QCPCI

Date: 23.10.2012

Exhibit number: 96

Statement of Witness

Name of Witness	Professor Kevin R Ronan
Date of Birth	[redacted]
Address and contact details	CQUniversity, Rockhampton, 4701
Occupation	Clinical Psychologist/Professor of Psychology

I, Kevin R Ronan, Clinical psychologist and Foundation Professor in Psychology of Central Queensland University Australia, c:/ Bruce Highway, Rockhampton, 4710, solemnly and sincerely affirm and declare/swear:

PROFESSIONAL BACKGROUND

1. My position as Foundation Professor, and Chair in Clinical Psychology, was to start a new postgraduate training program in Clinical Psychology (started 2010, now fully accredited) and to provide research leadership. Please refer to **attachment 1** for my up to date curriculum vitae.

2. I have been doing research since the 1980's in a number of areas of Clinical Psychology but with a real focus on the problems of children, youth and families. This includes various types of problems including those having to do with anxiety and trauma, maltreatment, conduct disorder and other problems.

3. In terms of the focus of the current Inquiry, as you can see on the attached CV, in 2010, with a former PhD student, I published a book on a new trauma-focused therapy program for children traumatised by maltreatment, published by JK Publishing in London. That book is now being translated and due for publication in Israel in 18 months time. In addition, in 2009, I was the senior guest editor for a special issue of the *Australian Psychologist* focussed on the topic of child maltreatment. I attached the introductory article that we authored (Ronan & Feather, 2009) (marked **attachment 2**) and another article from a team I lead that summarised research on etiology, risk, assessment and treatment in relation to child maltreatment (Ronan, Canoy, & Burke, 2009) (marked **attachment 3**). In addition, within that article, we summarise some of the major findings to date in the emergent area of implementation science, including what factors appear to both facilitate and impede the dissemination, implementation, and long-term sustainability of evidence-based, innovative intervention models in day-to-day settings that service children, youth and families.

Witness signature: _____ Officer signature: _____

TERMS OF REFERENCE

4. I would like to make a statement and follow this with an appearance at the Commission (QCPI), namely to address issues linked to the following terms of reference 3 (c) (ii) and (iii):

> ii the current Queensland government response to children and families in the child protection system including the appropriateness of the level of, and support for, front line staffing;
>
> iii tertiary child protection interventions, case management, service standards, decision making frameworks and child protection court and tribunal processes

CHILD PROTECTION RELATED INTERVENTION

5. The issues I would like to canvass include factors related to the "what" and "how" of child protection-related interventions, from a clinical psychology perspective.
6. In terms of the "what" interventions are useful, we wrote a review paper on child maltreatment etiology, risk, assessment and intervention. This review paper (Ronan, Canoy, & Burke, 2009) was part of a special issue of the *Australian Psychologist*, a special issue of which I was the guest editor along with a colleague, Dr Jackie Feather (please refer to attachment 2). This article, along with the introduction to the special issue (refer to attachment 3). As detailed in that article, these intervention models include the type our team has developed, a trauma-focused cognitive-behavioural intervention program. For the various types of problems linked to maltreatment (e.g., internalising problems including trauma, anxiety, depression; externalising problems), and owing to children being embedded within other systems (starting with the family), family-focused treatment programs are also evidence supported. This includes those types of programs that are delivered directly in the home to reduce barriers to engagement. They also include not only tertiary intervention approaches (i.e., once the problems have fully emerged) but also prevention programs that aim to assist parents to gain both the knowledge and skills to promote healthy development, including preventing child maltreatment.
7. Following on from that discussion, and an even more important area for consideration, is how to implement successfully such interventions into a public child protection service system. Since the 1950's, clinical psychology and related disciplines have been quite successful in developing an increasing number of interventions shown to be capable of producing clinically significant change across a wide spectrum of problems, including those typically thought to be "treatment resistant." On the other hand, the implementation and success of these

interventions in day-to-day settings, including settings focused on problems for children and families, has not been forthcoming.

8. As issues related to this research-practice gap have been amplified in academic discourse, an emerging area referred to as "implementation science" has begun to tackle this problem. The main problem focus might be best captured in a couple of questions:
    a. With the development of an increasing number of evidence-supported intervention approaches, why do these interventions have problems when implemented in day-to-day setting?
    b. How do we overcome these obstacles and implement these interventions in such a way so as to produce clinically significant gains for children and families while being sustainable over time?"

9. Findings from research in implementation science provide signposts about factors that need to be accounted for in the implementation of any new service. These include of course training and support factors and ensuring that the intervention that is supported in research settings is implemented in the manner intended (versus in a, for example, titrated, watered down fashion).
10. The type of training that would best facilitate successful implementation would be that which would mirror that done in the research setting, including comprehensive initial training, including an "accreditation" process. Following initial training, ongoing supervision, booster training, and measurement of treatment fidelity (e.g., asking families periodically to fill out a measure that has items reflecting treatment components and therapist actions that are integral to the approach). Alongside ensuring the integrity and fidelity of the treatment services, the other set of measures required of course would be those that can measure important intended outcomes of the service. These can include pre-post intervention measures but, with new research focused on "outcome-informed service delivery" principles, should also include ongoing session-by-session assessment of both outcomes as well as client (family, child) satisfaction with services and with the therapist. This overall model just described is one we are currently using in a randomised controlled trial (RCT) that is evaluating a new intervention for conduct disorder and youth offending, funded since 2009 by the Department of Communities. I will be happy to talk in more depth about various principles and practices linked to this type of treatment and training model.

11. However, in terms of implementing such principles and practices in day-to-day settings, including those settings that work within the child protection system, there are a range of organisational "culture" and "climate" factors that have been identified as either getting in the

way of implementation or, alternatively, facilitating its implementation. As can be seen in the summary provided in Ronan, Canoy, & Burke (2009) (see Attachment 3), one generalised factor that appears to underpin a range of implementation and sustainability problems is dissemination that is done too hastily, without due regard for various culture (e.g., rigid policy and procedure environment that makes it difficult for treatment programs requiring flexibility to fit within) and climate factors (e.g., stressful work environment that creates an unwillingness to embrace a promising new intervention). Thus, an ideal implementation process would be done in a systematic manner by first doing an assessment of culture and climate factors (e.g., staff surveys; interviews with leadership and select staff) and then tailoring implementation with the assistance of organisational-level interventions to ensure a better fit between the intervention approach and the organisation's way of operating. Organisational-level interventions would be aimed at whatever culture and climate factors emerge as important. Thus, as a couple of examples, working with leadership to make more flexible some policies and procedures and working with leadership and staff to help reduce stressful work climates might be areas that, with improvement, can then help make more possible the successful implementation of a new evidence-supported program.

12. Thus, in addition to talking about the "what" of the intervention approaches as introduced above (i.e., intervention approaches that focus on both the young person directly but also on important family, and parenting, factors), I would like to provide testimony on these additional "how" factors (i.e., how do we best ensure that evidence-supported interventions and programs are implemented in such a way so as to produce clinically- and socially-significant outcomes as well as be sustained over the long-term in day-to-day child protection settings).

Declaration

This written statement by me dated October 2012 and contained in the pages numbered 1 to 4 is true and correct to the best of my knowledge and belief.

Kevin R Ronan Signature

Signed at Rockhampton this 2nd day of October 20 12

Witnessed:

Signature

Name Rebecca Louise Mau Rank Reg. No. 104875

Justice of the Peace (Qual)

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND GOVERNMENT Reg.No.: DEPT. OF JUSTICE & ATTORNEY-GENERAL

Witness signature: Officer signature:

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Kevin R Ronan Signature

Signed at Rockhampton this 2nd day of October 20 12

Witnessed:

Signature

Name Rebecca Louise Mau Rank Reg. No. 104875

Justice of the Peace (Qual)

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND GOVERNMENT Reg.No.: DEPT. OF JUSTICE & ATTORNEY-GENERAL

Witness signature: Officer signature:

ATTACHMENT 1

CURRICULUM VITAE

Updated January, 2012

Kevin Robert Ronan, Ph.D.

[redacted]

AFFILIATION:

Foundation Professor in Psychology
Chair in Clinical Psychology
School of Health and Human Services
Institute for Health and Social Sciences Research
CQUniversity Australia
Rockhampton QLD 4702
Australia
61-7-4930-6746
61-7-4930-6460 (fax)
k.ronan@cqu.edu.au

PERSONAL BACKGROUND:

[redacted]

WORK EXPERIENCE:

Deputy Speaker and Board Member, Queensland Board, Psychology Board of Australia, 2011 - .

International Faculty Affiliate, Centre for Disaster and Risk Analysis, Colorado State Univ, 2011- .

Australian Senate Submission and Evidence, Environment and Communications References Committee, Inquiry into the capacity of communication networks and emergency warning systems to deal with emergencies and natural disasters. Submission through Australian Psychological Society's Disaster Reference Group (which I chair). Evidence provided to committee (Hon Doug Cameron, Chair), August 8, 2011.

Complex Case Clinic Convenor, Child Safety (Rockhampton), 2010 – current.

Developer and Coordinator, Clinical Psychology Training Program, CQUniversity, 2010 - (selection of first cohort for this new program, November 2009).

Invited Member and Participant, Think Tank on Disadvantaged Youth, Department of Education, Employment and Workplace Relations (DEEWR), December, 2010.

Chair, Disaster Preparedness and Response Reference Group, Australian Psychological Society, 2010 - .

Invited Member, Towards a National Research Agenda for Protecting Australia's Children. Invited by the Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs (FAHCSIA), October 2009.

Member, Disaster Preparedness and Response Reference Group, Australian Psychological Society, 2008 - 2010.

Coordinator, Centre for Longitudinal & Preventative Health, Institute for Health and Social Sciences Research, CQUniversity, 2007 - .

Head of Department, Department of Behavioural and Social Sciences, CQUniversity, 2007 - 2008.

Fourth Year Program Coordinator, Psychology, CQUniversity, 2006 - 2008.

Convenor, Practice and Service Delivery Section, Australian Child and Adolescent Trauma, Loss and Grief Network (a Commonwealth initiative), 2008 - 2009.

Member, Queensland Child Safety Innovators Research and Practice Advisory Group, 2008 - 2009.

Member, National Mental Health Disaster Taskforce, Child and Adolescent Working Group, 2007 - .

Member, National Mental Health Disaster Taskforce, Expert Working Group, 2009 - .

Member, Australian Child and Adolescent Trauma, Loss and Grief Network (a Commonwealth initiative), 2008 - .

Member, Expert Panel, Mental Health First Aid Guidelines for Traumatic Events,

ORYGEN Research Centre, University of Melbourne, 2007 - .

Organising Committee, Australasian Natural Hazards Management Conference, Brisbane, July, 2007.

Research Affiliate , Joint Centre for Disaster Research, Massey University, 2005-.

Director of Clinical Psychology Training, Massey University, overall head of three campus training programme, 1999 – 2002, 2004.

Director of Clinical Psychology Training, Massey University, Turitea Campus Programme, 1999 – 2005.

Senior Clinical Psychologist, Massey University Psychology Clinic, practice and supervision, 1997- 2005.

Member, Governance Advisory Panel, Stages 1-3 of Treatment Services for Severe Conduct Disorder, New Zealand Child, Youth and Family; Capital and Coast District Health Board, 2004 – 2008.

Consultant, Ministry of Social Development, Development of national inter-agency plan for treatment of severe conduct disorder, 2005 – 2007.

Consultant, Ministry of Health (New Zealand), Development of a national psychosocial recovery from disasters plan, 2004 – 2006.

Consultant, Member of Expert Panel, Development of High Level Specifications for Stages 1-3 of a Programme for Severe Conduct Disorder in Youth, New Zealand Child, Youth and Family, 2000 – 2003.

Consultant, New Zealand Child, Youth, and Family, Juvenile Justice Services, 2000 - 2008.

Consultant, Department of Corrections, Prison and Youth Justice Programmes, 1998-1999, 2002 - 2003.

Consultant, New Zealand Armed Forces, Post-deployment debriefing; critical incident assistance provider; employee's assistance therapy provider; 1998 - 2005.

New Zealand representative (nominated by NZ Ministry for Research, Science, and Technology in 1999, see below), APEC-related conference hosted by the National Science and Technology Program for Hazards Mitigation, Taiwan, June, 2001.

New Zealand representative (nominated by NZ Ministry for Research, Science, and Technology), APEC-related conference hosted by the National Science and Technology Program for Hazards Mitigation, Taiwan, July 1999.

Scientific Programme Coordinator, Cities on Volcanoes II, Auckland (NZ), 2001 (Jointly sponsored by International Association of Volcanology and Chemistry of the Earth's Interior (IAVCEI), Massey University, University of Auckland, Institute for Geological and Nuclear Sciences, Auckland Regional Council), 1998 - 2001.

Member, Cities of Volcanoes Board of Trustees, 1998 - 2001.

Member, New Zealand Director of Clinical Psychology Training Programme Committee (Chair: Professor Ian Evans, Waikato University), 1999 - 2002, 2004.

Consultant, New Zealand Ministry of Education, Assessment of Implementation of Prototype for Children with Severe Behaviour Problems. 1998.

Consultant, Institute Of Geological and Nuclear Sciences (New Zealand), Assessment of Hazards Education for Children in the Auckland Region. 1996 - 1997. Rapid Response Following Natural Hazards, 1998 - 2005.

Senior Lecturer, Massey University, 1997-1999.

Lecturer, Massey University, 1995-1997.

Facility Director, Butner Adolescent Treatment Center, North Carolina (USA) Willie M. Services, Butner, NC, 1993-1995. (N.C. Willie M Head: Marci White; Assistant Director: Charles Davis).

Private Practice, Oberlin Road Pediatrics Group, Raleigh, NC Working as independent contractor with children, adolescents, adults, and families (North Carolina Licensed Psychologist #1958), 1994-1995.

Consultant, Brunswick Hospital, Adolescent Treatment Services, Supply, NC 1994 - 1995. (David LeMay, Director).

Staff Clinical Psychologist, Napa State Hospital, Napa, CA: Assessment, Treatment, Research, Consultation, Inpatient and Forensic Services, 1991-1993 (Chief of Psychology: Loren Corotto, Ph.D.).

Employee's Assistance Therapist, Napa State Hospital: 1991 - 1993. (Coordinator, Loren Corotto, Ph.D.).

Program Development and Evaluation, Innovative Psychosocial Rehabilitation Services for the Persistently and Chronically Mentally Disabled (Wellspring), Napa State Hospital, Napa, CA, 1992 - 1993 (Project Director, Paula Garcia, R.N.).

Acting Chief, Psychology Services, Napa State Hospital, Napa, CA, December, 1992 - January, 1993.

Behavioral Consultation Hospital-Wide Consultant, Napa State Hospital, 1992 - 1993.

Clinical Psychology Intern, Napa State Hospital, Napa, CA, 1990 - 1991. (Director of Training, Steve Priebe, Ph.D.).

Consultant, Elkins Park Middle School, Elkins Park, PA. Stress Management Program, August, 1989 - 1990. Albert Trautwein, Director.

Project Coordinator, Child and Adolescent Anxiety Disorders Outcome Study, NIMH RO1 funded study, Temple University, 1988 - 1990 (PI, Philip C. Kendall, Ph.D.).

Therapist, Child and Adolescent Anxiety Disorders Clinic, Temple University, 1988 - 1990 (Clinic Director, Philip C. Kendall, Ph.D.).

Research Assistant, Department of Psychology, Division of Clinical Psychology, Temple University, 1985 - 1989 (Advisor, Philip C. Kendall, Ph.D.).

Practicum Placement, Testing and Therapy, Albert Einstein Medical Center, Philadelphia, PA, 1987 - 1988 (Supervisors: Terri Morris, Ph.D.; William Shapiro, Psy.D.).

Practicum Testing Placement, Temple University Hospital, March, 1986 - June, 1986 (Supervisor: Edmund Burke, Ph.D.).

Therapist/Counselor, Wediko Summer Program (simulated family systems/cognitive behavioral intervention with emotionally and behaviourally disturbed children and adolescents in the context of a 6 week camp program), Hillsboro, NH; June - August, 1987 (Supervisor, Lawrence Tucker, Ph.D.).

ATTACHMENT 2

Australian Psychologist, September 2009; 44(3): 143–145

EDITORIAL

Child maltreatment: Introduction to the Special Issue

On behalf of *Australian Psychologist* we would like to welcome you to a special issue focusing on child maltreatment. Similar to other countries, child abuse and neglect is a problem here in Australia. A recent estimate suggests that around 200,000 children in Australia in 2007 were subject to some form of abuse or neglect. A more upper bound estimate, however, suggests much higher numbers, over 500,000 (Taylor et al., 2008). Additionally, reported cases have grown substantially in some areas. For example, in New South Wales, reports rose by 79% between the 2001–2002 and 2006–2007 reporting periods (Australian Institute of Health and Welfare, 2008). That rise is coupled with indications that a good share of reports to child protection agencies may be identifying, and re-identifying, a small set of parents (Sammut & O'Brien, 2009):

> In NSW 2,100 dysfunctional, repeatedly reported families account for a quarter of the more than 300,000 reports made each year, and 7,500 of those dysfunctional families account for nearly half of all reports. (p. viii)

Thus, although mandatory reporting has no doubt underpinned an increase in reports, this kind of rise, coupled with indications that a small set of families are responsible for a large number of these reports, is cause for alarm.

Alongside these numbers, each individual child who is affected by abuse is at risk for a range of negative outcomes, including emotional and behavioural difficulties such as post-traumatic stress disorder (PTSD), externalising problems such as conduct disorder and longer-term outcomes. This includes an increased risk of intergenerational transmission of child maltreatment, an increased risk of adult victimisation and an increased risk of a range of antisocial and poor mental health outcomes, including both diagnosable disorders as well as subthreshold problems. Related to this latter category of "non-diagnosable" outcomes, the first article in this series by Carr and Francis (2009) addresses the link between child maltreatment and features of adult personality disorders (PD) in a non-clinical sample. That study evaluated the question of whether child maltreatment itself was a unique predictor of these PD features. That is, those authors assessed whether retrospective reports of maltreatment were confounded by current symptoms of anxiety or depression or by dysfunctional family environments during childhood. Their findings add to the literature that concerns itself with the multiplicity of risks and outcomes that abused and neglected children may experience. The authors discuss their findings in relation to both future research as well as clinical practice.

On the other side, research has also looked into the question of who is at risk for maltreating children over time. In relation to this issue, the second contribution to the special series by Ducat, Thomas, and Bloor (2009) focuses on matters related to sexual offending risk, including a brief review of incidence and risk for recidivism in the context of a study that addresses newspaper reporting trends linked to sexual offending. Finding an increase in reporting since the introduction of a sexual offender monitoring act in Victoria, the authors conclude that both the press and legislators have a role to play and both have a responsibility to pay attention to research evidence when reporting or considering legislation, respectively.

Given the overall incidence and prevalence of child maltreatment, and its associated risks, the question is what to do about it. There are of course a number of strategies that have been designed and tested for their ability to protect abused and neglected children, to reduce abuse-related impairment and to prevent the recurrence, and initial occurrence, of maltreatment. Two articles in this special series report on specific strategies. The first of these two is a study by Riggs, Augoustinos, and Delfabbro (2009) that focuses on foster care as an intervention designed to "protect and foster" children. That is, their study follows research here in Australia (Wise & Eggar, 2009) and overseas (see review by MacMillan et al., 2009) that has demonstrated that foster care can lead to benefits. What is not known, however, are precisely

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what types of fostering environments promote maximal outcomes for maltreated children. Some preliminary evidence suggests that promoting resilience through attachment-related and "belonging" strategies has promise. Drawing on data from a national study on foster care, these authors evaluate "how foster families enact forms of belonging that potentially work to ameliorate experiences of abuse among foster children" (p. 166; Riggs et al., 2009). Their findings contribute important information for those agencies who recruit, support and train foster carers. It is also important for policy discussions about how best to deal with those children coming from the small set of families that continue to be reported to child protection agencies over time (Sammut & O'Brien, 2009). That is, with child "best interest" as the criterion, well-intended family preservation interventions are not going to be in some children's best interests.

The second of the two intervention-focused studies focuses on an intervention designed to reduce PTSD-related impairment for children who have been abused (Feather & Ronan, 2009). This intervention draws from and is similar to models developed overseas, including those developed specifically for abuse-related trauma (Cohen, Mannarino, & Knudsen, 2005) as well as for more general forms of anxiety. In the latter category, this includes both our original "Coping Cat" cognitive behavioural therapy (CBT) 16-session intervention (Kendall et al., 1992; Ronan & Deane, 1998) as well as more recent variations, including those designed to be clinic-setting friendly (e.g., Girling-Butcher & Ronan, 2009). In this New Zealand research, the Trauma-Focused Cognitive Behavioural Therapy Program (TF-CBT) was subjected to two separate studies both of which used a multiple-baseline across-participants design. These studies evaluated the finalised treatment protocol that had been subjected to two previous piloting studies. The first of the two studies looked at its effectiveness across four abused children and as delivered by one of the developers. The second looked at its effectiveness as delivered by therapists other than the developers. Overall, this intervention appears to have promise as one intervention used in child protection and child mental health settings to help prevent long-term impairment in children. As the authors point out, however, it addresses only one area of risk, that of impairment to the child. It does not address other features such as child protection itself, including the risk of recurrence. Additionally, as discussed in this article, although the TF-CBT intervention was developed and tested in a child protection agency and thus has potential in these settings, it needs more in the way of randomised controlled trials and effectiveness study support, perhaps through partnerships between researchers and community agencies (Cline, Feather, Ronan, & Paradine, 2009).

One of the implications of this last point is that interventions in the field of child maltreatment need to be multi-faceted. Fortunately, a number of interventions across the various domains necessary have been developed in more recent years. For example, a fairly recent meta-analysis focused on psychological interventions for child maltreatment (Skowron & Reinemann, 2005) indicates that a growing number of interventions have been developed and tested, particularly over the past two decades. Thus, there now appears to be a number of intervention modalities internationally and locally that have evidence-informed promise and support. A number of these empirically supported interventions also focus on multiple risk and protective factors linked to the various problems associated with child maltreatment. Based on a child's best interests, there are interventions available for children best placed in foster care, interventions available to assist with family preservation, interventions for problems for the child following abuse and neglect and interventions for perpetrators of child abuse and neglect (MacMillan et al., 2009). That is the good news. In contrast, the not so good news is that systematic, long-term dissemination of evidence-supported services to prevent or reduce problems associated with child maltreatment has been slow to develop, including in Australasia, and rates of child maltreatment do not appear to be lessening.

The last article in this special series documents and reviews child maltreatment epidemiology and intervention, including research done here in Australia on epidemiology and intervention (Ronan, Canoy, & Burke, 2009). After first reviewing epidemiology, including documenting the extent of the problem here in Australia, this article goes on to review promising intervention practices. It also reviews recent research on problems linked to dissemination of innovative and evidence-informed services. One upshot from this review article is the identification of a number of interventions that have promise. A next step needs to focus on advocating for changes at political and policy levels as well as at the organisational and practice coalface. Of course, this would include as a first step advocating for evidence-informed policy decisions about interventions that are in children's best interests. Once done, then dissemination of these interventions using well thought out, long-term implementation strategies should be emphasised. Research in the United States has documented that innovative services tend to be implemented on a temporary basis, based on short-term funding packages, hasty dissemination that is

not well thought out, organisational resistance and other factors. In fact, that research found that such services tended to be discontinued within 5 years of initial implementation (Glisson et al., 2008).

Pending replication of this kind of research here in Australia, such findings implicate a number of changes to current implementation practices. This includes developing a longer term perspective, with support for best practice intervention and implementation practices coming first from the policy level and including support from across the political aisle. It also includes advocating for and implementing changes to organisational climates and cultures to emphasise environments that are increasingly receptive to evidence-informed innovation. This of course would include well thought out implementation of empirically supported interventions for families, foster carers and perpetrators. An important implication is that in addition to continuing to evaluate the effectiveness of interventions, a next step in research here in Australasia is to evaluate more systematically "implementation efficacy and effectiveness". Doing so can be one component in the larger effort designed to ensure that evidence-supported interventions do find their way from policy into real-life settings and, once there, are able to do the job (i.e., have documented effectiveness) over the long term. Of course, at a more local level, one of our strengths as a profession is our allegiance to a scientist–practitioner identity and to being open in our own practices to interventions that have been shown to work. Overall, there are an increasing number of evidence-supported interventions that have demonstrated capacity to reduce risk related to a number of outcomes related to child maltreatment. It is now increasingly the time for increased advocacy at both the practice as well as organisational and policy levels.

In welcoming you to this special issue, it is our hope that one outcome will be an increase in advocacy, research and practice that will help to reduce the various problems associated with child maltreatment in Australia.

Kevin R. Ronan
Institute of Health and Social Science Research
Department of Behavioural and Social Sciences
CQUniversity Australia, Rockhampton, Queensland
Australia
and
Jacqueline S. Feather
Department of Psychology
Auckland University of Technology, Auckland
New Zealand

References

Australian Institute of Health and Welfare. (2008). *Child protection Australia 2006–07. Child welfare series 43.* Cat. no. CWS 31. Canberra: Author.

Carr, S., & Francis, A. (2009). Childhood maltreatment and adult personality disorder symptoms in a non-clinical sample. *Australian Psychologist, 44,* 146–155.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse and Neglect, 29,* 135–145.

Cline, M., Feather, J. S., Ronan, K. R., & Paradine, K. (2009). *Treating abused traumatised children with trauma-focused cognitive behavioural therapy in regional Australia: A partnership between academia and community.* Manuscript in preparation.

