Preventing Child Maltreatment: A Critical Strategy for Stopping Intimate Partner Violence in the Next Generation

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About Shift
Shift's goal is to significantly reduce domestic violence in Alberta using a primary prevention approach to stop first-time victimization and perpetration. In short, primary prevention means taking action to build resilience and prevent problems before they occur. Shift's purpose is to enhance the capacity of policy makers, systems leaders, clinicians, service providers and the community at large to significantly reduce the rates of domestic violence in Alberta. We are committed to making our research accessible and working collaboratively with a diverse range of stakeholders to inform and influence current and future domestic violence prevention efforts through primary prevention.

About this report
This report is situated within a broader research agenda designed to serve as a foundation for a comprehensive intimate partner violence prevention strategy in Alberta. Please visit our website at www.preventdomesticviolence.ca to download our additional work thus far on violence prevention.

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1.0 Introduction

Shift: The Project to End Domestic Violence seeks to significantly reduce intimate partner violence[1] (IPV) using a primary prevention approach, that is, by preventing IPV before it ever occurs. *Preventing child maltreatment may be the most effective strategy for preventing IPV in the next generation*. Myriad studies completed over the past few decades have confirmed that both child maltreatment and IPV can be inter-generationally transmitted. While it is not inevitable, children who are maltreated are often damaged in a host of ways and, when they grow up, they are much more likely than other adults to abuse their own children[1] and to be IPV victims and perpetrators.[2]

Child maltreatment is very common in Canada. While precise prevalence rates are not available,[3] of all substantiated cases of child maltreatment investigated by child welfare authorities in 2008, the most common were exposure to IPV (34% of cases), neglect (34% of cases), and physical abuse (20% of cases). Less common were emotional maltreatment (9% of cases) and sexual abuse (3% of cases).[4] However, it is widely accepted that data on documented maltreatment under-represent the scope of the problem, as many cases do not come to the attention of authorities. For instance, recent research using retrospective data from the Ontario Child Health Study found that 28% of women and 34% of men reported having experienced physical abuse in childhood, with 22% and 8% reporting having experienced sexual abuse.[5] In addition, prevalence estimates vary depending on the definitions used, type of maltreatment studies, data source, and research methodology.

The cost of child maltreatment to society is staggering.[6] One study measuring individual and government costs across six areas (justice, social services, education, health, employment, and personal)[7] identified the total minimum cost of child abuse in Canada in 1998 to be approximately $15 billion dollars,[8] which amounts to $20.19 billion in purchasing power today.[9] Research shows that treating and later trying to remedy the negative consequences of child abuse and maltreatment are both less effective and more costly than preventing it in the first place.[10]

Efforts to prevent child maltreatment have grown substantially over the past few decades,[11] but much more can be done. This paper makes the case for strengthening child maltreatment prevention as a critical component of the Government of Alberta's Family Violence Prevention Framework and the Early Childhood Strategy. With a focus on preventing IPV in the next generation, the paper provides: i) an overview of the scope and consequences of child maltreatment; ii) a review of the risk factors for maltreatment; iii) a description of programs and

[1] As defined by the World Health Organization, "intimate partner violence" is behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, and psychological abuse and controlling behaviours. Alberta Justice defines "intimate partners" as opposite-sex or same-sex partners in current and former dating relationships, current and former common-law relationships, current and former married relationships, and persons who are the parents of one or more children, regardless of their marital status or whether they have lived together at any time.[1]

interventions that may prevent child maltreatment; and iv) policy, research, and program recommendations to strengthen child maltreatment prevention efforts specifically in the Alberta context.

2.0 Methods

The information in this paper was gathered through (i) searches of the academic databases (including PubMed, CINAHL, JSTOR, PsycINFO, SSRN, and Google Scholar); (ii) searches of specific journals that are focused on child maltreatment using search terms including but not limited to child abuse, child maltreatment, child neglect, child sexual abuse, corporal punishment, harsh discipline, harsh parenting, and spanking, in conjunction with the terms causes, risk factors, antecedents, etiology, parental, intra-familial, public campaign, prevention, primary prevention, positive parenting, intervention, and/or program; and (iii) searches of public health websites including the Centers for Disease Control and Prevention (CDC), National Institute of Health (NIH), World Health Organization (WHO), Health Canada, Canadian Medical Association, and Alberta Human Services. Given the high volume of published research on child maltreatment, particular attention was given to Canadian and American research published since 2009.

2.1 Scope and limitations

This paper focuses specifically on child maltreatment prevention as a primary prevention[2] strategy for IPV in the next generation. Excluded from the paper is research on child maltreatment that is not associated with IPV perpetration and/or victimization (for example, shaken baby syndrome and infant neglect resulting in death). Also excluded is child maltreatment not perpetrated by parents or caregivers or, in the case of child sexual abuse, siblings, along with an in-depth discussion of the consequences of child maltreatment other than those associated with IPV perpetration or victimization in adulthood. It should be noted that research on all aspects of child neglect and on the primary prevention of intra-familial child sexual abuse is limited.

In addition, some cultural groups are overrepresented in the child welfare system, which appears to be attributable to many factors that may include the use of force to discipline children, which is more common in some cultures; poverty and housing instability, which is experienced by a higher percentage of families in some cultures; and, probably, racial bias in reporting and investigating allegations of abuse.[12] However, very little is known about the etiology of abuse within Canada's ethnocultural minority groups and how it can be prevented. Much is known about the antecedents and causes of child abuse within Aboriginal cultures, but a distinct paper would be required to properly attend to these complex issues. Finally, while research on maltreatment of children with disabilities and by parents with disabilities does exist, there

[2] "Primary prevention" in this context means reducing the number of new instances of intimate partner violence by intervening before any violence has occurred. Primary prevention "relies on identification of the underlying, or 'upstream,' risk and protective factors for intimate partner violence, and acts to address those factors."[2] This report offers primary prevention strategies to reduce the chances that children will grow up to be perpetrators or victims of intimate partner violence.[2]

appears to be no research on inter-generational parenting practices or associations between child maltreatment and subsequent IPV perpetration or victimization that includes, or is specific to, persons with disabilities.

3.0 What is child maltreatment?

Although there are some variations in the ways child maltreatment is defined, identified, and tracked,[13] in Canada, child maltreatment is generally defined to include physical abuse, sexual abuse, physical neglect, emotional maltreatment, and exposure to parental IPV.[14] Alberta's *Child, Youth and Family Enhancement Act*[15] describes *actionable* child abuse to include:

- *Neglect*: failure or inability to provide a child with the necessities of life or adequate care or supervision, and failure or inability to obtain or permit the child to receive essential medical treatment.
- *Physical abuse*: deliberately causing substantial and observable injury to any part of the child's body through force or an agent.
- *Emotional abuse*: the child's mental or emotional functioning or development has been impaired by exposure to domestic violence; rejection; neglect; deprivation of affection or cognitive stimulation; inappropriate criticism; threats, humiliation, accusations or expectations of or toward the child; chronic alcohol or drug abuse by the guardian or by anyone living in the same residence as the child; or the mental or emotional condition of the guardian or of anyone living in the same residence as the child.
- *Sexual abuse*: inappropriately exposing or subjecting the child to sexual contact, sexual activity, or sexual behaviour, including prostitution-related activities.

