and just need supports, that would be really beneficial from a department point of view"*.

### **Team Meetings Involving Practice Staff**

While participants were generally positive about the review meetings, a number of workers suggested that they would benefit from a regular meeting involving just workers from the team *"I just think maybe once a month it would be helpful for us to have a meeting with the advocates, with [the in-house CPFS worker], with whatever interviewers are on. Yeah, just to touch base and see how everyone is going..."*. The purpose of this meeting would potentially be to resolve minor practice level issues, rather than bringing them up at the review meeting that can involve quite senior people from across agencies *"more of an on the ground team meeting.. probably comes down to the agencies and how that would work... it would be a benefit to sit down and talk about some of the teething issues that might come out"*. This potentially also can be used to continue to help build rapport between workers, including those not based in the building:

*"I think if we could create those relationships more... other than through MIST there's really not any relationship... all of those positive benefits we're seeing here aren't really being replicated because they don't know how each other's roles work... start incorporating other people from the districts into the project"*.

### **Continue Discussion about Interagency Responses**

A number of participants identified that regular interagency discussions had occurred in the past about how to develop an effective interagency response, and that such a forum would still have value in the context of the MIST pilot:

*"...there's no space for a dialogue for all the agencies that are involved in child protection, but as an agency we would have like to have had a more general discussion about what does Perth need [Prior to the Establishment of the MIST Pilot]"*.

### **Expansion to Other Types of Cases**

Some of the participants suggested that there may be value in extending a MIST type response to other types of cases, particularly sexual assault cases, which currently are allocated to Sex Assault squad:

*"I think the other thing for me is differentiating between SAS and CAS, because I think some of our young people could do with this type of model but they fall into SAS not MIST, and I think that's to their detriment sometimes"*.

Another participant was critical of the contrast between the response to sexual abuse cases and physical abuse cases, an artefact of the current division of labour within the WA police:

“I feel because of mandatory reporting there is a discrepancy in the way different types of abuse are managed in this state and there is a lot of emphasis on sexual abuse and there’s a whiff of that and everyone’s all over it, but physical abuse or neglect you sometimes can’t get any response at all”.

### **Certainty around Continuation of the Pilot**

A common theme from participants is the need for some certainty around the continuation of the pilot *“Having some sense of time to do this properly would be good... it’s almost like you’d want to have some certainty over a number of years... is going to enhance people’s motivation to engage in the project.* This was also identified as an issue at a broader cross-agency level: *“if everyone accepts that [MIST] is the way to go, then you have to do it at once, not this station, or another station, because it’ll get out of hand, and systems will break down”.* It should be noted that most of the interviews were conducted prior to the extension of the pilot to June 2017.

### **More CPFS District Input**

As discussed in the difficulties section, there was a sense that the districts weren’t quite as involved as they could have been in the development of MIST. From workers both in the building and out of the building, there was a feeling that improved integration with District CPFS would be beneficial for the pilot *“I would like to see more of the districts being a lot more closely together to get over some disagreements and fears about who is doing what... it would be beneficial for families to have more of a connect there”.* Similarly workers from outside the building thought that there was a need to have the CPFS districts better represented both in cases and in some of the planning around MIST:

“...the model needs maybe the Department being more involved in some way... sometimes I think DCP [CPFS] are not being included in things that are happening, so we’re kind of getting things after the ship has sailed. That’s both in terms of cases and in terms of things that are going on in the centre”.

## **Summary**

The interviews with staff indicated a strong degree of support for the model and provide some background on the changes to typical processes related to MIST.

Participants identified *advantages* particularly in terms of collaboration and communication. Being co-located, and working in a small cross-agency team was thought to resolve some of the typical difficulties that came from working across agencies. The earlier allocation of detectives to cases, and the in-house CPFS capacity were also thought to be particular advantageous for collaboration and communication. Workers also highlighted the perceived benefits of providing support to children and families throughout the interviewing and investigation process, and concern about the lack of support for children and families in Practice as Usual at the time. Connected to this was the work of the advocates which was seen to engage children and families in supportive services alongside the investigation. The improved convenience for families from the response being based from the one building was also thought to be an important benefit. Participants also thought that the MIST response worked well in minimising child and family distress during the interview and investigation process. Finally, participants identified the perceived advantage of being able to divert lower risk families from ongoing involvement with CPFS.

When asked about *disadvantages*, participants spoke about *difficulties*, problems that were more to do with how MIST was being done, rather than any inherent design flaw in the model. Primarily the perceived difficulties were to do with collaboration, trying to work across different processes and agency priorities, and differences in understanding processes. Workers also talked about capacity and resource issues that were seen to have made their work more difficult, reflecting that the MIST process involved more work for individuals than the standard system. The interagency politics around the foundation of MIST was raised as continuing to affect the quality of cross-agency efforts in a small number of interviews. Some participants felt there was a lack of clarity around the purpose of MIST. Difficulties in establishing the in-house medical service was also raised. Uncertainty about the pilot was talked about by many as a difficulty, not knowing whether the response would continue made developing the approach difficult. Differences between CPFS districts and the need for the in-house CPFS worker to work across districts as part of the model was also seen to involve some difficulties. Finally, participants thought that the lack of awareness of the MIST process across the broader agencies created some difficulties.

Participants provided *suggestions* to address some of the difficulties identified, primarily the need for additional workers due to the high load of cases being serviced by the MIST team. This applied to advocates, interviewers and the in-house CPFS worker. Participants also identified the need to work on some of the arrangements for information sharing, reflecting that some existing processes were clunky and involved people repeating information unnecessarily. Adding more detail to the SOP was also raised to clarify some of the roles and processes specific to MIST. A regular team meeting involving practice staff was suggested, to help maintain rapport between workers, particularly those not in the building. Separate to this, returning to high level discussion about inter-agency responses to child abuse including all agencies that play a part in the process was also mentioned. Another key theme was the need for an improved response to sex assault and physical child abuse cases, and to improve the integration of the Child Witness Service, Child Protection Unit, and the CPFS districts into the MIST model. Finally, participants wanted some certainty around the continuation of the pilot so that the approach could continue to develop and improve.

There has been limited action on these suggestions since the interim report, besides a number of meetings at the practice and manager level occurring in mid to late 2016 that included the CPFS districts.

## FINDINGS FROM THE DESCRIPTIVE STUDY OF THE IMPLEMENTATION OF THE MIST

The MIST pilot Standard Operating Procedures (SOPs) manual describes the process for the allocation of cases to the MIST team at the George Jones Child Advocacy Centre. As described above, the SOPs describes the referral of cases that meet the Child Abuse Squad charter, and include a child victim that lives within the catchment area for MIST. All other Child Abuse Squad cases are to be allocated to a Practice as Usual squad, with their allocation determined by capacity; the MIST squad is unique as they are primarily allocated cases based on geographic area (Cannington & Armadale) rather than capacity.

While this describes an orderly process of referral to the MIST response, the data are much more complex. Due to capacity limits across the Child Abuse Squad, the MIST team have needed to investigate a number of matters outside of their catchment area. Similarly, the interviewers (both Police and CPFS) are often asked to provide interviews for Practice as Usual cases outside of the catchment area, sometimes for other CAS teams, for Sex Assault Squad, for local detectives and district CPFS. In some situations, cases meeting the MIST criteria have been interviewed at CAS/Child First in Perth; particularly out of hours cases (weekend, or evening) or for cases that are within the catchment but where the child's residence is much closer to Perth (e.g. Belmont). Parkerville Children and Youth Care Inc. have committed to providing the same advocacy and support response for all cases interviewed at GJCAC regardless of whether the child resides within the catchment area, meaning that some of the workload of the advocates and therapists falls outside the official scope of the pilot and the comparison sample.

### **Analysis of Case Pathways**

Cases that are allocated to the MIST team follow a slightly different pathway to Practice as Usual cases. Of particular relevance, the process involves greater involvement by the CAS squad earlier on in the process, including with cases that do not proceed further for investigation by police and child protection authorities. Therefore, the point at which cases are allocated to the MIST and Practice as Usual squad are different (reflected in some gaps in the case flow data for PAU). This means that the MIST CAS squad worked on a much larger number of cases than the other CAS teams over the sample period, but many of these cases did not proceed to the interview stage and were closed for investigation. For the Practice as Usual squad these cases would be closed off by the central team at Child Abuse Squad, and would not have been allocated to a team of CAS Detectives.

It is important to include these cases screened out prior to interview in the description of the MIST pilot as it illustrates elements of the model hypothesised to be superior to Practice as Usual (i.e. earlier allocation of detectives), it also illustrates the additional elements of workload unique to the MIST CAS squad and not required in Practice as Usual. However, in examining differences in case outcomes (e.g. time to finalise, charges laid) the point at which an interview occurred is the point of equivalency for the two samples. As such, Figures 2-5 are provided as an illustration of case-flow and process across both conditions, the Quasi-Experimental section provides a comparison between conditions that proceeded to interview.

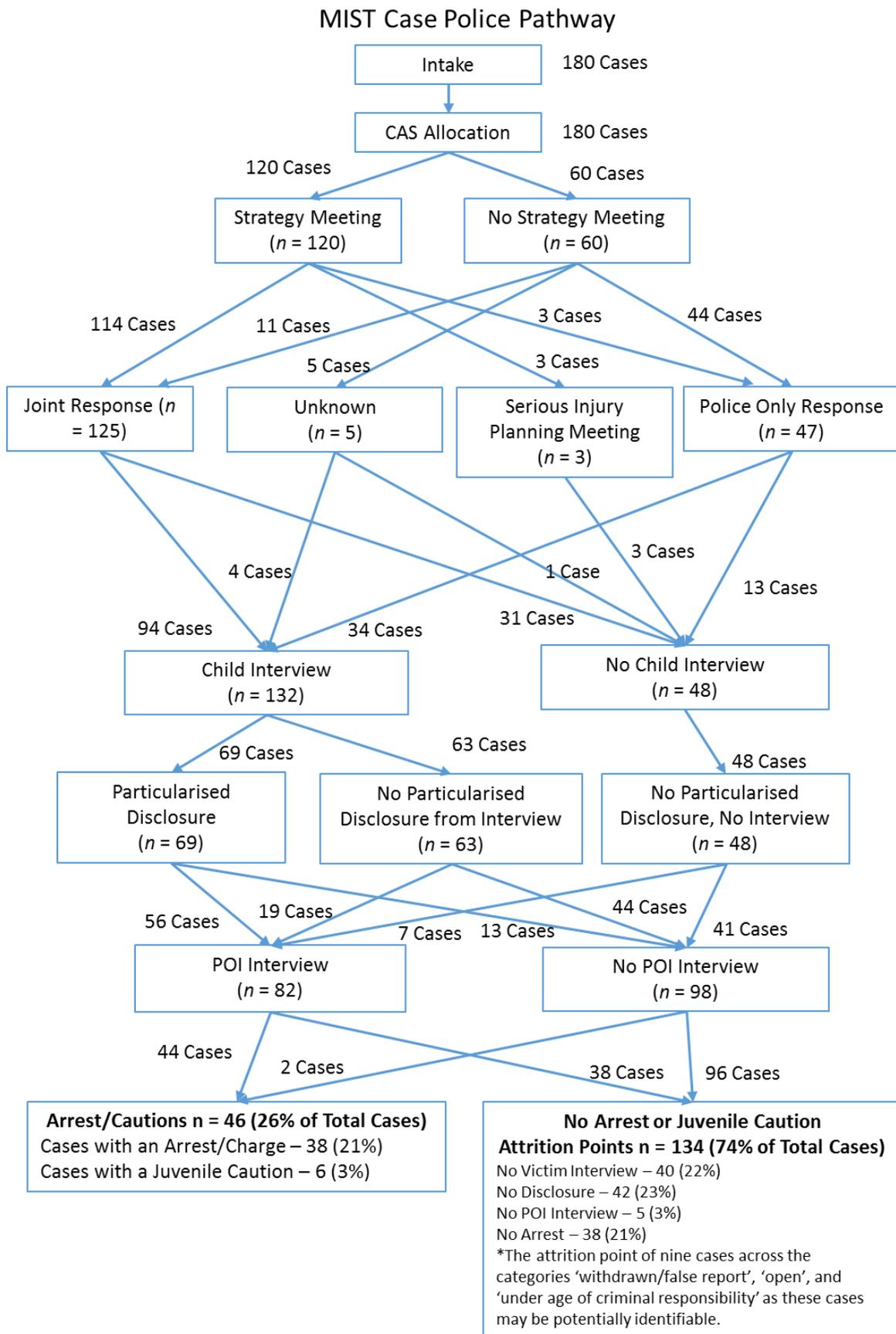
The data presented in the descriptive study includes all cases allocated to each of the squads during the pilot period, regardless of whether allocation was in accordance with the SOPs, including those that were still open either to WA Police or CPFS. Figures 2 & 3 show the general overview of the case flow from intake to arrest in the MIST and Practice as Usual conditions.

Figure 2 shows the case flow of all cases allocated to the MIST CAS Team over the pilot period. As

described in the MIST process, cases are sent straight from intake to the MIST team who undertake much of their own processing and background searching of information on the file. For screened in cases, this then leads to a strategy meeting where there is CPFS involvement in the case. Strategy meetings help to determine the need for a joint Police and CPFS response leading to a child interview, at interview the objective is to obtain a particularised disclosure of abuse, typically leading to the interview of an alleged offender, and where there is sufficient evidence to the arrest of an offender. The MIST sample also includes three Serious Injury Planning Meetings, a process initiated by WA Health where child abuse is detected within the health system, typically involving a very young child (i.e. under the age of three) that cannot be interviewed.

**Figures 2-5 provide an overview of the case flow for both conditions, however these are not equivalent samples; the Practice as Usual condition does not include all the cases that do not go on to be allocated to a CAS detective, and where the initial victim interview was refused. The quasi-experimental follow-forward study includes a comparison of these two conditions with equivalent samples (i.e. proceeded to interview).**

Figure 2 MIST Case Police Pathway

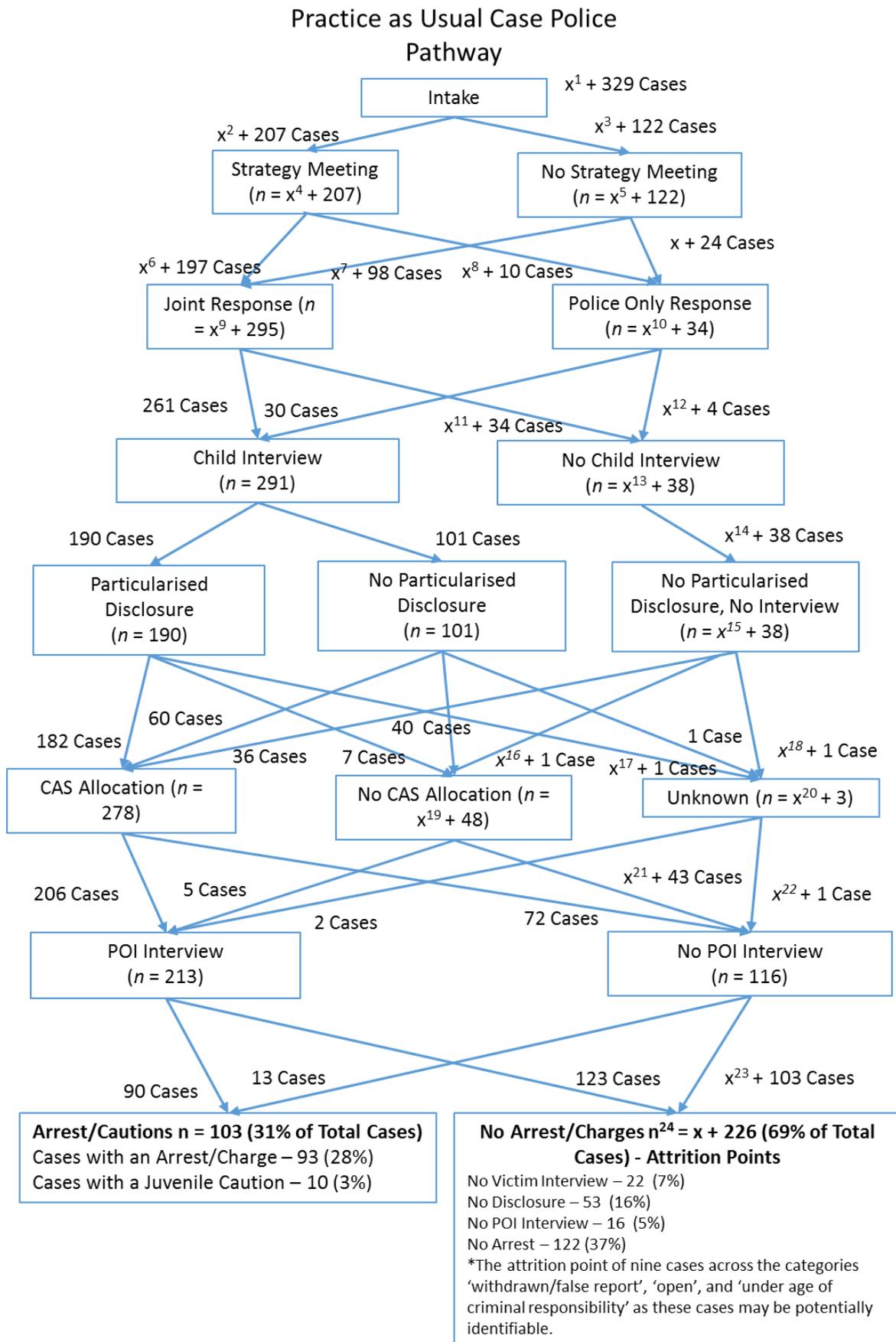


The case flow for Practice as Usual is slightly different (See Figure 3). From initial intake, a centralised team undertakes initial background searching for information on a case and conduct the strategy meeting if there is CPFS involvement. The majority of cases lead to a joint response, with a child interview conducted at the CAS interview suites. A detective will typically be allocated at the point at which there is a disclosure in the interview and/or there is other evidence (e.g. physical evidence, electronic evidence, or witnesses to interview) to investigate. If there is sufficient evidence this will typically lead to the interview of an alleged offender and the arrest of this offender.

As discussed above, the sample obtained includes all cases where an interview occurred and all cases where an investigator was allocated. The 'x' indicates where, from the data able to be obtained for this evaluation, there is uncertainty about the total number of cases that may exist. This uncertainty ends at the point where all cases either have been allocated or were interviewed. The pathway included some cases where CAS were originally involved in the processing and investigation of the case, but where the case was ultimately handed over to a different investigation group. These cases were excluded from the Quasi-Experimental samples in the next section.

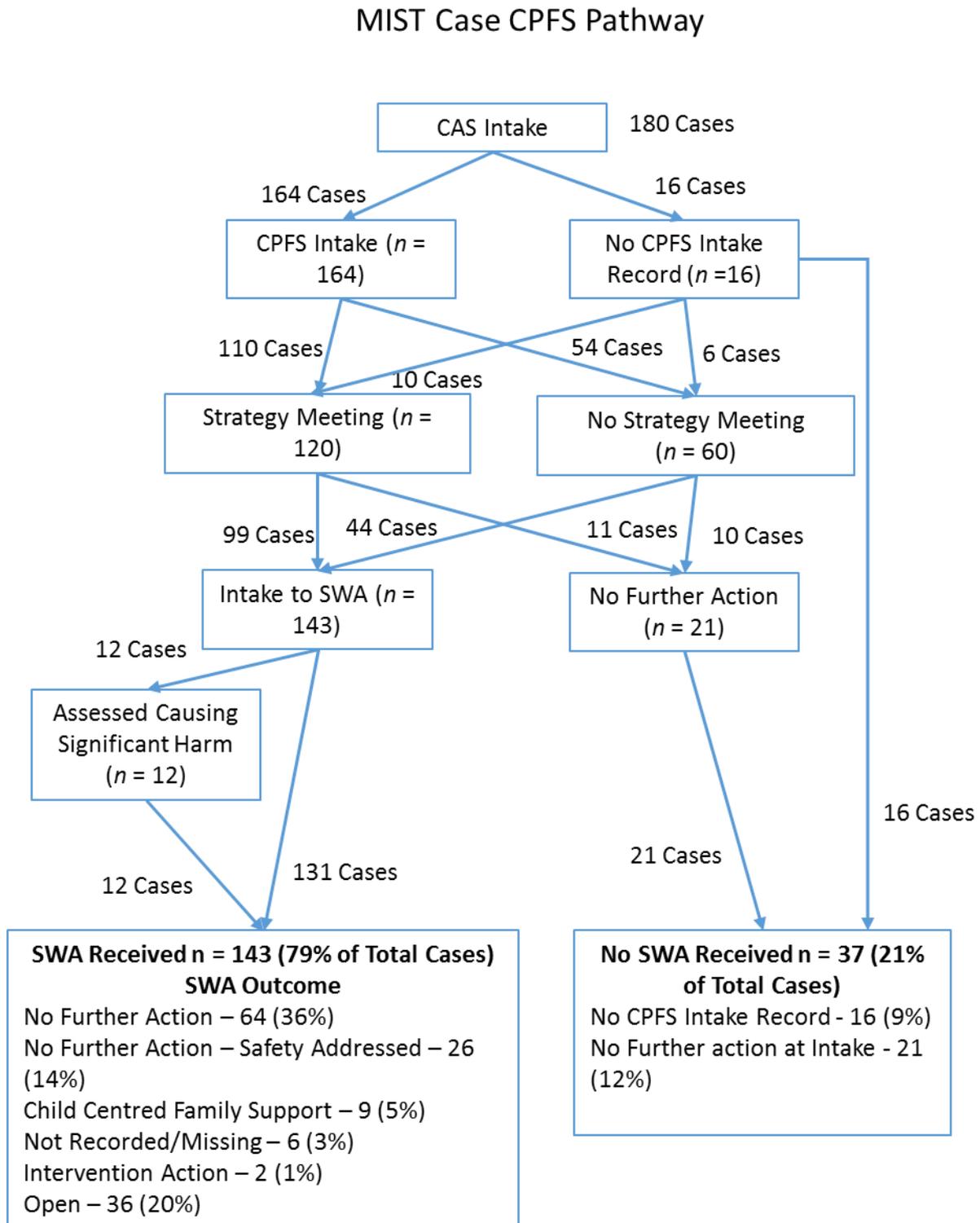
As discussed above, these pathways are not directly comparable to each other without population data on case-flow; it is not known whether there are systematic differences between the two conditions in the proportion of cases referred for interview – which was the sample selection point for the Practice as Usual condition. However, there are a number of interesting observations about the total volume of cases responded to by each condition. Compared to the Practice as Usual squad (See Figure 3), due to the different points at which cases are allocated, a much larger number of cases have been allocated to the MIST team over the sample period relative to the other CAS teams. Consistent with this a large proportion of MIST cases were closed prior to a child interview occurring (20%), compared with Practice as Usual (7%). The MIST condition was had a lower proportion of Joint Responses (71%), compared with the Practice as Usual Condition (90%). This may be attributable to the observation in the qualitative interviews that the MIST response also enabled some cases with relatively low concerns by CPFS to be diverted to the MDT follow-up without the case being formally allocated to a CPFS worker.

