Canadian Paediatric Society / Société canadienne de pédiatrie

Written Submission to the Standing Senate Committee on Social Affairs, Science and Technology: Study of S-249, *An Act respecting the development of a national strategy for the prevention of intimate partner violence*

April 2024

100–2305 St. Laurent, Ottawa ON K1G 4J8 613-526-9397 613-526-3332 info@cps.ca www.cps.ca

Summary

The Canadian Paediatric Society (CPS) is pleased to submit the following comments to inform the Standing Senate Committee on Social Affairs, Science and Technology's study of S-249, *An Act respecting the development of a national strategy for the prevention of intimate partner violence*.

As the national association of over 3,600 paediatric experts across the country, the CPS is dedicated to advancing the health and well-being of children and youth. Consequently, the following comments will focus largely on children and youth exposed to intimate partner violence (CEIPV). Many of the recommendations made in this submission come from the Canadian Paediatric Society's November 2023 position statement, "Recognizing and responding to children with suspected exposure to intimate partner violence between caregivers".

Context

Intimate partner violence (IPV) refers to a range of behaviours by a current or former intimate partner that can cause physical, psychological, or sexual harm. IPV impacts people of all genders, ages, and backgrounds. However, women account for the vast majority of people who experience this form of gender-based violence (GBV) and IPV is most often perpetrated by men. In 2018 self-reported data, over 44% of women in Canada who had ever been in an intimate partner relationship – or about 6.2 million women aged 15 and over – reported experiencing some kind of psychological, physical of sexual IPV in their lifetime. Adolescence and young adulthood is a time of higher risk for IPV. The Canadian Centre for Justice and Community Safety Statistics found that in 2018, 29% of females 15-24 years of age reported having experienced IPV in the past 12 months, more than double the proportion found among women between the ages of 24-34 or 35-44. Indigenous women (61%) are more likely to experience some form of IPV in their lifetime compared with non-Indigenous women (44%). Transgender women are also at elevated risks for IPV and can face greater barriers than cisgender women to accessing services and supports. In 2019, data from the Trans PULSE Canada survey found that 64% of respondents who identified as a trans woman or similar gender identity experienced IPV since the age of 16.

Obtaining comprehensive prevalence data about IPV in Canada is a significant challenge. Those who experience IPV often do not report it for a variety of reasons, including fears of escalating violence, stigma/shame, fear of family separation, social isolation, financial coercion, or lack of trust in the police, legal and child welfare systems. To improve the accuracy of IPV prevalence data in Canada, a national strategy should strive to reduce the many barriers that victims/survivors (hereafter referred to as 'victims' throughout) face to disclosing violence. A national strategy should also ensure that victims receive stigma-free services and supports that adequately prioritize both their safety and security, as well as their physical and mental health. Alongside efforts to reduce barriers to disclosing IPV, a national strategy should seek to strengthen the quality, accuracy and disaggregation of data and collate existing indicators and surveys to better measure changes over time and across population groups. Given the gendered realities of IPV, a greater prioritization of comprehensive and longitudinal data collection and analysis will advance provincial, territorial, national, and international commitments to gender equality and eliminating all forms of violence against women, girls, and gender diverse individuals.

IPV frequently occurs in the presence of children and youth and can include threats of harm or actual harm toward a child, often as an attempt to control a current or former partner. Childhood exposure to

IPV between caregivers has been shown to have similar negative health impacts as exposure to childhood physical, sexual, or emotional abuse. The negative health consequences of CEIPV have contributed to its recognition in Canada as a form of child maltreatment. CEIPV generally includes any incident of a child or youth seeing, hearing, being involved in, or being aware of, any form of violence involving their caregivers, including physical aggression or assault, sexual assault, harassment, coercion, psychological or emotional abuse, or controlling behaviours. There can be serious impacts on children who are exposed to IPV, including possible impairment to their lifelong mental, physical, and relational health. Importantly, some children will not experience impairment related to CEIPV. Positive factors that help promote resilience and adaptive well-being include a warm and empathic relationship with a trusted adult, strong caregiver mental health, and emotionally responsive parenting practices. The evidence is clear that a national strategy for the prevention of IPV must include the prevention of children's exposure to IPV.