It should be noted that most researchers believe that physical punishment and actions that cause a child pain but do not result in serious physical injury constitute maltreatment, even though they are not prohibited by law. This is because an overwhelming body of research shows that even mild and moderate corporal punishment has harmful side effects that can endure into adulthood.[16] Similarly, child neglect is sometimes broadly defined in research, but not in legislation, to include parenting omissions that have serious negative impacts on child development. Such omissions include lack of support for a child's social-emotional development and cognitive and language development, and parental unresponsiveness, such as consistently ignoring the child's need for attention. These "milder" forms of neglect are sometimes called "neglectful behaviours," defined as "the omission of ordinary parenting behaviours that are considered necessary for the development of healthy, happy children."[17]

4.0 The linkages between child maltreatment and domestic violence

It has long been established that child maltreatment is generally associated with enduring, serious harm to children, including post-traumatic stress disorder and attachment disorders. However, with the possible exception of child sexual abuse, it can be difficult to sort out which

types of maltreatment cause which types of harm. This is partly because many children suffer multiple types of maltreatment simultaneously or over time. The co-occurrence rate of child abuse and exposure to parental IPV is 60% to 75%[18] and, while some children experience sexual abuse, neglect, or emotional maltreatment alone, more often they occur in concert with other forms of abuse.[19] Moreover, children who have been subject to one type of abuse are at increased risk of re-victimization, even for different types of abuse, and those who experience multiple types of abuse within the family are at high risk of ongoing victimization by peers and others ("poly-victimization") over time, particularly children with high anger or aggression scores and children who have experienced recent life adversities.[20] The risk of ongoing victimization may be heightened for sexual abuse victims because sexual victimization may shape victims' personality and behaviour in negative ways that make them more vulnerable to other forms and/or sources of abuse.[21]

The World Health Organization observes that child "maltreatment causes stress that is associated with disruption in early brain development. Extreme stress can impair the development of the nervous and immune systems. Consequently, as adults, maltreated children are at increased risk for behavioural, physical and mental health problems such as perpetrating or being a victim of violence, depression, smoking, obesity, high-risk sexual behaviours, unintended pregnancy, and alcohol and drug misuse."[22] It should be noted that not all children who experience similar abuse are affected in the same ways: The severity and duration of the maltreatment suffered, along with age of onset and co-occurrence of multiple types of abuse, also play important roles.[23] In addition, some children are more resilient to abuse than others due to factors such as personality traits (such as high self-esteem, high self-confidence), a strong extended family network, and good peer relationships.[24]

The research is clear that the experience of child maltreatment is associated with a heightened risk of IPV perpetration and victimization for both males and females in adolescence and adulthood.[25] Not all children who have been abused will go on to become IPV victims or perpetrators, but the chances are higher than for children who grew up in stable, violence-free households with nurturing parents. One of the largest, clearest and most compelling studies conducted to date found that any one of three childhood experiences—physical abuse, sexual abuse, or growing up with a battered mother—doubled the risk of domestic violence victimization or perpetration in adulthood. Having all three experiences increased the risk by three-and-a-half times for women and even more for men.[26]

Other research shows the ways in which each type of child maltreatment is independently associated with increased risk of adult IPV perpetration and victimization:

- Longitudinal studies have shown that child physical abuse is associated with early anti-social behaviour, such as aggression and lying.[27] Early anti-social behaviour predicts anti-social behaviour and delinquency in adolescence, which, in turn, predict anti-social and violent behaviour in adulthood,[28] including IPV perpetration and victimization in adolescence and

beyond.[29] Even corporal punishment that is not severe enough to be legally deemed 'abuse' is strongly associated with increased risk of criminal behaviour,[30] physical[31] and mental[32] health problems, and IPV perpetration and victimization[33] in adolescence and adulthood.

- Neglect is the most common form of child maltreatment, although it is usually, but not always, accompanied by other forms of abuse.[34] Infants are neglected more commonly than children in other age groups, and they are more likely to die from neglect.[35] Early neglect is strongly associated with negative physical, social, emotional, and cognitive development in early childhood and beyond. At least two large studies from the U.S. have identified the experience of child neglect as a direct predictor of IPV perpetration by adolescent girls, a direct predictor of IPV victimization of adolescent boys, and an indirect predictor of perpetration through youth violence or delinquency by both girls and boys.[36]

- Sexual abuse is associated with mental and physical health problems in childhood and adolescence, including post-traumatic stress, depression, inappropriate sexualized behaviours, conduct problems, substance abuse, and self-harm.[37] A large body of research has documented that the effects of childhood sexual abuse often carry into adulthood, including increased risk of IPV victimization and perpetration.[38] A recent longitudinal study suggests that behavioural problems and stigmatization (abuse-specific shame) experienced by child sexual abuse victims are directly associated with later anger and dating aggression.[39]

- Emotional abuse is sometimes considered to be a less serious form of abuse than physical or sexual abuse, but research shows that it can be equally or more harmful to children's development, with the damage carried on throughout the life span. Some studies have shown, for example, that emotional abuse predicts sexual violence[40] and IPV perpetration[41] as strongly as or more strongly than physical or sexual abuse does. This appears to be because childhood emotional abuse is associated with many negative emotional and inter-personal outcomes, including but not limited to anger and irritability, marital dissatisfaction, and increased psychopathy and inter-personal problems, each of which increases the odds that an individual will have poor intimate relationships and engage in violent behaviours.[42] For these reasons, emotional abuse often predicates "relationship violence victimization and perpetration, above and beyond the contributions of childhood physical abuse, sexual abuse, and domestic violence exposure."[43]

- Exposure to parental IPV is associated with a wide range of social and emotional problems,[44] increased bullying victimization and perpetration in adolescence,[45] and increased IPV victimization and perpetration in both adolescence[46] and adulthood.[47] The pathway from exposure to parental IPV and IPV perpetration and victimization are complex, and appear to be influenced by factors including other types of abuse experienced in childhood,[48] gender,[49] exposure to community and school violence,[50] school performance,[51] attitudes accepting of violence,[52] dating abuse norms,[53] conflict-response style,[54] personality characteristics,[55] and the mother's mental health and ability to regulate emotions.[56]

5.0 Risk factors for child maltreatment

Preventing child maltreatment requires interventions to address the factors that place children at risk of abuse. As discussed below, most types of child abuse can be predicted by a combination of child, parent, family, and socio-demographic factors.[57] Sexual abuse, however, sometimes has unique antecedents, and is discussed separately.

5.1 Risk factors for physical abuse, emotional abuse, neglect, and exposure to parental IPV

Key risk factors for all forms of child maltreatment other than, in some cases, sexual abuse, include parents' experience of abuse or poor parenting in childhood; parental mental health problems (including depression) and/or drug or alcohol abuse; early, unplanned, and/or lone parenting; use of corporal punishment; and a range of contextual stressors and life circumstances, most notably poverty and social isolation.[58] Also, in addition to being a unique type of child maltreatment, exposure to parental IPV is a risk factor for other types of child abuse. Research suggests that the frequency of child abuse generally seems to increase with the frequency of IPV, with the pattern most commonly being that one parent abuses the other parent (or the parents abuse each other) and both parents abuse the child.[59]

Characteristics of children that are associated with child maltreatment include poor social competence, attention deficits, externalizing behaviour (e.g., acting out), and internalizing behaviour (e.g., withdrawal, anxiety), although it is not clear whether such characteristics are a cause or a consequence of child maltreatment.[60] Parents' own personality characteristics appear to partially influence the emotions that parents feel about and the attributions they make about the causes of a child's behaviour. For example, parents' belief that the child has a behaviour problem or acts to intentionally annoy the parent is a risk factor for child maltreatment ("negative attributions").[61] The risk of physical abuse is compounded when parents use corporal punishment as a discipline strategy, as some studies have found that a majority of child abuse cases arise in situations where the abuser intended to discipline the child. Over two-thirds of abusive parents admit that their physical abuse began as an attempt to discipline their child.[62]

Finally, a large body of research has identified community characteristics, such as poverty, unemployment, high residential mobility, and crime and social disorder with increased prevalence of poor parenting and child maltreatment.[63] At the risk of oversimplifying, it is believed that community factors place some parents at higher risk of perpetrating abuse due to increased stress levels, lack of social supports, services and other resources and, possibly, lack of social norms that support positive parenting. Consistent with other research from around the world, Canadian research using data from the National Longitudinal Survey on Children and Youth indicates that neighborhood disadvantage manifests its effects on child maltreatment via lower neighborhood cohesion. Lower neighbourhood cohesion is associated with maternal depression

and family dysfunction, which in turn is associated with poor parenting practices that lead to negative child outcomes.[64]

