Needs Analysis and Best Practices Review for the Increased Prevention and Intervention of Child Sexual Harm in New Brunswick

Submitted to the Roundtable on Crime and Public Safety

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Child Sexual Harm Advisory Committee

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Acknowledgements

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Executive Summary

In 2015, New Brunswick's Strategy for the Prevention of Harm for Children and Youth, highlighted the historically higher police-reported incidence of sexual harm against children and youth in New Brunswick. This Strategy noted that more research and analysis was required to fully understand the scope of child sexual harm in New Brunswick and what could be done to fully enforce the right of every child to live a life free from sexual harm. In 2016, the Roundtable on Crime and Public Safety sanctioned Activity #3 of the Province's 2016-2019 Crime Prevention and Reduction Strategy Action Plan which is to *conduct a needs analysis and best practices review for the increased prevention and intervention of child sexual abuse in New Brunswick with recommendations for improvement.* This work is meant to align with the revision of New Brunswick's Child Victims of Abuse and Neglect Protocols, the Strategy for the Prevention of Harm to Children and Youth, the Preventing and Responding to Sexual Violence in New Brunswick Framework, Department of Public Safety's Criminogenic Program Review, Sexual Crimes Working Group, and other related initiatives.

There are many reasons to increase efforts to prevent sexual harm of children beyond the obvious fact that it is the right thing to do. Sexual harm has been clinically linked to several conditions including post-traumatic stress disorder, major depressive disorder, substance abuse disorder and chronic pain. In addition, research shows a link between prior sexual victimization and perpetration with increased risk of future re-victimization and perpetration. Further, New Brunswick is committed to the implementation of all fundamental rights of children and young people to which Canada has subscribed under international human rights treaties, including the United Nations Convention on the Rights of the Child and its protocols which encompasses their right to be protected from all forms of sexual harm.

In this report, the term child sexual harm (CSH) is used in place of child sexual abuse (CSA) in recognition that sexual harm is not only a use of physical force; rather, it also encompasses the emotional, social, and psychological trauma of non-physical sexual injury. The scope of the needs analysis and best practices review includes all forms of sexual harm against children with a focus on primary, secondary and tertiary prevention.

Primary prevention aims to stop the problem before it happens through universal approaches in the general population.
Secondary prevention targets those at higher risk of criminal behaviour or victimization.
Tertiary prevention focuses on offending after it has occurred to prevent re-offending or revictimization and to repair harm.
Crime prevention is inclusive of both individuals at risk of **offending** and at risk of being **victimized**.

To address such a complex issue, the review identified four populations of concern that warranted particular consideration: 1) potential and current child and youth victims, 2) child and youth perpetrators, 3) adult sexual abusers of children, and 4) non-offending pedophiles. The report is made up of four sections: 1) a Child Rights Impact Assessment to outline the fundamental child rights in play and the global agenda for change in combatting sexual crimes against children and youth; 2) a best practices review intended to identify effective practices to prevent and reduce child sexual harm through a literature review and jurisdictional scan; 3) a needs analysis to provide a better understanding of the incidence of child sexual harm and scope of the problem in New Brunswick through analysis of available statistics and consultation with New Brunswick practitioners; and 4) recommendations to improve existing practices and fill gaps in service based on findings.

The Child Rights Impact Assessment (CRIA) revealed that New Brunswick's efforts to combat child sexual harm are best understood as part of a global effort to eradicate these behaviours. The United Nations

Convention on the Rights of the Child (UNCRC), to which Canada is a signatory, mandates State Parties to uphold the standards for the care, treatment, survival, development, and protection of children and expressly protects children from all forms of violence (Article 19) including sexual exploitation and sexual abuse (Article 34), child trafficking (Article 35), and all other forms of exploitation (Article 36). The interdependent and interrelated nature of child and youth rights means that failure to protect any one right also directly impedes the exercise of other fundamental child and youth rights, such as the right to education (Article 28) and to health (Article 24). The CRIA linked the high rate of sexual harm to children with the need for potential changes at the legislative, administrative, social, and educational levels, including necessary improvements to prevention, identification, reporting, referral, investigation, treatment, and follow-up practices.

The best practices review found that education and awareness programs can be effective in lowering child sexual victimization. Where one third of victims are under the age of nine, such programs need to start at an early age, be developmentally appropriate, and include a variety of formats with content reflecting the diverse ways in which victimization occurs across all ages (e.g., from familial abuse in early childhood to acquaintance/romantic partner abuse in adolescence/early adulthood). The belief that CSH prevention programs can have adverse consequences, such as anxiety and hypersexuality, is not empirically supported. The research shows that there is large benefit to involving parents and childcare professionals in programming. Additionally, youth-serving organizations can help reduce victimization by adopting CSH prevention policies and procedures. While many victims of CSH do not later offend sexually, CSH victimization remains a significant risk factor for future CSH perpetration. Therefore, ensuring thorough, evidence-based treatment is available to victims in a timely manner and for an appropriate time frame is an integral component of preventing further CSH.

When looking at child and youth perpetrators, or juvenile sex offenders (JSOs), the best practices review highlighted that this group often has extensive victimization backgrounds and noted that offending peaks between the ages of 12 and 14. JSOs do not solely commit sexual crimes – many have a history of non-sexual crimes, and many do not sexually recidivate. In addition to being overrepresented among victims, youth with intellectual or cognitive disabilities also make up a disproportionate number of JSOs. This is an essential factor to keep in mind when designing intervention programs. There are a multitude of assessment tools available for use with JSOs to determine risk of recidivism. When it comes to intervention, Cognitive-Behavioural Therapy (CBT) is the most common treatment for JSOs, however, research shows that Multisystemic Therapy (MST) is the most effective treatment approach. MST is also effective with Indigenous[1] JSOs and can also be tailored to the needs of youth with intellectual or cognitive disabilities. There is preliminary support that dating violence (including sexual) perpetration in early adulthood is associated with a two-fold risk of perpetrating dating violence in older adulthood. This is an important consideration where New Brunswick is known to have high rates of intimate partner violence (IPV).

The review of best practices found that adult sexual abusers of children (SACs) also have extensive victimization backgrounds. There are many ways to categorize SACs as their offences and motivations differ. Not all SACs are pedophiles, and not all pedophiles are SACs. Not all SACs are high-risk offenders and research shows that adherence to Risk-Need-Responsivity (RNR) principles is integral to effective treatment. The Violence Risk Scale: Sexual Offender Version (VRS:SO) appears to have the best predictive validity for sexual recidivism. The Static-99 is also relatively successful. There are effective treatments for SACs, most notably Cognitive-Behavioural Therapy (CBT). Good reintegration planning is an important consideration when releasing SACs into the community. Further, community-based treatment is effective in reducing recidivism.

[1] The 2019 version of this report presented to the Roundtable on Crime and Public Safety used the term, “Aboriginal.” The language has been changed to “Indigenous” to move towards reconciliation.

Volunteer groups such as Circles of Support and Accountability have reduced sexual, violent, and general recidivism by considerable margins (83%, 73%, and 71%, respectively).

Non-offending pedophiles are self-identified individuals with sexual attractions to children, who claim they have not committed a sexual offence against a child. The best practices review showed that many convicted child sexual abusers were aware of their sexual desires for at least one to five years prior to the offence. Similar to JSOs and SACs, non-offending pedophiles have particularly traumatic histories of victimization. A newly identified category, many of these individuals are reluctant but willing to receive support to continue to live an offence-free lifestyle. Assurances of anonymity or confidentiality are extremely important in working with this population. Many of the programs and services available for non-offending pedophiles can also be used by other groups as part of a broader CSH reduction strategy.

A jurisdictional scan was also undertaken to provide an understanding of initiatives that other provinces and territories have underway to tackle CSH. The jurisdictional scan revealed that NB is in line with other jurisdictions in some respects (e.g., child protection legislation) while other jurisdictions had programs in place that NB does not (e.g., Ontario has programming for children under the age of 12 who exhibit concerning sexual behaviours).

To provide an understanding of the scope and volume of CSH in New Brunswick, the needs analysis included an examination of police, Social Development and self-report data. A custom request from Statistics Canada for data for all years available (2009-2016) confirms that New Brunswick has had a consistently higher police-reported rate of sexual violations committed against children and youth (0 to 17 years of age). New Brunswick had the 3rd highest average rate (289 per 100,000 population) of children and youth victims of all sexual offences against children out of all provinces and had a higher rate than the national average (199 per 100,000 population).

The majority of victims are female with over half of all victims between the ages of 12 and 17. The most common incident reported to police was sexual assault level 1, which represents approximately 70% of offences. Over a 20-year span (1998-2017), NB had the 4th highest average rate (5.28 incidents per 100,000 population) of possession or accessing child pornography and the 3rd highest average rate (8.083 incidents per 100,000 population) of incidents relating to making or distributing child pornography in comparison to all other provinces. New Brunswick had the 2nd highest average rate (0.73 per 100 000) among all provinces of sexual exploitation of children, falling behind Manitoba only. From 2009-2017, New Brunswick's overall trend of victims of sexual violations increased for children ages 0 to 11. Female victims, in comparison to male victims, saw the largest increase.

Nationally, the majority (97%) of those accused of sexual violations against children are male. Approximately 30% of accused are males between the ages of 12 and 17 years, with rates of accused decreasing after the age of 14 years. More than half of accused (51%) are over the age of 25 years with reports that the average age of sexual abusers of children is 38 years. In New Brunswick, while data shows that more adults commit sexual crimes against children, youth perpetrators are charged at a rate 2.5 times higher than adult perpetrators.

Statistics Canada cautions that sexual offences in general tend to be under-reported in police statistics and that this under-reporting can be compounded in cases where the victim is a child. Based on a review of unfounded sexual crimes in New Brunswick from 2010 to 2014, a large proportion (74%) of victims of unfounded sexual crimes were youth from 0 to 18 years of age, a finding which warrants further exploration and action.

Although police-reported statistics provide a snapshot of the extent of child sexual harm in New Brunswick compared to the rest of the country, it is important to consider other forms of data to inform this review, such as the information collected through the Department of Social Development through reports of suspected CSH. A sample (n=3525) of suspected incidents of CSH reported to Social Development from 2012-2017 was analyzed which showed that 52% of referrals resulted in an investigation. Eighteen percent (18%) of all reports were substantiated and 22% were unsubstantiated, meaning evidence gathered lends weight to the belief that abuse or neglect did not occur. Twelve percent (12%) were inconclusive; this does not mean that CSH did not occur, only that harm could not be substantiated. Approximately half (48%) of reports did not meet Social Development's screening criteria for further investigation.

Of this 48%, a small percentage were provided service at intake or referred to another agency while the majority were screened out due to insufficient information provided by the referral agent to move forward with an investigation. While this number is alarming, it is important to note that it is mandatory in New Brunswick, as in other jurisdictions, to report the suspicion of harm to a child to Social Development and that high rates of unsubstantiated reports might be anticipated. For example, a review of 235,842 cases of suspected child maltreatment (including sexual harm) reported to 112 child welfare agencies across Canada found that 40.6% of all reports were unsubstantiated, however these reports were more often made in good faith (35%). The report noted that unsubstantiated reports can stem from misinterpreted signs of abuse, which may be the case in some instances of suspected CSH.

The largest proportion of cases (30%) reported to Social Development range in age from 7-11 years. Children 12 years of age or older represented a greater proportion of substantiated cases compared to younger age groups (children 11 years of age or younger). This raises questions including the ability of the interviewer to gather information from the victim (especially those aged 0-11 years) and identifies the role sexual education can play to aid children in knowing about and reporting inappropriate behaviours. Referrals to Social Development can come from multiple sources (e.g., school, police, etc.) and one referral may have multiple referral sources. The three most common referral sources were justice, health and school systems which collectively represented 56% of all reports to Social Development. Parents were the fourth highest referral source representing 12% of all referrals. Consistent with national trends, females were reported as victims of sexual harm more frequently than males across all age groups. Males aged 0 to 11 years were more likely to be reported as victims than males aged 12 to 17 years. Of all cases, 45% of suspected perpetrators were intrafamilial (i.e., the child's care giver, sibling or other relative) while 55% were extrafamilial (i.e., not a relative though this person may or may not reside in the same household as the victim). Female victims represent approximately two-thirds of victims for both extra-familial and intra-familial cases.

Self-reported victimization data was also gathered through the 2015-2016 New Brunswick Student Wellness Survey which includes input from 32,677 New Brunswick youth in grades 7 to 12. This data indicates that 10% of students from grades 7 to 12 reported being violated sexually at least once in their lifetime. This was more common among youth who identified as Indigenous, youth who identified as LGBTQIA2+, youth with learning exceptionalities and special needs, and youth of lower socioeconomic status. Sixteen percent (16%) of students from grades 7 to 12 self-reported being victims of some form of dating violence; more commonly reported among the Anglophone (18%) than the Francophone school districts (12%), in addition to the above listed vulnerable groups.

A comparison of police-reported and self-reported statistics using heat maps of the province highlight a discrepancy whereby some geographical areas indicate low police-reporting of sexual violations but high self-reporting of sexual violence. While there are many possible reasons for the variance, including interpretation of what constitutes a sexual violation, attitudes and beliefs, this discrepancy warrants further investigation. Regardless, this comparison of self-reported to police-reported statistics does not appear to support the

hypothesis that New Brunswick's higher rates of child sexual harm are attributable to better or increased reporting to the police. Although not directly comparable, if there were better or increased reporting practices to police then there should be less discrepancy between police-report and self-report statistics.

In addition to an assessment of available statistics, the needs analysis also provides a comparison of programs and services that currently exist in New Brunswick to best practices, and summarizes strengths and gaps as identified through a series of consultations that were conducted with New Brunswick professionals working in a variety of CSH-related fields. Overall, there are multiple programs, services and initiatives in New Brunswick that align with CSH best practices at the primary, secondary and tertiary prevention levels. While the existence of these initiatives is encouraging, very few are available consistently across the province and many are in the development or testing phase. The consultation results confirmed this finding and identified additional gaps in CSH prevention and intervention practices.

Sixty-four (64) New Brunswick professionals and service providers were consulted through questionnaires, interviews, and focus groups. These were held in both official languages in multiple locations. Professionals were identified based on their scope of work and included forensic clinical psychologists, probation officers, nurses, paramedics, social workers, law enforcement officials, representatives from various government departments, and members of community organizations whose work spanned sexual health, victim services, family services and services to those with intellectual disabilities. Representation was sought and obtained from jurisdictions across the province and included Indigenous perspectives.

While some interviewees believed that New Brunswick's child sexual abuse rates were inflated in comparison to other provinces due to better police-reporting practices, the majority felt that New Brunswick's ranking among provinces was accurate and due to a variety of factors (e.g., lack of sexual education, shortage of resources for victims and offenders, etc.). Participants identified few systematic, standardized approaches and noted a lack of prevention and intervention resources for all groups (child and youth victims, adult and youth perpetrators, and non-offending pedophiles), at all levels (prevention, intervention and rehabilitation) the effects of which are exacerbated in small communities. Consultation participants noted that the resources that do exist are often insufficient and multiple barriers to access exist for victims and perpetrators and that these barriers may be worse for vulnerable groups (Indigenous persons, those who identify as LGBTQIA2+, those with intellectual or cognitive disabilities and persons with lower socioeconomic status). All agreed that sexual education is a key component to preventing sexual abuse, and it should be implemented at an earlier age. The same professionals demonstrated a tremendous amount of knowledge, ambition, dedication, and a belief that improvements are possible. They noted that special consideration needs to be taken in the development and implementation of policy, practices, and resources for vulnerable populations and that this work should be undertaken in collaboration with these groups. Finally, several practitioners identified concern for vicarious trauma that can result from working with victims of child sexual harm. This trauma has impacts for service providers and their organization and can lead to negative outcomes if not addressed.

Overall, the needs analysis and best practices review confirms that all New Brunswickers must and can do better to protect the most vulnerable and valuable members of our communities. It is only through collective and sustained efforts of individuals, families, communities and systems that a reduction in the incidence of child sexual harm that is outlined in this report can be achieved. The review was broad in scope and is a starting point for many more difficult and important conversations. The recommendations target CSH at multiple levels including governance, education and awareness, professional development, investigation and prosecution, intervention, and policy and legislation. It is believed that strategic implementation of these recommendations could result in significant reductions of child sexual harm in New Brunswick.

Annotated Recommendations

Conclusions and recommendations can be found in Section 4. The following recommendations include a rationale and pertain to the entire scope of sexual harm to children and youth which includes:

- *any acts of a sexual nature that are unlawful or psychologically harmful, committed by any person through coercion, inducement, exploitation or force. Sexual harm can be physical or non-physical. Physical sexual harm refers to any violation of an individual's bodily integrity without their consent, and includes: assault; fondling; intercourse; and incest, among other violations. Non-physical sexual harm relates to experiences of sexual victimization that violate the mental or emotional integrity of an individual. They are not accompanied by physical force or restraint, but are nonetheless psychologically intrusive, exploitative or traumatic. Some examples of nonphysical sexual harms include: exhibitionism; sexualization; and demeaning comments or accusations of a sexual natur*e (Province of New Brunswick, 2015, p. 30). The scope of this report also includes human trafficking for sexual exploitation and sexual cyberviolence.

Governance

1. Whereas New Brunswick is committed to the implementation of all fundamental rights of children and young people as outlined in the United Nations Convention on the Rights of the Child and its protocols which encompasses their right to be protected from all forms of sexual harm; and whereas prevention of sexual harm to children and youth requires significant ongoing collaboration and communication at all levels of government and across multiple sectors; and whereas efforts need to be tailored to the unique needs of clients and communities; and whereas efforts are already underway to combat the sexual harm of children and youth through various projects and bodies; and whereas CSH is under-reported, it is recommended that a multi-sector Task Force be established to oversee implementation of recommendations. This Task Force should be results-focused and ensure that:

    a) an evaluation and monitoring framework be developed and implemented to measure progress and impact of recommendations over time, identify required adjustments, and ensure accountability of implicated partners;

    b) consideration be given to vulnerable groups[2] and unique factors in the implementation of recommendations. This includes age (specifically 0-5 years), sex, gender, ethnicity and origin (Indigenous, newcomer, immigrant, racialized, ethnocultural and refugee populations), socioeconomic status, intellectual ability, location (urban and rural), and legal status (i.e., those in care of the minister) as well as how these different factors intersect with each other. Keeping in mind the interplay of these different factors at the outset will ensure greater effectiveness in preventing, reducing and intervening into the problem of sexual harm;

[2] In this set of recommendations, the term vulnerable group will be inclusive of but not exclusive to age (specifically 0-5 years), sex, gender, ethnicity and origin (Indigenous, newcomer, immigrant, racialized, ethnocultural and refugee populations), socioeconomic status, intellectual ability, location (urban and rural), and legal status (i.e., those in care of the minister).

c) work be based on the social ecological model that recognizes and addresses risk and protective factors of CSH at the individual, relationship, community and societal levels;

d) the child and youth voice is continuously heard and incorporated into the work; and

e) efforts complement and align with current initiatives, such as *Preventing and Responding to Sexual Violence in New Brunswick Framework, Strategy for Partnering to Address Human Trafficking for Sexual Exploitation in New Brunswick, Strategy for the Prevention of Harm to Children and Youth, New Brunswick Plan to Prevent and Respond to Violence Against Aboriginal Women and Girls,* revision of the *Child Victims of Abuse and Neglect Protocols*, Public Safety's review of Criminogenic Programming, efforts of the Sexual Crime Working Group, steps to implement recommendations from the *Review of the Effectiveness of New Brunswick's Child Protection System* and others through continuous engagement of project champions within relevant working groups.

2. Whereas the history of Indigenous relations in New Brunswick, as in the rest of Canada, is marked by a legacy of colonialism, displacement, the *Indian Act*, and Indian residential schools, and where these actions, and related painful historical realities, continue to translate into negative outcomes for Indigenous peoples, including higher rates of sexual harm to Indigenous children and youth; and given the limitations of this review and the need for meaningful collaboration with Indigenous communities and existing initiatives in identifying solutions, it is recommended that a dedicated effort by the Task Force be undertaken to identify and support Indigenous communities' priorities in preventing and addressing sexual harm of Indigenous children and youth. This effort should include working with, and building on the work of, the Indigenous Guidance Team that was developed through the Network of Excellence.

Education and Awareness

3. Whereas all New Brunswickers have a role to play in ending sexual harm to children and youth, it is recommended that a public education and awareness campaign be developed and implemented which:

a) raises awareness of the issue by naming and defining the various forms of sexual harm;

b) provides information on what individuals, families, communities, organizations and systems can do to prevent, recognize and respond to sexual harm of children and youth;

c) provides information on support services available to victims, perpetrators and their families; and

d) builds on existing public education and awareness efforts.

4. Whereas evidence-based sexual harm prevention programs are linked with lower rates of victimization and perpetration; are most effective when partnered with healthy relationships curriculum rooted in social emotional learning (such as the Fourth 'R' Program or Roots of Empathy); have the largest impacts when started at an early age; and can help children establish positive

relationships, make responsible decisions, and handle challenging situations, it is recommended that Education and Early Childhood Development (EECD) review existing healthy relationships and sexual health education curriculum for all ages and developmental levels. This review should:

a) ensure content adheres to current best practice in sexual harm prevention;

b) encompass the content of the curriculum, the time devoted to it, delivery methods, and training of those responsible for delivery;

c) be conducted in consultation with educators and subject matter experts;

d) include collaboration between EECD and Public Health (e.g., Healthy Learner in Schools Nurses) to provide an option to have content delivered by trained staff who are comfortable teaching the content to all students including students with intellectual disabilities; and

e) include approval of best-practice resources for use by educators and options to invite external agencies to present evaluated material.

5. Whereas many caregivers of pre-school aged children may perceive dangers outside of the home to be greater ("stranger danger") and underestimate the risk of someone victimizing their child who is known to the family, it is recommended that early childhood education centres adopt an age appropriate CSH prevention program to educate children aged 0-5 years, including children with intellectual disabilities about appropriate touching and body ownership.

6. Whereas the responsibility for educating children and youth about healthy relationships and sexual health cannot be placed solely on the Department of Education and Early Childhood Development; and whereas parents and caregivers have a role as primary sexuality educators of children and youth in their care, it is recommended that resources be made available for parents and caregivers to help facilitate discussions at home with their children, including children with intellectual disabilities, regarding healthy relationships and sexual health. These resources should:

a) reinforce and complement knowledge learned in school;

b) help to facilitate disclosure of victimization to parents, caregivers and trusted adults; and

c) equip parents and caregivers with information on what to do if a child or youth discloses harm.

Professional Development

7. Whereas the identification and reporting of suspected incidents of sexual harm to children and youth are integral to combatting the problem; and whereas professionals and care givers have a legislated responsibility to report suspected harm, it is recommended that university and college programs develop and implement standardized training on recognizing and responding to disclosures of sexual harm for those who will be working with children and youth. Training should include but may not be limited to:

a) healthcare practitioners (e.g., nurses, first responders, etc.);

b) educational professionals (e.g., teachers, educational assistants, guidance counsellors, coaches, etc.);

c) social services workers (e.g., social workers, child/youth care workers, immigrant service workers, victim service workers, etc.);

d) human services workers (e.g., personal care workers, etc.); and

e) protective services workers (e.g., criminal justice staff, etc.).

8. It is recommended that training on recognizing and responding to disclosures of sexual harm be made available to professionals already working in the field. This could be undertaken in collaboration with professional associations and licensing bodies through continuing education efforts and reinforced through the revision of the Child Victims of Abuse and Neglect Protocols.

9. Whereas working with victims of child sexual harm impacts the service providers who work with them, as well as the organization they work for; and whereas, the effects of not addressing trauma exposure in workplaces leads to negative outcomes for:

    a) service providers (e.g., health issues, difficulty managing emotions);

    b) organizations (e.g., incapable of making changes, learned helplessness, lack of communication); and

    c) service users (e.g., additional stress from interacting with unhealthy staff, repeat visits due to insufficient service delivery);

    it is recommended that the Task Force undertake an exercise to develop and implement an integrated, trauma-informed government-wide approach for service providers who work with service users, including their loved ones who have been or potentially have been impacted by child sexual harm. This initiative would include review of existing policies and practices; consulting with the Fredericton Sexual Assault Centre which has experience in training organizations in and implementing trauma stewardship practices; developing policies and practices that define, outline and support the principles of trauma stewardship, the ethical care and support of other people's trauma, including supporting a clear commitment to trauma-informed practice with leadership at all levels of government (van Dernoot Lipsky & Burk, 2009). Service providers who work with victims of child sexual harm, including victims' loved ones, should be included in the development of this integrated, trauma-informed government-wide approach.

Investigation and Prosecution

: *Recommendations 10-14 will be further refined through efforts of the Sexual Crimes Working group which is focused specifically on investigation and justice response to sexual violence. The work of this group is ongoing.*

10. Whereas gaps have been identified in the investigation of suspected instances of child and youth sexual harm it is recommended that training and policy for Police and Social Development investigation of CSH be reviewed and revised to ensure it reflects best-practices including trauma-informed care.

11. Whereas the proportion of sexual incidents reported to police categorized as unfounded is higher in cases where the victim is under the age of 18 years, it is recommended that an independent agency be identified to regularly review police-reported sexual offence cases to ensure sexual crimes against children are thoroughly and properly investigated and classified.

12. Whereas the ability of the interviewer to gather information from the victim has been identified as a barrier to determine if CHS has occurred (especially for children under 12 years of age); and whereas a timely Sexual Assault Nurse Examiner (SANE) examination is critical for the suspected victim's physical and emotional well-being and can provide necessary evidence required by police and Social Development, it is recommended that police and Social Development offer a referral to SANE for suspected victims of child sexual harm. This protocol could be included in the revision of the Child Victims of Abuse and Neglect Protocols and incorporated into the New Brunswick Policing Standards.

13. Whereas judges and crown prosecutors can ensure an informed criminal justice response, while playing a key role in reducing trauma caused to child victims through participation in the court process, it is recommended that trauma informed training for Prosecution Services be provided by the Fredericton Sexual Assault Centre. Trauma informed training would include education on the social context of sexual harm to children and youth and research on the neurobiology of trauma including ways to reduce the trauma to child victims' participation in court (e.g., use of testimonial aids). It is further recommended that judges be offered information sessions on the same topics.

14. Whereas Child Advocacy Centers (CACs):

    a) were developed to reduce stress on child and youth victims during sexual abuse investigations by bringing together professionals into a Multi-Disciplinary Team (MDT) in one child-friendly location;

    b) aim to reduce the stress on the victim by reducing the number of interviews required;

    c) aim to reduce financial burden on the families of victims by having information and support from multiple service providers on location;

    d) allow for cultural competency by adding representatives to the MDT according to victim need; and

    e) appear to shorten the duration of time between first contact and file closure,

    it is recommended that the Task Force identify CAC best practices, and implement these practices province-wide. This work must take into consideration the unique strengths and realities of each jurisdiction and involve practitioners already working in the field.

Intervention

15. Whereas victims of sexual harm require services and programs to foster resilience and recovery; and whereas this review found that some victims of sexual harm may not qualify for intervention through specific program criteria (i.e., children or youth who are victims of abuse where the perpetrator is

extrafamilial but where the parent is providing adequate protection and/or cases where the incident has not been reported to the police); and whereas the Network of Excellence and Integrated Service Delivery Model were developed to ensure that client-centered services are delivered at the right time and at the right level of intensity to children and families regardless of which door they enter (Health, Social Development, Education, or Public Safety), it is recommended that the Network of Excellence[3] assess the lack of affordable specialized therapeutic services for children and their families and take steps to ensure victims and families are connected with sufficient, empirically-supported treatment and resources in a timely manner. This work should include removing financial barriers to treatment.

16. Whereas Juvenile Sexual Offenders (JSOs) aged 12-18 often have an extensive victimization history, including a higher prevalence of sexual abuse and whereas Multisystemic Therapy (MST) has been shown to be the most effective treatment for JSOs, reducing both sexual recidivism and other antisocial behaviors; is highly effective for both Indigenous and non-Indigenous youth; includes a family component; and has favourable cost-benefit analysis outcomes, it is recommended that Integrated Service Delivery partners adopt the use of MST treatment in adequate dosages for high risk-high need youth perpetrators of sexual harm, regardless of whether they have been charged or sentenced. This MST approach should align with the Risk-Need-Responsivity (RNR) model of offender rehabilitation and include an aftercare component. Common responsivity issues for sexual offending, such as previous trauma, cognitive impairments and motivation to change, must be addressed through this programming. A similar but less-intensive approach, that adheres to evidence-based principles, should be available for JSOs who have low to moderate needs.

17. Whereas youth diversion programs were revised in 2015 to include a focus on intervention in addition to accountability at the community level, it is recommended that the Department of Public Safety review available programming to ensure eligible diversion clients who offend sexually are receiving appropriate intervention to prevent future sexual recidivism. This programming should include a variety of modules (e.g., cyberviolence that is sexual in nature) and recognize the various types of sexual offending.

18. Whereas children under 12 years of age with problematic sexual behaviors are also in need of intervention, recognizing that they may be victims of sexual harm, it is recommended that these children be linked with Integrated Service Delivery (ISD) so that they may benefit from the right service, at the right time and at the right intensity according to their strengths and needs. It is further recommended that ISD consider programs such as Toronto/Central Region's Radius Child and Youth Services program which includes programming for children under 12 years who have engaged in concerning sexual behaviour.

[3] "*The Network provides a comprehensive vision from which to coordinate, assess and build service delivery capacity. The Network also provides services and supports, and spans the entire continuum, from prevention to tertiary out of home services" (Province of New Brunswick, 2015, p. 6).*

19. Whereas research consistently shows that implementing evidence-based practices can significantly reduce the sexual recidivism of adult sexual abusers of children and youth, it is recommended that the Department of Public Safety:

    a) provide criminal justice personnel with regular best practices training on the assessment and case management of adult sexual abusers of children;

    b) provide evidence-based multi-modal criminogenic programming that targets the multiple needs of moderate to high risk-high need adult sexual abusers of children in the community and/or institutional settings as part of a case management plan. Programming should be accompanied by quality assurance practices, rigorous evaluation, and provided at appropriate levels of dosage and intensity. Programming should align with the Risk-Need-Responsivity (RNR) model of offender rehabilitation and include a maintenance component. Common responsivity issues for sexual offending, such as previous trauma and cognitive impairments, must be met through programming. Integration of culturally appropriate practices (e.g., Indigenous) in interventions is a vital component of the responsivity principle;

    c) ensure this work is linked to the development of Integrated Case Management for adult offenders with complex needs; and

    d) ensure evidence-based reintegration plans are in place for all adult sexual abusers of children and youth being released from custody into the community. This could be accomplished through expansion of the Circles of Support and Accountability (CoSA) model, or a similar program, which currently operates in Moncton only.

20. Whereas research shows that many convicted child sexual abusers were aware of their sexual desires for at least one to five years prior to their offence and whereas research shows that that it is possible to reduce risk of CSH for non-offending pedophiles (*individuals with sexual attractions to children who claim they have not committed a sexual offence against a child*) through self-management skills programs (e.g., Ottawa's Sexual Behaviours Clinic, Prevention Project Dunkelfeld), it is recommended that the Taskforce explores and develops service options for non-offending pedophiles.

21. It is recommended that a feasibility study be undertaken to expand Circles of Support and Accountability (CoSA), or a similar program, to offenders under a community sentence, those not under sentence and to non-offending pedophiles.

Policy and Legislation

22. Where the review of available programs and services to prevent and respond to sexual harm of children and youth has shown inconsistencies in the availability and adequacy of programs and services across the province, it is recommended that standards of practice for working with victims and perpetrators of sexual harm be developed and consistently updated to reflect best practice. Strategies to ensure adherence to standards, such as involvement of champions and regular evaluation, should be put in place.

23. Where prevention, identification and reporting of suspected incidents of sexual harm to children and youth is integral to combatting the problem, it is recommended that all youth-serving-organizations have a child and youth sexual harm prevention policy in place for the prevention, identification and response to sexual harm (e.g., Commit2Kids, ASD-W Policy 703-14). Further, that youth-serving-organizations actively inform parents on the child and youth sexual harm prevention policy in place for the prevention, identification and response to sexual harm including information as to rationale and meaning of policy.

24. Whereas the Department of Social Development is drafting new child protection legislation (in response to recommendation in the *Review of the Effectiveness of New Brunswick's Child Protection System*), and recognizing that the impact of sexual harm has potentially long-term impacts on children and youth, it is recommended that new child protection legislation include an expansion of scope from the immediate protection of a child to the protection of the child and the child's path to healing and well-being. This legislative change would further support the work of the Network of Excellence and ISD.

Glossary of Terms

Term/Acronym	Definition
ADV	Adolescent Dating Violence
ASO	Adult Sex Offender
BST	Behaviour Skills Training
Bodily Autonomy	One's self determination over their own body
BST/ Body Safety Training	Teaches body-safety rules and skills, has similar but separate versions for parents and teachers.
CAAR	Coalition Against Abuse in Relationships, which is a non-profit organization that works towards prevention of violence .
CCJS	Canadian Centre for Justice Studies
Cyberviolence	Harm committed by one individual or group to another through use of any cyber-technology, including computers, mobile phones and through such mediums as the internet, social media and various apps.
JSOs	Child and youth perpetrators/ juvenile sex offenders
Client refused service	According to section 29.2 of the *Family Services Act*, an individual 16 years of age (unless child is a disabled person) may refuse protection services.
CBT	Cognitive-Behavioural Therapy is an evidence-based therapy that focuses on improving cognitive distortions (e.g., unhelpful thoughts, beliefs, and attitudes) and behaviours.
CoSA	Circles of Support and Accountability
CSA	Child Sexual Abuse
CSH	Child Sexual Harm
Dating Violence	Youth-on-youth violence confined to a particular context (dating).
Discontinued	(Context: Social Development) Consists of an investigation or Family Enhancement Services (FES) assessment that has ended, with supervisor approval, without completion of a Safety Assessment or Risk Assessment, if the referral information is found to be incorrect upon initial face-to-face contact.
D/IPV	Domestic/Intimate Partner Violence
DSD	Department of Social Development
Extrafamilial	(Context: Social Development) Extrafamilial abuse occurs when the person involved is not a relative as described in intrafamilial (e.g., a neighbor, teacher, boarder, babysitter, etc.). This person may or may not reside in the same household as the victim.

FSAC	Fredericton Sexual Assault Centre
GLM / Good Lives Model	This model emphasizes the environmental context in which the offender lives and the development of strategies to achieve primary goods, such as self-efficacy and positive family relationships, eroding the maladaptive pathways that were once in place to achieve them, which is what led the offender to offend in the first place.
Inconclusive	(Context: Social Development) Inconclusive indicates that critical information necessary for establishing the probability that abuse or neglect occurred or did not occur, cannot be obtained. This case finding does not mean that the worker has determined that abuse or neglect did not occur, but rather that a lack of information makes it impossible to establish a balance of probabilities that abuse/neglect did or did not occur. All appropriate attempts to gather assessment information have been exhausted before this conclusion is reached. This conclusion is not used as a "default" for cases where the decision to substantiate or not is difficult to make.
Ineligible	(Context: Social Development) Indicates that the case did not meet one of the following criteria: 1) whether the subject of the information is a child as defined by the *Family Services Act*, 2) whether there is sufficient evidence to locate the child or family, and 3) whether the information provided falls within the According to the Multiple Response Model Practice Standards in Child Protection and Family Services mandate of Section 31(1) of the *Family Services Act*.
Intrafamilial	(Context: Social Development) Intrafamilial abuse occurs when the following persons are involved: 1) father, mother, daughter, and/or son; 2) common law partner, daughter, or son; 3) step-father, step-mother, step-daughter, and/or step-son; 4) sibling, where the abuser is older and is an authority figure for his/her sibling; 5) uncle, aunt, niece, nephew, and/or cousin, even if they do not reside in a household.
Link to open case	(Context: Social Development) Indicates that the intake is being linked to an existing case.
MCAF	Multicultural Association of Fredericton
MMFC	Muriel McQueen Fergusson Centre for Family Violence Research
MST / Multisystemic Therapy	MST views human behaviour and development as products of series of complex interactions between an individual and the multiple systems in which they are embedded (e.g., family, school, community, society) and that the onset of problematic behaviours (such as sexual offending) cannot be explained simply by the individual alone.
NBACL	New Brunswick Association for Community Living
NCMEC	National Centre for Missing and Exploited Children
Non-offending hebefiles	Those sexually attracted to youth in early adolescence, who have not committed a sexual offence toward those in early adolescence.

Non-offending pedophiles	Non-offending pedophiles are individuals who either self-identify as being sexually attracted to children or have received a formal diagnosis of pedophilia but who have not committed a sexual offence against a minor.
Primary Prevention	Prevention efforts for potential victims.
Recidivism	The tendency to relapse into a previous condition or mode of behaviour, especially a relapse into criminal behaviour.
Refer to new case and link to open	(Context: Social Development) Indicates that the intake is being used to open a new case as well as being linked to an existing case.
Refer to new case	(Context: Social Development) Indicates that the intake is used to open one new case.
Referred out	(Context: Social Development) Indicates that the referral source provides evidence that is more closely related to another department's or agency's mandate.
RP	Relapse Prevention
RNR	Risk-Needs-Responsivity Model: The yield from programming is maximized when treatments and controls are responsive to the risk and needs of individual offenders.
SD Screening Criteria Not Met	(Context: Social Development) Indicates that the threshold for SD to intervene was not met, according to NB's Structured Decision Making® System: Policy and Procedures Manual 2010, and consequently, the case was screened out.
Secondary Prevention	Prevention efforts for those who may be at risk of offending or of being victimized.
Service provided at intake	(Context: Social Development) Consists of Social Development completing a courtesy interview based on the *Step-Wise Guidelines for Child Interviews: The New Generation*, using a common empirically-based tool known as the Statement of Validity Assessment (SVA), to be able to assess the credibility of verbal statements of victims in a structured manner. This information is provided to the investigating police force as part of their investigation.
Sexting	The transmission of sexually explicit messages and pictures via text message or an online messaging service.
Sexual Assault in Canada	*Sexual assault level 1* (Criminal Code s. 271): An assault committed in circumstances of a sexual nature such that the sexual integrity of the victim is violated. Involves minor physical injuries or no injury to the victim. *Sexual assault level 2* (Criminal Code s. 272): Sexual assault with a weapon, threats, or causing bodily harm. *Sexual assault level 3* (Criminal Code s. 273): Sexual assault that results in wounding, maiming, disfiguring, or endangering the life of the victim (Criminal Code, 1985).

SAFE-T	Sexual Abuse: Family Education and Treatment: Operates within a CBT-RP framework consisting of group, individual, and family therapies over a 12-month period, has demonstrated strong effects in preventing sexual recidivism.
SACs	Sexual Abusers of Children
Sexual Coercion	Unwanted sexual activity that happens when one is pressured, tricked, threatened, or forced in a nonphysical way.
Sexual Violations Against Children	Criminal Code offences including: Sexual interference (s. 151); Invitation to sexual touching (s.152); Sexual exploitation (s. 153); Parent or guardian procuring sexual activity (s. 170); Householder permitting prohibited sexual activity (s.172); Making sexually explicit material available to children (s. 171.1); Luring a child via a computer (s.172.1) but does not include: Sexual assault levels 1, 2, or 3 (s. 271, 272, & 273 respectively); or Child pornography (s. 163.1).
SST	Social Skills Training
Substantiated	(Context: Social Development): Substantiated is a decision that, on the balance of probabilities, is more probable than not that the harm or risk of harm has occurred, currently exists or is likely to occur.
Tertiary Prevention	Focuses on offending after it has occurred to prevent re-offending or revictimization.
TRC	Teen Resource Centre
UCR2	Uniform Crime Reporting Survey
Unable to locate client	(Context: Social Development) Indicates that there is not enough information to locate the parent or the child after an incident is reported.
Unsubstantiated	(Context: Social Development) Unsubstantiated is a decision that, on the balance of probabilities (it is not “more probable than not” that the harm or risk of harm has occurred, currently exists or is likely to occur), evidence gathered lends weight to the belief that abuse or neglect did not occur.
YRP	Youth Relationships Project: an 18-session program that focuses on aggression-based interpersonal problem-solving, gender-based role expectations, the role of the media, power dynamics, and abuse education.

