

ACEs/CSA Impact and Supervised Visitation

Supervised Visitation Network (SVN) International Conference, Oct. 6-7, Niagara Falls, Ontario, Canada

Pamela Pine, PhD, Director, Stop the Silence® - A Department of the Institute on Violence, Abuse and Trauma

WELCOME and taking care of yourself

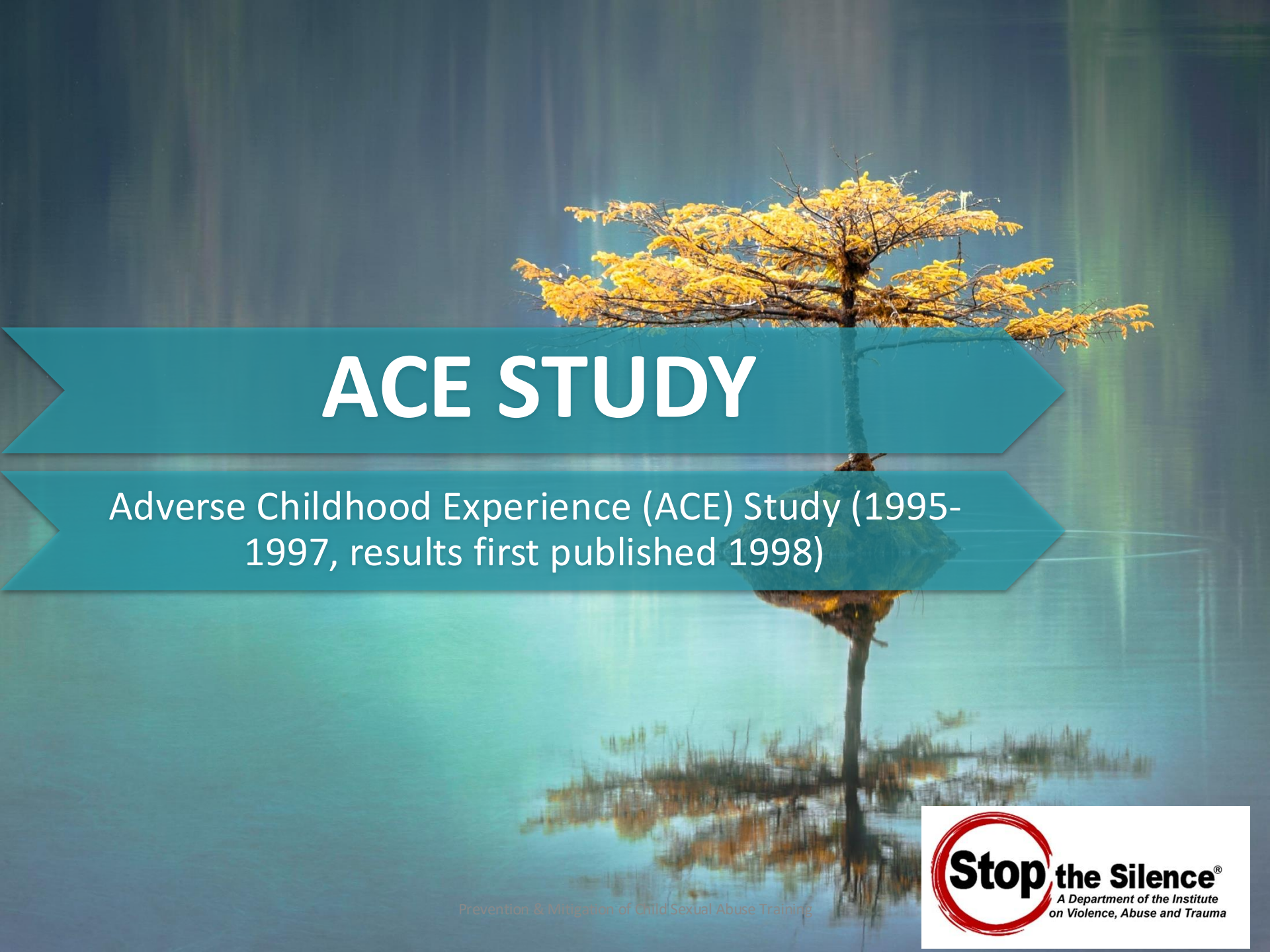
Prevention & Mitigation of Child Sexual Abuse Training



Part One/Objectives: Adverse Childhood Experiences (ACEs) – a base

Participants can state the rationale and need to “take care of themselves” during these presentations

Participants can generally describe the ACE Study & its overall findings



ACE STUDY

Adverse Childhood Experience (ACE) Study (1995-1997, results first published 1998)

The ACE Study

- Largest study ever done to determine long-term adult effects of ten common categories of adverse life experiences in childhood.
- 17,337 middle-class adults were involved in this retrospective and 20-year *prospective* analysis (CDC, Kaiser Permanente).
- Existence of these experiences found to be quite common, though unrecognized because they are lost in time and further protected by shame, by secrecy, and by social taboos against routinely exploring certain areas of human experience. Our typical medical history completely avoids them. History avoids them completely.
- Effects a half century later in adult life are powerfully and proportionately related to adult well-being, health risks, mental illness, job performance, social malfunction, suicide, range of bio-medical diseases including CA/premature death.



What are ACEs?

- Stressful experiences occurring during childhood that directly impact on a child or affect the family environment in which they live.
- Physical, sexual, and/or emotional abuse, neglect, or household adversity as a result of domestic violence, imprisonment, substance abuse, parental mental health problems or family breakdown (Bellis et al., 2015a).
- More recent work has extended the definition to include child neglect, parental bereavement, and children living in care (Allen & Donkin, 2015).
- Potential impacts of ACEs are physiological and behavioural, as well as psychological, and translate into poorer outcomes across a wide range of health domains, (Bellis et al., 2015b; Danese & McEwen, 2012, in Lorenc et al., 2020).

www.resilientchildfund.org/top-10-aces/



EXPERIENCES THAT LEAD TO MEDICAL OR SOCIAL PROBLEMS

Childhood abuse & neglect

Domestic Violence

Substance Abuse

Mental Illness

Crime

Specifically, the top 10 ACEs are...

The 10 ACEs measured in the research conducted by the Center for Disease Control are:

1. Physical abuse
2. Sexual abuse
3. Verbal abuse
4. Physical neglect
5. Emotional neglect
6. Depressed family member/diagnosed with other mental illness
7. Family member who is addicted to alcohol or other substance
8. Family member who is in prison
9. Witnessing a mother being abused
10. Losing a parent to separation, divorce or death

Other types of trauma also have an impact such as natural disasters & community violence.

(<https://www.resilientchildfund.org/top-10-aces/>)

- [illegible]

Adverse Childhood Experience Study – to view, go to:
<https://www.youtube.com/watch?v=lbsXh6wwc3Q>

ACE Study Prevalence (U.S.)