Figure 3. Practice as Usual Case Police Pathway



Figures 4 and 5 show the case pathway for the initial child protection response to cases. Similarly, for the child protection response to cases it is difficult to draw conclusions without knowing about the cases screened out before they are received by the Practice as Usual CAS team.

**Figure 4. MIST Case CPFS Pathway**

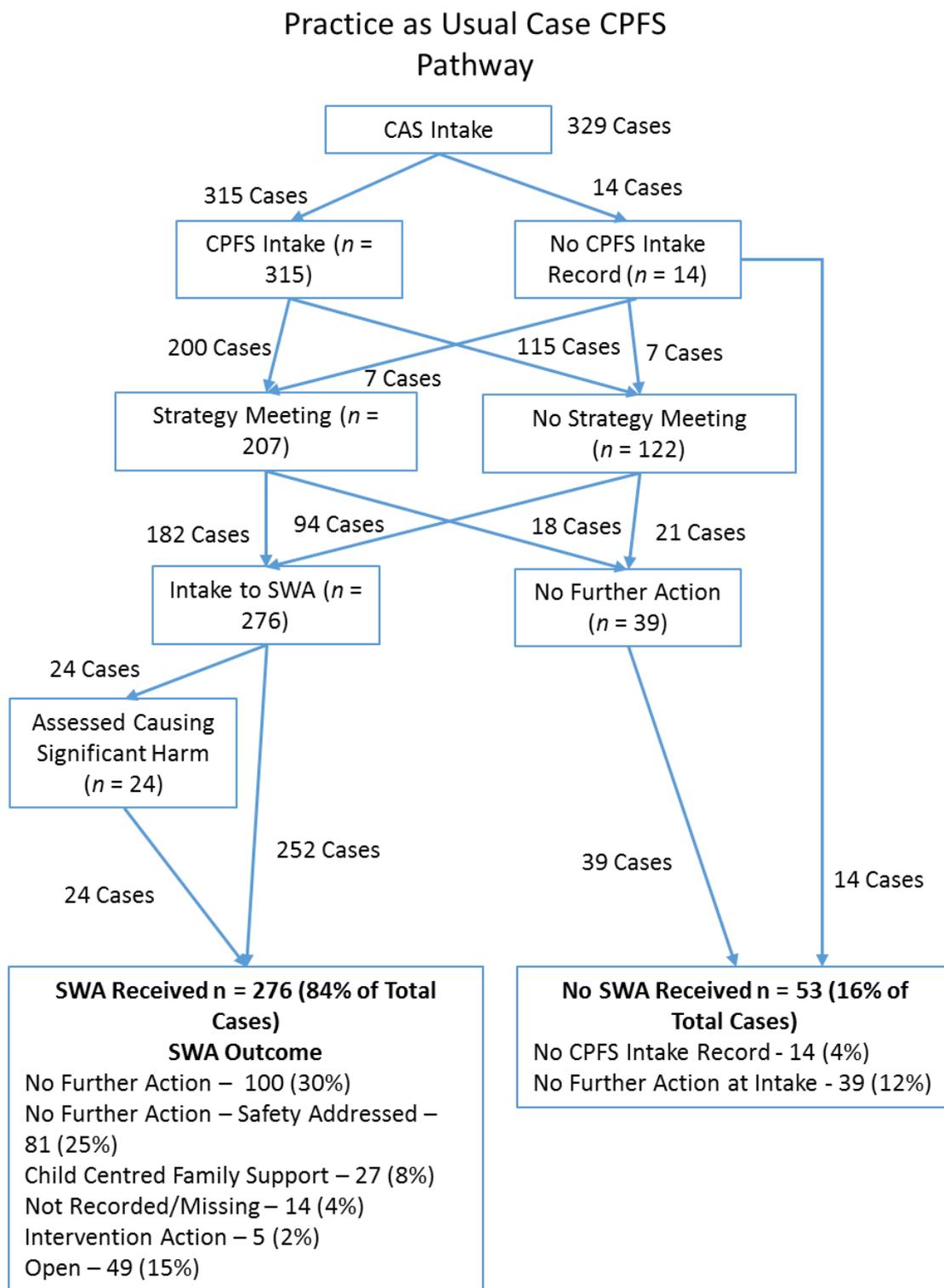


The CPFS case flow is the same for both conditions, with a CAS intake linked to a CPFS intake (we note that in many cases the CPFS intake occurred prior to the CAS intake). For both conditions a

CPFS intake existing did not seem to have any relationship with a strategy meeting occurring; many cases with a CPFS intake did not have a strategy meeting, and some cases without an intake record did have a strategy meeting. Across both conditions most matters were sent to intake for a Safety and Wellbeing Assessment. Both also had a large proportion of cases that remained open at the time of retrieval; this may be due to the case being open, but also due to case details not being entered into the ASSIST database.

A similar proportion of MIST cases received a Safety and Wellbeing Assessment (79%) compared with Practice as Usual (84%), this was also affected by the slightly higher proportion of cases where a CPFS intake record was not found in the MIST condition. This may have been because CPFS were not involved and had no records on the child or family, or because the information was not entered on ASSIST. When limited to cases where a record existed, in both conditions a Safety and Wellbeing Assessment occurred in 87% of cases.

Figure 5. Practice as Usual Case CPFS Pathway



### Caregiver Satisfaction Data

As discussed in the methodology section the outcomes in the OMS are more an indication of caregiver satisfaction and whether the intervention was delivered as intended than a genuine measure of child or family outcomes. Indeed, comparative satisfaction with the response received by children and caregivers may not be a good indicator of the quality of the response, particularly

where these groups do not know what they may have received in the other response. Previous comparative research between CACs and separate agency responses have similarly concluded that service user satisfaction may be a limited measure (Jones, Cross, Walsh, & Simone, 2007).

The OMS was administered to seventy caregivers of children interviewed as part of the MIST pilot who had contact with the advocates. The survey was incomplete for five participants, and participants were able to skip any questions they did not want to answer, so the number of responses vary from question to question. Broadly, the data suggest that MIST was delivered as intended in the SOPs manual, with a high level of attention to the needs of children and caregivers.

### **Child Demographics**

Consistent with the demographics in the administrative data samples (see Table 32) most of the child referents in the caregiver satisfaction survey were female (68%). The majority of children were between 6-12 years of age (53%), with a smaller group that were 13-17 (34%), and 0-5 years (13%). This was similar to cases in the MIST administrative data sample (see Figure 8), where the highest proportion was 6-12 years of age (48%), although a slightly larger proportion were 0-5 years (27%), than 13-17 years (25%). This suggests a slight underrepresentation of caregivers of children 0-5 years in the survey.

### **Satisfaction with the Response**

Survey items were measured on a 4 point likert scale (1 – low satisfaction; and 4 - high satisfaction). Broadly, the survey questions on caregiver satisfaction with the response was very high, particularly in terms of the friendliness of staff (*mean* = 4.00; *SD* = 0), if the child felt safe at the centre (*mean* = 3.93; *SD* = 0.31), child's feelings about the medical exam/medical services (*mean* = 3.92; *SD* = 0.28), if the person would recommend the centre to someone in the same situation (*mean* = 3.90; *SD* = 0.43), caregivers' satisfaction with the medical exam/medical services (*mean* = 3.85; *SD* = 0.38) and our child's questions were answered to our satisfaction (*mean* = 3.83; *SD* = 0.38). Both questions about a forensic medical exam/medical services had low numbers of respondents, but caregivers reported higher numbers of forensic medical exam/medical services than indicated by the administrative data (see Table 45). It is not clear from this data whether this is indicative of recording errors in relation to forensic medical examinations in the administrative data or whether other types of medical services provided may have been misunderstood by caregivers to be a forensic medical examination.

While also quite high, the items lowest in satisfaction were information/updates on the status of your child's case (*mean* = 3.04; *SD* = 1.04), and how my child felt about mental health/therapy services (*mean* = 3.38; *SD* = 0.74).

**Table 7 Mean Scores on Items in the OMS**

	Question	Mean Score (On a 4 point scale)	Don't Know/ Not Applicable	Valid Responses (n)
<b>Caregiver's Perception of their Child's Feelings about their Experience at the Centre</b>	My child felt safe at the centre	3.93 (SD = 0.31)	2	60
	My child's questions were answered to our satisfaction	3.83 (SD = 0.38)	8	56
	My child was included in the decision making process	3.63 (SD = 0.77)	11	51
<b>Caregiver's Perceptions of their Child's Feelings about the Following Services</b>	How my child felt about the forensic interview	3.57 (SD = 0.75)	9	53
	How my child felt about the mental health/therapy services	3.38 (SD = 0.74)	40	21
	How my child felt about the medical exam/medical services	3.92 (SD = 0.28)	47	13
<b>Caregiver's perception of Their and Their Child's Experience at the Centre</b>	Overall, the staff members at the centre have been friendly and pleasant	4.00 (SD = 0)	0	64
	As a result of our contact with the centre, we knew what to expect in the days and weeks that followed	3.55 (SD = 0.76)	2	62
	Since my first contact with the centre, centre staff has been available to answer any questions I had	3.67 (SD = 0.65)	1	63
	Overall, the services I have received from the centre thus far have been helpful to me and my child	3.64 (SD = 0.74)	0	64
	I feel I have received information that has helped me understand how I can best keep my child safe in the future	3.71 (SD = 0.68)	1	63
	I feel that the centre has done everything it can to assist my child and me	3.71 (SD = 0.70)	2	63
	If I knew anyone else who was dealing with a situation like the once my family faced, I would tell that person about the centre	3.90 (SD = 0.43)	2	63
	I feel I was included in the decision making process	3.63 (SD = 0.82)	0	65
<b>Caregiver's Satisfaction with the Following Services</b>	Forensic Interview	3.42 (SD = 0.94)	11	52
	Mental health services for your child	3.59 (SD = 0.59)	41	22
	Medical exam/medical services	3.85 (SD = 0.38)	50	13
	Info/updates on status of your child's case	3.04 (SD = 1.04)	8	55
	Mental health services for yourself	3.80 (SD = 0.41)	47	16

### Actions Taken

Some of the questions in the OMS covered whether more concrete actions were taken by the MIST team, such as referrals to services for children and caregivers, reasons for not taking up referred services, and the location of particular services.

**Table 8 Child’s Referral to Services**

	Yes	No	Don’t Know/ Missing	Total
Referral to Services	44 (70%)	19 (30%)	0 (0%)	63 (100%)
<b>Use of Referred Services</b>	<b>26 (59%)</b>	<b>16 (36%)</b>	<b>2 (5%)</b>	<b>44 (100%)</b>

The survey also asked about the reason for not taking up offered services; primarily caregivers indicated ‘other’ reasons ( $n = 7$ ) such as needing to obtain a referral from a doctor, using an external private service, looking at therapy options elsewhere, and not wanting to have children continue thinking about the abuse. Most caregivers indicated that services occurred at the George Jones Child Advocacy Centre.

**Table 9 Location of Services**

	Yes	No	Don’t Know/ Missing	Total
Forensic Interview at the Centre	40 (80%)	8 (16%)	2 (4%)	50 (100%)
<b>Mental Health/Therapy Services at the Centre</b>	<b>19 (83%)</b>	<b>3 (13%)</b>	<b>1 (4%)</b>	<b>23 (100%)</b>
Medical Exam/Medical Services at the Centre	4 (27%)	9 (60%)	2 (13%)	15 (100%)

Caregivers were also asked if there were additional services for their children they would have liked that were not offered by the centre; 8 caregivers from 63 indicated that they wanted additional services. These respondents indicated that they wanted more counselling and support for themselves, counselling for their children, and more follow ups to stay informed about what was happening with the case. Without knowing the particulars of these cases, it is difficult to know why these children and caregivers were not offered this support, or whether the need for support emerged later. Caregivers also reported that their children did not want to use the service ( $n = 3$ ), their child was already receiving a similar service ( $n = 2$ ), long wait lists ( $n = 2$ ), and that their child did not need the service ( $n = 1$ ).

**Table 10 Caregiver Referral to Services**

	Yes	No	Don’t Know/ Missing	Total
Referral to Services	22 (34%)	40 (62%)	3 (5%)	65 (100%)
<b>Use of Referred Services</b>	<b>11 (50%)</b>	<b>11 (50%)</b>	<b>0 (0%)</b>	<b>22 (100%)</b>

Mostly caregivers indicated that they did not think they needed the service ( $n = 3$ ) or ‘other’ reasons for not taking up the service ( $n = 3$ ), the days and times of the service did not suit them ( $n = 2$ ), the

location of the service did not suit them ( $n = 1$ ), and they were already receiving similar services elsewhere ( $n = 1$ ). Note these responses are very small and therefore not generalisable, they should be interpreted as indicative only.

Caregivers were also asked if there were additional services for themselves they would have liked offered. Nine caregivers from 65 indicated there were additional services they would have liked offered to them, primarily counselling or mental health services.

## Workforce

The workforce was composed differently across the MIST and Practice as Usual conditions. The MIST investigative team exclusively dealt with Child Abuse Squad cases (see Appendix C for CAS charter offences), whereas interviewers in both conditions dealt with all kinds of cases requiring a specialist child interview including for Sex Assault Squad, District Detectives, and some regional cases. This section describes the relative workforce available for both responses.

### Child Abuse Squad Detectives

Over the course of the pilot the four CAS teams were merged into three, pooling the available investigators into larger teams. By design the staffing of CAS team 3 (MIST) matched CAS team 1, as the evaluation originally involved a comparison between these teams with equivalent staffing (Herbert & Bromfield, 2016a). We note that these conditions share some more senior supervisory positions such the Officer in Charge of CAS and Investigations Manager.

**Table 11 FTE and Staff Rank in Child Abuse Squad Detectives**

	<b>Prior to Merger (Pre-February 2016)</b>	<b>Post-Merger (Post February 2016)</b>
CAS Team 1	7 FTE 2 x Detective Sergeants 3 x Detective Constables 2 x Probationary detectives	10 FTE 2 x Detective Sergeants 5 x Detective Constables 3 x Probationary Detectives
CAS Team 2	7 FTE 2 x Detective Sergeants 2 x Detective Constables 3 x Probationary Detectives	11 FTE 2 x Detective Sergeants 5 x Detective Constables 4 x Probationary Detectives
CAS Team 3 (MIST)	7 FTE 2 x Detective Sergeants 3 x Detective Constables 2 x Probationary Detectives	8 FTE 2 x Detective Sergeants 4 x Detective Constable 2 x Probationary Detectives.
CAS Team 4	7 FTE 1 x Detective Sergeant 3 x Detective Constables 3 x Probationary Detectives	N/A

### Child Abuse Squad/ChildFIRST Interviewers

The interviewing team at CAS/ChildFIRST is unique in Australia as a joint team of police and CPFS specialist child interviewers. These teams undertake interviewing for all kinds of cases involving child victims in Western Australia including cases that are investigated by District Detectives, Sex Assault Squad, and Child Abuse Squad. As discussed in the next section CAS were allocated many cases outside of area, partly due to the need to manage capacity across the teams. Similarly, the MIST interviewing team undertook interviewing beyond those allocated to CAS 3; this may be the reason

for the many cases in the Parkerville sample that were not allocated to CAS 3.

**Table 12 FTE Interviewing Staff**

	<b>FTE Staff Members</b>
Practice as Usual	5 x Police Interviewers 5.9 x CPFS Interviewers (5 Full Time, 2 Part-Time at 0.5 FTE and 0.4 FTE)
<b>MIST</b>	<b>1 x Police Interviewer</b> <b>1 x CPFS Interviewer (2 Part-Time at 0.5)</b>

We also note that both conditions share staff in terms of team leaders and police interview supervisors, although these staff are all based at Stirling St.

### **Child Protection Districts**

As the work of the districts extends far beyond the scope of MIST, it is difficult to provide a comparison of staffing figures. A single FTE was provided by CPFS in surplus of existing district workers to allow for an in-house child protection worker responding to MIST cases, working across both Armadale and Cannington districts. Each of these districts had their own compliment of intake and assessment staff, with the in-house worker adding a shared FTE across their normal staffing.

### **Child and Family Advocacy**

As discussed, during the study period only the MIST condition had Child and Family Advocates<sup>5</sup>, staffed by two full time advocates. A number of participants in the interviews identified that these workers carried a considerable caseload, which increased considerably as the pilot went on (see case volumes below).

### **Case Volumes**

As shown in Figure 6 there were quite dramatic fluctuations in the volume of cases associated with both the Practice as Usual and Practice as Usual-INT conditions, with spikes in March and May 2016. The volume of cases dealt with by MIST increased in February 2016 and stayed similarly high compared to previous periods. Some of these trends are explained by the phasing out of one of the CAS teams over the pilot period, with an increased case load and the workforce from CAS 4 being shared across the remaining teams (See Table 14).

<sup>5</sup> We note that since August 2016 CPFS has provided an advocate role at the CAS/ChildFIRST interview suites.

**Figure 6 Intake Figures for All Groups (October 2015 – July 2016)**

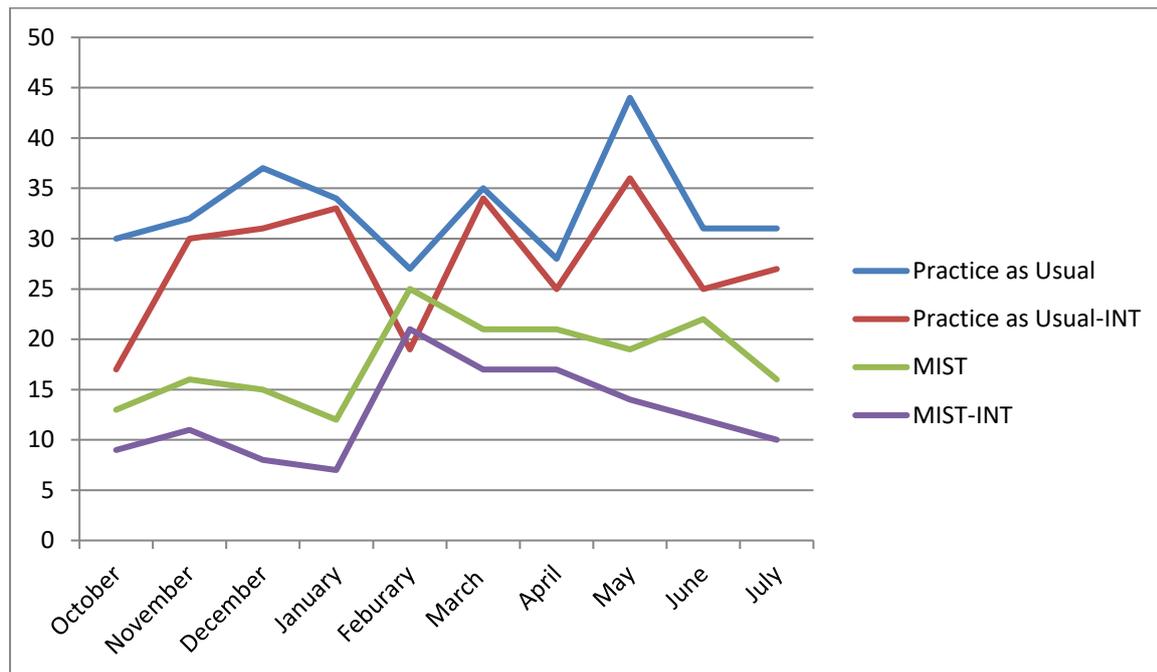


Table 13 compares total case volumes for the evaluation period across priority ratings. The priority ratings necessitate a different type of response, particularly for priority 1 cases which require an immediate response, and priority 4 cases (primarily historical abuse). Both Practice as usual and MIST had similar proportions of priority 1 cases (15%, 13% respectively), and similar proportions of priority 4 cases (4%, 2% respectively).