Recommendations

Meaningful and widespread consultations

The development of a national strategy for the prevention of IPV must be rooted in meaningful, widespread, and multisectoral consultations. These consultations should first and foremost be driven by the voices and needs of those with lived experience; this includes the perspective children and youth who have been exposed to violence between their caregivers, as well as the perspective of adults who can recall this childhood exposure. The perspectives of local advocacy organizations and the broad scope of professionals who provide care and support to those who have experienced IPV should also be prioritized within these consultations. In addition to ensuring that consultations are broad and have low barriers to participation, the formation of a multi-sectoral Advisory Council to provide oversight and accountability for the long-term success of a national strategy is recommended.

Current programs and strategies

The development of a national strategy should build on and clearly support and expand existing initiatives including the National Action Plan to End Gender-based Violence launched in 2022, the federal GBV Strategy announced in 2017, and the distinct strategies that have been adopted by provincial, territorial, and Indigenous governments. It will be important to ensure that any new IPV strategy avoids duplication or dilution of ongoing efforts, and instead, strengthens coordinated action to prevent IPV and improve supports for victims.

Education for healthcare professionals to increase their skills, confidence and competencies when working with patients where there is violence in the home is essential. Meaningful educational opportunities both early in training and throughout their careers will help front-line providers be best positioned to recognize IPV and respond appropriately and safely. The Violence, Evidence, Guidance, Action (VEGA) Project at McMaster University, with funding from the Public Health Agency of Canada (2015-2020), has created a freely available, online platform (bilingual) of pan-Canadian, evidence-based guidance and accredited resources. Using a trauma- and violence-informed approach, the VEGA® Family Violence Education Resources assist healthcare and social service providers (including students) in addressing the needs of those who may have experienced family violence (IPV, CEIPV and other forms of child maltreatment).

Healthcare providers identifying and responding to suspected or disclosed cases of IPV can also find support through consultation with professionals who have specialized knowledge and skills in IPV, including the availability of IPV-specific services, and can contact resources such as Shelter Safe or Hope for Wellness Helpline. The Department of Justice's HELP Toolkit: Identifying and Responding to Family Violence for Family Law Legal Advisors is also a pre-existing resource that would be useful to draw from in the development of a national strategy and for supporting front-line providers to discuss and respond to family violence.

Current programs and services are not enough however to meet the needs of families experiencing IPV. Inadequate availability of safe housing is a particularly significant barrier to supporting children, youth and their caregiver(s) experiencing IPV. A national strategy to address IPV should therefore include specific recommendations to make it easier for families experiencing IPV to find safe, affordable, and accessible housing. These recommendations should include support for families to be able to stay together, particularly where there is a range in ages and genders that may make accessing emergency housing more difficult. Improving access to safe spaces where pets are welcome can also help to reduce barriers for many families.

More targeted programs are needed not only to support the health and well-being of children and youth exposed to IPV, but to help caregivers, particularly mothers, parent in challenging situations. Healthy child development depends on the relationships children have with parents and other important people in their lives. Children learn to speak, think, and express emotion from an 'environment of relationships' and the parent-child relationship most strongly affects emotional and behavioural functioning. Initiatives to support positive parenting and to assist caregivers experiencing IPV should be expanded and supported to strengthen the lifelong physical, mental, and relational health of children who have been exposed to IPV. The CPS has a position statement with specific recommendations around supporting positive parenting in the early years that can be a useful resource for such initiatives.

Cross-sectoral partnerships

A national strategy to prevent IPV should look at innovative ways in which cross-sectoral partnerships can be strengthened and families can be assisted above and beyond traditional professionals and services. This can include a greater recognition of the wide range of professionals who assist families experiencing IPV, including social workers, mental health professionals, shelter and other non-profit workers, and community-based organizations. Supporting families experiencing IPV goes much further than fundamental legal, health, and emergency shelter services. Ensuring consultation with a broad range of stakeholders and strengthening partnerships both within and across sectors would strengthen the ability to actualize a national strategy and its capacity for fostering meaningful positive change.