Ducat, L., Thomas, S., & Bloor, W. (2009). Sensationalising sex offenders and sexual recidivism: The impact of the Serious Sex Offender Monitoring Act 2005 on media reportage. *Australian Psychologist, 44,* 156–165.

Feather, J. S., & Ronan, K. R. (2009). Trauma-focused CBT with maltreated children: Evaluation of a new treatment manual in a child protection setting. *Australian Psychologist, 44,* 174–194.

Girling-Butcher, R., & Ronan, K. R. (2009). Brief cognitive-behavioral therapy for children with anxiety disorders: Initial evaluation of a program designed for clinical settings. *Behaviour Change, 26,* 27–53.

Glisson, C., Landsverk, J., Schoenwald, S., Kelleher, K., Hoagwood, K. E., Mayberg, S., et al. (2008). Assessing the organizational social context (OSC) of mental health services: Implications for research and practice. *Administration and Policy in Mental Health, 35,* 98–113.

Kendall, P. C., Chansky, T. E., Kane, M. T., Kim, R. S., Kortlander, E., Ronan, K. R., et al. (1992). *Anxiety disorders in youth: Cognitive-behavioral interventions.* Needham Heights, MA: Allyn & Bacon.

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet, 373,* 250–266.

Riggs, D. W., Augoustinos, M., & Delfabbro, P. H. (2009). Role of foster family belonging in recovery from child maltreatment, *Australian Psychologist, 44,* 166–173.

Ronan, K. R., Canoy, D. F., & Burke, K. J. (2009). Child maltreatment: Prevalence, risk, solutions, obstacles. *Australian Psychologist, 44,* 195–214.

Ronan, K. R., & Deane, F. P. (1998). Anxiety disorders. In P. J. Graham (Ed.), *Cognitive behaviour therapy for children and families* (pp. 74–94). Cambridge, UK: Cambridge University Press.

Sammut, J., & O'Brien, T. (2009). Fatally flawed: *The child protection crisis in Australia.* CIS Policy Monograph 97. Sydney: Centre for Independent Studies.

Skowron, E., & Reinemann, D. H. S. (2005). Effectiveness of psychological interventions for child maltreatment: A meta-analysis. *Psychotherapy: Theory, Research, Practice, Training, 42,* 52–71.

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). *The cost of child abuse in Australia.* Melbourne: Australian Childhood Foundation and Child Abuse Prevention.

Wise, S., & Egger, S. (2009). *The looking after children outcomes data project: Final report.* Melbourne: Department of Human Services.

Therapist/Counselor, Wediko Summer Program, Hillsboro, NH; June - August, 1986 (Supervisor, Lewis Kruger, Ph.D.).

Assistant to Program Chair (Philip C. Kendall, Ph.D.), Association for the Advancement of Behavior Therapy Convention, Boston, 1987.

Research Assistant, Department of Psychology, University of Minnesota, 1982 - 1984 (Advisor: Steven D. Hollon, Ph.D.; Philip C. Kendall, Ph.D.)

COMMUNITY SERVICE (see also Professional Papers and Presentations section*):

Member, Perinatal and Infant Mental Health Advisory, Queensland Health, Brisbane, 2008 – 2009.

Member, Expert Panel, First Aid Guidelines Project for Traumatic Events, University of Melbourne, 2007 - .

Member, Attachment Informed Practice, Queensland Health, 2006 - 2007.

Member, Community Support Advisory Taskforce, Queensland Health, Rockhampton District Mental Health Service, 2005 - 2007.

Member, Steering Group, Centre for Advanced Engineering (Canterbury University, New Zealand), Risk Communication Project, 2003.

Member, New Zealand Schizophrenia Fellowship Awards Committee, 2000 - 2003.

Ronan, K. R. (1999). Schizophrenia and psychosocial rehabilitation in theory and practice. Public service consultancy (and presentation to staff scheduled for 8/99). Manawatu Accomodation and Sheltered Housing Trust (MASH).

Ronan, K. R. (1999). Dealing with disruptive callers. Public service consultancy (and presentation to staff 22/7/99), Youthline (Manawatu).

Ronan, K. R. (1998). Peer review of "A second step towards a strategy for responding to an eruption of the Auckland Volcanic Field." Proposal presented to Auckland Regional Council (by Environment and Business Group, Ltd).

Consultant, Milton Keynes ADD/ADHD Support Group, Milton Keynes, Bucks, United Kingdom. 1998 - 2000 (Monica Harris, Chairperson).

Consultant, New Zealand National Health Committee, New Zealand Ministry of Health, Development of guidelines for the treatment of anxiety by primary health care professionals. 1997 - 1998 (Emma Sutich, Clinical Psychologist, Analyst).

Organizing Committee, 1997 National Conference of the New Zealand Psychological Society, Palmerston North, 1996 - 1997.

Research Advisory Consultant, New Zealand Specific Learning Disability Association (SPELD), 1995 - 1996. (National President: Shirley Millward; Local Administrative Officer: Elizabeth Manson).

Ronan, K. R. & Johnston, D. M. School-based early intervention programme following volcanic (Mount Ruapehu) eruptions. Waiouru Primary School, December, 1995.

Ronan, K. R. & Johnston, D. M. School-based early intervention programme following volcanic (Mount Ruapehu) eruptions. Ohakune, Primary School, December, 1995.

Ronan, K. R. & Johnston, D. M. School-based early intervention programme following volcanic (Mount Ruapehu) eruptions. Raetihi Primary School, December, 1995.

Consultant, Parentline Manawatu, 1997 - present. Consulting on evaluation of programmes and interventions (Kathy Carmichael, Coordinator)..

Consultant, Manawatu (NZ) Specific Learning Disabilities Association (SPELD), 1995- present. Development of guidelines for parents of children with (a) Attention-Deficit Hyperactivity and (b) anxiety and depression (see publications) (Elizabeth Manson, Administrative Head).

Consultant, Ohakune Primary School, Vertical integration of classes, (Ellen Gould, Principal), 1997.

Consultant, Parent Support Group, Otaki (NZ), Dealing with disruptive youth (Chris Upjohn). 1997.

Advisor, Standards Committee, New Zealand Specific Learning Disabilities Association (SPELD), 1996 - 1997.

Consultant: Parent Support Group: Attention-Deficit Disordered Children, SPELD, Palmerston North, New Zealand, October, 1995 - 1996.

* Multiple media interviews and presentations to community groups in U.S., New Zealand and Australia on working with disorders of childhood and adolescence (see Presentations section).

FUNDING EXPERIENCE:

EXTERNAL FUNDING:

Queensland Department of Communities, $528 846, Youth at Risk for Antisocial Outcomes in Hard to Reach Families: A Randomised, Controlled Trial ($516 750) + CQUniversity top up funding (EERF, $12,096 cash)), 2009 – 2012.

Public Good Science Fund, Foundation for Science, Research and Technology, $200,000 (as part of $3.066 million total). Subcontract as part of Society's Readiness and Response to Hazards (with Institute of Geological and Nuclear Sciences (NZ)), 2004 – 2013.

Queensland Centre for Social Science Innovation, $100 000. Being prepared for and recovering from disaster: Working with parents to build resilience in children and in the family unit (with Vanessa Cobham & Matthew Sanders, University of Queensland), 2012-2013.

The Thomas Foundation, $105 000. Evaluation of the Provision of Personal Support Services by Australian Red Cross during the Queensland floods, 2010-2011 (with Australian Red Cross). 2011-2012.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Successful tender application of team of 5 from CQU for FaHCSIA Expert Panel/Preferred Supplier in Social Policy Research Services, 2012-2015.

Albany Strategic Research Fund (Massey University), $20,000, Prospective treatment outcome Evaluation (part of the Cognitive Therapy Homework Project) (with Nikolaos Kazantzis & others), 2005 - 2006.

Ministry of Social Policy, $50,000. Evaluation of a programme for severe conduct disorder (Youth Horizons Trust), 2001 - 2003.

New Zealand Earthquake Commission, $48,500, Developing a model to predict natural hazard reduction and preparatory adjustments, 2001-2002.

Public Good Science Fund, NSOF Research Grant, $90,000, Community vulnerability and preparedness for earthquake

hazards in the Hawkes Bay (with D. Paton, Massey, and D. Johnston, Institute of Geological and Nuclear Sciences), 1998 - 2000.

Public Good Science Fund, Foundation for Science, Research and Technology, $108,000 (part of an overall $4.5 million funding package, 1998-2004). Subcontract on Hazards and Society (with Institute of Geological and Nuclear Sciences (NZ)), 1998 - 2004.

New Zealand Earthquake Commission, $29,622. A Community's Understanding of Earthquake Risk in the Manawatu, 1998 - 1999.

New Zealand Ministry of Education, $10,000. Assessment of prototype programme for students with severe learning and behavioural difficulties, 1998.

Institute of Geological and Nuclear Sciences, $4500. Development of a Rapid Response Assessment for Major Disasters. 1998.

Auckland Regional Council/Auckland City Council, $23,000. Children's Risk Perceptions and Prepardness: Evaluation of the Effects of Hazard Education Programmes, 1996-1997.

Palmerston North Medical Research Foundation, $3101, The effects of intersession assignments in the treatment of mental illness (with Frank Deane and Nik Kazantzsis).

National Institute of Mental Health, RO1 Grant (Grant # MH44042), 1989 - 1992. Development of cognitive-behavioral therapy for anxious children, $332,310, Temple University (PI: Philip C. Kendall, Ph.D.). Project Coordinator of clinical research team that received NIMH grant funds to evaluate a new CBT program for anxiety disorders in children and adolescents.

Grants Applied For, 1996 – 2007 (Illustrative List): Marsden Fund; Health Research Council; Lottery Health Funding; Public Good Science Foundation, Australian Research Council, National Health and Medical Research Council (complete list available upon request).

INTERNAL FUNDING (Illustrative Listing):

Enhancing External Research Funding Grant, Institute for Health and Social Sciences Research (CQUniversity), $12, 096, Treatment for

Children and Youth at Risk for Long-Term Antisocial Outcomes in Hard to Reach Families: A Randomised, Controlled Trial, 2009-2010.

Population Research Grant Scheme, Hazards Perception and Preparedness Survey, Central Queensland Social Survey, $10,000. October, 2005.

Massey University Research Fund, Ruapehu research, Fall, 1996.

Graduate Research Fund: Funding for multiple graduate student projects (Master's and Ph.D. projects), 1996, 1997, 1998, 1999, 2000, 2001, 2002 (Listing available upon request).

Summer Assistanceship Funds, Seed for research: Massey University, 1995 – 1996; 2001-2002; 2002-2003.

Massey University Research Fund, Treatment of comorbid childhood disorders, July, 1995.

Massey University Research Equipment Fund, Dimensions of childhood disorders, 1995.

Massey University/Psychology Department Start-Up Funding, 1995.

TEACHING EXPERIENCE:

Course Coordinator and Instructor, Assessment I, CQUniversity, (Master of Clinical Psychology Course), 2010 – .

Course Coordinator and Instructor, Clinic Team II-IV, CQUniversity, (Master of Clinical Psychology Course), 2010 – .

Course Coordinator and Instructor, Therapy II: Theory, Research and Practice, CQUniversity, (Master of Clinical Psychology Course), 2010 – .

Course Coordinator and Instructor, Central Queensland University, Advanced Psychological Assessment (Fourth Year Course), 2005 – current.

Course Coordinator and Instructor, Abnormal Psychology, (Third Year Course), 2006 – 2007.

Course Coordinator and Instructor, Massey University, Psychotherapy: Theory, Research, and Practice (Graduate level), 1998 - 2004.

NB. Was highlighted by the external assessor of our graduate programme in 2003 as the course that provided the most comprehensive feedback to students (teacher rating from students in 2003 also averaged between 4.8/5 – 5/5; ratings available upon request).

Course Controller , Abnormal and Therapeutic Psychology (extramural), revision of entire course initially taught Fall, 1996 (1997-2001).

Instructor, Therapy and Counselling (Graduate level course), 1996-1997.

Invited Lecturer, Child and Family Psychology (Graduate level course), 1996 - current.

Invited Lecturer, Approaches to Assessment (undergraduate), Massey University, 1995 -1997.

Invited Lecturer, Developmental Psychology (internal and extramural lectures), Massey University, 1995.

Invited Lecturer, Behavioral Disorders, Massey University College of Education, 1996-1998, 2000.

Instructor, Abnormal and Therapeutic Psychology, Massey University, 1995- current.

Instructor, Cognitive Development, Affect, and Therapy Series. Intern Training Seminars, Napa State Hospital, 1991 - 1993.

Instructor, Introduction to Psychopathology, Temple University, Fall, 1989.

EDITORIAL AND REVIEW EXPERIENCE:

Associate Editor, *Journal of Applied Volcanology*, 2011 – current.

Editorial Board, *Australasian Journal of Disaster and Trauma Studies,* _1997 – current.

Registered Reviewer, *Analyses of Social Issue and Public Policy*, 2012 - .

Invited Reviewer, *Natural Hazards*, 2011 – 2012.

Invited Reviewer, *Risk Analysis*, 2002 – 2012.

Invited Reviewer, *Disaster Prevention and Management*, 2010 – 2012.

Invited Reviewer, *Studies in Learning, Evaluation, Innovation and Development*, 2012.

Invited Reviewer, Australasian Higher Education Evaluation Forum (AHEEF) submissions, 2012.

Invited Reviewer, *Journal of Environmental Psychology,* 2011.

Invited Reviewer, New Zealand Health Research Council, Grant Application, 2011.

Guest Editor (with Jackie Feather), *Australian Psychologist,* special issue on child maltreatment, 2009.

Invited Reviewer, *Children, Youth, and Environments,* 2008.

Invited Reviewer, *Child and Adolescent Mental Health*, 2008.

Invited Reviewer, *Journal of Child Psychology and Psychiatry*, 2006 – 2011.

Reviewer, Lottery Health Funding Applications (NZ), 2007.

Reviewer, pre-press version of *Disorders of Childhood: An Australian Perspective (*in Ed. L. Rieger, *Abnormal Psychology: Leading Research Perspectives (1e).* Review requested by publisher (McGraw-Hill Australia, Hawthorn, Victoria), 2007.

Invited Reviewer, *Clinical Schizophrenia and Related Psychoses*, 2007.

Invited Reviewer, *Environmental Hazards*, 2007.

Guest Editor (with Nik Kazantzis), *Journal of Psychotherapy Integration,* special issue on homework in psychotherapy, 2006.

Reviewer, manuscript submissions, *Australian Psychologist*, 2005 -

Invited Reviewer, *Journal of Volcanology and Geothermal Research* (special issue on volcanic risk perception), 2006 – 2007.

Reviewer, Grant Applications, New Zealand Earthquake Commission, 2005 – 2006; 2008.

Invited Reviewer, *Journal of Family Psychology*, 2004.

Invited Reviewer, *Journal of Clinical Child and Adolescent Psychology*, 1996 – 2005.

Invited Reviewer, *Clinical Psychologist*, 2003 – 2007.

Invited Reviewer, *Social Behavior and Personality*, 2002.

Invited Reviewer, *Social Science and Medicine*, 2002.

Invited Reviewer, *Personality and Individual Differences*, 2003.

Invited Reviewer, New Zealand Health Research Council, Grant Application, 2001.

Invited Reviewer, *British Journal of Developmental Psychology*, 1999.

Reviewer, 12th World Congress on Earthquake Engineering, review submissions in the following areas: Human Behaviour, Risk Mitigation Strategies, Earthquake Preparedness, Emergency Response and Post-Event Recovery. 1998 - 1999.

Invited Reviewer, *Journal of Consulting and Clinical Psychology*, 1996 - 2001.

Invited Reviewer, *New Zealand Journal of Psychology*, 1997 - 2005.

Invited Reviewer, manuscript submissions, *Cognitive Therapy and Research*, 1991 - 1996.

Notes and Announcements Editor: *Cognitive Therapy and Research*, 1987 - 1991.

COMMITTEE WORK:

Chair, Curriculum Consultation Committee, School of Psychology, 2008 – 2010.

Committee Member, Academic Board, 2005 – 2008; 2012 - current.

Committee Member, Faculty Research Committee, 2005 – 2008.

Committee Member, Research Committee of Academic Board (RECAB), 2005 – 2008.

Committee Member and Convenor, Promotions Committee, Faculty of Science,

Engineering and Health, 2006.

Committee Member, School of Psychology Strategic Management Committee, 2004 – 2005.

Committee Member, Summer Assistance Funding Committee, 2002 - 2005.

Convenor: Selection Committee, Clinical Psychology Lecturer Position: 2001.

Committee Member, Graduate Studies Committee, 1997, 1999 - 2005.

Committee Member, Undergraduate Coordinating Committee, 1998 - 1999.

Committee Member, Finance Committee, Massey University, 1996 - 1999.

Committee Member, Executive Management Committee, Massey University, 1996 - 1998.

Committee Member, Assistant Lecturer Selection, Massey University, August, 1995.

Committee Member, Research Advisory Board, North Carolina Willie M. Services, October, 1993 - 1995.

Committee Member, Committee for the Protection of Human Subjects, Napa State Hospital, 1991 - 1993.

EDUCATIONAL BACKGROUND:

Harding High School
Saint Paul, Minnesota
Valedictorian
Degree received June, 1979

University of Minnesota
Minneapolis, Minnesota
Phi Beta Kappa
Bachelor of Arts (Psychology): June, 1984

Temple University
Philadelphia, PA
Masters Degree (Clinical Psychology): June, 1989
Doctoral Degree (Clinical Psychology): January, 1992

PUBLICATIONS:

Feather, J. & Ronan, K. R. (2012). *Cognitive behavioural therapy for child trauma and abuse* (Hebrew edition). Tel Aviv: Ach Publishing: in press.

Ronan, K. R. & Davies, G. (2012). Fourth interim report on progress and outcomes for funded project, "Treatment for Children and Youth at Risk for Long-Term Antisocial Outcomes in Hard to Reach Families." CQUniversity: Rockhampton and Department of Communities: Brisbane (April).

Ronan, K.R, Crellin, K., & Johnston, D. M. (2012). Community readiness for a new tsunami warning system: Quasi-experimental and benchmarking evaluation of a school education component. *Natural Hazards, 61(3),* 1411-1425.

Becker, J.S., Paton, D, Johnston, D. M., Ronan, K. R. (2012). A model of household preparedness for earthquakes: How individuals make meaning of earthquake information and how this influences preparedness. *Natural Hazards, 64(1)*, 107-137.

Scott, D., Burke, K., Williams, S., Happell, B., Canoy, D. Ronan, K.R. (2012). A comparison of chronic physical disorder prevalence and lifestyle behaviours in Australian adults with and without a previous diagnosis of mental illness. *Australian and New Zealand Journal of Public Health*: in press.

Ronan, K. R. & Davies, G. (2011). Third interim report on progress and outcomes for funded project, "Treatment for Children and Youth at Risk for Long-Term Antisocial Outcomes in Hard to Reach Families." CQUniversity: Rockhampton and Department of Communities: Brisbane (September).

Johnston, D. M., Ronan, K.R., Finnis, K., Leonard, G. S., & Forsyth, P. J. (2011). Children's understanding of natural hazards in Te Anau, New Zealand, following the 2003 earthquake. Lower Hutt (NZ): GNS Science. GNS Science report 2011/05. 18 p.

Ronan, K. R. (2011). Special report: Response and recovery after the floods. Interview with Professor Kevin Ronan. *InPsych: The Bulletin of the Australian Psychological Society, 33(1),* 26.

Feather, J. & Ronan, K. R. (2010). *Cognitive behavioural therapy for child trauma and abuse.* London: Jessica Kingsley.

Lewis, G & Ronan, K. R. (2010). Improving outcomes of cognitive behavioural therapy in the treatment of schizophrenia. *Psychotherapy in Australia, 16(4),* 70-76.

Ronan, K. R., Davies, G., & Canoy, D. (2010). Second interim report on progress and outcomes for funded project, "Treatment for Children and Youth at Risk for Long-Term Antisocial Outcomes in Hard to Reach Families." CQUniversity: Rockhampton and Department of Communities: Brisbane (October).

Ronan, K.R, Crellin, K., & Johnston, D. M. (2010). Correlates of hazards education for youth: A replication study. *Natural Hazards, 53(3)*, 503-526.

Ronan, K. R. (2010). Education and training for emergency preparedness. In P. Bobrowsky (Ed.), *Encyclopedia of natural hazards.* Springer: Heidelberg: in press.

Kazantzis, N., Calvert, S. J., Orlinsky, D. E., Rooke, S., Ronan, K. R., & Merrick, P. (2010). Professional development perceptions and activities of psychiatrists and mental health nurses in New Zealand. *New Zealand Medical Journal, 123*, 24-34.

Finnis, K. K., Johnston, D. M., Ronan, K. R., & White, J. D. (2010). Hazard perceptions and preparedness of Taranaki youth. *Disaster Prevention and Management, 19(2)*, 175-184.

Farrar, L., McDonald, E., Kenardy, J., & Ronan, K. R. (2010). *What works for children and young people after disasters? An evidence review.* Funded by Australian Government for Victorian Bushfire Support and Training for Affected Schools Project. Canberra: Australian National University.

Kazantzis, N., Calvert, S. J., Orlinsky, D. E., Rooke, S., Ronan, K. R., & Merrick, P. (2009). Professional development of New Zealand counsellors across the career. *New Zealand Journal of Counselling, 29(1),* 72-96.

Kazantzis, N., Dobson, K. S., Merrick, P. L., Leathem, J. L., Dattilio, F. M., Scott, J., Newman, F. L., Ronan, K. R., & Moss-Morris, R. (2010). Therapist adherence and competence in using homework assignments, patient homework compliance and homework beliefs, in cognitive behavior therapy for depression. World Congress of Behavior and Cognitive Therapies, Boston: in press.

Ronan, K. R. & Canoy, D. (2010). Interim report on progress and outcomes for funded project, "Treatment for Children and Youth at Risk for Long-Term Antisocial Outcomes in Hard to Reach Families." CQUniversity: Rockhampton and Department of Communities: Brisbane (March).

Ronan, K.R. & Feather, J. (2009). (Ed). Child maltreatment. Special issue of *Australian Psychologist, 44(3).*

Ronan, K. R. & Feather, J. (2009). Child maltreatment: Introduction to the special issue. *Australian Psychologist, 44(3)*, 143-145.

Ronan, K. R., Canoy, D., & Burke, K. J. (2009). Child maltreatment: Prevalence, risk, solutions, obstacles. *Australian Psychologist, 44(3),* 195-215.

Feather, J. & Ronan, K. R. (2009). Trauma-focused CBT with maltreated children: Evaluation of a new treatment manual in a child protection setting. *Australian Psychologist, 44(3)*, 174-194.

Girling-Butcher, R. & Ronan, K. R. (2009). Brief cognitive-behavioral therapy for children with anxiety disorders: Initial evaluation a program designed for clinical settings. *Behaviour Change, 26(1),* 27-53.

Curtis, N. M., Ronan, K.R., Heiblum, N., & Crellin. K. (2009). Dissemination and effectiveness of Multisystemic Treatment in New Zealand: A benchmarking study. *Journal of Family Psychology, 23(2)*, 119-129.

Kazantzis, N., Wakefield, A, Deane, F. P., Ronan, K. R., & Johnson, M. (2009). Public attitudes toward people with mental illness in New Zealand, 1995 – 1996. *Australian Journal of Rehabilitation Counselling, 15(2)*, 74-91.

Gowan, M. E., Johnston, D. M. Kirk, R. C., & Ronan, K. R. (2009*). Self-management of disaster risk and uncertainty: Evaluating a preventive health approach for building resistance to disaster*. Research report 2009/01. Wellington: Earthquake Commission.

Becker, J.S., Johnston, D., Paton, D., and Ronan, K. R. (2009*).* Community resilience to earthquakes: Understanding how individuals make meaning of hazard information and how this relates to preparing for hazards. *Proceedings of the 2009 New Zealand Society for Earthquake Engineering Conference (April 3-5).* Christchurch (NZ): New Zealand Society for Earthquake Engineering.

Feather, J. & Ronan, K. R. (2009). Safeguarding children in the primary care context: Assessment and interventions for child trauma and abuse. In Taylor, J. & Themessl-Huber, M. (Eds.), *Safeguarding children in primary care: A guide for practitioners working in community settings.* London: Kingsley Publishing.

Kazantzis, N. Calvert, S., Orlinsky, D.E., Merrick, P. L, & Ronan, K. R. (2009). Perceived professional development in psychological therapies: Comparing New Zealand, Canadian, and USA psychologists. *The Bulletin (NZ), 112*, 36- 47.

Lees, D. & Ronan, K.R. (2008). Engagement and effectiveness of parent management training (Incredible Years) for solo high risk mothers: A multiple baseline evaluation. *Behavior Change, 25(2),* 109-128.

Burke, K.J., Ronan, K., Lockie, S., Douglas, J., Happell, B., & Taylor, S. (2008). Collaboration to Develop Healthy Communities: Promoting Population health and

community sustainability. *AUCEA National Conference,* Sunshine Coast & Fraser Island, July 2008.

Ronan, K. R., Crellin, K., Johnston, D. M., Finnis, K., Paton, D., & Becker, J. (2008). Promoting child and family resilience to disasters: Effects, interventions, and prevention effectiveness. *Children, Youth, and Environments, 18(1)*, 332-353.

Moxon, A. & Ronan, K. R. (2008). Providing information to relatives and patients about expressed emotion and schizophrenia in a community support setting: A randomized, controlled trial. *Clinical Schizophrenia and Related Psychoses, 2(1),* 47-58.