ACE Score Prevalence

0	33%
1	25%
2	15%
3	10%
4	6%
5 or more	11%*



*Credit to Dr Felitti & Dr Anda

ACE Study results - ABUSE

Psychological (By parents) 11%

Physical (By parents) 28%

Sexual 22%

ACE Study results - NEGLECT

Emotional

15%

Physical

10%

ACE Study results - HOUSEHOLD DYSFUNCTION

Alcoholism or drug use in home 27%

Loss of biological parent < age 18 23%

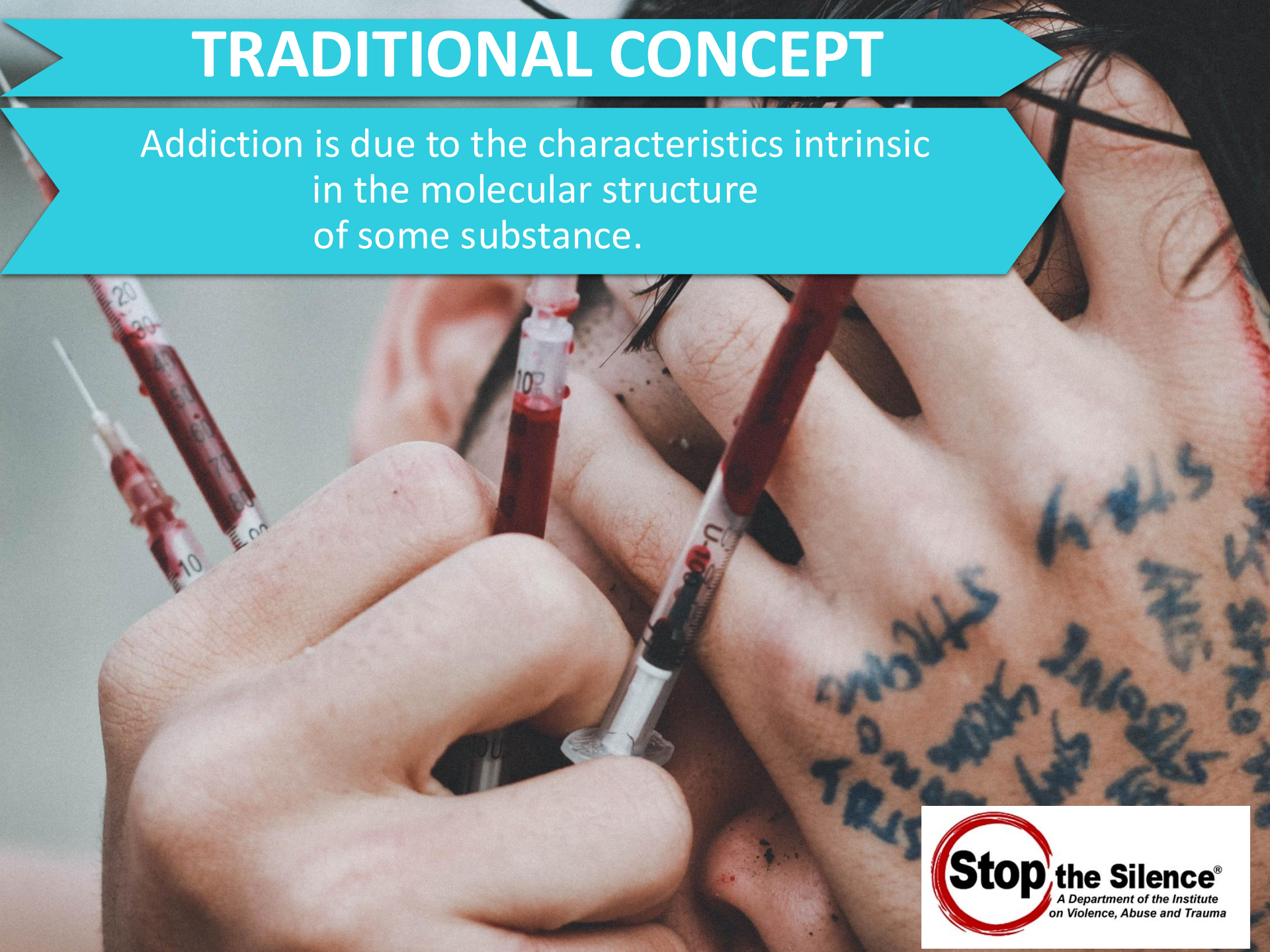
Depression or mental illness in the home 17%

Mother treated violently 13%

Imprisoned household member 6%

TRADITIONAL CONCEPT

Addiction is due to the characteristics intrinsic in the molecular structure of some substance.



BUT the ACE STUDY SHOWS...

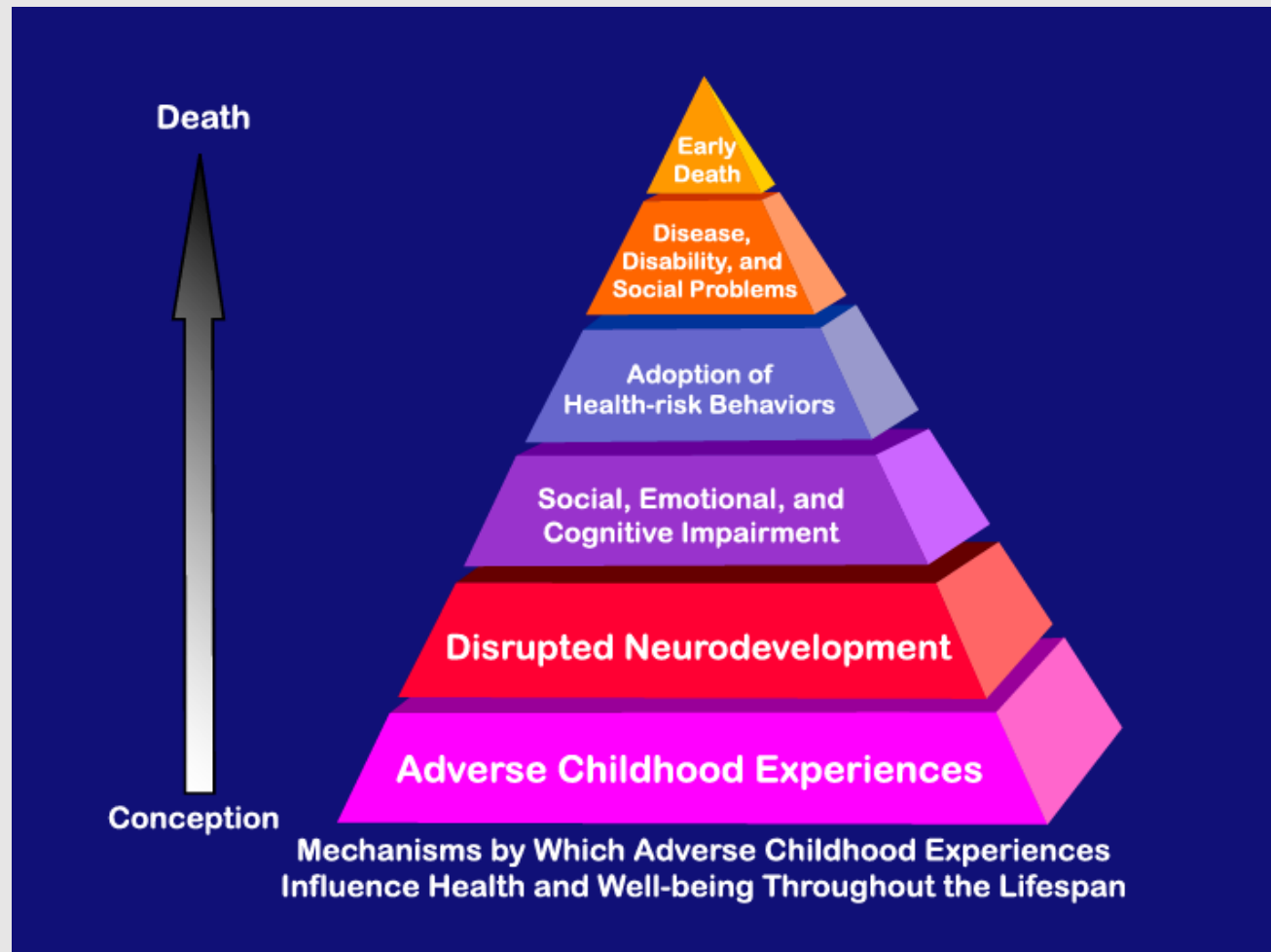
Addiction highly correlates with characteristics intrinsic to that individual's childhood experiences.