Risk factors for child maltreatment are often inter-related and concurrent. For example, low-income parents have been found to use less effective parenting strategies, including less warmth, harsher discipline, and less stimulating home environments.[65] Research indicates that economic hardship leads to parental stress and depression, which, in turn, can decrease sensitive, supportive parenting behaviours and increase negative discipline practices.[66] Poor parenting practices in conjunction with the higher levels of stress experienced by very low-income parents contribute to higher rates of child abuse than among higher income families, even when potential biases in reporting are considered.[67] Low-income families are also more likely to be socially isolated,[68] and parents without supportive networks of relatives and friends are more likely to maltreat their children.[69]

Paradoxically, removing children from their parents and placing them in the care of the state may also be a risk factor for child maltreatment. For the most part, the research on maltreatment in care is unreliable, and often fails to distinguish between abuse perpetrated by caregivers and by others (e.g., birth parents) while the child was in care. In addition, many studies use data on allegations of abuse, rather than confirmed cases.[70] That being said, a few recent, large studies from the U.S. and the Netherlands have concluded that children in care are abused more frequently than children in the general population, although all data were retrospective and self-reported. Two new Dutch studies found that 25% of all adolescents in Dutch out-of-home care had experienced physical abuse, most commonly in residential rather than foster care, which is three times the prevalence in the general population.[71] The prevalence of sexual abuse in foster care was similar to that for adolescents in the general population, but twice as high among youth in residential care.[72] Even more alarming are the findings from an American study using data from the 2009-2010 U.S. National Incidence Study (NIS), which showed that children in care were 10 times more likely, and children who lived with a single parent with a co-habiting partner (usually male) were 20 times more likely, to be sexually abused than children who lived with both biological parents.[73] There appear to be no rigorous studies on the maltreatment of children in care in Canada.

Specific factors that may place children at risk of maltreatment while in the care of the state include inadequate screening of foster parents and residential staff; insufficient training of, support for, and supervision of foster parents and caregivers; insufficient supervision and poor management of youth in residential facilities to prevent abuse by peers; and insufficient child welfare staff.[74] In addition, myriad studies have shown that, in addition to multiple physical health problems and cognitive delays, many—perhaps the majority of—children and youth in care have serious emotional and behavioural problems,[75] and the number of children coming into care with special needs has steadily increased over the past three decades.[76] It has been suggested that some foster parents and residential care staff may lack the special skills and attributes required to care for young people with the serious emotional and behavioural

problems, which may contribute to instances of physical or emotional abuse while in care.[77] In recent years, many provinces in Canada, including Alberta, have begun to incorporate training on "trauma-informed care" for a range of service providers within the child welfare system, including foster parents and child welfare workers.

5.2 Sexual abuse

The greatest risk factor for child sexual abuse is the existence of sexual predators within a child's family and social circle and, less commonly, in society at large. Canadian data from police-reported cases indicate that almost all child and youth sexual assault victims know the perpetrator,[78] and about one-third of these perpetrators are family members,[79] most often the victim's parent or parents.[80] However, child sexual abuse is also perpetrated by adolescents, usually males. In fact, it is estimated that adolescent males perpetuate between 30% and 50% of all child sexual abuse incidents[81] and, in about 40% of all incidents, they are related to the child victim.[82] Unlike adults, most adolescent sexual offenders also commit non-sexual offences and, other than committing sexual offences, most appear to be psychologically similar to other young offenders.[83] The proportion of adolescent sex offenders who continue to offend in adulthood appears to be quite small.[84]

The antecedents of child sexual abuse by both adults and adolescents are not well understood. Most adults who sexually abuse children are male but, otherwise, their profile is very diverse. Parents who sexually abuse children often present as "low risk"[85] and many are not persistently and exclusively attracted to prepubescent children. For example, a recent Australian study found that most parental child sexual offenders were in a marital or common law relationship, had participated in long-term intimate relationships with adult sexual partners, and maintained steady employment.[86] Although some perpetrators, whether related to the child or not, were themselves sexually abused in childhood, the majority of victims do not become perpetrators of child sexual abuse later in life.[87] Factors that increase the likelihood that a sexually abused child will grow up to be a child sexual abuse perpetrator may include experiencing physical abuse, emotional abuse, neglect, exposure to adult IPV, and/or early exposure to pornography.[88] Similar to adults, there is no single pre-determinant of adolescent sexual offending within or outside the family, although most adolescent sexual offenders have experienced physical abuse, most have emotional regulation problems and poor social skills, many have experienced sexual abuse, and some have adverse attitudes and beliefs about sexual offending and atypical sexual interests, which frequently emerged in childhood. All of these risk factors may be inter-related.[89]

Overall, sexually abused children most often live in families characterized by dysfunction and poor parenting and often have histories of neglect, physical abuse, and prior sexual victimization.[90] Finkelhor explains that these factors "appear to increase children's risks for abuse in two ways. First, they decrease the quantity and quality of supervision and protection that children receive. Second, they produce needy, emotionally deprived children who are vulnerable to the ploys of sexual abusers, who commonly entrap children by offering affection, attention,

and friendship."[91] Finkelhor's contentions are supported by many studies showing that child sexual abusers select victims based on the child's emotional or behavioural characteristics that make them attractive to abusers and less able to avoid or protect themselves from abuse.[92] Children are also more vulnerable to abuse at particular ages. Canadian data indicate that boys are most likely to be victimized between the ages of 5 and 8 years but for girls, victimization increases throughout childhood, peaking at 14 years of age. Overall, girls are about four times more likely than boys to be sexually abused by a family member, regardless of their age.[93]

6.0 Preventing child maltreatment

Efforts to prevent child maltreatment generally seek to prevent one or more specific risk factors and target all or selected parents and caregivers, children and youth or, in a few instances, service providers and/or entire communities. Unfortunately, only a few child maltreatment prevention initiatives have been demonstrated to be effective through rigorous and repeated evaluations, but many show sufficient promise that merit replication with accompanying evaluation to expand the knowledge base about child maltreatment prevention as a means of preventing IPV in the next generation.

6.1 Preventing physical abuse, emotional abuse, neglect, and the consequences of exposure to parental IPV

Initiatives that have prevented physical abuse, emotional abuse, neglect, and the consequences of exposure to parental IPV include: (1) increasing the income of low-income families with children; (2) prohibiting corporal punishment; (3) preventing young parenting and unplanned pregnancies; (4) improving parenting skills; and (5) mitigating the harm caused to children by direct maltreatment or exposure to parental IPV.

6.1.1 Increasing the income of low-income families with children

A new study using data from the U.S. National Child Abuse and Neglect Data System reports that both the child poverty rate and income inequality were positively and significantly correlated with child maltreatment rates from 2005 to 2009 across counties in the U.S. The researchers conclude that "reducing poverty and inequality would be the single most effective way to prevent maltreatment of children" and should be part of a multifaceted child abuse prevention strategy.[94]

These findings are consistent with many other studies in both Canada and the U.S. indicating that even incremental increases to or reductions in the income of low-income families via changes to social benefits can influence parenting practices and rates of substantiated child maltreatment. Findings from studies completed in the decade following the introduction of welfare reform in the U.S. in 1997 suggest the effects of decreased or discontinued welfare benefits on child maltreatment were mixed, but recent, rigorous studies have identified correlations between increases in substantiated child maltreatment and involuntary discontinuation of social assistance benefits.[95] Similarly, a rigorous experiment in Wisconsin found that mothers' whose

social assistance benefits were not "clawed back" due to receipt of child support from fathers were significantly less likely to be investigated for child maltreatment than were mothers whose benefits were reduced in proportion to the child support received. The researchers concluded that even modest increases in income for low-income families have important implications for child maltreatment prevention.[96]

While there appear to be no Canadian studies on social benefits and child maltreatment, using data from the National Longitudinal Survey on Children and Youth, researchers have correlated receipt of the National Child Benefit with decreased child hunger, improved child emotional well-being and reduced physical aggression, improved school performance, and decreased maternal depression.[97]The researchers suggest that these outcomes were realized by increasing families' ability to purchase resources, but also by reducing stress and conflict in the home,[98] which along with maternal depression, are risk factors for child maltreatment.