Introduction

Rationale

While child sexual harm (CSH) is a concerning topic for all families, communities, and provinces, it is particularly so in New Brunswick. In 2015, New Brunswick's Strategy for the Prevention of Harm for Children and Youth highlighted the historically higher reported incidence of sexual harm against children and noted that more research and analysis is required to fully understand the issue and what can be done about it. As such, the Roundtable on Crime and Public Safety included the following activity (#3) as a part of its 2016-2019 Crime Prevention and Reduction Strategy Action Plan: *Conduct a needs analysis and best practices review for the increased prevention and intervention of child sexual abuse in New Brunswick with recommendations for improvement.*

The Strategy for the Prevention of Harm for Children and Youth was initiated in 2014 and provides a holistic, rights-respecting coordinating framework that engages and guides citizens from across sectors in the joint task of keeping children safe from harm. The Strategy for the Prevention of Harm for Children and Youth is co-chaired by the Child and Youth Advocate's Office and the Executive Council Office and includes insights from young people, NGOs, youth-serving organizations, academics, community members and government departments.

New Brunswick's Roundtable on Crime and Public Safety was established in 2011 as a venue for community agencies, police, the private sector, academia, First Nations groups, municipal and federal governments, and several provincial departments to collaborate on improvements to New Brunswick crime prevention policy and practice. It is chaired by the Deputy Minister of Public Safety and supported by the Crime Prevention Branch. The Roundtable and its working groups bring together over 55 organizations to address root causes of crime, make better use of human and financial resources, and build safer more secure New Brunswick communities.

In addition to the harmful effects on the lives of individuals, families, and communities, CSH places incredible burdens on the health care, social welfare, education, and criminal justice systems. Child sexual harm has been linked to the development of numerous adverse outcomes, such as Post-Traumatic Stress Disorder (PTSD), depression, Attention Deficit Hyperactivity Disorder (ADHD), eating disorders, anxiety, substance abuse, personality disorders, weakened interpersonal relations, increased suicide risk, and increased likelihood of being sexually revictimized as an adult (Beitchman et al., 1991; Brezo et al., 2007; Dube et al., 2005; Fergusson, McLeod, & Horwood, 2013; Fillipas & Ullman, 2006; Kendall-Tackett, Williams, & Finkelhor, 1993; Kilpatrick et al., 2000; Lalor & McElvaney, 2010; Maniglio, 2009; Maniglio, 2010; Mullers & Dowling, 2008; Putnam, 2003). Furthermore, child sexual abuse (CSA) victimization has been identified as one of the most critical risk factors for future offending (Green et al., 2010), including the commission of sexual offences, which may perpetuate the cycle of violence (Levenson & Socia, 2016).

In 1991, Canada ratified the United Nations (UN) Convention on the Rights of Children which includes multiple Articles to protect children everywhere "from all forms of sexual exploitation and sexual abuse." Article 34 affirms:

> States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

The Committee on the Rights of the Child, which is a body of 18 independent experts that monitors implementation of the Convention on the Rights of the Child, has welcomed Canada's efforts to uphold children's rights, including the *National Strategy to Protect Children from Sexual Exploitation on the Internet* (May 2004), the establishment of Cybertip.ca as a national reporting centre and the *National Action Plan to Combat Human Trafficking* (June 2012). However, the Committee has noted several gaps and emphasized the need for a comprehensive and targeted approach to address the root causes of sexual harm with particular focus on vulnerable and marginalized situations and populations. Thus, increasing efforts to prevent CSH in New Brunswick also upholds obligations under United Nations Convention of the Rights of the Child.

It is important to note that the requirement for improvements to CSH prevention and intervention practices in the province is a historical issue. The Muriel McQueen Fergusson Centre for Family Violence Research (Muriel McQueen Fergusson Centre, 1997) completed a report two-decades ago in collaboration with the former New Brunswick Department of the Solicitor General (now Public Safety) and Correctional Services of Canada. This work was limited to obtaining a better understanding of the prevalence of CSH in New Brunswick with a specific focus on offender treatment needs. The present review has a much broader focus as outlined below.

Definition and Scope

All forms of sexual harm against children are within the scope of this review. The New Brunswick Strategy for the Prevention of Harm Against Children and Youth defines sexual harm as:

> *…any acts of a sexual nature that are unlawful or psychologically harmful, committed by any person through coercion, inducement, exploitation or force. Sexual harm can be physical or non-physical. Physical sexual harm refers to any violation of an individual's bodily integrity without their consent, and includes: assault; fondling; intercourse; and incest, among other violations. Non-physical sexual harm relates to experiences of sexual victimization that violate the mental or emotional integrity of an individual. They are not accompanied by physical force or restraint, but are nonetheless psychologically intrusive, exploitative or traumatic. Some examples of nonphysical sexual harms include: exhibitionism; sexualisation; and demeaning comments or accusations of a sexual nature* (Province of New Brunswick, 2015, p. 30). The scope of this report also includes human trafficking for sexual exploitation and sexual cyberviolence.

With such a broad definition, the review includes an examination of who is perpetrating this harm, who is being victimized, and the context within which the harm occurs. Perpetrators can be male or female, familial or non-familial, acquaintances or strangers, first-time offenders or re-offenders, juveniles or adults, who may or may not hold a position of authority over the child or youth victim. As well, offences can range from contact offences, such as fondling, to non-contact offences, such as exposing oneself to a child, to internet-based offences, such as soliciting images of child sexual harm. These offences can also occur within the context of a romantic/intimate relationship (e.g., dating relationship).

This review also takes into account the unique considerations of those who are, and have been historically, socially marginalized, including Indigenous persons, persons with disabilities, those of lower socio-economic status, members of LGBTQIA2+ as they are often overrepresented among victims of CSA and

may face additional obstacles in reporting their abuse or receiving services (Collin-Vezina, Dion, & Trocme, 2009; Mustaine, Tewksbury, Huff-Corzine, Corzine, & Marshall, 2014; Prentice, Blair, & O'Mullan, 2016; New Brunswick Health Council, 2017). Some of these groups are also overrepresented among the offender population (Prentice et al., 2016; Tidefors, Goulding, & Arvidsson, 2011). While causal explanations for these trends are not well developed or understood, it is important to acknowledge the roles that multigenerational trauma, systemic abuse, and an ongoing legacy of colonization continue to play as is the case of Indigenous overrepresentation.

As outlined above, recognition of the nuances in which CSH occurs can help to better identify the multi-faceted approaches that will be required to effectively reduce incidences in New Brunswick. With such a broad scope, and an understanding that CSH is a complex issue, it is important to note that this review is not exhaustive. Many of the identified findings and recommendations will require further investigation. Moreover, as concrete activities are identified and implemented, consultation with communities and practitioners will be required.

Approach

This report is structured in four sections:

1) **Section 1: Child Rights Impact Assessment (CRIA):** frames child sexual harm (CSH) in terms of child rights based-analysis and identifies the interdependencies between children's protection rights in relation to CSH and their impacts on their enjoyment of other fundamental rights.

2) **Section 2: Best Practices Review:** outlines empirically-supported evidence relevant to child sexual harm reduction within four groups: 1) potential and current child/youth victims, 2) child/youth perpetrators, 3) non-offending pedophiles, and 4) adult sexual abusers of children. This review includes primary prevention which are universal efforts within the general population, secondary prevention which focuses on those who may be at higher risk of offending or of being victimized, and tertiary efforts to tackle the specific needs of offenders and those who have been victimized. A jurisdictional scan was also undertaken to provide an understanding of initiatives that other provinces and territories have underway to tackle these issues.

3) **Section 3: Needs Analysis:** provides a better understanding of the prevalence of sexual harm against children and youth in New Brunswick by looking at available data. This includes police-reported offences as reported by Statistics Canada. Where Statistics Canada has consistently recognized that offences in general, and sexual offences specifically, are under-reported to police, the review examines self-report victimization data available from the 2015-2016 Student Wellness Survey of over 32,000 New Brunswick youth from grades 7-12. Additionally, the review includes an analysis of suspected reports of sexual harm to children and youth made to the New Brunswick Department of Social Development. Finally, the Needs Analysis provides a comparison of programs and services that currently exist in New Brunswick to best practices and summarizes strengths and gaps as identified through a series of consultations that were conducted with New Brunswick professionals working in a variety of CSH-related fields.

4) **Section 4: Review of Findings and Recommendations**: The final section of the report summarizes findings outlined in the CRIA Review, Best Practices Review and Needs Analysis sections and identifies recommendations for improving existing practices and addressing gaps in service.

Section 1: Child Rights Impact Assessment (CRIA) Review:

Purpose

The universal standards for the care, treatment, survival, development, and protection of children are outlined by the United Nations Convention on the Rights of the Child (UNCRC) which Canada ratified in 1991 (UN General Assembly, 1990). This legal instrument explicitly recognizes children as social actors and active rights holders who must be protected and empowered through the legislative, administrative, social and educational branches of government in every society. The interdependent and interrelated nature of child and youth rights shows how important each right is, and how overlooking or neglecting one right directly impedes the exercise of other fundamental child and youth rights. Therefore, it follows that the high rate of CSH in New Brunswick demonstrates potential shortcomings in respect to the State's duty to protect children and youth from all forms of violence as outlined generally in Article 19 and specifically in Articles 34, 35, 36 of the UNCRC (see descriptions below).

Additional background on the development of efforts to combat child sexual harm globally can provide insights on global trends that should be considered in New Brunswick, specifically the sexual exploitation of children through human trafficking, child pornography and internet child exploitation. In 1990 the United Nations appointed its first Special Rapporteur on the sale of children, child prostitution and child pornography. In Stockholm in 1996, governments across the world held the First World Congress against Commercial Sexual Exploitation of Children and adopted a Declaration to guide State action in combatting this harm. This was followed up by the adoption of International Labour Organization (ILO) Convention 182 on the Worst Forms of Child Labour in 1999. In 2000, the UN Convention against Transnational Organized Crime was adopted, together with its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. A Second World Congress in this area lead to the adoption of the 2001 Yokohama Global Commitment reaffirming the commitments of the Stockholm Declaration and affirming new resolve to combat internet child exploitation. A Third World Congress followed in Rio de Janeiro (2008) and produced the Rio Call for Action and an accountability framework for Governments and the private sector as duty-bearers to children. In 2006, Sergio Pinheiro's World Report on Violence Against Children helped motivate greater effort in combatting all forms of sexual harm of children and youth.

The purpose of this section is to examine how the issues identified in this report impact the various rights outlined in UNCRC. More precisely, this section examines results through the lens of the general provision of Article 19 and specifically through Articles 34, 35 and 36 of the UNCRC. Finally, it identifies the effects on other Articles including 6, 16, 24, 28, 39 and 40.

NOTE: To aid the reader in digesting the report, each Section includes a **'Summary of Key Considerations'** in a text box like this. Additional text boxes also include helpful explanations throughout the document.

General Provision

- **Article 19:**
  1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
  2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Specific Provisions

- **Article 34:** States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:
  (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
  (b) The exploitative use of children in prostitution or other unlawful sexual practices;
  (c) The exploitative use of children in pornographic performances and materials.

- **Article 35:** States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

- **Article 36:** States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Intersecting Provisions

- **Article 6: Survival and maximum development.** Every child has the right to life, and the government has an obligation to ensure the child's survival and development to the maximum extent possible.

- **Article 16: Protection of privacy and reputation.** Children have the right to protection from arbitrary or unlawful interference with privacy, family, home and correspondence, and from attacks on their character or reputation.

- **Article 24: Health and health services.** Children have the right to the highest possible standard of health and access to health and medical services.

- **Article 28: Education.** Children have the right to education.

- **Article 39: Recovery and reintegration of child victims.** Children who have experienced armed conflict, torture, abuse, neglect or exploitation shall receive appropriate treatment for their physical and psychological recovery and social reintegration.

- **Article 40: Administration of juvenile justice.** Children in conflict with the law are entitled to legal guarantees and assistance, and treatment that promotes their sense of dignity and aims to help them take a constructive role in society.

Assessment

Article 19 asserts children's equal right to have their dignity, physical and personal integrity respected and protected. The importance of preventing sexual harm as outlined in **Articles 34, 35** and **36** and protecting children's physical and emotional integrity is apparent when one understands how important the underlying concept of the integrity of a child is to the protection and maintenance of a child's right to life, survival and development (**Article 6**). The term, 'development', according to the Committee on the Rights of the Child, can be interpreted "in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological, and social development" (UN Committee on the Rights of the Child, 2003b).The optimal development of a child cannot be achieved with a lack of physical and emotional integrity.

Similarly, a child's right to health (**Article 24**) is compromised as a result of sexual victimization. Children and youth who are sexually exploited are exposed to significant health risks, including sexually transmitted infections (STIs), human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), unwanted pregnancies, unsafe abortions, violence and psychological distress (UN Committee on the Rights of the Child, 2003a).

The severe and long-term physical, emotional and psychological repercussions CSH has on children and youth can impede the child's right to education, pursuant to **Article 28**. The right to education cannot be achieved "progressively and on the basis of equal opportunity" if a higher proportion of Indigenous youth, youth who identify as LGBTQIA2+, youth with exceptionalities and special needs, and youth of lower socioeconomic status report being sexually violated (see *Section 3: Need Analysis: Self Report Data*). These children and youth are disproportionately disadvantaged and therefore limited in their ability to achieve quality education. According to the Convention on the Rights of Persons with Disabilities, developing a sense of dignity and self-worth in children and youth with disabilities is a means to achieving an inclusive education system (UN General Assembly, 2007).

As noted in **Article 19**, protective measures should include effective procedures for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment. According to Professor Sergio Pinheiro's *World Report on Violence Against Children* (2006), violence against children can be eliminated, by various measures such as "enhanc[ing] the capacity of all who work with and for children" (Hodgkin & Newell, 2007, p.252). Pinheiro's comments support the need for internal program reviews and staff development to ensure that disclosures of child sexual harm are reported to the appropriate authorities and lead to an eradication of reported behaviours. Unfortunately, CSH is often not prosecuted as fully, or as successfully, as it could be due to the challenges of capturing children's narratives and presenting them in court (Davies, Henderson & Seymour, 1997). The high proportion of unfounded or inconclusive cases where the victim is under the age of 18 (see *Section 3: Need Analysis: Police Report Data, Link to Unfounded Sexual Crimes* and *Social Development Reported Data)* highlights the need for better training and educational programs for those who work with and for children, including police. This will help ensure that CSH is appropriately identified, reported, classified and that previously unfounded cases are reopened as unsolved cases, as required. Such a recommendation is consistent with **Article 16,** which sets out to protect a child's

privacy and reputation. Adequately reviewing, investigating, and filing of reports is an exercise of respecting the privacy and reputation of children.

The lack of adequate evidence-based programs for child and youth victims identified in the review (see *Section 3: Need Analysis: Consultation Results*) shows a deficit in relation to **Article 39,** which speaks to the obligation to provide appropriate treatment for the physical and psychological recovery and social reintegration of victims. As emphasized by the Committee of the Rights of the Child, this right also imparts the duty to adopt a "non-punitive approach to child victims of sexual exploitation, including training on how to investigate complaints in a child-sensitive manner" (Hodgkin & Newell, 2007, p. 525).

The Needs Analysis (Section 3) in this report also highlighted required improvements to the treatment of child and youth perpetrators of sexual harm which is consistent with **Article 40** (i.e., treatment of youth that promotes their sense of dignity and aims to help them take a constructive role in society). This need is further supported by the finding that youth are charged at a greater rate than adults, even though adults represent the larger proportion of perpetrators of CSH (See *Section 3: Need Analysis: Police Report Data, Perpetrators*).

Lastly, while the sexual assault level 1 was the most common sexual crime reported to police in New Brunswick (*Section 3*), it is important to pay special attention to other forms of exploitation as defined in Articles **34, 35**, and **36**. New Brunswick is not immune to human trafficking and internet child exploitation, and prevention efforts should include a focus on these as well.

Overall, findings outlined in this report impact children's rights, both directly and indirectly. Many of the recommendations outlined are consistent with recommendations that have been made to Canada by the Committee on the Rights of the Child, which is a body of 18 independent experts that monitors implementation of the Convention on the Rights of the Child. This Committee has welcomed Canada's efforts to uphold children's rights, including the National Strategy to Protect Children from Sexual Exploitation on the Internet (May 2004), the establishment of Cybertip.ca as a national reporting centre, and the National Action Plan to Combat Human Trafficking (June 2012). However, the Committee has noted several gaps and emphasized the need for a comprehensive and targeted approach to address the root causes of sexual harm with particular focus on vulnerable and marginalized situations and populations. Thus, implementation of recommendations outlined in this report will also uphold New Brunswick's obligations under UNCRC.

Summary: Key Considerations for the Child Rights Impact Assessment

- It is important to look at the issue of child sexual harm from a child rights-based approach as part of a global effort.
- The United Nations Convention on the Rights of the Child (UNCRC) mandates State Parties to uphold standards for the care, treatment, survival, development, and protection of children.
- Child and youth rights are interdependent and interrelated; overlooking or neglecting one right directly impedes the exercise of other fundamental child and youth rights.
- Failing to protect a child from CSH can result in severe long-term physical, emotional and psychological repercussions and impacts other rights of the child.
- High CSH rates in New Brunswick identify the need for potential changes at the legislative, administrative, social, and educational levels to better protect children's rights.
- Identification, reporting, referral, investigation, treatment, follow-up procedures, and continuing education and training for those who work with and for children are important protective measures that need to be reviewed and improved.

Section 2: Best Practices Review

Child and Youth Victims

Overview

Traditionally, CSH prevention has been concentrated on potential victims, adopting a primary prevention approach. While this approach has been critiqued for putting the onus of CSH prevention on children (Finkelhor, 2007; Wurtele, 2009), the ubiquity of this method is understandable; any child can potentially be a victim of child sexual harm, and the school system – how many CSH prevention programs take place – allows for easy accessibility to large groups of children, maximizing program reach and cost-efficiency. What exactly these educational programs entail (e.g., healthy relationships, appropriate touching, online safety) varies across school districts as well as the child/youth's stage of development but the common goal is to help children and youth identify inappropriate sexual behaviour or its antecedents. Thus, this approach operates under the assumption that recognition of dangerous or concerning conduct will lead children or youth to be more assertive, to remove themselves from the situation, and to report it to a trusted adult, such as a parent or teacher. While the efficacy of such educational programs varies across ages, formats, and content, it is believed that some information and education is better than none. However, it is important to ensure that approaches to CSH reduction are empirically-driven, using the highest-quality methods available.

Potential Victims

As previously discussed, there has been considerable emphasis placed on protecting potential victims of CSH through educational programs. These programs are frequently aimed at strengthening the three R's: the ability to *recognize* inappropriate sexual situations or behaviours, the assertiveness to *resist* giving in to pressures (internal or external), and the willingness to *report* these instances to a trusted adult. Generally, these approaches are effective in improving participants' responses on knowledge and protective behaviour measures, effects which can be even more salient with younger children (Berrick & Barth, 1992; Davis & Gidycz, 2000; Finkelhor, 2007, 2009; Mikton & Butchart, 2009; Zwi et al., 2007). In a comparison among undergraduate students who were asked to recall their own participation in a school-based CSA prevention program and their own CSA victimization, nine percent of respondents who participated in such a program reported a history of victimization, compared to 16 percent of participants who had not participated, lending support to the notion that CSA prevention programs are effective in reducing occurrences of CSA (Gibson & Leitenberg, 2000). For this approach to reach maximum effectiveness, however, it is important to understand that CSA prevention programs need to be implemented at an early age – roughly one-third of CSA victims are under the age of nine (Vogeltanz et al., 1999; Wyatt et al., 1999), while lifetime prevalence rates for CSA in general range from 7.5% to 11.7% of all youth (Townsend & Rheingold, 2013). These also need to reflect the changing nature of sexual abuse which coincides with the victim's age. For instance, 62% of victims aged 4-6 were victimized by a family member, while victims aged 12-15 were more likely to be sexually abused by acquaintances (49%) than family members (28%) (Statistics Canada, 2014). Those between 12-15 years of age also had the highest rates of intimate partner victimization (10%). Research specific to New Brunswick suggests this may be an underestimate, with 44% and 40% of girls and boys, respectively, reporting sexual coercion within the context of a romantic relationship (Sears & Byers, 2010), higher than the rates of sexual dating victimization found in a national U.S. sample of similar-aged girls and boys (9% and 5%, respectively) (Ybarra et al., 2016). While this may lend credence to the validity of the

province's high CSH ranking, what is clear from victimization data is that a one-size-fits-all approach to school-based CSH prevention or sexual education programs will not suffice.

Programs need to be relevant and delivered in a developmentally-appropriate way. For example, one would not hold a discussion on 'sexting' (the transmission of sexually explicit messages and pictures via text message or an online messaging service) to a classroom of kindergarteners. However, this would be a particularly relevant topic of discussion for high-school students, where a recent survey found that 57.6% of New Brunswick females aged 16-19 have been solicited to send intimate/sexual photos of themselves (New Brunswick Association of Social Workers, 2015). Strategies also need to take into account that the vast majority of perpetrators of sexual abuse are known to the victims (Finkelhor et al., 2011; Statistics Canada, 2014; Wurtele & Kenny, 2010). This also appears to be the trend when it comes to online victimization, which has seen a considerable shift over the past two decades; according to self-report data in 2000, 3% of solicitors were known to the victim, but by 2010, 32% of solicitors were known personally prior to the solicitation taking place (Mitchell et al., 2013). It should be noted that in this study, figures may be underestimated, as participants were not asked whether they knew *of* the perpetrators (e.g., a friend of a friend), but if it was a similar-aged peer with whom they were in frequent contact. Additionally, survey responses over the 10-year period illustrated a shift in platforms where the sexual solicitation was occurring, from chat rooms (64% in 2000 to 16% in 2010) to social media sites (0% in 2000 to 58% in 2010), such as Facebook. Due to the latter's interconnectivity among users (e.g., their visible social networks), it is possible, and perhaps even likely, that these individuals connected through "mutual friends" and therefore, know *of* their solicitor. Thus, a strong emphasis on 'stranger danger' in education programs may be unwarranted. In fact, some school-based educational programs, such as Safe Touches, opt not to include a stranger component due to the rarity of these incidents (Pulido et al., 2015). That said, most programs do incorporate some aspects of stranger interaction (e.g., Stay Safe; MacIntyre et al., 2000).

In terms of program format, which can range from a didactic approach to a focus on skill-acquisition, it appears that the more dynamic and engaging the format, the better the outcome. For instance, children in an interactive psychoeducational program displayed greater skill knowledge than those who read a special-edition CSA prevention *Spiderman* comic (Woods & Dean, 1986). A similar trend was discovered for children who were either placed in a Behavioural Skills Training (BST) program or watched an educational film on sexual harm; the former group demonstrated better knowledge and skill acquisition (Wurtele et al., 1986). Upon reviewing several studies, Wurtele et al. (2008) concluded that children derive the greatest benefit when participating in a program that includes modeling or rehearsal compared to ones that incorporate more passive techniques, a conclusion also reached by Davis and Gidycz (2000). Often missed in both policy and practice is the inclusion of children and youth with intellectual disabilities in CSH prevention programs, which may be due to the false belief that they have little sexual interest (Dewinter et al., 2015). McDaniels and Fleming (2016) have identified this as a serious concern, linking nonexistent or insufficient sexual education for individuals with intellectual disabilities to their increased vulnerability to become victims of CSH. Simultaneously, children and youth with intellectual disabilities are also overrepresented in the sexual offender population, though the reasons for this are not well understood (Mulder et al., 2012). McDaniels and Fleming (2016) go on to note that for some, traditional CSH prevention programs may need to be altered to best suit the learning style and level of comprehension of the individual with an intellectual disability to be maximally effective. Given the association between intellectual disabilities and being a victim or perpetrator of a sexual offense, it is crucial to ensure that persons with intellectual disabilities receive proper education about bodily autonomy (one's self-determination over their own body), healthy relationships, consent, and other relevant information.

While there are clear benefits to sexual education programs, critics have suggested that children and youth's participation may lead to adverse outcomes, such as increased fear, conduct difficulties, false

reports, and sexual development problems. However, there is little to no evidence to support any of these claims (see Finkelhor, 2007, for a review; also, Chen & Chen, 2005). For instance, a recent meta-analysis of 24 studies indicated that there is no evidence of children's increased anxiety or fear following participation in a CSA prevention program (Walsh et al., 2015). Similar results were obtained in another meta-analysis of 26 school-based child sexual harm prevention programs (Fryda & Hulme, 2015). However, it is imperative that programs are delivered in a developmentally appropriate way (Lyles, Cohen, & Brown, 2009; National Centre for Missing and Exploited Children (NCMEC), 1999). One suggestion to alleviate the fears of parents is to incorporate CSA prevention into a more generic or more palatable-sounding safety program (e.g., "personal safety" or "healthy relationships") (Wurtele & Kenny, 2010). Additionally, involving parents may prove useful in garnering support for such initiatives.

Preschool and Elementary school-aged Children

In terms of content, Fryda and Hulme's (2015) meta-analysis of mostly preschool and elementary school aged youth CSA prevention programs identified seven common subject categories: 1) abuse spectrum, 2) body ownership, 3) grooming behaviours, 4) safe and unsafe situations, 5) saying no and assertiveness skill building, 6) telling adults and the dangers of not telling secrets, and 7) types of touch. While the effectiveness of the programs in the meta-analysis varied, these summary findings do serve as a foundation for sexual education or CSH prevention program curriculum. These subject categories are also supported by a study where it was found that 45% of convicted child sex offenders used grooming techniques—the building of trust for the purposes of later exploitation—on their victim (Canter, Hughes, & Kirby, 1998); however, research on the prevalence of grooming behaviours of internet-based child sex offenders is still in its infancy (Lorenzo-Dus & Izura, 2017). Despite the persistence and prevalence of grooming behaviours, even adults have difficulty identifying potential grooming behaviours and scenarios (Winters & Jeglic, 2017), which lends support for further education about this topic. Programs should also include specific rules, rather than relying on intuition about the appropriateness of situations, as young children in particular have shown difficulty in recognizing inappropriate touching in ambiguous situations when not following a rules-based approach (Boyle & Lutzker, 2005).

As previously identified, it is imperative that children are introduced to CSH prevention programs beginning as early as preschool. In 2012 alone, there were 580 cases of sexual violations against children ages 0-3 in Canada (Statistics Canada, 2014), yet many parents underestimate the risk to their preschool-age children (Collins, 1996; Tang & Yan, 2004). While a heightened fear of "stranger danger" exists among parents (Kenny & Wurtele, 2010), this concern is largely misplaced—two-thirds of those accused of CSA against this age group are family members and strangers only account for 4% of accused (Statistics Canada, 2014). Because children at this age are often victimized by a trusted family member, and given their vulnerability to both CSH and grooming techniques (e.g., it may be easier to convince a two-year-old that sexual touches from an adult is okay), additional programs may be necessary. Offering a CSH prevention program to preschool-aged children may help by offering them the opportunity to learn about concepts like appropriate touching.

Not all children are enrolled in daycare or preschool programs. Therefore, CSH prevention programs offer formats for both parents and teachers to educate children on sexual safety. For instance, the *Body Safety Training* (BST) program (Wurtele, 2007), which teaches body-safety rules and skills, has similar but separate versions for parents and teachers. Interestingly, children showed stronger gains in body-safety knowledge and skills when taught by their parents than when taught by teachers (although both groups demonstrated significant gains in comparison to control groups), emphasizing the role that parents can play in primary CSA prevention (Wurtele, Kast, & Melzer, 1992). The BST has also demonstrated an ability to increase children's knowledge of inappropriate touches made by "good" people, such as family members,

which is of particular importance given their prevalence among abusers of small children (Kenny & Wurtele, 2010). Alternatively, the *Kids Learning About Safety* program (Kenny, 2009), which incorporates aspects of the *Talking About Touching* program (Committee for Children, 1996; 2001) has shown to be an effective means of increasing child and parent safety knowledge, including sexual safety (Kenny, 2010). Its findings have also been replicated with marginalized groups (Kenny, Wurtele, & Alonso, 2012). This latter program is delivered to child-only and parent-only groups by a trained facilitator, similar to *Parents as Teachers of Safety* or PaTS (Kenny, 2009), another empirically supported program for increasing CSH knowledge. Overall, these programs provide parents of preschool-aged children ways they can make significant gains in CSH knowledge and behaviours.

Elementary school-aged Children

Since it is difficult to mandate CSH prevention programs for preschool-aged children (who may attend a private daycare, babysitter, or be cared for by their parent), their enrollment in elementary school is often the first opportunity to ensure that they are introduced to a universal, empirically-driven CSH prevention program. While ideally children have been educated about CSH before their entrance into the public-school system, elementary school programs must take into account that even children with prior education will not all demonstrate the same levels of CSH knowledge and prevention skills. To compensate, there is often considerable overlap in some of the suggested content between preschool- and elementary school-based CSH prevention programs. This is perhaps most evident in the *Good Touch-Bad Touch* program (Harvey et al., 1988), which has been found effective in increasing children's knowledge of inappropriate touches, even when adapted to other countries, such as Turkey (Çeçen -Erogul & Kaf Hasirci, 2013). Despite the relatively short duration of the *Good Touch-Bad Touch* program (three half-hour sessions), its robustness may be due to its interactive nature including instructions, modeling, rehearsal, and social reinforcement. Similarly, the 50-minute *Safe Touches* workshop, which uses puppets to role play scenarios, practice assertiveness skills, and discuss reporting to a trusted adult, has been shown to be effective in increasing sexual touch knowledge (Pulido et al., 2015). Designed for children in grades one and two, the interactive theatrical performance *(No) Child's Play*, which covers topics on touch, safe/unsafe situations, and disclosure, has resulted in significant improvement in children's knowledge and skill scores, results which were maintained 30 weeks later (Krahe & Knappert, 2009). *TOUCH Continuum*, a 45-minute series of vignettes presented theatrically on different kinds of touch, followed by a discussion session, has also been shown to have desirable effects, even at a three-year follow-up (Casper, 1999). After watching the film *Touch* followed by a discussion among groups of early or late elementary school students, children demonstrated greater knowledge, skills and willingness to report inappropriate touches to a trusted adult (Saslawsky & Wurtele, 1986). For older elementary students, the Irish program *Stay Safe* utilizes a film, music, role play, and a structured lesson plan to significantly improve and maintain children's safety skills and knowledge (MacIntyre & Carr, 1999a) as well as to increase disclosure rates (MacIntyre & Carr, 1999b). Meanwhile, the program *Keeping Me Safe* incorporates topics of body ownership, the abuse spectrum, assertiveness, safe/unsafe situations, reporting, and inappropriate touch, which is discussed and delivered through games and role play (Weatherley et al., 2012). Results indicate that this interactive approach, even at follow-up, increases participants' body ownership, assertiveness, and reporting skills. The use of games to educate children on personal safety is also a promising approach to teaching children with intellectual disabilities (Johnston, 2010), who are particularly vulnerable to CSA (Westcott & Jones, 1999).

Middle school-aged Youth

In shifting discussion to programs targeted toward middle school-aged youth, there is a distinct change in the content of empirically-supported programs. In the appropriately-named *Shifting Boundaries* program, students are offered a classroom-based or building-based approach to decreasing dating violence,

delivered over six sessions. Using a mixture of instructional material and engaging activities, self-reported sexual harassment victimization and perpetration showed significant declines (43% and 34%, respectively), as did the prevalence (50% reduction) and frequency (40% reduction) of self-reported sexual victimization by a dating partner (Taylor et al., 2013). Utilizing a building-based approach, which was shown to be more effective, adheres well to research that suggests that a large majority of sexual harassment occurs within the school (Espelage et al., 2016). Part of a broader safety skills program, the senior cycle of the *Stay Safe* program incorporates many of the same concepts as its previously described junior counterpart in a more concise multimodal approach using trained facilitators to instruct parents and teachers. Overall, the program seems to be effective for both age groups (MacIntyre et al., 2000). Lastly, *Second Step,* a social-emotional skill development and bullying prevention program, which focuses on empathy, assertiveness, emotion-regulation, pro-social communication, bystander intervention, and the reduction of pro-bullying attitudes, has been evaluated as a CSH prevention program. Upon implementation in Illinois, significant reductions in sexual violence perpetration and victimization were found, as well as a reduction in homophobic victimization (the perpetration of which has been linked to sexual violence perpetration among youth) (Espelage et al., 2015). These results were not replicated when implemented in Kansas. However, the program appropriately targets peers as the primary perpetrators of violence, consistent with Statistics Canada (2014) findings.

High school-aged Youth

For the most part, high school programs continue to fall under the umbrella of dating violence programs. Thus, they are not solely targeting sexual dating violence (see Jennings et al., 2017, and Ting, 2009, for an exhaustive review), which peaks in the 10th grade (Reyes & Foshee, 2013). However, many are still effective in reducing sexual violence victimization as the program components are often transferable to situations outside the dating context. For instance, one of the more widely studied programs *Safe Dates*, utilizes a play, a poster contest, and a 10-session curriculum to address dating violence norms, gender-role norms, and conflict management skills (Foshee et al., 2005). This multimodal approach has led to reductions in psychological, physical, and sexual dating violence perpetration. Furthermore, the intervention was equally effective in reducing perpetration for youth both with and without a history of perpetration, as compared to controls. Thus, it dually operates as a successful primary and secondary prevention program. Similarly, the *Youth Relationships Project* (YRP) is an 18-session program that focuses on aggression-based interpersonal problem-solving, gender-based role expectations, the role of the media, power dynamics, and abuse education (Wolfe et al., 2003). Through modelling, videos, guest speakers, rehearsals, and participation in a social action project, both physical and emotional abuse perpetration decreased significantly. While this evaluation did not measure for sexual abuse perpetration, as there is a strong link between physical and sexual abuse perpetration, it is surmised that this program may be effective in reducing sexual abuse perpetration (Ybarra et al., 2016). Shorter-term interventions such as *Project Muse*, a Québec-based 75-minute workshop, have been effective in reducing faulty sexual assault attitudes and increasing awareness of resources, knowledge and recognition of sexual assault (Daigneault et al., 2015). *You the Man*, a 30-minute play that presents five fictional characters' perspectives on dating violence, has demonstrated impressive increases in knowledge of, responses to, seriousness of, and the importance of bystander intervention in dating violence (Plourde et al., 2016). Other approaches, such as *Mentors in Violence Prevention* aimed at engaging youth to act as agents of change in their communities, have been shown to be effective in increasing bystander intervention and bringing about positive attitudinal and behavioural change in relation to dating violence (Katz, Heisterkamp, & Fleming, 2011; Williams & Neville, 2017; also see Waitt Institute for Violence Prevention, 2017). For a thorough review of dating violence bystander intervention programs, see Storer, Casey, and Herrenkohl, 2016.

Parents, Childcare Workers, and Youth-Serving Organizations

While children and youth are important to target as a means of lowering their likelihood of being exposed to CSH, their parents play an equally important role. Not only does participation in CSH or other safety programs increase communication between parents and children (Binder & McNeil, 1987; Hébert et al., 2001; Kenny, 2010), but it is hypothesized that discussing CSH with one's child may increase the likelihood that a child discloses past or current sexual victimization to that parent (Mendelson & Letourneau, 2015; Wurtele & Kenny, 2010). Additionally, when parents are included in efforts to prevent CSH and have taken part in education programs, their children get repeated exposure to this information, allowing for rehearsal, further questions, and long-term maintenance of their own CSH prevention knowledge. From a safer environments perspective, involving parents in CSH prevention efforts makes sense: parents often act as 'gatekeepers' for who has access to their children. If parents are able to identify potential grooming behaviours (for example) they can successfully intervene before any further harm is caused. However, it is insufficient to presume that parents are already equipped with this knowledge and are able to utilize it. Studies have indicated that parents are misinformed about CSH, including their child's level of risk, their child's likelihood of reporting abuse, and their child's response to abuse (Shackel, 2008; Wurtele & Kenny, 2010). When parents do talk to their children about CSH, they often do not utilize a multimodal approach, which has demonstrated to be a particularly salient method (Wurtele, Moreno, & Kenny, 2008). However, this may be due to a lack of resources, not necessarily an unwillingness of parents to adopt a more multifaceted, engaging approach.

Many of the effective programs mentioned above have incorporated a parental component. Casper's (1999) *TOUCH Continuum* includes as its final phase a series of pamphlets for parents to help educate themselves and their children. As mentioned above, both the *Kids Learning About Safety* (Kenny, 2009) and *Parents as Teachers of Safety* (Kenny, 2009) include adult education groups, which cover the same material as the child groups, but in greater detail. Hébert, Lavoie, and Parent's (2002) *ESPACE* program, a two-hour after school workshop, significantly increased parents' knowledge of and responses to a variety of CSH-related topics. *Prevent It!* workshops also have recent empirical support in increasing parental CSA vigilance (Martin & Silverstone, 2016). For parents of older children, *Families for Safe Dates* provides caregivers with six interactive booklets (five of which are completed with their child) which have significant positive impacts on both parent and child knowledge, communication, and dating involvement (Foshee et al., 2012). Although not empirically tested, the Boy Scouts of America also offer an information packet on child abuse (available at www.scouting.org).

Given that a large majority of CSH cases involving preschool-aged children have familial perpetrators, childcare professionals are in a unique and important position of being the first person a child may disclose abuse to, or the first to discover and report it. As such, ensuring that all childcare professionals are properly trained in identifying and reporting suspected CSH is of extreme importance. In one of the few studies examining childcare workers' perceptions of mandatory child abuse reporting, Levi et al. (2015) reported that there was little consensus in determining what constitutes "reasonable suspicion," the threshold that stipulates whether professionals are required to report or not. Walsh and Farrell (2008) point to a lack of standardized childcare education for the inconsistent application of knowledge and practices across classrooms.

Ensuring that childcare workers are able to discuss child sexual harm (CSH) and bodily autonomy in a developmentally-appropriate way (particularly if they are to deliver the programs mentioned above) may help reduce the frequency or prevalence of CSH. One such program is *Stewards of Children*, a 2 ½ hour interactive workshop, delivered either in-person or online. Regardless of format, prior research has shown that at a 3-month follow-up, both groups saw significant increases in CSH knowledge, attitudes, and

preventative efforts (Rheingold et al., 2015). The fact that the web-based format was equally effective (participants in this group actually had higher initial knowledge scores than those in the in-person group) is encouraging, as this training modality may be easier to implement on a large-scale basis (e.g., mandating that all childcare professionals receive this training).