**Table 13 Total Case Volumes and Priority**

	Priority 1	Priority 2	Priority 3	Priority 4	All Cases
Practice as Usual Squad Cases	49 (15%)	112 (34%)	155 (47%)	13 (4%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>41 (15%)</b>	<b>101 (37%)</b>	<b>126 (46%)</b>	<b>8 (3%)</b>	<b>276 (100%)</b>
MIST Squad Cases	24 (13%)	51 (28%)	102 (57%)	3 (2%)	180 (100%)
<b>MIST-INT</b>	<b>18 (14%)</b>	<b>33 (26%)</b>	<b>72 (57%)</b>	<b>3 (2%)</b>	<b>126 (100%)</b>

CAS team 3 (MIST) has handled a considerably larger number of cases relative to the other teams over the pilot period (See Table 14), although since the shift to three teams the other CAS squads have also taken on a larger load of cases. A considerable number of cases went unallocated; these are cases that followed the Practice as Usual process sometimes with a strategy meeting, and child interview. Primarily these are cases where a child interview did not occur, or an interview occurred without a disclosure, and there was no other evidence or statements for a detective to obtain. As previously noted, the Practice as Usual sample for this study comprised cases allocated to CAS squads 1,2 or 4 and cases where an interview occurred that would have been allocated to these squads. Cases unallocated or screened out prior to interview were not able to be retrieved for the

Practice as Usual sample.

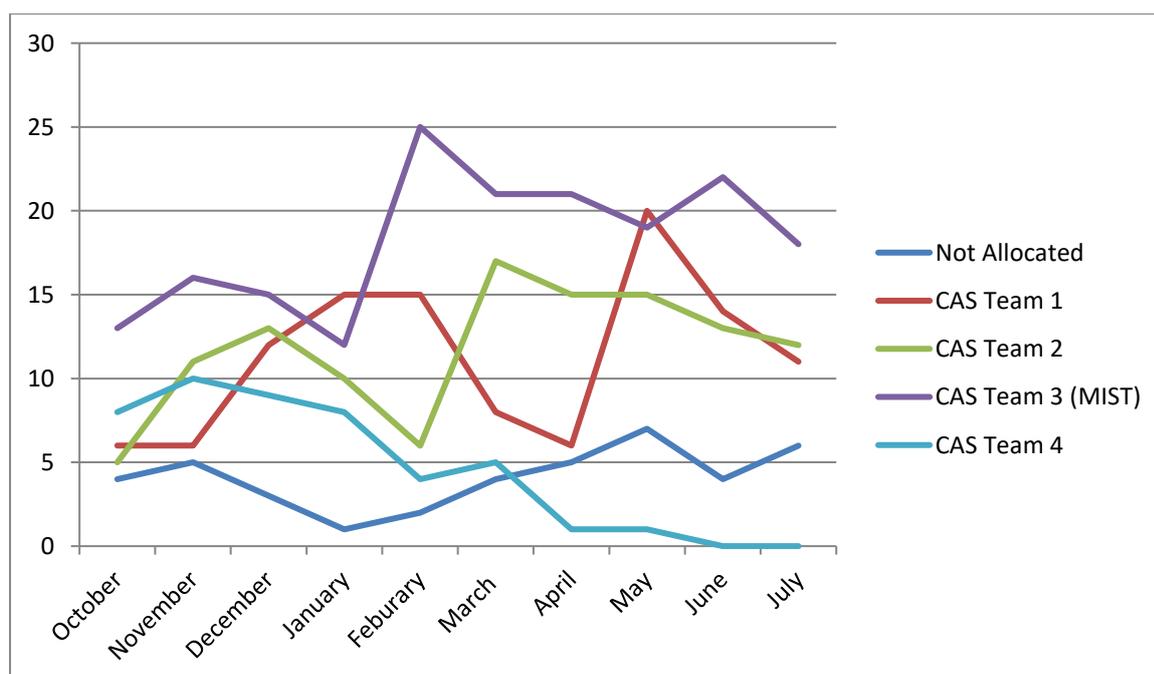
**Table 14 Total Case Volumes by CAS Teams**

	P1	P2	P3	P4	Total Cases
Not Allocated	9 (22%)	23 (56%)	8 (19%)	1 (2%)	41 (100%)
CAS 1	17 (15%)	37 (33%)	51 (45%)	8 (7%)	113 (100%)
CAS 2	17 (14%)	33 (28%)	63 (54%)	4 (3%)	117 (100%)
CAS 3 (MIST)	24 (13%)	51 (28%)	104 (57%)	3 (2%)	182 (100%) <sup>1</sup>
CAS 4	5 (3%)	15 (8%)	26 (14%)	0 (0%)	46 (100%)
Other	1 (10%)	4 (40%)	4 (40%)	0 (0%)	10 (100%)

<sup>1</sup> Two Practice as Usual cases were reported as being allocated to the MIST (CAS 3) suggesting that the case went through the Practice as Usual process, and was then allocated to the CAS 3 team.

Figure 7 shows the gradual reduction of cases allocated to CAS team 4, and the increase in cases dealt with by each of the remaining squads. As well, Figure 7 shows the volume month by month dealt with by each of the teams. CAS 3 (MIST) consistently dealt with the most cases, with only one month (May) where CAS 1 dealt with more cases. This difference is partly explained by the difference in the MIST model where the MIST CAS squad are allocated earlier in the processing of the case, and often deal with cases that will be finalised quickly (e.g. cases where a child interview is declined). The localised nature of the response may have also contributed to efficiency in the MIST pilot, reducing travel times to conduct interviews with persons of interest and witnesses. CAS 3 (MIST) dealt with a considerable peak in cases around February 2016, with the team allocated 25 cases for that month.

**Figure 7 Intake Figures by CAS Teams**



### Does the MIST Response Require a Greater FTE Relative to Practice as Usual?

The MIST condition involves greater multi-disciplinary and cross-agency collaboration for all staff members. The work role of the MIST CAS squad, interviews, and CPFS worker includes additional job demands (i.e. involvement in screening and decision making prior to a particularised child disclosure and/or decision to undertake a POI interview). The different allocation process means the MIST team are screening in cases that may not have received a response in the Practice as Usual condition, while many of these close with no actions to take, these still require workers to close these cases as part of their respective processes. On this basis, it might be expected that MIST would require more FTE than Practice as Usual.

On the basis of the FTE allocation for Practice as Usual (n = 21) and MIST (n = 8), a basic and conservative multiplier of 2.5 has been applied to the case volume data (see Table 14).

Practice as Usual and Practice as Usual-INT case volumes for Priority 1-4 and the total number of cases were divided by 2.5, the indicator calculated the target volume of cases that would need to be achieved in the MIST and MIST-INT conditions for it to be operating at equivalent case volumes to Practice as Usual.

Despite the additional workload demands on the MIST team and lower threshold for screening (in terms of evidence available for investigation) in cases for interview, both MIST and MIST-INT exceeded the efficiency target for Priority 1-4 and total case volume.

### Child and Family Advocacy Service

Table 15 presents the number of interviews where the two Child and Family Advocates provided support to families. As discussed previously the advocates provided support for some interviews outside the scope of the sample, and cases often required multiple interviews, particularly where other children were witnesses or multiple children had been offended against. Consistent with Figure 7 there was a significant increase in the volume of interviews in February 2016, and an according increase in the number of interviews attended by the Child and Family Advocates.

**Table 15 Number of Interviews Dealt with by Child and Family Advocates**

<b>Month</b>	<b>Number of Interviews Attended by Advocates</b>
Oct-15	20
Nov-15	22
Dec-15	12
Jan-16	23
Feb-16	39
Mar-16	27
Apr-16	31
May-16	35
Jun-16	22
Jul-16	29

Along with attending interviews in the MIST condition, the advocates also maintained ongoing contact with cases. The recording of the advocates' active caseload only began in December 2015, at its peak, with the number of active cases decreasing over time. An active case is one where the advocate is making assessments and referrals, providing ongoing counselling, and protective

behaviour sessions with children, and having regular contact with the family. From the interviews, advocates explained that the length and intensity of case work with children and families was highly variable; some families required extensive ongoing contact and support for long periods of time, while others more or less closed after the advocate made referrals for the family. The declining active caseload may reflect changes in the way the advocacy service was delivered, with a less intensive service following the peak of caseloads for the advocates six months after the beginning of the pilot. This pattern may also reflect the lower number of additional cases responded to over December 2015 - January 2016.

**Table 16 Active Caseload for the Child and Family Advocates**

<b>Month</b>	<b>Active Caseload for the Child and Family Advocates</b>
Dec-15	146
Jan-16	146
Feb-16	135
Mar-16	118
Apr-16	124
May-16	110
Jun-16	75
Jul-16	81

### **Child and Family Advocacy & Therapy Team Response**

As outlined, similar to the rest of the MIST team, the advocates have taken on a large amount of cases, many outside the SOPs manual definition of a MIST case. Some of these will include cases from other CAS teams, but also cases associated with Sex Assault Squad, district detectives, and CPFS districts. Table 17 provides an overview of the response across all cases that the advocates interacted with, and Table 18 provides an overview of cases from the MIST-INT condition used in the rest of the administrative data comparisons.

**Table 17 Total Services Provided Through MIST Advocacy & Support Program July 2015 – July 2016 (Parkerville Sample)**

Total Unique Case Records:	289
Number of Individuals Provided with a Response <sup>1</sup> :	415
Relation to Offence <sup>2</sup> :	
Victim	320
<b>Witness</b>	<b>58</b>
Sibling	6
<b>Parent/Carer</b>	<b>24</b>
Offender	4
<b>Unknown</b>	<b>3</b>
Advocate Interview Support in Record:	233 (81%)
Crisis Mental Health Care Provided by Therapist:	21 Individuals (5%) 17 Cases (6%)
Contact with Child & Family Following Interview or Other Initial Contact:	305 Individuals (75%) <sup>3</sup> 214 Cases (75%) <sup>4</sup>
Assessment Interview with Family:	270 Individuals (67%) <sup>5</sup> 186 Cases (66%) <sup>6</sup>

Case Reviewed at MDT:	403 Individuals (99%) <sup>7</sup> 282 Cases (99%) <sup>8</sup>
Case Referred to Parkerville Therapeutic Services:	130 Individuals (32%) <sup>9</sup> 92 Cases (33%) <sup>10</sup>
Intensive Support:	141 Individuals (35%) <sup>11</sup> 90 Cases (32%) <sup>12</sup>
Court Support:	60 Individuals (15%) <sup>13</sup> 38 Cases (13%) <sup>14</sup>
Parkerville Therapeutic Services Commenced:	107 Individuals (37%) <sup>15</sup>

<sup>1</sup> Parkerville records sometimes do not distinguish between the services provided to individual parents, these have been retained as a single record as it was not possible to distinguish between services provided to individual parents unless specified in the record.

<sup>2</sup> Note: Many individuals had more than one relationship to the offence, in this table they have been coded based on the following hierarchy offender-victim-witness-sibling-parent.

<sup>3</sup> Records on whether follow-up contact was made by the advocate was missing for seven individuals.

<sup>4</sup> Records on whether follow up contact was made by the advocate was missing for four cases.

<sup>5</sup> Records on whether an assessment interview occurred was missing for eleven individuals.

<sup>6</sup> Records on whether an assessment interview occurred was missing for eight cases.

<sup>7</sup> Records on whether a MDT review occurred was missing for seven individuals.

<sup>8</sup> Records on whether a MDT review occurred was missing for four cases.

<sup>9</sup> Records on whether a referral to TFS occurred was missing for fifteen individuals.

<sup>10</sup> Records on whether a referral to TFS occurred was missing for eight cases.

<sup>11</sup> Records on whether intensive support was provided was missing for seven individuals.

<sup>12</sup> Records on whether intensive support was provided was missing for four cases.

<sup>13</sup> Records on whether court support was provided was missing for seven individuals.

<sup>14</sup> Records on whether court support was provided was missing for four cases.

<sup>15</sup> Note: Some individuals were already engaged with Parkerville therapeutic services prior to advocate contact.

The service response from the advocates and therapy team that form part of MIST involve a number of elements; the services delivered have been split into both individual and case level in order to better show the spread of these services. It is routine for services to be provided for at least the victim and caregiver of the victim, with often services also sought for witnesses, or siblings that are affected by the offence.

Most of the cases involve the provision of interview support, although we note that many cases involved advocates providing support following an interview. This primarily involves the advocate providing support to the caregivers of the child interviewed during the interview, building rapport with the family to engage them with needed services. In some situations, this will also involve providing support to children following the interview. In some situations, the MIST team may request one of the therapeutic services team to provide crisis mental health support to a child or a member of their family.

Typically, the advocates would seek to make contact with a family around a week after the interview, or after the other initial contact with the advocate in order to arrange a time to undertake an assessment interview. For many cases, the advocates did not make contact either because the family were already engaged with services, or were in CPFS care. The advocate then brings their assessment to the MDT meeting for discussion and referral to particular services. This meeting also serves to plan out any challenges in providing services, such as if an offence has occurred between children from the same family, and both are receiving therapeutic services at the GJCAC.

If the therapeutic service at the GJCAC is identified as being convenient and appropriate for the child and family, they will be referred to the Therapeutic Family Service within Parkerville. Most cases also

include many services provided directly by the advocates determined by the particular needs identified in the assessment (e.g. protective behaviours, psychoeducation to parents, transport), and referrals to external services including external trauma therapy, and other types of family support. The main type of external referral is to therapeutic services, primarily their local Child Sexual Abuse Therapy Service. Many families were referred to the Armadale Family Service Network, a service within the GJCAC that coordinates local services across agencies.

Some cases with complex psychosocial needs were identified as requiring intensive services, a response that involves considerable contact from the advocates to put services in place to help the family provide a stable environment for children. Some cases also received court support, which often included transport to court, and support to the family on the day.

**Table 18 Total Services Provided for MIST-INT Advocacy & Support Program Matched to a CAS 3 Case October 2015 – July 2016**

Total Unique Case Records:	140
Number of Individuals Provided with a Response <sup>1</sup> :	208
Relation to Offence <sup>2</sup> :	
Victim	159
<b>Witness</b>	<b>30</b>
Sibling	1
<b>Parent/Carer</b>	<b>11</b>
Offender	4
<b>Unknown</b>	<b>3</b>
Advocate Interview Support in Record:	124 (89%)
Crisis Mental Health Care Provided by Therapist:	16 Individuals (12%) 12 Cases (9%)
Contact with Child & Family Following Interview or Other Initial Contact:	154 Individuals (76%) <sup>3</sup> 103 Cases (75%) <sup>4</sup>
Assessment Interview with Family:	143 Individuals (72%) <sup>5</sup> 95 Cases (70%) <sup>6</sup>
Case Reviewed at MDT:	203 Individuals (100%) <sup>7</sup> 137 Cases (100%) <sup>8</sup>
Case Referred to Parkerville Therapeutic Services:	70 Individuals (35%) <sup>9</sup> 49 Cases (36%) <sup>10</sup>
Intensive Support:	78 Individuals (38%) <sup>11</sup> 50 Cases (36%) <sup>12</sup>
Court Support:	31 Individuals (15%) <sup>13</sup> 19 Cases (14%) <sup>14</sup>
Parkerville Therapeutic Services Commenced:	58 Individuals (28%) <sup>15</sup>

<sup>1</sup> Parkerville records sometimes do not distinguish between the services provided to individual parents, these have been retained as a single record as it was not possible to distinguish between services provided to individual parents unless specified in the record.

<sup>2</sup> Note: Many individuals had more than one relationship to the offence, in this table they have been coded based on the following hierarchy offender-victim-witness-sibling-parent.

<sup>3</sup> Records on whether follow-up contact was made by the advocate was missing for five individuals.

<sup>4</sup> Records on whether follow up contact was made by the advocate was missing for three cases.

<sup>5</sup> Records on whether an assessment interview occurred was missing for eight individuals.

<sup>6</sup> Records on whether an assessment interview occurred was missing for five cases.

<sup>7</sup> Records on whether a MDT review occurred was missing for five individuals.

<sup>8</sup> Records on whether a MDT review occurred was missing for four cases.

<sup>9</sup> Records on whether a referral to TFS occurred was missing for ten individuals.

<sup>10</sup> Records on whether a referral to TFS occurred was missing for four cases.

<sup>11</sup> Records on whether intensive support was provided was missing for five individuals.

<sup>12</sup> Records on whether intensive support was provided was missing for three cases.

<sup>13</sup> Records on whether court support was provided was missing for five individuals.

<sup>14</sup> Records on whether court support was provided was missing for three cases.

<sup>15</sup> Note: Some individuals were already engaged with Parkerville therapeutic services prior to advocate contact.

Managing the active caseload involved a variety of actions including making referrals for therapeutic services, family support services, financial counselling, housing support, health services, legal aid, and school based support from a wide variety of providers. The services vary based on what the family request, the assessment of the advocate and the MDT review; the full range of services are briefly outlined in Table 19.

**Table 19 Descriptions of Advocate Services**

<b>Advocate Service</b>	<b>Description</b>
Family Meeting Support	Child and Family Advocate facilitate family meetings in the home or at the GJCAC
General Support	Support on day of interview, follow up phone call, give brochures, parents handbooks etc.
Home Visits	Child and Family Advocate provides support in the home, especially where families have no transport or if there is a lot of small children
Individual Supportive Counselling	Provision of individual support, rapport building sessions, providing supportive counselling to the client or individual family member until others supports are available.
Liaison	Involves liaising with outside agencies e.g. Department of Housing, Child Witness Service, Centrelink etc.
Mediation	Provide mediation between and with family members/schools outside agencies
Practical Support	Provide families with food or supplies especially in P1 cases. Family members given clothing, toiletries etc. if child not going home after interview.
Protective Behaviours	Advocate delivers protective behaviours training to either children or family
Phone Calls	Regular phone contact to follow-up on how the family is coping
Psycho-Education	Provide client/families with written or oral information regarding certain topics, e.g., trauma, behaviour management techniques etc.
Referrals	Referral either to internal (Parkerville) or external services
Signs of Safety Meeting	Child and Family Advocate would attend and participate in CPFS's Signs of Safety Meetings
School Support	Attend school meetings, bring child/young person to school, etc.
Transport	Bring child/families to appointments, bring them to or back from GJCAC. Collect and bring children to other services and support them to engage.

Table 20 provides an overall summary of the advocacy service across all cases identified in the Parkerville sample. This is indicative of the types of services the advocates most commonly provided, primarily liaison, psycho-education, general support, referrals, and phone calls.

**Table 20 All Advocate Services Provided**

<b>Advocate Service</b>	<b>Service Provided</b>
Family Meeting Support	7 Individuals (2%) 4 Cases (<1%)
General Support	235 Individuals (57%) 153 Cases (39%)
Home Visits	2 Individuals (<1%) 2 Cases (<1%)
Individual Supportive Counselling	62 Individual (15%) 49 Cases (17%)
Interview Support	312 Individuals (75%) 228 Cases (79%)
Liaison	256 Individuals (62%) 186 Cases (64%)
Mediation	27 Individuals (7%) 25 Cases (6%)
Practical Support	60 Individuals (14%) 40 Cases (9%)
Protective Behaviours	92 Individuals (22%) 62 Cases (15%)
Phone Calls	206 Individuals (50%) 145 Cases (35%)
Psycho-Education	247 Individuals (60%) 176 Cases (42%)
Referrals	219 Individuals (53%) 158 Cases (55%)
Signs of Safety Meeting	4 Individuals (<1%) 3 Cases (<1%)
School Support	71 Individuals (17%) 50 Cases (12%)
Transport	55 Individuals (13%) 38 Cases (13%)

### **Quasi-Experimental Sample Eligibility**

Due to the different allocation processes between MIST and Practice as Usual, a straight comparison between samples requires some screening of cases. Several additional processes occur before the allocation of a detective in Practice as Usual, meaning that sampling at the point of allocation would not provide an equivalent sample. Primarily what this means is that the MIST squad received cases once they had gone through the initial intake process and the allegation was identified as fitting the CAS charter, and the child was living within the catchment area of the pilot (although in many situations the MIST CAS team were allocated cases out of area). As discussed previously, many additional processes (including the child interview) typically occur prior to the allocation of a detective.

In order to identify a point of equivalency for a comparison between samples, all cases that went through the CAS intake desk during the sample period (October 2015 – July 2016) were obtained, with an aim to compare cases at the point at which a visually recorded interview occurs.

In order to get equivalent samples an additional search was completed in the police database for

cases that received a visually recorded interview, with allegations that fit the CAS charter, but did not go on to be allocated through the CAS intake desk. An additional 36 cases were identified, extracted and added to the sample from 1343 records in the IMS database with a child interview, that met the following criteria:

- Date range of 01/10/2015 - 31/07/2016 (Reported date range).
- A child interview was conducted and attached to the case record.
- The incident involved a child abuse allegation.
- The matter was assigned to the Child Assessment and Interview Team (CAIT).
- The incident would have been investigated by the Child Abuse Squad if it progressed past CAIT.