Jack, S. J. & Ronan, K. R. (2008). Bibliotherapy: Research and practice. *School Psychology International, 29(2),* 161-182.

Ronan, K.R & Curtis, N. M. (2008). Interventions with antisocial youth and families. In VandeCreek, L. (Ed.), *Innovations in clinical practice: Focus on group, couples, and family therapy* (pp. 5-27). Sarasota: Professional Resource Press.

Becker, J., Johnston, D. M., Paton, D., & Ronan, K. R. (2008). Increasing community resilience to disasters: Understanding how individuals make meaning of hazard information, and how this relates to preparing for hazards. In C. Stewart (Ed.), *Proceedings of 2nd Australasian Natural Hazards Management Conference: From Warnings to Effective Response and Recovery.* Wellington, 28-31 July: Institute of Geological and Nuclear Sciences, *GNS Science Miscellaneous Series* 15.

Gowan, M., Kirk, R., Johnston, D. M., & Ronan, K.R. (2008). Integrating the affective domain into community outreach for motivating disaster preparedness. In C. Stewart (Ed.), *Proceedings of 2nd Australasian Natural Hazards Management Conference: From Warnings to Effective Response and Recovery.* Wellington, 28-31 July: Institute of Geological and Nuclear Sciences, *GNS Science Miscellaneous Series* 15.

Becker, J.S.; Johnston, D.M.; Coomer, M.A.; Ronan, K. 2008 Flood risk perceptions, education and warning in four communities in the Hawkesbury-Nepean Valley, New South Wales, Australia : results of a questionnaire survey, February 2006.Lower Hutt (NZ): GNS Science. GNS Science report 2008/02. 68 p.

Becker, J.S.; Johnston, D.M.; Ronan, K.; Coomer, M.A. 2008 Flood risk perceptions, education and warning in four communities in the Hawkesbury-Nepean Valley, New South Wales, Australia : data report for a follow-up questionnaire, April 2008.Lower Hutt (NZ): GNS Science. GNS Science report 2008/23. 51 p.

Finnis, K., Johnston, D., Becker, J., Ronan, K.R., Paton, D. (2007). School and community-based hazards education and links to disaster resilient communities. In I. Kelman (Ed.), *Earthquake safety of schoolchildren (special issue), Regional*

Development Dialogue (RDD), 28(2). Nagoya, Japan: United Nations Centre for Regional Development.

Kazantzis, N. Calvert, S., Staniforth, B., Merrick, P. L, Orlinsky, D.E.,., & Ronan, K. R. (2007). Professional Development of New Zealand Social Workers Who Engage in Psychotherapy: Perceptions and Activities. *Aotearoa New Zealand Social Work Review, Summer,* 16-31.

Kazantzis, N., Busch, R., Ronan, K. R., & Merrick, P. L. (2007). Using homework assignments in psychotherapy: Differences by theoretical orientation and professional training? *Behavioural and Cognitive Psychotherapy, 35, 121-128.*

Williams, M., Fletcher, R., & Ronan, K.R. (2007). Investigating the theoretical construct and invariance of a self-control scale using confirmatory factor analysis. *Journal of Criminal Justice, 35,* 205-218.

Becker, J.S.; Johnston, D.M.; Coomer, M.A.; Ronan, K. (2007) 2007 Flood risk perceptions, education and warning in four communities in New South Wales, Australia : data report for a follow-up questionnaire, September 2007.Lower Hutt (NZ): GNS Science. GNS Science report 2007/31. 57 p.

Becker, J.S.; Johnston, D.M.; Coomer, M.A.; Ronan, K. (2007). 2007 Flood risk perceptions, education and warning in four communities in New South Wales, Australia : results of a questionnaire survey, November 2005.Lower Hutt (NZ): GNS Science. GNS Science report 2007/30. 66 p.

Feather, J. & Ronan, K.R. (2006). Trauma-focused cognitive behavioural therapy for abused children with Post-traumatic Stress Disorder: A pilot study. *New Zealand Journal of Psychology, 35(3),* 132-145.

Johnston, D.; Becker, J.; Coomer, M.; Ronan, K. R.; Davis, M.; and Gregg, C. (2006). *Children's risk perceptions and preparedness: Mt Rainier 2006 hazard education assessment tabulated results.* Science Report (2006/16). Gracefield (NZ): Institute of Geological and Nuclear Sciences.

Donaldson, S. & Ronan, K. R. (2006). The effects of sport participation on children's emotional wellbeing. *Adolescence, 41,* 369-389.

Ronan, K.R. & Kazantzis, N. (2006). The use of between-session (homework) activities in psychotherapy: Conclusions from the *Journal of Psychotherapy Integration* Special Series. *Journal of Psychotherapy Integration, 16,* 254-259.

Kazantzis, N. & Ronan, K.R. (Eds). (2006). Homework in psychotherapy: Special series. *Journal of Psychotherapy Integration, 16.*

Kazantzis, N. & Ronan, K.R. (2006). Can between-session (homework) activities be considered a common factor in psychotherapy? *Journal of Psychotherapy Integration, 16,* 115-127.

Ronan, K.R., Finnis, K., & Johnston, D.M. (2006). Interventions with youth and families: A prevention and stepped care model. In G. Reyes & G. A. Jacobs (Eds.), *Handbook of International Disaster Psychology*. New York: Praeger/Greenwood Publishing.

Ronan, K.R. (2006). Background review: Part C of the Psychosocial Recovery from Disasters plan. Wellington (NZ): New Zealand Ministry of Health.

Ronan, K.R. & Johnston, D. M. (2005). *Promoting community resilience in disasters: The role for schools, youth, and families.* New York: Springer.

Kazantzis, N., Deane, F. P., Ronan, K.R., & L'Abate, L. (Eds.) (2005). *Using homework assignments in cognitive behavior therapy*. New York: Routledge.

Kazantzis, N., Deane, F.P., Ronan, K.R., & Lampropoulos, G. K. (2005). Empirical foundations. In Kazantzis, N., Deane, F. P., Ronan, K.R., & L'Abate, L. (Eds.), *Using homework assignments in cognitive behavior therapy*. New York: Routledge.

Kazantzis, N., Deane, F.P., & Ronan, K.R. (2005). Assessment of homework completion. In Kazantzis, N., Deane, F. P., Ronan, K.R., & L'Abate, L. (Eds.), *Using homework assignments in cognitive behavior therapy*. New York: Routledge.

Kazantzis, N., Deane, F.P., Ronan, K.R., & L'Abate, L. (2005). Summary and conclusions. In Kazantzis, N., Deane, F. P., Ronan, K.R., & L'Abate, L. (Eds.), *Using homework assignments in cognitive behavior therapy*. New York: Routledge.

Blissett, W., Ronan, K. R., Mar, M. & McGeorge, P. (2005). *Programme for Severe Conduct Disorder: High Level Specifications*. Wellington (NZ): New Zealand Child, Youth and Family, Youth Justice.

Johnston, D, Paton, D., Crawford, G., Ronan, K.R., & Houghton, B., & Burgelt, P. (2005). Measuring tsunami preparedness in coastal Washington, United States. In E.N.Bernard (Ed.), *Developing tsunami-resilient communities: The National Tsunami Hazard Mitigation Program*. New York: Springer.

Ronan, K.R. (2005). Models of madness: Psychological, social and biological approaches to schizophrenia: Book review. *New Zealand Journal of Psychology, 34,* 199-200.

Johnston, D.M., Ronan, K.R., Becker, J., Gregg, C., & Davis, M. (2005). *Children's risk perceptions and preparedness: Mount Rainier 2005 hazard education assessment tabulated results*. Science Report (2005/029). Gracefield (NZ): Institute of Geological and Nuclear Sciences.

Johnston, D, Paton, D., Crawford, G., Ronan, K.R., & Houghton, B., & Burgelt, P. (2005). Measuring tsunami preparedness in coastal Washington, United States. *Natural Hazards, 35,* 173-184.

Curtis, N. M., Ronan, K.R., & Borduin, C. (2004). Multisystemic Treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18,* 411-419.

Vilke, M. & Ronan, K.R. (2004). Integration of Substance Abuse Treatment into Schools – Would it Work? In Adamson S.J. & Sellman, J.D. (Eds.) New Zealand Treatment Research Monograph, Alcohol, Drugs and Addiction. Research Proceedings from the Cutting Edge Conference, September 2004.

Feather, J. & Ronan, K.R. (2004). *Trauma-focused therapy programme for abused children: A treatment manual*. Massey University: Authors.

Ronan, K.R. (2003). *Massey University Clinical Psychology Training: Field supervisor update* (2 issues per year). Massey University: Author.

Kazantzis, N., Deane, F. P., Ronan, K. R. (2004). Assessing compliance with homework: Review and recommendations for clinical practice. *Journal of Clinical Psychology*, 1-15.

Johnston, D., Houghton, B., Ronan, K. and Paton, D. (2004). Children's risk perceptions and preparedness: a hazard education assessment in four coastal communities in Washington, USA - tabulated results. *Institute of Geological & Nuclear Sciences science report* 2004/26. 25pp. Wellington (NZ): author.

Finnis, K., Standring, S., Johnston, D., & Ronan, K. (2004). Children's understanding of natural hazards in Christchurch, New Zealand. *Australian Journal of Emergency Management, 19*, 11-20.

Ronan, K.R. & Johnston, D. M. (2003). Hazards education for youth: A quasi-experimental investigation. *Risk Analysis, 23,* 1009-1020.

Ronan, K.R.(2003). *Massey University Clinical Psychology Training: Field supervisor update* (2 issues per year). Massey University: Author.

Saville-Smith, K., Warren, J., Ronan, K.R., & Salter, D. (2003). *Evaluation report of the Youth Horizons Trust SCD (Severe Conduct Disorder) Programme*. Report prepared for the New Zealand Ministry of Social Development, August.

Ronan, K.R. (2003). *Outcome and fidelity evaluation of the Youth Horizons Trust Programme for severe conduct disordered youth*. Report prepared for the Ministry of Social Development (New Zealand), July.

Paton, D., Ronan, K.R., Johnston, D. M., Smith, L., & Johnson, M. (2003). Responding to earthquake hazards: promoting household resilience and preparedness. *Proceedings of 2003 Pacific Conference on Earthquake Engineering* (Paper no. 166).

Paton, D., Smith, L., Johnston, D. M., Johnson, M., & Ronan, K.R. (2003). *Developing a model to predict the adoption of natural hazard risk reduction and preparatory adjustments.* Earthquake Commission Research Project Number 01-479: Wellington (NZ).

Curtis, N., Ronan, K.R., Heiblum, N., Reid, M., & Harris, J. (2002). Antisocial behaviours in New Zealand youth: Prevalence, interventions and promising new directions. *New Zealand Journal of Psychology, 31*, 53-58.

Morrison, N. & Ronan, K.R. (2002). Assessment of core competency status and work environment of residential mental health support workers. *Australian Journal of Rehabilitation Counselling* , 8, 2, 114-126.

Ronan, K.R.(2002). *Massey University Clinical Psychology Training: Field supervisor update* (2 issues per year). Massey University: Author.

Huzziff, C.A. & Ronan, K. R. (2002). *Exposure based therapy for anxiety disorders in children: A treatment manual.* Massey University: Authors: in press.

Girling-Butcher, R. & Ronan, K. R. (2002). *Brief cognitive-behavioural therapy for anxious children: The Coping Kiwi treatment manual (2nd edition).* Massey University: Authors.

Kazantzis, N., Ronan, K. R., & Deane, F. P. (2002). Concluding causation from correlation: Comment on Burns and Spangler (2000). *Journal of Consulting and Clinical Psychology, 69*, 1079-1083.

Ronan, K.R. & Johnston, D. M. (2001). Correlates of hazard education programs for youth. *Risk Analysis, 21*, 1055-1063.

Johnston, D., Paton, D., Driedger, C., Houghton, B., Ronan, K. R. (2001). Student perceptions of hazards at four schools near Mount Ranier, Washington, USA. *Journal of American Society of Professional Emergency Planner, 7*, 41-51.

Ronan, K.R. & Johnston, D. M. (2001). Hazards education in schools: Current findings, future directions. *Proceedings of the APEC Workshop on Dissemination of*

Disaster Mitigation Technologies for Humanistic Concerns (Phase I: Earthquake Disaster). Taipei, Taiwan: National Science and Technology Program for Hazards Mitgation (National Taiwan University).

Ronan, K. R., Johnston, D. M., Daly, M., & Fairley, R. (2001). School children's risk perceptions and preparedness: A hazards education survey. *Australasian Journal of Disaster and Trauma Studies, 1* (on-line peer reviewed journal URL http://massey.ac.nz/~trauma/).

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2002). Study of Systematic Homework Administration: Research Manual for Therapists at Waitemata District Health Board Cognitive Therapy Center (Cognitive Therapy Center Research Programme. Vol 1). Albany, New Zealand: Massey University, School of Psychology: in press.

Johnston, D. M., Driedger, C., Houghton, B., Ronan, K. R., & Paton, D. (2001). *Children's risk perceptions and preparedness: A hazard education assessment in four communities around Mount Rainier, USA - preliminary results.* Institute of Geological and Nuclear Sciences Science Report, 2001/02.

Ronan, K. R., Johnston, D. M., & Paton, D. (2001). Communities' understanding of earthquake risk in the Hawkes Bay and Manawatu-Wanganui regions, New Zealand. *Proceedings of NZ Society for Earthquake Engineering 2001 Conference*, (Paper number 1.03.01, 1-9).

Paton, D., Ronan, K.R., Johnston, D.M., and Houghton, B.F. (2000) Mitigating Volcanic Hazard Effects: Integrating psychological and geological perspectives. *Psychomedia, Mental Health and Communication, 5,* (February), {Online Serial], URL http://www.psychomedia.it/pm/grpind/social/paton.htm

Paton, D., Ronan, K.R., Johnston, D.M., Houghton, B.F., and Pezzullo, L. (2000) La Riduzione del Rischio Vulcanico: Integrare le prospettive psicologiche e geologiche. *Psychomedia, Mental Health and Communication, 5,* (May), {Online Serial], URL http://www.psychomedia.it/pm/grpind/social/paton-it.htm

Ronan, K. R., Paton, D. Johnston, D. M., & Houghton, B. F. (2000). Managing societal uncertainty in volcanic hazards: A multidisciplinary approach. *Disaster Prevention and Research, 9*, 339-348.

Moxon, A. M. & Ronan, K. R. (2000). The effectiveness of a brief psychoeducation programme for families. *Schizophrenia Research Newsletter, 1*, 4-5.

Johnston, D. M., Houghton, B. F., Neall, V.E., Ronan, K. R., & Paton, D. (2000). Impacts of the 1945 and 1995-1996 Ruapehu eruptions, New Zealand: An example of increasing societal vulnerability. *Geological Society of America Bulletin, 112*, 720-726.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments effects in psychotherapy: A meta-analytic review. *Clinical Psychology: Science and Practice, 7*, 189-202.

Johnston, D. M. & Ronan, K. R. (2000). Risk education and intervention. In *Encyclopedia of volcanoes* (H. Siggurdsson, Ed.). New York: Academic Press.

Babbage, D. & Ronan, K. R. (2000). Philosophical worldview and personality factors in traditional and social scientists: Studying the world in our own image. *Personality and Individual Differences, 28,* 405-420.

Ronan, K. R. & Johnston, D. M. (1999). Behaviourally-based interventions for children following volcanic eruptions: An evaluation of effectiveness. *Disaster Prevention and Management: An International Journal, 8*, 169-176.

Girling-Butcher, R. & Ronan, K. R. (1999*). Brief cognitive-behavioural therapy for anxious children: The Coping Kiwi treatment manual.* Massey University: Authors.

Girling-Butcher, R. & Ronan, K. R. (1999). *Brief cognitive-behavioural therapy for anxious children: The Coping Kiwi workbook.* Massey University: Authors.

Ronan, K. R., Paton, D. Johnston, D. M., & Houghton, B. (1999). Hazards readiness and recovery: A multidisciplinary perspective. In *Proceedings of the Community Awareness and Hazards Mitigation Learning Workshop* (Edited by the Office of National Science and Technology Program for Hazards Mitigation). Taipei: National Science Council, Republic of China.

Kazantzis, N, Deane, F. P., & Ronan, K. R. (1999). *The effects of intersession assignments in the treatment of mental illness*. Report to the Palmerston North Medical Research Council. Massey University: Authors.

Paton, D., Johnston, D., Houghton, B., Ronan, K. R., Scott, B. (1999). Managing natural hazard consequences: Planning for information management and decision making. *Journal of the American Society of Professional Emergency Planners, 6*, 37-48.

Ronan, K. R. (1999). Children, trauma, and disasters (Introduction to special section. *Australasian Journal of Disaster and Trauma Studies, 3*. (on-line peer reviewed journal URL http://massey.ac.nz/~trauma/).

Huzziff, C. A. & Ronan, K. R. (1999). Prediction of children's coping following a natural disaster - the Mount Ruapehu eruptions: A prospective study. *Australasian Journal of Disaster and Trauma Studies, 3.* (on-line peer reviewed journal URL http://massey.ac.nz/~trauma/).

Ronan, K. R. (1999). Cognitive-behavioural counselling and children. *New Zealand Journal of Counselling, 20*, 84-91.

Huzziff, C. A. & Ronan, K. R. (1999). Anxiety disorders in childhood and adolescence. In H.van Bilsen (Ed.), *Focusing the mind: Effective and innovative interventions in counselling and psychotherapy*. Wellington (NZ): Central Institute of Technology.

Ronan, K. R., Johnston, D. M., & Hull, A. (1998). *A community's understanding of earthquake risk in the Manawatu*. Technical report prepared for the New Zealand Earthquake Commission.

Jack, S. & Ronan, K. R. (1998). Sensation seeking among high- and low-risk sports participants. *Personality and Individual Differences, 25*, 1063-1083.

Ronan, K. R., Kendall, P. C., & Rowe, M. (1998). *Negative Affect Self-Statement Questionnaire* (ONLINE). (CD-ROM). Abstracts from: OVID Technologies. Pittsburgh: Health and Psychosocial Instruments (HaPI).

Ronan, K. R. & Deane, F. P. (1998). Anxiety disorders. In P. Graham, (Ed.). *Cognitive behaviour therapy for children and families: Cambridge monograph series in child and adolescent psychiatry* (pp. 74-94). Cambridge: Cambridge University Press.

Ronan, K. R. (1998). *Anxiety and depression in youth: Information for teachers and parents*. Palmerston North: SPELD Manawatu.

Long, N. R., Ronan, K. R., & Perreira-Laird, J. (1998). Victims of disaster. In N. N. Singh (Ed.), *Comprehensive clinical psychology: Applications in diverse populations*. New York: Pergamon Press.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (1998). *Homework in the treatment of adult disorders: A treatment manual for therapists in general outpatient centers* (The Study for Homework in Psychotherapy. Vol 2). Palmerston North, New Zealand: Massey University, School of Psychology.

Kazantzis, N., Ronan, K. R., & Deane, F. P. (1998). *Homework in the treatment of adult disorders: A training packet for therapists in general outpatient centers* (The Study for Homework in Psychotherapy. Vol 4). Palmerston North, New Zealand: Massey University, School of Psychology.

Moxon, A. M. & Ronan, K. R. (1998). *Providing information to relatives about expressed emotion and schizophrenia: An intervention manual.* Massey University: Authors.

Ronan, K. R. & Kendall, P. C. (1997). Self-talk in distressed youth: States-

of-mind and content specificity. *Journal of Clinical Child Psychology, 26*, 330-337.

Ronan, K. R. (1997). The effects of a series of volcanic eruptions on emotional and behavioural functioning in children with asthma. *New Zealand Medical Journal, 110*, 11-13.

Ronan, K. R. (1997). The effects of a "benign" disaster: Symptoms of posttraumatic stress in children following a series of volcanic eruptions. *Australasian Journal of Disaster and Trauma Studies, 1*(on-line peer reviewed journal URL http://massey.ac.nz/~trauma/).

Ronan, K. R. (1997). Reducing stress in working with PTSD clients: The value of a practitioner's guidebook. Review of: *Treating post-traumatic stress disorder: A handbook and practice manual for therapy*.(D. Meichenbaum (1997)). John Wiley: Brisbane. *Australasian Journal of Disaster and Trauma Studies, 3* (on-line serial URL http://massey.ac.nz/~trauma/).

Ronan, K. R. & Johnston, D. M. (1997). *Auckland school children's risk perceptions and preparedness: Hazards education survey*. Technical report prepared for Auckland Regional Council/Auckland City Council.

Ronan, K. R. (1996). Bridging the gap in childhood anxiety assessment: A practitioner's resource guide. *Cognitive and Behavioral Practice, 3*, 63-90.

Ronan, K. R. (1996). Cognitive behavioral practice in pediatric primary care. *The Behavior Therapist, 19*, 44-45.

Ronan, K. R. (1996). Cognitive behavioural assessment of childhood anxiety: A practical guide. *NZ Psychological Society Bulletin (Dec.),* 14-17.

Ronan, K. R. & Johnston, D. M. (1996). The impact of volcanic eruptions on childhood emotional functioning. *Proceedings of the Pan Pacific Hazards '96 Conference, 1 (CD-ROM)*. Vancouver: University of British Columbia.

Johnston, D. M., Ronan, K. R., & Houghton, B. F. (1996). The physical and social impacts of the 1995 Ruapehu eruption, New Zealand: An overview. *Proceedings of the Pan Pacific Hazards '96 Conference, 1*. Vancouver: University of British Columbia.

Ronan, K. R. (1996). Anxiety in adolescence. *New Zealand Adolescent Health and Development Bulletin, 3*, 29-35.

Ronan, K. R. (1996). The effects of the Ruapehu eruptions on children. In D. M. Johnston (Ed.), *Ruapehu 95*. Institute of Geological and Nuclear Science: Taupo, New Zealand.

Ronan, K. R. (1996). Working with ADHD. *Proceedings of the SPELD 1996 Conference*. Palmerston North, NZ: SPELD.

Upjohn, C., & Manson, E., & Ronan, K. R. (1995). *Attention-deficit hyperactivity disorder: Information for parents and teachers*. Palmerston North, NZ: SPELD.

Ronan, K. R., Kendall, P. C., & Rowe, M. (1994). Negative affectivity in children: Development and validation of a self statement questionnaire. *Cognitive Therapy and Research, 18*, 509-528.

Ronan, K. R. (1993). Recent international developments in anxiety research. Review of *Anxiety: Recent developments in cognitive, psychophysiological, and health research. Contemporary Psychology, 38,* 1063-1065.

Kendall, P. C., Chansky, P. E., Kane, M., Kim, R, Ronan, K. R., Sessa, F., & Siqueland, L. (1992). *Anxiety disorders in youth: Cognitive behavioral interventions*. Needham, MA: Allyn & Bacon.

Kendall, P. C., Ronan, K. R., & Epps, J. (1991). Aggression in children and adolescents: Cognitive behavioral treatment perspectives. In D. Popler & K. Rubin (Eds.), *Development and treatment of childhood aggression* (pp. 341-360). Hillsdale, NJ: Earlbaum.

Ronan, K. R., & Kendall, P. C. (1990). Non-self-controlled adolescents and applications of cognitive behavioral therapy. In S. C. Feinstein (Ed.), *Adolescent psychiatry: Developmental and clinical studies* (pp. 479-505). Chicago: The University of Chicago Press.

Kendall, P. C., Reber, M., McLeer, S., Epps, J., & Ronan, K. R. (1990). Cognitive-behavioral treatment of conduct-disordered children. *Cognitive Therapy and Research, 14*, 279-297.

Ronan, K. R., & Kendall, P. C. (1990). Addressing children's phobias. Review of *Children's phobias: A behavioral perspective. Contemporary Psychology, 35*, 113-115.

Kendall, P. C., & Ronan, K. R. (1990). Assessment of children's anxieties, fears, and phobias: Cognitive behavioral models and methods. In C. R. Reynolds & R. W. Kamphaus (Eds.), *Handbook of psychological and educational assessment of children*. New York: Guilford Press.

Ingram, R. Kendall, P. C., Smith, T., Donnell, C., & Ronan, K. R. (1987). Cognitive specificity and emotional distress. *Journal of Personality and Social Psychology, 53*, 734-42.

MANUSCRIPTS SUBMITTED, IN REVISION OR IN PREPARATION (ILLUSTRATIVE LISTING):

Becker, J.S., Paton, D, Johnston, D. M., Ronan, K. R. (2012). Salient beliefs about earthquake hazards and household preparedness. Manuscript in revision (*Risk Analysis)*.

Ronan, K. R., Canoy, D., & Davies, G. (2012). *Effectiveness of a new intervention for conduct disorder in youth: Pilot findings*. Manuscript in preparation for submission.

Russell, C. & Ronan, K. R. (2012). *Dissemination and effectiveness of Multisystemic Treatment in New Zealand: A second benchmarking study*. Manuscript in preparation for submission.

Feather, J., Ronan, K. R., & Crellin, K. (2012). *Single case meta-analysis of intervention in child maltreatment: Findings and methodology.* Manuscript in preparation.

Feather, J. & Ronan, K.R. (2012). *The applicability of a trauma-focused intervention in different cultural contexts: An outcome evaluation*. Manuscript in preparation *(Child Abuse and Neglect)*. .

Huzziff, C.A. & Ronan, K.R. (2012). *Brief exposure based treatment of anxiety in youth: A series of single case studies*. Manuscript in preparation for submission.