Lastly, youth-serving organizations (e.g., national organizations like the Boys & Girls Club and Scouts Canada, or local associations like sport- or faith-based youth-groups) are important bodies to include in CSH prevention. Like childcare professionals, staff and volunteers of youth-serving organizations spend a great deal of time with children and youth in positions of trust and authority. As such, they could recognize signs of child abuse both past and present, including staff and volunteer member's conduct that may be a flag for abuse. While *Stewards of Children* has not been tested on members of youth-serving organizations, it is likely that this and other education programs or components intended for parents would be useful in this context as well. For some youth-serving organizations, such as the Catholic church and Boy Scouts of America, such education is mandatory (Wurtele, 2012). In addition to properly training staff and volunteers, it is recommended that policies be put in place to limit children's risk of CSH while participating in the activities at youth-led organizations. Programs like Commit to Kids, developed by the Canadian Centre for Child Protection, have CSH prevention training packages and resources tailored to different child and youth serving groups from sports teams to after school programs to volunteer run organizations.

One of the foremost recommendations is the proper screening of all staff and volunteers. This should not only include a criminal background check, but also a reference check and an internet search of the applicant's name (Wurtele, 2012). This is not currently a common practice (Parent & Demers, 2011; Webster & Whitman, 2008). In addition to screening for previous behaviour, there are validated measures available to identify persons who may pose a higher risk of sexually abusing a child, such as the *Diana Screen* (Abel et al., 2012), the *Screening Scale for Pedophilic Interests* (Seto & Lalumiere, 2001), and the *Boundary Violations Vulnerability Index* (Celenza, 2007). Wurtele (2012) also lists 20 self-reflective questions that staff can ask themselves or potential staff/volunteer applicants. It is also strongly recommended that youth-serving organizations implement policies limiting one-on-one time between staff and children, ensure that all staff-child interactions are regularly monitored, that social media policies be put in place (such as forbidding electronic/social media contact between staff and youth), that a specific code of conduct be implemented, and that sexual boundary education be undertaken (potentially also by youth and parents) (Wurtele, 2012).

Victims

While many victims of child sexual abuse do not go on to commit sexual crimes (Lussier & Blokland, 2014), there is a disproportionate amount of convicted juvenile and adult sexual abusers of children who have histories of childhood sexual victimization (Jesperson, Lalumiere, & Seto, 2009). In a sample of Canadian offenders, Nunes et al. (2013) found a link between an offender's own CSH victimization and pedophilic interest as well as significantly younger victims. Subsequent analyses revealed that being victimized by a male was associated with greater pedophilic interest, while victimization by a female and/or a person with whom they shared a close relationship was associated with higher sexual recidivism. A Finnish twin study discovered that engaging in sexual acts (regardless of the context) with other children prior to the age of 12 years was associated with an increased likelihood of being sexually attracted to someone under the age of 16 years in adulthood (Santtila et al., 2010). These results were not related to genetic factors. Sexual victimization between the ages of 3 and 7 years has also been linked to the development of atypical sexual fantasies as well as sexual offending in general in a sample of 193 Juvenile Sex Offender (JSOs) (Grabell & Knight, 2009). Furthermore, Williams and McCarthy (2014) found that the odds of rape perpetration were 510% higher for those who had a history of sexual abuse compared to those with no history. Aebi et al. (2015) found similar results for sexual coercion, and others for sexual offending (DeLisi et al., 2014). Thus, an important

component of a CSH prevention strategy is to target child and youth victims of sexual abuse who, due to the profound trauma of CSA victimization, may be at greater risk to engage in criminal sexual activity and to perpetuate the cycle of CSA (Green et al., 2010; Levenson & Socia, 2016). Additionally, victims of CSA are also at increased risk to be victims of future sexual violence (Maniglio, 2009)

Determining how to reduce the likelihood that child sexual abuse victims will perpetuate future sexually criminal behaviour proves challenging to empirically test. Lambie et al. (2002) compared sexual abuse victims who later sexually offended with those who did not and discovered that the former group was more likely to report their personal abuse history as pleasurable and to have experienced less support from family and friends. While these are important distinctions, they should not be considered exhaustive.

It is understood that victims of CSH require considerable attention from knowledgeable professionals, in positions such as school guidance counselors, clinical psychologists, and social workers. While the nature and extent of their work with CSH victims may vary, ensuring that professionals are well-trained to work with victims is imperative (Kenny & Abreu, 2015). Specifically, all should be trained in reporting laws and procedures, assessing abuse, signs of abuse, understanding of victim-offender relationships, disclosure, the potential self-blaming of victims, and empirically-supported interventions. Regarding the latter, it appears that trauma-focused cognitive behavioural therapy (TFCBT), trauma-focused play therapy, emotion-focused therapy, and eye movement desensitization and reprocessing (EMDR) are the frontrunners for effective treatment (Cohen, Mannarino, & Deblinger, 2006; Kenny & Abreu, 2015). While the content of therapy will vary from client to client, addressing interpersonal and emotional competence, control beliefs, coping behaviours, the need for optimism, social attachment, external attribution of blame are some of the strongest markers of resilience, and should thus be addressed (Domhardt et al., 2015). Support from parents and others close in one's social circle is one of the strongest predictors of resilience (Cohen & Mannarino, 2000; Domhardt et al., 2015) and a protective factor against future sexual offending (Hunter & Figuerdo, 2000). Yet, as one study reported, parents were more likely to blame or doubt their child when they disclose that their CSA victimization was perpetrated by an adolescent compared to an adult (Walsh, Cross, & Jones, 2012). Thus, mental health professionals may also need to work with parents to ensure the child has a fully supportive environment, including specialized prevention programming for children and youth with cognitive, intellectual and physical disabilities.

Although professionals should work with parents to ensure the victimized child has sufficient support, it is important to remember that parents and families of the offending youth may need professional support for themselves. Research suggests that parents, caregivers, siblings and other relatives of youth who offended sexually can be impacted. For example, families struggle not only with their own emotions and mental well-being (e.g., stress, hopelessness, etc.), but also with responsibilities and challenges of attending to both the needs of the perpetrator and the needs of the victim (Gervais & Romano, 2019; Gervais & Romano, 2018; Romano & Gervais, 2018). This research suggests that support services are essential for families that may experience collateral consequences due to youth sexual offending within their family.

Responding to Child and Youth Victims

Another important approach to consider are Child Advocacy Centres (CACs), which have been developed based on the need to reduce stress on child/youth victims during sexual abuse investigations and increase the justice system's ability to successfully prosecute CSH cases. They are child-focused community-based programs that aim to address the lack of coordination between social services and the criminal justice system. CACs are aimed at preventing system-induced trauma by bringing professionals together into a multi-disciplinary team in a child-friendly location.

The first CAC was developed in Alabama in 1985. Today, more than 800 CACs are functioning in the United States and several also exist in Australia, Croatia, Cuba, Finland, Israel, Moldova, New Zealand, Norway, South Africa, Sweden, and the United Kingdom. The CAC model has been in development in Canada as well, with the first Canadian CAC opening its doors in Regina in 1997. Today, there are more than 20 CACs developed and operating in Canada, including one in New Brunswick. Where CACs are designed to meet the unique needs of an individual community, no two centres are alike; however, according to the National Children's Alliance, there are key elements of the CAC model:

- **multidisciplinary teams:** bring together all relevant agencies (e.g., law enforcement, mental health professionals, prosecution, etc.) into one team;
- **cultural competency and diversity:** provide culturally sensitive services to all clients;
- **forensic interviews:** conduct child-friendly interviews that avoid duplicative interviews;
- **victim support and advocacy:** victim advocates provide ongoing, comprehensive support to victims and non-offending caregivers;
- **medical evaluation:** examinations/treatment provided on-site or at an affiliated medical facility by staff members specifically trained to handle child sexual abuse;
- **mental health:** trauma-focused mental health services to victims and non-offending caregivers;
- **case review:** a formal process for information sharing;
- **case tracking:** a system for monitoring case progress and tracking outcomes;
- **organizational capacity:** a governing entity oversees business aspects, implements policies, seeks funding, hires staff, and promotes employee well-being, and plans; and
- **child-focused setting:** rooms are private, safe, and comfortable for all clients.

It is important to recognize that the various components of the CAC model (e.g., cognitive-behavioural therapy, multidisciplinary teams, etc.) each have their own body of evidence to support their use in practice. Herbert and Bromfield (2016) reviewed 27 studies that have evaluated the effectiveness of CACs as a whole. These authors found that the majority of the research focused primarily on process measures (i.e., the model is operating as intended); whereas, less research focused on outcomes of the model. The majority of the research that did examine model outcomes focused on criminal justice outcomes, with limited research on child and family outcomes. For example, a few studies (e.g., Joa & Edelson, 2004; Miller & Rubin, 2009; Smith et al., 2006) found increased number of arrests and prosecutions; however, no study was able to adequately demonstrate that participation in CACs result in less systemic trauma, one of the central assumptions of the model, in comparison to traditional practices. Overall, although the various components of the CAC model have research to support their use as best practice, Herbert and Bromfield (2016) argue that more rigorous evaluation of CAC outcomes, beyond standard service delivery, is required.

Finally, it is important to consider the role of social pediatrics in responding to child and youth victims. According to the Dr. Julien Foundation (2019), social pediatrics is a holistic approach to medical problems of children. This multidisciplinary model targets the child's needs while also focusing on the strengths of the child, extended family and surrounding community. Bringing together expertise from multiple professions (e.g., medical, legal and social sciences), social pediatrics aims to reduce or eliminate stress and risk factors that negatively impact the development and well-being of children, including rights of the child that are not respected. Specifically, social pediatrics focuses on resiliency, attachment, culture and identity. In practice, the model provides a continuum of services that include welcoming children, completing an assessment or course of action, and continuous care and support. As with CACs, additional evaluation is required to fully understand outcomes.

Summary: Key Considerations for Child and Youth Victims

- CSH prevention programs are linked with lower victimization.
- CSH prevention programs need to start at an early age (one-third of CSH victims are under the age of nine).
- CSH prevention programs need to be developmentally appropriate and content needs to be relevant to the audience, reflecting the diverse ways in which victimization occurs across ages (e.g., from familial abuse in early childhood to acquaintance/romantic partner abuse in adolescence/early adulthood and include in-person and online victimization).
- Optimal CSH prevention programs should be engaging and include a variety of formats, such as lectures, discussions, workshops, skill-building activities, and multimedia presentations.
- To maximize the effectiveness of CSH prevention programs, facilitators of CSH prevention programs (e.g., teachers) should be provided adequate training and resources so that they are able to deliver the content in a developmentally appropriate way.
- The belief that CSH prevention programs have adverse consequences on children, such as anxiety and hypersexuality, is not empirically supported.
- Thorough CSH prevention programs or initiatives should also involve the parents/care givers/childcare professionals.
- Where a large majority of CSH cases with preschool-aged children (0-5) involve familial perpetrators, childcare professionals can play an important role in identifying and reporting CSH.
- Youth-serving organizations (e.g., national organizations like the Boys & Girls Club and Scouts Canada, or local associations like sport- or faith-based youth-groups) can help reduce victimization by implementing CSH prevention policies and procedures.
- While many victims of CSH do not later offend sexually, CSH victimization is a significant risk factor for future CSH perpetration and thus, ensuring thorough, evidence-based treatment is available to victims of CSH is an integral component of a CSH reduction strategy.
- Child Advocacy Centres (CACs) and social pediatrics are promising practices for responding to child victims of CSH; however, additional evaluation is required to fully understand the outcomes of these approaches.

Child and Youth Perpetrators

Overview

As discussed above, youth charged with sexual crimes (hereinafter referred to as juvenile sex offenders, or JSOs) largely affect the province's CSH rate. High rates of youth charged with sexual crimes is not unique to New Brunswick; it is estimated that youth under the age of 18 are responsible for thirty to fifty percent of all sexual offenses (including sexual assault) against children (Finkelhor et al., 2009; Ryan, 2010; Zolondek et al., 2001). While juvenile sexual deviancy was once minimized as sexual experimentation (Reiss, 1960) in the 1980's, knowledge of the prevalence of juvenile sex offending combined with John DiIulio Jr.'s (1995) perpetuating of the juvenile "super-predator" in the 1990's led to a dramatic shift in the way JSOs were treated (Barbaree, Hudson, & Seto, 1993). Amid concerns that JSOs were tomorrow's adult sex offenders (ASOs), adult-like punitive policies were enacted, with inclusion on a national sex offender registry being one of the more recent manifestations in the United States (Adam Walsh Child Protection and Safety Act, 2006). These policies are based on the false assumption that JSOs are dangerous and pose a high-risk for reoffending and often have harmful consequences (Kilmer & Leon, 2017). Yet the sexual recidivism rate for JSOs is estimated at 5-10% (McCann & Lussier, 2008), which may be an overestimate, as more recent studies report an average sexual recidivism rate of 2.75%, possibly due to a greater availability of treatment programs (Caldwell, 2016).

Understanding JSOs

While the visceral reaction to the graphic nature of these offenses is understandable, when combined with retrospective data from adult sex offenders (ASOs) suggesting a strong link between juvenile sex offending and its continuity into adulthood, one may be led to support highly punitive measures toward JSOs. However, JSOs are unlikely to continue offending into adulthood. For many, their sexual offending is limited to a single instance (Lussier, 2017; Taylor, 2003). Moreover, juvenile sexual offenders are highly heterogeneous in terms of their own victimization histories, mental health problems, skill deficits, and criminal trajectories (Burton, Duty, & Leibowitz, 2011b; Fanniff & Kimonis, 2014; Leibowitz, Akakpo, & Burton, 2016; Mulder et al., 2012; Seto & Lalumiere, 2010). For instance, Lussier, van den Berg, Bijleveld, and Hendriks (2012) found that JSOs fell into two categories of offending trajectories: adolescence-limited offenders, whose sexual offending peaks around age 14 and drops considerably afterwards, and high-rate slow desisters, whose sexual offending peaks at age 12 and slowly tails off, eventually reaching the same rate of sexual offenses as the adolescence-limited group by their thirties. Ninety percent of JSOs fell into the adolescence-limited taxonomy, only 2% of whom sexually recidivated in adulthood, compared to 60% of the high-rate slow desister group. These characteristics are important considerations for policy development and therapeutic approach.

It is equally important to note that JSOs often have non-sexual criminal histories as well. Compared to juvenile non-sex offenders (JNSOs), studies differ in whether JSOs are identified as the more criminally active (Lussier & Blokland, 2014) or less criminally active (Seto & Lalumiere, 2010) group. In assessing criminal trajectories of JSOs, Cale, Smallbone, Rayment-McHugh, and Dowling (2016) identified four distinct offender groups: rare offenders, late bloomers, low-rate chronics, and high-rate chronics. Similarly, McCuish, Lussier, and Corrado (2016), using data on both JSOs and juvenile non-sex offenders (JNSOs), identified four similar criminal trajectory pathways and noted that the prevalence of JSOs and JNSOs in each category did not differ. Taken together, these studies have two key implications: first, they note both the distinction and similarity between JSOs and JNSOs, and second, they suggest that with proper assessment, it may be possible to identify potential JSOs from a JNSO population and to provide specialized treatment to prevent a sexual crime from happening in the first place. This is consistent with findings that the likelihood of committing a

sexual crime in adulthood is significantly higher for chronic JNSOs than JSOs (Zimring et al., 2009; Zimring, Piquero, & Jennings, 2007).

There are several considerations with respect to JSO behaviours that must be taken into account when working with, or developing programs and policies for, this population. As discussed above, JSOs often have an extensive victimization history. Not only in terms of the higher prevalence of sexual abuse, but in the increased frequency, severity, and the amount of force used in their victimization compared to JNSOs (who themselves generally have higher rates than juvenile non-offenders) (Burton, Miller, & Shill, 2002). A large number also report experiencing multiple forms of abuse, with one study indicating that 63% reported having experienced all five types of abuse in their lifetime: emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse (Leibowitz, Burton, & Howard, 2012; Marini et al., 2013). In addition to being victims of abuse, sexually abused JSOs also report a greater prevalence of witnessing criminality in general, as well as violence in the home and in the community (Burton, Duty, & Leibowitz, 2011a). Multiple relocations and homelessness have also been linked to juvenile sexual offending (Felizzi, 2015).

Attributable to the instability of their home life, JSOs report worse relationships with their parents and use of alcohol and/or drugs around the time of their offense (Jonsson et al., 2015; Marini et al., 2013). In addition, brain imaging research has identified deficits in regions involving cognitive control, working memory, and emotion-processing (Jones et al., 2017). Available research shows that JSOs also have a disproportionate amount of intellectual disabilities and behavioural disorders, with 51% of one sample having an intellectual disability and 22% having ADHD (Tidefors et al., 2011). A higher prevalence of autism spectrum disorders, lower IQ, and other neurological deficits have also been noted in JSO populations (Mulder et al., 2012). Elevated levels of depression, anger, anxiety, social isolation, disruptive behaviours, rape myth endorsement, psychopathy, and sexual arousal are also commonly present in JSO populations, as are decreased emotion regulation skills, social skills, number of romantic relationships, body satisfaction, and less openness concerning sexuality (Burton et al., 2011a; Cale et al., 2015; Huang, 2016; Jones et al., 2017; Mulder et al., 2012; O'Brien, Burton, & Li, 2016; Seto & Lalumiere, 2010; Tidefors et al., 2011). Barbaree and Langton (2006) identified five key factors in juvenile sex offending: family environments characterized by instability/lack of resources; failure to establish strong emotional bonds between the parent(s) and child; early exposure to sexual material and behaviour; an environment where the child is at high risk of being abused; and a lack of resources to cope with effects of CSH. The latter factor again emphasizes the importance of providing treatment and support to CSH victims and their families as part of a larger CSH prevention strategy.

Child, Peer, & Mixed Sexual Abusers

In an attempt to better understand JSOs, a growing body of literature has begun to differentiate them by their victims. JSOs are categorized into child, peer, and mixed (child and peer/adult) sexual abusers, depending on the age of their victim(s). This has helped to identify different histories, criminal trajectories, and treatment needs that are otherwise not uncovered when observing the group as a whole. It is critical that these distinctions, expanded upon below, are reflected in criminal justice policies and practices.

While the extensive sexual victimization histories of JSOs have been discussed above, there are still within-group differences. JSOs in the mixed offender category report more sexual abuse victimization (47.6%) than those in the child group (39.9%), both of whom had significantly higher rates than the peer group (18.2%) (Kemper, 2006). In a subsequent study, Drew (2013) replicated this finding, noting that mixed child and peer offender group members were 13.30, 8.94, and 5.10 times more likely, respectively, to have experienced sexual abuse compared to JNSOs. Mixed offender members also reported a greater number of atypical sexual fantasies, more extensive criminal histories, more intrusive sexual offenses, had a higher likelihood of being diagnosed with a psychosexual disorder and/or ADHD, and had a lower likelihood of

completing treatment (Kemper & Kistner, 2007; Leroux et al., 2016; Lilliard, 2015). Sexual recidivism rates have also been found to be higher for mixed offenders (16.7%, possibly due to the lesser likelihood of completing treatment), than child (2.5%) and peer offenders (2.0%) (Kemper, 2006). Members of the child offender group reported less exposure to images of child sexual abuse and a greater likelihood of being victimized by a family member, which has been linked to higher levels of emotional dysregulation, callousness/manipulativeness, and sexualization (Berman & Knight, 2015; Kemper, 2006). In comparison to peer abusers, child abusers report greater sexual victimization histories, social isolation, anxious attachment, exposure to adult pornography, and lower masculine adequacy (Miner et al., 2016; Seto & Lalumiere, 2010; Simons, Wurtele, & Durham, 2008; van der Put et al., 2013). Child abusers also have higher sexual compulsivity, lower sexual preoccupation, lower sex drive, and higher social isolation than their non-delinquent peers (Miner et al., 2016). Paradoxically, other studies have found that peer abusers have more sexual functioning problems (Lilliard, 2015). Additionally, while some studies indicate that peer offenders have the highest rates of non-sexual recidivism (Kemper, 2006), others have found no between-group differences (Kemper & Kistner, 2007; Parks & Bard, 2006). Results from a meta-analysis, however, conclude that peer offenders have higher rates of historical delinquency than child offenders (Seto & Lalumiere, 2010). They also have lower executive functioning scores than child offenders (although not lower than JNSO comparisons) and are more likely than both child and mixed offenders to have been under the influence of drugs or alcohol at the time of their offense (Leroux et al., 2016; Morais et al., 2016).

While there has been little research examining the continuity of adolescent dating violence (ADV) perpetration into domestic/intimate partner violence (D/IPV) in adulthood, there is some support for its progression. In a longitudinal analysis, Greenman and Matsuda (2016) identified a statistically significant link between ADV perpetration in young adulthood (ages 18-22) and D/IPV perpetration in later adulthood, indicating that ADV perpetrators are almost twice as likely to commit D/IPV than non-ADV perpetrators, providing further support for the notion of continuity of D/IPV across the lifespan (Schumacher & Leonard, 2005; Whitaker, Le, & Niolon, 2010). While outside the scope of this current report, if a large percentage of youths in New Brunswick are committing dating violence (which may help explain the high rates of youth charged with a sexual offense), which Sears and Byers' (2010) data concludes, and there is a link between ADV and D/IPV perpetration, as suggested above, this may provide for a better understanding of the high IPV rates in New Brunswick (the fourth-highest among provinces in Canada) (Statistics Canada, 2017).

Risk Assessment & Treatment

Similar to adult offenders, Risk-Need-Responsivity (RNR) (Andrews, Bonta, & Wormith, 2011) seems to be the dominant model in assessing and treating juvenile offenders. The principles of RNR are straightforward: the risk principle dictates that the level of treatment or intervention be matched to the assessed risk for recidivism; the need principle states that treatment should target criminogenic needs or dynamic risk factors that have been linked to recidivism; and the responsivity principle refers to the use of empirically-supported treatment, delivered in a fashion that best considers the individual needs of the client (which would include factoring in the presence of an intellectual disability). In other words, a low-risk client would receive less intervention than a high-risk client. But both interventions should target the relevant emotions, attitudes, and behaviours that contributed to the commission of the crime. Regardless of risk level, treatment must be tailored to the individual, although intervention with high-risk offenders may more strongly require different delivery methods (such as both individual and family therapy).

Challengers of the RNR model criticize the approach as being too rigid and too simplistic in understanding the numerous pathways that may lead a juvenile to sexually offend (Fortune, Ward, & Print, 2014). Although the above authors concede the importance in identifying risk factors for recidivism, they feel that it alone is insufficient and that therapists and clinicians should utilize a strength-based approach when

working with JSOs. Through this, they believe that offenders will have greater motivation to live a pro-social, offense-free lifestyle. One of the more accepted strength-based approaches is the Good Lives Model (GLM). This model emphasizes the environmental context in which the offender lives and the development of strategies to achieve primary goods, such as self-efficacy and positive family relationships, eroding the maladaptive pathways that were once in place to achieve them, which is what led the offender to offend in the first place (Print, 2013). Thus, the GLM is an approach-focused method, which has been linked to better homework compliance in treatment, while the RNR is an avoidance-focused method (Mann et al., 2004). However, Andrews et al. (2011) argue that the addition of GLM to RNR is redundant, and that adherence to RNR principles would include many of the components of GLM.

In terms of actual risk assessment tools, there are a variety available including the AIM2 (Print et al., 2007), Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) (Worling & Curwen, 2001), Juvenile Risk Assessment Scale (JRAS) (New Jersey Attorney General's Office, 2006), Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) (Prentky & Righthand, 2003), Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (J-SORRAT-II) (Epperson et al., 2006), Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA♪) (Miccio-Fonseca, 2006), Minnesota Sex Offender Screening Tool–Revised (MnSOST-R) (Epperson et al., 2004), Psychopathy Checklist–Youth Version (PCL:YV) (Forth, Kosson, & Hare, 2003), and the Static-99 (Hanson & Thornton, 1999). Some of these have been specifically developed or modified for working with juveniles (AIM2, ERASOR, JRAS, J-SOAP-II, J-SORRAT-II, MEGA♪, PCL: YV), while others have been developed for use with adult offenders but have been utilized in assessing the recidivism risk in juveniles (MnSOST-R, Static-99).

A comparison of the JRAS, J-SOAP-II, MnSOST-R, and Static-99 indicated that all four performed at an above-chance level in predicting sexual recidivism (in juvenility or adulthood). However, accuracy was lower for predicting juvenility-specific recidivism (Ralston & Epperson, 2013). A meta-analysis which included both adult (Static-99) and juvenile (ERASOR, J-SOAP-II, J-SORRAT-II) risk assessments found that all were predictive of sexual recidivism, supporting the applicability of adult risk assessments to juvenile sex offenders (Viljoen, Mordell, & Beneteau, 2012). Evidence also supported the ERASOR and J-SOAP-II in predicting general recidivism as well (the other assessment tools were not measured). However, other reviews have not supported the robustness of the J-SOAP-II, finding only its Impulsive/Antisocial Behavior subscale to have any acceptable reliability (Fanniff & Letourneau, 2012). While the ERASOR has generally received support (see above), it appears that it may have better predictive validity in assessing risk in JSOs without a history of non-sexual offending (Rajlic & Gretton, 2010). MEGA♪, although less rigorously tested, has demonstrated comparable sexual recidivism predictability to the more established measures above. However, it is stronger in predicting sexual recidivism in those under 12 (Miccio-Fonseca, 2009, 2010, 2013). Use of the PCL: YV has received less support, having no predictability in a study of 193 adolescents followed over a 7.9-year period (Viljoen et al., 2009). McCann and Lussier's (2008) meta-analysis did not find that psychopathy was related to sexual recidivism. Given the large number of JSOs with intellectual disabilities, as discussed above, it is important to discuss the relevance of these assessment tools in determining their risk level. As such, both AIM2 and MEGA♪ have been used with JSOs with intellectual disabilities and have noted comparable re-offense predictability to JSOs that are non-intellectually disabled (Griffin & Vettor, 2012; Miccio-Fonseca & Rasmussen, 2013). This suggests that clinicians may not need to use distinct assessment tools when working with JSOs with intellectual disabilities, although the authors of both studies did suggest revising cut-off scores or classification systems to best assess risk. Risk assessments for Indigenous JSOs is another area that warrants further research.

In addition to the use of the above risk assessments, there are a number of distinct factors that also contribute to sexual recidivism, including a history of sexual offenses, non-sexual offenses, hands-off offending (such as exposing oneself), offending against a child (as opposed to a peer), lack of school

attendance, lower levels of family interaction, use of threats or weapons, sexual deviancy, and antisociality (but not psychopathy, as mentioned above) (Christiansen & Vincent, 2013; McCann & Lussier, 2008; Thompson, 2012). Christiansen and Vincent (2013) found that a younger age at the time of offense was predictive of sexual recidivism, while McCann and Lussier (2008) found that older age at intake was predictive. Conflictual findings between the two studies may suggest a bimodal distribution, where younger and older JSOs are at a higher risk of reoffense than middle-aged youth. Additionally, it may also be the case that the differences were found due to the grouping of child, peer, and mixed JSOs.

Regarding therapeutic interventions, approaches with JSOs have largely mirrored those with ASOs, with Cognitive Behavioural Therapy (CBT) identified as the most common treatment approach in the U.S. (McGrath et al., 2010). Treatment targets include a reduction of deviant sexual interests, acceptance of responsibility for the offense, development of empathy for victims, development of social skills, increase in family connectedness/support, and control of sexual arousal. Generally, CBT is effective in reducing recidivism and is one of the most robust approaches to date (Walker et al., 2004). Complementary components to CBT have also been identified, such as Relapse Prevention (RP) and Social Skills Training (SST), although stand-alone CBT and CBT-RP are the more popular and effective methods (Ikomi et al., 2009). For instance, the Sexual Abuse: Family Education and Treatment (SAFE-T) program, which operates within a CBT-RP framework consisting of group, individual, and family therapies over a 12-month period, has demonstrated strong effects in preventing sexual recidivism (Worling, Littlejohn, & Bookalam, 2010). However, other CBT programs have less potency or offer no significant improvement over traditional services and less than 10% of programs subscribe to a "sexual trauma" primary approach, despite the prevalence and link with juvenile sexual offending (Dopp, Borduin, & Brown, 2015; McGrath et al., 2010).

Given that JSOs report worse relationships with their parents and the use of alcohol and/or drugs around the time of their sexual offence (Jonsson et al., 2015; Marini et al., 2013), interventions that target substance abuse and family relationships will likely have an indirect impact on sexual behaviour. Strengthening Families is a multicomponent family skills training program, based on a cognitive-behavioural social learning model, that targets high risk children between the ages of 3 to 16 years and their families. The program's goals are to improve behavioural health outcomes (e.g., substance abuse) through promoting protective factors (e.g., family resilience) and reducing risk factors (e.g., poor supervision/monitoring). When evaluated, research has found mixed results (Brook, MacDonald, & Yan, 2012; Gottfredson et al., 2006; Maguin et al., 2007).

To address some of the shortcomings of CBT, a growing number of researchers and therapists are utilizing Multisystemic Therapy (MST), which draws on Bronfenbrenner's (1979) social ecological model to contextualize problem behaviour in youth. Essentially, MST views human behaviour and development as products of series of complex interactions between an individual and the multiple systems in which they are embedded (e.g., family, school, community, society) and that the onset of problematic behaviours (such as sexual offending) cannot be explained simply by the individual alone (Henggeler & Borduin, 1990). This also means that treatment should not focus solely on the individual but also on elements within their environment that when altered can lead to a reduction of problematic behaviour or a promotion of prosocial behaviour. It is important to note that the holistic approach that MST takes is not an alternative to CBT, but rather an expansion of it. CBT, as well as parenting skills training and structural family therapy, are all typical components of MST, which acts as a guiding framework for therapy more so than a specific treatment. Typically occurring over a period of 4-6 months, MST has nine key principles (Henggeler et al., 2009): 1) recognizes the link between the identified problem(s) and the broader systemic context, 2) ensures approaches are positive and strength-focused, 3) promotes responsibility among family members, 4) employs treatment that is present-focused, action-oriented, and targeted towards specific, well-defined problems, 5) targets sequences of behaviour within and between multiple systems, 6) presumes treatment

should be developmentally appropriate, 7) considers continuous effort by family members is necessary, 8) presumes intervention efficacy should be evaluated through multiple perspectives, and 9) deems treatment should be designed to promote generalization and long-term maintenance of therapeutic change. Due to the emphasis on an individual's social ecology, many MST practices incorporate the therapist spending time in their communities. For instance, Griffith Youth Forensic Service (GYFS) in Australia, which operates on similar principles as MST, have therapists devote an average of 18.82 hours to the individual treatment of the youth, 6.34 hours to family therapy, and 19.17 hours to the consultation with community members and other professionals (Allard et al., 2016).

A thorough analysis on evaluations of MST shows that they consistently deliver promising results. For instance, in a sample of high-risk JSOs who received either MST or CBT, those in an MST program had lower sexual recidivism rates (8% vs. 46%), lower nonsexual recidivism rates (29% vs. 58%), had 70% fewer arrests overall, and spent 80% less time in detention facilities (Borduin, Schaeffer, & Heiblum, 2009). Similar results were found with a group of serious/violent juvenile offenders at 13.7-year follow-up (Schaeffer & Borduin, 2005). A considerable gap in the effectiveness of treatment with offenders has emerged between Indigenous and non- Indigenous JSOs, with one study finding that Indigenous youth were more likely to sexually reoffend (2.8x), violently reoffend (3.3x), and non-violently reoffend (3.2x) than non-Indigenous youth after sex offender treatment (Rojas & Gretton, 2007). However, an evaluation of GYFS (described above) found no difference in sexual reoffending between Indigenous and non-Indigenous JSOs, which holds promise for the saliency of the MST approach when used with Indigenous offenders (Allard et al., 2016). Gap reductions for both violent and non-violent recidivism were also noted, although not tested against Rojas and Gretton's (2007) findings. Decreases in antisocial behaviour, deviant sexual interests, risky behaviours, delinquency, substance use, externalizing symptoms, delinquent peer affiliation, and out-of-home placements as well as improved mental health have also been associated with MST over follow-up periods of up to 20 years (Henggeler et al., 2009; Henggeler et al., 1997; Letourneau et al., 2009; Letourneau et al., 2013; Porter & Nuntavisit, 2016; Sheidow, McCart, & Davis, 2016). The robustness of these findings may be due to the effectiveness of family therapy in particular, which often incorporates problem solving, communication skills, and restructuring/uniting families (Dopp et al., 2017; Henggeler et al., 2009; Keiley et al., 2015; Yoder et al., 2015; Yoder & Ruch, 2016). Engaging school representatives in treatment and planning is also important, tripling the likelihood a JSO completes treatment (Yoder et al., 2016).

While such a holistic and multifaceted approach may appear to be strenuous to government and agency budgets, multiple cost-benefit analyses have been done. For instance, one analysis comparing an MST program to an individual therapy program for serious juvenile offenders found MST-related reductions in costs ranging between $75,110-119,374 USD (2008; approximately $115,000-183,000 CAD in 2018) per offender, or a return of $9.51-23.59 USD ($14.55-36.08 CAD) for every dollar spent on MST (Klietz, Borduin, & Schaeffer, 2010). JSO-specific analysis estimates the savings to be even higher; over an 8.9-year period, taxpayers can expect to save $343,455 USD (2013; approximately $485,000 CAD in 2018) per JSO, or a return of $48.81 USD ($69.00 CAD) for every dollar invested in MST (Borduin & Dopp, 2015). Impressively, these results do not take into account the subsequent reduction in criminality of family members of MST, which was reduced by a significant margin – 94% fewer felonies and 70% fewer misdemeanors – compared to parents whose children (juvenile offenders) were in individual therapy (Johnides et al., 2017). A recent 25-year follow-up also noted the positive effects of MST on the siblings of JSOs. Compared to siblings of JSOs who received individual therapy, MST siblings had lower arrest rates (43.3% vs. 72.0%), while individual therapy siblings were roughly three times as likely to be convicted of a felony offense and twice as likely to be sentenced to incarceration (Wagner et al., 2014). Of note, many treatments include a sexual education component, which supports the notion that CSA prevention programs can also lower the prevalence of sexual abuse by targeting would-be offenders (Criminal Justice Joint Inspection, 2013; Grimshaw, 2008; O'Donohue, 2014).

When treating sexual offenders, it is imperative to factor in cultural heritage. When working with an Indigenous offender, for instance, one should ensure that the course, content, format, and goals of treatment are all respectful to Indigenous culture. The amount of time spent consulting with community members (see GYFS above) may account for the increased efficacy of MST in treating Indigenous offenders; however, more research is still needed in this area. Additionally, given the large amount of JSOs with an intellectual disability, many aspects (such as the duration of treatment) may need to be altered to ensure maximum treatment benefits, in adherence to RNR's responsivity principle (Andrews et al., 2011). While this too is an area in need of future research, Waltrip (2014) has published a helpful manual outlining both the assessment and treatment implications that an intellectual disability may have on JSO treatment.

Early Identification

So far, this section has focused on the treatment of juveniles who have been charged with a sexual offense. However, it is possible to identify early behavioural, attitudinal, and situational factors that may contribute to one's risk of offending (Levine & Dandamudi, 2016; Vizard, 2007). For instance, Zolondek and colleagues (2011) suggest that atypical sexual behaviours precede the onset of sexual offending, while a joint commission in England and Wales identified the large number of missed opportunities for early intervention with juveniles who eventually sexually offended (Criminal Justice Joint Inspection, 2013). Thus, identification of risk factors for juvenile sex offending and proper mediation is an integral component to reducing the rate of CSH. One of the most robust predictors of future sexual offending is bullying perpetration, which also predicts violence within dating relationships (Carpentier, Leclerc, & Proulx, 2011; Ellis & Wolfe, 2015). This association has been found to be stronger for youth with stronger rape myth endorsement, which has implications for both treatment and inclusion in CSA prevention curriculum (Reyes & Foshee, 2013). Homophobic name-calling has also been implicated in multiple studies as a precursor to sexual violence perpetration, while endorsement of traditional gender role attitudes has been linked to general dating violence (Espelage et al., 2016 Miller et al., 2013; Reyes et al., 2016).

As discussed in the *Victim* section, both experiencing and witnessing sexual violence or coercion are risk factors for committing a sexual offense, with one study finding that the experience of sexual coercion tripled the likelihood of sexual coercion perpetration (Aebi et al., 2015; Cale & Lussier, 2017; Seto et al., 2010). Additionally, chronic JNSOs pose the greatest risk of sexually reoffending (Zimring et al., 2007; 2009). While it cannot be overemphasized that the presence of these risk factors does not guarantee that a child will go on to sexually offend, these are important considerations in developing a thorough strategy to reduce the prevalence of CSH.

Summary: Key Considerations for Child and Youth Perpetrators

- Juvenile sex offenders (JSOs) often have extensive victimization backgrounds.
- JSOs are distinct from their adult counterparts.
- JSOs have both similarities with other juvenile offenders (e.g., criminal pathways) as well as some differences (e.g., JSOs have a higher prevalence of being victims of sexual abuse).
- Juvenile sex offending peaks between the ages of 12 and 14.
- JSOs do not solely commit sexual crimes – many have a history of non-sexual crimes.
- JSOs are unlikely to continue offending into adulthood. For many, their sexual offending is limited to a single instance.
- While only a small number of youth with intellectual disabilities sexually offend, they are often overrepresented in this offender group.
- There is preliminary support that dating violence (including sexual) perpetration in early adulthood is associated with a two-fold risk of perpetrating dating violence in older adulthood. This may provide for a better understanding of the high IPV rates in New Brunswick.
- There are a multitude of assessment tools available for use with JSOs, with some emerging as better for certain uses.
- Cognitive-Behavioural Therapy (CBT) is the most common treatment for JSOs.
- Multisystemic Therapy (MST) is the most effective treatment approach, including with Indigenous JSOs.
- Cost-benefit analyses of MST for JSOs reveal significant savings, upwards of $343,455 per offender.
- Treatment of cognitively impaired JSOs warrants further attention in developing a thorough strategy to reduce the prevalence of CSH.

Adult Sexual Abusers of Children

Overview

While the rate of youths charged with a sexual offense against a child is roughly 2.5 times greater than the rate of adults, adult sexual abusers of children (hereafter SACs) compose the largest group of child sexual abusers in New Brunswick. Between 2011 and 2015, not including sexual assault, 202 adults were charged with a sexual offense against a child compared to 41 youth (Statistics Canada, 2019a). This also puts the rate of adults charged with a sexual offense against a child above both the Atlantic Canadian and national average (6.528 per 100,000, compared to 5.107 and 4.164, respectively). Recently released 2016 crime-report data indicates that this trend is continuing, with a sharp increase in the rate of adults charged across the province (14.3 per 100,000) and the country (9.86 per 100,000). Further investigation is warranted to determine to what to attribute the sudden escalation of CSH rates. Regardless of whether this is due to an actual increase in CSH, better reporting practices, or a decrease in other Criminal Code convictions (sexual

assault level 1 did see a decline), the identified increased SAC population amplifies the need for providing effective, evidence-based interventions, which will be the focus of this section.

Understanding Adult Sexual Abusers of Children

Perhaps one of the most misleading assumptions about SACs (often called "child molesters") is that all are pedophilic—having a sexual attraction to prepubescent children. This myth likely stems from the frequent interchanging of the terms, particularly in the media. This may also contribute to the misconception that all pedophiles are dangerous sexual offenders, as discussed above. Understanding that there exists both overlap and distinction between the two is imperative for both policy and treatment. For instance, while both groups have demonstrated weaknesses in inhibition compared to non-sexual offenders (NSOs), there were differences between pedophilic and non-pedophilic offenders (Eastvold et al., 2011). Exploration of these differences identified that among pedophilic SACs, poorer inhibition scores were due to slower processing speed, while their non-pedophilic counterparts' poor scores were due to generally poor inhibition. Pedophilic child molesters also demonstrate fewer deficits in executive functioning compared to non-pedophilic child molesters, who exhibit more severe dysfunctions in cognitive flexibility and verbal memory (Schiffer & Vonlaufen, 2010). The former group has also demonstrated greater planning skills than their non-pedophilic counterparts (Eastvold et al., 2011). Additional cognitive impairments have been noted in non-pedophilic child sexual abusers relative to both pedophilic child sexual abusers and non-sex abusers, although some results were mixed (Massau et al., 2017).