From the full sample, cases were screened to identify equivalent cases for the quasi-experimental comparison. A MIST case for the purposes of the quasi-experimental comparison is one that:

- **Has been allocated during the evaluation period (October 2015 – July 2016);**
- **The report was received during the pilot period (July 2015 – July 2016);**
- **Has received a child forensic interview (referred to as Visually Recorded Interviews);**
- **The case was allocated to CAS Team 3 (MIST);**

This criterion captures cases allocated to the MIST CAS, that received the intended MIST response.

A Practice as Usual-INT case for the purposes of the quasi-experimental comparison is one that:

- **Has been allocated during the evaluation period (October 2015 – July 2016);**
- **The report was received during the pilot period (July 2015 – July 2016);**
- **Has received a child forensic interview (referred to as Visually Recorded Interviews);**
- **The case was allocated to either CAS Team 1, 2, or 4, or would have been if there was enough evidence (i.e. a disclosure in a forensic interview) to proceed;**

These criteria reflect that cases are processed as usual, responded to by a case team, and received a response during a time period where practices in this condition were known.

Cases for both conditions were routinely interviewed at different sites, and both conditions responded to cases outside their defined catchment area; these cases have been retained as they reflect part of the ongoing response for both conditions. Requiring that cases be interviewed in order to be eligible reflects the point at which it is possible to screen cases from both conditions to make them as comparable as possible, given the different allocation processes.

From all the records provided by CAS, 509 unique cases were identified (see technical appendix for explanation of how duplicate records were merged), however only 403 cases met the above criteria for the quasi-experimental study. The samples used for the quasi-experimental comparison have been called Practice as Usual-INT and MIST-INT.

## Cases Allocated

**Table 21 Total Volume of Unique Cases Allocated to the MIST & Practice as Usual Teams (October 2015 – July 2016)**

<i>Squad</i>	<i>Case Type</i>	<i>Unique Cases</i>
<b>Practice as Usual Squad</b>		<b>329</b>
	Practice as Usual-INT (Victim interview, Reported in Pilot period, Responded to by CAS)	276
	Excluded Cases	52
<b>MIST Squad</b>		<b>180</b>
	MIST-INT (Victim Interview, Reported in Pilot Period, Responded to by CAS)	126
	Excluded Cases	54

Based on the criteria above (See Table 21), 276 Practice as Usual-INT cases were identified in the data, and 126 MIST-INT cases were identified. The matters that were allocated to the MIST CAS Team that did not meet the criteria to be MIST-INT cases primarily as they did not receive an interview. Similarly, a number of cases were screened out of the Practice as Usual condition due to not having a child interview, but some also as the matter was ultimately investigated by a non-CAS police unit, or the matter was reported prior to the pilot period (July 2015).

### **Eligibility by Interview**

As discussed above, for inclusion in the quasi-experimental comparison for both MIST and Practice as Usual, cases required an interview to occur. 27% of all cases referred to the MIST squad did not result in a child forensic interview, and 19% occurred away from the GJCAC. Reflecting the difference in the samples, with cases without a child interview and no further investigation not included, only 12% of the full Practice as Usual cases did not have a child interview.

**Table 22 Interview Site for MIST and Practice as Usual Cases**

	No Interview	CAS/Child First	GJCAC	Other	Total
Practice as Usual Squad Cases	38 (12%)	287 (87%)	3 (<1%)	1 (<1%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>0 (0%)</b>	<b>273 (99%)</b>	<b>2 (&lt;1%)</b>	<b>1 (&lt;1%)</b>	<b>276 (100%)</b>
MIST Squad Cases	48 (27%)	28 (16%)	97 (54%)	7 (4%)	180 (100%)
<b>MIST-INT</b>	<b>0 (0%)</b>	<b>24 (19%)</b>	<b>95 (75%)</b>	<b>7 (6%)</b>	<b>126 (100%)</b>

**Eligibility by CPFS District**

The highest volume area by far was Armadale, with near double the cases of the nearest district (See Table 23). Most of the other metropolitan districts had a similar volume of cases, although quite low numbers in Fremantle and Mirrabooka. As the Peel region (i.e. Mandurah and surrounds) is still technically a regional area, a large number of cases were classified as 'other'. This category also included cases where the child lived interstate but the offence occurred within Western Australia.

**Table 23 Total Volume of Cases by CPFS District (Based on Suburb of Residence for Child)**

	Cases
Armadale	110 (21.6%)
Midland	65 (12.8%)
Cannington	64 (12.6%)
Joondalup	58 (11.4%)
Rockingham	54 (10.6%)
Other (Regional, Interstate, International)	56 (11%)
Perth	49 (9.6%)
Fremantle	27 (5.3%)
Mirrabooka	26 (5.1%)
<b>Total</b>	<b>509 (100%)</b>

As discussed above, while the MIST process aimed to send cases from Cannington/Armadale districts to the GJCAC, some cases from outside the catchment have been responded to by the MIST CAS team; around 16% of the total volume of MIST cases were from out of area. This was primarily from the Rockingham and Peel regions where the GJCAC is significantly closer than the CAS interview suites in Perth City. Similarly, around 7% of Practice as Usual Cases involved children from the MIST catchment area. In some cases the primary residence of the child may not become clear until later in

the process.

**Table 24 Volume of Cases by CPFS District (Based on Suburb of Residence for Child)**

Group	Armadale	Cannington	Other Metro	Total
Practice as Usual Squad Cases	13 (4%)	10 (3%)	306 (93%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>11 (4%)</b>	<b>9 (3%)</b>	<b>256 (93%)</b>	<b>276 (100%)</b>
MIST Squad Cases	97 (54%)	54 (30%)	29 (16%)	180 (100%)
<b>MIST-INT</b>	<b>72 (57%)</b>	<b>36 (29%)</b>	<b>18 (14%)</b>	<b>126 (100%)</b>

### Report Dates

Some matters were already open to both conditions at the time of the evaluation, including both victim and perpetrator interviews that occurred under the previous response. To capture cases that received the MIST and Practice as Usual responses as described, older cases that were re-opened were screened out if the report was initiated prior to the beginning of the trial (July 2015). Cases were only eligible for the sample if they were responded to (i.e. allocated to a CAS team, strategy meeting, victim or perpetrator interview) during the sample period (October 2015 – July 2016). This report does not include cases received between July and September 2015 (which were covered in the interim report), allowing for a ‘settling-in’ period for the new MIST process and recognising that the in-house CPFS worker was only brought on site in October 2015.

**Table 25 Incident Report Dates in Relation to the Pilot Period**

Group	Reported Oct 2015 – July 2016	Reported July – Sept 2015	Reported Prior to July 2015	Total
Practice as Usual Squad Cases	298 (91%)	25 (8%)	6 (2%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>263 (95%)</b>	<b>13 (5%)</b>	<b>0 (0%)</b>	<b>276 (100%)</b>
MIST Squad Cases	173 (96%)	1 (<1%)	6 (3%)	180 (100%)
<b>MIST-INT</b>	<b>126 (100%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>126 (100%)</b>

### Investigation by Other Detectives

Some matters ended up being referred to other WAPOL detectives, primarily Sex Assault Squad, district and regional detectives. These cases were screened out of the comparison samples to ensure the Practice as usual sample was equivalent to the MIST sample. Two Practice as Usual cases were marked as assigned to CAS 3, reflecting that these were cases that were assigned by the CAS intake desk due to capacity limitations; these cases were also screened out for the comparison sample as it was not clear whether this involved a MIST or Practice as Usual response in terms of the processing and referral of the case.

**Table 26 Allocation to Detectives for Investigation**

	Not Allocated	CAS 1	CAS 2	CAS 3	CAS 4	SAS	Other	Unknown	Total
Practice as Usual Squad Cases	41 (12%)	113 (34%)	117 (36%)	2 (<1%)	46 (14%)	6 (2%)	1 (<1%)	3 (<1%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>40 (14%)</b>	<b>97 (35%)</b>	<b>102 (37%)</b>	<b>0 (0%)</b>	<b>35 (13%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>2 (&lt;1%)</b>	<b>276 (100%)</b>
MIST Squad Cases	0 (0%)	0 (0%)	0 (0%)	180 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	180 (100%)
<b>MIST-INT</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>126 (100%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>0 (0%)</b>	<b>126 (100%)</b>

### Advocacy

A key fidelity measure for the MIST Pilot is the delivery of advocacy support. Around 69% of all cases that the MIST Squad responded to received advocacy support. Cases that did not receive the advocacy support were primarily cases that did not receive an interview (18%), and some cases where interviews occurred off-site (11%), although many off-site cases did include an advocate. 15 cases in the sample involved advocacy being provided without a visually recorded interview occurring; in some cases families and children were referred for advocacy support without a disclosure of abuse. Only two cases interviewed at GJCAC did not have a record of advocacy being provided.

Amongst MIST-INT 83% of cases ( $n = 105$ ) received the advocacy service. In most of the cases where advocacy was not provided, interviews occurred off-site (15%), and the advocates were unable to subsequently make contact with the family following to offer support.

**Table 27 Receipt of Advocacy**

	No Advocacy Record	Advocacy Record	Total
Practice as Usual Squad Cases	329 (100%)	0 (0%)	329 (100%)
<b>Practice as Usual-INT</b>	<b>276 (100%)</b>	<b>0 (0%)</b>	<b>276 (100%)</b>
MIST Squad Cases	55 (41%)	125 (69%)	180 (100%)
<b>MIST-INT</b>	<b>21 (17%)</b>	<b>105 (83%)</b>	<b>126 (100%)</b>

### Assessment by In-House CPFS Worker

Part of the point of difference for the MIST response was the use of an in-house CPFS worker, covering both of the districts included under the pilot (Armada & Cannington). Distinct from Practice as Usual, this worker was involved in the early discussion of the case, and was onsite during interview planning, and typically observed the child interview. This worker was also able to make contact with the child and family directly after the interview, as opposed to this work being done by the CPFS interviewers.

In terms of the rate at which the in-house worker undertook assessments, only 22% of all Safety and Wellbeing Assessments associated with MIST were completed by this worker. The figure was similar for MIST-INT cases (27%). In part, the proportion of cases assessed by the in-house worker reflect that many cases outside the Armada/Cannington catchment were referred to the MIST team; this worker was not able to undertake these assessments.

**Table 28 Safety & Wellbeing Assessment by In-house CPFS Worker**

	District Assessment	In-House Assessment	No SWA or No CPFS Record	Total
<b>MIST Squad Cases</b>	112 (62%)	31 (17%)	37 (21%)	<b>180 (100%)</b>
<b>MIST-INT</b>	73 (58%)	27 (21%)	26 (21%)	<b>126 (100%)</b>

The interviews with workers at MIST identified that they thought the in-house CPFS worker role was invaluable, it was also pointed out that within a month of commencing, this worker was often well above their case load capacity, meaning that many Armada/Cannington cases had to be referred to the districts for an assessment. Also, sometimes in cases that had come through the CPFS reporting line before being referred to police, the assessment process will have begun before the case was identified as being a MIST case. Where possible the CPFS team leaders would transfer these cases to the in-house worker, although often it was too far into the assessment process or the in-house worker was above capacity.

## A QUASI-EXPERIMENTAL FOLLOW FORWARD COMPARISON STUDY OF MIST

This section provides a comparison of two equivalent samples to address whether the implementation of MIST has resulted in changes to attrition from the investigation of severe child abuse, the responsiveness of interviews and investigations, and the referral to support services.

This evaluation focuses on the effect of the MIST pilot on the early outcomes associated with the cross-agency investigation of abuse. As discussed in the theory of change chapter it is outside the scope of this evaluation to examine the longer term intended outcomes of this intervention, in part due to the relatively short follow up period and also as many of these longer-term factors are extremely complex and subject to many different confounding variables.

As discussed above, these samples are different to those in the descriptive study, as they have been screened in a way to make the two conditions equivalent. This involved restricting the sample to just cases that received a visually recorded interview, fit the Child Abuse Squad charter, and were reported during the pilot period.

### **Comparison of Case Characteristics**

This study design compares the intervention (MIST) against an assumed counterfactual; the response that the cases referred to MIST would have received if the intervention did not exist. This counterfactual is the Practice as Usual condition. The use of this type of comparison group depends on an assumption that there is equivalence between the conditions, that the cases referred to MIST do not differ from Practice as Usual in a way that might influence the likelihood of outcomes external to the response. As the study is quasi-experimental the results will need to be interpreted with more caution than a Randomised Control Trial (RCT), where participants are randomly assigned to the experimental and comparison condition as there is greater potential for undetected systematic differences between the samples to exist.

The study followed CAS cases until they closed. For the few ( $n = 5$ ) that remained open on the 17<sup>th</sup> February 2017, this allowed for a follow-up period of between 7-16 months across both conditions depending on the report date of the case.

This section compares the characteristics of the two samples (Practice as Usual-INT; MIST-INT) on several case, victim and perpetrator characteristics. For a meaningful comparison of variables that are assumed to be affected by the MIST pilot, the MIST-INT and Practice as Usual cases should not substantially differ in terms of characteristics that may affect the likelihood of obtaining particular outcomes. The key characteristics included here are: case priority ratings, the number of victims and offenders in a case, age of the child interviewed, the gender of the child interviewed, how recently the alleged offence occurred, the relationship between the offender and victim, age of the offender, and the type of abuse experienced.

Across all of the characteristics compared, no significant differences between groups were found. While not significant, the type of abuse ( $p = .057$ ), and the rates of penetrative sexual abuse in the case approached significance ( $\chi^2 (2, n = 401) = 3.38, p .066$ ).

Any differences found between the MIST-INT and Practice as Usual-INT groups need to be interpreted with these differences in mind.

### Case Priority at Intake

As the data involved comparisons with less than 5 expected cases per square, a Fisher's Exact Test was used instead of a Chi Square. A Fisher's Exact Test was used to compare MIST-INT and Practice as Usual-INT on case priority at the point of intake; no significant difference was found between the two samples ( $p = .155$ ).

**Table 29 Priority Rating at Intake**

	Priority One	Priority Two	Priority Three	Priority Four	Total
<b>Practice as Usual-INT</b>	41 (15%)	101 (37%)	126 (46%)	9 (3%)	276 (100%)
<b>MIST-INT</b>	18 (14%)	33 (26%)	72 (57%)	3 (2%)	126 (100%)

### Number of Victims & Offenders

A Chi-square test of independence was conducted comparing MIST-INT and Practice as Usual-INT cases in terms of the number of victims and offenders associated with a case. It found no significant differences in the proportion of cases across categories of number of victims ( $\chi^2 (2, n = 399) = 1.19, p = .551$ ) or alleged perpetrators ( $p = .391$ ).

**Table 30 Number of Child Victims per Case**

	One	Two	Three or More	Total
<b>Practice as Usual-INT</b>	221 (80%)	39 (14%)	16 (6%)	276 (100%)
<b>MIST-INT<sup>1</sup></b>	102 (79%)	17 (13%)	4 (3%)	123 (100%)

<sup>1</sup> In three cases the number of children in the case was missing/unknown.

**Table 31 Number of Perpetrators per Case**

	One	Two	Three	Total
<b>Practice as Usual-INT<sup>1</sup></b>	259 (96%)	8 (3%)	3 (1%)	270 (100%)
<b>MIST-INT<sup>1</sup></b>	113 (93%)	7 (6%)	1 (<1%)	121 (100%)

<sup>1</sup> In six Practice as Usual and five MIST cases the number of perpetrators associated with the case was missing/unknown.

### Gender of All Child Victims

A Chi-square test of independence was conducted comparing MIST-INT and Practice as Usual-INT cases in terms of gender. It found no significant differences in the proportion of males and female child victims between these groups ( $\chi^2 (1, n = 536) = .010, p = .920$ ). This comparison included the gender of all children identified as victims in the CAS records, so the totals add to more than 276 for Practice as Usual-INT and 180 for MIST-INT.

**Table 32 Gender of Child Victims**

	Female	Male	Total
Practice as Usual-INT	272 (71%)	112 (29%)	384 (100%)
MIST-INT	107 (70%)	45 (30%)	152 (100%)

**Type of Abuse Experienced by Case**

As the data involved comparisons with less than 5 cases per square, a Fisher's Exact Test was used to compare MIST-INT and Practice as Usual-INT on types of abuse reported at a case level. No significant difference between the two samples ( $p = .057$ ) was found, although the result approached significance. Practice as Usual had a higher proportion of cases with both sexual and physical abuse, and no cases involving neglect only. These were examined at the case level as there was not enough detail in the records in order to attribute abuse to particular children in the record.

**Table 33 Type of Abuse Alleged**

	Physical Only	Sexual Only	Sexual & Physical	Total
Practice as Usual-INT	23 (8%)	238 (86%)	15 (5%)	276 (100%)
MIST-INT	8 (6%)	116 (93%)	1 (>1%) <sup>1</sup>	125 (100%) <sup>1</sup>

<sup>1</sup> One neglect only case was excluded from this analysis.

The rates of penetrative abuse were also compared in terms of whether the case included an allegation of penetrative sexual abuse. No significant difference was found between MIST-INT and Practice as Usual-INT cases ( $\chi^2 (1, n = 401) = 3.38, p = .066$ ), although the result approached significance.

**Table 34 Rates of Penetrative Child Sexual Abuse**

	Penetrative Sexual Abuse	No Penetrative Sexual Abuse	Total
Practice as Usual-INT	108 (39%)	168 (61%)	276 (100%)
MIST-INT <sup>1</sup>	37 (30%)	88 (70%)	125 (100%)

<sup>1</sup> In one MIST case it was not known or the record was missing as to if penetrative sexual abuse occurred.

**Relationship between Offender and Victim**

Most records only contained details about the relationship between the offender and the first victim. A separate category between intra-familial and extrafamilial was included as abuse by an appointed carer did not cleanly fit into either category. A Chi-square test found no significant differences between samples on the relationship between the offender and victim ( $\chi^2 (2, n = 386) = .751, p = .687$ ).

**Table 35 Relationship between Offender and Victim**

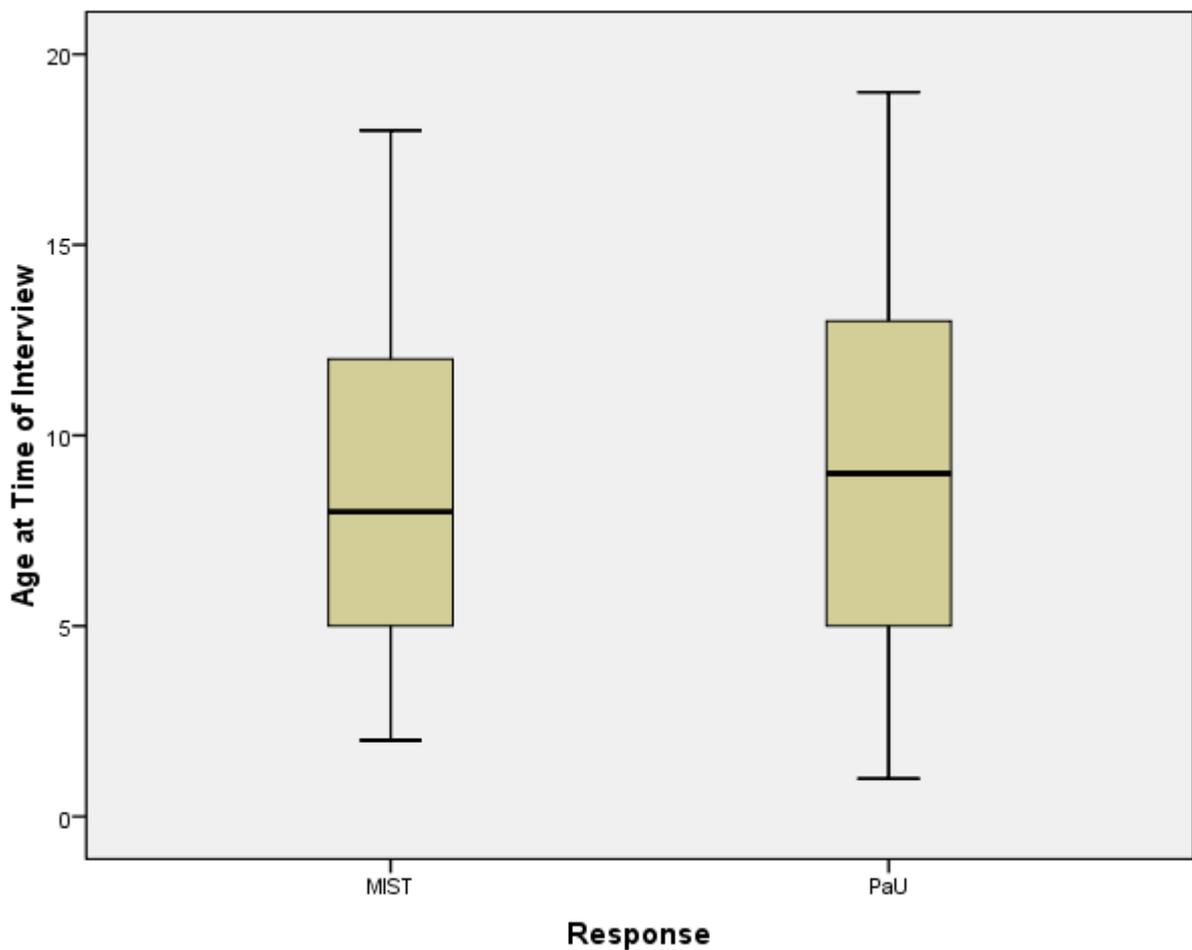
	Extra-Familial	Intra-Familial	Carer	Total
Practice as Usual-INT <sup>1</sup>	70 (27%)	181 (69%)	12 (5%)	263 (100%)
MIST-INT <sup>1</sup>	34 (28%)	81 (66%)	8 (6%)	123 (100%)

<sup>1</sup> In three MIST cases and 13 Practice as Usual cases the relationship between the alleged offender and victim was unknown.