6.1.2 Prohibiting corporal punishment

Thirty-five countries have banned corporal punishment in the past 30 years and a systematic review of changes in public attitudes and behaviours following the introduction of "anti-spanking" legislation revealed that legal bans on corporal punishment are closely associated with large decreases in support for, and use of, corporal punishment as a child-discipline technique.[99] For example, in Sweden, which was the first country to introduce "anti-spanking" legislation, the percentage of the population supporting physical punishment of children declined to 8%.[100] It is unclear whether the legislation has directly reduced physical child abuse because decreases in support for corporal punishment are also associated with increases in reporting of abuse.[101] Several large studies have concluded that public information campaigns to reduce corporal punishment are largely ineffective unless they are accompanied by legislation.[102]

6.1.3 Preventing young parenting and unplanned pregnancies

As discussed earlier, young parenting is a risk factor for child maltreatment and a broad range of poor outcomes for both children and mothers. In the U.S, 80% of pregnancies among girls and women aged 19 years and 98% of pregnancies among teens under 15 years of age were unintended.[103] Some research has found an association between unintended pregnancy and child abuse, even among adult mothers. For example, in the largest population-based study to date, researchers in the United Kingdom found that children who were registered with a child protection agency by the age of six were nearly three times more likely than others to have been the result of an unintended pregnancy.[104] In Alberta, the teen (age 15-19) pregnancy rate is 4.1%, considerably higher than the national rate of 2.9%.[105]

A large American study confirmed that providing birth control to women at no cost dramatically reduced unplanned pregnancies, adolescent birth rates, repeat abortions, and abortion rates. This study, called the Contraceptive Choice Project, enrolled 9,256 women and adolescents in the St. Louis area between 2007 and 2011. Participants were 14 to 45 years of age, at risk for

unintended pregnancy, and willing to start a new contraceptive method. Participants were encouraged to use long-acting reversible contraceptives, which other research suggests is most effective in preventing adolescent pregnancies,[106] although all types of contraceptive were available. The rate of teenage birth within the CHOICE cohort was 6.3 per 1,000, compared with the U.S. rate of 34.3 per 1,000.[107]

Research also shows that sexual education is associated with lower teen pregnancy rates. For example, in a large U.S. study of 15-19 year-olds, youth who received comprehensive sexual education were significantly less likely to report teen pregnancy than those who received no formal sexual education or those who received abstinence-only education.[108] Alberta's human sexuality education curriculum includes instruction in elementary school (puberty and the human reproductive system, within the health curriculum taught by teachers); junior high school (sexually transmitted infections, abuse, contraception, safer sex practices, preventing sexual risk, within the health curriculum taught by teachers);[109] and high school (healthy sexuality, sexual wellness and responsible sexual behaviour, within the Career and Life Management Curriculum [CALM]).[110] Upon request from their parents, students may be exempted from participation in the otherwise mandatory CALM program or from any course content that deals primarily and explicitly with human sexuality or sexual orientation.[111] In addition, the quality and content of sexuality education is not rigorously managed: while the curriculum is mandated, teachers have a great deal of latitude in delivery methods and aspects of the content. Alberta Health Services provides research-based best practice curriculum resources authorized by Alberta Education, and identifies appropriate community and government agencies to provide sexual health education,[112] however, the selection of guest speakers rests with individual teachers.

In addition, research reveals an association between birth control sabotage and other forms of pregnancy coercion by male partners with higher rates of IPV and unintended pregnancy.[113] American research has established that dramatic decreases in pregnancy coercion can be achieved when health care providers give women a wallet-sized card with printed information about IPV and reproductive and sexual coercion and take time to review the information with them.[114]

Access to sexuality education and no-cost birth control is very much needed by girls and young women in and leaving the care of the state, as they are more likely than the general population to become pregnant and to become a parent at an early age.[115] In addition, if they become mothers, they may be at even greater risk of maltreating their children than other adolescent and young mothers due to their own experiences of child maltreatment, lack of social support, and little preparation for parenthood.[116] As observed by Constantine, *et al.*, many youth in care do not receive sexual health education in high school due to frequent school and caregiver changes, poor school attendance or dropout, and lack of consistent, ongoing relationships with supportive adults.[117] In fact, a recent report from the Office of the Child and Youth Advocate states that youth leaving care felt that they had received insufficient life skills training to live

independently. The areas in which they said they lacked skills and knowledge included sexual health, pregnancy, and parenting.[118]

6.1.4 Improving the parenting and discipline skills of parents and guardians

Rigorous research has shown that particular types of educational initiatives that explicitly target risk factors for child abuse can reduce these risk factors and, in some cases, reduce the incidence of substantiated physical abuse. These initiatives include specific parenting programs, public campaigns, and brief educational interventions with new parents.

Parenting programs

Intensive, evidence-based[119] parenting programs may also be effective in preventing and stopping child physical abuse, even among high-risk parents.[120] Evaluations show that research-based programs such as the Triple P Positive Parenting Program, the Strengthening Families Program, and the Incredible Years Program clearly improve parenting skills, improve outcomes associated with physically abusive parenting, and reduce the recurrence of child welfare reports of physical abuse.[121] Additional evidence-based programs such as Families and Schools Together and Parents as Teachers have been demonstrated to be effective with some populations and not others. Overall, it must be stressed that effective parenting programs for at-risk parents are intensive, meaning that they go well beyond the provision of parental support and education, and include family therapy and family skills training.

The Government of Alberta currently offers the *Triple P - Positive Parenting Program* to Alberta parents through the provincial Child and Family Services Authorities and designated First Nations agencies.[122] Developed in Australia and used in countries around the world, *Triple P* is designed for families with children from birth to age 12, with extensions to families with teenagers ages 13 to 16. The program seeks to prevent social, emotional, behavioral, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. Triple P has five intervention levels of increasing intensity to meet each family's specific needs.[123] *Triple P Level 4* (Standard Triple P) is one of the few parenting programs in existence that may be described as effective because it has been demonstrated to be effective in multiple evaluations using large samples and an experimental design (i.e., randomized controlled trials).[124] One such evaluation found a 28% reduction in substantiated abuse cases, a 44% reduction in child out-of-home placements, and a 35% reduction in hospitalizations and emergency room visits for child injuries in nine study counties.[125]

Specific home visitation programs[126] have also proven to be effective in preventing and reducing child maltreatment, and new research is showing that they can also prevent and reduce intimate partner violence. One of the best examples of an effective program is the Nurse-Family Partnership (NFP) program, which has been tested through multiple randomized controlled trials and shown to improve pregnancy outcomes, child health and development, educational outcomes and family economic self-sufficiency, while reducing child maltreatment and injuries,

juvenile delinquency, crime and welfare dependency.[127] Alberta has implemented a different evidence-based model, Healthy Families America (HFA), which may or may not prevent child maltreatment, depending on the population served, degree to which a program has been implemented with fidelity to the model, and other factors.[128] There is some suggestion that, HFA may work best for young, first-time, at-risk mothers who initiate home visiting services prenatally, and for mothers who have had at least one substantiated child protective services report, although this has not been conclusively determined as yet.[129]