Like their juvenile counterparts, SACs have extensive victimization histories of their own. In one sample, 75% of convicted abusers reported a history of CSA (Abbiati et al., 2014). SACs disclose greater CSA victimization than both rapists and non-sex offenders (NSOs) (Jespersen, Lalumiere, & Seto, 2009; Simons et al., 2008). Greater incidence of early exposure to pornography (prior to age 10) and early onset of masturbation (prior to age 11) have also been noted, illustrating a very sexualized childhood for many SACs (Simons et al., 2008). Insecure parental attachment, specifically anxious attachment, has been found in multiple samples of SACs (Simons et al., 2008; Stirpe & Stermac, 2003; Wood & Riggs, 2008). Qualitative analysis on the childhoods of SACs also identified themes of sexual and other types of abuse, such as neglect/abandonment, verbal abuse, and physical abuse (Garrett, 2010a; 2010b; Thomas et al., 2012). Additionally, themes of frequent moving/instability, isolation, fights with peers, modeling their parents' maladaptive behaviours, inability to recall positive childhood events, and love being conflated with sex were also identified. A longing for what was missed in childhood was communicated to researchers as well. However, examining how SACs appraise their own CSA event(s), cope with it, and handle their emotions revealed heterogeneity among the group (Abbiati et al., 2014). Despite the different ways SACs respond to their own victimization, increased social anxiety, externalizing behaviours, internalizing behaviours, social skills deficits, use of emotion-oriented coping (e.g., wishful thinking, blaming), sexual problems, deviant sexual coping, problematic attitudes and beliefs, and endorsement of maladaptive schemas related to abandonment, shame, isolation, subjugation, and self-sacrifice have also been found to characterize SACs (Chakhssi, de Ruiter, & Bernstein, 2013; Feelgood, Cortoni, & Thompson, 2005; Nunes, McPhail, & Babchishin, 2012; Whitaker et al., 2008). A review of the criminal histories of Australian SACs uncovered that although many began their sexual offending in their 30's, over half had committed a non-sexual crime prior to their CSA offense (Smallbone & Wortley, 2004). While many were criminally versatile, the authors also noted that the SAC sample varied considerably in their persistence of both sexual and non-sexual offending.

Differentiating Adult Sexual Abusers of Children

In response to the variance noted by Smallbone and Wortley (2004), a number of researchers have broken down the SACs into various subcategories to gain a better understanding of such a broad group of offenders. Often, these subcategories are categorized by sexual interests (pedophilic vs. non-pedophilic, as described above), victim characteristics (e.g., the victim-offender relationship), the type of offense (e.g., contact vs. non-contact), the medium via which the offense occurred (e.g., the internet), and the offender's criminal history. For instance, a meta-analysis comparing intrafamilial and extrafamilial offenders concluded that the former scored significantly lower on measures of antisocial tendencies, atypical sexual interests, offense-supportive attitudes, and interpersonal deficits (Seto et al., 2015). Although higher levels of emotional congruence with children has been linked to greater social rejection, impulsive acts, preoccupation with sex, using sex as a coping mechanism, deviant sexual interests, and greater endorsement of child molester attitudes, intrafamilial offenders have lower levels of emotional congruence with children (McPhail, Hermann, & Fernandez, 2014; Seto et al., 2015). This coincides with Miner and Dwyer's (1997) assertion that intrafamilial offenders have higher levels of psychosocial development, yet are also more likely to have been victims of sexual abuse, neglect, and to have poor parent-child relationships (Seto et al., 2015). No differences in psychopathology were found between groups.

Three decades ago, Groth, Hobson, and Gary (1982) dichotomized SACs into motivation-based categories: fixated and regressed. The fixated offender is identified by their persistent, compulsive sexual attraction to children, their use of grooming techniques, their purposeful selection of vulnerable extrafamilial victims and premeditation of crimes, and the early onset of their criminal sexual behaviour. The regressed offender is one who, under environmental stressors which undermine their self-esteem and confidence, sexually abuses a child to whom they have easy access (thus, primarily intrafamilial). Unlike the fixated offender, the regressed offender is not characterized by a strong attraction to children. Rather, their offense is a departure from their attraction to adults and the child victim is used to satisfy needs that are not purely sexual in nature. Groth and colleagues (1982) identified the fixated offender to be at a much greater risk of sexual recidivism and the regressed offender as much more responsive to treatment.

Lanning (1992), in creating the FBI typologies of child molesters, expanded upon this idea of preferential (fixated) and situational (regressed) SACs, dividing each into subcategories. Thus, preferential offenders may be: 1) seductive – courting children, providing them with affection, gifts, and enticements with the idea of establishing and maintaining a relationship; 2) fixated – having poor psychosexual development, desiring mutual affection from children, and; 3) sadistic – aggressive, deriving sexual arousal from violence, often targeting stranger victims. Meanwhile, situational offenders fall under one of four subcategories: 1) regressed – having poor coping skills, targeting easily accessible victims, using children as substitutes for adult relationships; 2) morally indiscriminate – using whoever is available (children or adults) to fulfill sexual and other interests or needs; 3) sexually indiscriminate – motivated more by sexual experimentation, will abuse children out of boredom, and; 4) inadequate – socially isolated individuals who are insecure, lack self-esteem, and see sexual acts and/or relationships with children as their only available sexual outlet. This was later revised into a series of continuums which assess multiple offender characteristics and motivations, applying to sex offenders more generally instead of exclusively SACs (Lanning, 2010).

Alternatively, Knight and Prentky (1990) typified offenders on two axes: Axis I assessing the degree of fixation and level of social competence and Axis II assessing the amount of contact, the meaning of contact, extent of physical injury suffered (by the victim), and the offender's level of sadism. Within this classification system, SACs receive independent Axis I and Axis II typologies, which are expanded upon in Prentky, Knight, and Lee (1997). While each of the three hypothesized classification systems offer some unique insights, what is important to note is that all acknowledge that there exist situational offenders – those who are not

necessarily pedophilic, predatory, or at a high-risk of reoffending, misconceptions that are often perpetuated by the media.

Wortley and Smallbone (2014) identified four classes of SACs based on their criminal histories. In their sample of 177 offenders, 41.0% had at least one prior conviction for a non-sexual crime (limited/versatile), 36.4% had no previous convictions of any kind (limited/specialized), 17.8% had prior convictions for both sexual and non-sexual crimes (persistent/versatile), and 4.8% had at least one prior conviction for a sexual crime (persistent/specialized). Further analysis of the group members yielded meaningful differences. For instance, the limited/specialized group experienced the least amount of sexual abuse as a child, most frequently committed an intrafamilial offense, had few victims, but tended to abuse them over an extended period of time. Generally not pedophilic, at least exclusively, victims tended to be those to whom they had easy access. According to the authors, this category reflected a parent or authority figure who abused their position of trust to sexually abuse the child.

The limited/versatile offender shares many characteristics with the limited/specialized group, except for earlier contact with the criminal justice system and having less sexual contact with their victims, abuse which also takes place over a shorter period of time. Essentially, members of this group are opportunists, more sexually ambivalent than sexually deviant. Persistent/versatile offenders, on the other hand, report a higher prevalence of sexual abuse as a child, have more victims, and begin sexually offending against children at an early age. They are also more likely to commit extra-familial abuse and more likely to target male victims, abusing them infrequently over a short period of time. Improving prevention of CSH by serial offenders has more to do with treatment than with reducing access to children. In contrast, reducing access would be a more effective approach with the former groups. Lastly, the persistent/specialized group was characterized by high rates of sexual victimization as a child (90% reporting a history of CSH, compared to 43.5% of limited/specialized offenders), earlier sexual contact with children, extra-familial abuse, targeting male victims (coinciding with a non-heterosexual orientation), having a larger number of victims, and having frequent contact with them over a longer period of time. This group seems to be most interested in establishing a relationship with the victim and the offender is in need of the most treatment. In comparing detected SACs to undetected SACs, researchers uncovered both similarities and differences, notably that undetected SACs reported less CSA victimization, used less emotion-oriented coping, had a higher degree of education, and were more likely to be employed than those who were detected (Neutze et al., 2012). No differences were found on measures of offense-supportive cognitions, coping self-efficacy, loneliness, or hostility toward women.

Using 2009 police data, Wolak and Finkelhor (2013) categorized SACs who used the internet to commit a sexual offense against a child into two groups: 1) those who knew the child in-person as well as online (e.g., family members or acquaintances) and 2) those who only knew the child online (e.g., strangers). Comparison of offender characteristics between both groups revealed similarities in age, employment status, marital status, mental health variables, prior CSH offenses, and possession of images of child sexual abuse (commonly called child pornography). However, online-only offenders were more likely to belong to a racial minority group (32% vs. 13%), while the 'know-in-person' group was more likely to include female offenders (5% vs. 1%), to have known prior violent behaviour (15% vs. 4%), to have alcohol or substance use problems (29% vs. 11%), and to have a history of nonsexual offenses (44% vs. 19%). Aside from the latter group being less likely to use both the internet and cell phone in their offenses (primarily using only a cell phone), the groups were remarkably similar in their victim and crime characteristics.

Analysis of online chat logs between prospective SACs and undercover police officers identified four types of online offender: cybersex-only, cyber-sex/schedulers, schedulers, and buyers (DeHart et al., 2017). Cybersex-only SACs were characterized as predominantly white (98%) and exposing themselves at a

significantly higher rate (75%). Forty-two percent of this group also asked the "child" (i.e., the undercover police officer) for explicit photos and often chatted to them for months (although 29% terminated interaction within 24 hours), asking about sexual features and coaching the "child's" masturbation.

Cybersex/schedulers were also predominantly white (92%), exposed themselves at a higher rate than schedulers and buyers, and had the highest interest in child-specific or incest themes. Like cybersex-only offenders, they often chatted with their victims for months (only 13% terminated contact within 24 hours), but also made concrete plans to meet the "child." Yet they were also the most likely to cancel or not show up to these scheduled meetings. Schedulers, on the other hand, were the least likely group to expose themselves, to request explicit photos, and to display interest in child-specific or incest themes. Unlike cybersex/schedulers, their interactions were often brief (43% terminating contact within 24 hours), instead searching for quick "hook-ups" of an opportunistic nature. Similar to schedulers, buyers are more racially diverse and expose themselves at a lesser rate. Although roughly one-third request an explicit photo, this is often done in the context of assuring the authenticity of the young person with whom they are online chatting. For the most part, this group is focused on scheduling the sexual services of a child and quickly negotiating the terms of the exchange, following through 96% of the time.

Examination of police reports of online SACs also identified four typologies of offenders, which share some overlap to the four categories above: 1) the cynical, 2) the expert, 3) the affection-focused, and 4) the sex-focused (Tener, Wolak, & Finkelhor, 2015). The cynical group comprised 34.6% of cases, usually offending against one or a small number of victims to whom they had easy access. They tended to have specific preferences in their ideal victims, used some grooming techniques to improve compliance, and demonstrated an awareness that they were committing a sexual crime. They did not get emotionally attached to the victim, although they may exhibit some affection in an effort to win the trust of the victim. This group was mixed in whether or not they presented their true identities online (offenders often know the victims) and are considered to be "novice experts." As the name suggests, experts (32% of cases) demonstrate many of the characteristics of cynics, but spend much more time grooming their victim(s) with much more sophistication and often do not know their victims beforehand. Affection-focused (21.3%) offenders differ considerably from the former two groups, exposing their true identities and genuine feelings of affection toward the victim with the intent of pursuing a romantic relationship. Use of manipulative tactics and grooming was absent in this group, as was possession of images of child sexual abuse. Some members of this group were older teenagers, unaware of the illegality of their intentions, seeing them as legitimate and moral. The last group, sex-focused (12%) were looking for quick sexual encounters, ambivalent toward the age of the victim. As the name suggests, their primary motivation was to quickly fulfill sexual goals and needs and thus did not use grooming techniques.

As a whole, online sexual offenders are better educated than contact offenders and often have different demographic backgrounds and motivations than those who access images of child sexual harm. Additionally, they tend to have lower levels of sexual preoccupation, deviant sexual preference, demonstrate a lower capacity for relationship stability, and have less severe criminogenic factors (Briggs, Simon, & Simonsen, 2011; Navarro & Jasinski, 2015; Seto et al., 2012).

Risk Assessment & Treatment

Similar to JSOs, the Risk-Need-Responsivity (RNR) model exhibits a high popularity across sex offender treatment programs (Andrews et al., 2011). Overall, the literature is supportive of this framework; results of a meta-analysis of 23 outcome studies on sex offender treatment programs indicated that those that adhered to the RNR principles had the lowest recidivism rates (Hanson et al., 2009b). Various studies

and commentaries have also supported the applicability of RNR's three components with sex offenders (Kraemer et al., 1997; Lovins, Lowenkamp, & Latessa, 2009; Seto, 2008). However, Hanson, Bourgon, Helmus, and Hodgson (2009a) highlight the importance of assuring that the needs component is adhered to in treatment, as many treatment program targets have not been found to predict recidivism. Seto (2008) also calls for increased attention to the responsivity principle. It is possible that a lack of fidelity to the RNR principles has led to the criticism that it is too rigid, too avoidance-focused, which spurred the creation of the GLM described above (Print, 2013). Understood as a fundamentally empowering approach, the GLM inspires offenders to use adaptive, prosocial strategies to achieve the "goods" in their lives. This approach has been endorsed by previously incarcerated SACs (Dervley et al., 2017). While some argue that the two approaches are counterintuitive, others call for incorporating the GLM into the more traditional relapse-prevention models given that it is more strength-based (Abracen et al., 2011; Andrews et al., 2011). Proponents of RNR claim that this is redundant and that many GLM principles are already embodied within the RNR model (Andrews et al., 2011).

While there are a large number of risk assessment tools used on adult offenders, only a select few have been evaluated using a SAC sample, such as the MOLEST, Psychopathy Checklist-Revised (PCL-R) (Hare, 2003), the Rapid Risk Assessment of Sex Offender Recidivism (RRASOR) (Hanson, 1997), the Screening Scale for Pedophilic Interests (SSPI) (Seto et al., 2004), the Sexual Offender Risk Appraisal Guide (SORAG) (Quinsey et al., 2006), the Sexual Violence Risk-20 (SVR-20) (Boer et al., 1997), the Stable-2007 (Eher et al., 2012), the Static-99 (Hanson & Thornton, 1999), and the Violence Risk Scale: Sexual Offender Version (VRS:SO) (Olver et al., 2007). Unfortunately, evaluations of these tools give mixed support at best. For instance, the ability of the PCL-R to predict sexual recidivism among SACs has been found to be weak or less accurate than other measures, although it appears to have better predictive accuracy among intrafamilial SACs or those with low intelligence (Beggs & Grace, 2010; Eher et al., 2015; Kingston et al., 2008; Olver & Wong, 2006; Turner et al., 2016). The SSPI has also received mixed support in its predictive accuracy (Eher et al., 2015; Moulden et al., 2009; Nunes et al., 2013) and in its reliability (Mokros et al., 2012).

In a comparison of the Static-99, SORAG, SVR-20, and PCL-R, Turner and colleagues (2016) found that Static-99 was the best predictive instrument for sexual recidivism among SACs in general, as well as for SACs who worked with children, and extrafamilial SACs. An evaluation of the RRASOR with 130 SACs found that it—but not a DSM diagnosis of pedophilia or phallometric testing—significantly predicted sexual recidivism (Wilson et al., 2011). Lastly, the VRS:SO has received strong support in both its static and dynamic measures (Beggs & Grace, 2010). Additionally, the VRS:SO predicted sexual recidivism significantly better than the Stable-2007, the combined Static-99/Stable-2007 score, and the PCL-R (Eher et al., 2015).

As evidenced above, use of a formal diagnosis of pedophilia to predict sexual recidivism is not widely supported. However, Eher and colleagues (2015) found that a diagnosis of exclusive pedophilia significantly predicted sexual recidivism. Factor analysis of a large psychometric battery identified four dimensions, specifically social inadequacy, sexual interests, anger/hostility, and pro-offending attitudes as significantly correlated with sexual recidivism and substantially adding to the predictive validity of the Static-99, suggesting the utility of combining its use with traditional risk assessment measures (Allan et al., 2007). While the VRS:SO appears to have emerged as the dominant risk assessment tool, it should be noted that aside from one study (of which the VRS:SO wasn't included), evaluations of the predictive accuracy of these have not differentiated between the different categories of SACs described above. In this area, more research is needed.

While there was once great deliberation over whether SACs could effectively be treated, a debate still being waged in the public sphere, numerous studies have been published which demonstrate the potency of sex offender treatment (Mancini & Budd, 2016). A meta-analysis which included 2,119 SACs found

that recidivism rates were lower among treated offenders than untreated ones, although findings were mixed (Walton & Chou, 2015). This may be due to the difference between "completing treatment" (e.g., attending all sessions) and "successfully completing treatment" (e.g., completing treatment goals). For instance, an evaluation of a Cognitive-Behavioural Therapy Relapse Prevention (CBT-RP) program found no significant differences in sexual or violent recidivism at an 8-year follow-up between those in the program and those who were left untreated (Marques et al., 2005). However, upon further inspection, differences in recidivism were found between those who completed treatment goals and those who did not, highlighting the importance of differentiating the two terms above, which are often used interchangeably within the field. Another reason for some meta-analyses finding mixed results may be due to a contagion effect of older treatment approaches, which Hanson and colleagues (2002) noted in their meta-analysis. Specifically, modern treatments (13 CBT and 2 systemic therapies in this sample) were found to be effective in reducing both sexual and general recidivism, while those operating prior to 1980 had little effect on either rate.

When working with Indigenous offenders, however, CBT may not be as salient, at least as a stand-alone method. In an evaluation of New Zealand's Te Piriti program for Maori (Indigenous) offenders, which incorporates traditional values and customs of the Maori people into a CBT-based therapeutic/recovery process, results demonstrated significant reductions in sexual recidivism compared to untreated controls (Nathan, Wilson, & Hillman, 2003). Furthermore, Maori men who completed the Te Piriti program had a lower sexual recidivism rate (5.47%) than those who were in the Kia Marama program (13.58%), which operates as a traditional CBT program. Thus, despite both programs having the same modules (group norm building, offending patterns, sexual reconditioning, victim empathy, relationship skills, sexuality education, mood management, and relapse prevention), the incorporation of Maori culture (which adheres to the responsivity component of RNR) has a profound effect on the reduction of recidivism. This also demonstrates the wide applicability of CBT approaches, which has led to its emergence as the most popular treatment approach among North American practitioners (McGrath et al., 2010). Correctional Service of Canada has provided similar evidence-based programming that adheres to the RNR model, including involvement of Indigenous Elders in program design and delivery. Although not specific to sexual offending, a meta-analytic review found that the odds of not offending were approximately one and a half times greater for Indigenous offenders who participated in CBT-based programming in comparison to non-Indigenous offenders who did not participate in programming (Usher & Stewart, 2014). However, some argue that CBT may not be optimal as it is not designed to facilitate trauma recovery, which many offenders desire and may help lower recidivism (Thomas et al., 2012).

Another area of contention, still prevalent in academic circles, relates to the continuity of pedophilic sexual interest, or more specifically, whether it can be altered. In his summary on pedophilia, Seto (2009) cites the lack of evidence for the malleability of pedophilia, which is why interventions target voluntary control over sexual desires/arousal and self-management skills. Tozdan and Briken (2015a) believe that through self-efficacy, pedophilic sexual interest can be changed. The later the onset of pedophilia, they argue based on emerging research on non-offending pedophiles, the more amenable it is to treatment (Tozdan & Briken, 2015b). The pliability of pedophilia also has some support among the offending population as well; research on a group of Canadian offenders between 1983 and 2011 who were diagnosed with pedophilia indicated that half of the men demonstrated significant decreases in pedophilic sexual arousal while also increasing their nonpedophilic sexual arousal (as measured by penile plethysmography) after attending Ottawa's Sexual Behaviours Clinic (Muller et al., 2014).

In addition to interventions provided within correctional settings, there are also a number of means of reducing recidivism that take place at the community level. Many SACs fear their release from prison and struggle to adjust to society, which they link to poor reintegration planning (Russell, Seymour, & Lambie, 2013). Interviews with previously incarcerated SACs reveal that many reintegration plans were too simplistic,

primarily focusing on managing risk factors than promoting successful reintegration. Overall, their feedback fell into six themes: 1) fear of community members' reactions, 2) need to have prearranged accommodations, 3) importance of finding employment, 4) desire for social support within the community, 5) necessity of probation officers to get to know them, and 6) hope for a new way of life. Recognizing the obligation to address the diverse needs of SACs to better support successful community reintegration, La Fond and Winick (2004) called for special sexual offender reentry courts, based on the effectiveness of this model with other groups of offenders (e.g., Hiller et al., 2002). Some jurisdictions have heeded this advice, aiming to promote collaboration across government sectors (see Budd, Burbrink, & Connor, 2016, for a review). Evaluations of these are promising (e.g., Grant, 2010), but more research is warranted. In an effort to address some of the shortcomings of reintegration planning, the Mennonite Central Committee of Ontario (MCCO) launched a pilot project called Circles of Support and Accountability (CoSA), which sets up each released offender with a team of four to six community volunteers who help promote reintegration within the community setting. In addition to receiving the appropriate training, Circle volunteers also have contact with an advisory committee comprised of professionals in corrections, law enforcement, and clinical services. Evaluations of CoSA's impact on recidivism are startling: sexual offenders who participated in CoSA had an 83% reduction in sexual recidivism, 73% reduction in violent recidivism, and a 71% reduction in general recidivism compared to released SACs without the support group (Wilson, Cortoni, & McWhinnie, 2009). An earlier evaluation on high-risk released offenders found reductions of 70%, 57%, and 35% for sexual, violent, and general recidivism, respectively (Wilson, Picheca, & Prinzo, 2007b). CoSA participation has also led to improvements in reflective skills, openness, problem-solving skills, social skills, agency, self-regulation, emotion regulation, internal locus of control, and improvement trends in coping skills and self-esteem (Hoing, Vogelvang, & Bogaerts, 2017). Additionally, the presence of CoSA in the community is associated with greater perceptions of community safety by community members and increased offender responsibility and accountability, as perceived by the professionals and agencies that work with the offender (Wilson, Picheca, & Prinzo, 2007a).

The effectiveness of community-based treatment programs is also promising. Evaluations of three programs for SACs in New Zealand, which included individual therapy, family therapy, and a family support group (only two of which had these) found that participation was associated with a significant decrease in sexual recidivism (Lambie & Stewart, 2012). All three programs also included group therapy, which had offense chain (understanding the antecedents to one's offending and the consequences that ensue), mood management, victim empathy, relationship skills, and relapse prevention components. All three programs also had at least a 52-week minimum program length. The effectiveness of three more community-based interventions in the United Kingdom also showed favourable results, reducing recidivism by 40% (Beech, Mandeville-Norton, & Goodwill, 2012). In these group programs, offenders focused on victim empathy, life skills, cognitive distortions, and relapse prevention, which took place over 100 hours for lower-risk offenders or 200 hours for higher-risk offenders. Of note, the extra sessions in the latter format reduced recidivism rates of high-risk offenders to those in the lower-risk group. While these evaluations do not specify whether the victim empathy component is specific to their victim(s) or potential future victims, it has been argued that many programs spend a disproportionate amount of time developing empathy for past victims (Barnett & Mann, 2012; 2013). Instead, overall victim empathy should be developed by targeting the components (emotional contagion, perspective-taking, belief in others' intrinsic worth, influence of situational factors, and ability to manage personal distress) of the empathic process. Additionally, when addressing cognitive distortions and implicit attitudes supportive of CSH, it is important to note that these distortions (towards girls but not boys) increase during sexual arousal (Sewell, 2010). Eighty-three percent (83%) of pedophilic SACs have difficulty inhibiting their sexual arousal (Babchishin et al., 2017). Thus, areas for further development should incorporate addressing ways for offenders to combat sexual arousal beyond the confines of a clinical setting.

Summary: Key Considerations for Adult Sexual Abusers of Children

- Sexual Abusers of Children (SACs) have extensive victimization backgrounds.
- Not all SACs are pedophiles, and not all pedophiles are SACs.
- There are similarities and differences between intrafamilial and extrafamilial SACs.
- There are a number of different ways to categorize SACs, including by victim age, relationship with victim, motivations, criminal trajectories, type of offense, and means of offense.
- Like JSOs, there is a great deal of heterogeneity among SACs.
- Not all SACs are high-risk offenders – adherence to Risk-Need-Responsivity principles is integral to effective treatment.
- The VRS:SO appears to have the best predictive validity for sexual recidivism. The Static-99 is also relatively effective.
- There are effective treatments for SACs, most notably cognitive-behavioural therapy (CBT) and Multisystemic Therapy (MST).
- Integration of Indigenous culture into interventions is a vital component of both the responsivity principle and in reducing recidivism.
- Reintegration planning is an important consideration when releasing SACs into the community.
- Community-based treatment is effective in reducing recidivism.
- Volunteer groups, such as Circles of Support and Accountability, reduce sexual, violent, and general recidivism by considerable margins (83%, 73%, and 71%, respectively, in one study).

Non-Offending Pedophiles

Overview

There is perhaps no group that is more stigmatized than pedophiles, or those who are sexually attracted to children (Jahnke & Hoyer, 2014; Jahnke, Imhoff, & Hoyer, 2015). Yet not all pedophiles will go on to commit sexual offenses against children (Mitchell & Galupo, 2016). The following section will focus on non-offending pedophiles. As the name suggests, non-offending pedophiles are individuals who either self-identify as being sexually attracted to children or have received a formal diagnosis of pedophilia but who have not committed a sexual offense against a minor. Non-offending hebephiles, or those sexually attracted to youth in early adolescence, will also be included under the category of non-offending pedophiles for simplicity and practicality. Of the little research done in this area, almost all has dealt with non-offending pedophiles or has included hebephiles in the grouping. Additionally, many of the measures and recommendations will be applicable to both.

Determining the prevalence of pedophilia or hebephilia is difficult, primarily due to the intense public shame that often accompanies it. However, estimates range from 1% to 9.5% to 20%, with males consistently demonstrating more sexual interest (both in internet based images of child sexual abuse and in willingness

to engage in sexual acts) in children than females (Ahlers et al., 2011; American Psychiatric Association, 2013; Hall, Hirschman, & Oliver, 1995; Joyal & Carpentier, 2017; Wurtele, Simons, & Moreno, 2014). Hall and colleagues (1995) also noted that a greater number of men (26%) demonstrated arousal to images of girls than had reported pedophilic interest (20%), which suggests that self-report measures of pedophilic interest may be underestimated. Additionally, over 60% of SACs reported that the onset of their deviant sexual fantasies began at least one year prior to their first commission of a sexual offense against a child, with many indicating that they began at least five years prior (Piché et al., 2016). Over 60% of those surveyed indicated that they would have been very likely (41.8%) or somewhat likely (19.8%) to have used a preventative service prior to the commission of their offense. Given the pervasiveness of pedophilia and the willingness to access services in this area, the inclusion of non-offending pedophiles in a CSH prevention strategy is essential.

Understanding Non-Offending Pedophiles

Little is known about non-offending pedophiles, primarily due to an unwillingness to disclose sexual interests in children. What we know about those who commit sexual offenses against children may help us to understand non-offending pedophiles, an otherwise hard to research group due to stigma and fear of reprisal; for instance, only 18% of convicted child sex offenders reported talking about their sexual desires to someone (Piché et al., 2016). Among a sample of pedophiles, 51% doubted that their disclosure to a mental health professional would remain confidential (B4U-ACT, 2011). This fear of discovery has been linked to reduced social and emotional functioning (Jahnke et al., 2015). However, the anonymity offered by the internet has allowed researchers the opportunity to further investigate non-offending pedophiles, which has been more effective in obtaining disclosures of paraphilic interests than traditional phone survey methods (Joyal & Carpentier, 2017).

Similar to sexual abusers in general, pedophiles report experiencing more adverse life events, such as physical abuse, sexual abuse, witnessing domestic violence, early exposure to pornography (prior to age 10), early sexual experiences, and greater anxious and avoidant attachment compared to controls (Houtepen, Sijtsema, & Bogaerts, 2016; Wurtele et al., 2014). Many self-identified pedophiles also report having struggled with their pedophilic interests in adolescence which manifested in various psychological difficulties (Houtepen et al., 2016). Hierarchical multiple regression analyses indicate that some of these developmental predictor variables (abuse, insecure attachment, and early sexual experience) account for 16% and 4% the variance in pedophilic interest for males and females, respectively (Parker, 2016). Furthermore, heritability (what can be attributed to genetic factors in contrast to environmental ones) may account for an additional 14.6% of the variance in adult men's pedophilic interest (Alanko et al., 2013). In a joint neuroimaging and behavioural task study, non-offending pedophiles, compared to offending pedophiles, demonstrated superior inhibitory control (i.e., self-control), specifically involving the left posterior cingulate and the left superior frontal cortex (Kargel et al., 2017). No differences were found between non-offending pedophiles and the non-pedophilic non-offender group. Similar results were found between functional connectivity in the left amygdala as well as the orbitofrontal and anterior prefrontal regions: pedophiles who offended against children displayed deficits in these regions, while non-offending pedophiles and healthy controls showed no significant differences (Kargel et al., 2015).

An emerging area of research which may have treatment implications is in the area of autopedophilia, known as the sexual arousal of imagining oneself as a child (Hsu & Bailey, 2017). In a sample of pedophiles recruited online, a bimodal distribution in the endorsement of autopedophilia was found; in other words, many (33.6%) were not autopedophilic, but a large proportion (21%) also scored the highest-attainable score on the measure. While this study was not specifically conducted on an offender sample (participants were not asked to disclose any offending behaviour), the concept of autopedophilia warrants future investigation, as it may help uncover offending trajectories and/or treatment needs for pedophiles.

Current Initiatives

Due to the lack of research on the treatment and assessment implications based on the small amount of non-offending pedophile research, the rest of this section will highlight some of the pioneering work that is being conducted across the globe to target the treatment of non-offending pedophiles. However, this is not to suggest that some of the treatments or interventions for convicted SACs (specifically those who have pedophilic interests) would not be effective in helping non-offending pedophiles continue their desistance from acting on their urges; simply, there is little empirical evidence to date.

One of the most noteworthy programs for non-offending pedophiles is *Prevention Project Dunkelfeld* (PPD), a 2005 German initiative to provide free, confidential treatment to those diagnosed with pedophilia or hebephilia (Beier et al., 2015; Schaefer et al., 2010). Due to the client-therapist confidentiality laws in Germany, both offending (including those who have not been caught) and non-offending pedophiles are able to seek support through both an anonymous hotline and access to individual and group therapy. Once established, hundreds of people from across Europe contacted PPD (Cantor, 2012). The treatment program, entitled Berlin Dissexuality Therapy (BEDIT) is described as follows:

> According to the integrated theory of sexual offending, a group-based treatment program featuring a broad cognitive-behavioural approach was expanded into a multimodal program that utilizes pharmacological, psychological, and sexological intervention strategies to prevent child sexual offending behaviour in pedophiles and hebephiles. Cognitive-behavioural interventions include aspects of the relapse prevention, self-regulation, and Good Lives models. Treatment targets include motivation for change, self-efficacy, self-monitoring (including sexual fantasies and interests), sexualized vs. adequate coping strategies, emotional and sexual self-regulation, social functioning, attachment and sexuality, offense-supportive attitudes, developing empathy for children involved in CSA or CPO [child pornography offenses], and relapse prevention strategies and goals. A written manual defined the strategies required to deal with threats of contact CSA during therapy (Beier et al., 2015, pp. 530-531).

An evaluation on the effectiveness of the group therapy model (45-50 3-hour sessions with 6-10 participants) reported significant decreases in self-esteem deficits, loneliness, emotion-oriented coping, emotional victim empathy deficits, CSH supportive attitudes, and some sexual self-regulation deficits; however, these were only found for pedophiles who have a history of offending, including child pornography use (Beier et al., 2015). There were few differences between groups on baseline measures, suggesting that programs for non-offending pedophiles may need further refinement, as this model was based on manuals for convicted child sexual abusers who thus had a victim.

Another European initiative is Stop It Now! (www.stopitnow.org), a service that offers an email and telephone helpline as well as an online directory of services and resource guides. While the helpline's primary goal is to provide information and advice to callers (parents, professionals, pedophiles, etc.) about CSH, more extensive support is available. This enhanced support is referred to as the "second line" in the UK, which provides short-term, targeted support for callers either over the phone or in person. Like PPD, Stop It Now! is not exclusive to non-offending pedophiles; however, a large percentage of pedophiles (53% of Dutch callers) who have contacted the free, anonymous helpline are those who are non-offending (Van Horn et al., 2015). Of all callers, about half in both the UK and Netherlands are contacting the helplines regarding concern for their own sexual interests and behaviours. While only 488 of 3,451 calls to the UK helpline in March 2013 were able to be answered, the sheer volume of calls speaks to the popularity of the resource and the willingness of both offending and non-offending pedophiles to come forward to receive support.

While the anonymity of the internet has allowed researchers to further study non-offending pedophiles, it has also allowed non-offending pedophiles to congregate and form support groups. One of the most popular is Virtuous Pedophiles (www.virped.org), a website that aims to reduce the stigma around pedophilia and to provide peer support and resource information for non-offending pedophiles to help them lead law-abiding, meaningful lives. As of 2015, the site had over 1,000 members – considerably more than the estimate of 330 reported by CBC in 2014 – and provides unique opportunity to disclose their sexual desires to a group of similar-interest peers, some for the first time (Bailey, Bernhard, & Hsu, 2016; Hildebrandt, 2014; Virtuous Pedophiles, 2017). The founders of Virtuous Pedophiles have a long history in helping non-offending pedophiles remain law-abiding, formerly being members of the peer support group in B4U-ACT (www.b4uact.org), another online resource for non-offending pedophiles. However, the founders Nick Devin and Ethan Edwards (both pseudonyms) opted to develop Virtuous Pedophiles, feeling that B4U-ACT did not take a strong enough stance against adult-child relations (Virtuous Pedophiles, 2017). The Blue Angel Association (www.ange-bleu.com) also hosts an online community, but is unique in that its forums and discussions allow for the contributions of CSH victims in addition to self-disclosed pedophiles. While none of these online forums have undergone a rigorous evaluation in their ability to prevent CSH, on face value they appear to be useful supports in helping reduce the likelihood that their members offend by reducing CSH supportive attitudes and social isolation while potentially increasing victim empathy (in the case of the Blue Angel Association).

Summary: Key Considerations for Non-Offending Pedophiles

- Estimates of the prevalence of pedophilic interest range from 1% to 26%.
- Both juveniles and adults report sexual interest in children.
- Many convicted child sexual abusers were aware of their sexual desires for at least one to five years prior to the offense.
- Similar to JSOs and ASOs, non-offending pedophiles have particularly traumatic histories of victimization.
- Non-offending pedophiles are also distinct from offending pedophiles and SACs.
- Non-offending pedophiles have demonstrated a willingness to seek help and support.
- Assurance of anonymity or confidentiality are extremely important in working with this population.
- Many of the programs and services for non-offending pedophiles can also be used by other groups as part of a broader CSH reduction strategy.

Jurisdictional Scan Summary

Federal Provincial Territorial colleagues were contacted to determine the efforts their respective jurisdictions have in place for child sexual harm prevention and intervention programs, services and initiatives. Seven jurisdictions responded. An analysis of responses shows that, in some respects, New Brunswick is in line with other jurisdictions when it comes to child sexual harm initiatives. Legislation regarding reporting suspected child abuse, victim services and child advocacy centres were common across jurisdictions including New Brunswick. In other respects, other jurisdictions have initiatives in place that would address a gap in New Brunswick, strengthening child sexual harm efforts.

British Columbia (BC), Ontario and Manitoba have programs in place for children and youth who exhibit concerning sexual behaviors and/or youth who engage in sexually abusive behaviours. BC's Sexual Abuse Intervention Program (SAIP) has a contracted community-based program that provides a range of appropriate, timely and accessible assessment, treatment and/or support services to children and youth who have been sexually abused and to children under the age of 12 with sexual acting out behaviours. The BC Ministry also has Child and Youth Mental Health (CYMH) community-based teams that provide assessment, treatment and/or support services for children and youth who are experiencing complex mental health issues. This can include those who experienced sexual abuse or sexual acting out behaviours as well as those who fall outside the SAIP mandate.

In Ontario, Durham Family Court Clinic (DFCC) provides assessment and treatment for adolescents who have engaged in problematic sexual behaviour. Their Family Support Program offers parents and caregivers of youth who have sexually offended a 12-week support group. Research has shown that participation in this type of specialized group improves the ability for parents and caregivers of the offending youth cope with the situation, reduces the risk for the youth to re-offend and expedites the treatment process for the youth and the family. Family support plays a vital role in the healing process for the youth but often caregivers experience their own feelings of guilt and pain that need to be addressed.

Ontario's Radius Child and Youth Services provides clinical assessment and counselling services to children, youth and families affected by interpersonal abuse: physical, sexual, or emotional abuse, neglect, or those who have witnessed incidents of domestic violence. This program also provides services for children under 12 years old who have engaged in concerning sexual behaviour and adolescents who have engaged in sexually abusive behaviour. As part of their counselling services, they offer Sexual Offence-Specific Counselling for youth aged 12 to 19 years (up to 19 for youth involved with Youth Justice) who have engaged in sexually abusive behavior.

Ontario also offers Sexually Offending Behaviour Counselling. It provides programs and services to address the issues and challenges of young persons with mental health and/or behavioural needs who are involved the youth justice system. Group and individual programs are designed to meet the individual needs of youth who have sexually acted out. Programs are based on current research and best practice intervention that both optimize treatment outcomes for youth and address community safety. Once the referral is made, the youth is seen immediately for an initial assessment to determine the most appropriate level of treatment. Finally, Ontario's Sexually Healthy Attitudes & Relapse Prevention (S.H.A.R.P.) offers youth who are convicted of a sexual offence be mandated as part of their probation order to participate in this program which consists of several components, namely sexual education, group therapy, individual therapy, individual/family community-based counselling and review meetings.

Manitoba provides Forensic Psychological Services that offer comprehensive treatment planning and a range of treatment services for children, adolescents and adults who engage in problematic sexual, aggressive and antisocial behaviors. Treatment is provided in an empirically informed, strengths-based, holistic framework that is tailored according to the risk, needs, and responsivity of clients. The treatment approach is person-, child- and family-centered and attachment-informed, and includes cognitive-behavioral, self-regulation and solution-focused methods. It is based on the premise that clients tend to be largely influenced by the many systems and individuals with whom they interact (e.g., family, child welfare, school, justice, mental health and support systems). Therefore, the program practices within a multisystemic framework that promotes and cultivates collaboration and teamwork. Regular team meetings are another important form of intervention used, as well as (for example) individual therapy, play therapy, psychosexual and arousal re-conditioning and Community Integration Manager (CIM) support services.

Manitoba also has Edgewood, a licensed child care facility offering a prevention, intervention and recovery program for male youth aged 12 to 16 with a history of sexually aggressive behaviour. The program offers unique opportunities for these youth to gain insight into thoughts, behaviours and emotions, address safety concerns, develop life skills, restore and preserve family and community relationships, and build community supports and resources. Experts in the field of sexually aggressive behaviour, treatment and recovery work closely with placing agencies, probation and cultural services, families, schools and community services to provide, for example, strengths/ needs/risk assessments, safety planning, treatment and personalized plans, and transition planning.