A PUBLIC HEALTH PARADOX

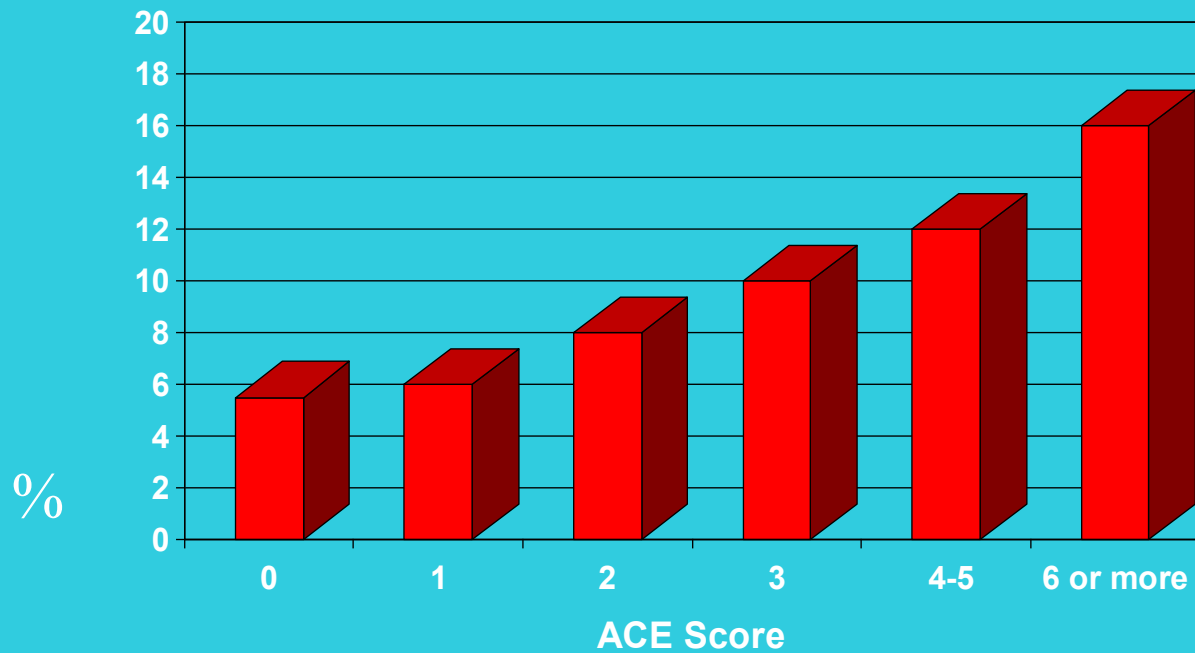
Many of our most common and intractable public health problems are unconsciously attempted solutions to personal problems dating back to childhood and buried in time and concealed by time, by shame, and by social taboo.

EFFECTS ON BRAIN AND OTHER DEVELOPMENT

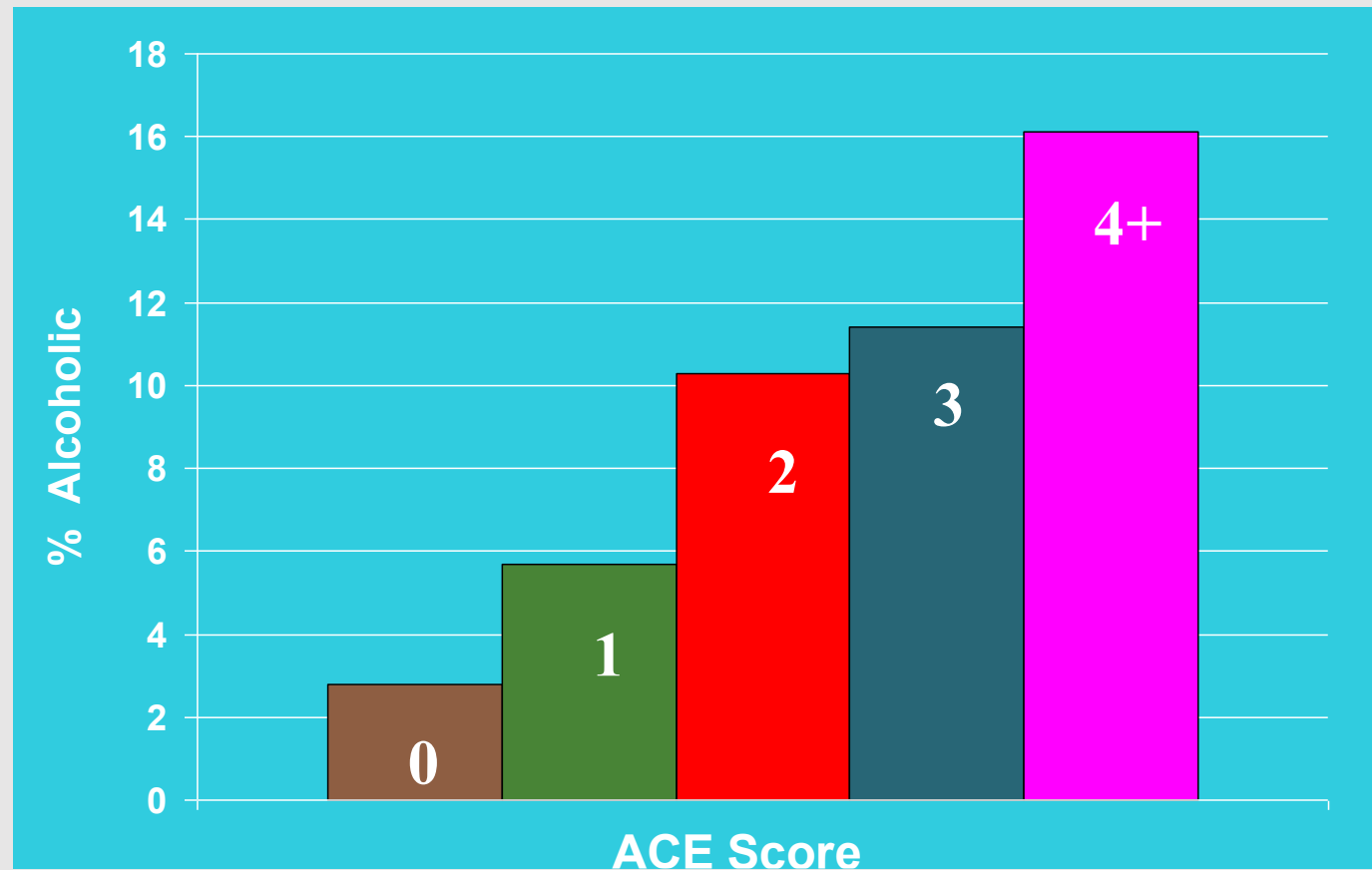


BRAIN DEVELOPMENT – to view and listen, go to:
<https://www.youtube.com/watch?v=IPftosmseYE>

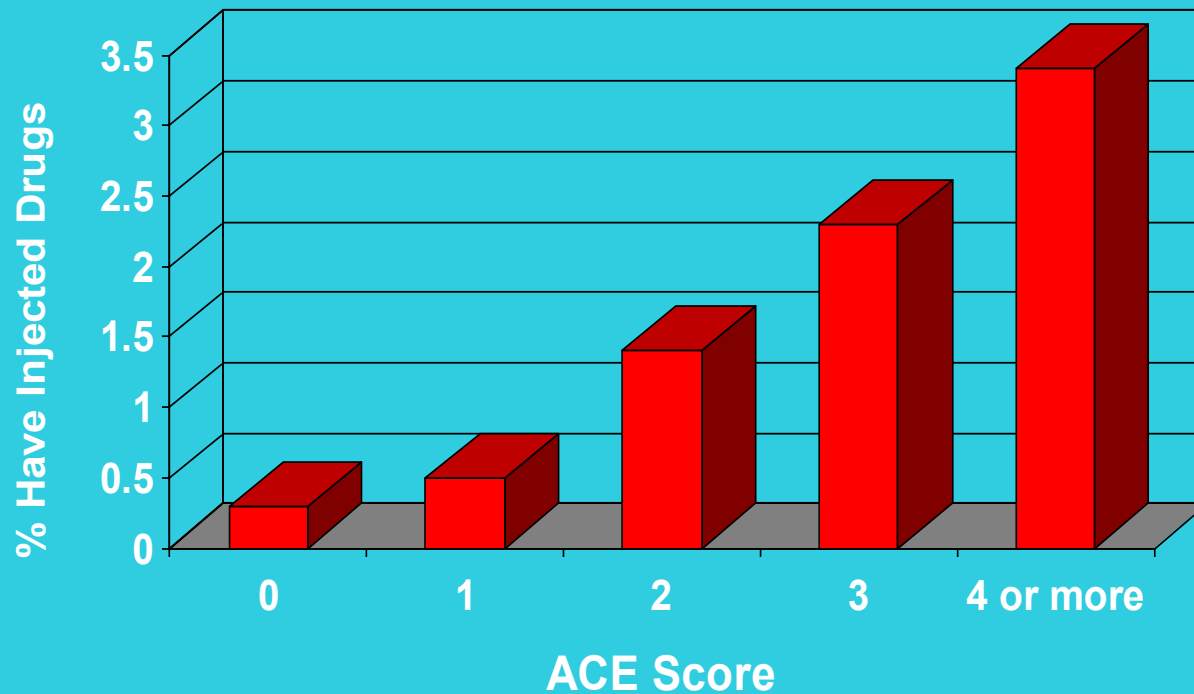
ACE vs SMOKING AS AN ADULT



ACE vs ADULT ALCOHOLISM



ACE vs INJECTION DRUG USE



ACEs INCREASE LIKELIHOOD OF HEART DISEASE

Emotional abuse 1.7x

Physical abuse 1.5x

Sexual abuse 1.4x

Domestic violence 1.4x

Mental illness 1.4x

Substance abuse 1.3x

Household criminal 1.7x

Emotional neglect 1.3x

Physical neglect 1.4x

*After correction for age, race, education and convention risk factors like smoking & diabetes Circulation Sept 2004



DEPRESSION



What if depression were *not* a disease, but a *normal response* to abnormal life experiences?