Additional cross-sectoral partnerships that should be considered and studied within a national strategy include those that support structural safety improvements (e.g. strengthened doors, panic buttons, security bars, motion detectors etc.) to improve the safety and security of the homes of IPV victims and their families. Funding to improve access to practical safety improvements and facilitating cross-sectoral partnerships to support their implementation could be a convening role for the federal government and an important consideration within a national strategy.

Informing and supporting suspected victims

Paediatricians and other health professionals have a critical role in helping children and youth who may have been exposed to IPV. The VEGA© principles for safe recognition of CEIPV that paediatric health care providers can use include:

a) Creating safe environments and interactions
b) Being alert to potential signs and symptoms of CEIPV
c) Inquiring about CEIPV when signs and symptoms are present
d) Taking steps to consider or rule out exposure via phased inquiry
e) Responding safely
f) Ensuring follow-up care
g) Reporting to child welfare services when CEIPV is suspected or disclosed
h) Carefully documenting

Requirements to report

The CPS has serious concerns over any potential requirement for healthcare providers to report suspected or disclosed IPV to police. Notifying the police is not warranted unless a clinician determines that a child, youth, or non-offending caregiver is at imminent risk of harm, or the caregiver specifically requests that a call be made. When there is no imminent risk of safety to an adult who discloses IPV or who is suspected to be experiencing IPV, reporting suspicions or disclosures of IPV to police can be considered a breech of confidentiality and professional ethics. In addition, requiring healthcare providers to report any suspected or disclosed IPV to police will reduce the likelihood of those who are experiencing violence seeking out essential healthcare services or disclosing their experiences.

In Canada, suspecting CEIPV meets the threshold for a report to child welfare authorities as its own type of maltreatment or as a form of child emotional abuse or neglect. Reporting suspected CEIPV to child welfare authorities is a potentially challenging component of the response process and depends on age-related thresholds for each province/territory. Reporting can also be complicated by the need to provide for the safety and well-being of children, youth, and non-offending caregivers. When CEIPV is suspected or disclosed, and if it is developmentally appropriate and safe to do so, providers should indicate that they have concerns about safety to the child, youth, or non-offending caregiver(s), and explain their obligation to share this information with the child welfare agency. Clinicians should clarify that this step is taken with the goal of arranging help for the family. Involving child welfare authorities can be stressful both for families and clinicians.

Conclusion

The CPS strongly supports the federal government prioritizing action to reduce the prevalence of IPV in Canada and to better support and protect victims and their families. We are concerned however of the potential for the development of a separate national strategy for IPV to detract from action on pre-existing commitments, including those made under the National Action Plan to End Gender-Based Violence.

Should the federal government decide to develop a national strategy for the prevention of IPV, we recommend that it should:

a) Cohesively support and build upon pre-existing initiatives and strategies to address IPV, CEIPV, and GBV.
b) Be rooted in meaningful, inclusive and multisectoral consultations and be driven by the voices, needs and experiences of those with lived experience of IPV and CEIPV.
c) Raise awareness about CEIPV as a public health problem with significant individual, family, community, and societal impacts.
d) Recognize the harms of CEIPV as a type of maltreatment and include specific supports for children and youth.
e) Position risks for IPV within the broader social context and prioritize initiatives that strengthen improvements in the social determinants of health, including but not limited to housing, education, social inclusion, income, early childhood development and food security.
f) Adopt a trauma- and violence-informed, culturally appropriate, and non-judgemental approach that centers the individual and avoids the use of stigmatizing language or stereotypes.
g) Acknowledge the ongoing role of colonialism and systemic discrimination at all levels when identifying and responding to IPV and CEIPV.
h) Promote educational initiatives that strengthen the knowledge, skills and confidence of front-line providers responding to confirmed or suspected IPV and CEIPV.
i) Include meaningful and reliable accountability measures to track and report on implementation and impact.

About the CPS

The Canadian Paediatric Society is the national association of paediatricians, committed to working together to advance the health of children and youth by nurturing excellence in health care, advocacy, education, research, and support of its membership. Founded in 1922, the CPS is a voluntary professional association that represents more than 3,600 paediatricians, paediatric subspecialists, paediatric residents, and others who work with and care for children and youth. The CPS is governed by an elected Board of Directors representing all provinces and territories.