Other initiatives of note that could strengthen New Brunswick's child harm prevention efforts include British Columbia's Toddler's First Steps. This resource provides parents and caregivers with information about how they can help keep their toddlers safe from sexual abuse, including information about listening to children when they say they are uncomfortable around someone (including friends and relatives) and helping children to develop personal boundaries by, for example, allowing them to refuse unwanted kisses or hugs.

Section 3: Needs Analysis

This section aims to provide a better understanding of the incidence of child sexual harm and scope of the problem in New Brunswick by examining several sources of information including: 1) police-reported statistics from Statistics Canada, 2) self-reported data from the Student Wellness Survey (SWS) provided by the New Brunswick Health Council, and 3) a de-identified dataset of suspected child sexual harm cases reported to the Department of Social Development. The Needs Analysis also provides a comparison of programs and services that currently exist in New Brunswick to best practices and summarizes strengths and gaps as identified through a series of consultations that were conducted with New Brunswick professionals working in a variety of CSH-related fields.

Police-Reported Statistics

In partnership with the policing community, Statistics Canada's Canadian Centre for Justice Statistics (CCJS) collects crime statistics from across the country using the incident-based Uniform Crime Reporting Survey (UCR2), which reflects crime that has been reported to and substantiated by police. CCJS releases these statistics yearly so that jurisdictions can get an understanding of the volume and nature of crime taking place in their communities. Prior to April 2008, sexual assaults against children were included in the Uniform Crime Reporting (UCR) category of 'Other Sexual Crimes.' There were no distinctive sexual assault codes which captured data against youth until approximately the middle of 2008. Therefore, 2009 is the earliest available data that could be gathered from Statistics Canada on the incidence of child sexual harm that could compare New Brunswick data to other jurisdictions reliably.

In 1988, the UCR2 replaced the traditional UCR (which began in 1962), expanding the scope of the survey to include characteristics of the incident, its victim(s), and perpetrator(s) (Statistics Canada, 2019b).

Special Report: Canadian Centre for Justice Statistics

Statistics Canada released a special report in 2014 on police-reported sexual offences against children and youth in Canada based on 2012 UCR statistics. The report provided a broad overview of the nature and magnitude of sexual crimes against children. The report cautioned that sexual offences in general tend to be under-reported in police statistics and that this under-reporting can be compounded in cases where the victim is a child. In fact, according to the General Social Survey on Canadians' self-reported victimization, only 1 in 20 sexual assault incidents perpetrated by someone other than a spouse were reported to police in 2014, the same ratio as in 2004 (Conroy & Cotter, 2017). The 2014 report on police-reported sexual offences against children and youth highlighted the following (Cotter & Beaupré, 2014):

- More than half (55%) of police-reported sexual offences in Canada involve a child or youth victim.
- The national rate of police-reported sexual offences against children and youth was 205 per 100,000 population. The highest rates were recorded in the territories, though New Brunswick ranked 3rd highest among the provinces (296 per 100,000 population) below Manitoba and Saskatchewan.
- Among census metropolitan areas, Moncton recorded the 3rd highest rate of sexual offences against children and youth in the country (312 per 100,000 population).
- Level 1 sexual assault was the most common violation against children and youth in Canada, representing 72% of offences.
- Victims were typically in their early teens and female.
- One-third of sexual offences against children or youth were committed by another youth.

- Most child and youth victims of sexual offences knew the accused persons.
- The majority of persons accused of sexual offences against children and youth are male.
- Most sexual offences against children and youth occur in a private residence.
- Sexual offences against children and youth were often delayed in coming to attention of police and a proportion are never reported.
- Three-quarters (74%) of cases that move to adult criminal and youth courts involving sexual offences against children result in a finding of guilt. Of completed cases with a guilty finding, 81% of adults and 9% of youth were sentenced to custody.

Caution When Interpreting Data

- Generally, when referring to 'sexual offences' throughout the needs analysis of this report, this is inclusive of a combination of offences or measures.
- Although Statistics Canada's '**Total Sexual Violations Against Children**' measure is commonly used throughout this report, several other similar measures are also used. Thus, it is important to be cognizant of the specific measure being used in each graph.
- Police-reported incidents or rates are reported to Statistics Canada by police departments **only if they are founded by police.**
- 'Total Sexual Violations Against Children' is used in graphs A, B, and G.
- Graphs C, E, and F include 'Sexual Assaults' and 'Total Sexual Violations Against Children' collected from Statistics Canada, which was obtained via a customized request.
- Frequency refers to the number of times an event has occurred. For example, if 122 houses sold in 2018, the frequency of house sales in 2018 would be 122.
- The rate is a measurement of a variable in relation to another measured quantity. For example, if a community has a rate of 122 houses sold per 100,000 population and the community has a population of 500,000 people, there were approximately 610 houses sold in 2018.
- The Canadian rate (or average) is calculated based on the rate per 100,000 population of Canada (this would be inclusive of both provinces and territories).

Total Sexual Violations Against Children

Statistics Canada does not have a set schedule for in-depth reviews like the 2014 report quoted above. Instead, at the time of analysis, jurisdictions relied on Canadian Socio-Economic Information Management System (CANSIM) tables. CANSIM was Statistics Canada's main database which contained most of the aggregate data collected by Statistics Canada on a regular basis. Child sexual harm is reported annually by CCJS through a measure called 'Total Sexual Violations Against Children.' This measure includes the following Criminal Code offences:

- Sexual interference (s. 151)
- Invitation to sexual touching (s. 152)
- Sexual exploitation (s. 153)
- Parent or guardian procuring sexual activity (s. 170)
- Householder permitting prohibited sexual activity (s. 171)

- Making sexually explicit material available to children (s. 171.1)
- Luring a child via a computer (s. 172.1)

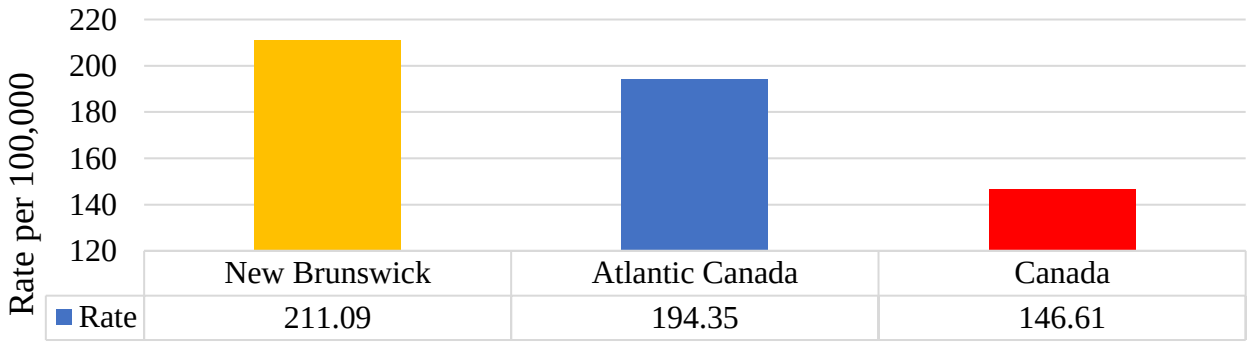
The measure of 'Total Sexual Violations Against Children' above does **not** include the following offences:

- Sexual assault level 1 (s. 271): *An assault committed in circumstances of a sexual nature such that the sexual integrity of the victim is violated. Involves minor physical injuries or no injury to the victim.*
- Sexual assault level 2 (s. 272): *Sexual assault with a weapon, threats, or causing bodily harm.*
- Sexual assault level 3 (s. 273): *Sexual assault that results in wounding, maiming, disfiguring, or endangering the life of the victim.*
- Child Pornography (s. 163.1)
- Other sexual offences not involving assault or sexual violations against children are included within 'Other Violent Offences' which includes a variety of offences that Statistics Canada does not capture within their 'Sexual Assault' and 'Total Sexual Violations Against Children' categories, such as 'Other Sexual Violations,' 'Voyeurism,' 'Trafficking in Persons,' etc.

Crimes are included within 'Total Sexual Violations Against Children' based on the method in which the information is collected through Statistics Canada. For example, given that Statistics Canada includes both adults and children in their sexual assault data, sexual assaults level 1, 2, or 3 are not captured by the 'Total Sexual Violations Against Children' category and not readily available online to the public.

Level 1 sexual assault is the most common police-reported violation against children and youth in Canada. **Graph A**: **Child and Youth Victims (0-17 years) of Sexual Assault Level 1 (2009-2015)** depicts New Brunswick's average rate of child and youth victims of 'Sexual Assault Level 1' from 2009-2015. NB had a consistently higher child and youth victim rate (211.09) of sexual assaults (level 1) than both the Canadian average (146.61) and the Atlantic Canadian average (194.35).

Graph A: Child and Youth Victims (0-17 years) of Sexual Assault Level 1 (2009-2015)



Source: Statistics Canada (2018a). Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey. Custom data request, received: November 10, 2016.

Custom Statistics Canada Request

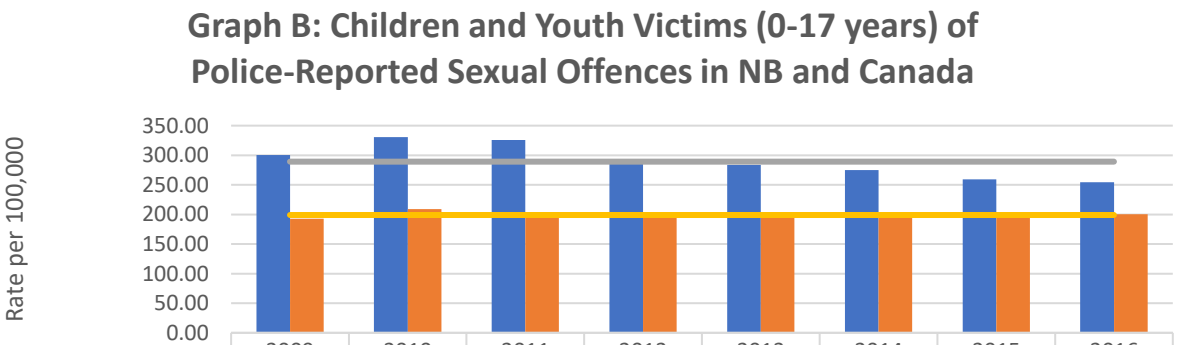
To obtain a comprehensive understanding of all sexually-related crimes committed against children and youth in New Brunswick, a custom request was made to Statistics Canada to obtain all relevant data for all possible years available (2009-2016). This request includes the following Criminal Code sexual offences:

- Sexual assault level 1 (s. 271)
- Sexual assault level 2 (s. 272)
- Sexual assault level 3 (s. 273)
- Sexual interference (s. 151)
- Invitation to sexual touching (s. 152)
- Sexual exploitation (s. 153)
- Making sexually explicit material available to children (s. 171.1)
- Luring a child via a computer (s. 172.1)
- Bestiality in presence of, or incites, a child (subsection 160(3))
- *Parent or guardian procuring sexual activity (s. 170)
- *Householder permitting prohibited sexual activity (s. 171)

**Included as of December 2014.*

Offences related to child pornography are not included here due to the way statistics are reported to and collected by Statistics Canada. First, when the actual victim is not identified, this offence is reported to the Uniform Crime Reporting Survey with the most serious offence being "Child Pornography," which falls under the larger crime category of "*Other Criminal Code.*" Second, in cases where a victim is identified, police will report the most serious offence as sexual assault, sexual exploitation or other sexual violations against children, which falls under the category of "Violent Violations," and child pornography may be reported as a secondary violation. These offences are discussed separately below.

Graph B: Children and Youth Victims (0-17 years) of Police-Reported Sexual Offences in NB and Canada compares New Brunswick and Canadian rates (inclusive of territories) of child and youth victims of police-reported sexual offences from 2009 to 2016. Although it appears that the gap between New Brunswick's rates and the national rates may be closing, New Brunswick's rate has been consistently above the Canadian rate since 2009.

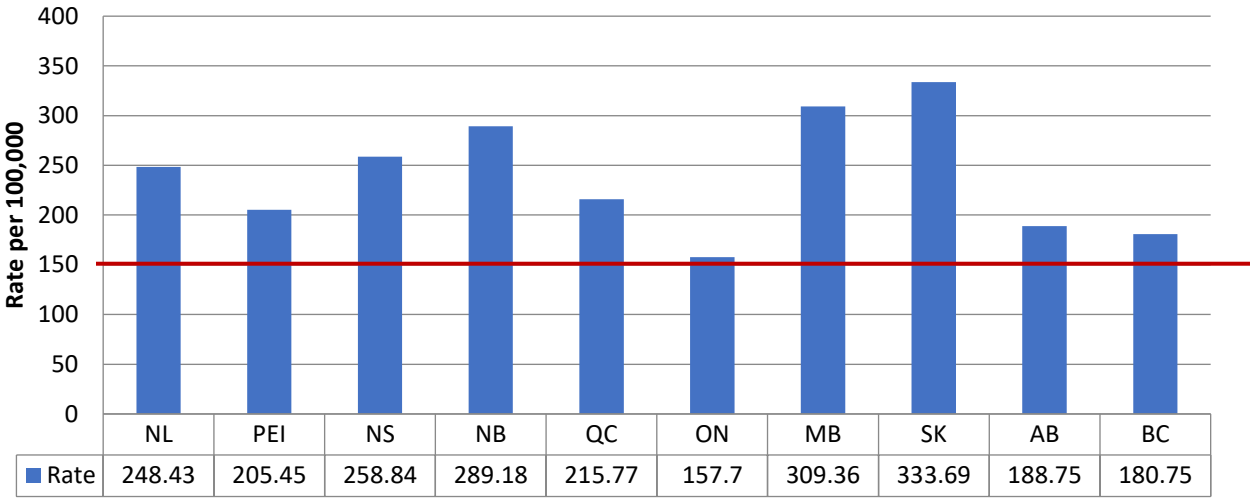


	2009	2010	2011	2012	2013	2014	2015	2016
New Brunswick	300.10	330.63	325.55	285.58	283.35	274.75	259.15	254.31
Canada	192.67	209.22	202.42	200.24	197.72	195.18	194.39	200.58
NB Avg.	289.18	289.18	289.18	289.18	289.18	289.18	289.18	289.18
Canada Avg.	199.05	199.05	199.05	199.05	199.05	199.05	199.05	199.05

Source: Statistics Canada. (2018b). Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey. Custom data request, received: June 22, 2018.

As shown in **Graph C: Children and Youth Victims (0-17 years) of Police-Reported Sexual Offences All Provinces (2009-2016 avg.)**, New Brunswick has the 3rd highest 7-year average rate of children and youth victims of police-reported sexual offences among all provinces (excluding the territories). NB's 7-year average rate of 289.18 per 100,000 is also higher than the 7-year national average (199.05 per 100,000 population).

Graph C: Children and Youth Victims (0-17 years) of Police-Reported Sexual Offences All Provinces (2009-2016 Avg.)



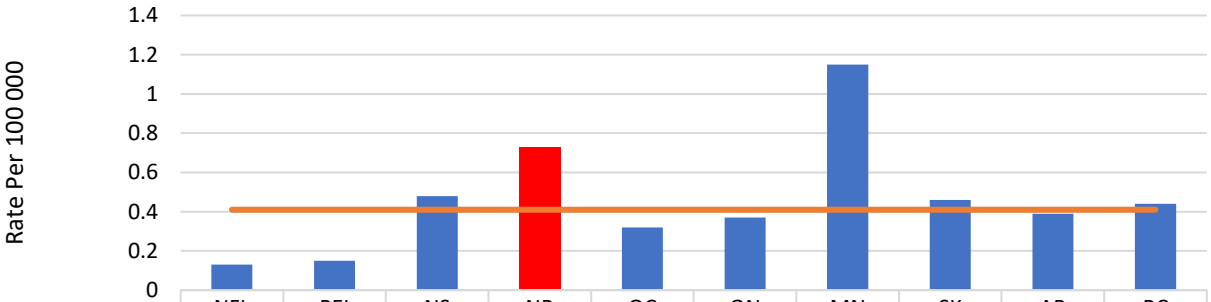
Source: Statistics Canada (2018b). Canadian Centre for Justice Statistics, Incident-based Uniform Crime Reporting Survey, Trend Database. Custom data request, received: June 22, 2018.

Additional Focus: Human Trafficking and Child Pornography

As discussed in the Child Rights Impact Assessment, it is important to take note of concerning international trends, specifically sexual exploitation of children through human trafficking, child pornography and internet child exploitation. New Brunswick is not immune to these issues. Police-reported sexual exploitation data was teased apart from Statistic Canada's 'Total Sexual Violations Against Children' metric.[4] From 2009 to 2017, it was found that New Brunswick had the 2nd highest average rate (0.73 per 100,000) of sexual exploitation of children among all provinces, falling behind Manitoba only. Furthermore, New Brunswick had the highest average rate in Atlantic Canada and a higher average rate compared to the Canadian average rate of sexual exploitation of children (0.41 per 100,000). **Graph D: Rate of Sexual Exploitation of Children by Province (2009-2017)** depicts the rate of sexual exploitation of children by province, including Canada's average rate.

[4] Sexual exploitation includes the following Criminal Code section: 153(1)(a)(b). This would include an individual 16 years of age or more but less than 18 years old.

Graph D: Rate of Sexual Exploitation of Children by Province (2009-2017)

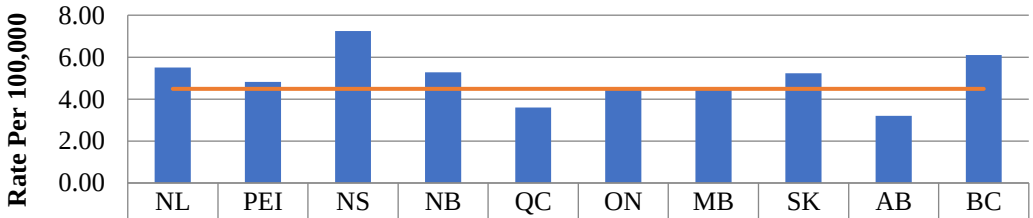


	NFL	PEI	NS	NB	QC	ON	MN	SK	AB	BC
Provinces	0.13	0.15	0.48	0.73	0.32	0.37	1.15	0.46	0.39	0.44
Canada	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41	0.41

Source: Statistics Canada. (2019a). Table 35-10-0177-01. Incident-based crime statistics, by detailed violations. Sexual Exploitation.

In 1993, Canada introduced child pornography and corrupting morals legislation (s. 163.1 of the *Criminal Code of Canada*). This law made it an offence to make, print, publish, import, distribute, sell, or possess images of child sexual abuse. Offences committed using the internet are included as well (Kong, Johnson, Beattie, & Cardillo, 2003). Since 1998, Statistics Canada has collected data on child pornography.[5] Over a 20-year span (1998-2017), New Brunswick had the 4th highest average rate (5.28 incidents per 100,000 population) of possession or accessing child pornography in comparison to other provinces of Canada (see **Graph E: Rate of Incidents, Possession or Accessing of Child Pornography (1998-2017)**). Furthermore, New Brunswick's average rate (5.28 incidents per 100,000 population) since 1998 is slightly higher than the Canadian average (4.49 incidents per 100,000 population).

Graph E: Rate of Incidents, Possession or Accessing of Child Porngraphy (1998-2017)

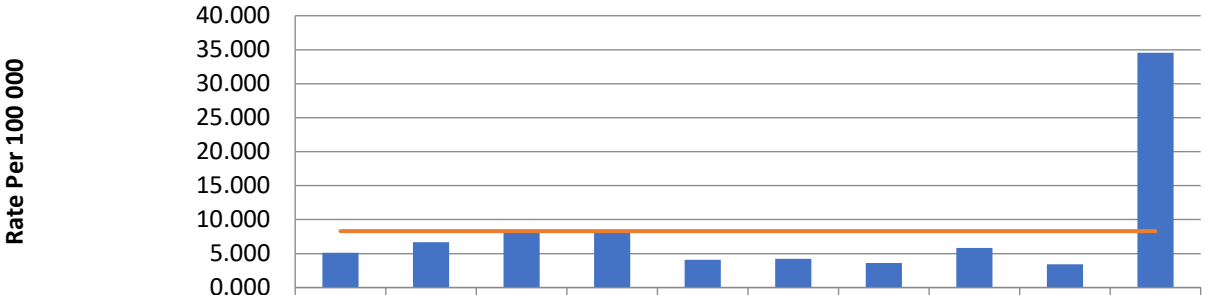


	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC
Provincial Avg. Rate	5.50	4.82	7.24	5.28	3.60	4.49	4.44	5.22	3.20	6.10
Canadian Avg. Rate	4.49	4.49	4.49	4.49	4.49	4.49	4.49	4.49	4.49	4.49

Source: Statistics Canada. (2018c). *Table 35-10-0177-01. Incident-based crime statistics, by detailed violations*. Child Pornography A.

[5] The term "child pornography" is used within this section of the report given that this is the common term used by Statistics Canada. The term "images of child sexual harm" will be used interchangeably within other sections of the report.

Graph F: Average Rate of Incidents for Making, or Distribution of, Child Pornography (2015-2017)



	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC
Provincial Avg. Rate	5.103	6.653	8.113	8.083	4.063	4.227	3.637	5.847	3.423	34.537
Canadian Avg. Rate	8.303	8.303	8.303	8.303	8.303	8.303	8.303	8.303	8.303	8.303

Source: Statistics Canada. (2018d). Table 35-10-0177-01. Incident-based crime statistics, by detailed violations. Child Pornography B.

More recently, Statistics Canada has collected data on offences relating to making or distribution of child pornography. Data has been collected consistently since 2015. New Brunswick has the 3rd highest average rate (8.083 per 100,000 population) in comparison to all other provinces, falling significantly behind British Columbia's average rate (34.537 per 100,000 population),[6] pictured in **Graph F**: **Average Rate of Incidents for Making, or Distribution of, Child Pornography (2015-2017)**, and slightly behind Nova Scotia (8.113 per 100,000 population). New Brunswick's average rate (8.083 per 100,000 population) is slightly below the Canadian average (8.303 per 100,000 population).

Victim Age and Gender

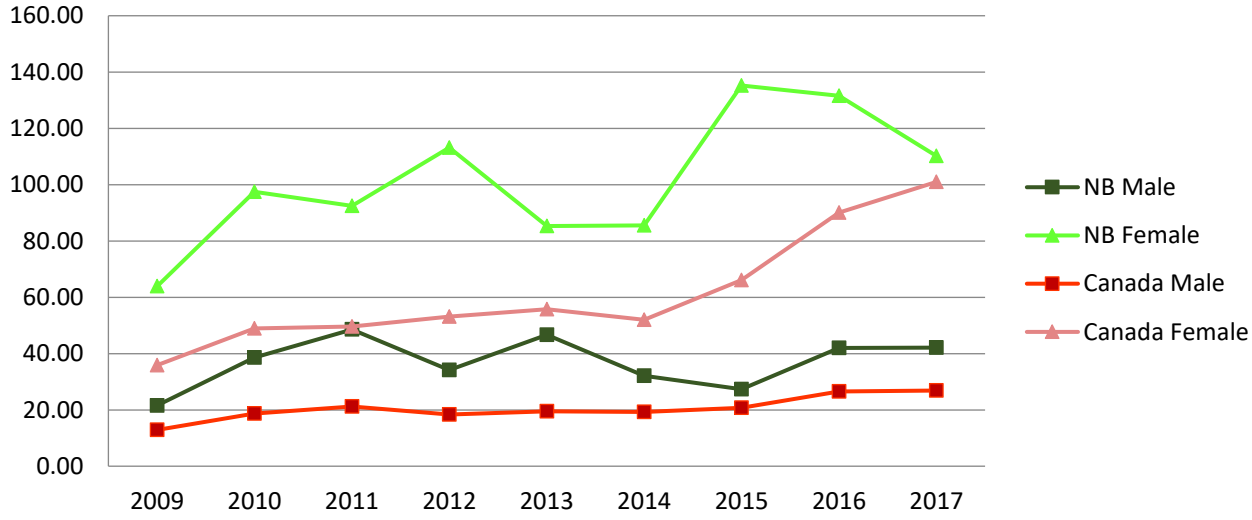
Graph G: Rate of Total Sexual Violations Against Children by Gender (2009-2017) shows the trend of Total Sexual Violations Against Children (aged 0 to 11) by victim's gender over time. It should be noted that the overall trend of the rate of sexual violations is increasing over the 9-year span. The rate of sexual violations against females has been consistently higher than the rate for males. Regardless of gender, New Brunswick has higher rates of sexual violations against children than the national rates. Furthermore, both in New Brunswick and nationally, it appears that the rates of sexual violations against females increased more than the rates for males, which remained relatively stable over time. Specifically, sexual violations against New Brunswick females increased from approximately 64 per 100,000 population in 2009 to 110 in 2017.

The end of this trend may be impacted by movements, like #MeToo, which is a movement against harassment and sexual assault that began to spread virally in October 2017. According to Rotenberg and Cotter (2018), after three months of the movement going viral, there was a 25% increase of victims of police-reported sexual assaults nationally, compared to the three-month period leading up to the #MeToo movement. Specifically, the average number of police-reported sexual assault victims increased from 59 per day (before #MeToo) to 74 per day (after #MeToo). It is important to note that the increase in police-reported

[6] The higher rate found in BC is partly attributable to a proactive project initiated by the BC Integrated Child Exploitation Unit in the Victoria and Vancouver areas. The BC Integrated Child Exploitation Unit recorded Internet Protocol (IP) addresses that were in possession of sexual images of children and potentially sharing with others.

sexual assaults post - #MeToo is likely due to a combination of factors, such as an increased willingness to report to police, public awareness of sexual assault, and changes in police practice regarding classifying unfounded sexual assaults. When comparing police-reported sexual assaults pre - #MeToo to post - #MeToo, New Brunswick saw a rate increase of 9% (12.3 and 13.4, respectively) (Rotenberg & Cotter, 2018). Given the impact factors, such as the #MeToo movement, can have on police-reporting, it is important to keep this in mind when interpreting trends in data.

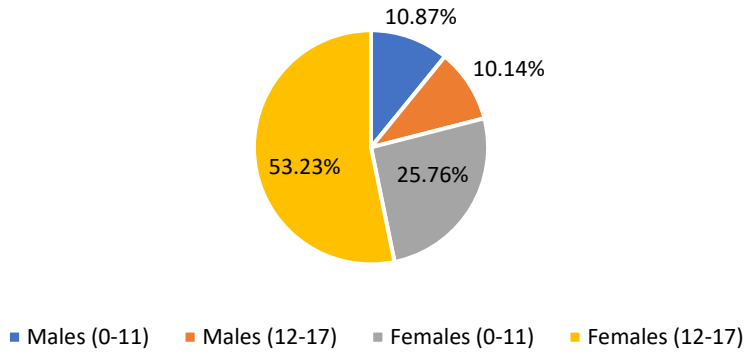
Graph G: Rate of Total Sexual Violations Against Children by Gender (2009-2017)



Source: Statistics Canada (2018e). Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey. Custom Request from November 15, 2018.

As shown in **Graph H**: **Proportion of Sexual Violence Offence Victims by Age and Gender (2013-2017)**, of 1766 child and youth victims of sexual offences between 2013 and 2017, the majority (78.99%) were female. Specifically, over half (53.23%) of all victims were females between the ages of 12 and 17 years. An additional quarter (25.76%) of the sample were females between the ages of 0 to 11 years. Males aged 0 to 17 years made up slightly over 20% of the entire sample. This information should be taken into consideration in the development of programming for victims.

Graph H: Proportion of Sexual Offence Victims by Age and Gender (2013-2017)



Source: Statistics Canada (2018f). Canadian Centre for Justice Statistics, Uniform Crime Reporting Survey, Trend Database. Custom Request from January 16, 2019.

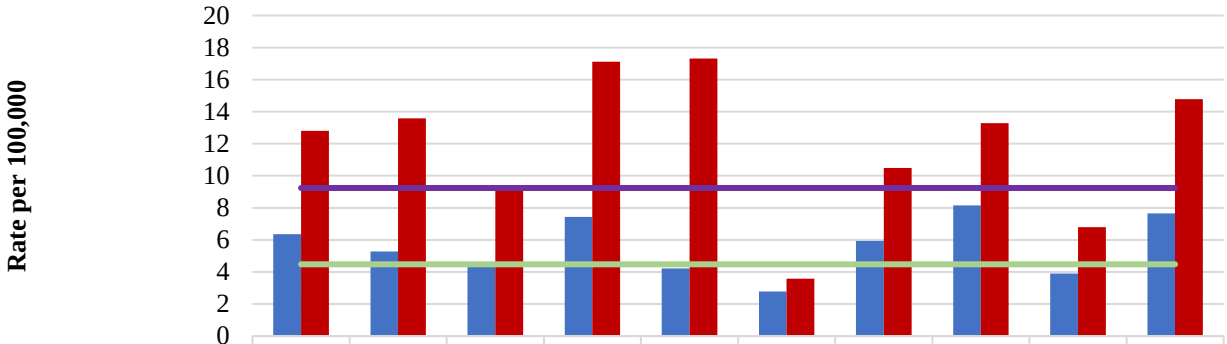
Perpetrators: Age and Gender

Males comprise 97% of the accused in cases of child sexual harm. Approximately 30% of persons accused of a sexual offence against a child were between the ages of 12 and 17 years, with the peak ages among all offenders for this type of offence occurring when the accused person was 13 or 14 years of age (Statistics Canada, 2014). More than half (51%) of accused are over the age of 25 years (Statistics Canada, 2014), with international research reporting that the average age of sexual abusers of children is between 37 to 39 years (Hanson, 2001). In 2012, the majority (81%) of sexual offences against children involve a male as the accused and a female as the victim (Statistics Canada, 2014).

The number of adults charged with a sexual crime outnumbers the youth charged; however, youth have a higher rate of being charged with a sexual violation against a child or youth. While this phenomenon is consistent with other provinces (the number of adults age 18+ is much larger than youth age 12-17), the 2011-2015 average rate for New Brunswick youth charged with a sexual offence (17.11 per 100,000) was 2.5 times higher than adults (7.43 per 100,000), a discrepancy only outpaced by Québec (mostly due to a lower rate of adult perpetration) (Statistics Canada, 2019a). Further, the rate of adults being charged in NB is lower than the Canadian average (4.47), while the rate of youth being charged is above the Canadian average (9.24).

Graph I: Rate of Adults and Youth Charged as Measured by the Total Sexual Violations Against Children Category (2011-2015) depicts the higher rates of youth charged compared to that of adults across the provinces (excluding territories).

Graph I: Rate of Adults and Youth Charged as Measured by the Total Sexual Violations Against Children Category (2011-2015)



	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC
Adult	6.348	5.282	4.372	7.432	4.214	2.786	5.94	8.15	3.898	7.658
Youth	12.802	13.58	9.258	17.112	17.324	3.572	10.496	13.284	6.79	14.776
Can Adult avg.	4.478	4.478	4.478	4.478	4.478	4.478	4.478	4.478	4.478	4.478
Can Youth avg.	9.238	9.238	9.238	9.238	9.238	9.238	9.238	9.238	9.238	9.238

Source: Statistics Canada (2018g). Table 35-10-0177-01 Incident-based crime statistics, by detailed violations. Total Sexual Violations Against Children.

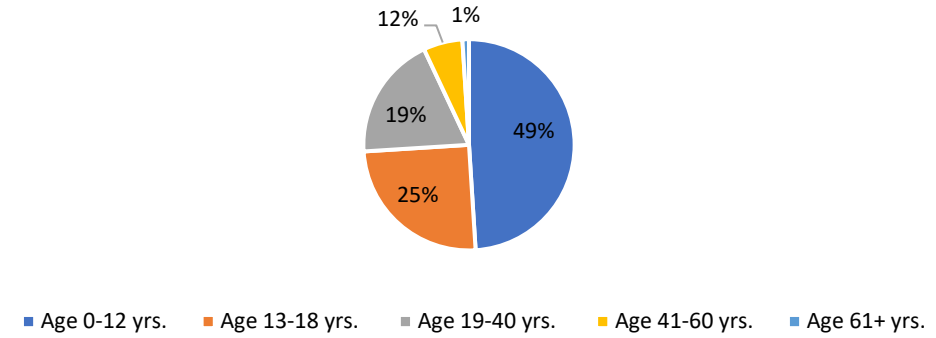
Link to Unfounded Sexual Crimes

Criminal incidents are first reported to police, investigated by police, then determined to be founded (the offence occurred or was attempted) or unfounded (the offence did not occur or was not attempted). Following a 20-month review of police sexual assault investigations conducted by the Globe and Mail, an article titled 'Will the police believe you?' was released in 2017. According to this article, Canada's national average of unfounded complaints of sexual assault was 19.39% based on data from 2010 to 2014. New Brunswick had the highest rate at 32%. As a result, the Canadian Association of Chiefs of Police requested that all police forces review practices of sexual assault investigations to determine whether or not reported incidents were adequately investigated and scored properly (Province of New Brunswick, 2017).

As reported in the Province of New Brunswick's Sexual Crimes Review (2017), municipal/regional police forces in New Brunswick reviewed 1746 incidents of sexual crime from 2010 to 2014. Of the 1746 files, 573 (33%) had been classified as unfounded and were further examined. The review revealed that all municipal/regional police forces, to varying degrees, incorrectly applied the unfounded code. After this process, 217 (12%) files remained classified as unfounded, while the remaining were reclassified. All police forces found a reduction in the rate of files classified as unfounded at the end of this review period (Province of New Brunswick, 2017).

As can be seen in **Graph J: Age Range of Reported Victims** below, the Sexual Crimes Review found that the majority (74%) of victims of unfounded sexual crimes in New Brunswick were youth between 0 and 18 years of age. Specifically, 49% were 0 to 12 years old and 25% were 13 to 18 years old.

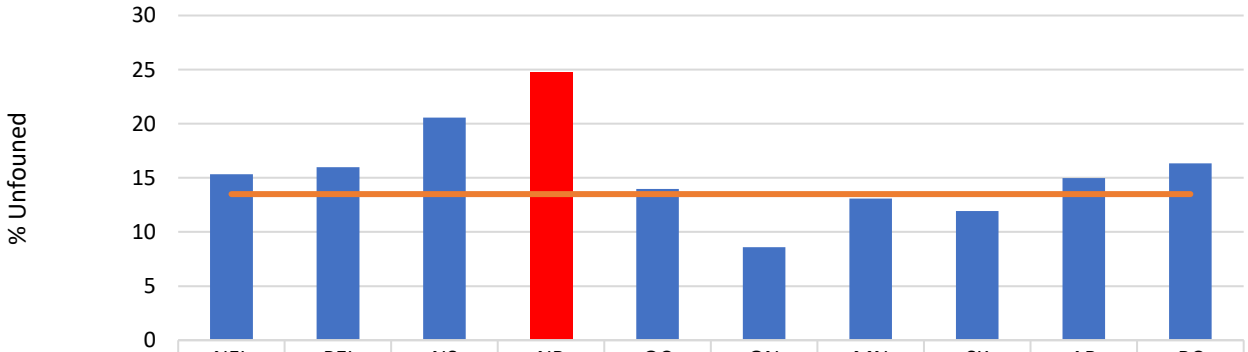
Graph J: Age Range of Reported Victims



Source: Province of New Brunswick. (2017). *Sexual Crimes Review 2017.* https://www2.gnb.ca/content/dam/gnb/Departments/jus/PDF/sexual_crimes_review2017.pdf

According to Statistics Canada, approximately 14% of 8046 sexual crimes coded as 'Total Sexual Violations Against Children' were classified as unfounded in Canada in 2017.[7] New Brunswick had the highest percentage of unfounded Total Sexual Violations Against Children of all provinces at 25% (see **Graph K: Percent of Unfounded Total Sexual Violations Against Children by Province (2017)**).

Graph K: Percent of Unfounded Total Sexual Violations Against Children by Province (2017)



	NFL	PEI	NS	NB	QC	ON	MN	SK	AB	BC
Provinces	15.33	16	20.56	24.78	13.97	8.58	13.09	11.93	14.98	16.35
Canada	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5	13.5

Source: Statistics Canada. (2019a). Table 35-10-0177-01 Incident-based crime statistics, by detailed violations. Unfounded Total Sexual Violations Against Children.

It is important to determine why such a large proportion of sexual violations against children and youth are unfounded. It is possible that younger age groups may have challenges in communicating information to investigators, police may experience barriers in collecting reliable information through the

[7] Data for unfounded incidents are currently only available for 2017 from Statistics Canada. Data collection was halted in 2006 due to inconsistent reporting. The definitions of founded and unfounded incidents were revised in 2017 in the hopes of improving comparability between jurisdictions. Given that changes are still taking place up until 2019 data, it should be noted that inconsistencies may still exist in 2017 and 2018.

investigation, or there may be challenges in proceeding through the court process. Another possibility could be the understanding of mandatory reporting requirements of child protection legislation where reports are made to police based on a suspicion that sexual harm to a child has occurred, but evidence is lacking to confirm this suspicion. These issues are further explored in the Social Development section below. Regardless of the cause, the high rates of unfounded cases where the victim is a child warrants further exploration and action.

The Government of New Brunswick, through the Department of Public Safety, has engaged a stakeholder group consisting of the New Brunswick Police Commission, the New Brunswick Women's Council, the Fredericton Sexual Assault Centre, the Office of the Child, Youth and Seniors' Advocate, the Government of New Brunswick's Women's Equality Branch, the New Brunswick Association of Chiefs of Police and the Royal Canadian Mounted Police "J" Division to examine opportunities to address the barriers victims face in reporting a sexual crime and ensure they are supported along the entirety of the criminal justice system. The Child Sexual Harm Advisory Committee has been working with the Sexual Crimes Working Group to look at identified issues and recommendations with a child and youth lens. Where this work is ongoing, high-level recommendations have been included in this report and will be refined through the Sexual Crimes Working Group process.

Summary: Key Considerations for Police-Reported Statistics

- 'Sexual Assault Level 1' is the most common sexual offence perpetrated against children and is not included in the measure for 'Total Sexual Violations Against Children,' as reported by Statistics Canada. New Brunswick's average rate (211.09 per 100,000) of victims of child and youth sexual assault level 1 from 2009-2015 was higher than both the national average (146.61 per 100,000) and the Atlantic Canadian average (194.35 per 100,000).
- Out of 1766 child and youth victims of sexual offences between 2013 and 2017, the majority (78.99%) were female.
- From 2009-2017, NB's overall trend of victims of sexual violations increased for children aged 0 to 11. Female victims, in comparison to male victims, saw the largest increase. Specifically, females between 0 and 11 years of age saw an increase from 64 victims per 100,000 population in 2009 to 110 victims in 2017.
- The average rate of NB youth (17.11 per 100,000 population) that committed a sexual offence was 2.5 times higher than the average rate of NB adults (7.43 per 100,000 population) that committed a sexual offence between 2011-2015.
- Based on a custom request to Statistics Canada that included all sexual offences against children (inclusive of those captured in the measure for 'Total Sexual Violations Against Children' in addition to other sexual offences such as 'Sexual Assault Level 1'), NB has the 3rd highest 7-year average rate (289.18 per 100,000 population) of children and youth victims of all police-reported sexual offences among the provinces and has a higher 7-year average rate than Canada (199.05 per 100,000 population).
- From 2009 to 2017, New Brunswick had the 2nd highest average rate (0.73 per 100,000) among all provinces of sexual exploitation of children, falling only behind Manitoba.
- Over a 20-year span (1998-2017), NB had the 4th highest average rate (5.28 incidents per 100,000 population) of possession or accessing child pornography in comparison to other provinces of Canada. Between 2015-2017, NB had the 3rd highest average rate (8.083 incidents per 100,000 population) of incidents relating to making or distributing child pornography among the provinces.
- The majority of those accused of sexual violations against children are male. Approximately 30% were between the ages of 12 and 17 years and rates of accused have been found to decrease after the age of 14 years. More than half of accused (51%) are over the age of 25 years with reports that the average age of sexual abusers of children is 38 years.
- Statistics Canada cautions that sexual offences in general tend to be under-reported in police statistics and that this under-reporting can be compounded in cases where the victim is a child.
- Based on a review of unfounded sexual crimes in NB from 2010 to 2014, a large proportion (74%) of victims of unfounded sexual crimes were youth from 0 to 18 years of age.