Ronan, K. R. & Crellin, K. (2012). *Attitudes and behaviours in relation to disaster preparation: Results of a Queensland, Australia population survey.* Manuscript in preparation for submission.

Webb, M. & Ronan, K.R. (2012). *A quasi-experimental investigation of a hazards education program for underprivileged youth through a community centre.* Manuscript in preparation for submission.

Moxon, A. & Ronan, K. R. (2012). Providing information to relatives and patients about expressed emotion and schizophrenia in a community support setting: A second randomized, controlled trial. Manuscript in preparation for submission.

McCormick, M. & Ronan, K.R. (2012). Australian mental health consumers' experiences and perceptions of stigma and discrimination. Manuscript in preparation for submission (*Schizophrenia Bulletin*).

PROFESSIONAL PAPERS AND PRESENTATIONS:

Ronan, K. R. (2012). Promoting psychosocial recovery from disaster: Evidence-informed practice. Presentation provided for Gladstone (Aus) Australian Psychological Society, June 6.

Taylor, P., Akers, R., & Ronan, K.R. (2012). Skills for Psychological Recovery: Training for local practitioners, day-long training workshop. Rockhampton, April 18.

Ronan, K. R. (2012). Delivering what works in hazards education: what should we be delivering and how should we be delivering it?" Invited presentation by Australian Fire and Emergency Services Authorities Council (AFAC) and Western Australia Fire and Emergency Services Authority (FESA). Perth, April 3.

Ronan, K. R. (2012). Intensive Support Work with Complex, High Risk Youth and Families: Being effective when it looks just all too hard. 3 day training provided to government and NGO support workers, Rockhampton, Jan 23-25.

Ronan, K.R. (2011). Promoting social recovery from disasters: Evidence-informed practice. Presentation provided as part of CQUniversity's Research Unplugged series of community presentations, Rockhampton, December 8.

Ronan, K.R. (2011). Promoting psychosocial recovery from disasters: Evidence-informed practice. Presentation provided to Queensland Health social work staff, Rockhampton Hospital, Rockhampton, November 18.

Reimer, W. & Ronan, K. R. (2011). Supervision workshop for graduating Clinical Psychology Students. CQUniversity, Rockhampton, November 4.

Ronan, K.R. (2011). Highly disruptive youth and families: Solutions, interventions, initial outcomes. Presentation provided to CQUniversity Library staff, Rockhampton, October 20.

Ronan, K.R. (2011). Psychosocial recovery from disasters: Research and practice. Presentation provided as part of Jocelyn Wales Seminar Series, James Cook University. Cairns, October 14.

Ronan, K.R. (2011). Forum Session Chair: Best practice in disaster recovery after large scale natural disasters. Australian Psychological Society Annual Conference, Canberra, October 5.

Ronan, K.R. (2011). Commitment to evidence-based services: APS-Red Cross research. Forum presentation, Working on disasters with The Red Cross. Australian Psychological Society Annual Conference, Canberra, October 5.

Ronan, K. R. (2011). Community resilience to disasters: Active ingredients in preparedness. Workshop presentation, Community resilience. 3rd Australasian Mental Health and Psychosocial Disasters Conference 2011, Brisbane, September 28.

Ronan, K. R. (2011). Research workshop – building an evidence base for public education post the Canterbury earthquakes: Reflections and the role of combining single modalities. Presentation provided at Joint Centre for Disaster Research, Massey University, New Zealand, September 13.

Ronan, K. R. (2011). Disaster-related research with children and families: Planning and design in a new area. Master class sponsored by The School of Psychology at the University of Western Australia in partnership with the Bushfire Corporate Research Centre and the Fire & Emergency Services Authority of Western Australia. Perth, August 25.

Ronan, K. R. (2011). Community disaster preparedness: The role of children, families, schools. Presentation sponsored by The School of Psychology at the University of Western Australia in partnership with the Bushfire Corporate Research Centre and the Fire & Emergency Services Authority of Western Australia. Perth, August 25.

Ronan, K. R. (2011). Working with Highly Disruptive Youth and Families: Evidence-Based Practice & Practice-Based Evidence. Full day workshop sponsored by Australian Psychological Society. Bundaberg, August 12.

Reimer, W. & Ronan, K. R. (2011). Supervision workshop for field supervisors. Community Health, Rockhampton, August 1.

Wade, D. & Ronan, K. R. (2011). Skills for Psychological Recovery: 2 Day Training Workshop. Brisbane, June 30 – July 1.

Ronan, K. R. (2011). Exploring conduct disorder: Assessment and treatment. Workshop provided at induction training of EVOLVE teams, Disability Services Queensland, Brisbane, May.

Ronan, K.R. (2011). Disaster recovery after the floods in Rockhampton: community and personal risk and support in disasters. Presentation provided to clinical directors medical staff, Rockhampton Hospital, April 29.

Reimer, W. & Ronan, K. R. (2011). Supervision workshop for field supervisors. CQUniversity Psychology Wellness Centre, Rockhampton, March 11.

Ronan, K. R. (2011). Community and personal problems and support in disasters. Address provided at Queensland Flood Disaster Recovery Briefing, Brisbane, January 28.

Ronan, K. R. (2010). Workshop presenter, Children, families, schools and disasters: lessons from the Canterbury earthquake. Multi-agency workshop organised by Joint Centre for Disaster Research, Massey University, Wellington, December 21.

Ronan, K. R. (2010). Opening address: National Summit for Youth Preparedness. Washington, DC, September 15.

Ronan, K. R. (2010). Supporting children and young people: Evidence-informed practices for complex & extreme behaviours. Keynote address at Anglicare Service Excellence Conference, November 5.

Ronan, K. R. (2010). Supporting children and young people: Moderator, service excellence staff discussion. Anglicare Service Excellence Conference, November 5.

Ronan, K.R. (2010). Panel discussion member, youth and family disaster scenario (Mark Creamer, Moderator; Beverley Raphael, Vanessa Cobham, Panel members). Australasian Conference on Traumatic Stress, Brisbane, September 3.

Ronan, K. R. (2010). Treatment for conduct disorder and youth offending. Presentation at Department of Communities, Queensland. Brisbane, June 16.

Ronan, K. R. (2010). Exploring conduct disorder: Assessment and treatment. Workshop provided at induction training of EVOLVE teams, Disability Services Queensland, Brisbane, May 17.

Ronan, K. R. (2010). Highly disruptive youth and families: Solutions, mechanisms, initial findings. Presentation at CQUniversity Research Expo 2010, April 12.

Ronan, K. R. (2010). Highly disruptive youth: Mechanisms and interventions. Presentation for Education Queensland, Rockhampton, January 25.

Ronan, K. R. (2009). Highly disruptive youth: Solutions and interventions. CQUniversity Research Unplugged Presentation, Criterion Hotel, Rockhampton, December 10.

Lewis, G. & Ronan, K. R. (2009). Cognitive Remediation Therapy: Treatment effects in schizophrenia. Poster presented at the Society for Psychotherapy Research Regional Meeting, Brisbane, November 30 – December 1.

Ronan, K. R. (2009). Intervention for youth at risk. Keynote presentation, Coordinated Referral for Young Persons At-Risk (CRYPAR), Queensland Police integrated referral program launch. Rockhampton, November 6.

Ronan, K. R. (2009). Mechanisms and interventions for severe conduct disorder in youth and families, Queensland Health Social Work, Rockhampton, October 29.

Ronan, K.R. (2009). Preparedness and obstacles for preparedness for disasters. Podcasts and transcripts presented at Australian Child, Adolescent Trauma, Loss and Grief Network website: http://www.earlytraumagrief.anu.edu.au/ . Posted October 14.

Ronan, K. R. (2009). Child and family resilience to disaster. Presidential Symposia, Australian Psychological Society Conference, Darwin, October 3.

Nepean-Hutchison, A.& Ronan, K. (2009). Prevention based intervention of children with anxiety disorders: Is the gestational period the key? Poster presented at Australian Association for Infant Mental Health Inc. and The Australasian Marcé Society; The infant, the family and the modern world: Intervening to promote healthy relationships. Melbourne, October 1-3.

Ronan, K. R. (2009). A new intervention for conduct disorder: Training of therapists and research staff. CQUniversity, Rockhampton, September 14-18.

Ronan, K. R. (2009). Clinical Psychology Training. Presentation for Queensland Health psychologists, Community Health, Rockhampton, August 24.

Ronan, K. R. (2009). Seminar chair: Incredible Years. Seminar as part of New Zealand Psychological Society Conference, Palmerston North, August 27.

Ronan, K. R. & Johnston, D. M. (2009). Working with children, families and schools in disasters. Workshop presented at 3rd Australasian hazards management workshop series 2009: From warnings to effective response and recovery. Melbourne, August 6.

Ronan, K. R. (2009). Preparedness for disasters: The role for schools, youth and families. Presentation at Australian Child and Adolescent Trauma, Loss & Grief Network seminar, July 13-14, Australian National University, Canberra.

Ronan, K. R. (2009). Exploring conduct disorder: Assessment and treatment. Workshop provided at induction training of EVOLVE teams, Disability Services Queensland, Brisbane, May 14.

Ronan, K. R. (2009). Conceptualising complex, disruptive disorders: Professional development workshop. Workshop for Guidance Officers, Brisbane, January 23.

Ronan, K. R. (2008). The cycle of violence in families: Mechanisms and interventions. Address to Child Safety Conference, Brisbane, November 12.

Ronan, K. R. (2008). Psychologists' role in disaster management. Presentation to local branch of Australian Psychological Society, October 6, Rockhampton.

Ronan, K. R. & Johnston, D. M. (2008). Enhancing community resilience to disasters: Frameworks, research and practices. Workshop presented at 2nd Australasian Mental Health and Psychosocial Disaster Management Conference, Brisbane, October 23.

Ronan, K.R. (2008). Community resilience to natural disasters. Presentation and participation in Community Resilience Workshop convened by National Counter-terrorism Committee, Office of National Security, Department of Prime Minister and Cabinet, Canberra, August 21.

Ronan, K.R. (2008). Working with highly disruptive youth: Bringing the evidence into day to day practice. Workshop presented for Youth Horizons Trust, Auckland, June 25.

Ronan, K.R. (2008). Working with highly disruptive youth: Bringing the evidence into day to day practice. Workshop presented for Youth Horizons Trust, Auckland, June 24.

Ronan, K. R. (2008). Therapeutic care: Interventions aimed at the cycle of violence. Keynote address to the Child Safety Research Mini-Conference, Rockhampton, June 11.

Ronan, K.R. (2008). Assessment, diagnosis and formulation. Workshop presented to Child and Youth Mental Health Service, Queensland Health, Rockhampton, February 28.

Ronan, K. R. (2008). Working with highly disruptive youth and families. Workshop to Epuni treatment staff (Lower Hutt, Wellington NZ), February 20-21.

Ronan, K. R. (2008). Working with highly disruptive youth and families: Risk and protective factors. Presentation to Youth Horizons Trust staff (Auckland NZ), February 18.

Ronan, K. R. (2008). Working with highly disruptive youth and families: Risk and protective factors. Presentation to Youth Horizons Trust staff (Hamilton NZ), February 18.

Crellin, K., Ronan, K. R., & McMurray, K. (2007). Meta analysis of childhood anxiety treatments. In Grenyer, Brin, King, R., Crowe, T, & Deane, F. (Eds), Evidence-Based Psychotherapy: Proceedings of the 2007 Psychotherapy Research Group Meeting, Wollongong: Illawara Institute of Mental Health, University of Wollongong, December 5-6.

Girling-Butcher, R. & Ronan, K. R. (2007). Brief cognitive-behavioral therapy for children with anxiety disorders. In Grenyer, Brin, King, R., Crowe, T, & Deane, F. (Eds), Evidence-Based Psychotherapy: Proceedings of the 2007 Society for Psychotherapy Research Group Meeting, Wollongong: Illawara Institute of Mental Health, University of Wollongong, December 5-6.

Lees, D. & Ronan, K. R. (2007). Engagement and effectiveness of parent management training for solo high risk mothers: A multiple baseline evaluation. In Grenyer, Brin, King, R., Crowe, T, & Deane, F. (Eds), Evidence-Based Psychotherapy: Proceedings of the 2007 Society for Psychotherapy Research Group Meeting, Wollongong: Illawara Institute of Mental Health, University of Wollongong, December 5-6.

Moxon, A. M. & Ronan, K. R. (2007). Providing information to relatives and patients about expressed emotion and schizophrenia in a community support setting: A randomized, controlled trial. In Grenyer, Brin, King, R., Crowe, T, & Deane, F. (Eds), Evidence-Based Psychotherapy: Proceedings of the 2007 Society for Psychotherapy Research Group Meeting, Wollongong: Illawara Institute of Mental Health, University of Wollongong, December 5-6.

Curtis, N. M., Ronan, K. R., Heiblum, N., & Crellin, K. (2007). Dissemination and effectiveness of multisystemic treatment in New Zealand: A benchmarking study. In Grenyer, Brin, King, R., Crowe, T, & Deane, F. (Eds), Evidence-Based Psychotherapy: Proceedings of the 2007 Society for Psychotherapy Research Group Meeting, Wollongong: Illawara Institute of Mental Health, University of Wollongong, December 5-6.

Ronan, K.R. (2007). Working with highly disruptive youth and families. Workshop sponsored by the Australian Psychological Society, Mackay (Queensland), November 22-23.

Ronan, K.R. (2007). Child and youth pre-disaster preparedness: The role of hazards education programs. Invited presentation at Psychosocial Response and Recovery Symposium, Brisbane, November 2-3.

Becker, J., Johnston, D. M, Paton, D., & Ronan, K.R. (2007). Creating hazard-resilient communities: Understanding how people make meaning of hazard information and how this influences preparedness. Poster presented at the Australasian Natural Hazards Management Conference, Brisbane, July 1-4.

Towers, B. Paton, D., & Ronan, K.R. (2007). Educating children about bushfire risk and mitigation. Poster presented to the Australasian Natural Hazards Management Conference, Brisbane, July 1-4.

Ronan, K. R. (2007). Session chair. Australasian Natural Hazards Management Conference, Brisbane, July 1-4.

Ronan, K.R. (2007). Managing workplace stress. Workshop provided to Bureau of Meteorology senior forecasters, Brisbane, June 29.

Ronan, K. R. (2007). Exploring conduct disorder: Assessment and treatment. Workshop provided at induction training of Disability Services Queensland, Brisbane, June 12.

Ronan, K. R. (2006). Working with highly disruptive youth and families: Bringing the evidence into day-to-day practice. Follow-up, pro bono workshop provided to participants of previous workshop (August 4, see below). Rockhampton (Queensland), November 10.

Ronan, K.R. (2006). Working with troubled teenagers. Presentation provided at Mental Health Week Forum, Aboriginal and Torres Strait Islander Health Service, Rockhampton (Queensland), October 12.

B. Towers, D. Paton, K. R. Ronan (2006). The socio-cognitive construction of bushfire risk perception: A developmental perspective. Poster presentation at 2006 Joint Conference of the Australian Psychological Society and New Zealand Psychological Society. Auckland, September.

Ronan, K. R., Johnston, D. M., & Pederson, S. (2006). The role of schools in disasters: From hazards education to disaster response. Workshop presented at the New Zealand Natural Hazards Conference, August 22.

Ronan, K. R. (2006). Working with highly disruptive youth and families: Bringing the evidence into day-to-day practice. Workshop sponsored by the Australian Psychological Society, Rockhampton (Queensland), August 4.

Ronan, K. R. (2006). Update on interventions for trauma: Research and practice on recovery from hazardous events. Keynote address to Central Region Combined Emergency Services Workshop, Rockhampton (Queensland), June 17-18.

Ronan, K.R. (2006). Treatment of conduct and oppositional disorders: Research and practice. Workshop provided at induction training of Disability Services Queensland, Brisbane, June 8.

Ronan, K.R. (2005). How best to treat conduct disordered youth and families within traditional practice settings: A look at research and practice models. Presentation provided to Queensland Health Psychology Group, Rockhampton, October 31.

Ronan, K.R. (2005). Working with conduct disordered youth and families: Research and practice. Keynote presentation provided at the National Child and Family Mental Health Conference, Dunedin (NZ), September 22.

Ronan, K.R. (2005). Treatment of conduct and oppositional disorders: Research and practice. Workshop provided at induction training of Disability Services Queensland, Brisbane, September 6.

Kazantzis, N., Newman, F. L., Ronan, K.R., Deane, F.P., Tompkins, M. (2005). The role of client homework adherence and therapist competence in predicting cognitive behavior therapy outcomes – an efficacy study. Presentation provided at the New Zealand Psychological Society Conference, Dunedin (NZ), September 3.

Ronan, K.R. (2005). Treatment of conduct disorder: Research and practice. Presentation provided to the local branch of the Australian Psychological Society, Rockhampton (Queensland), August 26.

Ronan, K.R. (2005). Risk, protection, and working with violent juvenile offenders. Workshop presented at Epuni (Severe Conduct Disordered Unit), Wellington (NZ), May 19.

Ronan, K. R. (2004). Training for juvenile justice facility employees: Working with youth offenders. Workshop presented at Epuni (Severe Conduct Disordered Unit), Wellington (NZ), October.

Ronan, K.R. (2004). The Manawatu experience: Research on recovery from hazards. Workshop presentation provided to Trauma Response Counsellors, Thames/Coromandel districts, Thames (NZ), June 17.

Ronan, K.R. (2004). Recovery after recent floods: Review of the research and implications for emergency management practice. Presentation provided to Manawatu District Council (NZ) staff, April 23.

Curtis, N. & Ronan, K.R. (2003). Outcomes from a trial of Multisystemic Treatment. Paper presented at the New Zealand Psychological Society Conference, August.

Doree, A.C. & Ronan, K.R. (2003) Fostering Relationships. The organisation of attachment in foster care. Paper presented at the Child Adolescent and Family Mental Health Service Conference, Wellington (NZ), September.

Jory, A.M.M. & Ronan, K.R. (2003). Combining motivational interviewing and cognitive-behavioural therapy for the treatment of adolescent substance abuse. Paper presented at the New Zealand Psychological Society Conference at Massey University, Palmerston North, September.

Johnston, D. M., Kerr, J. Paton, D., Ronan, K.R., Houghton, B.F. (2003). Improving societies' preparedness for future volcanic eruptions. Plenary presentation, Cities on Volcanoes 3, July 18.

Ronan, K.R. & Johnston, D. M. (2003). Hazards education for youth: A quasi-experimental investigation. Paper presented at Cities on Volcanoes 3, Hilo (Hawaii), July 14.

Vilke, M., Jory, A.M.M., & Ronan, K.R. (2003). Cognitive-behavioural interventions with substance-abusing adolescents. Paper presented at the 4th International Conference on Drugs and Young People, Wellington Convention Centre, Wellington, May.

Paton, D., Smith, L., Johnson, M., Johnston, D., & Ronan, K.R. (2003). Responding to earthquake hazard effects: Promoting household resilience and preparedness. Poster presented at 2003 Pacific Conference on Earthquake Engineering, Christchurch (NZ), February 13-15.

Ronan, K.R. (2003). Working with disruptive youth from a private practice setting: Using the evidence to enhance the practice. Presentation provided to GAINS private practice staff, December 19.

Ronan, K.R. (2003). Symposia convenor: Child Clinical Psychology. New Zealand Psychological Society Annual Conference, August.

Vilke, M., Jory, A. & Ronan, K. Cognitive-behavioural interventions with substance abusing adolescents. CAMHS conference.

Ronan, K.R. (2003). Risk and readiness for hazards: What the evidence tells us. Presentation provided at the Disaster Mental Health Institute, University of South Dakota (USA), July 1.

Ronan, K.R. (2002). Working with conduct disordered youth and their families. Presentation to Rangatane iwi social services (Best Care (Whakapai Hauora) Charitable Trust), October 29.

Feather, J. & Ronan, K.R. (2002). Trauma-focused cognitive behavioural therapy for abused children. Paper presented at the New Zealand College of Clinical Psychologists Conference, Auckland, September.

Feather, J. & Ronan, K.R. (2002). Trauma-focused cognitive behavioural therapy for abused children. Paper presented at the New Zealand Psychological Society Conference, Christchurch, August.

Johnston, D. M., Houghton, B. F., Ronan, K. R., & Paton, D. (2002). A hazard education assessment in four communities around Mount Rainier, Paper presented at Montagne Pelee 1902-2002: Explosive Volcanism in Subduction Zones, Saint-Pierre, Martinique, May.

Ronan, K.R. & Dickson, J. (2002). Interviewing, assessment, and report writing as a clinical psychologist. Workshop presented to staff and clinical psychology students, Massey University, April.

Ronan, K.R. (2002). Hazards education in schools: Findings and implications for educators. Workshop presented at Auckland Regional Council, 27 March.

Ronan, K.R. (2002). Clinical psychology training. Workshop presented at Te Rau Puawai hui, 23 February.

Ronan, K.R. (2001). Supervising clinical psychology trainees: Theory, research, practice. Workshop presented to field supervisors of Massey Clinical Training Programme, December 7.

Ronan, K.R. & Williams, M. (2001). Interviewing, assessment, and report writing as a clinical psychologist. Workshop presented to staff and clinical psychology students, Massey University, July.

Williams, M.W. & Ronan, K. R. (2001). A general theory of crime. Paper presented at the New Zealand Psychological Society Conference 2001, August 26.

Ronan, K. R. (2001). Hazards education for youth: Current findings, future directions. Keynote presentation at APEC Workshop on Dissemination of Disaster Mitigation Technologies for Humanistic Concerns (Phase I: Earthquake Disaster), Taipei, Taiwan, June 19.

Ronan, K. R. (2001). Working with ADHD and disruptive youth. Presentation to school personnel and parents, Awapuni Primary School (Palmerston North, New Zealand), April 3.

Ronan, K. R. (2001). Anxiety in adolescence. Workshop presented to Nelson (NZ) Health professionals, 7 March.

Ronan, K. R. (2001). Plenary session convenor. Cities on Volcanoes II, Auckland (NZ), February 12-16.

Ronan, K. R. (2001). Symposia convenor: Education. Cities on Volcanoes II, Auckland (NZ), February 12-16.

Johnston, D. M., Driedger, C. L., Houghton, B. F., Ronan, K. R., & Paton, D. (2001). A hazard education assessment in four communities around Mount Rainier, Washington, USA (also presented in Abstracts volume). Paper presented at Cities on Volcanoes II, Auckland (NZ), February 12-16.

Ronan, K., Johnston, D. (2000). A community's understanding of earthquake risk in the Manawatu. In: Proceedings of the Natural Hazards Management Conference, Napier (NZ), 16-17 August 2000. Institute of Geological and Nuclear Sciences information series 48. p. 72.

Ronan, K., Paton, D., Johnston, D., Houghton, B. and Long, N. (2000). Volcanic hazards and societal risk: A multidisciplinary approach. Health and Risk Conference, University of Oxford, UK, 16-17 July.

Ronan, K.R. (2000). Conduct disordered youth and their families: Multiple systems approaches to treatment. Presentation at Te Whare Marie (Maori Mental Health), Capital Coast Health, Porirua (NZ), November 27.

Ronan, K. R. (2000). Hazard education programmes for youth. Keynote address presented at Natural Hazards Management Conference, Napier (NZ), 16-17 August.

Ronan, K. R. (2000). Working with ADHD and disruptive youth. Freyberg College, Palmerson North (NZ), August 14.

Ronan, K. R., Mickleson, J., & Kingi, D (2000). ADHD Workshop: Research looking at current practice in New Zealand and implications. Workshop sponsored by the New Zealand Psychological Society (Central Districts Branch), Palmerston North (NZ), 14 July.

Moxon, A., & Ronan, K.R. (2000). The effectiveness of a brief psychoeducation programme for families. Presentation at the annual Schizophrenia Research Meeting, April.

Ronan, K. R. (2000). Working with ADHD and disruptive youth. Freyberg College, Palmerson North (NZ), March 22.

Paton, D. & Ronan, K.R. (2000). Symposium convenors. Psychological Vulnerabililty to Volcanic Eruptions: Long Term Issues in the Management of Psychological and Community Problems. Third World Conference for the International Society for Traumatic Stress Studies, Melbourne, Australia, March.

Ronan, K. R. & Johnston, D. M. (2000). Behaviourally-based interventions for children following volcanic eruptions: An evaluation of effectiveness. Paper presented as part of symposium Psychological Vulnerabililty to Volcanic Eruptions (see above for full

title). Third World Conference for the International Society for Traumatic Stress Studies, Melbourne, Australia, March.

Huzziff, C.A., & Ronan, K. R. (2000). Prediction of children's coping following the Mount Ruapehu eruptions: A prospective study. Paper presented as part of symposium Psychological Vulnerabililty to Volcanic Eruptions (see above for full title). Third World Conference for the International Society for Traumatic Stress Studies, Melbourne, Australia, March.

Ronan, K., Johnston, D. 1999. A community's understanding of earthquake risk in the Manawatu. Abstract, Proceedings of the Joint New Zealand Geophysical Society and Meteorological Society of New Zealand, 1-3 September 1999, Wellington (NZ).

Kazantzis, N., Ronan, K. R., & Deane, F. P. (1999, November). *Practical, Theoretical and Empirical Support for Homework in CBT.* Clinical Workshop presented at the Capital Coast Health, Puketiro Centre, Kenepururu Hospital, Porirua, New Zealand.

Ronan, K. R. (1999). Psychosocial rehabilitation in theory and practice. Presentation to staff. Manawatu Accomodation and Sheltered Housing Trust (MASH), September.