Another effective intervention is *Supporting Father Involvement*, a parenting program that targets low- and middle-income, at-risk fathers of children from birth to 11 years of age and is currently being replicated and evaluated in three sites in Alberta through the Alberta Family Wellness Initiative.[130] The curriculum targets five aspects of family life for intervention to enhance fathers' involvement: both partners' individual well-being; the quality of the relationship between the parents; the quality of relationship between parent and child; breaking negative cycles across generations; and coping with life stress and enhancing social support.[131] Different versions of the program have been demonstrated through large, clinical trials to reduce the risk factors for child maltreatment, including parental substance use, conflict between parents, violent problem solving, and harsh parenting, and to reduce children's behavioural problems.[132]

Educational materials for pregnant women and new mothers

Low-cost, low-literacy educational materials have proven to be an effective way of teaching new mothers about typical child development and injury prevention.[133] A recent study funded by the U.S. National Institute of Child Health and Human Development (NICHD) indicates that they can also be effective in teaching mothers about appropriate discipline and significantly improving attitudes about corporal punishment. Mothers were recruited in their third trimester of pregnancy and followed until their child was 18 months old. They received the first book at the beginning of the study and additional books when their babies were two, four, six, nine, and 12 months old. Relative to control groups, attitudes about physical discipline in the experimental group (i.e., mothers who received the educational books) improved as a result of the intervention. The books had the largest effect on mothers who had not completed post-secondary education.[134]

Public campaigns

Public campaigns have proven to be an effective component of broader strategies to change attitudes and behaviours. Notable examples include campaigns against impaired driving and smoking, and campaigns to increase the use of seat belts. While most public campaigns to prevent child maltreatment have not been rigorously evaluated, there is sufficient evidence to indicate that they can reduce risk factors for child abuse.[135]

Examples of effective public campaigns targeting parents include a 12-episode television series, entitled "Families," that was aired in Australia as the first level of the Triple P Parenting Program. Relative to a control group, parents of children aged two to eight years who watched the show reported significantly lower levels of disruptive child behaviour and higher levels of perceived parenting competence. At the end of the intervention and at six months follow-up, the proportion of children in the clinically elevated range for disruptive behaviours declined from 43% to 14%.[136] A second example is the Florida Winds of Change Campaign to prevent child maltreatment, which included public service announcements and a print booklet. Experimental evaluation of the campaign revealed that exposure to the public service announcement and the booklet was significantly related to increased knowledge of child development, knowledge of community resources for parents, attitudes toward the prevention of child abuse and neglect, motivation to prevent child abuse and neglect, and action or behavior to prevent child abuse and neglect.[137]

6.1.5 Mitigating the harm caused to children by direct maltreatment or exposure to parental IPV

Some children and youth require intensive supports and therapy to address and grow beyond the maltreatment they have experienced or witnessed and avoid IPV perpetration and/or victimization in adulthood. Many types of therapy have been shown to be effective for victims of child maltreatment. Examples of intensive therapies that are effective and are delivered by trained therapists include Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT), Integrative Treatment of Complex Trauma (ICT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Child-Parent Psychotherapy.[138] TF-CBT has been extensively tested with and is often recommended for children and youth in care and in shelters.[139]

There is also promising evidence that mother-child and child-focused therapies for children exposed to parental IPV can improve children's behavioural and mental health outcomes.[140] There is emerging evidence suggesting that child-parent psychotherapy may improve child outcomes, but the research base is still very small.[141] Evaluation of *Project Support*, an individualized program from the U.S. consisting of weekly, 90-minute home visits provided to mothers and their children after leaving a shelter, indicates that this program can be effective in increasing mothers' parenting capacity, decreasing mothers' psychiatric symptoms, and decreasing children's behavioural problems.[142] An evaluation of *The Kids' Club*, a 10-week manualized group intervention for children exposed to IPV, reported declines in children's externalizing and internalizing problems, with the greatest improvements among children whose mothers also participated and when the mothers' own symptoms of post-traumatic stress could be reduced.[143] Developed in the U.S., the program is now being implemented in Sweden and the Netherlands. [144]

Children and youth in care are at particular risk of poor developmental and life outcomes due to their experiences prior to coming into care and, in some cases, while in care, and often require very intensive and long-term therapy to overcome the effects of maltreatment. "Therapeutic"

foster care, particularly Multidimensional Treatment Foster Care (MTFC), has been demonstrated to be an effective intervention. "Therapeutic" foster care refers to out-of-home placements where caregivers have the capacity to provide specific treatment or supports to children and youth with emotional and behavioural problems.[145] MTFC appears to be the only type of therapeutic foster care that has been demonstrated to be effective for *adolescents* with serious emotional and behavioural problems in repeated studies using an experimental design. Youths are individually placed with highly trained and supervised foster parents and are provided with intensive support and treatment. MTFC typically lasts six to nine months and relies on coordinated, multi-method interventions conducted in the MTFC foster home, with the youth's biological or aftercare family, and with the youth. MTFC has been demonstrated through repeated studies to be effective in reducing delinquency, violent behaviour, pregnancy, and drug use.[146]

Schools also play an important role in providing maltreated children with safe and predictable learning environments and in connecting students to various levels of support at the universal, targeted and individual levels.[147] In 2006, The Calgary Board of Education created the Trauma Sensitive Schools Initiative in an effort to support students impacted by traumatic stress in achieving their potential and to support staff in undertaking this important work. The ARC (Attachment, Self-Regulation and Competency) framework is the tool the Calgary Board of Education selected to help guide trauma-informed practice in schools. Members of the Initiative have worked with over 30 schools and introduced trauma-informed practice to staff across the system that now use a trauma lens every day to better understand and work with students. At the universal level, trauma-informed practice is good for all students, but critical for students who have experienced maltreatment.

6.1.6 Community-wide initiatives

Community-wide efforts to prevent child maltreatment are often touted as a promising strategy because they would allow, at least in theory, for coordinated delivery of multiple, complementary prevention initiatives, including changes in social norms that support or allow for child maltreatment. However, few such initiatives have actually been attempted, fewer still have been rigorously evaluated, and those which have been evaluated have demonstrated little preventive impact. Two comprehensive initiatives that were thoughtfully developed in 2002 and have been rigorously evaluated are the *Durham Family Initiative (DFI)*, implemented in Durham County, North Carolina, and the *Strong Communities initiative (SCI)*, implemented in six communities in or near Greenville County, South Carolina.

Both initiatives were developed by university researchers and both initiatives and their evaluations were funded through the Duke Endowment at Chapin Hall, University of Chicago. The initiatives sought to reduce child abuse rates, improve parenting practices and behaviors, strengthen formal service delivery, and strengthen informal, community supports to protect children and support parents.

The SCI focused on building a collective sense of shared ownership and reciprocity among community members through many community engagement activities (e.g., community wellness activities, back-to-school events, child abuse prevention month). Funding for the SCI was discontinued in 2008 when it was determined that the initiative had no effect on child maltreatment or social interactions among community members.[148]

The DFI initially included a range of strategies to improve parental capacity and functioning, community capacity and collective efficacy, and the public service response to child protection. Although many prevention initiatives were launched, by 2007 the researchers had determined that their impact would be minimal so all initiatives other than a home visit provided by a nurse to all babies born in Durham Country were dropped.[149] Funding for the DFI continued until 2014, and the nurse visitation service has been taken over by a health centre. At last report, the official community-wide rate of child maltreatment in Durham County had declined by 50% since 2002.[150] Several researchers have noted that child maltreatment also declined in nearby communities that did not have a child maltreatment prevention initiative, although the decline in other communities was less pronounced than that in Durham County. A rigorous evaluation using an experimental design concluded that home visitation by nurses to at-risk families of newborns increased identification at-risk families; improved connections to community resources, parenting skills, and the safety and quality of the home environment; significantly reduced infant medical emergencies; and generated an estimated $3 in cost savings for every dollar invested.[151]

6.2 Preventing child sexual abuse

To date, there have been two main child sexual abuse primary prevention strategies: (i) school-based prevention programming for children and (ii) efforts by the justice and mental health systems to prevent child sexual offenders from re-offending. Strategies have not, however, focused on targeting potential intra-familial child sexual abusers through programming and other initiatives before any abuse occurs. This is probably because it is so difficult to detect parents who may be at risk of child sexual abuse perpetration, although it is less clear why at-risk adolescents, some of whom are more easily identified than their adult counterparts, are not targeted for intervention.