Social Development: Reports of Suspected Child Sexual Harm

Although police-reported statistics provide a snapshot of the extent of child sexual harm in New Brunswick as compared to the rest of the country, it is important to consider other forms of data to inform this review, such as the information collected through the Department of Social Development. Including the following information alongside police-report and self-report data provides additional insight on the reality of child sexual harm in New Brunswick in terms of who is identifying and reporting potential abuse, who may be perpetrating the abuse, characteristics of the victim, and information on system response.

Data on the incidence of suspected sexual abuse in New Brunswick was obtained from the Social Development spanning the 2012-2017 fiscal years (April-March).[8] New Brunswick's *Family Services Act* requires "any person who has information causing him to suspect that a child has been abandoned, deserted, physically or emotionally neglected, physically or sexually ill-treated or otherwise abused must inform this Department of the situation without delay".[9] Social Development uses the Structured Decision Making® Model to screen and assess all reported incidents of harm, including child sexual harm. Social Workers then investigate cases that meet screening criteria and follow up with necessary interventions or services as required. It is important to note that Social Development also completes interviews with suspected victims of child sexual harm in cooperation with police agencies across the province, even for cases that do not meet Social Development's sexual harm screening criteria (discussed below).

The *Family Services Act* mandates the **protection** of children by the Minister of Families and Children while intervention and treatment go beyond the scope of Social Development investigation. However, if it is determined through the investigation that the child's security and development is compromised, the Minister may intervene and may provide services to children through an on-going case, which is individually tailored to the strengths and needs of each child and family.

Data Limitations

The following information represents a sample of incidents reported to Social Development over 2012-2017. After removing cases that included more than one child in the home to ensure that only victims were included in the dataset, there were 3525 individual suspected incidents of CSH reported to Child Protection during this time. Removing these cases helped to ensure that findings relate to the CSH victim specifically, and enabled a fair comparison across cases. As such, while the sample size is large, the following data does not reflect all reported cases of suspected CSH. Further, data from all regions was unavailable at the time of this report. Please see below for a variety of graphs, analyses, and interpretations.

Substantiation

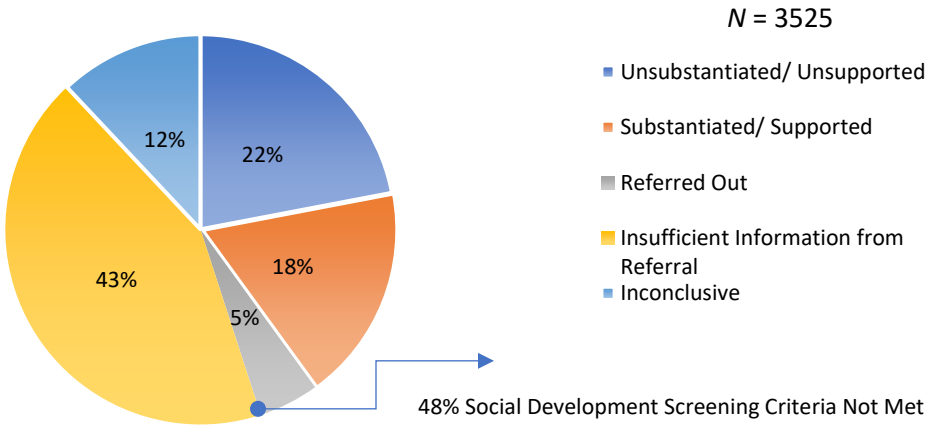
Social Development's Structured Decision Making® System's sexual abuse screening criteria includes the following: a) any sexual act on a child by an adult caregiver or other adult **in the household**, or unable to rule out household member as alleged perpetrator; b) sexual act(s) among siblings or other children **living in the home**; c) sexual exploitation; and d) threat of sexual abuse (known or highly suspected sexual abuse perpetrator **lives with the child** and severely inappropriate sexual boundaries). Structured Decision Making® screening results include:

[8] Data from all regions was unavailable at the time of this report.
[9] http://www2.gnb.ca/content/gnb/en/services/services_renderer.9355.Child_Protection.html

- **SD Screening Criteria Not Met** indicates that the threshold for Social Development to intervene (the screening criteria identified above) was not met, according to NB's Structured Decision Making® System: Policy and Procedures Manual 2010, and consequently, the case was screened out.
- **Unsubstantiated** means the case was investigated and a decision made that, on the balance of probabilities (it is not "more probable than not" that the harm or risk of harm has occurred, currently exists or is likely to occur), evidence gathered lends weight to the belief that abuse or neglect did not occur.
- **Substantiated** is a decision that, on the balance of probabilities, it is more probable than not that the harm or risk of harm has occurred, currently exists or is likely to occur.
- **Inconclusive** indicates that critical information necessary for establishing the probability that abuse or neglect occurred or did not occur, cannot be obtained. This case finding does not mean that the worker has determined that abuse or neglect did not occur, but rather that a lack of information makes it impossible to establish a balance of probabilities that abuse/neglect did or did not occur. All appropriate attempts to gather assessment information have been exhausted before this conclusion is reached. This conclusion is not used as a "default" for cases where the decision to substantiate or not is difficult to make.

According to the *Family Services Act*, individuals who suspect that a child is being abused or neglected must immediately report suspicions to Social Development. Graphs below illustrate a break down of the reported child sexual abuse to the Department of Social Development with associated screening results.

Graph L: CSA Reports by Outcome (2012-2017): NB Social Development Data



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

Graph L: CSA Reports by Outcome (2012-2017): NB Social Development Data illustrates the number of suspected CSH instances reported to the Department of Social Development that included only one applicant/victim over 5 fiscal years (2012-2017; *N*= 3525). Conclusions of these instances, as coded by Social Development staff, are included. Of these, 52% were investigated with 22% found to be unsubstantiated, 18% substantiated/supported and 12% were found to be inconclusive, meaning that there was insufficient information gathered to lend weight to the belief that abuse did (or did not) occur. The remaining 48% of

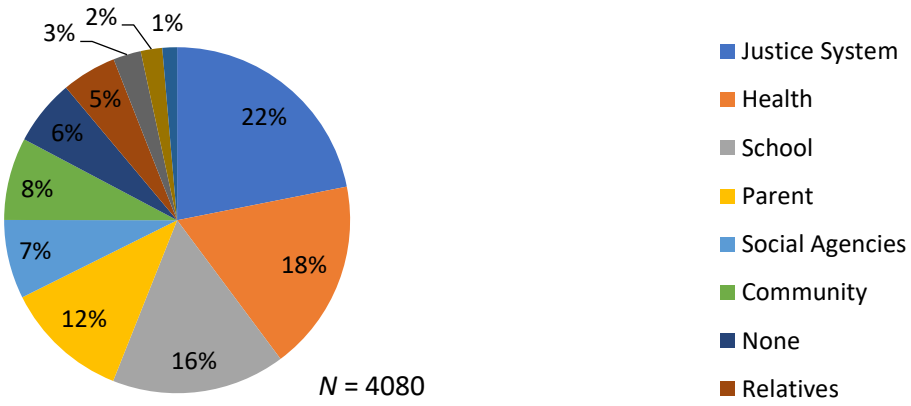
reports did not meet Social Development's sexual abuse screening criteria. It is important to note that this does not mean that CSH did not occur in these instances, rather that the case was not investigated further because the threshold for Social Development intervention based on the Structured Decision Making® Model was not met. Specifically, 43% of all referrals to Social Development did not include sufficient information to proceed with the investigation and 5% were referred outside of Social Development (i.e., directly to a policing agency or another jurisdiction). The review did not find any specific indicators, including age, that appeared to be a factor in whether a case met Social Development screening criteria or not.

While these findings may seem alarming, the results appear to be consistent with Simpson et al. (2008), who conducted the third Canada-wide study in a series that examined the incidence of outcomes of allegations of abuse and neglect reported to child welfare agencies. This report included a review of 235,842 cases from 112 child welfare agencies across Canada and focused on all allegations, including sexual harm. Simpson et al. (2008) found that 40.6% (174,411) of all reports to social welfare agencies in the sample were unsubstantiated by child welfare agencies. These reports are more often made in good faith (35%), but occasionally can be done maliciously (6%). The report noted that unsubstantiated reports can stem from misinterpreted signs of abuse. While not conclusive, these findings provide a reference point when interpreting both the findings of Social Development's Structure Decision Making® screening criteria and may also help to explain why a greater proportion of cases involving children and youth are unfounded in police statistics as well.

Referral Sources

While all persons are mandated to report child abuse or neglect, professionals are held to a higher standard in regard to reporting suspected instances of child harm, a child who may be in immediate danger, or a disclosure that has been made to them. Social Development data, presented in **Graph M: Percentage of Child Sexual Harm Referrals by Referral Source (2012-2017)**, shows that the three most common types of referral sources include the justice system (22%), health care system (18%), and school system (16%); combined, these systems are responsible for more than half (56%) of the referrals to Social Development. Some situations may have more than one referral source. Original referral sources were collapsed into categories.

Graph M: Percentage of Child Sexual Harm Referrals by Referral Source (2012-2017)



Source: Department of Social Development. (2018c). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on May 4, 2018.

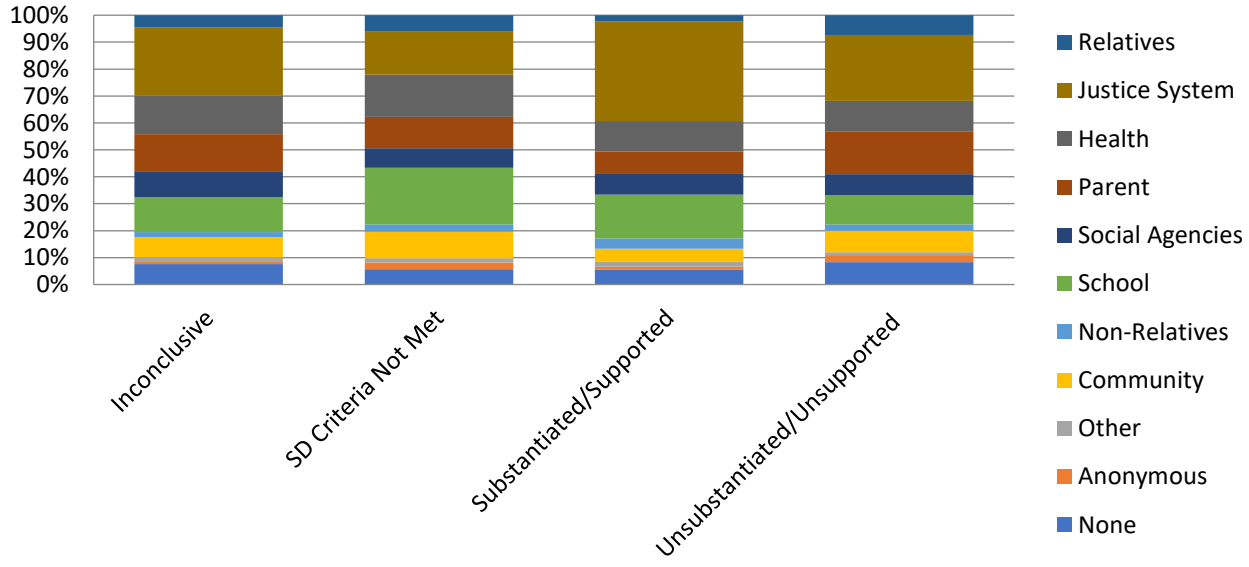
It is important to note that, as per the Child Victims of Abuse and Neglect Protocols, all reports of sexual assault are reported to the police unless the child-victim is over 16 years of age and he or she refused services. These youths have a presumptive right of privacy, the same as any adult subject to the *Family Services Act*. Social Development can alert the police to criminal activity but they must not disclose any private or confidential information to the police without the youth's consent.

Referral Source and Outcome

The justice system represents the majority of referrals across all outcomes (i.e., *inconclusive, substantiated/supported, unsubstantiated/unsupported*), with the exception of *Social Development criteria not met,* where schools (21.03%) were the most common referral source. The justice system represents over one-third (36.94%) of referral sources determined to be substantiated/supported. Parents were the most common referral sources for cases that were determined to be inconclusive (14.07%) and unsubstantiated (15.87%), pictured in **Graph N: Child Sexual Abuse by Outcome and Referral Sources (2012-2017)**. These findings point to several opportunities for improvements related to education and training.

Graph N: Child Sexual Abuse by Outcome and Referral Sources (2012-2017)

N = 4080



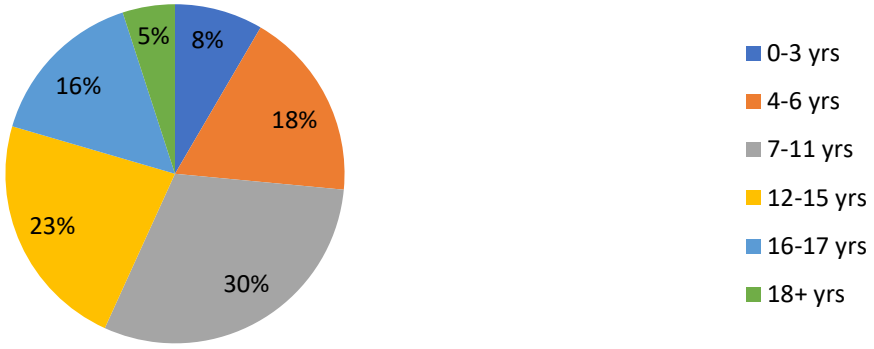
Source: Department of Social Development. (2018c). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on May 4, 2018.

Victim Age and Gender

Graph O: Victim by Age Group (2012-2017) shows the age of victims as reported by the Department of Social Development. The largest proportion of cases (30%) reported to Social Development are victims in the 7-11 age group. There may be multiple explanations for this finding. For example, sexual education is provided to youth in New Brunswick around the adolescent period, which may help youth better identify

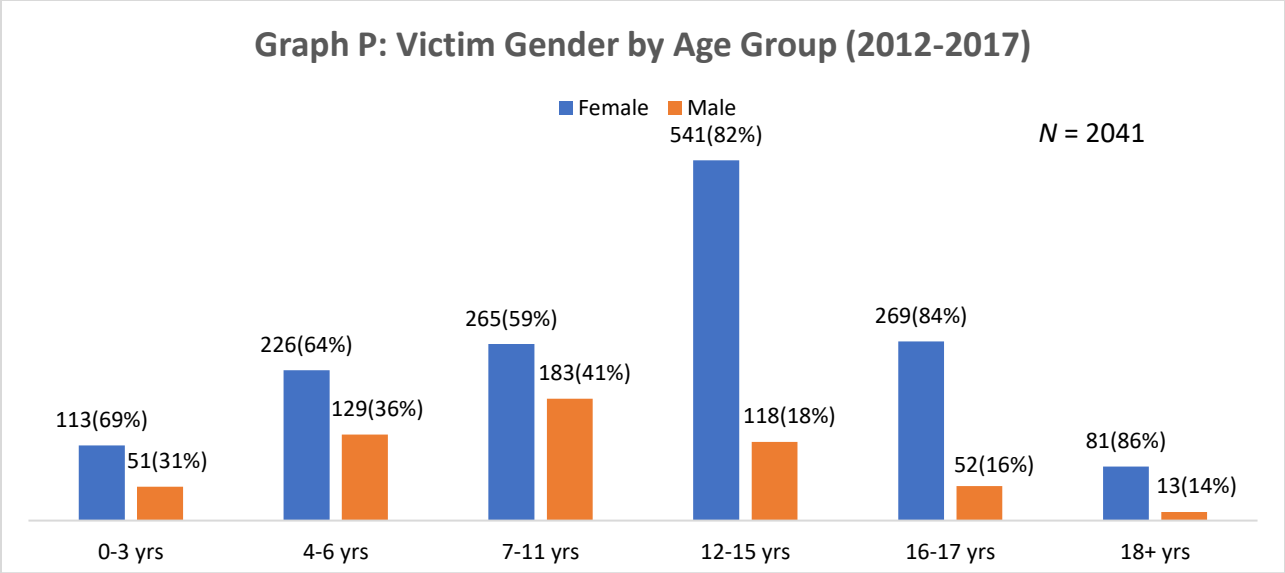
inappropriate behaviour. It is also possible that this age group is starting to be exposed to the internet, and social media, which may be a risky situation if unsupervised by a parent or guardian. Finally, older adolescents may prefer to report to their peers, as opposed to an authority figure, resulting in a smaller proportion being reported.

Graph O: Victim by Age Group (2012-2017)



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

Graph P: Victim Gender by Age Group (2012-2017) represents the frequency of female and male victims by age group. As can be seen below, the gender gap appears to widen during adolescence. For example, the proportion of male victims, in comparison to female victims, is almost half when comparing male victims ages 4 to 6 years (36%) to male victims ages 16 to 17 years (16%). This trend aligns with national police-reported sexual offence rates against children provided by Statistics Canada (Cotter & Beaupré, 2014). Furthermore, across all age groups, there is a higher frequency of female victims than male victims; the difference between females and males is smallest in the 4-6 age group (24%) and largest in the 18+ age group (64%).



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

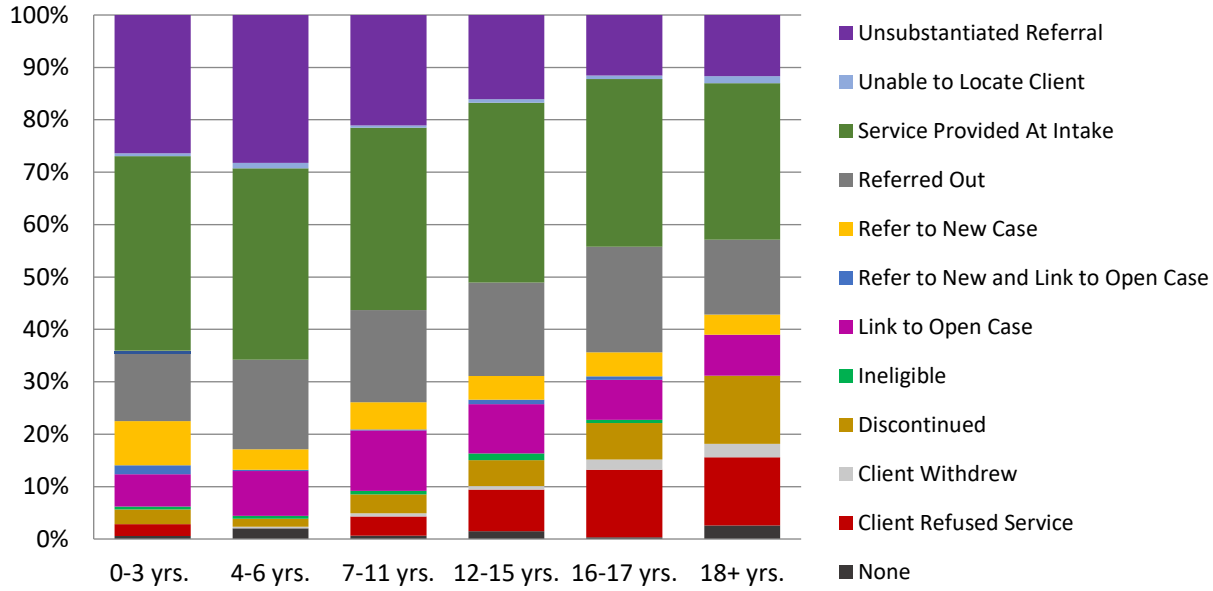
Service Provision

Graph Q: Victim Outcomes by Age Group (2012-2017) outlines the outcome of reports to Social Development by age group. According to the *Multiple Response Model Practice Standards in Child Protection and Family Enhancement Services*, outcomes include:

- ***Unable to locate client*** indicates that there is not enough information to locate the parent or the child after an incident is reported.
- ***Service provided at intake*** consists of Social Development completing a courtesy interview based on the *Step-Wise Guidelines for Child Interviews: The New Generation*, using a common empirically-based tool known as the *Statement Validity Assessment (SVA)* that assesses the credibility of verbal statements of victims in a structured manner. This information is provided to the investigating police force as part of their investigation.
- ***Referred out*** indicates that the referral source provides evidence that is more closely related to another department's or agency's mandate.
- ***Refer to new case*** indicates that the intake is used to open one new case.
- ***Refer to new case and link to open*** indicates that the intake is being used to open a new case as well as being linked to an existing case.
- ***Link to open case*** indicates that the intake is being linked to an existing case.
- ***Ineligible*** indicates that the case did not meet one of the following criteria: 1) the subject of the information is not a child as defined by the *Family Services Act*, 2) there is insufficient evidence to locate the child or family, and 3) the information provided does not fall within the mandate of Section 31(1) of the *Family Services Act*.

The chart excludes victims/applicants that did not meet Social Development criteria to intervene (*n* = 1484), according to New Brunswick's Structured Decision Making® Initial Intake Assessment. Approximately one-third of reports across all age groups were provided with a service by Social Development at intake. The proportion of unsubstantiated cases appears to decrease as victims grow older in age. There was a trend in the opposite direction found for cases that the client withdrew. Unsubstantiated referrals ranged from a high of 28% (4 to 6 years of age) to a low of 12% (18 years of age or older). See potential reasons for these trends below.

Graph Q: Victim Outcomes by Age Group (2012-2017) *N* = 2041



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

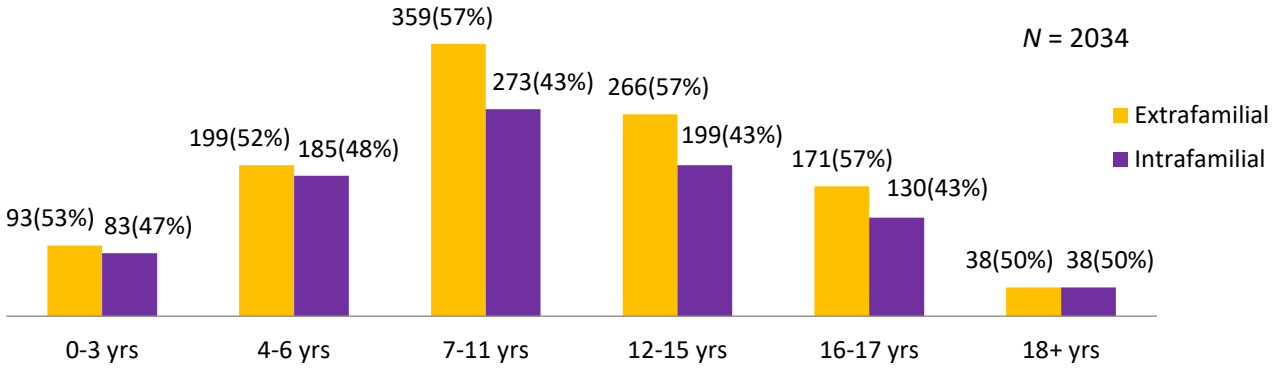
Victim Association to Perpetrator

Graph R excludes victims/applicants that did not meet Social Development criteria to intervene (*n* = 1484), according to New Brunswick's Structured Decision Making® Initial Intake Assessment. Some comparisons can be made between Graph R and national statistics reported by Statistics Canada regarding intrafamilial and extrafamilial cases.[10] For example, Cotter and Beaupré (2014) found that 66% of victims aged 0 to 3 years were victimized by family members (17% considered extended family); 62% of victims aged 4 to 6 years were victimized by family members; and 55% of victims aged 7 to 11 years were victimized by family members. Cotter and Beaupré (2014) also found that 28% of victims aged 12 to 15 years, and 19% of victims aged 16 to 17 years, were victimized by family. Whereas the national statistics from Statistics Canada

[10] According to the NBFamilies training/program documentation**, intrafamilial** abuse occurs when the following persons are involved: 1) father, mother, daughter, and/or son; 2) common law partner, daughter, or son; 3) step-father, step-mother, step-daughter, and/or step-son; 4) sibling, where the abuser is older and is an authority figure for his/her sibling; 5) uncle, aunt, niece, nephew, and/or cousin, even if they do not reside in a household. On the other hand, **extrafamilial** abuse occurs when the person involved is not a relative as described in intrafamilial (e.g., a neighbor, teacher, boarder, babysitter, etc.). This person may or may not reside in the same household as the victim.

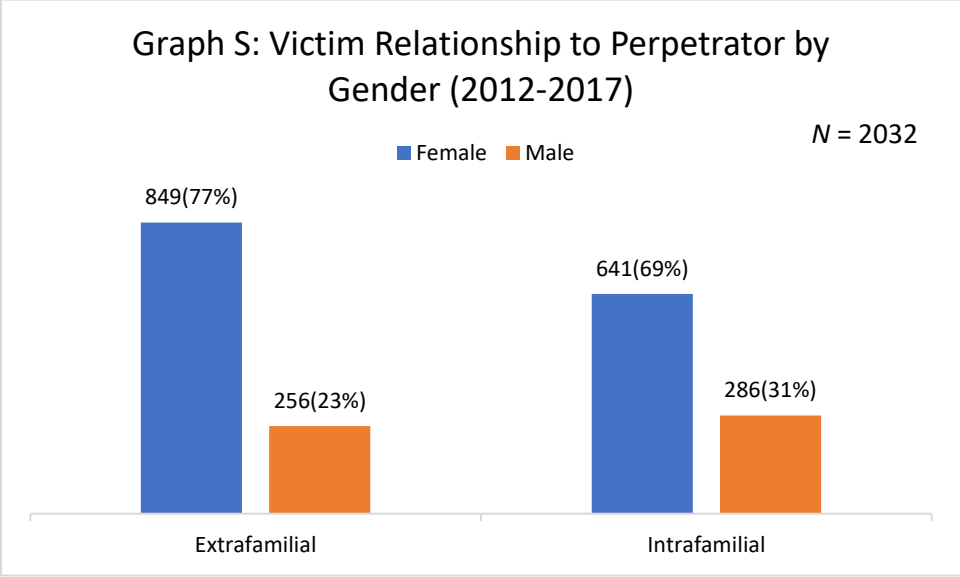
show that younger victims are more likely to be victimized by family members than older victims, the proportion of children and youth victimized by familial and extrafamilial members is more evenly distributed within the current sample of victims from Social Development, with victimization peaking in the 7-11 year age range then declining thereafter.

Graph R: Victim Relationship to Perpetrator by Age Group (2012-2017)



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

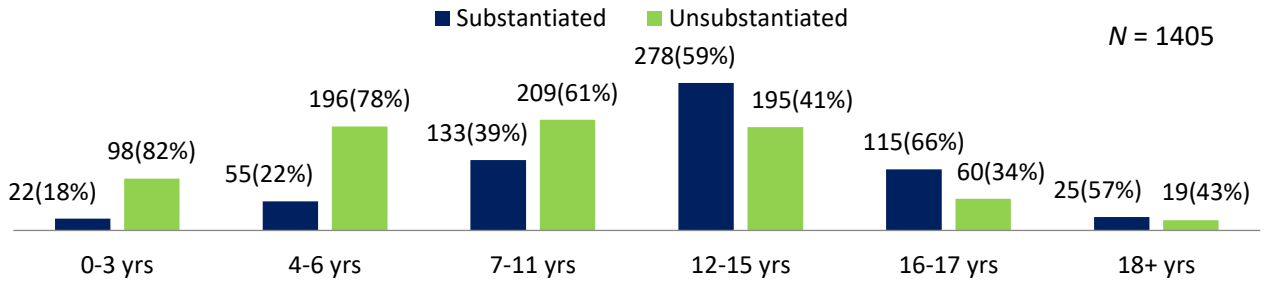
Graph S: Victim Relationship to Perpetrator by Gender (2012-2017) represents victims' relationship to the perpetrator by gender of the victim. While both females and males can be victims of extrafamilial and intrafamilial abuse, more females than males are victims of both forms of abuse. Male victims represent approximately one-third of victims for both extra-familial and intra-familial cases; whereas, Statistics Canada has reported 22% of male victims in 2012, which is in line with the proportion reported in Nova Scotia (22%) and Ontario (21%). This is consistent with findings in the literature, as generally males may be less likely to report, or delay reporting, incidents to the police (Cotter & Beaupré, 2014).



Source: Department of Social Development. (2018a). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on January 19, 2018.

Graph T: Sexual Abuse Conclusion by Age Group (2012-2017) displays the frequency of cases that were substantiated or unsubstantiated by age group. There is a greater proportion of unsubstantiated cases, in comparison to substantiated cases, within younger age groups (i.e., 0-3 yrs., 4-6 yrs., 7-11 yrs.); whereas, for older age groups (i.e., 12-15 yrs., 16-17 yrs., 18+ yrs.), substantiated represents the greater proportion. It is possible that this difference reflects the younger victim's inability to effectively communicate the incident to investigators due to age. In other words, investigations may be limited by the evidence (or lack of evidence) that the child can provide to the investigators at the time. Another possible explanation for the greater proportion of substantiated cases for older age groups is that sexual education is provided to youth in New Brunswick around the adolescent period, which may help individuals better identify inappropriate behaviour by a perpetrator. Furthermore, older age groups may be more likely to be influenced by external factors, like peers and the media (including social media).

Graph T: Sexual Abuse Conclusion by Age Group (2012-2017)

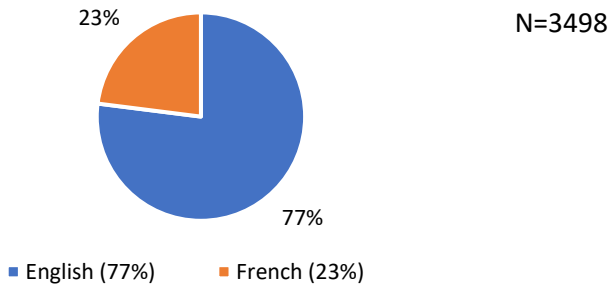


Source: Department of Social Development. (2018b). Department of Social Development: NB Families System (R3733772). Government of New Brunswick. Retrieved on April 4, 2018.

Language Preference

Based on 3498 files reviewed (there was no indicated language preference in 27 of referred cases), there was a greater proportion of victims/applicants with a preferred language of English (77%) in comparison to French (23%), though this is in line with the language profile of New Brunswick, depicted in **Graph U: Language Preference of Child Sexual Harm Referral**.

Graph U: Language Preference of Child Sexual Harm Referral



Summary: Key Considerations for Social Development Reported Data

- A sample (n=3525) of suspected incidents of Child Sexual Abuse (CSA) reported to Social Development from 2012-2017 was analyzed. Fifty-two percent of referrals were investigated with 18% of these reports substantiated. Twenty-two percent were unsubstantiated meaning evidence gathered lends weight to the belief that abuse or neglect did not occur. Twelve percent were inconclusive. This does not mean that CSA did not occur, only that it could not be substantiated.
- Approximately half (48%) of reports did not meet Social Development's screening criteria, as outlined in the Structured Decision Making® Intake Assessment. This does not mean that CSA did not occur, only that the case was not investigated further.
    - Of this 48%, the majority (89%) were screened out due to insufficient information provided by the referral agent. The remaining 11% were provided service at intake or referred to another agency (e.g., incident occurred in NB but the caregiver currently lives in another province).
    - Findings are consistent with national review that found 40.6% of all reports to social welfare agencies were unsubstantiated, however these reports are more often made in good faith (35%). Unsubstantiated reports can stem from misinterpreted signs of abuse.
- The three most common referral sources included the justice system (22%), health care system (18%), and school system (16%).
- The justice system represents the majority of referrals across all outcomes (i.e., inconclusive, substantiated/supported, unsubstantiated/unsupported), with the exception of SD criteria not met, where schools (21.03%) were the most common referral source. Parents were the most common referral sources for cases that were determined to be inconclusive (14.07%) and unsubstantiated (15.87%).
- The largest proportion of cases (30%) reported to Social Development have victims in the 7-11 year age range.
- There were more female victims across all age groups. In addition, there appeared to be an age by gender interaction, with more males represented within younger age groups in comparison to older age groups. For females, this effect is also present, but not to the same degree.
- Substantiated cases represent a greater proportion of victims within older age groups (12 years of age or older) in comparison to younger age groups (11 years of age or younger).
    - This could reflect the victim's inability to effectively communicate the incident to investigators (11 years of age or younger), which may require an examination of current information gathering practices to determine appropriateness for the age group.
    - Alternatively, where sexual education is provided to New Brunswick youth around the adolescent period, this may reflect an increase in ability to identify inappropriate behaviour by a perpetrator (12 years of age or older).
- A smaller proportion of victims in NB, aged 11 years and younger, were victimized by family members (intrafamilial) in comparison to national data published by Statistics Canada.
- A larger proportion of victims in NB, aged 12 years and older, were victimized by family members (intrafamilial) in comparison to national data provided by Statistics Canada.

Self-Report Data

Self-report data in Canada is most often collected from the General Social Survey (GSS) which was established in 1985 to gather data to monitor changes in social trends, the living conditions and well-being of Canadians and to provide information on social policy issues. Themes covered by the GSS include caregiving, families, time use, social identity, volunteering, and victimization. The GSS is important because it captures data that does not come to the attention of police. That said, results on childhood victimization is not captured in the GSS as participants are age 15 years and older. Fortunately, New Brunswick conducts a Student Wellness Survey every three years. "The purpose of the New Brunswick Student Wellness Survey (NBSWS) is to examine students' perceptions, attitudes and behaviours in a number of key areas related to student well-being. It is a provincial initiative of the New Brunswick Department of Social Development - Wellness Branch in cooperation with the Department of Education and Early Childhood Development. Data collection and analysis is carried out by the New Brunswick Health Council" (New Brunswick Health Council, 2021). The student wellness survey data is publicly available on the New Brunswick Health Council website www.nbhc.ca. The 2015-2016 survey included responses from 32,677 youth in grades 7-12 from across the province and included questions on sexual violation and dating violence (which includes sexual violence).[11]

New Brunswick Student Wellness Survey Questions relating to Victimization

The following are the exact questions that were used in the NBSWS.

1. Question: Has anyone ever made you do any sexual activity (e.g., kissing, oral sex, intercourse) when you didn't want to (by pressuring you with their words or actions, or by using alcohol or drugs)? Potential Answer: Yes or No

2. Question: During the past 12 months, did someone you were dating or going out with physically, sexually, psychologically or emotionally hurt you? (Count such things as being hit or injured, yelled at, bullied, keeping you from friends or family or making you to do unwanted sexual activities.) Potential Answer: Yes or No

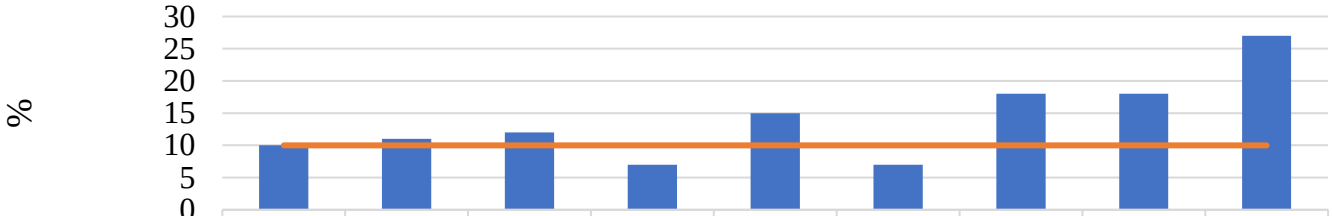
3. I did not date or go out with anyone during the past 12 months. Potential Answer: Yes or No

Results: Sexual Victimization

Results from the NBSWS in 2015-2016 revealed that 10% of New Brunswick students from grades 7-12 reported being sexually violated at least once in their lifetime (see **Graph V: Sexual Violations in Lifetime**). While this number was fairly consistent across school districts, there was an increase in the prevalence of sexual violations reported among Indigenous youth (15%), Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Ally, Two-Spirit, and others (LGBTQIA2+) children and youth (18%), students with learning exceptionalities or special needs (LESN; 18%), and those of lower socioeconomic status (SES; 27%).

[11] In total, data was collected from 38,573 students in grades 6 to 12. Questions regarding sexual harm and dating violence, however, were only asked to students in grades 7 to 12.

Graph V: Sexual Violations in Lifetime



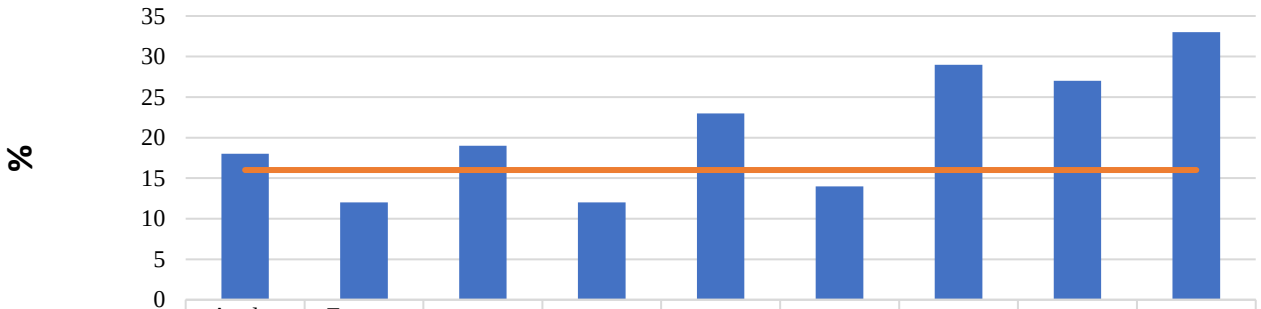
	Anglo-phone Districts	Franco-phone Districts	Female	Male	Indigenous	Immigrant	LESN	LGBTQ	Low SES
Percentage	10	11	12	7	15	7	18	18	27
NB avg.	10	10	10	10	10	10	10	10	10

Source: NBHC and Department of Social Development (Wellness Branch). New Brunswick Student Wellness Survey, Grades 7 to 12, 2015-2016, n = 32,677.

Results: Dating Violence

Similar trends were found for dating violence victimization, although there was greater discrepancy across school districts as well. As can be seen in **Graph W: Dating Violence, Last 12 Months**, during the last 12 months, 16% of students reported being the victim of some form of dating violence. Numbers were higher among the Anglophone (18%) compared to the Francophone school districts (12%). Again, these findings were higher among Indigenous youth (23%), LGBTQIA2+ youth (27%), students with LESN (27%), and those of lower SES (33%). It should be noted that the dating violence measure encompasses multiple forms of dating violence. Thus, information on sexual dating violence alone cannot be gathered from the larger metric.

Graph W: Dating Violence, Last 12 Months



	Anglo-phone Districts	Franco-phone Districts	Female	Male	Indigenous	Immigrant	LESN	LGBTQ	Low SES
Percentage	18	12	19	12	23	14	29	27	33
NB avg.	16	16	16	16	16	16	16	16	16

Source: NBHC and Department of Social Development (Wellness Branch). New Brunswick Student Wellness Survey, Grades 7 to 12, 2015-2016, n = 32,677.