**Age of Child at Interview and at Onset of Abuse**

As the samples of child age at interview were not normally distributed on a Shapiro-Wilk test of normality (<.05), a Mann-Whitney U test was used. No significant difference ( $U = 26523.500, p = .154$ ) was found in the age of child victims at interview in the MIST-INT condition (Median = 8; Range = 2-18) compared to the Practice as Usual-INT condition (Median = 9; Range = 1-19).

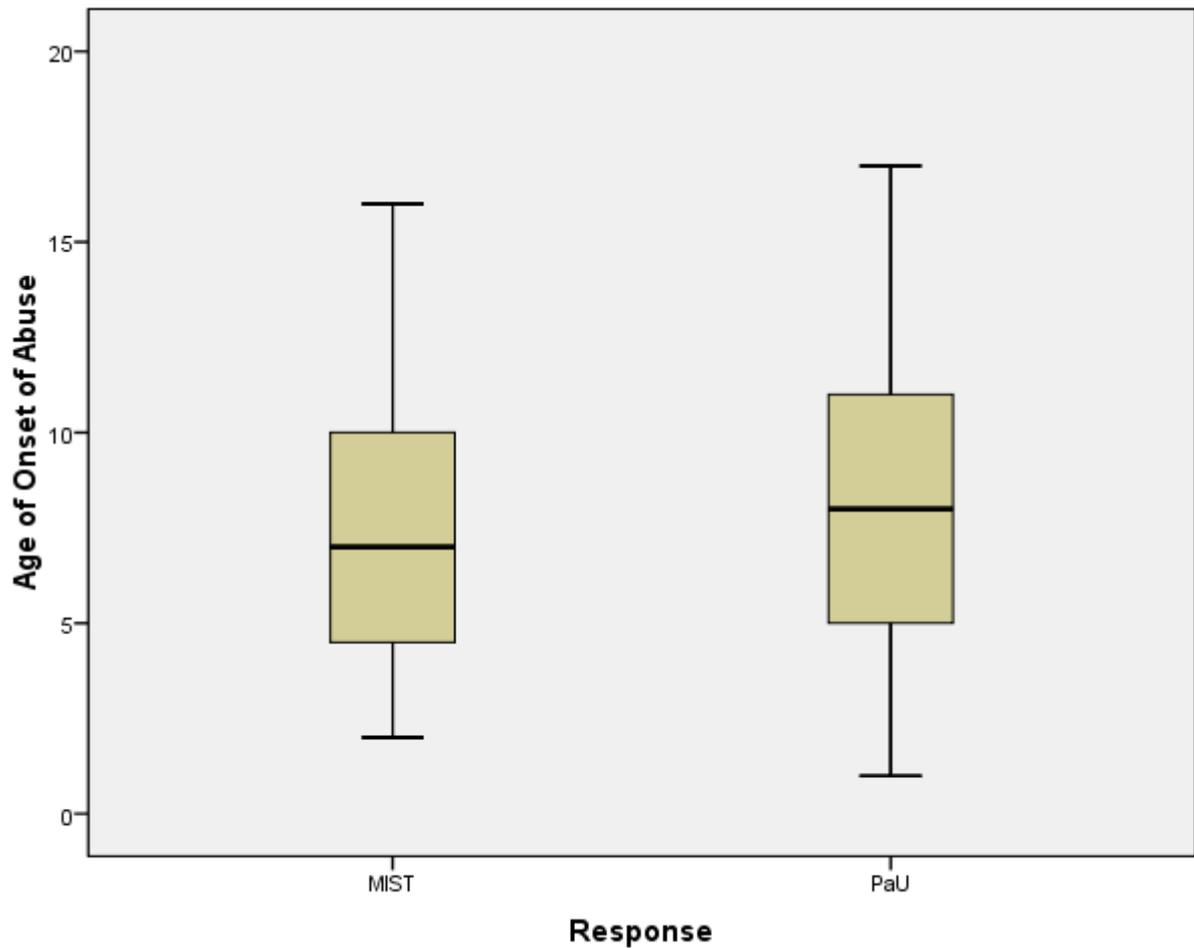
**Figure 8 Boxplot of Age at Time of Interview by Sample**



As the samples of child age at onset of abuse were not normally distributed, a Mann-Whitney U test was used. No significant difference ( $U = 18839.00, p = .188$ ) was found in the age of children at the onset of abuse between the MIST-INT (Median = 7; Range = 2-16), compared to the Practice as Usual-INT (Median = 8; Range = 1-17) sample. Age of the child at the onset of abuse was missing for

45 cases, all from the MIST-INT condition, which appears to be related to an issue with the recording of data for the MIST condition.

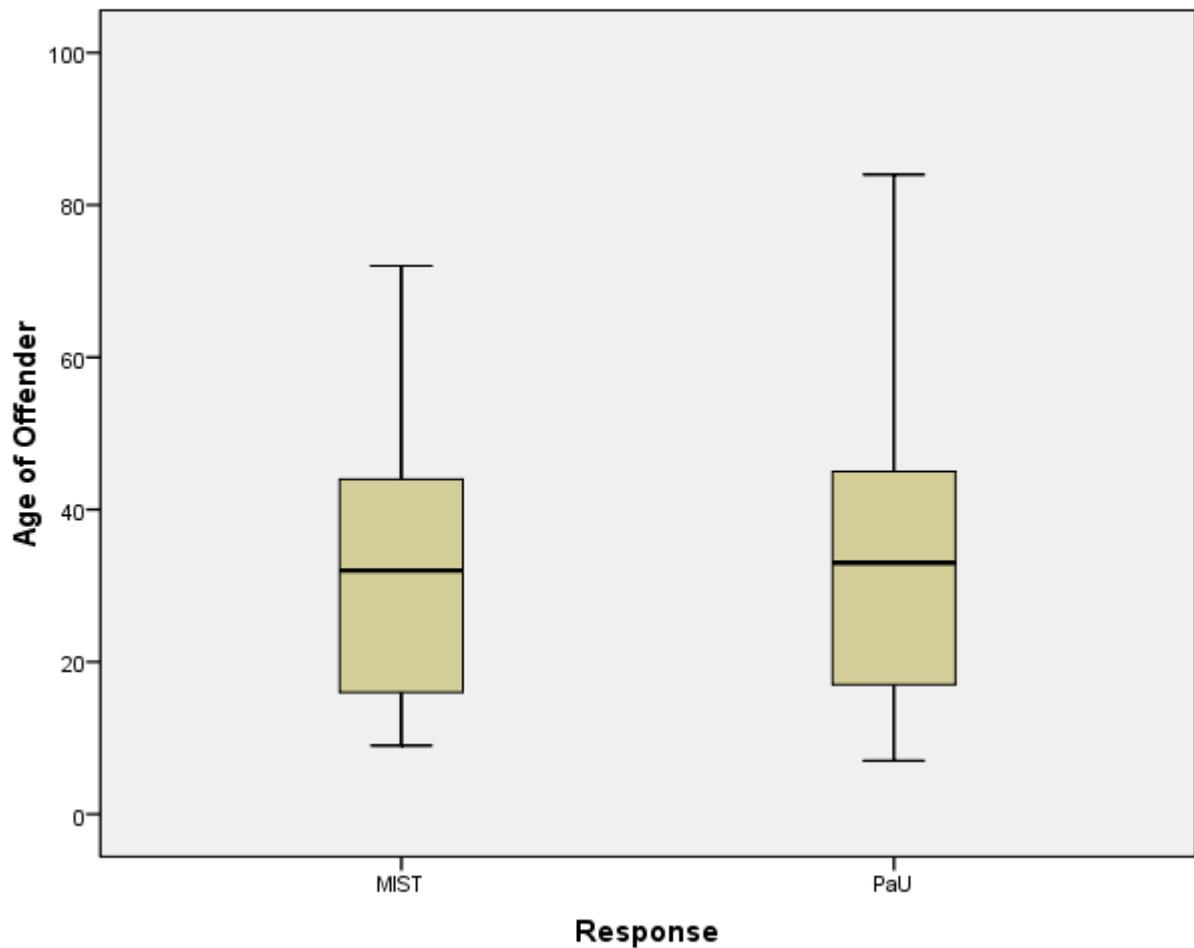
**Figure 9 Boxplot of Age at Onset of Abuse by Sample**



### **Age of the Alleged Offender**

As the ages of the alleged offender were not normally distributed, a Mann-Whitney U test was used. No significant difference ( $U = 19227.50$ ,  $p = .784$ ) was found in the age of the alleged offender at the onset of abuse between the MIST-INT (Median = 32; Range = 9-72), compared to the Practice as Usual-INT (Median = 33; Range = 7-84) sample. The age of the alleged offender was missing from four MIST cases, and 16 Practice as Usual cases.

Figure 10 Boxplot of Age of Offender by Sample



As both samples were bimodally skewed, the age of offender was coded categorically to present the proportions of the ages of offenders. A Fisher’s Exact Test found no difference between the two samples on age of offender by category ( $p = .628$ ). Table 36 illustrates the rate of offences committed by young people, nearly 30% in both conditions, with a similar proportion of persons alleged to be responsible were in the 40 and older category.

Table 36 Age of Person Responsible

	Under 10	11-20	21-30	31-40	40 and older	Total
Practice as Usual-INT <sup>1</sup>	4 (1%)	84 (29%)	48 (16%)	57 (19%)	101 (34%)	294 (100%)
MIST-INT <sup>1</sup>	3 (2%)	38 (29%)	19 (14%)	33 (25%)	40 (30%)	122 (100%)

<sup>1</sup> In four MIST and sixteen Practice as Usual cases the age of the alleged perpetrator was not known.

### Do the MIST and Practice as Usual Conditions Differ in Terms of the Police Investigation Process?

As discussed previously, the quasi-experimental analysis has been restricted to cases that received a victim interview and fit the offence conditions to be assigned to a Child Abuse Squad team (Practice

as Usual-INT; MIST-INT). As such the key points in the police investigation following this are obtaining a disclosure in a victim interview, the interview with a person of interest, and the charging of an offender.

Figures 11 and 12 presents the MIST-INT and Practice as Usual-INT police pathways side by side. While Practice as Usual-INT cases were significantly more likely to result in a disclosure ( $\chi^2 (1, n = 402) = 6.38, p < .05$ ) and a POI interview ( $\chi^2 (1, n = 402) = 5.21, p < .05$ ), this did not translate to an increased number of cases with charges; there was no significant difference between the two conditions on the rate of substantiation of offences ( $\chi^2 (1, n = 402) = .223, p = .625$ ), meaning offences that resulted in either a charge or a juvenile caution. Analysis of differences in substantiation across priority ratings identified that MIST had a slightly higher rate of substantiations on Priority 1 and Priority 2 cases, and slightly lower on Priority 3 cases.

It appears from the data that the MIST CAS are responding to cases that may be screened out of Practice as Usual, in terms of the information available for investigation (i.e. disclosures, witnesses, or other evidence), than Practice as Usual for cases screened in for interview. This is reflected in the proportionally higher volume of interviews, proportionally higher number of Priority 3 cases screened in for interview and the proportionally lower rate of particularised disclosures. Priority 3 cases are primarily those where the child is not in danger of being subjected to abuse in the short or long term, and there are no other circumstances that may cause concern for a child's safety and wellbeing.

It may be that the MIST CAS team are investigating cases that would have been otherwise not pursued by CAS (due to the lack of a particularised disclosure or other evidence to investigate), or dealt with individually by CPFS in the Practice as Usual condition. Operating at a lower screening threshold for interviews is likely to affect charge/caution rates, however there were no significant difference between MIST-INT and Practice as Usual-INT in charges/cautions. Although the lower rate of substantiations for Priority 3 cases may have been influenced by this lower threshold.

An analysis was also conducted on the number of charges between the MIST-INT and Practice as Usual-INT teams (including charges associated with a juvenile caution) and the number of charges associated with contact offences. No significant difference was found for either the number of charges ( $U = 1734.500, p = .665$ ) or the number of charges for contact offences ( $U = 1716.500, p = .601$ ).

A significant difference was found in terms of the rate at which cases received a forensic medical examination ( $\chi^2 (1, n = 402) = 6.40, p < .05$ ), with MIST-INT cases significantly less likely to have a forensic medical examination. A comparison of only penetrative sexual abuse cases found no significant difference between the conditions ( $p = 0.73$ ). Therefore, the most likely explanation for the difference in FME is that MIST responded to a significantly lower number of penetrative sexual abuse cases.

Figure 11 MIST-INT Police Pathway

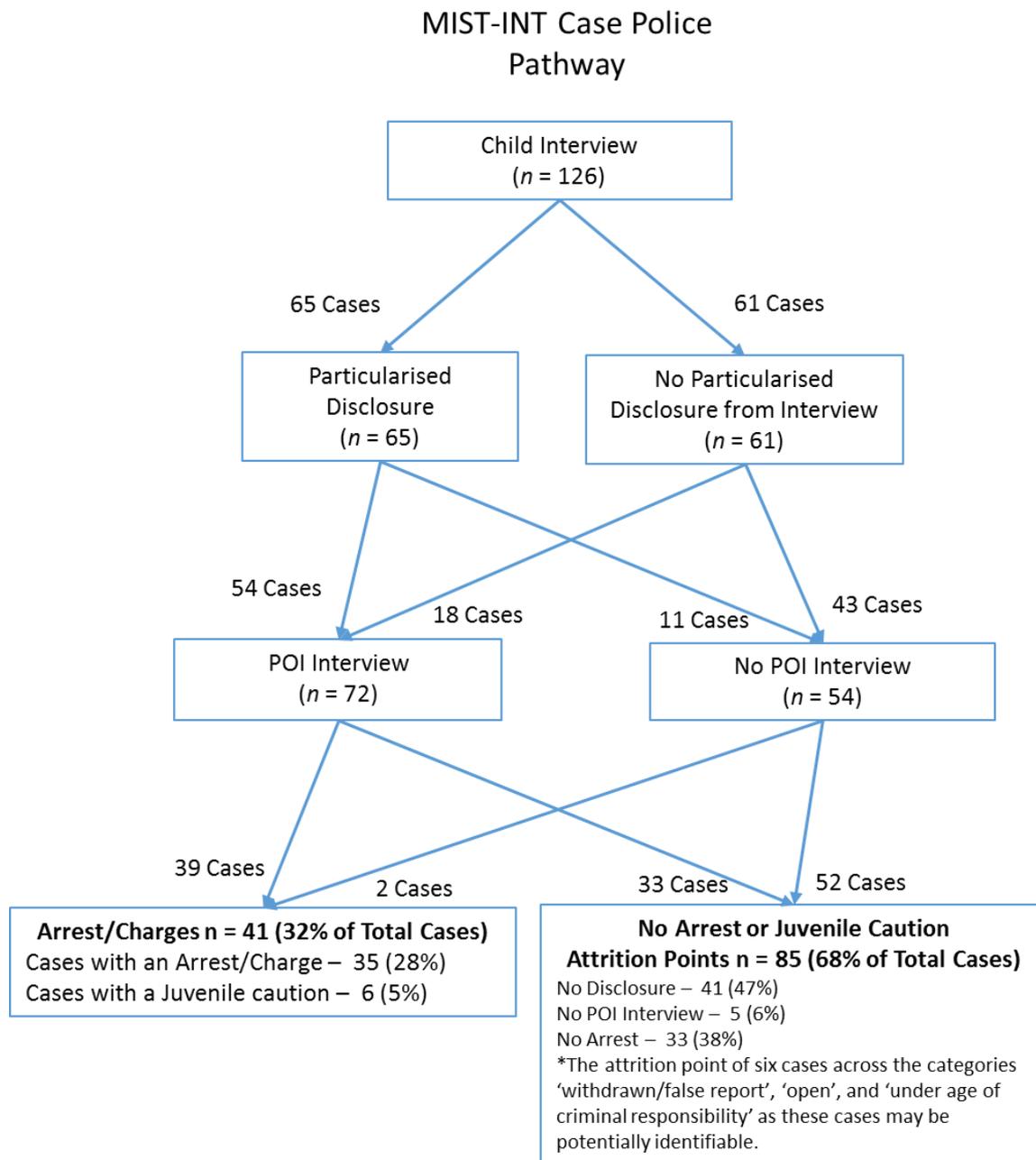
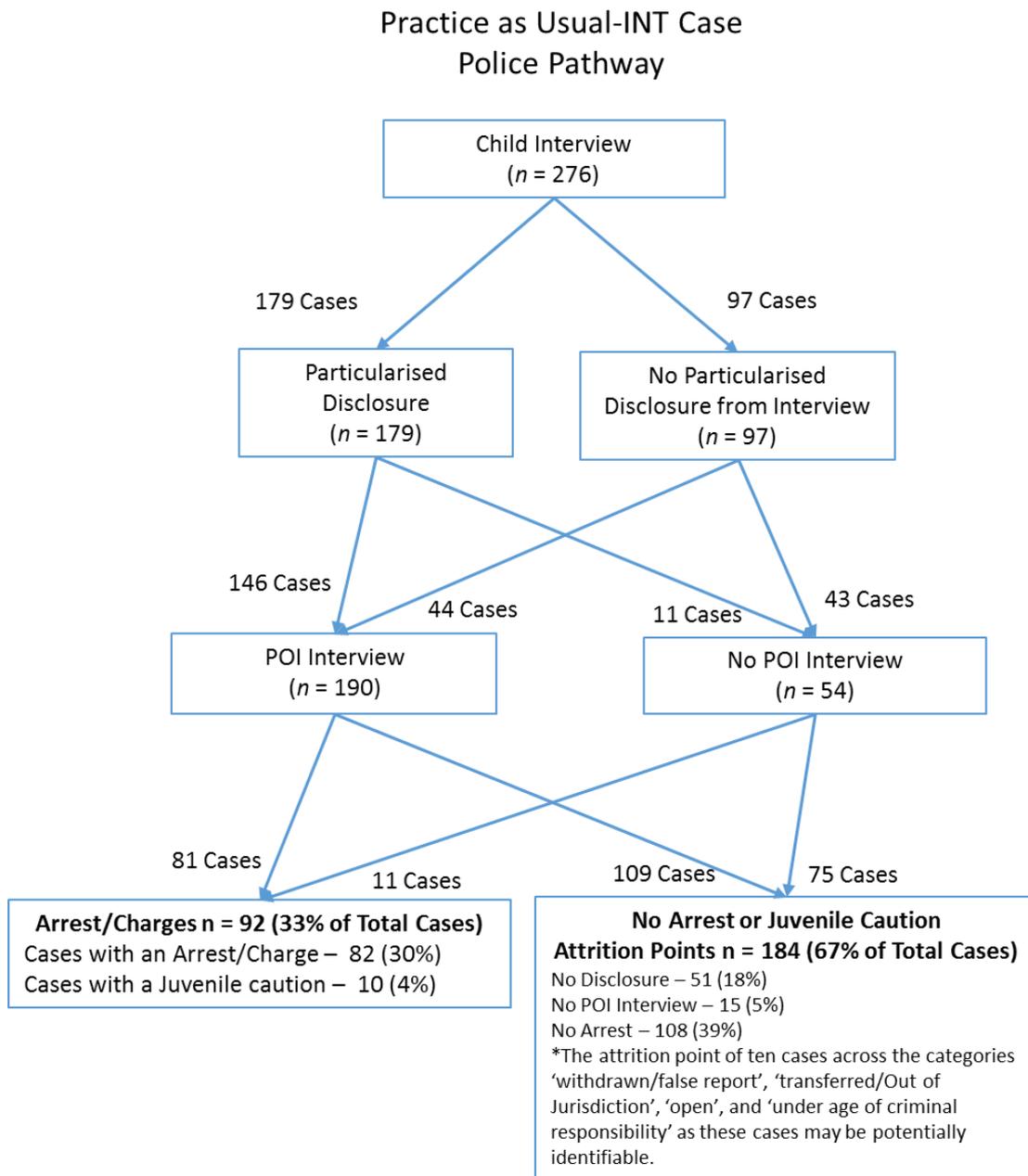


Figure 12 Practice as Usual-INT Police Pathway



### Particularised Disclosure

The Practice as Usual-INT condition was found to have a significantly higher rate of disclosure at forensic interviews ( $\chi^2 (1, n = 402) = 6.38, p < .05$ ).

**Table 37 Rate of Particularised Disclosures at Forensic Interview**

	No	Yes	Total
<b>Practice as Usual-INT</b>	97 (35%)	179 (65%)	276 (100%)
<b>MIST-INT</b>	61 (48%)	65 (52%)	126 (100%)

Despite rate of disclosures at forensic interviews differing overall, the two samples did not differ in the rate of disclosures for Priority 1 ( $\chi^2 (1, n = 59) = 1.09, p .296$ ) and Priority 2 cases ( $\chi^2 (1, n = 134)$

= .177, p .674). A significant difference was found on Priority 3 ( $\chi^2 (1, n = 198) = 8.32, p <.05$ ). The numbers were too small for a comparison on Priority 4 cases.