6.2.1 Sexual abuse prevention programs for children

There is strong evidence that high-quality school-based sexual abuse prevention programs can increase children's knowledge about how to prevent sexual abuse, such as distinguishing between "good" and "bad" touching and avoiding would-be predators.[152] However, further research is required to determine whether knowledge and skills are retained over time, transferred into real-life behaviours, or reduce the incidence of child sexual abuse.[153] It appears to be generally agreed that school-based sexual abuse programs should be considered as part of a broader prevention strategy, rather than a stand-alone way to prevent child sexual abuse.

6.2.2 Targeting potential child sexual abuse offenders

At present, there appear to be no high-quality studies on the effectiveness of psychological or pharmacological interventions on adults who are considered to be at risk of child sexual abuse, but who have never been convicted of perpetrating abuse. With respect to tertiary prevention efforts targeting adults who have been convicted of child sexual abuse, some studies have suggested that cognitive behavioural therapy may reduce risk of re-offence, but a recent in-depth review of the research concluded that there is insufficient evidence on the effectiveness of these interventions in studies that use an experimental or prospective design.[154]

There appears to be no research whatsoever on primary prevention strategies or interventions targeting intra-familial sexual offenders, that is, potential abusers of children within the family. This is because, as discussed earlier, it is extremely difficult to identify potential adult intra-familial child sex offenders in advance, as many appear to function normally in society. Identifying adolescents who may be likely to perpetrate intra-familial child sexual abuse is also very challenging because, for the most part, they comprise a small subsection of the larger group of male adolescents who have experienced adversity and child maltreatment and who commit other types of crimes. Finkelhor recommends that "special attention should be paid to assessing and intervening in sexually inappropriate behaviour among juveniles"[155] as a primary prevention strategy, although this may be challenging, given that many young offenders do not attend an education program, hold a job in which such behaviour might be observed, or have responsible parents or other adult role models in their lives.

Leading researchers have called for early and low-intensity *secondary* prevention strategies targeting relatively low-risk youth and family offenders (e.g., the absence of multiple victims, abuse that did not include penetration), such as efforts to engage family and friends to stay engaged with and monitor the offender to minimize the potential for offending.[156] For example, Circles of Support and Accountability (CoSA) is a strategy developed in Canada in the 1990s to create a community to both support and hold accountable sex offenders (of any type) who are released from prison and considered to be at high risk to re-offend. A circle is generally comprised of four to seven volunteers who are primarily from the faith community.[157] Although no large studies have been conducted and there has been no research specific to child sexual abusers, a few small studies indicate that CoSA may be an effective strategy to prevent repeat sex offences in general. The first study, conducted in Ontario, found that offenders who participated in CoSA had a 70% reduction in sexual recidivism relative to a comparison group (5% vs. 16.7%), a 57% reduction in all types of violent recidivism (including sexual - 15% vs. 35%), and an overall reduction of 35% in all types of recidivism (including violent and sexual - 28.3% vs. 43.4%).[158] A second study using a small sample of sex offenders from across Canada reported an 83% reduction in sexual recidivism, a 73% reduction in all types of violent recidivism, and an overall reduction of 71% in all types of recidivism among CoSA participants relative to a comparison group.[159] Similar results were observed in a recent, small study of offenders in Minnesota.[160]

6.2.3 Targeting parents and professionals

Although they are far less common, strategies for the primary prevention of child sexual abuse occasionally target parents or service providers. As discussed earlier, home visitation programs can be effective in preventing child maltreatment, and this may include child sexual abuse. Other efforts may help to increase parents' knowledge about recognizing and responding to child sexual abuse and how to prevent perpetration by adults who are involved in a child's life, but parent-focused workshops are often poorly attended.[161] While there is some preliminary evidence that such programs can improve parents' knowledge and ability to talk to their children about child sexual abuse,[162] it does not appear that any rigorous evaluations have been conducted to determine whether such efforts translate into parental behavioural change and prevent child sexual abuse from occurring in the first place.[163] Likewise, public campaigns to raise awareness about child sexual abuse have been demonstrated to increase public awareness and knowledge,[164] but it appears that no research has been done to determine their effects on behaviour.[165]

6.2.4 Community-wide initiatives

Many researchers have argued that child sexual abuse prevention requires multi-faceted approaches that target parents, professionals, and the public as well as children and youth with a view to changing both individuals and environments.[166] In response, some states and cities in the U.S. have developed comprehensive community-wide primary prevention initiatives specific to child sexual abuse. One example is Massachusetts' "Enough Abuse Campaign," launched in 2003 and funded by the Centers for Disease Control and Prevention, is a multi-disciplinary, collaborative effort to change community conditions and systems, along with individual behaviours and risk factors. The mission of the campaign is "to prevent people from sexually abusing children now and to prevent children from developing sexually abusive behaviors in the future." Ten years after its inception, the Enough Abuse Campaign has been successfully implemented and boasts many accomplishments, including improved knowledge among professionals about how to identify possible cases of child sexual abuse and respond to disclosures of abuse, along with a large increase in the percentage of residents who believe that adults should take responsibility for preventing child sexual abuse.[167] In addition, the campaign's community-based model is being replicated in several other states.[168] However, it appears that the impact of the campaign on preventing or reducing child sexual abuse in Massachusetts has not been evaluated. While the rate of reported incidents in Massachusetts declined from the early to mid-2000s, this decline was consistent with declines in other states that had not implemented similar initiatives.[169] Researchers have speculated that these declines might have been attributable to a combination of factors including economic improvement, improvements in law enforcement and child welfare practices, and public awareness,[170] rather than community-wide initiatives.

7. Conclusion and recommendations

Preventing child maltreatment may be the most effective strategy for preventing IPV in the next generation. Alberta is recognized as a leader in Canada and in the world for its proactive and innovative efforts to prevent and stop all forms of family violence. The Government is urged to strengthen its efforts to prevent child maltreatment as a critical component of the Family Violence Prevention Framework and the Early Childhood Strategy through the research initiatives, legislative amendments, policy changes, and program enhancements recommended below.

1. Increase the income of low-income families with children

1.1 At present, Alberta recovers (or "claws back") funds provided by the National Child Benefit Supplement (NCBS) from households receiving social assistance and reinvests this funding into programs such as child care subsidies and child health benefits for low-income families.[171] It is recommended that the Government of Alberta discontinue the practice of subtracting the NCBS from recipients of income support provided through Alberta Works. The Government of Alberta should continue to provide the child care subsidy and child health benefit to low-income Albertans, but fund these programs with provincial revenues other than NCBS funding received from the federal government.

1.2 Consistent with recommendations of the Calgary Poverty Reduction Initiative,[172] the Government of Alberta should index social assistance benefits to the rate of inflation and revise Section 6(b)(iii) and (iv) of the *Income Supports, Health and Training Regulation* to increase the earnings exemptions for employment income so that the total household income threshold aligns with the Low-Income Cut-Off identified by Statistics Canada for families with children under the age of 18.

2. Prohibit corporal punishment

2.1 Amend Alberta's *Protection Against Family Violence Act*, RSA 2000, c. P-27, section 1(1)(e) to revise the definition of "family violence" to disallow parents and persons standing in the place of parents from using physical force to correct a child.

2.2 Amend Alberta's *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12 to include a provision explicitly stating that "[c]hildren are entitled to care, security and a good upbringing. Children are to be treated with respect for their person and individuality and may not be subjected to corporal punishment or any other humiliating treatment."[173]

2.3 Lobby the Government of Canada to repeal section 43 of the Criminal Code, RSC 1985, c. C-46, which currently allows the use of "reasonable force" by schoolteachers, parents and persons standing in the place of a parent to correct children's behaviour.