Summary: Key Considerations for Self-Report Data

- Ten percent (10%) of New Brunswick students from grades 7 to 12 self-reported being sexually violated at least once in their lifetime.
- Youth who identified as Indigenous, youth who identified with LGBTQIA2+, youth with learning exceptionalities and special needs, and youth of lower socioeconomic status reported higher percentages of being sexually violated in their lifetime.
- Sixteen (16%) of students from grades 7 to 12 self-reported being victims of some form of dating violence; this was more common among the Anglophone (18%) than the Francophone school districts (12%). Higher rates were also found among members of the groups outlined above.

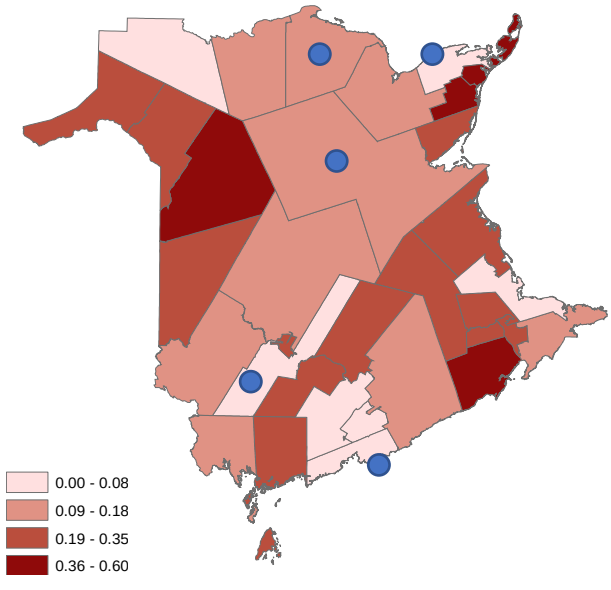
Comparing Police-Report to Self-Report Data

The findings of the self-report 2015-2016 Student Wellness Survey were compared to 2015 police-reported crime statistics (UCR2) by the New Brunswick Health Council using heat-maps, which allows for a region-level comparison of the two indices. These two data sources offer ways of measuring sexual harm to children and youth at the sub-provincial level; however, they are not directly comparable due to differing definitions and data collection methods, including interpretations and the context in which the incident occurred.

Discrepancies

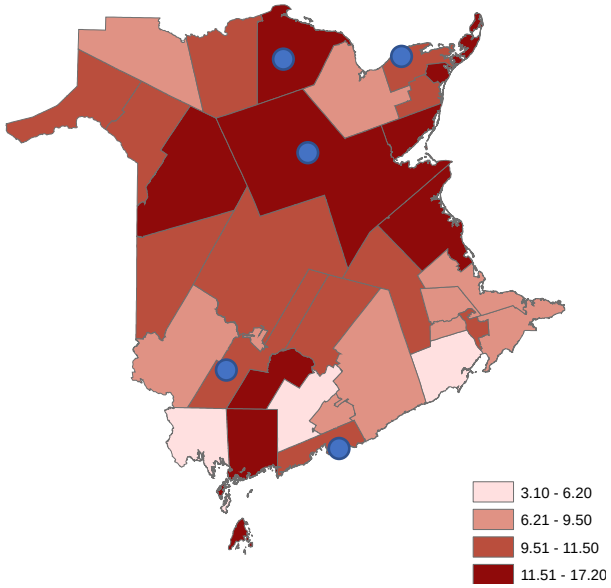
While both indices provide insight on geographical areas that appear to have a higher prevalence of child sexual harm, there are some notable discrepancies between the two. **The five areas with the largest discrepancy are marked by blue circles on the maps below and identify the areas with higher self-reported victimization rates that have lower rates of police-reporting.** While not conclusive, this comparison does not appear to support the hypothesis that child sexual harm is higher in New Brunswick due to better or increased reporting practices to police. However, although not directly comparable, if there were better or increased reporting practices to police in New Brunswick, there should be less discrepancy between police-reported and self-reported statistics.

Police Reported Sexual Violations Against Children, Rate per 1,000



Source: Statistics Canada, Uniform Crime Reporting Survey – 2015, NBHC in-house calculations

Self-Reported Percent of Youth who were Sexually Violated in Lifetime



Source: NBHC and Department of Social Development (Wellness Branch). New Brunswick Student Wellness Survey, Grades 7 to 12, 2015-2016.

Potential Explanations

Further investigation of these discrepancies is warranted as there are likely multiple elements at play, some of which may be a factor in some areas but not others. Geographical regions that have been highlighted

with a darker shade of red on both maps likely indicate that there is an issue worthy of exploring further. It is important to note that findings may be influenced by the inherent differences between self-report and police-report data. Nonetheless, here is a list of potential explanations to consider:

- interpretation of what is meant by 'sexual violation' by youth completing the NBSWS; some areas may have greater awareness/different understanding of appropriate sexual touching when compared to others.

- regional attitudes and beliefs about the sexual abuse, whether it is viewed as a family matter versus criminal matter or a desire to maintain the family unit (in cases of intrafamilial abuse).

- level of trust in police, social workers, and the criminal justice system. This may be particularly relevant for areas with a higher number of First Nation Communities whose residents may be reluctant to contact their local policing services or Child and Family service agency given the history that these government bodies have had with Indigenous communities across the country. Memories of the "Sixties Scoop," which saw thousands of Indigenous children removed from their homes and placed in non-Indigenous households may understandably impede one's willingness to report sexual abuse.

- delayed reporting is common with child sexual abuse, especially amongst males (Cotter & Beaupré, 2014; Cashmore, Taylor, & Parkinson, 2017). A greater proportion of males (17%), in comparison to females (7%), have a reporting delay of more than 10 years. Furthermore, an unknown proportion of victims never tell anyone about the abuse. It has been found that reporting is more likely to occur to a peer for adolescents, potentially due to comfort levels (Priebe & Svedin, 2008). Thus, it is evident that the reporting of this type of crime to authority figures is a complex process for an individual. It is likely that youth feel more comfortable self-reporting this information in a confidential, anonymous, and secure manner and environment.

- the quality of child-parent relationships may help explain some discrepancies. Children, in comparison to adolescents, are more likely to report abuse to a parent or parental-figure. Research has shown that girls that perceive their parents as non-caring are less likely to disclose abuse (Priebe, 2008). Similar to the point above, it may be that youth are more comfortable self-reporting abuse as opposed to talking to a parent or parental-figure, who may act as the first point of contact and facilitate initial contact with authorities.

- differences in disclosure patterns for girls and boys (Priebe & Svedin, 2008). Priebe and Svedin's (2008) study found that children's difficulties with disclosure are associated with both severity and abuse; relationship with the perpetrator; and the family structure and environment. This can impact the likelihood of the abuse being reported and to whom, whether it be a family member or professional.

- According to Statistic Canada's General Social Survey (GSS), common reasons for not officially reporting abuse to the police were that respondents felt the incident was not important enough (58%), the incident was dealt with in another way (54%), it was a personal matter (47%), and that the victim simply did not want any police-involvement (41%). Additional reasons include that the incident involved a current/previous intimate partner or friend, fear of reprisal, not wanting others to know, a belief that there was not enough evidence to file charges, and fear of the justice system. Lastly, lack of reporting may be due to the low probability that the report will result in a conviction.

Summary: Key Considerations for Comparison of Police-Report to Self-Report Data

- Heat maps comparing police-reported to self-reported data highlight several geographical discrepancies, which do not appear to support the hypothesis that child sexual abuse is higher in New Brunswick due to better or increased reporting practices. Although not directly comparable, if there were better or increased reporting practices to police in NB, then there should be less discrepancy between police-reported and self-reported statistics.
- Although further investigation is required, there are several possible explanations for these discrepancies, including interpretation of what is meant by 'sexual violation'; regional attitudes and beliefs about the sexual abuse (whether it is viewed as a family matter versus criminal matter); level of trust in police, social workers, and the criminal justice system; delayed reporting; the quality of child-parent relationships; differences in disclosure patterns for girls and boys; not believing the incident to be important; and dealing with the abuse in another way.

Current New Brunswick Practices

In addition to assessing the need for the increased prevention and intervention of child sexual harm based on an analysis of available data, a review of programs and services that currently exist in New Brunswick was also conducted. These programs function at the primary, secondary, and tertiary prevention levels. Primary programs are aimed at preventing child sexual harm before it happens, and are generally implemented through educational campaigns and policy targeted at the general population. These types of programs focus on preventing the social and situational factors which would allow for child sexual harm to occur. Secondary prevention programs and initiatives target individuals who may be at higher risk of victimization or offending. These programs might include effective early interventions for individuals who exhibit problematic behaviours. Finally, tertiary prevention programs refer to those which support victims and perpetrators after a crime or victimization has occurred. These include supporting victims in their healing processes and providing services to offenders to reduce recidivism.

This brief overview highlights promising New Brunswick programs and initiatives that align with Best Practices identified in Section 1. Additional detail on available child sexual harm programs, services and initiatives can be found in **Appendix A.** A more in-depth discussion on strengths and gaps of New Brunswick's existing practices as identified by practitioners are further outlined in Consultation results below.

Primary Prevention Initiatives

Primary prevention policies that have been implemented in New Brunswick include the Anglophone School District West Policy 703-14. Policy 703-14 seeks to protect all students from abuse by ensuring the elimination of non-professional conduct through defining acceptable standards of behaviour, prevention, and effective interaction with any student. Work is also underway by multiple partners to ensure that all individuals who enter the school district for any reason—including volunteers, coaches, teachers, administration—are trained on the policy. The Canadian Red Cross offers Violence, Bullying and Abuse Prevention programs province-wide and online. A Framework released in 2018 on Preventing and Responding to Sexual Violence in New Brunswick includes a focus on prevention and awareness of sexual violence, professional education and training, intervention, and policy, research and evaluation. While this Framework has a broad focus on all sexual violence (not only sexual harm to children and youth), there are opportunities to align efforts to achieve effective and efficient outcomes.

Secondary Prevention Initiatives

Promising secondary prevention programs in New Brunswick include Integrated Service Delivery/Network of Excellence (ISD/NOE). ISD/NOE was developed to ensure the positive growth and development of children and youth with multiple needs, recognizing that our siloed approach to working with children and youth was ineffective. It is a strength-based, child-centered approach whereby all partners work together in a collaborative, integrated manner to address emotional-behavioural concerns. While it was not developed specifically to address child sexual harm, it has a solid foundation in that it brings together the experiences and expertise of different government and community partners from across the system. It also has an evaluation framework in place to measure outcomes. Other existing secondary prevention programs include Child Protection Services, which carries a responsibility to intervene and assist any child who is abused or neglected. Child Protection Services cooperates with other community and professional resources in offering preventative, protective and supportive services to families and children. A Review of

the Child Protection System was released in January 2019 and includes multiple recommendations for improvements, many of which are complimentary to this review.

Tertiary Prevention Initiatives

There are multiple promising practices already underway in New Brunswick that align with the best practices review. For example, the Fredericton Sexual Assault Centre provides multiple programs and services including a support group to non-offending parents/guardians of children who have been sexually abused so that parents can look after themselves and in turn effectively parent through the aftermath of their child's sexual abuse. The Sexual Assault Nurse Examiner (SANE) Program provides victims of sexual or domestic violence support and forensic examination care and helps to increase the conviction rate of attackers by obtaining quality DNA samples. The Boreal Child Advocacy Centre provides services to child and youth victims of sexual abuse by offering services in a coordinated, child-centric manner in one location.

Recently as part of the provincial Crime Prevention and Reduction Strategy's 2016-2019 Action Plan, the Department of Public Safety conducted a review of criminogenic programs to help identify and make recommendations to fill tertiary treatment gaps at the community level. Recommendations include specialized assessment and training for working with sexual offending clientele, introduction of evidence-based programming such as multisystemic therapy for youth offenders and comprehensive multimodal criminogenic programming for adult sexual offenders rooted in cognitive-behavioural therapy, including a maintenance component to maintain skills learned in the core program. Recommendations are in phase 1 of implementation. Work through this initiative also aligns with the Auditor General's report to improve addiction and mental health services in provincial adult correctional institutions. Additionally, Circles of Support and Accountability currently operates in the Moncton region. This program works with released offenders providing reintegration support and a group environment where they are able to openly speak about triggers and difficulties.

As noted, these are only a few examples of promising New Brunswick CSH prevention and intervention programs that exist at the primary, secondary and tertiary levels. While the existence of these initiatives and others described in Appendix A are encouraging, very few are available consistently across the province and many are in the development or testing phase. The consultation results summarized below confirm these findings and identify additional CSH prevention and intervention gaps.

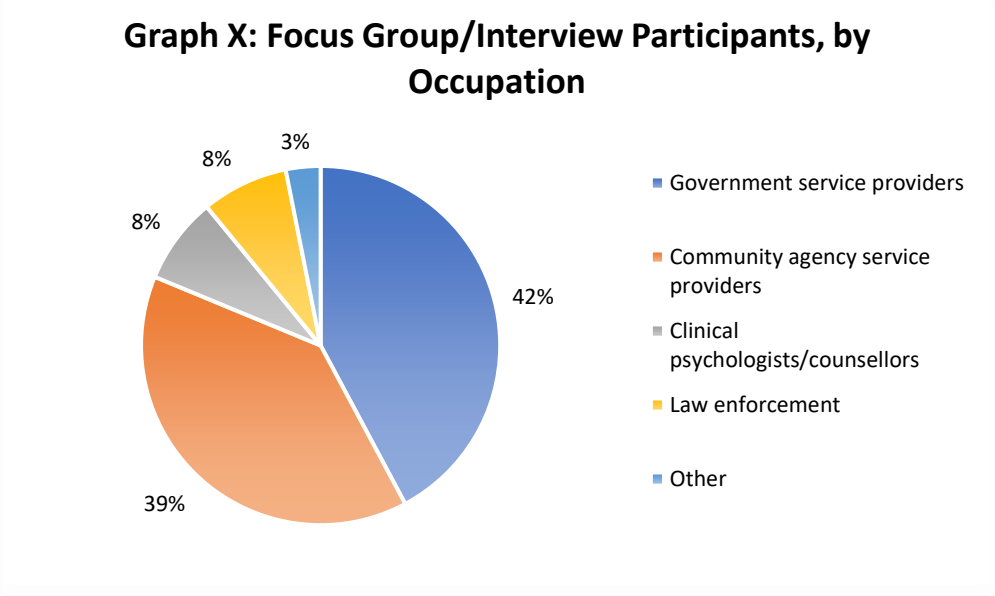
Summary: Key Considerations for Current New Brunswick Practices

- There are multiple programs, services and initiatives in New Brunswick that align with CSH Best Practices at the primary, secondary and tertiary prevention levels.
- While the existence of these initiatives is encouraging, very few are available consistently across the province and many are in the development or testing phase.
- The consultation results confirm this finding and identify additional prevention and intervention gaps.

Consultation results

Overview

Between summer 2017 and spring 2019, sixty-four (64) New Brunswick professionals and service providers (**see Graph X: Focus Group/Interview Participants, by Occupation**) were consulted through questionnaires, interviews, and focus groups. These were held in both official languages in multiple locations. Professionals were identified based on their scope of work and included forensic clinical psychologists, probation officers, nurses, paramedics, social workers, law enforcement officials, representatives from various government departments, and members of community organizations whose work spanned sexual health, victim services, family services and services to those with intellectual disabilities. Representation was sought and obtained from jurisdictions across the province and included Indigenous perspectives. Regardless of format, participants were asked a series of questions about each of the four groups outlined above (child and youth victims, child and youth perpetrators, adult sexual abusers of children, and non-offending pedophiles) centered around themes of what programs or services were available to them, whether or not these were effective, and what recommendations for improvement they would make (either to improve or to add new services). The following sections summarize their responses, interspersed with findings from documents and data that were reviewed as a part of this report.



Method

At the beginning of each questionnaire, interview and focus group, participants were briefed on New Brunswick CSH statistics and were provided with a Juristat publication (see Statistics Canada, 2014) that encouraged a greater understanding of the context in which CSH occurs. Following this, participants were asked what they believed was contributing to the province's high CSH rates, if they believed these rates were accurate, and whether or not the province's high ranking is reflective of the New Brunswick reality.

Overall Views

Participants expressed universal agreement that CSH is under-reported but differing opinions emerged regarding the validity of New Brunswick's rates and ranking in relation to other provinces.

Specifically, some argued that New Brunswick's police-reported rates were inflated with respect to other provinces due to better police-reporting practices, notably in smaller jurisdictions where there are stronger partnerships between police, Social Development and Crown prosecutors. Others felt that New Brunswick communities as a whole are more closely-knit, made up of active, engaging people, resulting in a better awareness of abuse when it occurs. Alternatively, many participants indicated that the province's high rates (and ranking) are accurate, heavily emphasizing a lack of sexual education and a reluctance of parents to discuss sexual harm with their children as contributing factors. In addition, a shortage of resources for working with offenders, inadequate programming, a lack of training, high rates of poverty (where sexual abuse is more prevalent), and greater barriers to disclosure, including an unwillingness for many people to talk about CSH and the travel that may be required for services if living in a rural setting. As the following results suggest, more participants proposed that the province's high CSH rate is the outcome of poor social and economic factors in contrast to greater police-reporting and community factors, although some did acknowledge that it could be a culmination of all of these factors.

Child and Youth Victims

For the most part, when asked what programs or interventions are in place to prevent children and youth from being sexually victimized (i.e., primary prevention programs), most respondents identified school-based sexual education as the primary vehicle for these initiatives. This was universally agreed as the most effective means of reaching the greatest number of students, however, the efficacy of the current curriculum and policies was questioned by many; there was concern that the content of these courses is outdated, focused too much on the biological aspects of sexual health, and that delivery is inconsistent. To illustrate this last point, it was mentioned that most sexual education programming falls under a larger curriculum (such as personal safety) and that it is up to individual teachers to determine how much time is allocated to each component of the syllabus. Thus, teachers who may not be comfortable with sex-related topics may spend less time on this material. This discussion often led to observations that there is a heavy reliance on community organizations, such as the Fredericton Sexual Assault Centre (FSAC), the New Brunswick Association for Community Living (NBACL), the Coalition Against Abuse in Relationships (CAAR), and the Red Cross, to deliver presentations and workshops on sexual abuse to children. While it was generally agreed that these community organizations do valuable work, it further compounds the issue of inconsistent delivery, as children residing in communities with more resources are more likely to get to participate in these seminars. Curriculum differences across school districts and a dependence on individual initiatives by social workers, guidance counselors, and police officers to provide sexual health or safety education may also contribute to this.

Diving further into the sexual education curriculum, it was revealed that in the Anglophone School District, the content of the Personal Wellness program for grades 3-5 had recently been revised, as had the content of Personal Development and Career Planning (PDCP) classes for grades 9-10. For instance, beginning in the 2016-2017 school year, the Red Cross' Healthy Youth Relationships program (available for youth in grades 7-12), which provides thorough, empirically-supported lesson plans on dating violence, was incorporated into the PDCP curriculum. Many of these modifications, such as an increased focus on healthy relationships, came at the request of the teachers themselves, demonstrating an awareness of the role education can play in protecting children and youth as well as a willingness to teach these topics. The need to improve the current middle school curriculum, which coincides with the peak ages for juvenile sex offending, was raised as well. While educators have access to an online portal, which links them to helpful resources and is updated more frequently than the curriculum, more assessment in this area is needed. However, the presence of the portal is promising, as it provides an opportunity to integrate evidence-based practices into the classroom in an easy and efficient manner as well as keeping curriculum up to date with current technology, one of the recommendations from participants.

Overall, there was unanimous support for the need for greater sexual education of children and a strong belief that this is an effective way to reduce CSH. It was recommended numerous times that this education needs to begin in elementary school, if not earlier. However, this was often described as a "forbidden subject", a topic that is difficult to get parental and public support to cover in detail, even if educators are willing to discuss it. Participants indicated that these support problems are exacerbated when discussing sexual education for students with intellectual disabilities, fueled by the false belief that they do not have sexual desires. As a result, many get little to no sexual education at school or at home, when many may need extended sexual education provided in modified ways (such as the SEXCESS! Program), especially given that children and youth with intellectual disabilities are at increased risk of becoming CSH victims and are overrepresented in the sexual offender population.

Among children with and without intellectual disabilities, it was noted that there not only needs to be parental support for sexual education in schools, but further education at home about sexual health and sexuality to build upon and reinforce what has been covered in school. Attempts to support parents in this initiative were mixed; some community organizations, such as CAAR, do awareness sessions for parents, while others mentioned that they had trouble recruiting willing parents to participate in workshops. Concern was expressed that parents who did not engage in topics of sexual health and safety with their children would cause the latter to seek answers elsewhere, such as the internet, which may not provide accurate or developmentally appropriate answers. Having an open dialogue with one's child was not only suggested to improve the child's knowledge of appropriate sexual behaviour but was also identified as a catalyst in increasing the likelihood that a child will disclose their experience of CSH in the event that they are victimized. In order to facilitate buy-in from parents, it was recommended that advertising a CSH education program under a more palatable title (or incorporating it into a larger program), such as "healthy relationships," may make the topic seem less daunting and controversial.

In addition to sexual education programs for children and parents, participants also mentioned the value in ensuring that teachers and other individuals who work with children and youth are trained in recognizing and reporting CSH. Recommendations were also made for agencies and organizations who work with youth to develop policies to reduce CSH. Similar to those described in the best practices review, these included the extensive screening of staff and volunteers as well as supervision of those who are supervising children/youth (meta-supervision). It was noted that some larger youth-serving organizations already had these policies in place, which are publicly available (e.g., http://www.scouting.org/Training/YouthProtection.aspx), which should make for easy implementation in similar smaller-scale or local organizations.

When asked what resources were available for children and youth who had been victims of CSH, the most common responses were vague descriptions of the roles played by the Department of Social Development (DSD) and private practice clinicians (to whom DSD may outsource). While many expressed confidence in the quality of private clinicians, there was concern over the little time that was allotted to victims (generally 5-10 sessions), which may impact the meeting of treatment goals or require the clinician to voluntarily offer services until completion. Some community organizations (e.g., CAAR, FSAC) also operate in this area, but similar to the availability of clinicians, there appears to be little consistency in the availability of resources across the province. Many of these under-resourced regions were also identified as housing vulnerable populations, such as Indigenous peoples, who face additional burdens in reporting and receiving support. It was suggested that additional resources be invested here, and that "put[ting] our dollars in areas that are higher risk" will yield considerable benefits. A failure to do so, noted one participant, can lead to adverse health outcomes, putting increased strain on the scarce resources that do exist. A few participants noted that this can also play a role in perpetuating the victim-offender cycle. Other resources mentioned were victim services (which also outsources) and Addictions and Mental Health, whose jurisdiction this could

fall under only if the abuse led to a mental health diagnosis. While the partnership between policing agencies and DSD were mentioned by a large number of participants, overall many called for further collaboration in working with victims, referring to the current system as a "disjointed approach."

From the standpoint of the professionals, major concerns for CSH victims were lack of accessibility to programs and duration of treatment. Many of the survey participants felt that most victims were not receiving sufficient services to meet their treatment needs. It was further noted that different service providers have different approaches to working with CSH survivors. This raises the question of what qualifications and approach should be expected when it comes to working with victims of CSH.

Additionally, several practitioners identified concern for vicarious trauma that can result from working with victims of child sexual harm. This trauma has impacts on service providers and their organization and can lead to negative outcomes if not addressed. This includes health issues and difficulty managing emotions for service providers; organizations (e.g., incapable of making changes, learned helplessness, lack of communication) and to service users (e.g., additional stress from interacting with unhealthy staff, repeat visits due to insufficient service delivery).

Vulnerable Youth

Based on initial review findings, additional input was gathered from professionals who work with vulnerable youth populations. Interviews deviated from the questions that were asked to earlier participants and instead centered around the needs of the populations they serve and what extra considerations may need to be made going forward. Six additional interviews were conducted (included in the statistics above) with vulnerable youth serving organizations.

Representatives from an organization which serves youth who are struggling with addictions, home instability (including homelessness), poverty, and school truancy, identified suspected high prevalence of sexual abuse among their clientele. One participant estimated that a high percentage of youth case files make mention of sexual abuse yet initial contact is generally the result of other issues the youth is facing. However, these issues were often linked to sexual abuse including drug use to cope with the pain inflicted and homelessness to escape an unsafe home environment. Parental neglect, isolation, and a failure of parents to model healthy relationships also arose as other problems youth may be facing. Given these realities, it was stressed that any programs for vulnerable youth need to be flexible. Specifically, programs should be offered in both group and individual formats, when possible. Policies that terminate youth enrollment after missing a certain number of appointments also need to be reconsidered, as it can be difficult for youth who are having substance abuse and/or homelessness issues to keep appointments. Service providers must be aware that missed appointments may not be the result of a lack of motivation or commitment, but of extenuating circumstances. Participants also recommended that treatment be all-encompassing, allowing time for immediate issues to be addressed (e.g., housing) before more distal traumas (e.g., their victimization history) can become the targets of therapy. Representatives noted the need for an increase in the intensity of treatment provided to vulnerable youth and for more training for service providers so they can better understand and meet the needs of disadvantaged youth. Lastly, for parents who are more engaged with their children, it was recommended that more information is provided to parents from the school regarding the sexual education or healthy relationships curriculum, allowing for conversations to be taking place at home as well as at school.

Representatives of an organization that provides services to LGBTQIA2+ youth were keenly aware of the higher rates of sexual abuse and dating violence that members of the LGBTQIA2+ community report. Representatives pointed to another report from Egale that found highly elevated rates of sexual harassment among LGBTQIA2+ members with 49% of trans students, 40% of gay male students, and 33% of lesbian

students surveyed having experienced at least one incident in the past school year (Taylor et al., 2011). These findings highlight the importance of Gay-Straight Alliances, as many LGBTQIA2+ members may experience isolation at home, school, or both, which may put LGBTQIA2+ youth at increased danger of victimization. For instance, if a youth is abused within the context of a same-sex relationship, but their parents either aren't aware of their sexual orientation or are not supportive of it, the youth may be reluctant to disclose such abuse. Similarly, it was mentioned that they may be reluctant to speak to medical professionals out of concern about judgment. The isolation experienced by many LGBTQIA2+ youth may also lead them to seek out companionship with strangers online, who may be more accepting of their sexual orientation or gender identity. While this can be a positive resource, it was noted that this vulnerability could easily be exploited online, putting LGBTQIA2+ youth at even greater risk of victimization. In addition to the risks associated with isolation, one of the most troubling was the elevated risk of suicide among LGBTQIA2+ youth, which is considerably higher when parents aren't supportive of the youth's sexual orientation. Thus, one critical recommendation was that parents need to be given resources to help them better understand their child's sexuality, which may be seen as in conflict with the parents' religious or cultural beliefs. Another recommendation was for the sexual education curriculum to use more general examples and that examples of healthy relationships not be restricted to heterosexual relations. By including other sexual orientations in class, it was hoped that this would not only better resonate with non-heterosexual youth, but also help normalize other sexual orientations. It was noted that teachers may require additional training which may increase their comfort in talking about sexuality and healthy relationships.

Representatives of an organization serving racialized populations were brought together in a focus group to discuss their observations and recommendations regarding child sexual abuse among the diverse clientele they serve. While the group reported that they do not generally get explicit disclosures of sexual abuse, they acknowledged an awareness of an issue among the population that they serve and underlying cultural influences. Skepticism was raised about the school survey results, which found that immigrant youth were less likely to experience sexual abuse and slightly less likely to experience dating violence. Questions about the terminology used to explain sexual abuse were raised, with one individual noting that many youths refer to unwanted sexual attention (particularly from peers) as them being "annoying" and do not appear to classify it as a sexual violation/offence. Fluency in English or French was also raised as an issue in immigrant youth fully comprehending the questions. Finally, properly answering questions pertaining to sexual abuse and dating violence requires an understanding of these concepts, which some youth may not have. A topic of considerable discussion was the students' trust in their teachers and the educational system, both in terms of the student's willingness to disclose abuse on the school survey, but also directly to a peer/educator/adult. It was noted that in many cultures, teachers are viewed as extensions of parents or as strict disciplinarians, likely hindering a youth's willingness to disclose sexual abuse. Relations with teachers are also strained when teachers do not intervene when students make racist comments, or when teachers themselves make passive, ignorant comments. Reluctance to disclose can also be particularly salient in cultures where there is a large degree of shame associated with being a victim of sexual abuse. Thus, it is important for both youth and parents to be made aware about the role of teachers, their limits on confidentiality, and the protection of anonymity on school surveys. Efficient communication was also seen as a catalyst to immigrant youth receiving services or being enrolled in programs that require parental permission, parents may not understand why multiple agencies or government branches need information on their child and may decline service since each member's involvement isn't made apparent. Regarding sexual education specifically, it was mentioned that curriculum needs to be developed (perhaps in consultation with a multicultural agency) with attention paid to the cultural and religious diversity of the audience to maximize reach and participation. Further, the role of parents in sexual education was raised as a huge factor. As discussed above, the inclusion of parents into the discussion of sexuality and healthy relationships is a must in reducing CSH and D/IPV rates. It was noted that in some cultures, parents remain figures of authority longer than they do in others in many

Western countries, and that policies need to understand the persisting different influences that parents may hold. As the data has shown, having parents on board with teaching curriculum and having them discuss sexuality and healthy relationships are key to preventing sexual abuse among any group.

Child and Youth Perpetrators

Despite universal agreement that child and youth perpetrators make a significant contribution to the province's CSH rate and that their inclusion in a CSH-reduction strategy is integral, many participants had a difficult time listing resources that were available for this segment of the population. For the most part, participants referred to the work of a select few private-practice psychologists who have been contracted out to work with child and youth perpetrators, although there was confusion as to how much treatment was provided; some participants mentioned that some offenders are only eligible to receive five one-hour sessions, while others cited a much more extensive therapy, comprised of four cycles of nine sessions each. However, this latter program was only available through one practitioner in select regions. Only a small number of community organizations were identified that work with this population as well, one of which primarily is involved in restorative justice and in acting as a liaison between the perpetrator and community resources, of which there are often none. Serving Albert and Westmorland counties, CAAR (the Coalition Against Abuse in Relationships) was the only community organization identified that works with this population and has noted that a strong relationship with the RCMP has been helpful in this endeavour. This program reported good outcomes through working with both youth and their parents, however, a lack of substance to the action plans (upon release from court) was identified as an area of improvement that could help sustain these effects.

Those who have worked with or encountered child and youth perpetrators in their work identified three items of concern: first, many of these perpetrators lacked education around consent and sexual norms; second, perpetrators could have or should have been referred to someone earlier and; third, many perpetrators have extensive victimization histories. This last point again emphasizes the importance of providing victims of CSH (and their families) with thorough, evidence-based treatment in attempt to derail the victim-offender cycle. The first two points indicate that there exists a recognized opportunity for early intervention. Some participants indicated that schools had students who were displaying concerning behaviour, but lacked the resources (internal or external) to deal with them. Both participants who work with child and youth perpetrators and those that do not, agreed that a more comprehensive sexual education curriculum would help reduce CSH by preventing the offending from occurring, indicating the multiple ways through which empirically-supported sexual education programs can be effective in this regard. Without this education, deviant sexual norms, which may be perpetuated by the internet, may develop. One of the programs mentioned to combat this was Man2Man, an initiative to reduce domestic and sexual violence which targets both adult and juvenile men, but little else about the program was known, such as its effectiveness in meeting its objectives. The Red Cross' Healthy Youth Relationships program was named as well. In addition to empirical backing, it was felt that the opportunity for peer facilitators (who can participate in youth facilitator training) to deliver the program to young offenders may improve the saliency of the program material. If so, its recent incorporation into the Personal Development and Career Planning (PDCP) curriculum is promising.

While many participants did not work with youth perpetrators, their insights and recommendations were similar to those who are more familiar in working with this group. In addition to the need for better sexual education and more extensive therapy, as described above, one of the most common recommendations was for offenders to take part in some form of group therapy or attend a support group with similar risk-level offenders. The rationale given for this was the efficacy of this approach in working with adult offenders, and participants posited that it may work with their juvenile counterparts as well. However,

many expressed a desire to better understand child and youth perpetrators in both a general sense as well as on an individual level before they would make any formal recommendations or develop a solidified treatment plan.

The lack of qualified professionals who specialize in working with sexually abusive youth was also raised with respect to both the facilitation of group work and in conducting individual therapy. Difficulty in obtaining client and/or case information due to confidentiality or departmental policies was addressed by a number of working professionals, who felt that the impact that their roles could play were limited as a result. Consequently, greater collaboration between departments, agencies, and others who work with child and youth perpetrators was called for by many. Shifting to a preventative lens, another recommendation was for the participation of children in family programs designed for domestic violence survivors. It was felt that children were often neglected in this regard, despite experiencing secondary or vicarious trauma. Implied in this is that these participants saw a link between witnessing domestic/intimate partner violence and sexual offending in adolescence. Overall, participants from all lines of work expressed a genuine interest in this population, some suggesting that they would be interested in more training if it were available.

Adult Sexual Abusers of Children

While there is ample evidence that the treatment of sexual abusers of children (SACs) is an effective endeavor, not only in improving the lives of the offenders, but also in creating safer communities, the Muriel McQueen Fergusson Centre (1997) report indicated that only two-thirds of SACs under provincial jurisdiction were receiving any kind of treatment, compared to 96% of those under federal jurisdiction. Of these, just over half were receiving sex offender treatment while in provincial custody, and less than half were receiving any form of individual counseling. Federal offenders on the other hand, were receiving sex offender treatment (79%) and individual counseling (54%) at a much greater rate. While it is possible that these numbers may be deflated provincially due to the shorter nature of their sentences, the discrepancies are concerning. What amplifies this concern is the extensive sexual offending history of many of these offenders (one-third had prior convictions of sexual assault against a child, thirty percent had prior convictions for sexual violations against children) indicating a failed intervention response at first offence. Additionally, despite 48.5% of the sample under provincial jurisdiction reporting a history of problems associated with drug or alcohol use, only 2.1% and 6.0% were receiving any treatment for those addictions, respectively.

It is important to note that the existence of a program, or a SAC's participation in it is only meaningful if it is provided over an adequate length of time while adhering to empirically-supported principles. The short period of time (generally 5-10 sessions) that clinicians are given to work with SACs was one of the biggest concerns raised through the consultation process. Even more concerning is that clinicians often have to spend an extra amount of time completing reports (sometimes in excess of three hours) due to a lack of data on the offender, including offence-related information and other relevant reports or assessments that may have been completed. As a result, providing treatment to offenders may become more costly (due to increased billing) or clinicians may have to spend the extra time completing their reports on a volunteer-basis in order to avoid having the limited sessions they are budgeted to provide cut to accommodate the extra cost. Alternatively, treatment can be provided by private-practice psychologists who would be contracted out for a similar number of sessions. Regardless of where the treatment is offered, there was universal agreement that the amount of time allotted for therapy for each offender falls far short of what is needed. Some community agencies, such as CAAR also work with SACs, delivering education programs revolving around concepts of anger management and healthy lifestyles. Again, this reliance on individuals and agencies already in place contributes to the inconsistency or "localization" of services available across the province. Such dependence on partner agreements, the participants noted, highlighted the inability to sustain and enhance current programs, let alone facilitate the development of new ones.

When discussing the assessment of risk levels and eligibility for provincial institution programs, there was some confusion among participants. Some stated that programs were only available to medium- and high-risk offenders, while many declared that their practice was to override risk assessments based on the index crime that was committed, resulting in sweeping high-risk level categorizations for all SACs until another risk assessment was completed by a psychologist, the length of time between the two assessments was not specified. It is important to note that if the index offence indeed overrides the risk assessment, this is in contrast to the underlying principles of RNR and allows for contagion if group therapy is conducted with individuals who would fall under different risk level categories. Many of those responsible for completing risk assessments (especially probation officers) expressed a desire for further training using instruments that best predict recidivism as well as more instruction on working with sex offenders in general. Like the teachers (in the child and youth victims section), this willingness to best address the issue of CSH from their respective professions is both admirable and promising.

In addition to Circles of Support and Accountability which operates in the Moncton region, a group therapy and maintenance group operating out of Saint John was identified as the only other resource for released SACs (although the group is not exclusive to them). Participants expressed confidence in these groups, co-facilitated by a clinical psychologist and a probation officer, who use a cognitive-behavioural therapy-based approach to address issues such as impulse control and triggers. However, many individuals did not know about the program. It is also not uniformly available across the province. For some released SACs, these groups may be the only opportunity to talk about their specific needs, struggles, and reintegration narratives.

Multiple participants noted that the perceived 'one-size-fits-all' approach to sex offender treatment in New Brunswick does not take into account the needs of offenders with intellectual disabilities (let alone the heterogeneity of SACs in general). For this subgroup of sexual offenders, it was uncovered that they face an even greater disadvantage (compared to SACs without an intellectual disability) resource-wise, with only one psychologist (in Edmundson) identified who specializes in sexuality and intellectual disabilities. Participants also noted an increase in the number of intellectually disabled SACs in recent years, which may further exacerbate this resource gap in the years to come. In addition, treatment often does not touch on (either by design or due to time constraints) offenders' extensive victimization histories; as one participant put it "[SACs] get therapy for what they've done, but not what's been done to them."

Non-Offending Pedophiles

For many participants, this needs analysis was the first time they had ever heard of non-offending pedophiles. Across the board, there were no known programs for this particular population, some wondering whether this would fall under the jurisdiction of Addictions and Mental Health while others posited that non-offending pedophiles may be able to see a private-practice psychologist, paying out of pocket or relying on workplace coverage. As one participant noted, "there is no current approach" in targeting non-offending pedophiles as part of a CSH reduction strategy. Another conveyed that people's hands are too full dealing with offenders to even begin focusing on non-offenders. All agreed that members of this group face extreme stigma ("completely vilified" in the words of one participant), which is important to note when working with or designing programs to target this population. Others noted that for this to take place, more training is needed to build up competency and effective means of advertising services (which may upset or offend some people, as one participant noted) will also need to be developed.

One suggestion for what services to offer was to provide them with the same treatment that convicted SACs receive, but the difficulty in doing so due to the stigma and the desire for many non-offending pedophiles to remain anonymous was acknowledged. Others suggested the opening of a new or promotion of an existing online forum (such as Virtuous Pedophiles), while another held up the Prevention Project

Dunkelfeld as an ideal, “dream big” initiative. While advertisements for Prevention Project Dunkelfeld and Stop It Now! were done through mass-marketing campaigns, one participant had a particularly creative suggestion, noting that Integrated Child Exploitation (ICE) units, who can have difficulty keeping up with the sheer magnitude of online CSH and CSH-related activities, could send out contact information for online forums to new or low-end offenders. However, this suggestion raises questions of legality and may cause online offenders to be more cautious online, instead of simply desisting. One participant summed up others’ responses quite well, stating that while providing treatment or services to this group is challenging, there is great importance in having a forum for non-offending pedophiles as part of a CSH reduction strategy.