KEY TERMS & EFFECTS

Stress

Trauma

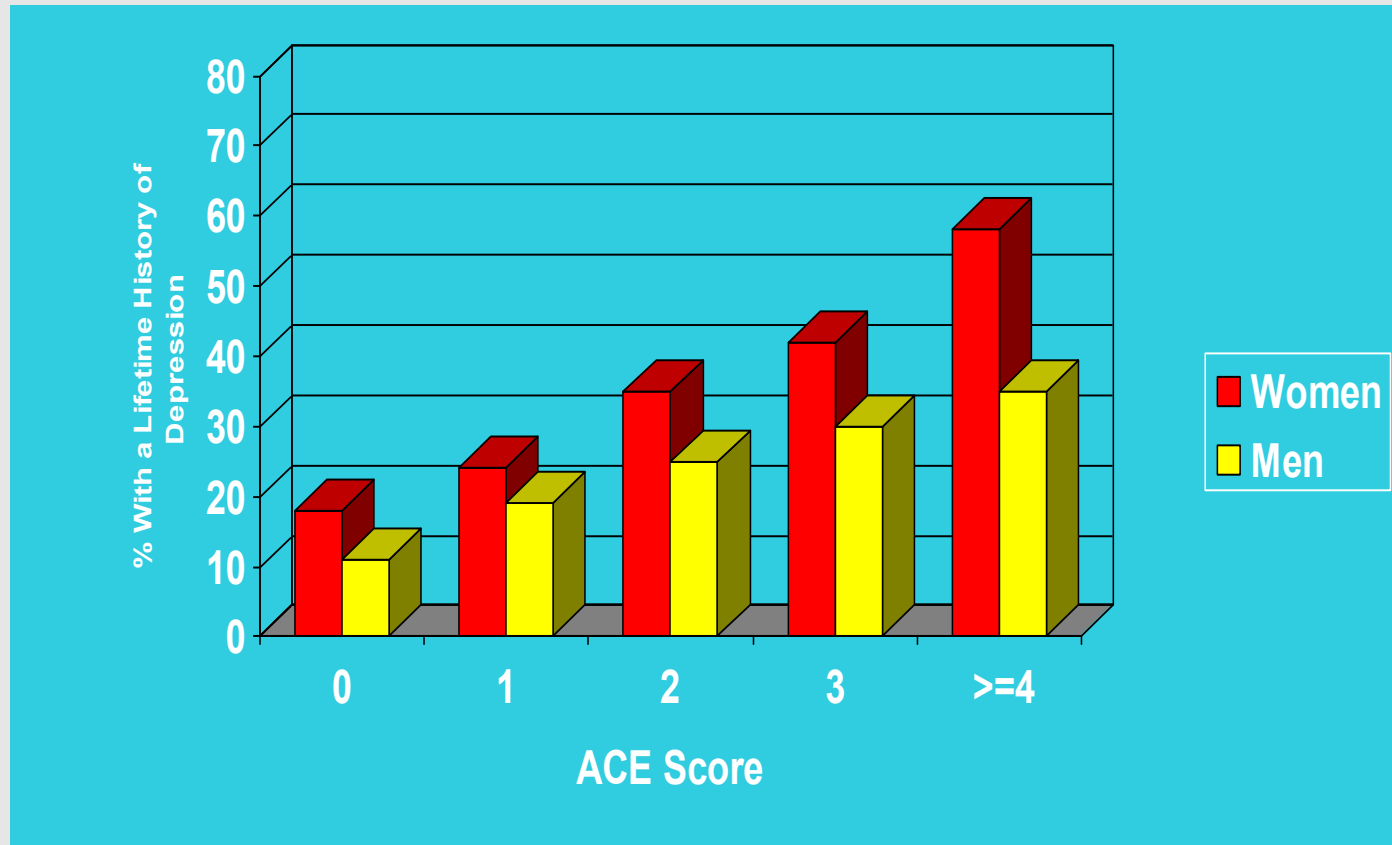
Traumatic stress

Post-traumatic stress

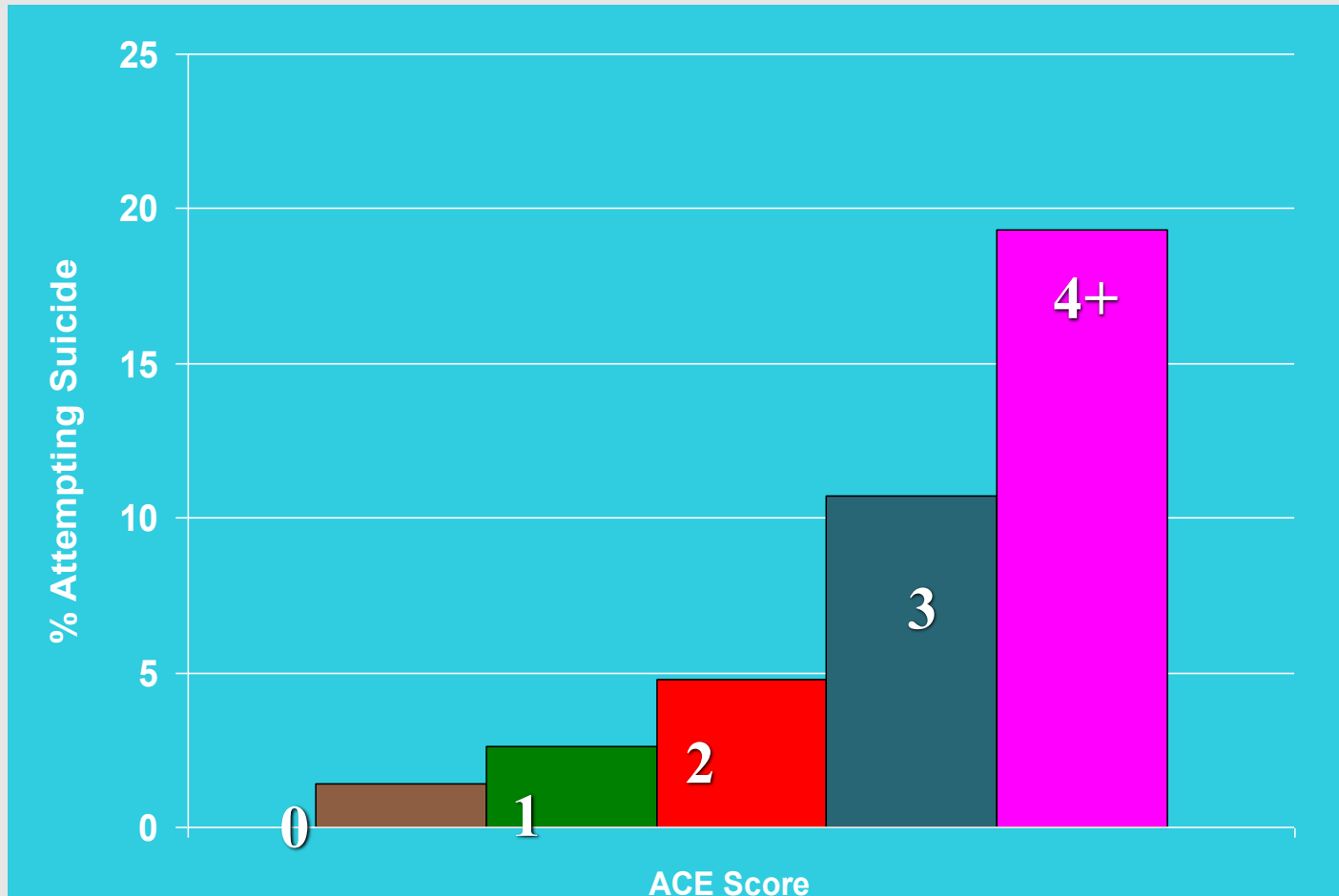
EFFECTS OF TRAUMA – to view, go to
<https://www.youtube.com/watch?v=SJhcn7Q0-LU>