3. Improve the parenting and discipline skills of parents and guardians

3.1 When the Government of Alberta's current initiative to increase fidelity in *Triple P* implementation and delivery has been completed, continue to increase the availability of and participation in Triple P Levels 4 and 5 and *Pathways Triple P* throughout the province on an annual basis by increasing the number of sessions provided annually and by increasing the number of referrals to the program. Directly market the program to *fathers* and to programs serving fathers as well as to mothers and, as recommended by Fletcher and other researchers,[174] modify the program to better engage and serve fathers by including more active learning components and by including men as co-facilitators of the program. Using an experimental design, evaluate the modified program.

3.2 In conjunction with Recommendations 2.1, 2.2, and 2.3, build on the success of Alberta's *Triple P* program by replicating Australia's Triple P-based television series. This low-cost initiative would greatly extend the reach of the *Triple P* program. It is further recommended that the television series be accompanied by rigorous, longitudinal evaluation of its effects on parenting attitudes and behaviours.

3.3 Invest in scientifically rigorous research and evaluation to identify and support the most effective strategies to increase positive father involvement and improve parenting practices. Do not invest in any new family support or parenting programs that are not supported by high-quality, comprehensive research or accompanied by a comprehensive, experimental evaluation. Rather, invest in Alberta-based demonstrations, replications, and/or experimental evaluations of fatherhood programs. More detail on the types of fathering programs that should be replicated and evaluated is provided in a separate Shift paper, *Promoting Positive Father Involvement: A Strategy to Prevent Intimate Partner Violence in the Next Generation*, available at http://preventdomesticviolence.ca/sites/default/files/research-files/Promoting%20Positive%20Father%20Involvement.pdf.

3.4 Alberta Health Services should purchase or develop and distribute educational materials on corporal punishment for pregnant women and new mothers and fathers through Alberta Health Services programs and services such as Child Health Clinics, Best Beginnings, Healthy Beginnings, and Home Visitation. These materials should be similar to those developed and evaluated for effectiveness by Stephanie Reich at the University of California, Irvine, with funding from the U.S. National Institute of Child Health and Human Development (NICHD).

3.5 Assign priority for participation in Alberta's home visitation program to (i) families with children who have already had at least one substantiated child services report; and (ii) young, at-risk, pregnant women, identified by primary care physicians.

4. Prevent young parenting and unplanned pregnancies

4.1 Alberta Health Services should follow the lead of the Government of the United States in its efforts to remove all cost barriers to contraception and provide universal access to publicly funded contraception, including emergency contraception, with no restrictions on age.

4.2 The Alberta Ministry of Human Services should ensure that all youth aged 14 years and up who are in the care of the Government of Alberta and live in residential care receive comprehensive sexuality education before they leave care. The Ministry should provide a sexual health curriculum that is delivered by trained educators based on the *Canadian Guidelines for Comprehensive Sexuality Education*[175] developed by the Public Health Agency of Canada, as these guidelines reflect the research-based practices that are associated with lower teen pregnancy rates.[176]

4.3 All child and youth care professionals in Alberta should be certified by the Child and Youth Care Association. Training leading to certification should include knowledge of human sexuality and knowledge about sexuality education in accordance with the *Canadian Guidelines for Comprehensive Sexuality Education.* The Child and Youth Care Professional Certification Exam in Alberta should include testing for this knowledge. In addition, the Certification Exam should be more detailed and stringent in all areas and should be completed in person and under supervision; it should not be possible to complete the exam on-line.

4.4 Alberta Education should amend the Alberta Learning Curriculum to implement comprehensive sexuality education from grades 4 to 11, ensuring that instruction is standardized, hours of instruction are mandated and the curriculum is based on the *Canadian Guidelines for Comprehensive Sexuality Education.*[177] This policy change requires amending Alberta Education Directive 4.1.2, Human Sexuality Education, which states that every board-operated school offering grades 4, 5, 6 Health, grades 7, 8, 9 Health and Life Management, and the high school Career and Life Management Program shall ensure that the human sexuality component is offered to all students. The amendment would state that Human Sexuality Education in Alberta will be aligned with the principles of the *Canadian Guidelines for Comprehensive Sexuality Education*.

4.5 Amend the *Alberta Human Rights Act*, RSA 2000, c.A-25.5, to repeal section 11.1 (added in 2009 by Bill 44) in order to make the sexual health curriculum mandatory (i.e., no opting out).

4.6 In partnership with teen parent programs throughout Alberta, Alberta Human Services should design and evaluate mentoring programs for teen parents for both parents.

5. Mitigate the harm caused to children by maltreatment

5.1 Amend Alberta's *Protection Against Family Violence Act*, RSA 2000, c. P-27, sections 2(3) and 4(2) to include a requirement that completion of a government-sanctioned parenting program is mandatory for any parents or individuals acting in the capacity of parent who are made subject to an Emergency Protection Order or Queen's Bench Protection Order involving child maltreatment or where children have been exposed to IPV. Programs should be available at no cost to participants.

5.2 Implement a replication of *Project Support*, with a comprehensive experimental evaluation component, in partnership with at least two women's shelters in Alberta, to provide the program to mothers and their children upon leaving the shelter.

5.3 Implement a replication of *The Kids' Club*, with a comprehensive experimental evaluation component, in at least two second stage women's shelters in Alberta.

5.4 Dramatically increase the availability of intensive, evidence-based therapies for children and youth who manifest serious emotional, cognitive, or behavioural problems due to child maltreatment or exposure to parental IPV.

- The Ministry of Education should work with Alberta Mental Health and the Faculties of Medicine at the University of Calgary and the University of Alberta to increase the supply of pediatric psychiatrists in the province.
- Cross-ministry efforts should be made to ensure that children and adolescents who are observed by parents or professionals to have adverse attitudes and beliefs about sexual offending and atypical sexual interests or who have demonstrated "sexually intrusive" behaviour should swiftly receive a clinical assessment and a psychiatric consultation, followed by individual, group, and/or family therapy as directed by a psychiatrist.
- Ensure that adolescents who have perpetrated or who are clearly at risk of perpetrating child sexual abuse are able to attend an intensive residential treatment program, such as the Phoenix Program provided by Wood's Homes in Calgary. To strengthen the knowledge base on the prevention of child sexual abuse perpetration by adolescents, fund a comprehensive, experimental evaluation of an Alberta residential program for adolescent sex offenders, such as the Phoenix Program.

5.5 Dramatically increase the supply of Therapeutic Foster Parents in Alberta by increasing funding to recruit and train current and prospective foster parents to become licensed Therapeutic Foster Parents, and to support and financially compensate licensed Therapeutic Foster Parents.

5.6 To enhance the Government of Alberta's ongoing efforts to prevent the maltreatment of children and youth in care, complete or commission a study on the prevalence of all forms of maltreatment in residential and foster care in Alberta. This study must be rigorous and

comprehensive, and distinguish between abuse perpetrated by caregivers and by others (e.g., birth parents) while the child was in care.

6. Improve school-based child sexual abuse prevention programs in Alberta

6.1 It is not clear that all school-based child sexual abuse prevention programs in Alberta reflect best practices as identified by research. Therefore, it is recommended that the Government of Alberta convene a working group to identify Alberta programs with best practice components and, ideally, evaluate such programs using a longitudinal, quasi-experimental design to determine their long-term effectiveness in preventing child sexual abuse.

7. Conduct research on reducing recidivism among intra-familial child sexual abuse perpetrators

7.1 In Alberta, the Circles of Support and Accountability (CoSA) program is provided by the Mennonite Central Committee (MCC). The Government of Alberta should investigate the possibility of working with MCC Alberta to initiate an independent, quasi-experimental evaluation of the program's effects on recidivism by intra-familial child sexual abusers who have received custodial sentences, if there is a sufficient number of such offenders in Alberta to complete a study.