Summary: Key Considerations from the Consultation Results

- While some interviewees believed that New Brunswick's child sexual abuse rates were inflated in comparison to other provinces due to better police-reporting practices, the majority felt that New Brunswick's ranking among provinces was accurate and due to a variety of factors (e.g., lack of sexual education, shortage of resources for victims and offenders, etc.).
- Participants identified few systematic, standardized approaches and noted a lack of prevention and intervention resources for all groups (child and youth victims, adult and youth perpetrators, and non-offending pedophiles), at all levels (prevention, intervention and rehabilitation) - the effects of which are exacerbated in small communities.
- The services that do exist in NB often rely on community agencies or the initiative of government employees to design and deliver these resources.
- All agreed that sexual education is a key component to preventing sexual abuse, and it should be implemented at an earlier age.
- Service providers who work with victims often have different backgrounds and offer different interventions to victims and noted that it would be helpful to develop standards of practice to ensure victims are receiving adequate services.
- Some youth who have been victims of sexual offences may have more pressing issues, such as finding housing or receiving addiction services that they need to address before they are willing or able to participate in therapy. It was noted that sexual abuse victimization is a likely contributor to many of these issues.
- Communication and collaboration between service providers needs to be increased. For instance, individuals working with children were often unaware of some available services for juvenile sexual offenders.
- Policies, practices, and resources need to be developed in collaboration with representatives from different minority or vulnerable populations to ensure that they are respectful and are applicable to all.
- There is a lack of service providers in the province with required expertise to work with sexual offending populations.
- Offenders often have extensive victimization histories; treatment should include therapy for what has been done to them.
- The amount of time allotted for therapy or treatment programs (intervention dosage) needs to be increased dramatically. Many providers expressed that they often had to write reports and even provide additional therapy on their own time.
- Community support groups for released sexual offenders was recommended as a cost-effective means of reducing recidivism.
- Several practitioners identified concern for vicarious trauma that can result from working with victims of child sexual harm. This trauma has impacts for service providers and their organization and can lead to negative outcomes if not addressed.

Section 4: Conclusion and Recommendations

The following section summarizes findings outlined in the report and identifies recommendations for improving existing practices and addressing gaps in service to protect New Brunswick children and youth, and to ensure that their rights, including the right to be free from sexual harm, are upheld.

The Child Rights Impact Assessment (CRIA) identified the interdependencies between children's rights in relation to CSH and the impacts on their other fundamental rights. It is important to recognize children as social actors and active rights holders who must be protected and empowered through the legislative, administrative, social and educational branches of government in every society. These rights are outlined by the United Nations Convention on the Rights of the Child (UNCRC) which Canada ratified in 1991. Review findings, including the high rate of CSH in New Brunswick and identified gaps in available programs and services, demonstrate potential shortcomings in protecting children's rights and highlight the urgency of moving forward with recommendations.

The best practices review outlined empirically-supported evidence relevant to child sexual harm prevention and reduction within four groups: 1) potential and current child and youth victims, 2) child and youth perpetrators, 3) adult sexual abusers of children, and 4) non-offending pedophiles. The needs analysis provided a comparison of programs and services that currently exist in New Brunswick as informed by a series of consultations with New Brunswick professionals working in a variety of CSH-related fields to best practices and sought to provide a better understanding of the prevalence of sexual harm against children and youth in New Brunswick by looking at available data.

A review of the available data does not appear to support the hypothesis that New Brunswick's higher rates of child sexual harm are attributable to better or increased reporting to the police. In fact, Statistics Canada cautions that sexual offences in general tend to be under-reported in police statistics and that this under-reporting can be compounded in cases where the victim is a child. New Brunswick has had a consistently higher police-reported rate of sexual violations committed against children and youth (0 to 17 years of age) based on a review of available police-reported data. New Brunswick had the 3rd highest average rate of children and youth victims of all sexual offences against children out of all provinces and had a higher rate than the national average.

The majority of victims are female with over half of all victims between the ages of 12 and 17. The most common incident reported to police was sexual assault level 1, which represents approximately 70% of offences. Over a 20-year span, NB had the 4th highest average rate of possession or accessing child pornography and the 3rd highest average rate of incidents relating to making or distributing child pornography in comparison to all other provinces. New Brunswick had the 2nd highest average rate among all provinces of sexual exploitation of children, falling behind Manitoba only. From 2009-2017, New Brunswick's overall trend of victims of sexual violations increased for children ages 0 to 11. Female victims, in comparison to male victims, saw the largest increase.

Nationally, the majority (97%) of those accused of sexual violations against children are male. Approximately 30% of accused are males between the ages of 12 and 17 years, with rates of accused decreasing after the age of 14 years. More than half of accused (51%) are over the age of 25 years with reports that the average age of sexual abusers of children is 38 years. In New Brunswick, while data shows

that more adults commit sexual crimes against children, youth perpetrators are charged at a rate 2.5 times higher than adult perpetrators.

Self-reported victimization data was also gathered through the 2015-2016 New Brunswick Student Wellness Survey which indicates that 10% of students from grades 7 to 12 reported being violated sexually at least once in their lifetime. This was more common among youth who identified as Indigenous, youth who identified as LGBTQIA2+, youth with learning exceptionalities and special needs, and youth of lower socioeconomic status. Sixteen percent (16%) of students from grades 7 to 12 self-reported being victims of some form of dating violence; more commonly reported among the Anglophone (18%) than the Francophone school districts (12%), in addition to the above listed vulnerable groups.

While the review identified significant work underway in New Brunswick to prevent and respond to child sexual harm, a comparison of what currently exists to the identified needs and best practices confirms that more can, and must be done. Concerted, collective efforts by individuals, families, community groups and government are required to achieve a meaningful reduction in the rates of child sexual harm in the province while also supporting and responding to those already affected by child sexual harm. For example, it cannot solely be the responsibility of schools to instruct children and youth on how to avoid being victims nor is this a child-centered approach to ending sexual harm. Research demonstrates that evidence-based sexual harm prevention programs are linked with lower rates of victimization and perpetration and are most effective when partnered with healthy relationships curriculum rooted in social emotional learning. Such programs have the largest impacts when started at an early age and can help children establish positive relationships, make responsible decisions, and handle challenging situations. Efforts, therefore, must start early (0-5 age group) and include resources for parents and caregivers so that they can support and continue learning at home.

Recognizing, identifying, reporting and responding to suspected incidents of sexual harm to children and youth are also integral to combatting the problem. The existing legislated responsibility of New Brunswick professionals and care givers to report suspected harm to children provides a solid foundation from which to build. However, the review identified that additional professional development and education and awareness efforts could increase consistency in identifying and reporting child sexual harm and thus, enabling earlier interventions. The review further identified the opportunity for youth serving agencies of all levels to put in place policies to better identify and respond to instances of child sexual harm.

Victims of sexual harm and their families require services and programs to foster resilience and recovery. The review found that some victims of sexual harm may not be accessing these vital services, either because of policy limitations or lack of available programs and services. A challenge identified throughout the review relates to the identified difficulty of determining whether sexual harm of a child has occurred and ensuring that victims are supported appropriately. For example, of sexual offences reported to police that were deemed ‘unfounded,’ the vast majority were cases where the victim was under the age of 18. Further, a high proportion of suspected incidences of child sexual harm reported to Social Development were either screened out, deemed inconclusive or unfounded. Several explanations for these issues were discussed including the ability of the interviewer to gather information from the victim (especially for children under 12 years of age), barriers in collecting reliable information through the investigation, or challenges in proceeding through the court process. Another possibility could be the understanding of mandatory reporting requirements of child protection legislation where reports are made based on a suspicion that

sexual harm to a child has occurred, but evidence is lacking to confirm this suspicion or there were misinterpreted signs of abuse. Regardless of the cause, this issue warrants further exploration and action.

The impact of CSH on service providers and organizations who work with victims of child sexual harm was also identified as an area of concern. Specifically, the effects of not addressing trauma exposure in workplaces can lead to negative outcomes for service providers (e.g., health issues, difficulty managing emotions), organizations (e.g., incapable of making changes, learned helplessness, lack of communication), and service users (e.g., additional stress from interacting with unhealthy staff, repeat visits due to insufficient service delivery, etc.).

The best practices review identified various types of perpetrators, including their motivations to offend, and highlighted that higher risk perpetrators of sexual harm require evidence-based treatment that is tailored to their unique needs. For example, research shows that juvenile sexual offenders (JSOs) aged 12-18 years often have an extensive victimization history, including a higher prevalence of sexual abuse. Multisystemic Therapy (MST) has been shown to be the most effective treatment for high-risk JSOs, reducing both sexual recidivism and other antisocial behaviors. It is effective for both Indigenous and non-Indigenous youth and has favourable cost-benefit analysis outcomes. This is an opportunity to build on existing New Brunswick efforts, such as the Integrated Service Delivery model, which could ensure JSOs get access to treatment that is tailored to their risk and needs whether they are involved in the justice system or not. Given that most JSOs will not go on to sexually reoffend, it is important to note that not all JSOs require an intensive level of treatment (like MST) and could benefit from less-intensive interventions tailored to the nature of their offending (e.g., cyberviolence that is sexual in nature). The review identified children under 12 years of age with problematic sexual behaviors as a group who would also benefit from intervention recognizing that they may be victims of sexual harm themselves. Very few programs or services currently exist tailored to this population. While not proven to be a direct cause, many adult sexual offenders have cited a history of untreated sexual harm against them. Research consistently shows that implementing evidence-based treatment, such as the Risk-Need-Responsivity model, with adult sexual abusers of children can significantly reduce their sexual recidivism and are most effective when integrated with ongoing community supports. As with victims of CSH, the needs analysis shows that there are significant gaps in programs and services for both youth and adult perpetrators of sexual harm. However, there are efforts underway, such as the Department of Public Safety's criminogenic program review process, that provide an opportunity for improvements in this area.

Non-offending pedophiles are individuals with sexual attractions to children who claim they have not committed a sexual offence against a child. The review identified that there are currently no programs or services for this population in New Brunswick. Filling this gap with best practices, such as self-management skills and availability of community supports, could go a long way in preventing CSH. This is especially relevant when considering that many convicted child sexual abusers were aware of their sexual desires for at least one to five years prior to their offence.

This review was broad in scope and is meant to be a starting point for further critical and, at times, difficult conversations. With such a broad scope, it is important to identify limitations of the review, most notably the requirement for more engagement with Indigenous communities beyond the limited consultation that took place with practitioners in the field. With this, it is important to recognize that the history of Indigenous relations in New Brunswick, as in the rest of Canada, is marked by a legacy of colonialism, displacement, the *Indian Act*, and Indian residential schools, and that these actions, and related

historical realities, continue to translate into negative outcomes for Indigenous peoples, including higher rates of sexual harm to Indigenous children and youth. Given this understanding, it will be important to undertake dedicated efforts to identify and support Indigenous communities' priorities in preventing and addressing sexual harm of Indigenous children and youth going forward.

Recommendations

The following recommendations target CSH at multiple levels. The governance recommendations aim to ensure the work continues building on strengths that already exist; that the voices and needs of vulnerable populations are reflected going forward; and that efforts are measured to ensure accountability and demonstrate results. Education and awareness recommendations recognize that education must be provided to children, youth and parents about sexuality, consent, and sexual violence; facilitate conversations about healthy relationships and boundaries; and ensure that all New Brunswickers know what to do to prevent and intervene in CSH. Professional development recommendations will equip professionals to recognize, prevent and respond to CSH and ensure these service providers are provided with the support they require. Investigation and prosecution recommendations recognize that systems can do more to encourage reporting of CSH and to increase successful prosecution of offenders in trauma-informed ways that lessen the trauma for the victim. Intervention recommendations are meant to fill the multiple gaps that have been identified for victims and perpetrators. Finally, policy and legislation recommendations recognize that good faith and best intentions are not enough to create the change that is required. Recommendations pertain to the entire scope of sexual harm to children and youth, which includes:

> *any acts of a sexual nature that are unlawful or psychologically harmful, committed by any person through coercion, inducement, exploitation or force. Sexual harm can be physical or non-physical. Physical sexual harm refers to any violation of an individual's bodily integrity without their consent, and includes: assault; fondling; intercourse; and incest, among other violations. Non-physical sexual harm relates to experiences of sexual victimization that violate the mental or emotional integrity of an individual. They are not accompanied by physical force or restraint, but are nonetheless psychologically intrusive, exploitative or traumatic. Some examples of nonphysical sexual harms include: exhibitionism; sexualization; and demeaning comments or accusations of a sexual natur*e (Province of New Brunswick, 2015, p. 30). The scope of this report also includes human trafficking for the purpose of sexual exploitation and sexual cyberviolence.

Given the results of the needs analysis and best practices review, it is recommended that:

Governance

1. A multi-sector Task Force be established to oversee implementation of recommendations. This Task Force should be results-focused and ensure that:

    a) an evaluation and monitoring framework be developed and implemented to measure progress and impact of recommendations over time, identify required adjustments, and ensure accountability of implicated partners;

b) consideration be given to vulnerable groups[12] and unique factors in the implementation of recommendations. This includes age (specifically 0-5 years), sex, gender, ethnicity and origin (Indigenous, newcomer, immigrant, racialized, ethnocultural and refugee populations), socioeconomic status, intellectual ability, location (urban and rural), and legal status (i.e., those in care of the minister) as well as how these different factors intersect with each other. Keeping in mind the interplay of these different factors at the outset will ensure greater effectiveness in preventing, reducing and intervening into the problem of sexual harm;

c) work be based on the social ecological model that recognizes and addresses risk and protective factors of CSH at the individual, relationship, community and societal levels;

d) the child and youth voice is continuously heard and incorporated into the work; and

e) efforts complement and align with current initiatives, such as *Preventing and Responding to Sexual Violence in New Brunswick Framework, Strategy for Partnering to Address Human Trafficking for Sexual Exploitation in New Brunswick, Strategy for the Prevention of Harm to Children and Youth, New Brunswick Plan to Prevent and Respond to Violence Against Aboriginal Women and Girls,* revision of the *Child Victims of Abuse and Neglect Protocols*, Public Safety's review of Criminogenic Programming, efforts of the Sexual Crime Working Group, steps to implement recommendations from the *Review of the Effectiveness of New Brunswick's Child Protection System* and others through continuous engagement of project champions within relevant working groups.

2. A dedicated effort by the Task Force be undertaken to identify and support Indigenous communities' priorities in preventing and addressing sexual harm of Indigenous children and youth. This effort should include working with, and building on the work of, the Indigenous Guidance Team that was developed through the Network of Excellence.

Education and Awareness

3. A public education and awareness campaign be developed and implemented which:

    a) raises awareness of the issue by naming and defining the various forms of sexual harm;

    b) provides information on what individuals, families, communities, organizations and systems can do to prevent, recognize and respond to sexual harm of children and youth;

    c) provides information on support services available to victims, perpetrators and their families; and

    d) builds on existing public education and awareness efforts.

[12] In this set of recommendations, the term vulnerable group will be inclusive of but not exclusive to age (specifically 0-5 years), sex, gender, ethnicity and origin (Indigenous, newcomer, immigrant, racialized, ethnocultural and refugee populations), socioeconomic status, intellectual ability, location (urban and rural), and legal status (i.e., those in care of the minister).

4. Education and Early Childhood Development (EECD) review existing healthy relationships and sexual health education curriculum for all ages and developmental levels. This review should:

    a) ensure content adheres to current best practice in sexual harm prevention;

    b) encompass the content of the curriculum, the time devoted to it, delivery methods, and training of those responsible for delivery;

    c) be conducted in consultation with educators and subject matter experts;

    d) include collaboration between EECD and Public Health (e.g., Healthy Learner in Schools Nurses) to provide an option to have content delivered by trained staff who are comfortable teaching the content to all students including students with intellectual disabilities; and

    e) include approval of best-practice resources for use by educators and options to invite external agencies to present evaluated material.

5. Early childhood education centres adopt an age appropriate CSH prevention program to educate children aged 0-5 years, including children with intellectual disabilities about appropriate touching and body ownership.

6. Resources be made available for parents and caregivers to help facilitate discussions at home with their children, including children with intellectual disabilities, regarding healthy relationships and sexual health. These resources should:

    a) reinforce and complement knowledge learned in school;

    b) help to facilitate disclosure of victimization to parents, caregivers and trusted adults; and

    c) equip parents and caregivers with information on what to do if a child or youth discloses harm.

Professional Development

7. University and college programs develop and implement standardized training on recognizing and responding to disclosures of sexual harm for those who will be working with children and youth. Training should include but may not be limited to:

    a) healthcare practitioners (e.g., nurses, first responders, etc.);

    b) educational professionals (e.g., teachers, educational assistants, guidance counsellors, coaches, etc.);

    c) social services workers (e.g., social workers, child/youth care workers, immigrant service workers, victim service workers, etc.);

    d) human services workers (e.g., personal care workers, etc.); and

    e) protective services workers (e.g., criminal justice staff, etc.).

8. Training on recognizing and responding to disclosures of sexual harm be made available to professionals already working in the field. This could be undertaken in collaboration with professional associations and licensing bodies through continuing education efforts and reinforced through the revision of the Child Victims of Abuse and Neglect Protocols.

9. The Task Force undertake an exercise to develop and implement an integrated, trauma-informed government-wide approach for service providers who work with service users, including their loved ones who have been or potentially have been impacted by child sexual harm. This initiative would include review of existing policies and practices; consulting with the Fredericton Sexual Assault Centre which has experience in training organizations in and implementing trauma stewardship practices; developing policies and practices that define, outline and support the principles of trauma stewardship, the ethical care and support of other peoples' trauma, including supporting a clear commitment to trauma-informed practice with leadership at all levels of government (van Dernoot Lipsky & Burk, 2009). Service providers who work with victims of child sexual harm, including victims' loved ones, should be included in the development of this integrated, trauma-informed government-wide approach.

Investigation and Prosecution

Recommendations 10-14 are will be further refined through efforts of the Sexual Crimes Working group which is focused specifically on investigation and justice response to sexual violence. The work of this group is ongoing.

10. Training and policy for Police and Social Development investigation of child sexual harm be reviewed and revised to ensure it reflects best-practices including trauma-informed care.

11. An independent agency be identified to regularly review police-reported sexual offence cases to ensure sexual crimes against children are thoroughly and properly investigated and classified.

12. Police and Social Development offer a referral to Sexual Assault Nurse Examiner (SANE) for suspected victims of child sexual harm. This protocol could be included in the revision of the Child Victims of Abuse and Neglect Protocols and incorporated into the New Brunswick Policing Standards.

13. Trauma-informed training for Prosecution Services be provided by the Fredericton Sexual Assault Centre. Trauma-informed training would include education on the social context of sexual harm to children and youth and research on the neurobiology of trauma including ways to reduce the trauma to child victims' participation in Court (e.g., use of testimonial aids). It is further recommended that judges be offered information sessions on the same topics.

14. The Task Force identify Child Advocacy Centers (CAC) best practices, and implement these practices province-wide. This work must take into consideration the unique strengths and realities of each jurisdiction and involve practitioners already working in the field.

Intervention

15. The Network of Excellence[13] assess the lack of affordable specialized therapeutic services for children and their families and take steps to ensure victims and families are connected with sufficient, empirically-supported treatment and resources in a timely manner. This work should include removing financial barriers to treatment.

16. Integrated Service Delivery partners adopt the use of Multisystemic Therapy (MST) treatment in adequate dosages for high risk-high need youth perpetrators of sexual harm, regardless of whether they have been charged or sentenced. This MST approach should align with the Risk-Need-Responsivity (RNR) model of offender rehabilitation and include an aftercare component. Common responsivity issues for sexual offending, such as previous trauma, cognitive impairments and motivation to change, must be addressed through this programming. A similar but less-intensive approach, that adheres to evidence-based principles, should be available for JSOs who have low to moderate needs.

17. The Department of Public Safety review available programming to ensure eligible diversion clients who offend sexually are receiving appropriate intervention to prevent future sexual recidivism. This programming should include a variety of modules (e.g., cyberviolence that is sexual in nature) and recognize the various types of sexual offending.

18. Children under 12 years of age with problematic sexual behaviors be linked with Integrated Service Delivery (ISD) so that they may benefit from the right service, at the right time and at the right intensity according to their strengths and needs. It is further recommended that ISD consider programs such as Toronto/Central Region's Radius Child and Youth Services program which includes programming for children under 12 years who have engaged in concerning sexual behaviour.

19. That the Department of Public Safety:

    a) provide criminal justice personnel with regular best practices training on the assessment and case management of adult sexual abusers of children;

    b) provide evidence-based multi-modal criminogenic programming that targets the multiple needs of moderate to high risk-high need adult sexual abusers of children in the community and/or institutional settings as part of a case management plan. Programming should be accompanied by quality assurance practices, rigorous evaluation, and provided at appropriate levels of dosage and intensity. Programming should align with the Risk-Need-Responsivity (RNR) model of offender rehabilitation and include a maintenance component. Common responsivity issues for sexual offending, such as previous trauma and cognitive impairments, must be met through programming. Integration of culturally appropriate practices (e.g., Indigenous) in interventions is a vital component of the responsivity principle;

[13] "*The Network provides a comprehensive vision from which to coordinate, assess and build service delivery capacity. The Network also provides services and supports, and spans the entire continuum, from prevention to tertiary out of home services"* (Province of New Brunswick, 2015, p. 6).

c) ensure this work is linked to the development of Integrated Case Management for adult offenders with complex needs; and

d) ensure evidence-based reintegration plans are in place for all adult sexual abusers of children and youth being released from custody into the community. This could be accomplished through expansion of the Circles of Support and Accountability (CoSA) model, or a similar program, which currently operates in Moncton only.

20. The Taskforce explores and develops service options for non-offending pedophiles.

21. It is recommended that a feasibility study be undertaken to expand Circles of Support and Accountability (CoSA), or a similar program, to offenders under a community sentence, those not under sentence and to non-offending pedophiles.

Policy and legislation

22. Standards of practice for working with victims and perpetrators of sexual harm be developed and consistently updated to reflect best practice. Strategies to ensure adherence to standards, such as involvement of champions and regular evaluation, should be put in place.

23. All youth-serving-organizations have a child and youth sexual harm prevention policy in place for the prevention, identification and response to sexual harm (e.g., Commit2Kids, ASD-W Policy 703-14). Further, youth-serving-organizations actively inform parents on the child and youth sexual harm prevention policy in place for the prevention, identification and response to sexual harm including information as to rationale and meaning of policy.

24. New child protection legislation include an expansion of scope from the immediate protection of a child to the protection of the child and the child's path to healing and well-being. This legislative change would further support the work of the Network of Excellence and Integrated Service Delivery (ISD).

Appendix A: New Brunswick Child Sexual Harm Prevention and Intervention Programs, Services and Initiatives.

Program/ Initiative	Description	Provided by	Location Available	Link
360 Stand: Keeping Kids Safe	**Goal:** to advance prevention and education initiatives that will eradicate abuse and violence in the lives of children, youth and their families. **Method:** Facilitates "Making a Difference" training, designed and focused to all those who provide services, supervision, and support to children by defining and identifying child abuse, understanding legal and moral responsibilities with respect to reporting suspicions of child abuse and children exposed to family violence, responding to disclosures, how to report suspicions of child abuse, including strategies that assist in overcoming fears of reporting, how to document suspicions of abuse, the system's response and how to maintain the client relationship when a report to child protection authorities has been made.	360 Stand	Saint John	
A Strategy for Partnering to Address Human Trafficking for Sexual Exploitation in New Brunswick	5 Year strategy to address domestic Human Trafficking for Sexual Exploitation by identifying at risk populations such as indigenous and rural youth, creating awareness of HTSE and how it occurs, and the coordination of a provincial team to address and mitigate the risk of HTSE for New Brunswick's youth and women.	Partners for Youth		http://www.partnersforyouth.ca/en/wp-content/uploads/sites/2/2017/07/HTSE-Strategy-Web.pdf
Beauséjour Family Crisis Resource Centre	**Goal:** Offer individuals and families in crisis education, information and services. **Method:** Offers information, intervention and referral services to individuals and families in crisis including family violence and sexual assault. Provides educational programs for the prevention of family violence.	Beauséjour Family Crisis Resource Centre	Shediac, NB	http://healingstartshere.ca/
Boréal Centre: Child and Youth	**Goal:** Provide services to child and youth victims of sexual abuse.	Kent Centre for Prevention of Violence	South East region	https://www.centreboreal.com/en/

Expertise Centre	**Method:** Offer services (i.e., SANE, RCMP, Social Worker, social development, counseling) in a coordinated, child-centre manner in one location.			
Child Protection	**Goal:** Child Protection Services carries a responsibility to intervene and assist any child who is abused or neglected. **Method:** Child Protection Services has a responsibility to cooperate with other community and professional resources in offering preventative, protective and supportive services to families and children.	Department of Social Development	Province-wide	1-888-992-2873 After Hours Emergency Services: 1-800-442-9799
Circle of Friends	**Goal:** Support and development of friendships. **Method:** Provides instruction and opportunities for participation to individuals who are not typically included or who have difficulty participating with peers.	NBACL	Manual & brochure; province-wide	https://nbacl.nb.ca/product/circle-of-friends/
Circles of Support	**Goal:** Socialize, reach personal goals, overcome barriers and plan for the future. **Method:** Invites individuals with an intellectual disability to gather a supportive group of individuals to enhance inclusion.	NBACL	Province-wide (The program is based around the individual and is held where the individual is)	https://nbacl.nb.ca/circles-of-support-by-erin-wilson/
Circles of Support and Accountability	Canadian-made restorative justice program for individuals who have committed serious sexual offences. CoSA allows the community to play a direct role in the restoration, reintegration, and risk management of people who are often seen with only fear and anger.	CoSA Canada	Moncton	http://cosacanada.com/
Commit to Kids	**Goal:** Helps child-serving organizations reduce the risk of sexual abuse and create safer environments for children in their care. **Method:** Print materials, customizable templates, check lists, electronic resources and online training to offer tailored options to help organizations create a culture of safety in which employees/volunteers feel confident in both their interactions with children and their decision making when it comes to reporting inappropriate behaviour.	Canadian Centre for Child Protection Inc.	National	https://commit2kids.ca/en/#

Community Outreach Service for Victims of Abuse	**Goal:** To provide information, support and services to victims of domestic violence. **Method:** The Domestic Violence Outreach Program is a service for victims of domestic violence who need support and information on dealing with their individual situation. Individuals learn about domestic violence and are helped in accessing services in their community.	Women's Equality Branch	Province-wide	https://www2.gnb.ca/content/gnb/en/departments/women/services/services_renderer.201258.Community_Outreach_Service_for_Victims_of__Abuse.html
Daycare / Early Childhood Education	**Goal:** Children who participate in these programs are very young and have a trust relationship with the staff, they will share information with the staff about themselves. Staff persons are in a good position to note those children who are possible victims of abuse and neglect. Further, the staff of the facility are probably the ones who, next to the parents, spend the most time with the children and come to know the children well. **Method:** Staff in day care, early intervention programs, Headstart and other early childhood development programs provide support services to families and children, and are ideally situated to play a strong role in the prevention, identification and referral of child abuse and neglect situations.	Department of Education and Early Childhood Development	Province-wide	https://www2.gnb.ca/content/gnb/en/departments/education/elcc.html
L'Éclipse: Centre de ressources pour les victimes d'agression sexuelle	**Goal:** Provide services to survivors of sexual violence. **Method:** 24-hour support, accompaniment and counseling for survivors (women, men, children and LGBTQI +) of sexual violence.	L'Éclipse	Edmundston region	https://www.facebook.com/eclipseedmundston/
Education Programming	**Goal:** preventing violence and abuse, including bullying prevention, promoting healthy youth relationships, and preventing child maltreatment. **Method:** With emphasis on prevention education, the Canadian Red Cross provides educational programs for children, youth and adults.	Red Cross	Fredericton, Woodstock, Saint John, Sussex, Miramichi, Moncton, Grandfalls, Richibucto, Sackville area, Bathurst, Edmundston,	http://www.redcross.ca/in-your-community/new-brunswick/violence,-bullying-and-abuse-prevention/fredericton-branch-violence,-bullying-and-

			Tracadie and Campbellton	abuse-prevention
Enhancing Criminal Justice Response	Specialized training for Crown prosecutors.	Fredericton Sexual Assault Centre		http://fsacc.ca/en
Fredericton Sexual Assault Centre	**Goal:** Provide services to survivors of sexual violence ages 16+. **Method:** Provide hospital accompaniment, police and court accompaniment, short and long term specialized counseling, advocacy, and outreach to survivors of sexual violence.	Fredericton Sexual Assault Centre	Greater Fredericton region	http://fsacc.ca/en
Fredericton Sexual Assault Centre-Parent Support Group	**Goal:** Provide support to non-offending parents/guardians of children who have been sexually abused so that parents can look after themselves and in turn effectively parent through the aftermath of their child's sexual abuse. **Method:** Provide professional service, operate a psycho-educational support group, reduce isolation, provide information, increase understanding of the effects of sexual abuse.	Fredericton Sexual Assault Centre	*Where needed	http://fsacc.ca/en
Greater Saint John Sexual Assault Response Team	**Goal:** Provide services to survivors of sexual violence. **Method:** A community-based response by a group of volunteers and professionals from healthcare, public safety, victim advocacy, counseling, and community service agencies working together to provide integrated and comprehensive care and service delivery to adult victims of sexual assault.	Sexual Assault Response Team St. Joseph's Community Health Centre	Saint John region	https://www.facebook.com/SJSART/
Improving Outcomes Training	One and three day training courses for front line professionals to provide trauma informed victim centered investigative techniques.	Fredericton Sexual Assault Centre		http://fsacc.ca/en
Integrated Correctional Program Model (ICPM) – Sex Offender Stream	**Goal:** To teach skills to moderate and high risk offenders, either in an institution or the community, that helps reduce risk and/or harmful behaviour and helps in changing anti-social attitudes, beliefs and associates related to problematic sexual behaviour.	Correctional Service Canada (CSC)	Province-wide	https://www.csc-scc.gc.ca/correctional-process/002001-2011-eng.shtml

	Method: Targeting criminogenic needs through evidence-based techniques, such as social learning and cognitive behavioral strategies.			
Integrated Service Delivery (ISD)	**Goal:** To enhance the system capacity to respond in a timely, effective and integrated manner to the strengths, risks and needs profiles of children, youth and their families (right service intensity at the right time). **Method:** ISD is a local and regional governance and service delivery framework that enables partners to better work together, using a coordinated and integrated approach to meet the needs of children and youth at risk. ISD is intended to address service gaps in early assessment and intervention services for children, youth and their families. Needs related to the positive development of children, youth and their families provide a specific focus of intervention services.	The Departments of Education and Early Childhood Development, Social Development, Public Safety and Health, as well as the School Districts (Four Anglophone and three Francophone) and Regional Health Authorities (Horizon and Vitalité).	Province-wide	https://www2.gnb.ca/content/gnb/en/corporate/promo/isd.html
Intensive Support Program	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Family Services	Campbellton	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Intensive Support Program	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Centre Évolution Jeunesse	Bathurst	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html

Intensive Support Program for Young Persons	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Youth Impact Jeunesse Inc	Moncton	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Intensive Support program (Youth)	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Carleton Victoria Community Vocational Board Inc	Edmundston	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Intensive Support Program (Youth)	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	John Howard Society	Miramichi, Saint John	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Kent Centre for Prevention of Violence	**Goal:** The centre provides assistance to people who are affected by all forms of violence, including physical abuse, emotional and verbal abuse, sexual abuse and financial abuse. **Method:** They also offer services for individuals exhibiting aggressive or abusive behaviours. Therapy services for children of all ages affected by violence or who have behavioural challenges are also available. **Method:** Offers individual counselling sessions based on the needs of clients (children inclusive), as well as resources and information, and referrals to appropriate services.	Kent Centre for Prevention of Violence	Boutouche, NB	https://www.centrepreventionviolence.com/en/
Kids in the Know	**Goal:** The Kids in the Know program engages students with interactive safety education to	Department of Education and	Province-wide	http://www2.gnb.ca/content/da

	help build skills that increase their personal safety and reduce their risk of victimization online and in the real world. **Method**: The purpose of the program is to help educators teach children and youth effective personal safety strategies in an engaging, age-appropriate and interactive way that builds resiliency skills and reduces their likelihood of victimization in the online and offline world. This program is part of the Personal Wellness curriculum for students in grade 3 to 5.	Early Childhood Education (EECD)		m/gnb/Departments/ed/pdf/K12/curric/Health-PhysicalEducation/PersonalWellness3-5.pdf https://www.kidsintheknow.ca/app/en/about
Libère – toi: Acadien Peninsula Sexual Assault Crisis Line	La Table de concertation pour contrer la violence conjugale et familiale dans la Péninsule acadienne.	Acadien Peninsula Sexual Assault Crisis Line	Acadien Peninsula	www.contrelaviolence.com
Mentoring for Intensive Support Clients	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Fredericton Boys & Girls Club	Fredericton	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Mentoring for Intensive Support Clients	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	Metapra Associates / Représentant de l'entreprise	Woodstock	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Policy 703	**Goal:** Ensure students are protected from abusive behaviour by adults including physical, sexual and emotional abuse and discrimination. **Method:** Policy for the Protection of Pupils in the Public School System from Misconduct by Adults (Policy 703).	Department of Education and Early Childhood Education (EECD)	Province-wide	http://web1.nbed.nb.ca/sites/ASD-W/Policies/Documents/700%20-%20Health%20and%20Safety/ASD-W-703-

				14%20-%20Sexual%20Violence.pdf
Preventing and Responding to Sexual Violence in New Brunswick: A Framework for Action	Strategic Provincial recommendations for the focus of government, community and joint programs, on the prevention, education and training, intervention and investigation, and treatment of sexual violence. Focus is on best practice and needs of victims and affected community members mindful of gender identity, sexual orientation, cultural, racial, socio-economic background.	Government of New Brunswick	Province-wide	https://www2.gnb.ca/content/dam/gnb/Departments/eco-bce/WEB-EDF/Violence/PDF/en/preventing_responding_to_SV_NB-e.pdf
Provincial Strategy on Sexual Assault Services	**Goal:** to respond to the identified need to enhance, expand, create and coordinate community based sexual assault services in New Brunswick. **Method:** Provincial awareness campaigns, Sexual Assault Crisis Intervention Training, the development and delivery of facilitator training in The Empowerment Project and Man to Man toolkits in working with youth in issues around sexual violence, the development of resources on a variety of topics including services for sexual assault survivors, influencing policy, and community awareness, a comprehensive Sexual Violence Framework to influence provincial policies, protocols and operations, in partnership with provincial government departments such as Public Safety, Justice, Women's Equality Branch, Health and Education, and the enhancement of several community based sexual assault services including "Libère-toi", a sexual assault crisis line located in the Acadian Peninsula, Sexual Assault Response Teams created in Saint John and Fredericton.	Women's Equality Branch	Fredericton & Saint John—Sexual Assault Response Teams Acadian Peninsula—Libère-toi All other programs are province-wide	http://www2.gnb.ca/content/gnb/en/departments/women/Violence_Prevention_and_Community_Partnerships/content/Provincial_Strategy_on_Sexual_Assault_Services.html
Public Health	**Goal:** Public Health nurses, nutritionists, physicians and inspectors play a key role in the identification of abused and neglected children. **Method:** These professionals, by virtue of their broad involvement and non-threatening working relationships with individuals, families and communities are in unique front-line positions to make a significant contribution to primary prevention, early identification, and	Public Health	Province-wide	http://en.horizonnb.ca/media/930238/broadening_our_focus_final.pdf

	referral. In cases of abuse and neglect, Public Health works collaboratively with DSD to provide interventions based on the identified care plan.			
Regional Violence Prevention Network	**Goal:** The Committees fosters networking opportunities, sharing of best practices and public awareness and advocacy on family violence issues generally. **Method:** The Women's Equality Branch liaises and supports the networks.	Women's Equality Branch	Province-wide	http://www2.gnb.ca/content/gnb/en/departments/women/Violence_Prevention_and_Community_Partnerships/content/Regional_Violence_Prevention_Networks.html
Respect Education	**Goal:** Provide education that helps create a safer world for everyone. **Method:** Offers affordable, flexible online courses to learn ways to create safety for you, your family, your colleagues and your clients.	Red Cross	Province-wide	https://www.redcross.ca/training-and-certification/course-descriptions/respect-education-courses
#Roar4Change	**Goal:** to end the silence stigma and shame that has governed the way society views child sexual abuse. **Method:** Age appropriate, empowering education (prevention workshops, community presentations, youth presentations, lessons for children and social media) to change the way society views child sexual abuse through education and conversation.	Project Roar	Saint John focus, online campaign	https://www.facebook.com/theprojectroar/
Sexcess!	**Goal:** Supporting individuals with an intellectual disability in achieving health sexuality and relationships. **Method:** 3-day training designed to give real life skills.	NBACL	Varies	https://nbacl.nb.ca/event-view/sexcess-3/
Sex Offender Program for Male Offenders	**Goal:** To prevent domestic violence and other societal problems, targets moderate- and high-risk offenders. **Method:** Narrative Therapy Domestic Violence—high intensity intervention.	Beausejour Family Crisis Resource Centre Inc	Moncton	http://healingstartshere.ca/

Sexual Assault Crisis Intervention Training	Sexual assault crisis training for those who are in a position where they might receive an assault disclosure.	Fredericton Sexual Assault Centre		http://fsacc.ca/en
Sexual Assault Nurse Examiner (SANE) Program	**Goal:** Provides victims of sexual or domestic violence support and forensic examination. **Method:** Provides care and specialized services that meet the needs of the victims, promote recovery and healing, increase the conviction rate of attackers, obtain quality DNA samples, maximize the options available to victims, ensure the cooperation of community and government partners, provide access to services of a SANE program nurse in a reasonable time frame and geographical location and inform the public and raise awareness about healthy relationships.	Vitalité and Horizon Health	Edumundston, Grand Falls, Saint-Quentin, Campbellton, Chaleur Region, Tracadie-Sheila, Moncton, Saint John, Fredericton, Miramichi	http://www.vitalitenb.ca/en/points-service/sane-program or http://en.horizonnb.ca/home/facilities-and-services/services/clinical-services/sane-(sexual-assault-nurse-examiner)-program.aspx
South-Eastern Sexual Assault Centre	**Goal:** Provide services to survivors of sexual violence. **Method:** Provide hospital accompaniment, police and court accompaniment, short and long term specialized counseling, advocacy, and outreach to survivors of sexual violence.	South-Eastern Sexual Assault Centre	South-East region	https://www.sesacnb.com/
Strengthening Families Program	**Goal:** Improve parenting skills and family relationships, reduce problem behaviours, delinquency and alcohol and drug abuse in children and improve social competencies and school performance. **Method:** 14-session, evidence-based parenting skills, children's social skills, and family life skills training program specifically designed for high-risk families. Parents and children participate in SFP, both separately and together.	John Howard Society, and others	Acadian Peninsula, Saint John, St. Mary's and Elsipogtog (Moving to target youth in Indian Island, Esgenoopititj, Oromocto, Kindsclear, Pabineau and Neguac; was delivered in Tobique, Campbellton,	https://www.strengtheningfamiliesprogram.org/

			Miramichi, Fredericton, Woodstock, Charlotte County and Moncton).	
Support program for youths in the Restigouche area	**Goal:** Address contributing factors of a young person's criminal behaviour in a holistic manner. **Method:** Providing support and direction through the facilitation team, innovative assessment and intervention techniques, and the delivery of high quality intensive services focusing on the young person and their families.	C.H.O.I.C.E.S Group Home	Dalhousie	http://www2.gnb.ca/content/gnb/en/services/services_renderer.201059.Intensive_Support_Program.html
Various Community Sexual Offending Programs (Youth and Adult)		*Family Services; Independent Psychologists/ Therapists*	Province-wide	
Various Community Sexual Delinquency Services (Youth and Adult)		*Family Services; Independent Psychologists/ Therapists*	Province-wide	
Victim Services	**Goal:** Provide services to victims throughout court process. **Method:** Provides support for victims in crisis situations, referrals to other services and support through the court process, assistance with victim-impact statements, information on compensation.	Department of Public Safety	Province-wide	https://www2.gnb.ca/content/gnb/en/departments/public-safety/community_safety/content/victim_services.html

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