Ronan, K. R. (1999). Dealing with disruptive callers. Presentation to staff, Youthline (Manawatu), July.

Ronan, K. R., (1999). Hazards readiness and recovery: A multidisiplinary perspective. Keynote presentation. Conference sponsored by the National Science and Technology Program for Hazards Mitigation, Taipei, Republic of China, July.

Ronan, K. R. (1999). Multiple gating and early intervention in various spheres of mental health: Theory and research examples. Seminar presented at the Department of Psychology, University of Wollongong, Australia, July.

Kazantzis, N., Ronan, K. R., & Deane, F. P. (1999). The role of homework in psychotherapy. Clinical Workshop presented at the Department of Psychology, University of Wollongong, Australia, March.

Kazantzis, N., & Ronan, K. R. (1999). The Collaborative Research Network study of psychotherapists. Poster session presented at the annual conference of the New Zealand Association of Psychotherapists, Dunedin, New Zealand, February.

Ronan, K. R. (1998). Preparing for hazards, recovery from disasters in New Zealand: Starting at the beginning. Presentation made at the U. S. Disaster Mental Health Institute, Vermillion, SD (USA), December.

Ronan, K. R. (1998). Children's understanding of hazards in the Auckland volcanic field, New Zealand. Paper presented at Cities on Volcanoes Conference. Rome and Naples, Italy, June-July.

Moxon, A. & Ronan, K. R. (1998). Providing information to relatives about expressed emotion and schizophrenia. Presentation at the annual Schizophrenia Research Meeting, April 17-18, Wellington.

Kazantzis, N., Deane, F. P., Patchett-Anderson, L. S., & Ronan, K. R. (1998, August). The professional development of New Zealand psychologists: Concepts, questions, and methods of the Collaborative Research Network (CRN) international study. Paper presented at the annual meeting of the New Zealand Psychological ociety and New Zealand College of Clinical Psychologists, Wellington, New Zealand, September.

Ronan, K. R. (1998). Working with disruptive youth in school settings. Presentation at North School, Fielding, February 17.

Ronan, K. R. (1998). Working with disruptive youth. Presentation to professionals in health and education settings. South School, Dannevirke, April 2.

Ronan, K. R. (1998). Child and adolescent behaviour management strategies. Rotorua (sponsored by Roturua ADD Association), May 8.

Ronan, K. R. (1997). Risk education and intervention. Talk sponsored by Auckland Regional Council, November.

Ronan, K. R. & Johnston, D. M. (1997). Hazard Management Workshop: Risk Education and Intervention. Taupo (NZ), October.

Ronan, K. R. (1997). Keynote Address: Working with anxiety disorders in children. Focusing the Mind Conference, Wellington, NZ, November.

Ronan, K. R. (1997). Chair, Child Clinical Symposia. New Zealand Psychological Society Conference, Palmerston North, September.

Donaldson, S. J. & Ronan, K. R. (1997). The effects of sport participation and perceived athletic competence on children's emotional well-being. New Zealand Psychological Society Conference, Palmerston North, September.

Huzziff, C. A. & Ronan, K. R. (1997). Prediction of children's coping with posttraumatic stress following the Mount Ruapehu eruptions: A prospective study. New Zealand Psychological Society Conference, Palmerston North, September.

Johnston, D. M., Ronan, K. R., & Houghton, B. F. (1997). Living with an erupting volcano: The physical and social impacts of the 1995-1996 Ruapehu eruption on New Zealand communities. New Zealand Psychological Society Conference, Palmerston North, September.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (1997). The use of assigned homework activities among New Zealand practising psychologists. New Zealand Psychological Society Conference, Palmerston North, September.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (1997). What do psychologists think they are doing: Theoretical orientation of practicing New Zealand psychologists. New Zealand Psychological Society Conference, Palmerston North, September.

Ronan, K. R. (1996). Treating the conduct-disordered, anxious adolescent: The issue of resolving uncertainty. Presentation to psychologists, psychiatrists, and social workers. Palmerston North Child, Adolescent, and Family Services, 5 December 1996.

Ronan, K. R. (1997). Working with ADHD and comorbid disorders in youth. Second Annual SPELD-Sponsored Conference on Attention-Deficit Hyperactivity Disorder. Palmerston North (NZ), 5 April.

Ronan, K. R. (1997). Working with disruptive youth. Public Health Nurse Forum, Palmerston North Hospital, Palmerston North, 30 July.

Ronan, K. R. (1997). Working with disruptive youth. Presentation to academic staff, Wanganui Collegiate, 13 October.

Ronan, K. R. (1997). Working with disruptive youth. Presentation to school staff. Presentation sponsored by Rural Education Activities Programme (Southern Hawke's Bay), Dannevirke (NZ), 13 November.

Ronan, K. R. (1996). Comorbidity of learning disability and attention-deficit disorder: Treatment implications. Presented at the Annual SPELD New Zealand National Meeting, May, 1996.

Ronan, K. R. (1996). Presentation of initial findings of Ruapehu Research: Waiouru Primary School, 29 April.

Ronan, K. R. (1996). Presentation of initial findings of Ruapehu Research: Raetihi Primary School, 30 April.

Ronan, K. R. (1996). Presentation of initial findings of Ruapehu Research: Ohakune Primary School, 1 May.

Ronan, K. R. (1996). Working with disruptive youth. SPELD-sponsored presentation to parents, teachers, professionals. Christchurch, 17 September.

Ronan, K. R. (1996). Disruptive youth: Themes and research. Blenheim Presentation #1, 15 November (2-4 PM).

Ronan, K. R. (1996). Disruptive youth: Techniques. Blenheim Presentation, #2, 15 November 1996 (7-9 PM).

Ronan, K. R. (1996). Working with disruptive youth. Guidance and Learning Presentation, Winchester School, Palmerston North, 11 September 1996.

Ronan, K. R. (1996). Treatment with anxiety disorders in children. Psychology Department-sponsored workshop attended by students and professionals from the community, 6 September.

Ronan, K. R. & Johnston, D. M. (1996). Volcanic eruptions and children: Assessment and school based intervention. Paper presented at the Pan Pacific 96 Conference, Vancouver, July-August.

Ronan, K. R. (1996). Presentation of findings of Ruapehu Research to various media outlets (Newstalk ZB radio interviews: Manawatu, Wellington, Bay of Plenty; TVNZ report; newspaper reports).

Ronan, K. R. (1996). Treatment of ADHD. Keynote presentation. SPELD Conference on Attention-Deficit Hyperactivity Disorder in Children. Palmerston North, June, 1996.

Ronan, K. R. (1996). Comorbidity of learning disability and attention-deficit disorder: Treatment implications. Workshop presented at the Annual SPELD New Zealand National Conference, May, 1996.

Ronan, K. R. (1996). Treatment of anxiety disorders in adolescence. Workshop presented at the annual Youth Conference of the New Zealand Adolescent and Health Development Society, April, 1996.

Ronan, K. R. (1996). Coping with anxiety in adolescence. Keynote presentation of the Youth Conference, New Zealand Adolescent and Health Development Society, April, 1996.

Ronan, K. R. (1995). Treatment of anxiety disorders in youth. Workshop presented at the annual conference of the New Zealand Psychological Society, August, 1995.

Ronan, K. R. (1995). Working with ADHD youth. Presentation to ADHD Support Group, Palmerston North, August.

Ronan, K. R. (1995), Keynote speaker: Learning Disability and ADHD in children: Implications for treatment. SPELD AGM, November, 1995.

Ronan, K. R. (1995). Predictability, consistency, and safety in treatment of conduct disorder. Staff development workshop, Butner Adolescent Treatment Center, February.

Ronan, K. R. (1994). The multicomponent treatment philosophy of the Butner Adolescent Treatment Center, Willie M. Regional Services Manager Meeting, October, 1994.

Ronan, K. R. (1994). Staff Development Workshop Leader, Developing a staff contract. Butner Adolescent Treatment Center, March.

Ronan, K. R. (1993). Staff Development Workshop Leader, Working with the conduct disordered, Willie M. clients. Butner Adolescent Treatment Center, November 8 - 10.

Workshop Presenter, Staff development workshop, Innovative psychosocial rehabilitation services. Napa State Hospital, Napa, CA, July 15 - 16, 1993.

Workshop Leader, Stress management in the worksite. Personnel Department, Napa State Hospital, Napa, CA, December, 1992.

Ronan, K.R., Kendall, P. C., & Rowe, M. Negative affect in children: Development of a self statement questionnaire. Paper presented at the Association for Advancement of Behavior Therapy Convention, Boston, November, 1992.

Workshop Leader/Presenter, Staff development/orientation, Innovative psychosocial rehabilitation services, (Wellspring), Napa State Hospital, July 24 - 27, 1993.

Kendall, P. C., Siqueland, L., Kane, M., Chansky, T., Kortlander, E., Brady, E., Ronan, K. R., & Howard, B. Anxiety disorders in children: Outcomes from a randomized clinical trial. Paper presented as part of symposium entitled: Advances in the Assessment and Treatment of Childhood Anxiety, T. H. Ollendick (Chair). American Psychological Association Convention, San Francisco, August, 1991.

Workshop Presenter, The nature and treatment of anxiety disorders in children. Presented at the Pennsauken School District, Pennsauken, NJ, November 7, 1989.

Workshop Presenter, The nature and treatment of anxiety disorders in children. Presented at the Delaware County Association of School Psychologists, Philadelphia, February 1989.

Workshop Presenter, The nature and treatment of anxiety disorders in children. Presented at the Counseling or Referral Assistance (CORA) Agency, Philadelphia, December 1988.

Ronan, K. R., Rowe, M., & Kendall, P. C. Development and validation of a Children's Anxious Self Statement Questionnaire. Paper presented at the Association for Advancement of Behavior Therapy Convention, New York, November, 1988.

Epps, J., Ronan, K. R., & Kendall, P. C. Hostility, aggression, and attributional style as moderator variables in a cognitive behavioral treatment of antisocial behavior in children. Association for Advancement of Behavior Convention, Boston, November, 1987.

Rowe, M., Ronan, K. R., & Kendall, P. C. Development and validation of a Children's Automatic Thoughts Questionnaire (CATQ). Association for Advancement of Behavior Therapy Convention, Boston, November, 1987.

Kendall, P. C., McLeer, S., Reber, M., Epps, J., & Ronan, K. R. Treatment of antisocial behavior in children: Efficacy of a cognitive behavioral therapy. Association for Advancement of Behavior Therapy Convention, Boston, November, 1987.

PROFESSIONAL SOCIETIES AND SERVICE

Australian Heads of Department and Schools of Psychology (HODSPA), 2007 – 2008.

Australian Psychological Society, Member, 2005 – current.

Registered Psychologist, Clinical, Australia, 2011 - current.

Registered Psychologist, Queensland and Australia, 2005 – 2011.

New Zealand Directors of Clinical Training, 1999 – 2002; 2004 – 2005.

New Zealand Psychological Society (including Institute of Clinical Psychology), 2000 - 2005.

Registered Clinical Psychologist, New Zealand, 2005 – current.

Registered Psychologist, New Zealand, 1996 – 2005 (based on NZ legislation,

prior to 2005, all psychologists were registered as Registered Psychologist).

International Society for Research in Child and Adolescent Psychopathology, Member, 1997 - 2001.

American Psychological Association, Member (and, from 1996, International Affiliate), 1993 - 2001.

Association for the Advancement of Behavior Therapy, Member, 1989 - 1997.

AWARDS, HONORS, AND ACTIVITIES:

Phi Beta Kappa, University of Minnesota, Inducted 1984.

Valedictorian, Harding Senior High School, St. Paul, MN, 1979.

Commendation, Temple University Psychology Department, Outstanding Ph.D. Student, 1990.

President, Napa Valley Velo Cycling Team, Napa, CA, 1993.

United States Cycling Federation Licensed Racer: Category II, 1988-1996.

Outstanding Paper, Disaster Prevention and Research, 1999 (Ronan & Johnston, 1999; see Publications section).

ATTACHMENT 3

Australian Psychologist, September 2009; 44(3): 195–213

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Child maltreatment: Prevalence, risk, solutions, obstacles

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[1]*Department of Behavioural and Social Sciences and* [2]*Institute for Health and Social Science Research, CQUniversity Australia, Rockhampton, Queensland, Australia*

Abstract

Child maltreatment is a growing problem nationally in Australia. This paper documents the extent of the problem. It also presents a range of interventions shown to work, including a number that have been developed and used here in Australasia. Despite the fact that there are evidence-based services available, the problem of child maltreatment continues to grow. Problems linked to implementing and sustaining an evidence-based program or culture include organisations that are resistant to change, whose staff see a new program as short term and not a part of longer-term, routine service delivery. In the face of such a climate, these initial conditions then have potential to become exacerbated through hasty implementation of new services that are not well thought out, resourced or supported. With intervention services that have documented potential, the critical next step is to ensure that implementation is done correctly to guarantee that successful services are being delivered effectively over the long term. Thus, following a description of the problem of child maltreatment and review of potential intervention-based solutions, this paper then discusses factors that need to be considered when advocating for or adopting a new, evidence-supported service. Psychologists have a role to play in the future to help stem the growth of child maltreatment in Australia, at both local service delivery as well as state and national policy levels.

Key words: *Child abuse, child and adolescent psychopathology, childhood, child maltreatment, clinical/counselling psychology, family issues, organisational behaviour, parent–child interactions.*

Child maltreatment is a major and growing problem in Australia and worldwide (Australian Institute of Health and Welfare [AIHW], 2008). Effective child protection and abuse-related interventions are needed in the face of the multiple problems that child maltreatment cause for the child, family and society. Even with effective child protection practices helping to keep an individual child safe, interventions are also needed to help reduce future problems including impairment and intergenerational transmission effects (Belsky, 1993; D'Onofrio et al., 2003; Jaffee, Caspi, Moffit, Polo-Tomas et al., 2004; Jaffee, Caspi, Moffitt, & Taylor, 2004; Serbin & Karp, 2004; Skowron & Reinemann, 2005; Widom, 1989). There is a need to increase evidence-based knowledge and skills in an effort to ensure that those at risk or with immediate need are able to receive both timely and effective care (Feather & Ronan, 2006; Kazdin & Nock, 2003; Klevens & Whitaker, 2007; Kolko, Cohen, Mannarino, Baumann, & Knudsen, 2009; MacMillan et al., 2007; NSW Department of Community Services (NSW DoCS), 2007; Rosenman & Rodgers, 2004; Skowron & Reinemann, 2005; Tyler, Allison, & Winsler, 2006). Our literature review and consultation for this article found some troubling facts. First, with some exceptions, child protection agencies continue to receive a growing number of reports of maltreatment. Second, a well-known fact among those in child protection is that front-line staff caseloads are high and retention can be problematic (Australian Institute of Family Studies [AIFS], 2008). This state of affairs, however, is not limited to child protection agencies; it is one that permeates many agencies responsible for providing children and families with psychosocially based services (Glisson, Schoenwald, et al., 2008; Massatti, Sweeney, Panzano, & Roth, 2008). Third, overseas literature indicates that the use and delivery of evidence-based services for children and families, including psychological prevention and intervention

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strategies, is limited (Kazdin & Nock, 2003; Kolko et al., 2009; Olds, Sadler, & Kitzman, 2007; Tyler et al., 2006).

In contrast to this seemingly pessimistic state of affairs, there are a range of services that do have research support and promise. These include psychological interventions linked to individual and systemic features of child maltreatment and child protection. In addition, and importantly, there are promising practices that are emerging and in use both overseas and here in Australasia (Dawe & Harnett, 2007; Dawe, Harnett, & Frye, 2008; Feather & Ronan, 2006; Olds et al., 2007; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Against this backdrop, the first goal of this paper is to promote increased awareness of child maltreatment epidemiology as well as intervention practices currently available, including those available here. A second goal is to urge increased attention to the use of evidence-based practices that incorporate known findings on risk and protection with specific strategies that have empirical support (Feather & Ronan, 2009a,b; Tyler et al., 2006). Related to this goal is the issue of finding ways to implement evidence-supported practices in day-to-day service delivery settings. Mindful of significant problems often associated with transporting services from research to practice (Macmillan et al., 2007; Olds et al., 2007; Ronan, 1996), a final goal then is to consider how best to implement and sustain best practice in the child protection and child mental health service delivery sectors (Queensland Government Department of Child Safety, 2007; Ronan & Curtis, 2008; Tyler et al., 2006).

Child maltreatment: Definitions and prevalence

There is general consensus in the research literature regarding child abuse subtypes: physical, sexual, and emotional abuse, and neglect (Feather & Ronan, 2009a). There are no consensus-based definitions, however, nor are all of these subtypes included in each study undertaken, thereby making comparisons of data difficult (Belsky, 1993; Cicchetti & Manly, 2001; Jaffee, Caspi, Moffitt, Polo-Tomás, & Taylor, 2007; MacMillan et al., 2007; Taylor et al., 2008; Tyler et al., 2006). Nevertheless, there is general agreement about major features of each category. Thus, sexual abuse commonly reflects violation of a sexual nature involving a child, with the offender typically being older than the child (Trickett, Noll, Reiffman, & Putnam, 2001). Physical abuse would generally be thought to include any deliberate physical injury inflicted upon a child by an adult (Taylor et al., 2008). Emotional abuse includes witnessing violence between parents, being regularly humiliated or, as reflected in findings in a recent study, being told by parents such things as they wished them dead or never born (Cawson, Wattam, Brooker, & Kelly, 2000). In addition to maltreatment "commission", there is also the major problem of maltreatment by "omission", or serious neglect of physical and emotional needs at home. This can include being left without food or children having to fend for themselves and look after younger siblings because parents are absent or have substantial problems (Cawson et al.; Watson, 2005).

However these categories are defined, the fact is that prevalence of child maltreatment is a major problem worldwide. The following section of the paper presents an overview of the findings from a small number of representative international studies to give a sense of the international picture. The paper will then move toward a more specific focus on Australian incidence and prevalence.

International overview

In the United States, figures released by the Healthcare Cost and Utilization Project (Russo, Hambrick, & Owens, 2008) estimate 899,000 children to have been victims of child abuse in the United States in 2005. Hospitalisations resulting from this maltreatment were estimated at 6,700, with an in-hospital death rate at more than seven times that of stays unrelated to child maltreatment (Russo et al.). Alarmingly, these deaths all related to children younger than 5 years of age. While this age group accounts for only 27.1% of the US general population under 18 years, they accounted for 79.4% of the hospitalisations related to child maltreatment (Russo et al.).

Lifetime prevalence data from the United Kingdom, United States and New Zealand show remarkable consistency in the figures for sexual abuse (10%, mostly female) and familial physical abuse (7–9%) (Cawson et al., 2000; Fergusson, Horwood, & Lynskey, 1996; Finkelhor & Dziuba-Leatherman, 1994; Lynskey & Fergusson, 1997; Millichamp, Martin, & Langley, 2006). Interestingly, the UK and US studies also found that at least 20% of young people had experienced non-family physical assault or bullying (Cawson et al.; Finkelhor & Dziuba-Leatherman). The UK study, however, found that children were most at risk in their own family, and that overall they were much more at risk of physical and emotional abuse than of sexual abuse (Cawson et al.). These findings reflect a degree of consensus that exists across studies regarding the prevalence of physical maltreatment being greater than sexual abuse (Feather & Ronan, 2009a; Queensland Government Department of Child Safety, 2007; U.S. Department of Health and Human Services, 2007).

In general, neglect and emotional abuse tend to be the most recorded forms of abuse followed by physical and sexual abuse, although there are exceptions (AIHW, 2008; U.S. Department of Health and Human Services).

In addition, there is a trend related to socio-economic status, with those from the lowest socio-economic strata more likely to have been maltreated (AIHW, 2008; Tyler et al., 2006; Watson, 2005). A UK study, however, found that, even in the professional and managerial class, 4% of adult respondents reported being physically abused as children (Cawson et al., 2000), illustrating that this is not a problem unique to the lower tiers of societal wealth and opportunity (Gilbert et al., 2009). The UK study found that a great majority of those who were abused as children confirmed that they did not report the abuse to anyone including the police, social services, teachers, or other professionals (Cawson et al.). The findings here are a salient reminder that young people may tend not to disclose traumatic experiences, particularly those that occur within their family homes.

Australian prevalence

Accurate data regarding the number of children abused or neglected in Australia are difficult to obtain. Although information can be gathered from a variety of sources such as child protection agencies, police and court records, health service records, and the Australian Bureau of Statistics (ABS), no one source is able to provide an accurate indication alone. Thus, multiple sources must be evaluated in any attempt to produce a prevalence estimate (Taylor et al., 2008). The establishment of such an estimate is therefore problematic due to variations in the definition and levels of abuse and neglect reported, differences in the methodology implemented, and information sources having differing purposes for the collection of data (Belsky, 1993; Finkelhor, Ormrod, Turner, & Hamby, 2005; MacMillan et al., 2007; Watson, 2005; Taylor et al., 2008). Most importantly, not all incidents of child abuse are reported to authorities, making it difficult to provide accurate estimates (Feather & Ronan, 2009a; MacMillan et al.; Rheingold et al., 2007; Taylor et al., 2008).

A recent report evaluating the cost of child abuse in Australia used three different estimates regarding incidence and prevalence: lower bound estimate, best estimate, and an upper bound estimate (Taylor et al., 2008). The lower bound prevalence estimate of 36,570 children experiencing abuse in 2007 is based on adjusted substantiated child abuse cases from State and Territory Government child protection data. These data are considered to underestimate the actual rate due to the number of cases not reported to these authorities (MacMillan et al., 2007; Taylor et al.). The best estimate of abuse draws its data from the ABS Personal Safety Survey (PSS) and places the annual prevalence at 177,300 children in 2007. These data, however, are also believed to be an underestimate of the actual occurrence of childhood abuse (Taylor et al.). One possible reason for this is that only sexual and physical abuse are included in the ABS PSS survey. Emotional abuse, including living with family violence and neglect, is not included. The upper bound prevalence estimate is based on criteria used in a study from the United States (Finkelhor et al., 2005). Based on these criteria an estimated 666,500 Australian children were abused in 2007. Taylor et al. cautioned that the upper bound estimate be interpreted with care due to various factors (e.g., possible cultural differences; varying definitions of child abuse). Taken together, these figures suggest an estimate of the number of children abused or neglected in Australia in 2007 of between 177,000 and 666,000. Translated into economic terms, the cost imposed on the Australian community is estimated to range between $AU10.7 bn and $AU30.1 bn (Taylor et al., 2008). Some representative State figures are provided in the next section to help clarify the scope of the problem.

Specific Australian facts and figures

In NSW, from 2001–2002 to 2006–2007, reports for maltreatment, including neglect, rose by 79% (AIHW, 2008). By contrast, in Queensland, substantiation figures for 2006–2007 showed a quite promising decrease of 36% from the previous year, reflecting a decrease overall of 4,743 substantiations from the previous year, contrary to the national trend (AIHW; Queensland Government Department of Child Safety, 2007). Although extensive data are available regarding State incidence and prevalence, care must be taken when comparing results due to differences in State and Territory definitions, notification and investigation processes. Data collected by the Queensland Department of Child Safety between April and June 2007 followed the national trend, with emotional abuse being the most commonly reported form of maltreatment in general. When considering specific household types, however, April–June 2007 figures indicated neglect to be the most reported form of maltreatment in households of single mothers (59%), young (52%) and indigenous parents (43%) compared to the average of 36% of substantiations overall for neglect (Queensland Government Department of Child Safety, 2008a). Across other States and Territories emotional abuse or neglect are the most reported with one exception. Within the Northern Territory physical abuse has been the

most commonly reported form of abuse/neglect (AIHW, 2008).

An overview of child deaths in 2007–2008 undertaken by the Commission for Children and Young People and Child Guardian Queensland (2008) showed a slight increase in the number of deaths for those children known to the department in the 3-year period prior to their death. In addition, children known to child protective services died from external causes and non-accidental trauma at a rate three times higher (35.2 per 100,000) than children in the general population (11.2 per 100,000). Of those child deaths, 56% were between birth and 4 years of age and 30% were Indigenous children, thus indicating two particularly vulnerable groups within the community (Commission for Children and Young People and Child Guardian Queensland). While more figures could be provided, including from other States and Territories, these figures are representative of a problem that is nationwide (Taylor et al., 2008).

Risk factors and course

In order to provide well informed prevention and intervention programs regarding child maltreatment, a solid understanding of the risk factors involved in the aetiology and course of abuse is necessary (Serbin & Karp, 2004). Before listing these individual risk factors, it is worth noting that each should be considered within an ecological context, with risk factors in one domain often having systemic relationships to factors in other domains. These domains include individual, family, peer, school, neighbourhood, community and cultural contexts and are reflected in the literature both in Australia and internationally (AIFS, 2002; Dawe et al., 2008; Klevens & Whitaker, 2007; Ronan & Curtis, 2008).