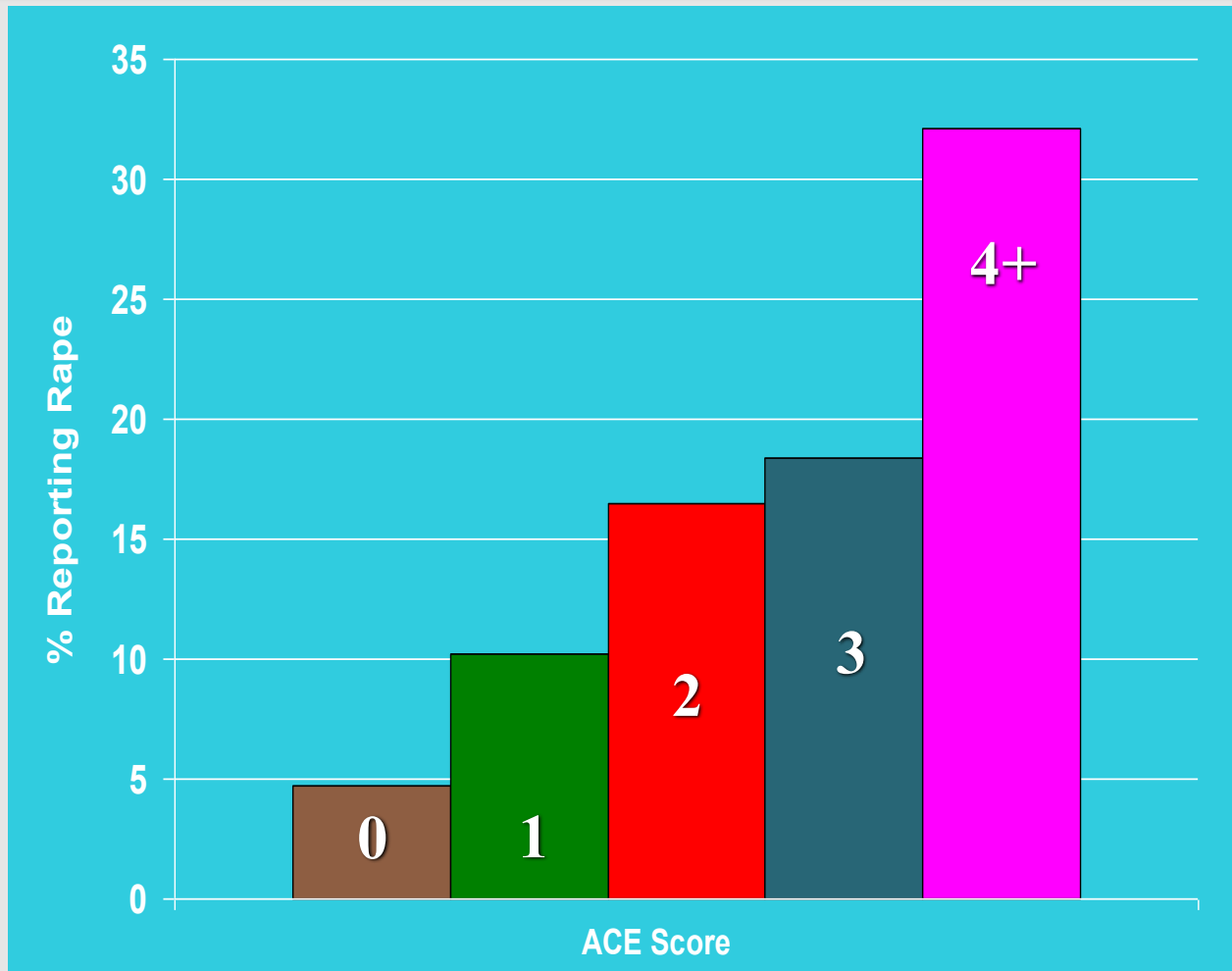
ACEs UNDLIE CHRONIC DEPRESSION



ACEs underlie SUICIDE ATTEMPTS



ACEs UNDERLIE LATER BEING RAPED

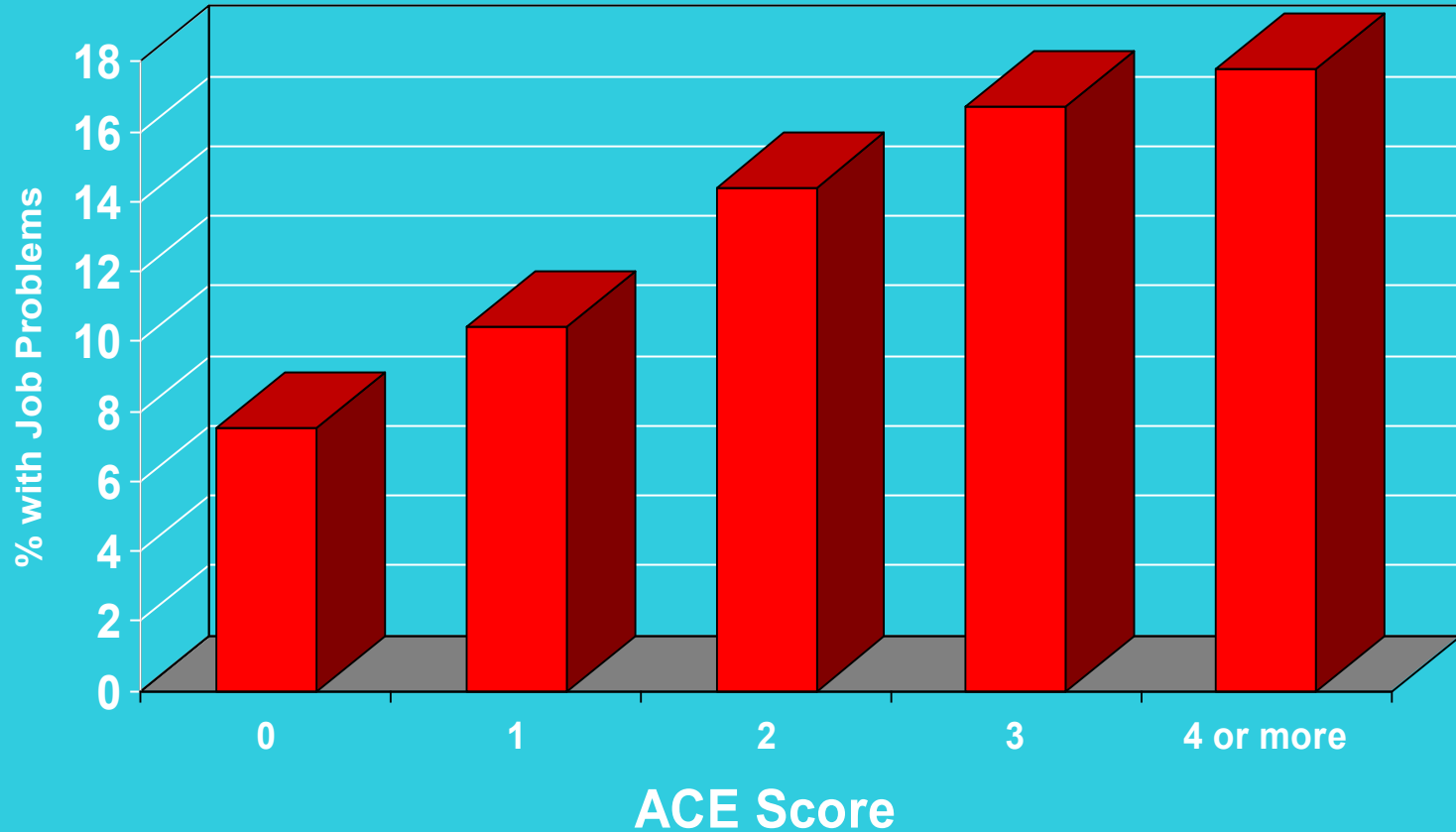


ACEs & THE LIKELIHOOD OF INTIMATE PARTNER EXPERIENCES

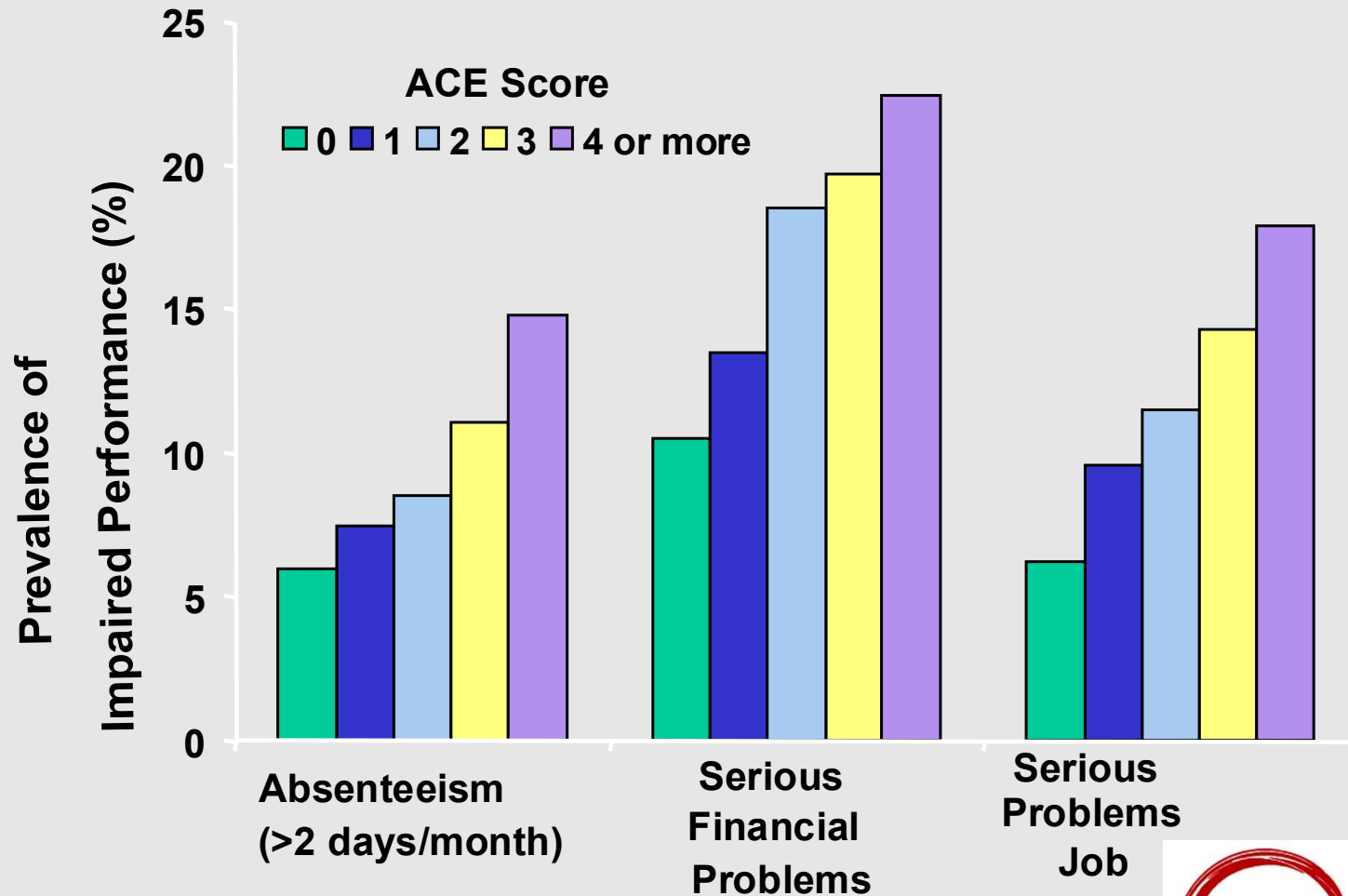
ACE Score	Intimate Partner Violence victim*	Being Raped*
0	1.0	1.0
1	1.9	2.0
2	2.1	2.8
3	2.7	4.2
4	4.5	5.3
≥5	5.1	8.9

***Adjusted Odds Ratio**

ACEs vs. SERIOUS JOB PROBLEMS



ACEs & INDICATORS OF IMPAIRED WORKER PERFORMANCE



ACE Study SUMMARY OF FINDINGS

Common & largely unrecognized

Basis of much adult medication and public health problems

Strong predictors of later social functioning

Interrelated & not solitary

Leading determinant of health & social wellbeing

SYSTEMIC ISSUES/CHANGES NEEDED (e.g., medical, etc.)

Routinely seek a history of ACE

Acknowledge their reality

Develop systems to help with current problems

Develop systems for early prevention

TO THINK ABOUT: ACEs, IMPACT, & RESPONSE

What do we know?

Impact, prevention & intervention

Mitigation continuum



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DISCUSSION

Thank you for your participation



Prevention & Mitigation of Child Sexual Abuse Training





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Abuse and Trauma (IVAT)

A close-up photograph of three young children of diverse backgrounds smiling and hugging each other. The child on the left is a young girl with dark hair, wearing a blue shirt. The child in the middle is a young girl with dark hair, wearing a purple and pink striped shirt. The child on the right is a young girl with dark hair, wearing a dark blue shirt. They are all smiling broadly and looking towards the camera. A teal arrow-shaped banner is overlaid on the top left of the image, pointing to the right.

HELLO and Welcome





TAKING CARE OF OURSELVES - SAFETY

Part 2 Presentation Focus: CSA

PARTICIPANTS WILL BE ABLE TO STATE AND DESCRIBE AND DISCUSS THE FOLLOWING:

Who is victimized