**Table 38 Rate of Particularised Disclosures at Forensic Interview by Priority Rating**

	Disclosure at Victim Interview				Total
	P1	P2	P3	P4	
Practice as Usual-INT	22 (54% of P1s)	57 (56% of P2s)	92 (73% of P3s)	8 (100% of P4s)	179
MIST – INT	7 (39% of P1s)	20 (61% of P2s)	38 (53% of P3s)	0 (0% of P4s)	65

### POI Interview

The Practice as Usual-INT condition was found to have a significantly higher rate of interviews with a person of interest ( $\chi^2 (1, n = 402) = 5.21, p <.05$ ).

**Table 39 Rate of POI Interviews**

	No	Yes	Total
Practice as Usual-INT	86 (31%)	190 (69%)	276 (100%)
MIST-INT	54 (43%)	72 (57%)	126 (100%)

Despite a significant difference overall in the rate of person of interest interviews occurring, the two conditions did not differ among Priority 1 ( $\chi^2 (1, n = 59) = 1.79, p .181$ ), Priority 2 cases ( $\chi^2 (1, n = 402) = 6.38, p <.05$ ), and Priority 4 cases ( $p = 1.00$ ). A significant difference was found on Priority 3 cases ( $\chi^2 (1, n = 198) = 11.82, p <.05$ ).

**Table 40 Rate of POI Interviews by Priority Rating**

	POI Interviews				Total
	P1	P2	P3	P4	
Practice as Usual-INT	28 (68% of P1s)	57 (56% of P2s)	102 (81% of P3s)	3 (38% of P4s)	190
MIST – INT	9 (50% of P1s)	20 (61% of P2s)	42 (58% of P3s)	1 (33% of P4s)	72

### Offences Substantiated

Despite the increased rate of POI interviews by the Practice as Usual-INT group, the two conditions were found to have no significant difference in terms of the rate of charges/juvenile cautions for offences ( $\chi^2 (1, n = 402) = .025, p = .875$ ).

**Table 41 Rate of Offences Substantiated**

	No	Yes	Total
Practice as Usual-INT	184 (67%)	92 (33%)	276 (100%)
MIST – INT	85 (68%)	41 (32%)	126 (100%)

The rate of arrest was compared between the two conditions across the different priority categories. The conditions did not differ significantly on the rate of arrests/cautions for Priority 1 cases ( $\chi^2 (1, n = 59) = .325, p = .569$ ), Priority 2 cases ( $\chi^2 (1, n = 134) = .513, p = .474$ ), Priority 3 cases ( $\chi^2 (1, n = 198) = 1.85, p = .173$ ). Too few cases existed to make a comparison across Priority 4 cases.

**Table 42 Rate of Offences Substantiated Across Priority Categories**

	Arrest/Caution				Total
	P1	P2	P3	P4	
<b>Practice as Usual-INT</b>	15 (37% of P1s)	30 (30% of P2s)	47 (37% of P3s)	0 (0% of P4s)	92
<b>MIST – INT</b>	8 (44% of P1s)	12 (36% of P2s)	20 (28% of P3s)	1 (33% of P4s)	41

A more detailed comparison was also made of police outcomes, distinguishing between juvenile cautions and arrests, and including separate categories of open investigations, and cases where a child was not able to be charged with an offence because they were under the age of criminal responsibility. This comparison also found no difference between MIST-INT and Practice as Usual-INT on a Fisher’s Exact Test ( $p = .812$ )<sup>6</sup>.

**Table 43 Rate of Offences Substantiated for Matters Finalised**

	Arrest/Charge	Juvenile Caution	No Arrest/Charge	Investigation Open	POI Under Age of Responsibility	Total
<b>Practice as Usual-INT</b>	82 (30%)	10 (4%)	180 (65%)	2 (<1%)	2 (<1%)	276 (100%) <sup>1</sup>
<b>MIST – INT</b>	35 (28%)	6 (5%)	81 (64%)	3 (2%)	1 (<1%)	126 (100%) <sup>1</sup>

### Point of Attrition

The conditions were compared on the point at which they did not proceed any further towards the arrest of an offender. Where the case reached the no disclosure stage, the case also did not go forward to an interview of a person of interest, or arrest. Where the case reached the stage of no interview with a person of interest, the case also did not go on to an arrest/juvenile caution. While we note that in terms of actual case-flow the case could proceed without some of these stages occurring, most cases resulting in arrests involved all of these stages. Some of the other points of attrition were different; a small number of cases involved a case being withdrawn or identified as a false report, a case being transferred to a different policing unit, a case remaining open to investigation at the point of extraction, and the offender being under the age of criminal responsibility. A significant difference was found between MIST-INT and Practice as Usual-INT ( $\chi^2 (3, n = 269) = 12.20, p = .007$ ), with the difference between the conditions mainly being in terms of attrition at the point of non-disclosure, and the point of no arrest.

<sup>6</sup> Four cases from Practice as Usual-INT and four cases from MIST-INT were excluded from the analysis due to the small number of cases in ‘Investigation Open’ and ‘Under Age of Criminal Responsibility’ across both conditions.

**Table 44 Point of Attrition for Cases**

	No Disclosure	No POI Interview	No Arrest	Other <sup>1</sup>	Total
<b>Practice as Usual-INT</b>	51 (28%)	15 (8%)	108 (59%)	10 (5%)	184 (100%)
<b>MIST – INT</b>	41 (48%)	5 (6%)	33 (39%)	6 (7%)	85 (100%)

<sup>1</sup>Other includes withdrawn/false reports, cases that were transferred to a different investigation group, cases that were still open as of 17<sup>th</sup> February 2017, and cases where the person of interest was under the age of criminal responsibility.

### Number of Offences per Case that Resulted in Charges & Number of Contact Offences Charged per Case that Resulted in Charges

As the data on the number of charges per case were not normally distributed, they were compared on a Man-Whitney U test. The two samples were compared on the total number of charges per case with no significant difference found between the MIST-INT (Median = 3; Range = 26) and the Practice as Usual-INT (Median = 3; Range = 50) conditions ( $U = 1734.500$ ,  $p = .665$ ). Both conditions had a small number of cases with many charges.

The data on the number of contact offences per charged incident were also not normally distributed so they were compared on a Mann-Whitney U test. No significant difference was found in the number of contact offences charged between the MIST-INT (Median = 3; Range = 23) and Practice as Usual-INT (Median = 3; Range = 46) conditions ( $U = 1716.500$ ,  $p = .601$ ).

### Referral for a Forensic Medical Examination

While both conditions had low rates of medical examinations occurring as a part of the case, there was a significant difference between MIST-INT and Practice as Usual-INT on the rate of forensic medical examinations ( $\chi^2 (1, n = 402) = 6.40$ ,  $p < .05$ ). This included both cases where a prior forensic medical examination had occurred, and where the strategy meeting was used to refer for a forensic medical exam.

**Table 45 Rate of Forensic Medical Examinations**

	No	Yes	Total
<b>Practice as Usual-INT</b>	250 (91%)	26 (9%)	276 (100%)
<b>MIST – INT</b>	123 (98%)	3 (2%)	126 (100%)

Looking just at only cases of penetrative sexual abuse for both samples, MIST-INT and Practice as Usual-INT did not differ on a Fishers Exact Test ( $p = 0.73$ ).

**Table 46 Rate of Forensic Medical Examinations for Only Penetrative Sexual Abuse Cases**

	No	Yes	Total
<b>Practice as Usual-INT</b>	98 (91%)	10 (9%)	108 (100%)
<b>MIST – INT</b>	35 (95%)	2 (5%)	37 (100%)

We note that this sample includes primarily intra-familial abuse, or abuse by an adult in authority, sexual assault cases are managed by Sex Assault Squad in Western Australia. Most acute sexual assault cases are likely to be responded to by Sex Assault Squad.

It is difficult to interpret this finding, particularly without knowing about the proportion of acute sexual abuse cases where the conducted forensic medical exams were likely to have evidentiary value. Further, when the police make a referral to the Child Protection Unit the recorded information may not distinguish between a forensic medical examination, and a number of the other health check procedures that may be completed by the Child Protection Unit. Further consultation is required in order to better understand this finding and whether the MIST team were systematically not referring to the Child Protection Unit, or if this was an artefact of case allocation in some way.

### **Do the MIST and Practice as Usual Conditions Differ in Terms of the Child Protection Process?**

The MIST response differed slightly from Practice as Usual in terms of the child protection response by having the assessing child protection worker on-site. Importantly we note that due to case capacity limits and the volume of out of area cases dealt with by MIST, the in-house child protection worker only dealt with 27% of Safety and Wellbeing Assessments for MIST-INT cases. While this limits the impact the in-house worker may have had on cases, the interviews also identified that having the in-house worker was an important connection to the child protection districts, allowing for easier and more timely contact between workers across agencies, even for cases not directly dealt with by the in-house worker. Figure 13 presents the child protection response for both conditions side by side. Results are presented at the case level as data on the response for individual children within an incident response number were not consistently available.

Consistent with expectations, no significant differences were found across conditions in terms of the likelihood of receiving a Safety and Wellbeing Assessment ( $X^2 (2, n = 402) = 3.28, p = .184$ ), or in terms of the likelihood of a perpetrator being Assessed Causing Significant Harm ( $X^2 (1, n = 402) = .421, p = .516$ ), or in the outcomes of Safety and Wellbeing Assessments ( $p = .546$ ).

As with the information received about the police response the data follows a case up until close. For cases that were still open as of 17<sup>th</sup> February 2017, the follow-up period differs anywhere between 7-16 months depending on when the case was received by CPFS.

Figure 13 MIST-INT CPFS Pathway

### MIST-INT Case CPFS Pathway

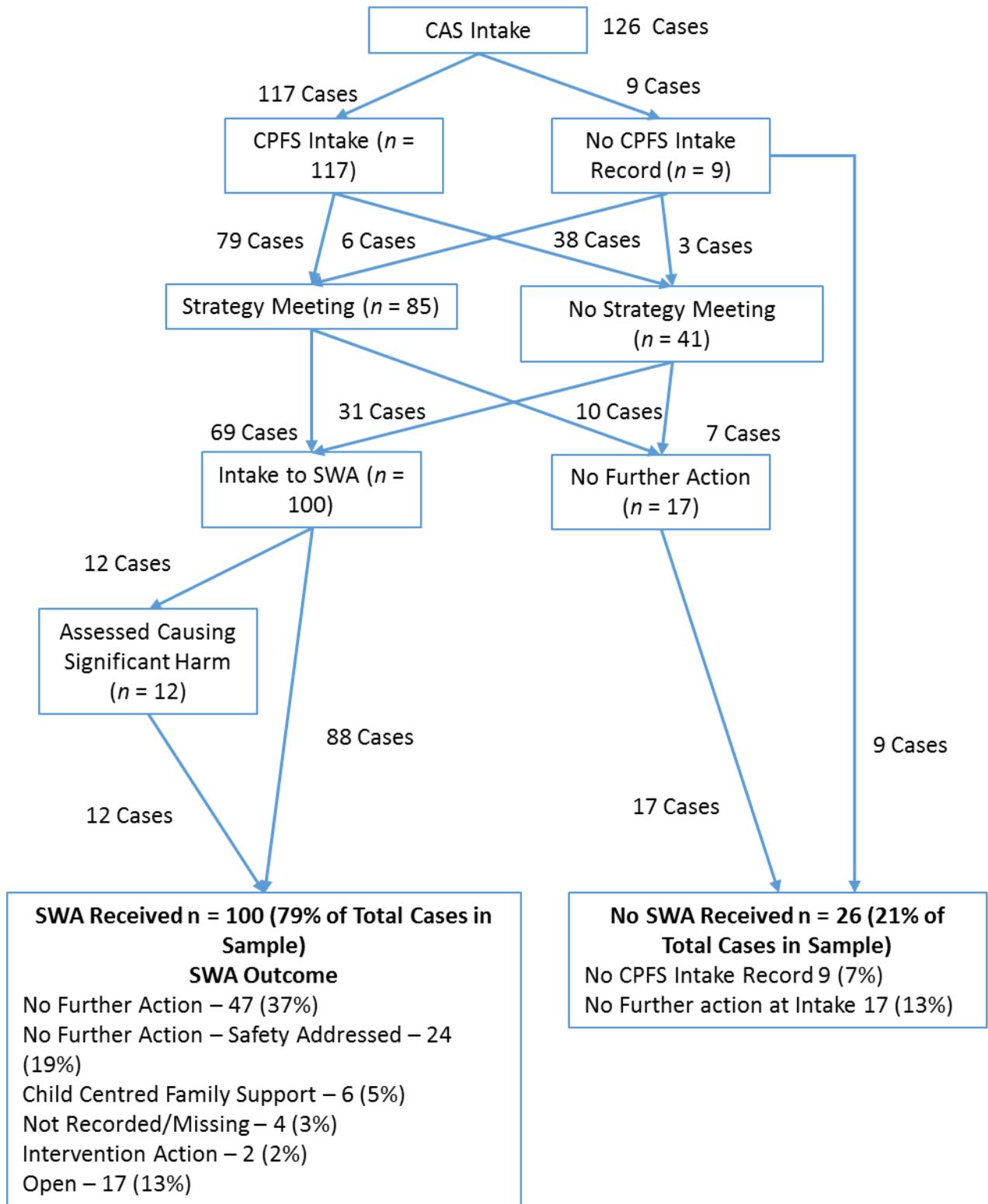
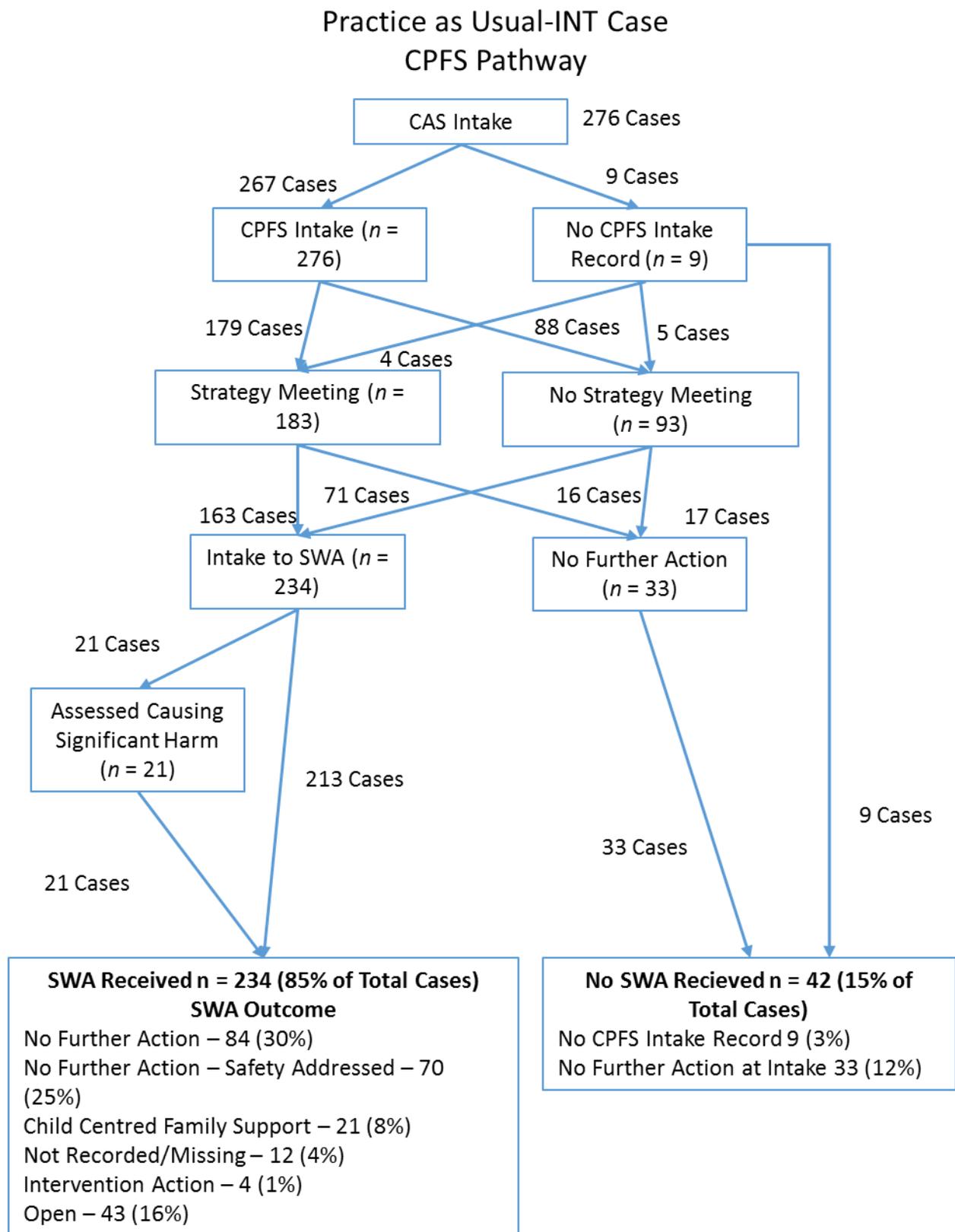


Figure 14 Practice as Usual-INT CPFS Pathway



#### CPFS Intake

The two groups were not significantly different in terms of the initial intake decision by CPFS ( $\chi^2 (2, n = 402) = 3.28, p = .184$ ). This included cases that did not have an intake record in ASSIST; these are

included as from the existing data it isn't possible to distinguish between cases with no CPFS intake record, and cases where the record was missing or could not be identified.

**Table 47 Rate of Safety and Wellbeing Assessments Undertaken**

	Intake to SWA	No Further Action at Intake	No CPFS Record/ Missing	Total
Practice as Usual-INT	234 (84%)	33 (12%)	9 (3%)	276 (100%)
MIST-INT	100 (79%)	17 (14%)	9 (7%)	126 (100%)

#### Assessed Causing Significant Harm

The two groups were not significantly different in terms of cases including a finding of Assessed Causing Significant Harm by CPFS ( $X^2 (1, n = 402) = .421, p = .516$ ).

**Table 48 Rate of Cases Assessed Causing Significant Harm**

	No	Yes	Total
Practice as Usual-INT	255 (92%)	21 (8%)	276 (100%)
MIST-INT	114 (90%)	12 (10%)	126 (100%)

#### Safety and Wellbeing Assessment Outcome

The conditions were compared on decisions made from Safety and Wellbeing Assessments, with no significant differences between the rates of decisions made on SWAs ( $p = .546$ ).

**Table 49 SWA Outcome**

	No Further Action	NFA – Safety Addressed	CCFS	Not Recorded/ Missing	Intervention Action	Open	Total
Practice as Usual-INT	84 (36%)	70 (30%)	21 (9%)	12 (5%)	4 (2%)	43 (18%)	234 (100%)
MIST-INT	47 (47%)	24 (24%)	6 (6%)	4 (4%)	2 (2%)	17 (17%)	100 (100%)

Only a very small number of cases resulted in removal to the CEO's care in the sample ( $n = 6$ ), although CPFS data suggested that many of the cases were in care at the time of sampling (see Table 50). The two samples did not differ in the proportion of cases where children from these cases were in care ( $X^2 (1, n = 402) = .218, p = .641$ ). The rate of children in care has limited utility in examining the effect of MIST as most cases involve children that were already in care at the point of contact with CAS/ChildFIRST, and had often been removed many years prior.

**Table 50 Currently in Care (February 2017)**

	Not in Care	Abused Occurred While in Care	Removed as a Result of Allegation	Total
Practice as Usual-INT	235 (85%)	37 (13%)	4 (1%)	276 (100%)
MIST-INT	105 (83%)	19 (15%)	2 (2%)	126 (100%)

### **Do the MIST and Practice as Usual Conditions Differ in the Timeliness of the Police Response?**

On most stages in the process, the MIST-INT condition was found to be significantly faster than the Practice as Usual-INT condition, with the differences becoming more marked further into the criminal justice process (See Figure 15). Significant differences were found on the days between the incident report and allocation to a detective ( $U = 7379.500$ ,  $p = <.05$ ), this was attributable to inherent differences in the allocation process in the two conditions. Part of the theory of change for MIST suggests that earlier allocation will result in faster response times. Significant differences were also found on the number of days to a victim interview ( $U = 13059.00$ ,  $p = <.05$ ), a POI interview ( $U = 4510.50$ ,  $p = <.05$ ), and to the close of a police investigation  $U = 120008.50$ ,  $p = <.05$ ).

The order of events following an incident report being filed also differed between the two conditions (See Figure 15), with the allocation of a detective occurring on average within a day of the strategy meeting for the MIST-INT condition, and the allocation of a detective on average following the victim interview for the Practice as Usual-INT condition.

As stated above, the MIST-INT condition being significantly faster to allocate cases is not surprising given that the earlier allocation of detectives is part of the MIST process, however it is notable that this earlier allocation resulted in such marked differences in terms of the time to interview victims and offenders, and to close investigations. We note that the process has now changed for part of Practice as Usual, in order to allow for an earlier allocation of detectives.