Precursors to child maltreatment

Risk factors that have been consistently associated with child maltreatment include poverty, larger family size, single parenthood, young maternal age, poor parental mental health and parenting skills, low level of intellect, parental history of own exposure to maltreatment, substance abuse, domestic violence, favourable attitudes to antisocial behaviour, lack of social support, and a coercive pattern of family interaction (NSW DoCS, 2007; Prinz et al., 2009; Queensland Government Department of Child Safety, 2008b; Sledjeski, Dierker, Brigham, & Breslin, 2008; Taylor et al., 2008; Tyler et al., 2006; Watson, 2005). Child-specific characteristics associated with maltreatment are age, temperament, ethnicity, gender, and disability (Taylor et al.; Watson). A significant proportion of maltreated children are from lower socioeconomic households and neighbourhoods, with single-parent households being overrepresented (AIHW, 2008; Queensland Government Department of Child Safety; Watson). Of the large number of singular risk factors that predict maltreatment, a particularly pernicious factor is parental substance abuse (Dawe et al., 2008; Scott, 2009). Data from the US have implicated parental substance abuse as a documented or suspected factor in 79% of all cases in which a child was removed from the home because of maltreatment (US Department of Health and Human Services, 1997). Here in Australia, 33% of substantiated cases of maltreatment involved parents who had significant problems with substance abuse generally and 31% involved alcohol abuse more specifically (Dawe et al., 2008; Department of Human Services, 2002). As noted by Dawe et al., however, substance abuse problems tend to co-occur with other difficulties.

As an example at State level, five major risk factors for families involved in substantiated cases were recently assessed in Queensland (Queensland Government Department of Child Safety, 2008b): substance abuse, domestic violence, abused as a child, criminal activity, and history of mental illness. Queensland's Department of Child Safety reported that between April and June 2007, almost half of the families with substantiated child abuse cases in Queensland had one or both parents in the household with a drug or alcohol problem (see also Dawe & Harnett, 2007). Of those families with a history of previous contact with the department, this percentage rose to 65% (Queensland Government Department of Child Safety, 2008c). Thirty-five percent of households in substantiated cases reported two or more cases of domestic violence in the last year (Queensland Government Department of Child Safety, 2008b). Again, for those with previous contact, the percentage increased to 43% (Queensland Government Department of Child Safety, 2008c). Although one quarter of the primary caregivers in substantiated cases had been abused themselves as children, parents with a history of previous contact were one and a half times more likely to have been abused as a child (Queensland Government Department of Child Safety, 2008c). Twenty-nine percent of households involved in substantiated cases during the targeted period did not have any of the five major risk factors, but 44% of households had multiple risk factors impacting on their family environments. Parental risk factors were not common in households involved in substantiated cases of sexual abuse, with just over half of the cases reporting none of the five risk factors measured (Queensland Government Department of Child Safety, 2008b).

In considering risk factors in sexual abuse, a major New Zealand longitudinal study found risk factors

for sexual abuse to be female gender, marital conflict, low parental attachment, overprotective parents, and parents with alcohol problems (Fergusson et al., 1996). Interestingly, low socioeconomic background tends not to emerge from these types of studies as a salient risk factor for sexual abuse, which sets it apart from other forms of abuse (Leventhal, 1998).

Consequences and course of maltreatment and corporal punishment

The risk factors in the previous section are not only risk factors for child maltreatment, they are also more generally risk factors for poor psychosocial outcomes for children across time. In addition, research has also shown child maltreatment itself to be a predictor of poor outcomes independent of other risk factors (Cicchetti & Toth, 1995; Fergusson et al., 1996). Child maltreatment outcomes have been shown to impact on emotional, social, biological, and cognitive functioning (Cicchetti & Toth). Documented outcomes include post-traumatic stress disorder (PTSD), anxiety, depression, suicide, antisocial behaviour, eating disorders, substance abuse, criminal involvement, behavioural problems, aggression, delinquency, and teenage pregnancy. Other outcomes such as reduced self-esteem, poor social skills, low academic ability, and language delays are also well documented. For those who are exposed to an aggressive home environment characterised by physical maltreatment, coercive parenting and other forms of domestic violence, there is the very real possibility that these children will grow up and continue this cycle of violence (Bedi & Goddard, 2007; Collishaw et al., 2007; Feather & Ronan, 2009a,b; Gilbert et al., 2009; Jaffee, Caspi, Moffitt, & Taylor, 2004; Jaffee, Belsky, Harrington, Caspi, & Moffitt, 2006; Kaplow & Widom, 2007; Leventhal, 1998; Lynskey & Fergusson, 1997; Taylor et al., 2008; Tyler et al., 2006; Widom, 1989). In particular, earlier estimates regarding the rate of intergenerational transmission of child abuse (ITCA) was $30 \pm 5\%$ (Buchanan & Oliver, 1977; Kaufman & Zigler, 1987). More recent studies report slightly lower estimates, with Pears and Capaldi (2001) reporting an ITCA rate of 23%, and Kim (2009) identifying a rate of 20% as well as a tendency toward type-specific ITCA with regard to physical abuse and neglect (i.e., the tendency to repeat the same form of abuse as one was subjected to earlier in life). Of course, other longer term effects linked to violence and other poor outcomes (e.g., antisocial behaviour, being an adult victim) are also quite possible (e.g., Gershoff, 2002a; Jaffee, Caspi, Moffitt, Polo-Tomas et al., 2004).

Reflecting findings from an earlier study (Keiley, Howe, Dodge, Bates, & Pettit, 2001), Kaplow and Widom (2007) found age of onset of child physical maltreatment to hold specific relevance to later outcomes, with an earlier age of onset predicting greater symptoms of anxiety and depression in adulthood, whereas later onset predicted more behavioural problems. By contrast, and reflecting some of the complexity linked to child maltreatment, Manly, Kim, Rogosch, and Cicchetti (2001) found that emotional maltreatment and physical abuse under 5 years of age tended to predict externalising behaviour and aggression. In contrast, physical neglect during this same period was more often associated with internalising behaviours. For childhood sexual abuse (CSA), research has indicated that features of the CSA itself and its aftermath (e.g., use of force or threats, abuse by a family member, negative response when disclosure made; Bulik, Prescott, & Kendler, 2001) and other factors (lack of paternal care or support in childhood; affiliation with deviant peers; Lynskey & Fergusson, 1997) produce greater risk for poor outcomes.

An area worthy of consideration here involves outcomes that have been documented as a function of corporal punishment. Corporal punishment has been a topic debated for many decades and currently shows no sign of slowing. In terms of what the evidence says, Gershoff (2002a) conducted a meta-analysis reviewing factors that may mediate and moderate the relationship between corporal punishment and child behaviour and outcomes. Corporal punishment sits on a continuum, with mild corporal punishment at one end and child maltreatment at the other. What may begin in the parent's mind as a mild form of discipline may escalate to more severe and frequent action directed at the child (Gershoff, 2002a). Considerable debate surrounds this topic (Baumrind, Larzelere, & Cowan, 2002; Gershoff, 2002a,b; Holden, 2002; Jaffee, Caspi, Moffitt, Polo-Tomas et al., 2004; Jaffee, Caspi, Moffitt, & Taylor, 2004; Parke, 2002). Based on findings to date, however, the evidence is such that there is clear merit in psychologists, at a minimum, encouraging alternatives to corporal punishment given evidence demonstrating negative effects linked to its use. Thus, while Gershoff noted that corporal punishment is associated with immediate compliance (Cohen's $d_+ = 1.13$), it is also associated with adverse short and longer term outcomes such as decreased moral internalisation ($d_+ = -0.33$), increased child ($d_+ = 0.36$) and adult aggression ($d_+ = 0.57$), increased child delinquent and antisocial behaviour ($d_+ = 0.42$), increased adult criminal and antisocial behaviour ($d_+ = 0.42$), decreased quality of relationship between parent and child ($d_+ = -0.58$), decreased child mental health ($d_+ = -0.49$), increased risk of being a later victim ($d_+ = 0.69$) and an adult perpetrator ($d_+ = 0.13$)

(Gershoff, 2002a). Based on her comprehensive review, Gershoff concluded the following.

> That unless and until researchers, clinicians, and parents can definitively demonstrate the presence of positive effects of corporal punishment (including effectiveness in halting future misbehaviour), not just the absence of negative effects, we as psychologists cannot responsibly recommend its use. (Gershoff, 2002b, p. 609)

Protective factors leading to resilience

Not all maltreated children go on to develop psychosocial problems or display negative life outcomes (Collishaw et al., 2007; Finkelhor, 1994; Lynskey & Fergusson, 1997; NSW DoCS, 2007). For example, with regard to sexual abuse, early estimates were that between 20% and 40% of those affected would not develop psychological problems (Finkelhor). These estimates were replicated in a later study in New Zealand conducted by Lynskey and Fergusson (1997). In relation to both sexual abuse and physical maltreatment, data from the Isle of Wight longitudinal study showed similar findings, with nearly half of those affected not developing any form of adult psychopathology (Collishaw et al.).

Variables identified in the literature that appear to enhance outcomes include a number of protective factors, factors that improve the chances of coping with life stressors in an adaptive manner and reducing the chance of poor developmental and psychosocial outcomes (Collishaw et al., 2007; Finkelhor, 1994; Hoge, Austin, & Pollack, 2007; Lynskey & Fergusson, 1997). Research has indicated that the following factors promote increased resilience to maltreatment: parental warmth and affection, parental attachment, family and peer support, positive peer associations and inter-personal relationships, bond to community, church and school, easy temperament, high level of self-esteem, internal locus of control, and self-efficacy (Bulik et al., 2001; Collishaw et al.; Hoge et al.; Lynskey & Fergusson; Rutter, 2007).

Other factors found to be protective include reporting abuse that is not met with a negative response and that leads to the abuse being effectively stopped (Bulik et al., 2001). Age may also be considered a protective factor in some cases, with older children better able to process events due to better developed cognitive abilities (Bolger & Patterson, 2001; Feather & Ronan, 2009a; Lynskey & Fergusson, 1997). Other studies, however, show maltreatment that has commenced and ceased in early childhood to be less associated with detrimental outcomes than persistent maltreatment through adolescence. Findings here are not clear-cut, demonstrating again the multiple layers involved in understanding causes and consequences of child maltreatment (Keiley et al., 2001; Manly et al., 2001; Thornberry, Ireland, & Smith, 2001).

Pathways/mechanisms of risk and resilience

What has been discussed to this point is that exposure to certain risk factors places children at risk for maltreatment, and maltreated children at greater risk for developing mental health problems and poor outcomes later in life. As introduced in the previous section however, this life path is not fixed, and a number of factors have been identified that reduce risk. Rutter (2007) suggested that it may be time to move from "variables to processes or mechanisms" (p. 205) and identify what it is that people actually do to cope with the adversity that life has placed before them. A variety of mechanisms have been identified that can either raise risk or promote resilience and these are influenced by factors that fall under the broad domains of individual functioning: genetic, biological, cognitive, emotional, behavioural, and inter-personal (Collishaw et al., 2007; Rutter). Of course, these individual factors also extend across multiple systems including family, peer, school/vocational, community and cultural domains (Ronan & Curtis, 2008).

Research on risk and protective factors has shown that there is no one simple answer in explaining the interplay between the factors that can result in either resilience or continuing risk and problems (Belsky, 1993). For example, in testing a cumulative stress model, Jaffee et al. (2007) found children who were exposed to multiple family and community stressors to be at higher risk for poor outcomes regardless of individual strengths or protective factors. It appears that although strengths build resilience in low-stress conditions, under the influence of multiple risks or high stress, the impact of these protective factors appears to be reduced (Jaffee et al.). In keeping with the cumulative stress model, further research has also found evidence of the increased likelihood for poor outcomes when the level of risk is increased. No threshold effect, however, has been found and, in some cases, increased resilience can result from singular factors. For example, early interventions focusing on positive and loving parenting are capable of bringing about positive changes (Appleyard, Egeland, Van Dulmen, & Sroufe, 2005; Trentacosta et al., 2008).

In contrast, a coercive family process (Granic & Patterson, 2006) that includes poor parenting (e.g., coercive discipline/maltreatment; lack of warmth; poor monitoring and supervision) is an initial pathway through which risk for intergenerational transmission of problems can accumulate over time (Ronan & Curtis, 2008). This pathway involves

mechanisms that include children developing a hostile attributional bias and coercive problem-solving strategies (Dodge, Bates, & Pettit, 1990), early rejection by prosocial peers and resultant deviant peer affiliation (Dodge et al., 2003; Granic & Patterson). Once affiliated with deviant peers, then a number of socialisation mechanisms have also been identified that promote rule-breaking, coercive socialisation (including bullying and being a victim of bullying) and favourable attitudes to antisocial and aggressive behaviour (Dishion, McCord, & Poulin, 1999; Patterson, Dishion, & Yoerger, 2000; Prinstein & Wang, 2005; Ronan & Curtis; Snyder et al., 2005).

Developing an understanding of child maltreatment risk and protective factors and associated pathways and mechanisms are important for prevention and intervention programs (Collishaw et al., 2007). Additionally, a number of interventions have shown some success in reducing risk and improving outcomes. The next section provides a review of major interventions that are available in this area and a summary of the evidence.

Prevention and intervention

Promising practices

A recent meta-analysis (Skowron & Reinemann, 2005) and reviews (Klevens & Whitaker, 2007; MacMillan et al., 2009) have indicated some promising intervention modalities for dealing with problems related to child maltreatment. These focus on three major areas: (a) preventing impairment, (b) preventing recurrence of maltreatment and, most importantly in the long-term, (c) preventing initial child maltreatment (MacMillan et al., 2009). Across these major areas of focus, numerous modalities are available that range from an individual focus on children, a focus on parents, a focus on both children and parents, removal of the child and placement in various settings. Additionally, different programs are variously carried out or enacted within home settings, clinics, hospitals, schools, foster care settings (i.e., foster care, kinship care), group and residential facilities. Some programs deal with more singular risk factors (e.g., individual focus on helping a child process trauma and build coping skills), whereas others deal with a larger range of risk and protective factors. Thus, given the growing size of the literature, space limitations, and the availability of recent reviews both internationally (e.g., MacMillan et al., 2009) and here in Australia (e.g., Dawe et al., 2008), the review here is not exhaustive. We start with a review of interventions developed for dealing with the effects of maltreatment on children followed by those developed for reducing the risk of recurrence and, finally, those developed to prevent an initial occurrence of abuse or neglect. While we do focus to some extent on international programs, the review is also aimed at identifying programs in Australasia that have research support.

Interventions for abuse-related problems for children

A number of trauma-focused programs have been developed to assist children following maltreatment (Klevens & Whitaker, 2007; Skowron & Reinemann, 2005). A prominent model is trauma-focused cognitive behavioural therapy (TF-CBT). These programs have been developed with the aim of helping children manage their symptoms and process associated trauma and related problems (Feather & Ronan, 2009a). One such program available in Australasia has been developed by Feather and Ronan (2006). Similar to empirically supported models developed overseas (e.g., Cohen & Mannarino, 1996, 1997; Cohen, Mannarino, & Knudsen, 2005; Deblinger, Lippman, & Steer, 1996; Deblinger, Steer, & Lippman, 1999), this program includes a number of components: psychosocial strengthening, coping skills, trauma processing (incorporating gradual exposure techniques), and relapse prevention. Additional sessions are allocated towards the end of therapy to assist the child with any special issues related to their particular situation. Therapy is conducted over a period of 16 sessions and is designed for children aged between 9 and 15 years. Although this program is designed primarily as a child intervention, parents/caregivers are involved in three of the sessions in an effort to encourage the involvement of a safe adult outside of therapy to provide ongoing support to the child (Feather & Ronan, 2004, 2009b). Results from the initial pilot study were promising, with PTSD symptoms decreasing and children's level of coping increasing. Improved coping skills were still evident at 3-, 6-, and 12-month follow-up intervals (Feather & Ronan, 2006). Additional single case evaluations support this specific intervention, including showing effectiveness across different cultures (Feather, Ronan, Murupaenga, Berking, & Crellin, 2009) and as carried out by different therapists (Feather & Ronan, 2009b). Another CBT intervention carried out in Melbourne by King et al. (2000) aimed at reducing impairment linked to sexual abuse has randomised control trial (RCT) support.

TF-CBT is showing considerable promise as an effective tool in helping children resolve problems associated with trauma (Berliner, 2005). Further research, however, is necessary here in Australasia, including additional RCT and effectiveness evaluations, including studies that address implementation difficulties (Kolko et al., 2009). Additionally, a number of studies have recommended the need to

go beyond a sole focus on individual treatment to focus on caregivers and multiple risk factors for maladjusted course and continuing maltreatment (Feather & Ronan, 2006, 2009a; King et al., 2000; Swenson & Chaffin, 2006). The next section reviews interventions that have been aimed at stopping recurrence of maltreatment as well as additionally assisting a child's health and development.

Interventions to stop recurrence of abuse and neglect

Numerous interventions have been developed to stop the re-occurrence of abuse and neglect in families and includes a number of social work and psychological interventions.

Removal and placement. Social work interventions include removal of the child from the home and placement in various settings including foster care homes, kinship care, group homes, and residential facilities. A review of those interventions is beyond the scope of this article but, with respect to foster care, the research available indicates some mixed findings (MacMillan et al., 2009), with some studies noting no differences between placed versus non-placed children (Runyan & Gould, 1985; Widom, 1991) and another noting placed children to have more difficulties (Lawrence, Carlson, & Egeland, 2006). More studies, however, have found that foster placed children fare better than non-placed children across a variety of outcome domains (Chung, Webb, Clampet-Lundquist, & Campbell, 2001; Colton, Aldgate, & Heath, 1991; Davidson-Arad, Englechin-Segal, & Wozner, 2003; Horwitz, Balestracci, & Simms, 2001; Kessler et al., 2008; Nelson et al., 2007; Polit, Morton, & White, 1989; Wald, Carlsmith, & Leiderman, 1988). Obviously, this is a complex area and simply looking at foster placement versus non-placement obscures a number of additional factors that will affect child outcomes. Nevertheless, based on the available evidence, MacMillan et al. (2009) concluded in their review that "foster care placement can lead to benefits compared with (remaining at home or reunification)" (p. 250). This would include what these authors referred to as enhanced foster care. One such program includes multidimensional treatment foster care (MTFC), a program developed by a psychologist, Patricia Chamberlain, at the Oregon Social Learning Center in the United States (Chamberlain, 2003). This program is aimed primarily at equipping foster parents with parenting and other fostering skills and is carried out in the home setting.

Parenting programs. Various parenting interventions are used here in Australia, notably Triple P (Sanders, 2008; Sanders et al., 2004) and Parents Under Pressure (PUP) (Dawe & Harnett, 2007; Dawe, Harnett, Rendalls, & Staiger, 2003) and, in New Zealand, most notably the Incredible Years program (e.g., Beauchaine, Webster-Stratton, & Reid, 2005; Lees & Ronan, 2008; Webster-Stratton & Reid, 2007). As a consequence, these programs are briefly reviewed. Prior to that, however, it is worth noting that based on findings to date, parenting programs for reducing risk for problems such as child maltreatment very likely need to be more intensive and involve additional components compared to standard parent education programs. This would include elements such as *in vivo* enactment strategies and a focus on multiple risk factors (for reviews, see Dawe et al., 2008; Lundahl, Nimer, & Parsons, 2006). One such program developed in the United States, parent–child interaction therapy (PCIT; Chaffin et al., 2004), was identified in the MacMillan et al. (2009) review (see also Barlow, Johnston, Kendrick, Polnay, & Stewart-Brown, 2006) as currently the most effective parenting program for reducing recurrence of physical abuse including reductions in post-treatment notifications for physical abuse compared to a standard parenting group (19% of PCIT vs. 49% of standard parenting participants). That study also found significant reductions in indicators reflecting potential emotional abuse (e.g., negative parent–child interactions) following PCIT. For neglect, no program has yet demonstrated a capacity for reducing the recurrence of neglect, particularly in the long term (MacMillan et al., 2009). A number of parenting interventions, however, have potential to reduce recurrence of emotional abuse, physical abuse and neglect in particular, including those now reviewed. (For sexual abuse, there are various programs available for child sex offenders, e.g., Borduin, Schaeffer, & Heiblum, 2009; Henggeler et al., 2009; see also MacMillan et al., 2009.)

In Australia, the PUP program is a parenting-based program that is carried out across 10 modules delivered over 10–12 weeks, delivered by trained psychologists. PUP goes beyond standard parent education through home-based service delivery, a focus on multiple risk factors (e.g., marital conflict, social support, housing, legal advice, parent psychological functioning, intervention in other contexts such as schools) and includes additional complementary case management. PUP is also guided by an individualised assessment and formulation that helps to individualise treatment goals and module and case management delivery. In addition to traditional areas of focus in parenting programs, including positive parent–child interaction and discipline strategies, the program also teaches parents stress tolerance and emotional regulation strategies (e.g., mindfulness; relapse prevention) as an alternative to impulsive,

maladaptive coping, including substance use and child maltreatment. Research thus far has included supportive evaluations involving methadone-maintained parents (Dawe & Harnett, 2007; Dawe et al., 2003), parents involved with care and protection (Harnett & Dawe, 2008), and women who were former inmates (Frye & Dawe, 2008). Findings include reductions in self-reported potential for child abuse (e.g., Dawe & Harnett, 2007). As pointed out, however, by Dawe et al. (2008), owing to follow-up intervals being short (6 months), additional support for maintenance of gains over longer intervals is required. This should also include assessment of documented notifications of maltreatment. The other parenting program developed and used here in Australia is Triple P. That program is reviewed in the Prevention section.

In New Zealand, Webster-Stratton's Incredible Years Program is being used increasingly and is included as one of the recommended interventions in the New Zealand national plan for reducing rates of conduct disorder and antisocial outcomes (Ministry of Social Development, 2007). Developed as an early intervention for disruptive outcomes including conduct disorder, the program has also been evaluated for its ability to reduce risk in relation to other outcomes, including maltreatment (e.g., Gross et al., 2003; Hughes & Gottlieb, 2004). The program itself has a number of components that revolve around basic and advanced parenting programs. These programs focus first in the basic program on teaching parents reinforcement and child-directed play strategies and "specific non-violent, discipline techniques" (p. 163; Webster-Stratton, 2006). These basic skills can then be supplemented in the advanced program to deal with additional risk factors, including anger management, communication, support-giving and -seeking skills, problem-solving, managing stress and mood problems. Both basic and advanced programs are normally carried out across 12 sessions each, typically in small group format. For example, in a randomised dismantling study (i.e., RCT with components analysis) done with parents of toddlers in low-income areas, groups of participants (8–12 per group), attended 2-hr basic program sessions across 12 weeks. Those who received parent training (parent training, parent plus teacher training) were found to have less coercive discipline and more positive parenting behaviours compared to conditions in which parent training was not carried out (teacher training, waitlist control). In another RCT evaluation of the Incredible Years Program with maltreating families (Hughes & Gottlieb, 2004), support was found across a 16-session version of the intervention for improvements in parenting skills (Involvement, Autonomy-Support) assessed through direct observation in the home setting. No changes, however, were seen in a parent discipline variable (Structure) or a child behaviour variable (Autonomy). Thus, although developed primarily to prevent conduct disorder, this parenting program does currently have some demonstrated support for assisting at-risk families, including those who have documented maltreatment. More evaluation, however, is necessary to ascertain its full potential in preventing child maltreatment or its recurrence.

Systems interventions. A range of models has been developed that focus explicitly on multiple systems. Like PUP, these models focus on parents/caregivers as central to treatment (Ronan & Curtis, 2008), include home-based service delivery and a focus on multiple risk factors. Two prominent and similar models developed overseas but available in parts of Australasia include MTFC (Chamberlain, 2003) and multisystemic therapy (MST) (Brunk, Henggeler, & Whelan, 1987; Curtis, Ronan, & Borduin, 2004; Curtis, Ronan, Heiblum, & Crellin, 2009; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Swenson et al., 2009).

Of these models, MST has had the most scrutiny in Australasia, including in New Zealand (Curtis et al., 2009) and in a number of States here in Australia, including Queensland and Western Australia. MST begins with, and is guided by, a functional assessment and formulation that is designed to account for all major risk and protective factors within a particular family ecology (Ronan & Curtis, 2008; Schoenwald, Heiblum, Saldana, & Henggeler, 2008). Once done, and alongside engagement strategies, "sequences are targeted" with decisions made about where in the formulation sequence treatment impact might occur most quickly based on the principle of using family "strengths as levers for change" (Henggeler et al., 1998). Findings overall are promising, both in terms of increasing "successful completion" rates as well as overall outcomes (see meta-analytic review by Curtis et al., 2004). This includes for problems associated with child abuse (e.g., antisocial behaviour, criminality, delinquency, substance use, sexual offending) (e.g., Borduin et al., 2009; Letourneau et al., 2009; Schoenwald, Heiblum et al., 2008; Timmonss-Mitchell, Bender, Kishna, & Mitchell, 2006) as well as a direct intervention for child abuse and neglect (Brunk et al., 1987; Swenson et al., 2009).

In terms of targeting child abuse and neglect directly, a recent RCT found that MST for child abuse and neglect (MST-CAN) was significantly more effective than an enhanced outpatient treatment (EOT) on the following indices: youth mental health indicators, parent emotional distress, parent–child interactions linked to maltreatment, fewer child-out-of-home placements and fewer changes in

child placements (Swenson et al., 2009). Additionally, over a 16-month post-baseline period, rates of documented re-abuse were lower for MST-CAN (4.5%) compared to EOT (11.9%). This difference, however, did not reach significance. Although overall findings are quite encouraging, implementation of MST and many other evidence-supported intervention models require substantial organisational commitment, including changes in philosophy, structures and delivery practices (e.g., Henggeler, 2004). The issue of implementation and transport of evidence-based services into practice settings is a vital issue and is considered more fully in the final section of this article.

Prevention of child maltreatment

Prevention of child maltreatment can include any intervention that reduces risk or increases protective factors linked to child maltreatment and that is subsequently shown to prevent the occurrence of child maltreatment. Thus, interventions discussed in subsequent sections, including a range of parenting programs, can quite conceivably be used in this way. These types of programs, however, have tended to be evaluated more often as secondary or tertiary interventions. Thus, this section focuses on the two approaches that have supportive evaluation data related specifically to primary prevention (MacMillan et al., 2009): (a) home visitation programs, and (b) a parenting program aimed at both targeted and universal prevention.