Who perpetrates

Grooming process

Signs & symptoms of abuse

Shame & its impact

Why children & adults don't disclose the abuse

How to take action

Our orientation on CSA

Prevent, Expose & Stop Child Sexual Abuse (CSA)

Awareness, Prevention, and Healing

Through Awareness-raising/Advocacy, Education,
Training & Policy Reform and Development

Measure & review

What is Child Sexual Abuse?



ACCEPTED DEFINITION

CSA occurs when an adult or older child engages a child in sexual activities

Violates the law

Often takes place on an increasing continuum of abuse

CSA occurs when full consent of involved parties is not possible due to differences in size, power, age, developmental level, or authority

SEXUAL ABUSE BEHAVIOURS: A Continuum

Voyeurism/peeping

Exhibitionism

Inappropriate physical contact & sexualized talking

Taking sexually explicit photos & commercial exploitation

Insertion of objects, Rape



What do we know about the World and CSA?

Worldwide Prevalence

U.S – Estimated at 1 in 4-6 girls and 1 in 6-8 boys

EUROPE - 1 in 5 girls and 1 in 6 boys

Estimates of prevalence of CSA, or how often CSA occurs, range from 8-31% of girls and 3-17.6% of boys internationally

CSA Prevalence – Canada Wide

Canada's 2018 *Survey of Safety in Public and Private Spaces*, 2022.

Group	Reported childhood sexual abuse by an adult before age 15 Important clarification: Likely an underestimate of total burden of CSA: it covers abuse perpetrated by an adult & relies on self-disclosure.	Approximate equivalent
Girls / women	12%	About 1 in 8
Boys / men	3.7%	About 1 in 27
All Canadians	7.8%	Almost 1 in 10

What kind of start in life is this?!



CONTEXT OF ABUSE

SURVIVORS – Who, How, What?

PERPETRATOR – Who & Why?

Who are the Canadian Victims/Survivors

Children and adolescents, regardless of their race, culture or economic status though **poorer and marginalized children can be at higher risk.**

Statistics show that girls are more often sexually abused than boys.