Endnotes

[1] See, for example, Belsky, J.; Conger, R.; Capaldi, D.M. 2009. "The intergenerational transmission of parenting: Introduction to the special section." *Developmental Psychology,* 45*,* 1201–1204; Bailey, J.A.; *et al.* 2009. "Parenting practices and problem behavior across three generations: Monitoring, harsh discipline, and drug use in the intergenerational transmission of externalizing behavior." *Developmental Psychology,* 45*,* 1214–1226; Belsky, J.; *et al*. 2005. "Intergenerational transmission of warm–sensitive–stimulating parenting: A prospective study of mothers and fathers and 3-year-olds." *Child Development,* 76, 384–396; Neppl, T. K.; *et al*. 2009. "Intergenerational continuity in parenting behavior: Mediating pathways and child effects." *Developmental Psychology,* 1241–1256.

[2] See, for example, Whitfield C.L.; *et al*. 2003. "Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization." *Journal of Interpersonal Violence,* 18(2), 166–185; Lackey, C. 2003. "Violent family heritage: The transition to adulthood and later partner violence." *Journal of Family Issues*, 24, 74-85; Cast, A.D.; *et al*. 2006. "Childhood physical punishment and problem solving in marriage." *Journal of Interpersonal Violence*, 21, 244-254.

[3] See, for example, Tonmyr, L.; Hovdestad, W.E.; Draca, J. 2013. "Commentary on Canadian child maltreatment data." *Journal of Interpersonal Violence*, published online before print, October 3, 2013.

[4] Trocmé, N.; *et al*. 2010. *Canadian Incidence Study of Reported Child Abuse and Neglect 2008: Major Findings.* (Ottawa, ON: Public Health Agency of Canada).

[5] MacMillan, H.L.; *et al*. 2013. "Child physical and sexual abuse in a community sample of adults: Results from the Ontario Child Health Study." *Child Abuse & Neglect*, 37(1), 14-21.

[6] Fang, X.; *et al.* 2012. "The economic burden of child maltreatment in the United States and implications for prevention." *Child Abuse & Neglect,* 36, 156-165.

[7] The model of calculating economic costs includes measuring costs in 6 areas: judicial, social services, education, health, employment and personal costs. The authors acknowledge that in each category there are many possible costs and calculations depend on the availability of data. Included in the area of judicial costs are: policing, court trials, legal aid, the Criminal Injuries Compensation Board, and penal costs including incarceration, parole, and statutory release. These costs associated with the justice system are entirely funded by the public sector. Social services, both publicly and privately funded, are included. Education costs focus on the demand for special education services as a consequence of behavioural and learning problems in child abuse victims. Employment costs are calculated in the area of lost income. Health costs are measured by: immediate effects of abuse, persistent medical costs and long-term medical costs experienced by adult survivors of child abuse. Personal costs include transportation, relocation, costs associated with legal proceedings, drugs, therapies, alcohol, self-defence systems and goods and services purchased as a result of the abuse. See Bowlus, A.; *et al*. 2003. *The Economic Costs and Consequences of Child Abuse in Canada: Report to the Law Commission of Canada*. Retrieved October 2, 2013 from http://dalspace.library.dal.ca:8080/bitstream/handle/10222/10274/Bowlus_McKenna%20et%20al%20Research%20Child%20Abuse%20EN.pdf?sequence=1.

[8] The total calculated minimum cost to society across the six domains was $15,705,910,047. See Bowlus, A.; *et al*. 2003. *The Economic Costs and Consequences of Child Abuse in Canada: Report to the Law Commission of Canada*. Retrieved October 2, 2013 from http://dalspace.library.dal.ca:8080/bitstream/handle/10222/10274/Bowlus_McKenna%20et%20al%20Research%20Child%20Abuse%20EN.pdf?sequence=1.

[9] Assuming that there has been no change in prevalence, severity of abuse, types of abuse (with different costs), or relative price in the components of the cost calculation, so that only general price inflation has taken place since 1998, then with the Consumer Price Index (all items 2002=100), the value of the index in June 1998 was 91.4 and the value of the index in June 2013 was 123. This means that a dollar in 1998 has 123/91.4=1.346 more purchasing power than a dollar in 2013 such that $15 billion in 1998 would have the purchasing power of $20.19 billion in 2013. Analysis provided to the author through personal communication dated September 1, 2013 by Hugh Emery, Department of Economics, University of Calgary.

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[13] See Portwood, S.G. 2006. "What we know – and don't know – about preventing child maltreatment." *Journal of Aggression, Maltreatment & Trauma,* 12(3/4), 55-80.
[14] Canadian Child Welfare Research Portal, http://cwrp.ca/child-abuse-neglect; Fang, X; *et al*. 2012. "The economic burden of child maltreatment in the United States and implications for prevention." *Child Abuse & Neglect,* 36, 156-165.
[15] Child, Youth and Family Enhancement Act, RSA 2000, Section 1, Chapter C-12, Subsections 2.1., 3
[16] Gershoff, E.T. 2010. "More harm than good: A summary of scientific research on the intended and unintended effects of corporal punishment on children." *Law and Contemporary Problems*, 73, 31-46.
[17] Hines, D.A.; Kaufman Kantor, G.; Holt, M.K. 2006. "Similarities in siblings' experiences of neglectful parenting behaviors." *Child Abuse & Neglect,* 30(6), 619-637, p. 620.
[18] Osofsky, J.D. 2003. "Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention." *Clinical Child and Family Psychology Review*, 6(3), 161-170.
[19] For a concise summary of this research, see Price-Robertson, R.; *et al*. 2013. "Rarely an isolated incident: Acknowledging the inter-relatedness of child maltreatment, victimization and trauma." Child Family Community Australia, Paper No. 15. (Melbourne, AUS: Australian Government, Australian Institute of Family Studies).
[20] See, for example, Finkelhor, D.; Ormrod, R.K.; Turner, H.A. 2007. "Re-victimization patterns in a national longitudinal sample of children and youth." *Child Abuse & Neglect*, 31(5), 479-502.
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[111] Section 11.1 of the *Alberta Human Rights Act*, RSA 2000, c.A-25.5,states: " A board as defined in the School Act shall provide notice to a parent or guardian of a student where courses of study, educational programs or instructional materials, or instruction or exercises, prescribed under that Act include subject-matter that deals primarily and explicitly with religion, human sexuality or sexual orientation. (2) Where a teacher or other person providing instruction, teaching a course of study or educational program or using the instructional materials referred to in subsection (1) receives a written request signed by a parent or guardian of a student that the student be excluded from the instruction, course of study, educational program or use of instructional materials, the teacher or other person shall in accordance with the request of the parent or guardian and without academic penalty permit the student (a) to leave the classroom or place where the instruction, course of study or educational program is taking place or the instructional materials are being used for the duration of the part of the instruction, course of study or educational program, or the use of the instructional materials, that includes the subject-matter referred to in subsection (1), or (b) to remain in the classroom or place without taking part in the instruction, course of study or educational program or using the instructional materials. (3) This section does not apply to incidental or indirect references to religion, religious themes, human sexuality or sexual orientation in a course of study, educational program, instruction or exercises or in the use of instructional material." Available at: http://www.qp.alberta.ca/documents/Acts/A25P5.pdf See also: http://www.education.alberta.ca/media/6542444/guidetoed_2011-2012.pdf

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[119] Evidence-based parenting programs are those which: (i) employ professional staff such as nurses or social workers; (ii) are associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement; and (iii) demonstrate fidelity to a parenting or family strengthening model that has: been in existence for at least three years; been evaluated using a well-designed and rigorous randomized controlled trial (RCT) and the evaluation results have been published in a peer-reviewed journal; and where one or more RCT evaluations have demonstrated significant and sustained positive child abuse outcomes.

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peer-reviewed journal; and for which, one or more RCT evaluations have demonstrated significant and sustained positive child abuse and intimate partner violence outcomes.

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