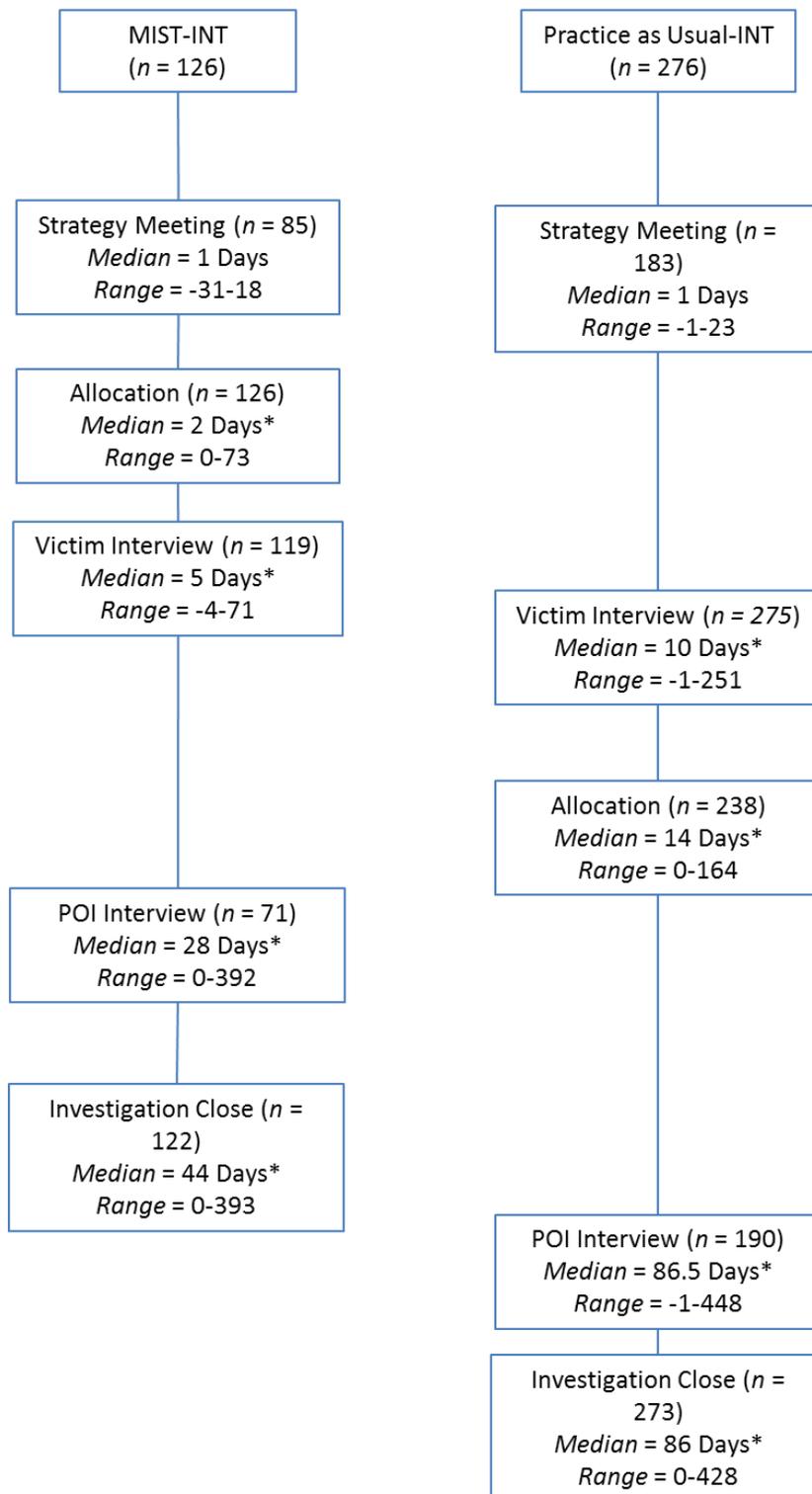
The time between the initial report of abuse and stages of the criminal justice response may be affected by many different factors. While a quick response has a number of key advantages (Walsh, Lippert, Cross, Maurice, & Davison, 2008; Walsh, Lippert, Goldberg-Edelson, & Jones, 2015), in many circumstances it may be outside of the control of police and child protection staff to ensure each of these stages occur quickly.

**Figure 15 Time from Incident Report to Stages in the Police Response**

**MIST-INT & Practice as Usual-INT**

**Time From Report to Response**

\* Denotes a Significant difference between MIST-INT and Practice as Usual-INT



All of the data on time from incident report to police events were not normally distributed, so a Mann-Whitney U was used instead of an independent samples t test.

### **Time from Report to Strategy Meeting**

A comparison of the samples on days from report to the strategy meeting found no significant difference ( $U = 7156.500$ ,  $p = .283$ ) between the MIST-INT (Median = 1 day; Range = -31-18) and the Practice as Usual-INT (Median = 1 day; Range = -1-23) conditions.

### **Time from Report to Police Allocation**

A comparison of the days from the incident report to the allocation of a detective found a significant difference between the MIST-INT (Median = 2 days; Range = 0-73) condition compared to the Practice as Usual-INT (Median = 14 days; Range = 0-164) condition ( $U = 7379.500$ ,  $p = <.05$ ).

### **Time from Report to Victim Interview**

A comparison of the days from the incident report to a victim interview occurring found a significant difference ( $U = 13059.00$ ,  $p = <.05$ ) between the MIST-INT (Median = 5 Days; Range = -4-71) and the Practice as Usual-INT (Median = 10 Days; Range = -1-251) conditions. The date of interview was missing for seven MIST-INT cases, and one Practice as Usual-INT case.

### **Time from Report to POI Interview**

A comparison of the days from the incident report to a person of interest being interviewed for the offence found a significant difference ( $U = 4510.50$ ,  $p = <.05$ ) between the MIST-INT (Median = 28 Days; Range = 0-392) and the Practice as Usual-INT (Median = 86.5 Days; Range = -1-448). The date of a person of interest interview was missing for one MIST case.

### **Time to Investigation Closed**

A comparison of the days from the incident report to a closure of a CAS investigation was significantly different ( $U = 120008.50$ ,  $p = <.05$ ) between the MIST-INT (Median = 44 Days; Range = 0-393) and the Practice as Usual-INT (Median = 86 Days; Range = 0-428). The date of the close of an investigation was missing for four MIST-INT cases and three Practice as Usual-INT cases. In addition, two Practice as Usual, and three MIST cases were still open as of the 17<sup>th</sup> February 2017; these cases were not included in this analysis.

## **Do the MIST and Practice as Usual conditions differ in the Timeliness of the Child Protection Response?**

The time to a child protection response is similarly important to that of a police response; a swifter CPFS response improves the chance that ongoing risks to children are addressed potentially reducing additional abuse and harm to children.

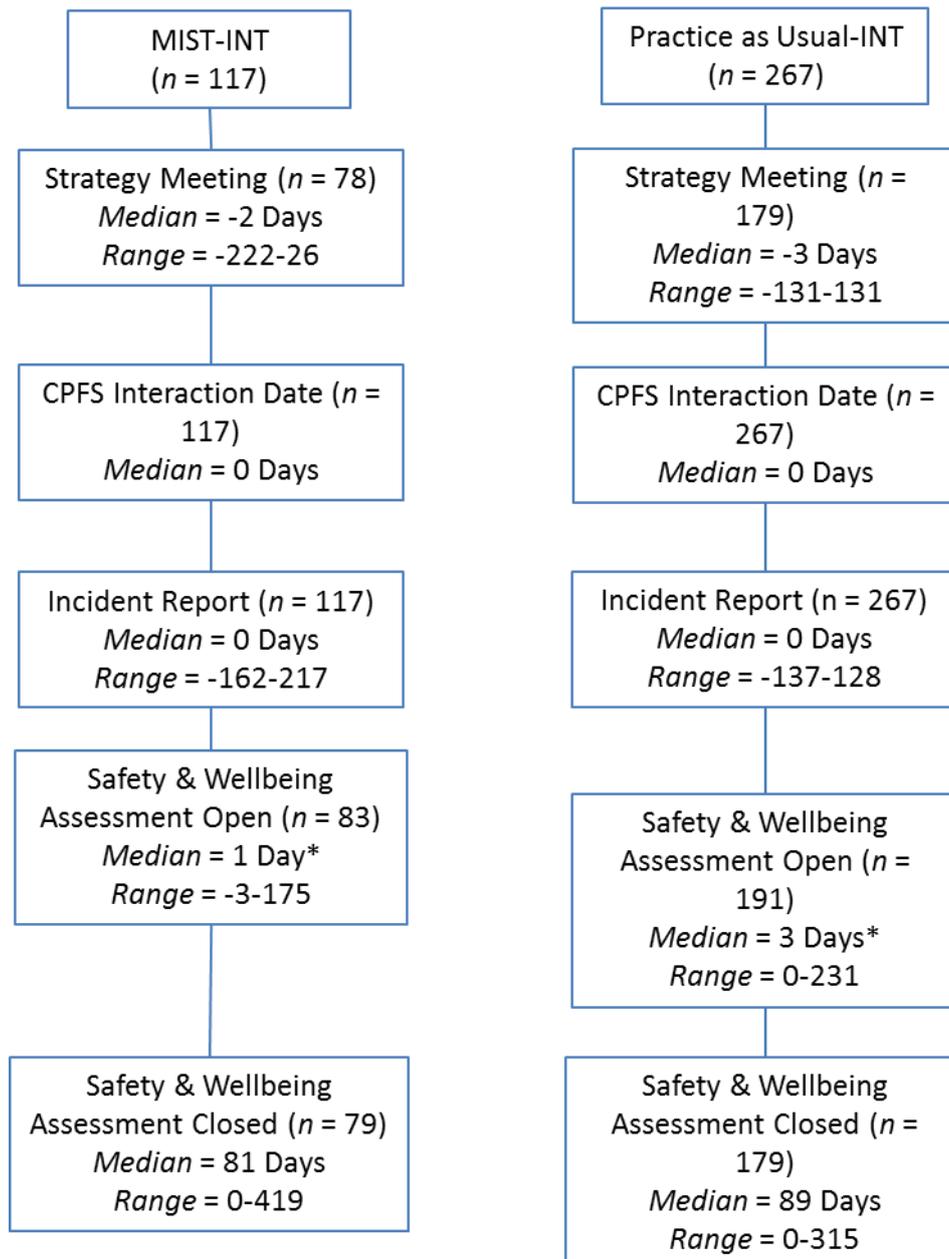
Figure 7 shows the average timeline beginning with the CPFS interaction date, which was typically around the same date as the incident report date. For both conditions, strategy meetings generally occurred prior to the CPFS interaction date, and the opening of a Safety and Wellbeing Assessment. The only significant difference between conditions was in the number of days between the CPFS interaction date and the opening of a Safety and Wellbeing Assessment ( $U = 6331.500$ ,  $p = <.05$ ), which may be attributed to the availability of the additional in-house CPFS worker on top of the existing district resources. There was however no difference in the number of days between the CPFS interaction date and the closure of a SWA ( $U = 7020.500$ ,  $p = .928$ ), and the total number of days a SWA was open ( $U = 6477.00$ ,  $p = .283$ ).

Figure 16 Time from CPFS Interaction to Response

## MIST-INT & Practice as Usual-INT Time From CPFS Interaction to Response

\*Denotes a significant difference between the conditions

Note: Nine cases from each condition did not have a linked CPFS Record



For all results the number of days from CPFS interaction to an incident report being filed was not normally distributed, so a Mann-Whitney U test was used instead of an independent samples T-Test.

### **Time from CPFS Interaction to Incident Report**

A comparison of days between the initial CPFS interaction and strategy meeting found no significant difference ( $U = 14693.50$ ,  $p = .346$ ) between the MIST-INT (Median = 0 Days; Range = -162-217), and Practice as Usual-INT (Median = 0 Days; Range = -137-128). The data suggest that on average the incident report to the police occurred around the same time as the CPFS interaction date, although both samples included cases where one occurred before the other.

### **Time from Strategy Meeting to CPFS Interaction**

A comparison of days between the initial CPFS interaction and strategy meeting found no significant difference ( $U = 6367.50$ ,  $p = .259$ ) between the MIST-INT (Median = 2 Days; Range = -222-26), and Practice as Usual-INT (Median = 3 Days; Range = -131-131) conditions.

### **Time from CPFS Interaction to SWA Date**

A comparison of days between the initial CPFS interaction and the date a Safety and Wellbeing Assessment was opened identified a significant difference ( $U = 6331.500$ ,  $p = <.05$ ) between the MIST-INT (Median = 1 day; Range = -3-175) and Practice as Usual-INT (Median = 3 days; Range = 0-231) conditions.

### **Time from CPFS Interaction to SWA End Date**

Analysis of days from CPFS interaction to the SWA end date found no significant difference ( $U = 7020.500$ ,  $p = .928$ ) between the MIST-INT (Median = 81 days; Range = 0-419) and Practice as Usual-INT (Median = 89 days; Range = 0-315) conditions.

### **Number of Days SWA was Open**

A comparison of days between the opening and closing dates of a Safety and Wellbeing Assessment found no significant difference ( $U = 6477.00$ ,  $p = .283$ ) between the MIST-INT (Median = 76 days; Range = 0-419) and Practice as Usual-INT (Median = 77 days; Range = 0-314) conditions.

## **Do the MIST and Practice as Usual Conditions Differ in the Referral and Uptake of Therapeutic and other Supportive Services?**

The increased and more rapid referral of families and children to supportive services is a key assumption of the MIST model, and an important part of this evaluation. It was anticipated that comparison data would be obtained through CPFS about the extent of referral and engagement of Practice as Usual children and families in supportive services. While this information exists within the CPFS ASSIST database, it is not easily or readily extractable from fixed response fields in ASSIST, available fields are inconsistently completed by CPFS staff making the data that is available unreliable and therefore unsuitable for use. Alternative strategies to obtain this data, primarily involving contact with families or casefile review, was considered, but none of these approaches were considered viable due to the considerable ethical issues of conducting research with such a vulnerable population, and the likelihood of low response rates meaning any data obtained would be of limited value. Therefore, this research question can't be answered using the existing data. Information about the type of services provided by the advocates and therapy team have been included in the descriptive section.

Lacking Practice as Usual data to enable a comparison to the MIST response, it is not possible to draw conclusions on the relative benefit of this approach. This is particularly complicated as parts of the existing service system appear to overlap with some of the services provided by the advocates (e.g. intensive support & court support).

## CONCLUSION

The present analysis of the short-term outcomes associated with the MIST pilot suggest that the intervention has some promise. While there were no significant differences between MIST and Practice as Usual on headline rates of arrests/cautions, or decisions made by CPFS, the MIST response seems to be significantly faster in terms of police investigations and in opening an assessment by CPFS. The volume of cases being processed by the MIST team appears to be equivalent to if not greater than Practice as Usual even after controlling for the different allocation points. At least theoretically, the response seems to be more victim-centred in terms of being localised and actively incorporating a therapeutic engagement element through the advocates and the onsite availability of therapy staff. Perceptions of MIST by staff involved are overwhelmingly positive and caregivers who responded to the survey expressed high levels of satisfaction.

### **Summary of Findings for Each Sub-Study in the Evaluation**

#### **Staff Interviews of Perceptions of the MIST Pilot**

The qualitative study described some of the deficiencies of the Practice as Usual response, that children are often not linked into services, and that there can be significant difficulties in communication and collaboration between the agencies involved in the response. Interviews early in the implementation of the MIST with MIST staff, and workers affected by the MIST pilot were very positive about the potential for the pilot in addressing some of these deficiencies, particularly in terms of communication across agencies, and the value of built-in support and referral for children and non-abusive caregivers. Workers also talked about collaboration across agencies being difficult despite the potential to improve the response, and talked about issues to do with capacity and resourcing and concerns about the future of the pilot. The interviews also highlighted that the de-centralisation of the MIST team involved some additional work for staff compared with their Practice as Usual counterparts. Workers suggested a need for additional workers to match demand, more input and involvement from the CPFS districts, Child Witness Service, and the Child Protection Unit, and the need for continuous discussion across all agencies involved across the entire process to create the best possible cross-agency response. Some participants also pointed to the need for the specialist response to be extended to physical abuse cases, and the need for increased contact and coordination between the MIST and court support staff.

#### **Descriptive Study of the Implementation of the MIST Pilot**

The descriptive study provided a broad outline of the case-flow for each of the conditions; highlighting differences in the processes between MIST and Practice as Usual. The data showed there were many different types of cases receiving advocacy support at the George Jones Child Advocacy Centre, including those outside of the scope of the evaluation. The caregiver survey data suggests that the respondents were highly satisfied with the response, although we have noted that satisfaction is problematic as an outcome measure, and the difficulty of obtaining a representative sample for surveys.

The MIST Pilot was more efficient than Practice as Usual in terms of both case volume and time to disposal. The MIST team had staff allocation comparable to other CAS teams, although they were relatively understaffed in terms of interviewers, CPFS district workers, and Child and Family Advocates. The allocation process meant that the MIST CAS team were allocated a much larger proportion of cases. That said many of these involved cases where the victim declined an interview,

meaning the response primarily involved writing off the case for CAS. MIST appeared to be responding to cases that would be likely to be screened out of Practice as Usual, even among cases that received a child interview. There was a particularly high demand for both the in-house CPFS worker and the two advocates, with both working to capacity.

The cases in both samples were screened in order to present the degree of fidelity to the intended MIST model, and to identify a comparable sample for the quasi-experimental study. Despite the intent of the SOPs manual, many cases outside of area were investigated by CAS and vice versa, many MIST cases were interviewed at CAS, MIST at times were required to pick up overflow from Practice as Usual squads and the movement of cases through WAPOL was often complicated. The allocation of cases to MIST or Practice as Usual outside of the SOP appeared to occur as a result of logical and purposeful victim/workflow oriented decision making rather than being a consequence of drift. The need for some flexibility appears desirable. Most MIST cases received advocacy support, particularly when the interview occurred at the GJCAC. A relatively small proportion of MIST cases received a Safety and Wellbeing Assessment by the in-house Child Protection worker, primarily due to case-load capacity limits. Overall fidelity to the key principles and practices that comprised the MIST Pilot was high, although we note that only a small proportion of Safety and Wellbeing Assessments were completed by the in-house worker.

The evaluators undertook some very basic calculations based on FTE and case volumes in the Practice as Usual compared to the MIST conditions to estimate whether MIST was a more resource intensive intervention in terms of CAS Squad time. It would appear that MIST was at least as efficient as Practice as Usual, even after controlling for differences in the point of allocation. This was surprising given the greater workload demands, but was consistent with the faster response times in MIST at all stages of the Police response. It is possible that localised investigations and co-location with key stakeholders offer efficiency gains. Another possible explanation is that worker satisfaction is associated with productivity gains. This warrants further and more methodologically rigorous exploration.

### **Quasi-Experimental Follow-Forward Study**

The comparison study found that broadly the two samples were equivalent on proportions of cases with particular priority ratings, cases with multiple victims and persons of interest, victim gender, relationship between victim and offender, age of the child at interview and at onset of abuse, types of abuse in the case, and the age of the person of interest.

Overall, Practice as Usual had significantly higher rates of disclosures and person of interest interviews, however there was no significant difference in terms of rates of arrest/cautions. More detailed analysis identified that differences in the MIST were restricted to their response to Priority 3 cases; as noted above MIST may have operated at a lower threshold (in terms of cases having a disclosure or other evidence to investigate) than Practice as Usual for cases screened in for interview. The two conditions were not significantly different in terms of disclosures, person of interest interviews, or arrests/cautions on Priority 1 and Priority 2 cases. The two conditions did not differ for Priority 1-3 cases in terms of the number of charges.

No significant differences were found in terms of the child protection response, including whether a Safety and Wellbeing Assessment was conducted, whether a person was assessed as causing significant harm, and the action taken following the assessment. This can likely be attributed to the fact that the only real change from practice as usual in the CPFS response was the allocation of an in-

house CPFS worker to assist primarily with Safety and Wellbeing Assessments and case consultation. The caseload demand for this individual routinely exceeded their capacity. It is difficult to interpret the effect of having an in-house worker may have had on the child protection response because of the small proportion of cases.

The MIST condition was found to be significantly different in terms of the number of days following an incident report for the allocation of a detective, a victim interview, person of interest interview, and the closure of a case. The MIST condition was found to be significantly different in terms of days between the CPFS interaction date and the opening of a Safety and Wellbeing Assessment, but not in terms of days between the CPFS interaction date and the Police incident report, the strategy meeting, the closing of a Safety and Wellbeing Assessment, and the total number of days a Safety and Wellbeing Assessment was open.

Service delivery data was not available for Practice as Usual to compare against MIST. Information about the service provided in the MIST condition was included in the descriptive section.

## **Limitations**

In addition to the methodological limitations identified in the methodology section, this evaluation has a number of limitations that should be clearly acknowledged.

As discussed in the methodology section much of this evaluation relied on administrative data, much of it extracted manually and provided to the researchers. While in most cases the researchers were able to check back with the people that provided the data where there seemed to be an error or a piece of information that did not make sense in the context of the case, it is possible that there are errors in the data. These may be errors from the point of entry into the database, or errors at the point of extraction.