In a large Alberta, Canada survivor survey, first incidents most commonly occurred between ages 6–11 or 12–17, depending on the type of sexual abuse. (This is provincial evidence, not a national average, Association of Alberta Sexual Assault Services-AASAS, January 29, 2020)



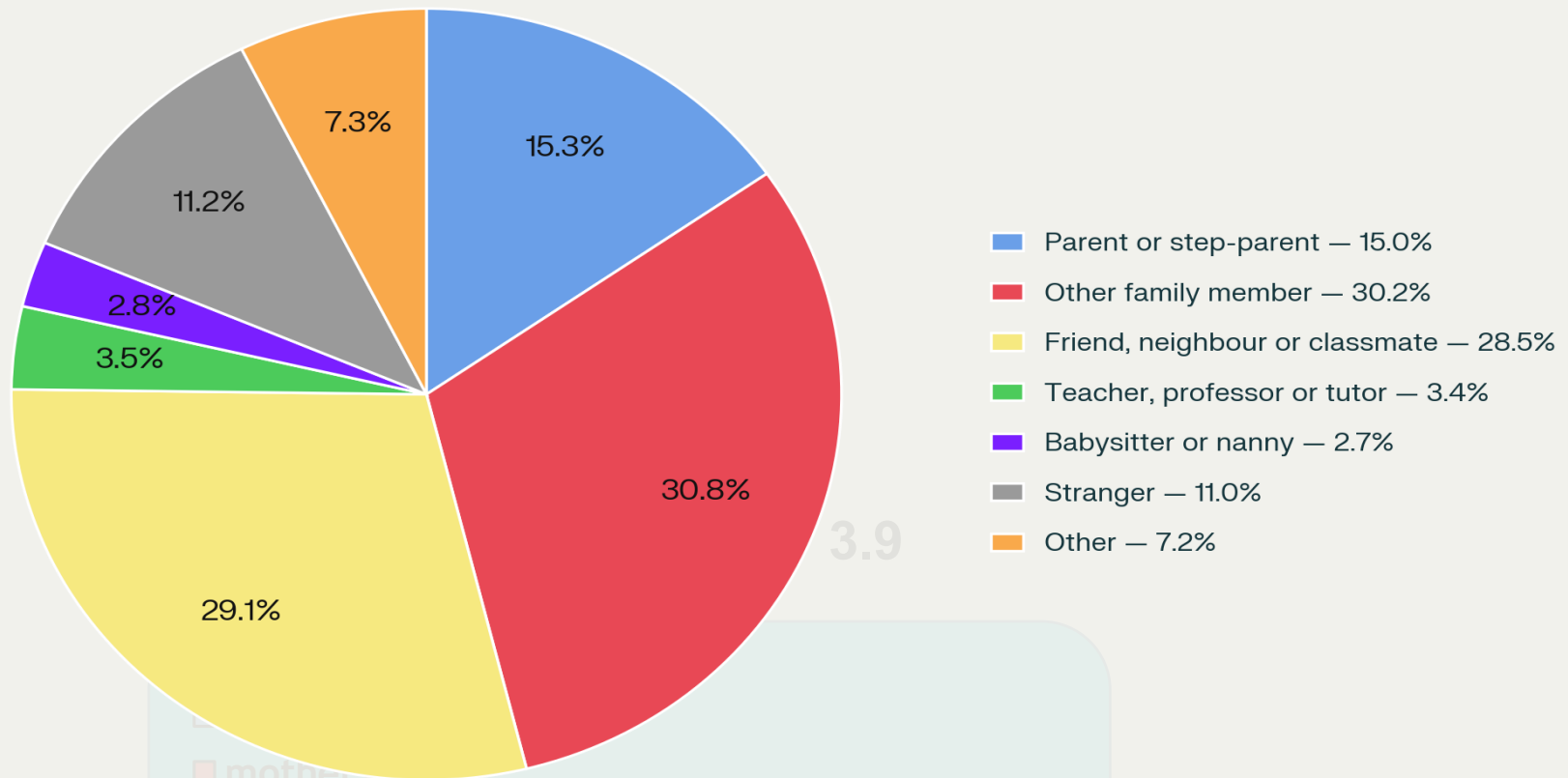
Four crocheted bunny dolls are arranged in a row against a dark, textured background. Each doll is made of light-colored yarn and has long, upright ears. They are wearing different colored bows on their heads and tutus around their waists. From left to right, the bows are pink, purple, red, and blue. The tutus are also in corresponding colors. The dolls are positioned behind two large, light blue arrow-shaped banners that point to the right.

GROOMING

Understanding grooming behaviors

Perpetrator Overview – Relationship to Victim: Only 11% are “strangers” (Canada)

Most serious incident of childhood sexual abuse reported by survivors



mothers only
other relatives
mothers acting with another person
day care providers
other



Canadian adults age 15+ recalling sexual abuse by an adult before age 15; categories may not be directly comparable to U.S. chart categories.

Source: Statistics Canada, Survey of Safety in Public and Private Spaces (2018), released 2022.

Perpetrators/Offenders (Canada) — a closer look

- Taken together, **73.7%** of these most serious incidents were committed by someone known to the child; this figure combines the reported categories of parent/step-parent, other family member, friend/neighbour/classmate, teacher/tutor, and babysitter/nanny.
[canada](#)
- Canadian police-reported data likely understate the problem because childhood victimization, particularly in family contexts, is often difficult to detect and report.statcan+1
- **Instead of looking for a “type” of perpetrator, look for situations that create opportunity, secrecy, isolation, boundary violations, or unequal power.**

Statistics Canada, *Profile of Canadians who experienced victimization during childhood, 2018 (2022)*, based on the 2018 Survey of Safety in Public and Private Spaces.[canada](#)



Grooming Behaviors

Gifts or money

Special attention

Threats/manipulation/control

Physical and sometimes deniable acts

Context of Abuse

Sexual abuse can take place:

- In everyday situations, at different times of day, different places
- Always in the same locations: e.g., the child's bed, the abuser's bed, on a chair in the living room, in the classroom
- At the same time every day or week (e.g., every Thursday when the child is left alone with the abuser)
- With or without being clothed
- As part of a wider range of physical or sadistic abuse
- In an "special" place away from the child's home (a car, shed, or building used for community activities)
- In a fleeting way as the child or adult come into physical contact with each other (abuser fondles child's genitals as he passes her on the stairs or in the swimming pool)
- Possibly to maximize the child's guilt it can take place in the parents' bed or in front of other children
- In a context where the child is rewarded with gifts or money

SIGNS & SYMPTOMS OF CSA

Sudden change in behavior

Physical problems

Demonstrates age-inappropriate knowledge

Reluctance to be alone

Regressive behavior

Effects of CSA

- Low self-esteem
- Depression
- Anxiety
- Isolation
- Regressive behaviors
- Dissociation
- Nightmares
- Flashbacks
- Difficulty concentrating
- Feeling unsafe
- Runaways (43%)
- Promiscuity
- Teen pregnancy (60%)
- Prostitution (95% of prostitutes/ people in porn industry)
- Drug and alcohol abuse (60-80%)
- Self-harm behaviors (cutting, burning)
- Eating disorders
- Abstinence of sex
- Interpersonal difficulties (trouble at work or home...)
- Incarceration (In U.S.: 59% of females, about 1/3 of all those in prison for homicide)





Why is it so difficult to deal with CSA?

FACTORS THAT CONTRIBUTE TO CSA

Individualism/Privacy

Images from popular culture

Value of children women/"isms"

Children, women as property

Discomfort with subjects



SEXUALISATION



SHAME (and discomfort, fear, distrust, marginalization, etc.)

Brene Brown on SHAME:

https://www.ted.com/talks/brene_brown_listening_to_shame?language=en



PAUSE: CSA in Children and the Response

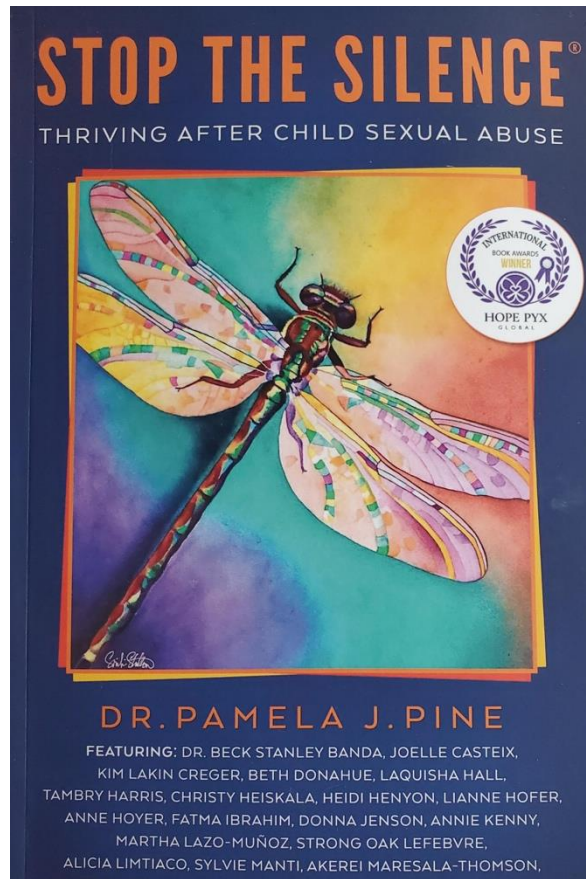
What do we know?