Home visitation programs. Home visitation by health or mental health professionals has been carried out in various countries, including Australia and New Zealand (e.g., Plunket, 2008), for a long period of time. Internationally, however, findings related to their effectiveness in preventing child maltreatment have been mixed (e.g., Sweet & Applebaum, 2004). Owing to space limitations, the review that follows focuses on the one overseas program with the most robust empirical support as well as programs in New Zealand and Australia that have some preliminary support (for more comprehensive meta-analytic and qualitative reviews, see Bilukha et al., 2005; Gomby, 2007; MacLeod & Nelson, 2000; MacMillan et al., 2005, 2009; Olds et al., 2007; Sweet & Appelbaum).

Nurse–family partnership. This primary prevention model was developed in the United States (Olds, 2002) and focuses on building a nurse–family partnership from birth, not dissimilar in some ways from the Plunket model in New Zealand (Plunket, 2008). The Olds program, known as the Nurse–Family Partnership (NFP) program, has been evaluated through three separate RCTs and has shown a number of positive outcomes including fewer reports of child abuse, fewer recorded injuries, changes on positive maternal child care indicators and later beneficial outcomes in adolescence. The NFP program is grounded and guided by an epidemiologic/ecological framework, child development theory, and behavioural change through increasing competencies and a sense of mastery. Thirty years of development has seen the NFP program conceptualised, developed, trialled, improved, and prepared for dissemination in community settings (Olds; Olds et al., 2007). The goals of the program are (a) to assist expectant mothers with antenatal and postnatal health behaviours and economic self-sufficiency, including planning for the future; and (b) to assist mothers to provide healthy and responsible care and support for their child, including providing warmth; rearing strategies; and child health.

This program focuses on women who have had no previous live births, are on a low income and are single or adolescents. The program is delivered by nurses who have gone through a 4-week training period and is carried out via a standardised manual that specifies the focus for each visit. This program is carried out in the home environment and has demonstrated improvements in pre-natal care, pregnancy outcomes, child development, parental efficacy, and reductions in child abuse and neglect (Olds et al., 2007; see also MacMillan et al., 2009). For children whose mothers were initially involved in the NFP program, findings have also included reductions in criminal activity, substance use, and risky sexual involvement (Olds, 2002).

Acknowledging the effect that intimate partner violence has on families, further refinement of the NFP program has seen the inclusion of components specifically to help women cope and to promote improved communication between partners (Olds et al., 2007). Comparing the effectiveness of program delivery by paraprofessionals to that of nurses shows paraprofessional delivery not to be as effective in reducing child protection reports. It is also noted, however, that although delivery by nurses is more effective, program success relies on more than the provision of a nurse (MacMillan et al., 2009; Olds et al.). Other "active ingredients" besides tertiary level qualifications speculated about include an intensive focus on treatment fidelity and, related to this, that this program's development included a planned evaluation strategy (vs. being simply a service delivery model with no systematic evaluation strategy; MacMillan et al., 2009).

Australia and New Zealand programs. A New Zealand-based program, Early Start, has much in common with NFP. Well-trained, tertiary-level

practitioners (nurses, social workers who undergo 5-week training) carry out an intensive program of home visits aimed at at-risk mothers and families. Based on a social learning model, program goals are similar to those in NFP and include promoting family stability, parenting, child health, and helping families plan for child, family, social and economic wellbeing in the future (Fergusson, Grant, Horwood, & Ridder, 2005). The program itself is based on an assessment carried out in the first month of home visitation that then allows the program to be tailored to an individual family's circumstances as well as identify those families in most need. The practitioner then visits once a week on average, and the program is designed to be able to be provided for up to 5 years if necessary. In terms of research support, although this program has been currently subjected to only one RCT, the sample size was large (> 400 families involved) and findings were generally supportive. That is, compared to the control condition at the 3-year mark, and in relation to child maltreatment, supportive findings were as follows: treated parents reported much less physical abuse of their children (approx. one third compared to control parents); lower attendance and admission to hospitals in relation to indicators of maltreatment, including injuries. In contrast, and importantly, actual reports of child maltreatment to agencies did not differ between groups. Although this finding has been attributed to the potential obscuring of real differences by closer surveillance of treated families (Fergusson et al., 2005), it also indicates that further examination is required beyond this one RCT (MacMillan et al., 2009). Nevertheless, based on other supportive findings, this program does appear to have potential.

In Australia, a nurse home visitation program supplemented with social work input and additional services, Family Care, was found to have initially supportive outcomes across a range of domains, including reduced potential for child abuse as assessed through self-report (Armstrong, Fraser, Dadds, & Morris, 1999; Fraser, Armstrong, Morris, & Dadds, 2000). Actual reports, however, of child abuse or neglect were not assessed and gains did not generalise across a 12-month follow-up interval (Fraser et al., 2000). Differences in outcomes between this program and Early Start may have been a function of possible differences in the level of training in the approaches (5 weeks in Early Start; unspecified for Family Care), level of intensity and duration of the program (average 50 visits per year for up to 5 years in Early Start; in Family Care, a minimum of 18 visits over 1 year that included weekly visits until 6 weeks, fortnightly visits to 3 months, monthly visits to 12 months of age) and fidelity assessment in Early Start versus no fidelity assessment reported for Family Care. Thus, as seen for intervention programs for other difficult problems in childhood (e.g., conduct disorder; Curtis et al., 2009), initial formalised training along with intensity and duration of interventions in home visitation programs may need to be such that they match the level of difficulty and risk within particular families and better ensure long-term outcomes.

Parenting program as primary prevention. A number of parenting intervention models are available that have a focus on primary through tertiary prevention. But only one program internationally – Triple P – has focused directly on whether parenting intervention is capable of preventing initial occurrences of child maltreatment at a population level.

Developed at the University of Queensland in 1981, this program was originally designed as an in-home individual training program for parents with children aged under 5 years who were displaying behavioural problems (Sanders, 2008). Over the last two decades this program has evolved into a multilevel parenting support and training program with a primary goal of increasing parents' self-regulation and parenting capacity (Sanders, 2008; Sanders, Turner, & Markie-Dadds, 2002). Grounded in social learning theory, Triple P aims to increase parents' levels of self-efficacy, personal agency, and problem-solving abilities as well as incorporating the use of self-management tools through a multilevel system of parental support (Sanders, 2008; Sanders et al., 2002). Overall, like other parenting programs, Triple P has been used and evaluated primarily for parents with known problems (i.e., secondary and tertiary prevention). In these trials, findings have shown increases in parenting confidence, decreases in coercive parenting and enhanced outcomes for children, as follows.

> When parents change problematic parenting practices, children experience fewer problems, are more cooperative, get on better with other children, and are better behaved at school. Parents have greater confidence in their parenting ability, have more positive attitudes toward their children, are less reliant on potentially abusive parenting practices, and are less depressed and stressed by their parenting role. (Sanders et al., 2002, p. 177)

This includes RCT support for Triple P when delivered to parents showing signs of emotional abuse and who were at risk for other forms of maltreatment. In addition to enhanced parent functioning (parenting practices, adjustment) and child functioning (behaviour, adjustment), overall findings indicated reduced child abuse potential both at post-treatment assessment and at 6-month follow-up (Sanders et al., 2004; see also Sanders,

2008). Thus, like other parenting programs reviewed earlier, Triple P has been used successfully to reduce risk related to recurrence of maltreatment and related difficulties. Like other programs, however, longer follow-up intervals and including documented notifications as one long-term follow-up indicator are also warranted in future evaluations of this sort.

In relation to the more universal prevention of child maltreatment, the Triple P program has recently undergone one population trial across 18 counties in one US state (Prinz et al., 2009). That trial used a stratified random assignment by county approach and compared Triple P – combining dissemination of Triple P across the entire workforce of over 600 service providers and universal strategies (media and communication approaches) – with services as usual. Compared to services as usual, Triple P demonstrated significantly improved outcomes and large between-group effect sizes for intervention-produced decreases in substantiated reports of child maltreatment (Cohen's $d_+ = 1.09$), out-of-home placements ($d_+ = 1.22$), and child maltreatment injuries ($d_+ = 1.14$) (Prinz et al.). Owing to some problems, however, identified for that study by a recent review (e.g., that some analyses such at *t*-tests and details related to calculation of effect sizes are not clear; MacMillan et al., 2009), and with it being the only such population study available, replicating findings through further evaluation is necessary. Nevertheless, this initial demonstration of preventative impact at a population level is promising and supplements evaluation of the Triple P program when carried out more intensively with at-risk parents (Sanders, 2008; Sanders et al., 2004, 2008.). It also portends promise for other parenting programs being used for primary prevention, including in antenatal programs.

Implementation of evidence-supported interventions

Regardless of intervention modality, we recommend that programs be strongly grounded in epidemiological and theoretical knowledge, including incorporating all known risk and protective factors within individual case formulations, and be evidence supported (Feather & Ronan, 2009a; Olds et al., 2007; Ronan & Curtis, 2008; Tyler et al., 2006). We also recommend that programs focus on both reducing maltreatment and its recurrence, as well as associated impairments experienced by children.

A socioecological approach (Bronfenbrenner & Ceci, 1994) places emphasis on obtaining the right balance of reducing risk and promoting individual strengths and protective factors across multiple layers linked to a child's functioning. Consistent with this philosophy, a focus on parent, child, and family characteristics and mechanisms, the possibility of intergenerational transmission effects, along with broader social environmental influences such as peer, school, cultural and community factors are all important considerations (Belsky, 1993; Curtis et al., 2004; Serbin & Karp, 2004). Further, when planning any intervention program, change and improvement also needs to be monitored (Harnett, 2007; Jacobson & Truax, 1991; Kazdin & Nock, 2003; Skowron & Reinemann, 2005). We would add here that change can be monitored using pragmatic indices that can be used in the face of resource limitations (Ronan & Curtis, 2008).

Timing of prevention and intervention programs is also an important consideration. For example, research does support early intervention for reducing well-known risk factors associated with multiple negative outcomes (Appleyard et al., 2005; Kaplow & Widom, 2007; Trentacosta et al., 2008; Tyler et al., 2006). In addition, data have also shown that families who do not access the appropriate services when needed tend also to become the families known to the department through continuing contact, placing a child at continued risk (Queensland Government Department of Child Safety, 2008c). By contrast, a recent US study found that if families, including those with a history of domestic violence, are engaged early and actively in case planning, maltreatment risk to the child can be significantly reduced (Sledjeski et al., 2008).

As a consequence, barriers that may prevent the family from engaging in services need to be identified and dealt with directly (Dawe et al., 2008; Nock & Kazdin, 2005; Olds et al., 2007; Ronan & Curtis, 2008). Services that address obstacles and motivational issues are likely to see engagement and successful completion rates increase (Curtis et al., 2009; Harnett, 2007; Lees & Ronan, 2008; Nock & Kazdin; Ronan & Curtis). These family obstacles include emotional/conceptual factors (e.g., treatment not perceived as voluntary; belief that intervention will not work; lack of trust in social service agencies; poor relationship with providers) as well as concrete obstacles (e.g., lack of transport, time off work) (Kazdin & Whitley, 1997).

Transport of research-supported services including obstacles and pragmatics

Effective delivery of services for children and youth is difficult work, whether in the child protection (MacMillan et al., 2007) or child mental health sectors (Glisson, Landsverk et al., 2008). For example, despite the public health priority to provide effective services to maltreated and other child populations (e.g., Chaffin, 2004; Schoenwald,

Chapman et al., 2008; Schoenwald, Kelleher et al., 2008), including here in Australia (AIFS, 2008), there are significant problems. Problems with staff retention (Glisson, Schoenwald et al., 2008) and new program sustainability (Massati et al., 2008), combined with less than optimal organisational cultures (Glisson, Landsverk et al.), are commonplace (Glisson, Schoenwald et al.). Thus, in addition to family obstacles, there are a number of organisational obstacles to implementing evidence-based practices in child protection agencies and child treatment settings. As early as 1963 discussions were being held regarding the importance of those in the helping professions needing to assist politicians in helping those referred to as the "forgotten people" (p. 291) (Humphrey, 1963). Bridging the gap between science and practice is a well-documented and difficult task, including in the child protection and mental health area (LaGreca, Silverman, & Lochman, 2009; Lewig, Arney, & Scott, 2006; MacMillan et al., 2007; Salveron, Arney, & Scott, 2006). Continued efforts, however, to produce workable frameworks to address this problem in the delivery of services for children and families are continuing to emerge, including from a recent special issue of an administrative mental health journal (Chorpita, Bernstein, Daleiden, & The Research Network on Youth Mental Health, 2008; Glisson, Landsverk et al., 2008; Kimberly & Cook, 2008; Klevens & Whitaker, 2007; Mendel, Meredith, Schoenbaum, Sherbourne, & Wells, 2008; Schoenwald, Chapman et al., 2008; Schoenwald, Kelleher, Weisz, & The Research Network on Youth Mental Health, 2008; Zazzali et al., 2008).

To enable the successful transport of (a) evidence-based practices and (b) an evidence-based culture (e.g., commitment to evaluating programs, to keeping current with research, to sharing research with each other and with clients; Ronan & Curtis, 2008), multiple issues at multiple levels need to be considered (Lewig et al., 2006; Salveron et al., 2006; Schoenwald, Chapman et al., 2008; Schoenwald, Kelleher et al., 2008): (a) governance and financing structures; (b) fit of the research evidence (e.g., does it meet the current needs of health service providers or is it a research area of interest); (c) consensus regarding what is considered research (e.g., published research findings, professional "in the field" findings); (d) provider organisation factors (e.g., culture, work attitudes, leadership, readiness); (e) staff characteristics (allegiance and adherence to a model/culture; expectancies; attitudes and beliefs); and (f) service delivery features (content of services; delivery mechanisms including training and ongoing support).

At first glance this list of organisational tasks may appear to be insurmountable. Recent research, however, provides useful data about specific factors that can assist, or get in the way of, implementing and sustaining an evidence-based culture emphasising delivery of innovative, evidence-supported practices. The factors that have been shown to enhance transport of empirically supported treatments (EST) in mental health service organisations include (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Perepletchikova, Hilt, Chereji, & Kazdin, 2009; Salveron et al., 2006; Schoenwald, Chapman et al., 2008; Schoenwald, Kelleher et al., 2008): (a) effective dissemination of research findings; (b) fit of the EST with current implementation practices (e.g., with current therapies, with current supervision and training practices); (c) high level of treatment integrity; (d) infrastructure (e.g., reduced administrative burden; political pressure; extra-agency support; fiscal benefits); and (e) organisational culture supporting EST (support by clients, staff, management; fit between EST and client population; fit with organisational mission).

A major problem with implementation is summed up well by Schoenwald et al. (2008), "Indeed, the press to attenuate human suffering often translates into a push to speed the dissemination of ... innovations using inadequately tested implementation strategies (e.g., Adams, 1994; Backer, David, & Soucy, 1995; Brown, 2000; Weiss, 1972)" (p. 67).

Thus, an all too often hasty dissemination within an organisation that does not have the culture capable of embracing and sustaining the innovation is a situation all too well known for those who work at the clinical, administrative or policy levels (Kimberly & Cook, 2008; Mendel et al., 2008). Additionally, it is no surprise that a collection of factors well known anecdotally have now also been confirmed empirically as impacting on the sustainability of a new, innovative service (Massati et al., 2008): (a) the intervention model's fit with the mission or with current staff knowledge and skills (e.g., will to sustain the service, perceived capacity to retain service); (b) perception among staff and stakeholders that the intervention is being used on a temporary versus permanent, and routine, basis; (c) staff retention (attracting and retaining qualified staff who are receptive to the use of innovative services); (d) level of external support for continuing a program (e.g., strong external support that continues versus wanes); and (e) financial resources (e.g., short-term vs. permanent funding streams).

Inspection of the latter two lists of factors highlight important considerations for agencies considering the use of evidence-supported services aimed at reducing problems linked to child maltreatment. A first has to do with organisational "will", climate and culture. This would include doing preliminary work to increase the chances that adoption of a new

program is welcomed by and ultimately carried out effectively by staff as a part of that organisation's ongoing, routine practice. Related to this general principle is gaining initial and ongoing support internally and externally, from both staff and a wide variety of stakeholder groups. In general, these lists highlight the importance of an organisation being capable of inculcating and sustaining a requisite level of staff motivation, knowledge and skills necessary to implement and sustain a new service (Aarons et al., 2009). Of course, long-term funding and ongoing political, administrative and other support are also necessary in the face of new and innovative programs generally being discontinued within 5 years (Glisson, Landsverk et al., 2008).

Once a new program is implemented, further research confirms the vital role that organisational climate and culture play in both staff and new program retention. Organisational climates characterised by (a) high functionality (perceptions by staff that they are supported by the organisation and by peers to do a good job; staff clarity about job roles linked to successful job performance) and (b) low stress (perceptions of job overload and emotional exhaustion) had half the staff turnover compared to organisations low and high on these two variables, respectively (Glisson, Schoenwald et al., 2008). Further, new program sustainability has been linked to organisational culture. Those organisations that had the best cultures sustained new programs for an average of >4 years compared to those that had the worst cultures (<2 years). The best cultures were characterised by what was called a proficient organisational culture, "expectations that service providers will place the wellbeing of each client first and by expectations that individual service providers will be competent and have up-to-date knowledge" (Glisson, Schoenwald et al., p. 129).

Two cultural styles were linked to reduced program sustainability: (a) rigid cultures (limited staff input, discretion, flexibility; too much bureaucracy) and (b) resistant cultures (staff apathy and resistance to adoption of innovative services). Interestingly, it was also found that services that addressed both adults' and children's needs had lower staff turnover than those that provided only children's services (Glisson, Schoenwald et al., 2008). As pointed out by Glisson et al., overall findings suggest that strategies directed at developing positive climates together with relevant training should assist in creating a climate and culture capable of supporting the implementation and ongoing use of a new service. Certainly, at the individual organisation level, attention to such factors should be able to be translated into more effective service implementation, delivery, evaluation and continuing improvement (e.g., Glisson et al.). To ensure widespread changes, however, this is also a story of increased political and policy will. One component of this will is a longer term vision on the part of politicians and policy analysts at both national and state levels in relation to child protection (MacMillan et al., 2007) and child mental health (Schoenwald, Chapman et al., 2008). In relation to problems with implementation and with sustainability, certainly a critical part of this vision would include considerations of policies that promote well thought out versus hasty implementation of new services.

Summary and recommendations

Taking all of this together, child maltreatment is a major problem here in Australia, with known risk and protective factors and related pathways. A number of interventions have been developed and tested including those developed specifically for various aspects related to child maltreatment including interventions focused on individual reactions including trauma and other sequelae, parenting and family factors, and a range of systemic factors. These also range from primary through to tertiary interventions. The implementation of these services, however, is difficult. Based on the evidence, it is our opinion that developing the necessary culture and climate conducive to the use of evidence-supported child maltreatment programs and services starts with leadership and a vision that incorporates the ideas discussed in the previous section. With a vision, there are a number of services described in this paper that have documented potential to increase outcomes for youth, for families and for the community at large. As we have already discussed, our empirically supported bias leans in the direction of early interventions that explicitly target multiple layers of risk and that focus directly on family as well as provider- and organisational-level obstacles. Finally, those that also engage in pragmatic evaluations of both current and innovative services, as a reflection of a larger commitment to incorporating a scientist–practitioner ethos, will have begun to put in place important mechanisms that can assist with continuing improvements to service delivery over time.

In conclusion, it has become increasingly clear that with the growth in reports of child maltreatment nationally, something needs to be done differently. This is with respect to (a) reducing rates of child maltreatment, (b) altering maladaptive trajectories, and (c) reducing intergenerational transmission. It also has to do, however, with organisational climates that are capable of doing things differently. That is, in the face of continuing high rates of staff turnover in the child protection and child mental health service delivery sectors (AIFS, 2008; Glisson, Schoenwald et al., 2008; National Council on Crime and Delinquency, 2006; Queensland Government

Department of Communities, 2007), a new and longer-term vision, supported by political leaders across the aisles, is in our opinion a critical step necessary to support the development of organisational cultures and climates that can implement and routinely deliver those practices that work. We as psychologists have perhaps even a critical role to play here. This includes our own adoption of evidence-based practices with respect to child maltreatment. Additionally, part of the movement forward is also around our focusing at both organisational and policy levels, not only the use of best practice interventions, but also for implementation practices that are equally best practice.

References

Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal of Consulting and Clinical Psychology, 77*, 270–280.

Adams, P. (1994). Marketing social change: The case of family preservation. *Children and Youth Services Review, 16*, 417–431.

Appleyard, K., Egeland, B., Van Dulmen, M. H. M., & Sroufe, L. A. (2005). When more is not better: The role of cumulative risk in child behaviour outcomes. *Journal of Child Psychology and Psychiatry, 46*, 235–245.

Armstrong, K. L., Fraser, J. A., Dadds, M. R., & Morris, J. (1999). A randomized, controlled trial of nurse home visiting to vulnerable families with newborns. *Journal of Paediatrics and Child Health, 35*, 237–244.

Australian Institute of Family Studies (AIFS) (June, 2002). *LSAC Discussion Paper No. 1: Introducing the Longitudinal Study of Australian Children.* Melbourne: Author.

Australian Institute of Family Studies (AIFS) (2008). Analysis of challenges and strategic directions: CDSMC National approach for child protection project. *Protecting Australian children.* Retrieved 14 April 2009, from http://www.aifs.gov.au/nch/pubs/reports/cdsmac/protecting.pdf

Australian Institute of Health and Welfare (AIHW) (2008). Child protection Australia 2006–07. *Child welfare series 43* (Cat. no. CWS 31). Canberra: AIHW.

Backer, T. E., David, S. L., & Soucy, G. (Eds.). (1995). *Reviewing the behavioural science knowledge base on technology transfer* (NIDA Research Monograph 155, NIH Publication No 95-4035). Rockville, MD: National Institute on Drug Abuse.

Barlow, J., Johnston, I., Kendrick, D., Polnay, L., Stewart-Brown, S. (2006). Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. *Cochrane Database System Review (3)*, CD005463.

Baumrind, D., Larzelere, R. E., & Cowan, P. A. (2002). Ordinary physical punishment: Is it harmful? Comment on Gershoff (2002). *Psychological Bulletin, 128*, 580–589.

Beauchaine, T. P., Webster-Stratton, C., & Reid, M. J. (2005). Mediators, moderators, and predictors of 1-year outcomes among children treated for early-onset conduct problems: A latent growth curve analysis. *Journal of Consulting and Clinical Psychology, 73*, 371–388.

Bedi, G., & Goddard, C. (2007). Intimate partner violence: What are the impacts on children? *Australian Psychologist, 42*, 66–77.

Belsky, J. (1993). Etiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin, 114*, 413–434.

Berliner, L. (2005). The results of randomized clinical trials move the field forward. *Child Abuse and Neglect, 29*, 103–105.

Bilukha, O., Hahn, R. A., Crosby, A., et al., for the Task Force on Community Preventive Services. (2005). The effectiveness of early childhood home visitation in preventing violence: A systematic review. *American Journal of Preventative Medicine, 28*, 11–39.

Bolger, K. E., & Patterson, C. J. (2001). Pathways from child maltreatment to internalizing problems: Perceptions of control as mediators and moderators. *Development and Psychopathology, 13*, 913–940.

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*, 26–37.

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualised in developmental perspective: A bioecological model. *Psychological Review, 101*, 568–586.

Brown, B. S. (2000). From research to practice: The bridge is out and the water's rising. In J. A. Levy, R. C. Stephens, & D. C. McBride (Eds.), *Emerging issues in the field of drug abuse. Advances in medical sociology* (Vol. 7, pp. 345–365). Stamford, CT: JAI Press.

Brunk, M., Henggeler, S. W., & Whelan, J. P. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Psychology, 55*, 171–178.

Buchanan, A., & Oliver, J. (1977). Abuse and neglect as a cause of mental retardation: A study of 140 children admitted to subnormality hospitals in Wiltshire. *British Journal of Psychiatry*, 458, 467.

Bulik, C. M., Prescott, C. A., & Kendler, K. S. (2001). Features of childhood sexual abuse and the development of psychiatric and substance use disorders. *British Journal of Psychiatry, 179*, 444–449.

Cawson, P., Wattam, C., Brooker, S., & Kelly, G. (2000). *Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect.* London: NSPCC.

Chaffin, M. (2004). Is it time to rethink Healthy Start/Healthy Families? *Child Abuse and Neglect, 28*, 589–595.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., et al. (2004). Parent–child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 500–510.

Chamberlain, P. (2003). *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model* [Online version]. Washington: American Psychological Association.

Chorpita, B. F., Bernstein, A., Daleiden, E. L., & The Research Network on Youth Mental Health. (2008). Driving with roadmaps and dashboards: Using information resources to structure the decision models in service organizations. *Administration and Policy in Mental Health, 35*, 114–123.

Chung, E. K., Webb, D., Clampet-Lundquist, S., & Campbell, C. (2001). A comparison of elevated blood lead levels among children living in foster care, their siblings and the general population. *Pediatrics, 107*, 1172–1173.

Cicchetti, D., & Manly, J. T. (2001). Editorial: Operationalizing child maltreatment: Developmental processes and outcomes. *Development and Psychopathology, 13*, 755–757.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 541–565.

Cohen, J. A., & Mannarino, A. P. (1996). A treatment study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 42–50.

Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during 1-year follow-up. *Journal of American Academy of Child and Adolescent Psychiatry, 36*, 1228–1235.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse and Neglect, 29*, 135–145.

Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse and Neglect, 31*, 211–229.

Colton, M., Aldgate, J., & Heath, A. F. (1991). Behavioural problems of children in and out of care. *Social Work Social Science Review, 2*, 177–191.

Commission for Children and Young People and Child Guardian Queensland (2008). *Child death case review committee: Annual Report 2007–08.* Retrieved 17 March 2009, from http://www.ccypcg.qld.gov.au/pdf/publications/reports/annual_report_cdcrc_2007-2008/CDCRC-chapter1.pdf

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of Family Psychology, 18*, 411–419.

Curtis, N. M., Ronan, K.R., Heiblum, N., & Crellin. K. (2009). Dissemination and effectiveness of multisystemic treatment in New Zealand: A benchmarking study. *Journal of Family Psychology, 23*, 119–129.

Davidson-Arad, B., Englechin-Segal, D., & Wozner, Y. (2003). Short-term follow-up of children at risk: Comparison of the quality of life of children removed from the home and children remaining at home. *Child Abuse and Neglect, 27*, 733–750.

Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment, 32*, 381–390.

Dawe, S., Harnett, P., & Frye, S. (2008). Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do. *Child Abuse Prevention Issues, 29*, 1–14.

Dawe, S., Harnett, P., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents Under Pressure Programme. *Drug and Alcohol Review, 22*, 299–307.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1*, 310–321.

Deblinger, E., Steer, R., & Lippmann, J. (1999). Two-year follow-up study of cognitive-behavioural therapy for sexually abused children suffering posttraumatic stress symptoms. *Child Abuse and Neglect, 23*, 1371–1378.

Department of Human Services. (2002). *An integrated strategy for child protection and placement services.* Melbourne: Community Care Division.

Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behaviour. *American Psychologist, 54*, 755–764.

Dodge, K. A., Bates, J. E., & Pettit, G. S. (1990). Mechanisms in the cycle of violence: How child abuse affects later aggressive behaviour. *Science, 250*, 1678–1683.

Dodge, K. A., Lansford, J., Burks, V. S., Pettit, G. S., Bates, J. E., Fontaine, R., et al. (2003). Peer rejection and social information processing factors in the development of aggressive behaviour problems in children. *Child Development, 74*, 374–393.

D'Onofrio, B. M., Turkheimer, E. N., Eaves, L. J., Corey, L. A., Berg, K., Solaas, M. H., et al. (2003). The role of the Children of Twins design in elucidating causal relations between parent characteristics and child outcomes. *Journal of Child Psychology and Psychiatry, 44*, 1130–1144.

Feather, J., & Ronan, K. (2004). *Trauma-focused cognitive behavioural therapy for abused children: A treatment manual.* Massey University: Authors.

Feather, J., & Ronan, K. (2006). Trauma-focused cognitive behavioural therapy for abused children with posttraumatic stress disorder: A pilot study. *New Zealand Journal of Psychology, 35*, 132–145.

Feather, J., & Ronan, K. R. (2009a). Safeguarding children in the primary care context: Assessment and interventions for child trauma and abuse. In J. Taylor, & M. Themessl-Huber (Eds.), *Safeguarding children in primary care: A guide for practitioners working in community settings* (pp. 4–27). London: Kingsley Publishing.

Feather, J. S., & Ronan, K. R. (2009b). Trauma-focused CBT with maltreated children: A clinic-based evaluation of a new treatment manual. *Australian Psychologist, 44*, 174–194.

Feather, J. S., Ronan, K. R., Murupaenga, P., Berking, T., & Crellin, K. (2009). Trauma-focused cognitive-behavioural therapy for Maori and Samoan children with multiple-abuse and PTSD in a New Zealand child protection setting: A single-case multiple-baseline study. Manuscript in preparation.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorders in young adulthood: Part II: Psychiatric outcomes of sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1365–1374.

Fergusson, D. M., Grant, H., Horwood, L. J., & Ridder, E. M. (2005). Randomized trial of the Early Start program of home visitation. *Pediatrics, 116*: e803–09.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse and Neglect, 18*, 409–417.

Finkelhor, D., & Dziuba-Leatherman, J. (1994). Children as victims of violence: A national study. *Pediatrics, 94*, 413–420.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10*, 5–25.

Fraser, J. A., Armstrong, K. L., Morris, J. P., & Dadds, M. R. (2000). Home visiting intervention for vulnerable families with newborns: Follow-up results of a randomized controlled trial. *Child Abuse and Neglect, 24*, 1399–1429.

Frye, S., & Dawe, S. (2008). Interventions for women prisoners and their children in the post-release period. *Clinical Psychologist, 12*, 99–108.

Gershoff, E. T. (2002a). Corporal punishment by parents and associated child behaviors and experiences: A meta-analytic and theoretical review. *Psychological Bulletin, 128*, 539–579.

Gershoff, E. T. (2002b). Corporal punishment, physical abuse, and the burden of proof: Reply to Baumrind, Larzelere, and Cowan (2002), Holden (2002), and Parke (2002). *Psychological Bulletin, 128*, 602–611.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet, 373*, 68–81.

Glisson, C., Landsverk, J., Schoenwald, S., Kelleher, K., Hoagwood, K. E., Mayberg, S., et al. (2008). Assessing the organizational social context (OSC) of mental health services: Implications for research and practice. *Administration and Policy in Mental Health, 35*, 98–113.

Glisson, C., Schoenwald, S. K., Kelleher, K., Landsverk, J., Hoagwood, K. E., Mayberg, S., et al. (2008). Therapist turnover and new program sustainability in mental health clinics as a function of organizational culture, climate, and service structure. *Administration and Policy in Mental Health, 35*, 124–133.

Gomby, D. S. (2007). The promise and limitations of home visiting: Implementing effective programs. *Child Abuse and Neglect, 8*, 793–799.

Granic, I., & Patterson, G. R. (2006). Toward a comprehensive model of antisocial development: A dynamic systems approach. *Psychological Review, 113*, 101–131.

Gross, D., Fogg, L., Webster-Stratton, C., Garvey, C., Julion, W., & Grady, J. (2003). Parent training of toddlers in day care in low-income urban communities. *Journal of Consulting and Clinical Psychology, 71*, 261–278.

Harnett, P. H. (2007). A procedure for assessing parents' capacity for change in child protection cases. *Children and Youth Services Review, 29*, 1179–1188.

Harnett, P. H., & Dawe, S. (2008). Reducing child abuse potential in families identified by social services: Implications for assessment and treatment. *Brief Treatment and Crisis Intervention, 8*, 226–236.

Henggeler, S. W. (2004). Decreasing effect sizes for effectiveness studies: Implications for the transport of evidence-based treatments: Comment on Curtis, Ronan and Borduin (2004). *Journal of Family Psychology, 19*, 420–423.

Henggeler, S. W., Letourneau, E. J., Chapman, J. E., Borduin, C. M., Schewe, P. A., & McCart, M. R. (2009). Mediators of change for multisystemic therapy with juvenile sexual offenders. *Journal of Consulting and Clinical Psychology, 77*, 451–462.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behaviour in children and adolescents.* New York: Guilford Press.

Hoge, E. A., Austin, E. D., & Pollack, M. H. (2007). Resilience: Research evidence and conceptual considerations for post-traumatic stress disorder. *Depression and Anxiety, 24*, 139–152.

Holden, G. W. (2002). Perspectives on the effects of corporal punishment: Comment on Gershoff (2002). *Psychological Bulletin, 128*, 590–595.

Horwitz, S. M., Balestracci, K. M., & Simms, M. D. (2001). Foster care placement improves children's functioning. *Archives of Pediatric and Adolescent Medicine, 155*, 1255–1260.

Hughes, J. R., & Gottlieb, L. N. (2004). The effects of the Webster-Stratton parenting program on maltreating families: Fostering strengths. *Child Abuse and Neglect, 28*, 1081–1097.

Humphrey, H. H. (1963). The behavioural sciences and survival. *American Psychologist, 18*, 290–294.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Jaffee, S. R., Belsky, J., Harrington, H., Caspi, A., & Moffitt, T. E. (2006). When parents have a history of conduct disorder: How is the caregiving environment affected? *Journal of Abnormal Psychology, 115*, 309–319.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Polo-Tomas, M., Price, T. S., & Taylor, A. (2004). The limits of child effects: Evidence for genetically mediated child effects on corporal punishment but not on physical maltreatment. *Developmental Psychology, 40*, 1047–1058.

Jaffee, S. R., Caspi, A., Moffitt, T. E., Polo-Tomás, M., & Taylor, A. (2007). Individual, family, and neighbourhood factors distinguish resilient from non-resilient maltreated children: A cumulative stressors model. *Child Abuse and Neglect, 31*, 231–253.

Jaffee, S. R., Caspi, A., Moffitt, T. E., & Taylor, A. (2004). Physical maltreatment victim to antisocial child: Evidence of an environmentally mediated process. *Journal of Abnormal Psychology, 113*, 44–55.

Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology, 116*, 176–187.

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 57*, 186–192.

Kazdin, A. E., & Nock, M. K. (2003). Delineating mechanisms of change in child and adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry, 44*, 1116–1129.

Kazdin, A. E., & Whitley, M. K. (1997). Treatment of parental stress to enhance therapeutic change among children referred for aggressive and antisocial behaviour. *Journal of Consulting and Clinical Psychology, 71*, 504–515.

Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., & Pettit, G. S. (2001). The timing of child physical maltreatment: A cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Development and Psychopathology, 13*, 891–912.

Kessler, R. C., Pecora, P. J., Williams, J., Hiripi, E., O'Brien, K., English, D., et al. (2008). Effects of enhanced foster care on the long-term physical and mental health of foster care alumni. *Archives of General Psychiatry, 65*, 625–633.

Kim, J. (2009). Type-specific intergenerational transmission of neglectful and physically abusive parenting behaviors among young parents. *Children and Youth Services Review, 31*, 761–767.

Kimberly, J., & Cook, J. M. (2008). Organizational measurement and the implementation of innovations in mental health services. *Administration and Policy in Mental Health, 35*, 11–20.

King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., et al. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of American Academy of Child and Adolescent Psychiatry, 39*, 1347–1355.

Klevens, J., & Whitaker, D. J. (2007). Primary prevention of child physical abuse and neglect: Gaps and promising directions. *Child Maltreatment, 12*, 364–377.

Kolko, D. J., Cohen, J. A., Mannarino, A. P., Baumann, B. L., & Knudsen, K. (2009). Community treatment of child sexual abuse: A survey of practitioners in the National Child Traumatic Stress Network. *Administration and Policy in Mental Health, 36*, 37–49.

LaGreca, A. M., Silverman, W.K., & Lochman, J. E. (2009). Moving beyond efficacy and effectiveness in child and adolescent intervention research. *Journal of Consulting and Clinical Psychology, 77*, 373–382.

Lawrence, C. R, Carlson, E. A., & Egeland, B. (2006). The impact of foster care on development. *Developmental Psychopathology, 18*, 57–76.

Lees, D. G., & Ronan, K. R. (2008). Engagement and effectiveness of parent management training (Incredible Years) for solo high-risk mothers: A multiple baseline evaluation. *Behaviour Change, 25*, 109–128.

Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., & Chapman, J. E. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology, 23*, 89–102.

Leventhal, J. M. (1998). Epidemiology of sexual abuse of children: Old problems, new directions. *Child Abuse and Neglect, 22*, 481–491.

Lewig, K., Arney, F., & Scott, D. (2006). Closing the research-policy and research-practice gaps: Ideas for child and family services. *Family Matters, 74*, 12–19.

Lundahl, B. W., Nimer, J., & Parsons, B. (2006). Preventing child abuse: A meta-analysis of parent training programs. *Research on Social Work Practice, 16*, 251–262.

Lynskey, M. T., & Fergusson, D. M. (1997). Factors protecting against the development of adjustment difficulties in young adults exposed to childhood sexual abuse. *Child Abuse and Neglect, 21*, 1177–1190.

MacLeod, J., & Nelson, G. (2000). Programs for the promotion of family wellness and the prevention of child maltreatment: A meta-analytic review. *Child Abuse and Neglect, 24*, 1127–1149.

MacMillan, H. L., Jamieson, E., Wathen, C. N., Boyle, M. H., Walsh, C. A., Omura, J., et al. (2007). Development of a policy-relevant child maltreatment research strategy. *Milbank Quarterly, 85*, 337–374.

MacMillan, H. L., Thomas, B. H., Jamieson, E., Walsh, C. A., Boyle, M. H., Shannon, H. S., et al. (2005). Effectiveness of home visitation by public-health nurses in prevention of the recurrence of child physical abuse and neglect: A randomised controlled trial. *Lancet, 365*, 1786–1793.

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *Lancet, 373*, 250–266.

Manly, J. T., Kim, J. E., Rogosch, F. A., & Cicchetti, D. (2001). Dimensions of child maltreatment and children's adjustment: Contributions of developmental timing and subtype. *Development and Psychopathology, 13*, 759–782.

Massatti, R. R., Sweeney, H. A., Panzano, P. C., & Roth, D. (2008). The de-adoption of innovative mental health practices (IMHP): Why organizations choose not to sustain an IMHP. *Administration and Policy in Mental Health, 35*, 50–65.

Mendel, P., Meredith, L. S., Schoenbaum, M., Sherbourne, C. D., & Wells, K. B. (2008). Interventions in organizational and community context: A framework for building evidence on dissemination and implementation in health services research. *Administration and Policy in Mental Health, 35*, 21–37.

Millichamp, J., Martin, J., & Langley, J. (2006). *On the receiving end: Young adults describe their parents' use of physical punishment and other disciplinary measures during childhood.* Retrieved 8 March 2009, from http://www.nzma.org.nz//journal/119-1228/1818

Ministry of Social Development. (2007). *Inter-agency plan for conduct disorder/severe antisocial behaviour 2007–2012* [Online version] (ISBN 978-0-478-29303-6). Wellington, New Zealand: Ministry of Social Development.

National Council on Crime and Delinquency. (2006). Relationship between staff turnover, child welfare system functioning and recurrent child abuse. *Cornerstones for kids: The human services workforce initiative.* Houston, TX: Cornerstones for Kids.

Nelson, C. A. III, Zeanah, C. H., Fox, N. A., Marshall, P. J., Smyke, A. T., & Guthrie, D. (2007). Cognitive recovery in socially deprived young children: The Bucharest Early Intervention Project. *Science, 318*, 1937–1940.

Nock, M. K., & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*, 872–879.

NSW Department of Community Services (NSW DoCS) (2007). *Research to practice notes: Risk, protection and resilience in children and families.* Retrieved 19 March 2009, from http://www.community.nsw.gov.au/docswr/_assets/main/documents/research notes_resilience.pdf

Olds, D. L. (2002). Prenatal and infancy home visiting by nurses: From randomized trials to community replication. *Prevention Science, 3*, 153–172.

Olds, D. L., Sadler, L., & Kitzman, H. (2007). Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry, 18*, 355–391.

Parke, R. D. (2002). Punishment revisited: Science, values, and the right question: Comment on Gershoff (2002). *Psychological Bulletin, 128*, 596–601.

Patterson, G. R., Dishion, T. J., & Yoerger, K. (2000). Adolescent growth in new forms of problem behaviour: Macro-and micro-peer dynamics. *Prevention Science, 1*, 3–13.

Pears, K. C., & Capaldi, D. M. (2001). Intergenerational transmission of abuse: A two-generational prospective study of an at-risk sample. *Child Abuse and Neglect, 25*, 1439–1461.

Perepletchikova, F., Hilt, L. M., Chereji, E., & Kazdin, A. E. (2009). Barriers to implementing treatment integrity procedures: Survey of treatment outcome researchers. *Journal of Consulting and Clinical Psychology, 77*, 212–218.

Plunket. (2008). *Annual report: Today's children, tomorrow's future.* Retrieved 14 April 2009, from http://www.plunket.org.nz/uploads/file/Annual%20Report/7893_Plunket_AR_(latest%20version).pdf

Polit, D. F., Morton, T. D., & White, C. M. (1989). Sex, contraception and pregnancy among adolescents in foster care. *Family Planning Perspectives, 21*, 203–208.

Prinstein, M. J., & Wang, S. S. (2005). False consensus and adolescent peer contagion: Examining discrepancies between perceptions and actual reported levels of friends' deviant and health risk behaviors. *Journal of Abnormal Child Psychology, 33*, 293–306.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science, 10*, 1–12.

Queensland Government Department of Child Safety. (2007). *Annual Report 2006–07.* Retrieved 31 March 2009, from http://www.childsafety.qld.gov.au/departmentannual-report/documents/dchs-annual-report-2006-full.pdf

Queensland Government Department of Child Safety. (2008a). *Characteristics of parents involved in the Queensland child protection system, Report 1: Demographic profile.* Retrieved 12 March 2009, from http://www.childsafety.qld.gov.au/performance/child-protection/documents/report-1-parents-profile.pdf

Queensland Government Department of Child Safety. (2008b). *Characteristics of parents involved in the Queensland child protection system, Report 2: Parental risk factors for abuse and neglect.* Retrieved 12 March 2009 from http://www.childsafety.qld.gov.au/performance/child-protection/documents/report-2-parents-risk.pdf

Queensland Government Department of Child Safety. (2008c). *Characteristics of parents involved in the Queensland child protection system, Report 3: History of contact with the department.* Retrieved 23 March 2009 from http://www.childsafety.qld.gov.au/performance/child-protection/documents/report-3-history-of-contact.pdf

Queensland Government Department of Communities. (2007). *Our challenges.* Retrieved 14 April 2009, from http://www.childsafety.qld.gov.au/department/ challenges.html

Rheingold, A. A., Campbell, C., Self-Brown, S., de Arellano, M., Resnick, H., & Kilpatrick, D. (2007). Prevention of child sexual abuse: Evaluation of a community media campaign. *Child Maltreatment, 12*, 352–363.

Ronan, K. R. (1996). Building a reasonable bridge in childhood anxiety assessment: A practitioner's resource guide. *Cognitive and Behavioral Practice, 3*, 63–90.

Ronan, K. R., & Curtis, N. (2008). Treatment of antisocial youth and families. In L. VandeCreek, & J. B. Allen (Eds.), *Innovations in clinical practice: Focus on group, couples, and family therapy* (pp. 5–27). Sarasota: Professional Resource Press.

Rosenman, S., & Rodgers, B. (2004). Childhood adversity in an Australian population. *Social Psychiatry and Psychiatric Epidemiology, 39*, 695–702.

Runyan, D. K., & Gould, C. L. (1985). Foster care for child maltreatment: Impact on delinquent behaviour. *Pediatrics, 75*, 562–568.

Russo, C. A., Hambrick, M. M., & Owens, P. L. (2008). Hospital stays related to child maltreatment, 2005. *Healthcare Cost and Utilization Project: Statistical Brief No. 49.* Retrieved 18 March 2009, from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb49.pdf

Rutter, M. (2007). Resilience, competence, and coping. *Child Abuse and Neglect, 31*, 205–209.

Salveron, M., Arney, F., & Scott, D. (2006). Sowing the seeds of innovation: Ideas for child and family services. *Family Matters, 73*, 38–45.

Sanders, M. R. (2008). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22*, 506–517.

Sanders, M. R., Pidgeon, A. M., Gravestock, F., Connors, M. D., Brown, S., & Young, R. W. (2004). Does parental attributional retraining and anger management enhance the effects of the Triple P – Positive Parenting Program with parents at risk of child maltreatment? *Behavior Therapy, 35*, 513–535.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S., et al. (2008). Every family: A population approach to reducing behavioural and emotional problems in children making the transition to school. *Journal of Primary Prevention, 29*, 197–222.

Sanders, M. R., Turner, K. M. T., & Markie-Dadds, C. (2002). The development and dissemination of the Triple P – Positive Parenting Program: A multilevel, evidence-based system of parenting and family support. *Prevention Science, 3*, 173–189.

Schoenwald, S. K., Chapman, J. E., Kelleher, K., Hoagwood, K. E., Landsverk, J., Stevens, J., et al. (2008). A survey of the infrastructure for children's mental health services: Implications for the implementation of empirically supported treatments (ESTs). *Administration and Policy in Mental Health, 35*, 84–97.

Schoenwald, S. K., Heiblum, N., Saldana, L., & Henggeler, S. W. (2008). The international implementation of multisystemic therapy. *Evaluation and the Health Professions, 31*, 211–225.

Schoenwald, S. K., Kelleher, K., Weisz, J. R., & The Research Network on Youth Mental Health. (2008). Building bridges to evidence-based practice: The MacArthur Foundation Child System and Treatment Enhancement Projects (Child STEPs). *Administration and Policy in Mental Health, 35*, 66–72.

Scott, D. A. (2009). The landscape of child maltreatment. *Lancet, 373*, 101–102.

Serbin, L. S., & Karp, J. (2004). The intergenerational transfer of psychosocial risk: Mediators of vulnerability and resilience. *Annual Review of Psychology, 55*, 333–363.

Skowron, E., & Reinemann, D. H. S. (2005). Effectiveness of psychological interventions for child maltreatment: A meta-analysis. *Psychotherapy: Theory, Research, Practice, Training, 42*, 52–71.

Sledjeski, E. M., Dierker, L. C., Brigham, R., & Breslin, E. (2008). The use of risk assessment to predict recurrent maltreatment: A classification and regression tree analysis (CART). *Prevention Science, 9*, 28–37.

Snyder, J., Schrepferman, L., Oeser, J., Patterson, G., Stoolmiller, M., Johnson, K., et al. (2005). Deviancy training and association with deviant peers in young children: Occurrence and contribution to early-onset conduct problems. *Development and Psychopathology, 17*, 397–413.

Sweet, M. A., & Appelbaum, M. I. (2004). Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. *Child Development, 75*, 1435–1456.

Swenson, C. C., & Chaffin, M. (2006). Beyond psychotherapy: Treating abused children by changing their social ecology. *Aggression and Violent Behavior, 11*, 120–137.

Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., Saldana, L., & Mayhew, A. M. (2009). *Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial.* Manuscript submitted for publication.

Swenson, C. C., Schaeffer, C. M., Tuerk, E. H., Henggeler, S. W., Tuten, M., Panzarella, P., et al. (2009). Adapting multisystemic therapy for co-occurring child maltreatment and parental substance abuse: The building stronger families project. *Emotional and Behavioral Disorders in Youth, Winter*, 3–8.

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). *The cost of child abuse in Australia.* Melbourne: Australian Childhood Foundation and Child Abuse Prevention Research.

Thornberry, T. P., Ireland, T. O., & Smith, C. A. (2001). The importance of timing: The varying impact of childhood and adolescent maltreatment on multiple problem outcomes. *Development and Psychopathology, 13*, 957–979.

Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An independent effectiveness trial of multisystemic therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology, 35*, 227–236.

Trentacosta, C. J., Hyde, L. W., Shaw, D. S., Dishion, T. J., Gardner, F., & Wilson, M. (2008). The relations among cumulative risk, parenting, and behaviour problems during early childhood. *Journal of Child Psychology and Psychiatry, 49*, 1211–1219.

Trickett, P. K., Noll, J. G., Reiffman, A., & Putnam, F. W. (2001). Variants of intrafamilial sexual abuse experience: Implications for short- and long-term development. *Development and Psychopathology, 13*, 1001–1019.

Tyler, S., Allison, K., & Winsler, A. (2006). Child neglect: Developmental consequences, intervention, and policy implications. *Child and Youth Care Forum, 35*, 1–20.

U.S. Department of Health and Human Services, Administration for Children and Families (USD-HHS, 1997). *National study of protective, preventive, and reunification services delivered to children and their families.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2007). *Child Maltreatment 2007.* Washington, DC: U.S. Government Printing Office.

Wald, M. S., Carlsmith, J. M., & Leiderman, P. H. (1988). *Protecting abused and neglected children.* Stanford, CA: Stanford University Press.

Watson, J. (2005). Child neglect: Literature review. *NSW Department of Community Services: Research report.* Retrieved 19 March 2009, from http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_child_neglect.pdf

Webster-Stratton, C. (2006). Treating children with early-onset conduct problems: Key ingredients to implementing the Incredible Years programs with fidelity. In N. T. Kerby (Ed.), *Helping others help children: Clinical supervision of child psychotherapy* (pp. 161–175). Washington, DC, US: American Psychological Association.

Webster-Stratton, C., & Reid, M. J. (2007). Incredible years parents and teachers training series: A head start partnership to promote social competence and prevent conduct problems. In P. Tolan, J. Szapocznik, & S. Sambrano (Eds.), *Preventing youth substance abuse: Science-based programs for children and adolescents* (pp. 67–88). Washington, DC: American Psychological Association.

Weiss, C. H. (1972). Evaluating educational and social action programs: A "treeful of owls." In C. H. Weiss (Eds.), *Evaluating action programs: Readings in social action and education.* Boston: Allyn & Bacon.

Widom, C. S. (1989). The cycle of violence. *Science, 244*, 160–166.

Widom, C. S. (1991). The role of placement experiences in mediating the criminal consequences of early childhood victimization. *American Journal of Orthopsychiatry, 61*, 195–209.

Zazzali, J. L., Sherbourne, C., Hoagwood, K. E., Greene, D., Bigley, M. F., & Sexton, T. L. (2008). The adoption and implementation of an evidence based practice in child and family mental health services organizations: A pilot study of Functional Family Therapy in New York State. *Administration and Policy in Mental Health, 35*, 38–49.