The comparison between MIST-INT and Practice as Usual-INT is based on the two samples being equivalent in characteristics that may affect the likelihood of particular police or child protection decisions. While analyses were conducted to check whether the two samples were comparable, it is also possible that these conditions vary on some other characteristics not controlled for in the study. This is a limitation of a quasi-experimental versus a randomized control trial.

We also note that this evaluation may be limited in terms of its relevance to current practices. We have noted throughout that CAS is currently undertaking a trial of a different process for allocating detectives and undertaking interviewing. Due to the considerable follow-up time needed on cases, and efforts to evaluate two distinct conditions, Practice as Usual under this new process has not been included in this report.

While the limitations of satisfaction as an indicator of effectiveness has been discussed, it remains a limitation that that satisfaction surveys were not conducted in the Practice as Usual condition and are a single point in time measure. While the surveys suggest that there is a high degree of satisfaction with the response this data comes from a fairly small sample of MIST cases representing a response rate of 21%. Caregiver satisfaction data need to be interpreted with a high level of caution.

The conclusions of the evaluation were also limited by the lack of comparison group data on receipt of services and support. While it is known that only a small proportion of cases receive family support services from CPFS, there was no consistent available data on the referral and uptake of services for Practice as Usual cases. However, the evaluators note the difficulty in developing a

viable, effective, and ethical methodology of obtaining this information in the Practice as Usual condition.

## **Summary of Conclusions for each Research Question**

### **Q1. To what extent has the MIST pilot been implemented as planned among severe child abuse cases referred to the team in the South-East Metropolitan district of Perth?**

Overall, fidelity to the key principles and practices that comprised the MIST Pilot was high. Case allocation was largely consistent with the SOP, however many cases outside of area cases were investigated by the MIST CAS team and vice versa. The allocation of cases to MIST or Practice as Usual appeared to occur as a result of logical and purposeful victim/workflow oriented decision-making rather than being a consequence of drift from the intent of the MIST pilot. Advocacy was almost universal for MIST cases and cases interviewed at GJCAC, exceptions were all attributable to circumstances of the individual case.

One issue that did emerge was that there may still be differences in the types of cases investigated at MIST in terms of having a disclosure or other avenues for investigation than Practice as Usual even among cases that received a child interview.

### **Q2. What are the weaknesses and strengths of the MIST pilot process compared to standard practices?**

#### *Weaknesses*

There were no significant differences between MIST and Practice as Usual on headline rates of arrests/cautions, or decisions made by CPFS.

The MIST Pilot does not appear to be translating into greater arrests/cautions, which may be due to MIST investigating cases that may have been unlikely to be allocated in Practice as Usual. On the information available to the evaluators no benefits of investigating these cases are apparent in terms of the rate of arrest among priority 3 cases. The investigation of these additional cases may be contributing unnecessarily to the workload of interviewers and CAS Squad detectives in the MIST pilot. It would be desirable to provide support to these families, while maintaining the existing thresholds of Practice as Usual.

#### *Strengths*

The model is theoretically sound, and aligns with international evidence for best practice; it compares favourably to responses operating within the Australian context.

The MIST response seems to be significantly faster in terms of police investigations and in opening an assessment by CPFS.

The volume of cases being processed by the MIST team appears to be equivalent to if not greater than Practice as Usual even after controlling for the different allocation points.

Practitioners perceived the response to be more victim-centred in terms of being localised and actively incorporating a therapeutic engagement element through the advocates; and to overcome some of the limitations of Practice as Usual in connecting victims and their families to therapeutic services and supports. Caregivers who responded expressed high levels of satisfaction with the MIST response. Staff involved in the MIST Pilot appeared to feel positive about the Pilot and their work within it.

### **Q3. How effective has the implementation of the MIST pilot been in improving collaboration between professionals involved in the response to severe child abuse?**

Based on the interviews with professionals, the MIST pilot seems to have been successful in improving collaboration between professionals. Participants talked about some of the communication difficulties between police and child protection in particular and pointed to the value of not only having a CPFS worker on-site, but also the improved collaboration with interviewers.

The interviews did also identify some gaps in cross-agency collaboration that remain, in particular with the CPFS districts, the Child Protection Unit, and the Child Witness Service. Issues were identified both in terms of the process of consultation and development of the MIST response, and in terms of ongoing case management. Much of the concerns were due to the potentially overlapping role that the advocates played.

### **Q4. How effective has the implementation of the MIST pilot been in improving the referral to support services to abused children and their (non-abusive) caregivers?**

The evaluators were unable to obtain comparison data in order to address this question. However, among the MIST sample the degree of service delivery was high, drawing on both the advocates, the in-house therapeutic team, and various external services networked into the MIST response.

### **Q5. How effective has the implementation of the MIST pilot been in decreasing attrition from the investigation of severe child abuse?**

Based on the available data it appears that the MIST pilot has a negligible effect on attrition from the investigation of abuse, although this does not account for the fact that MIST appeared to be responding to cases that may not have received an investigation in Practice as Usual. Interview data showed that professionals perceived MIST, and particularly the advocates, to have enhanced referral and uptake of therapeutic services and the time for this to occur.

### **Q6. How effective has the implementation of the MIST pilot been in increasing the responsiveness of interviews and investigations for severe child abuse?**

Based on the available data it appears that the MIST pilot significantly increases the responsiveness of the policing and to a limited extent the child protection response to cases. The MIST response was much quicker from the point of report to each of the key points of the policing response (allocation of a detective, victim interview, POI interview, police outcome). MIST was also significantly faster in terms of the opening of a Safety and Wellbeing Assessment, but not in terms of the closing of an assessment.

## **Recommendations**

On the basis of this report, the evaluators are of the view that there are no efficiency losses in terms of case volume, some efficiency gains in terms of response times, no impacts to arrest/caution rates and that the model represents a more victim-centred approach. On this basis, the evaluators have concluded that there would be benefits to the scale up of MIST to other locations in Western Australia.

While much of the MIST response appears to be neutral in terms of its effect on the investigation process for police and children protection, the more rapid response, improved collaboration across agencies, and more victim centred response suggest the model has the potential to improve the response and outcomes experienced by children and families. However, the critical element involves

children and families receiving support and services they would have otherwise not received. While we can't directly evidence an improvement in the referral and uptake of these services, having clear arrangements for 'warm' referral to services is in line with best practice in other jurisdictions. This however needs to be monitored and evaluated over the long term, including provision to collect a baseline or comparison response.

The evaluation did identify a number of ongoing issues with the MIST pilot which would need to be managed more effectively in the event of continuation or expansion of the pilot. It is clear that the volume of cases coming through the GJCAC is challenging to maintain for all staff, but in particular the Child and Family Advocates, and the in-house CPFS worker. While the advocates have been able to continue to deliver their service, the CPFS worker has struggled to keep with the caseload coming in through the MIST pilot. While in part this was due to the extra work involved with assisting the CAS team, and due to some of the IT issues, it seems likely that the MIST pilot would benefit from additional capacity in terms of CPFS assessment. Although we note that participants identified the benefits of the in-house worker extended to cases that weren't being directly managed in-house.

The interviews highlighted some of the challenges in working to set up a forensic medical service at the GJCAC in order to have a full one-stop-shop. Despite the inclination to fully integrate all services, research on CACs has identified that it is relatively rare to have such a service on-site in non-hospital settings (Herbert et al., Under Review). Indeed, while many CACs may employ sexual assault nurse examiners, and a much higher rate of medical examinations occur (although we note that the CACs include sexual assault cases not included in this pilot), often these examinations are more about the physical health and wellbeing of young people than their evidentiary value (Walsh et al., 2007). We note that CAS cases, as opposed to Sex Assault Squad cases were in general less likely to require a forensic medical. Further consultation is needed in order to better understand the findings that MIST cases were significantly less likely to involve penetrative sexual abuse or a forensic medical, whether this was due to chance or some difference in the allocation of these cases which would need to be understood should scale up be considered.

As observed in the qualitative interviews, it is problematic for Western Australia to remain with a partially de-centralised response, including only two districts. Therefore, there are some key decisions to be made about the cross-agency design of responding to child abuse across the Perth metro area.

As discussed in the national comparison paper (Herbert & Bromfield, 2017c), New South Wales, Victoria, Queensland, and South Australia all have decentralised specialist responses, with specialist units distributed across the state. Some of these states have achieved this by combining some victim centred response units: for example in Victoria the Sexual Offences and Child Abuse Investigation Teams respond to both adult sexual assault and child sexual abuse, in South Australia the Family Violence Sections respond to all kinds of domestic and family violence. Currently CAS is a centralised response, meaning that these teams (other than MIST) deal with all different CPFS districts, with different teams, structures, and staff. By localising the CAS response there are opportunities to harmonise better with existing CPFS districts, although for this response to scale additional areas of victim centred policing may need to be combined.

The current cross-agency interviewing unit is part of the centralised response, providing dedicated interviewing for children with a team including both police and CPFS interviewers. A potential scale-up of the MIST response may bring up questions of the value of CPFS providing interviewers, as

opposed to having the assessing CPFS caseworker attend interviews. This has in part formed the rationale for the current CAS 1 trial of integrating police interviewers and detectives. The CAS/ChildFIRST arrangement is the only one of its kind in Australia, with all other jurisdictions requiring or allowing child protection workers to attend and in some cases contribute to the planning of forensic interviews, usually conducted by the investigating officer of a specialist child abuse unit.

Another option may be to adopt a large scale centralised MIST type model in Stirling St, similar to international models such as Boost Child Advocacy Centre in Toronto or Puawaitahi in Auckland. While the current CAS 1 trial has addressed some of the perceived deficiencies of Practice as Usual, at least from the police perspective, this approach does not include the assessing child protection worker as part of the process, nor does the response provide integrated support for children and families.

The descriptive study showed a benefit to centralised oversight of allocation as it facilitated workload redistribution when a squad was at capacity which will be important for maintaining timely investigations. The descriptive study also suggests that MIST was operating at a lower threshold than Practice as Usual even for cases screened in for a child interview and that this was not associated with increased particularised disclosures, person of interest interviews, arrests or cautions; and thus increased workload of the MIST CAS Squad with no observable benefits. The difference in threshold for screening in cases and the impacts on workload illustrate a particular vulnerability of localised responses. Should localised models be scaled up in Western Australia then particular attention will need to be given to these issues. This could comprise processes for reviewing caseloads and threshold in local sites; or retaining a centralised element of the response such as Strategy Meetings occurring centrally with a 1-day KPI for allocation to localised CAS squads for screened in cases. Consultation with staff involved in the MIST and allocation decision-making in Practice as Usual is recommended to inform action in this area.

The undertaking of linking data sources from three agencies highlighted the critical need for a cross-agency data system that both allows for case tracking/monitoring by the agencies involved, and the monitoring of clearly identified and measured outcomes. A well-designed system with procedures that are implemented with fidelity would provide ongoing data that would enable efficient monitoring of outcomes in the future.

The evaluation also highlighted the need for a clearer set of cross-agency protocols and procedures, and effective governance of these procedures. The national comparison highlighted the critical role of a detailed process, and the willingness of agencies to collectively take ownership of the process (Herbert & Bromfield, 2017c).

While the advocate role appears to have value, there are broader capacity challenges in the service environment. Part of the value provided by the MIST is the provision of counselling and therapeutic services free of charge with no cap on sessions. While the Child Protection Unit provides a similar service, and participates in strategy meetings to facilitate referrals this service is provided in Subiaco, which may be a long distance from many children and families. The MIST response currently serves a catchment area, whereas the Child Protection Unit counselling and therapeutic service serves the entire Perth metropolitan area. Similarly, CPFS fund Child Sexual Abuse Therapy Services at sites across metro and country areas, however there is often a considerable waiting list for these services. Part of the value a cross-agency system may be able to provide is to network across services and

manage limited resources to ensure services have the greatest impact and to improve rates of completion by allowing children and family a choice of services.

## APPENDIX A

### Additional Research Projects/Papers Complimenting the Evaluation of MIST

<b>MIST Evaluation – Primary Research</b>		
Interviews with staff on perceptions of the MIST Pilot	Analysis of perceptions of the MIST pilot by both MIST and equivalent Practice as Usual Staff	<b>Complete</b>
Analysis of CPFS, Police, and Parkerville Administrative Data for MIST and Practice as Usual Comparison Groups	Analysis of administrative data examining the effect of the MIST pilot on the response to abuse by police, child protection, and support service providers	<b>Complete</b>
<b>Literature/Evidence Reviews</b>		
Evidence for the Efficacy of Child Advocacy Centres: A Systematic Review	Review paper summarising the evidence for the efficacy of child advocacy centres across a number of outcomes.	<b>Completed – Published in Trauma, Violence, &amp; Abuse</b>
Better Together? A Review of Evidence for Multi-Disciplinary Teams Responding to Physical and Sexual Child Abuse and Neglect	Review paper summarising the evidence for the efficacy across different types of multi-disciplinary teams across a number of outcomes.	<b>Completed – Published in Trauma, Violence &amp; Abuse</b>
Variations in Multi-Disciplinary Teams and their Implications for Child, Family, and Agency Outcomes	Review paper summarising the characteristics and processes of different models of multi-disciplinary teams	<b>Completed</b>
Evidence for approaches to implementing effective multi-disciplinary teams	Review paper summarising the evidence for approaches to building, developing and sustaining effective cross-agency teams	<b>Not Yet Commenced - Estimated Oct 2017</b>
Comparative National Review of Multi-Disciplinary Processes	Paper summarising the processes for collaboration across agencies in each Australian jurisdiction	<b>Completed – Under Review</b>
<b>Conceptual/Theory Papers</b>		
Multi-Disciplinary Teams: A Broad Theory of Change & Case Example of Team Based Responses to Severe Child Abuse	Conceptual paper describing a broad theory of change across different types of multi-disciplinary teams. Discusses the MIST pilot as a case example of the application of the theory of change to a specific model.	<b>Completed – Under Review</b>
<b>Other Research</b>		
Survey of the Characteristics of Child Advocacy Centres in the United States	Survey of directors of child advocacy centres/multi-disciplinary teams in the United States on characteristics of their collaborations and importance of particular elements of their models for inter-agency collaboration.	<b>Completed – Under Review</b>
Honours Supervision – Identifying Factors Associated with High and Low Quality Working Relationships in Child Advocacy Centres	Supervision of an honours project working with the Child Advocacy Centre Directors survey data to identify structural characteristics that may be important for developing and maintaining good quality collaboration relationships across teams responding to child abuse	<b>Completed</b>
Research Review of the Joint Investigation and Response Team (NSW)	Preparation of existing research material into two research reports for the NSW Ombudsman, NSW Police, Family and Community Services NSW, and NSW Health. Reports directly informed a review of the JIRT by the NSW Ombudsman	<b>Completed</b>

## Overview of Literature Reviews

This appendix includes summaries of the evidence for the effectiveness of multi-disciplinary teams in improving the following outcomes. These findings have been drawn from the two literature reviews completed as part of the post-doc (Herbert & Bromfield, 2016b, 2017a).

### Criminal Justice Outcomes

Overall, the previous research seems to suggest that multi-disciplinary teams have a beneficial effect on criminal justice outcomes, relative to cases that are handled by police outside of a multi-disciplinary team. The studies included examined many different types of criminal justice outcomes, under different types of conditions, with different types of teams. 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, Witte, & Fricker-Elhai, 2006; Wolfeich & Loggins, 2007) than not (Wolfeich & 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, Laib-Koehnemund, & Fegert, 2007; Wolfeich & Loggins, 2007). Similarly the results were mixed in terms of criminal convictions, though more studies suggested a significant difference (Bradford, 2005; Joa & Edelson, 2004; Turner, 1997), than studies that did not (Edinburgh et al., 2008; Joa & Edelson, 2004).

### Mental Health & Support Service Referral

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. 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). Five studies found mostly significant results for the effect of increased collaboration or ties between responding agencies (Bai, Wells, & Hillemeier, 2009; Cross, Finklehor, & Ormrod, 2005; Hurlburt et al., 2004) such as co-location, presence of a case review coordinator). On the other hand, Cross, Finkelhor and Ormrod (2005) had null findings between the effect of collaborative teams on support service receipt for some types of abuse. One study found that having a single agency responsible for care resulted in an increased likelihood that clients would receive mental health services (Chuang & Wells, 2010).

### Child Protection

The few studies that included a comparison group had mixed findings in relation to whether a multi-disciplinary team increases child protection substantiations. Wolfeich and Loggins (2007) found a significant difference between the rate of substantiation for all types of abuse between cases referred to a multi-disciplinary team compared to a standard child protection response for that jurisdiction. Brink et al. (2015) found significant agreement between the assessment of a multi-disciplinary team, and the eventual findings of child protection investigations to substantiate child sexual abuse. Turner (1997) however found no difference between the rate of substantiation before and after the implementation of an investigation focused multi-disciplinary team, however a significant improvement in the time from receipt of a report by child protection to police

involvement in a child sexual abuse matter. Cross, Finklehor, and Omrod (2005) found no difference between higher levels of collaboration across a team and the proportion of cases that received an out of home placement for physical and sexual abuse, but did find a difference for neglect.

### **Satisfaction with the Response**

Few studies provided a comparison of satisfaction with the multi-disciplinary team response compared with a standard response. 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 there was no significant difference in satisfaction for children. Walsh et al. (2007) found that caregivers were not any more satisfied with medical examinations at a CAC than at a standard response. 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 teams themselves.

### **Medical Referral**

Again, very few studies examined outcomes related to medical referral and improvement in symptoms, but all those that did found that a multi-disciplinary team was significantly more likely to be associated with the receipt of medical services than comparison conditions (Chomba et al., 2010; Edinburgh et al., 2008; Smith et al., 2006; Walsh et al., 2007).

### **Process Variables**

Quite a few outcomes assessed by studies related more to outputs, 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 (Jaudes & Martone, 1992; Turner, 1997), however the more contemporary studies found no difference across conditions (Cross, Jones, Walsh, Simone, & Kolko, 2007). All studies found that teams increased police involvement and joint investigations (Cross et al., 2007; Smith et al., 2006), along with other characteristics in the CAC model such as the use of appropriate interviewing environments (Cross et al., 2007).

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. (2007) 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.

## APPENDIX C

The pilot includes cases within the South-East Metro District that fit within the Child Abuse Squad Charter. Child Abuse Squad primarily deals with cases of sexual and physical abuse within the family, or with a known offender, cases which are more likely to require also require a child protection response to assess the safety of the child and protectiveness of caregivers. This identifies the following types of cases as part of the CAS metropolitan charter:

- **Sexual Abuse where:**
  - Offender has a familial relationship with the child;
  - Known extra-familial offender of a child under 13;
  - Child is in the care of the CEO of CPFS, where the offender is associated or linked to CPFS;
  - Offender is a person in authority over the child;
  - Where an investigation has commenced via the serious incident planning meeting at Princess Margaret Hospital;
- **Physical Abuse where:**
  - Offender has a familial relationship with the child and the abuse results in a serious injury;
  - Child is in the care of the CEO of CPFS, where the offender is associated or linked to CPFS;
  - Offender is a person in authority over the child;
  - Where an investigation has commenced via the serious incident planning meeting at Princess Margaret Hospital;
- **Neglect where:**
  - Criminal neglect for children under 13 years

Other types of child sexual abuse cases will be allocated to the relevant response group, but remain outside of the scope of the MIST pilot. These groups include:

*Sexual Assault Squad:* Historical child sexual abuse offences committed by an unknown person; sexual penetration of a child aged 13 and older by a known offender (extra-familial); Sexual penetration offences on a child under 13 by an unknown offender; sexual penetration offences against incapable persons over the age of 13 (extra-familial);

*Online Child Exploitation Squad:* Offences related to sexually predatory behaviour online; possession and distribution of child exploitation material; production and distribution of child exploitation material;

*Police Districts:* All sexual offences other than penetration on a child under 13 years where the offender is unknown; historical child abuse offences alleged by adults where the offender is known; historical child abuse offences alleged by children under 18 committed on them while between 13-16 years (extra-familial); and obscene acts.

The priority ratings are based on the following Risk Assessment and Priority Allocation protocol by the Intake and Assessment Team (Western Australia Police, 2017, pp. 32-33)

### PRIORITY ONE

- Child is in immediate danger of being abused by the alleged perpetrator;
- Child other than an identified victim is in immediate danger of being abused by the alleged perpetrator;
- Suspect is a Person in Authority;
- Suspect is a person of high profile;
- Any other circumstances that dictate an immediate response;
- An alleged perpetrator is intending to flee from the state to avoid interview or apprehension. Child victim is a Child in the Care of the CEO DCP;
- Immediate action is required to avoid the loss of evidentiary matter.

**PRIORITY TWO**

- Child must be removed from potential danger within a time frame, i.e. an upcoming access visit etc;
- Suspect is registered with the Sex Offender Management Squad;
- Suspect is believed to be in possession of CEM and lives with children;
- Suspect is believed to be in possession of CEM and has a current Working With Children Card.

**PRIORITY THREE**

- A child is in no danger of being subjected to further abuse in the short term or the long term;
- No extenuating circumstances are present giving rise of concern for a child's safety or wellbeing;
- Child exploitation material files where the suspect has a history of CEM / sex offences.

**PRIORITY FOUR**

- Historical allegations made by an adult of offences committed upon them as a Child;
- Child exploitation material files where there is no other intelligence holding suggesting a child is at imminent risk.

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