Impact, prevention & intervention

Treatment & mitigation continuum

Websites and Two Books to Help You Move Forward re CSA...

- Stop the Silence®, for adults, is written by 23 international survivors and experts (I am lead author). A good place to continue learning about the issue and impact regarding one type of ACE, child sexual abuse (CSA).
- Brave Kids Vol. 3 has a story I wrote ("Squishy's and Squoosh's Shared Secret - Staying Safe by Talking About Things That Don't Feel Right") for parents/trusted caregivers to read with children. In a non-explicit way, the story tells a tale that helps us talk to kids about grooming, offending, signs & symptoms, rescue, protection, reporting, and safety. Other stories in the book support growth, learning, and self-esteem.



[https://www.ivatcenters.org/stop-the-silence;](https://www.ivatcenters.org/stop-the-silence)
<https://www.drpamelajpine.com>



Coming up-Focus of Part 3:

ACEs/CSA, SV, & Canadian Policies, Procedures, Standards, Practices

Canadian Policies, Procedures, and Standards Guiding Responses in an SV environment

Why Having the Conversation is Important: Dealing with Allegations and Legal Convictions

Call to action: Warning signs, Trauma-Informed Care, Changes needed



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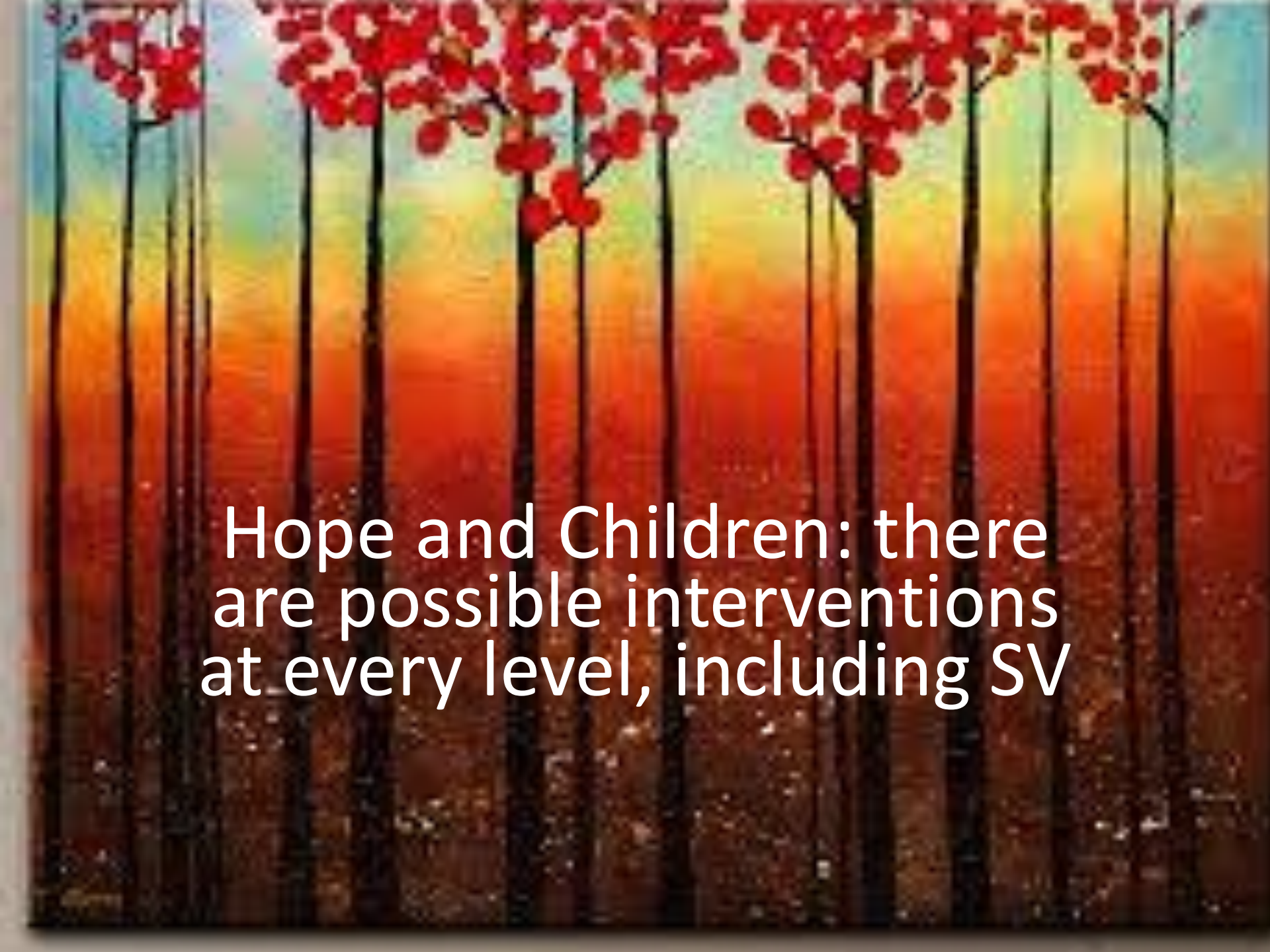
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A vertical painting of a forest scene. The background is a gradient of warm colors, transitioning from a pale yellow at the top to a deep orange and then a dark, textured brown at the bottom. Several tall, thin, dark vertical lines represent tree trunks. At the top of these trunks, there are clusters of small, bright red berries or flowers. The overall style is abstract and expressive, with visible brushstrokes and a textured surface.

Hope and Children: there
are possible interventions
at every level, including SV



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THANKS FOR YOUR ATTENTION



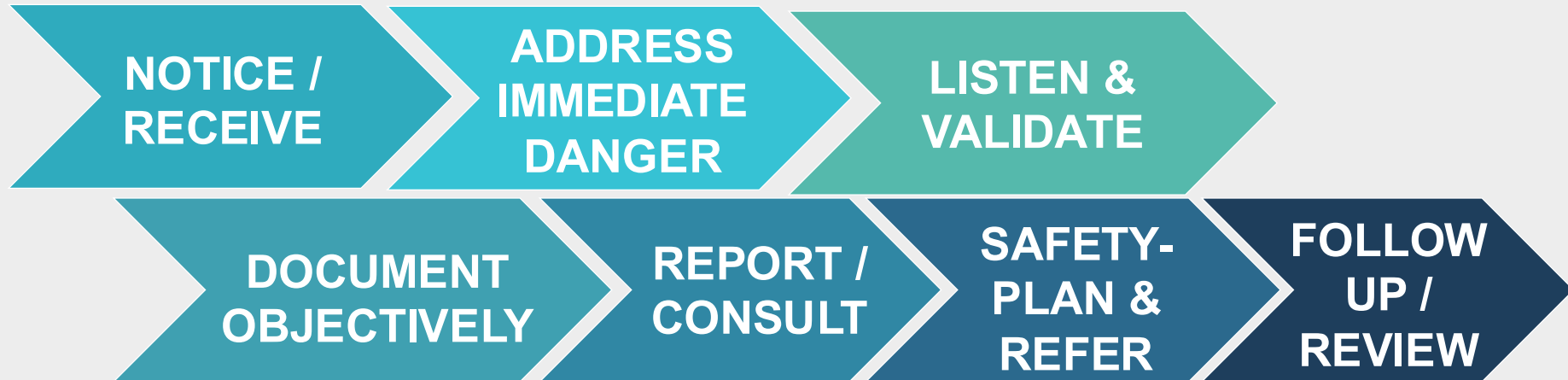
Agree? Getting to Intent on Supervised Visitation and the Reality

In child-abuse cases, supervised visitation is intended to permit carefully structured parent-child contact only when it can occur safely and serves the child's best interests. A court order or written agreement should specify the purpose, conditions, frequency, duration, and circumstances for pausing or ending contact; each adult should receive a separate intake and agree to program rules. Visits should occur in a neutral, child-focused setting with trained, appropriately supervised staff, while staff document factual observations rather than provide therapy or make custody recommendations. Planning should be individualized and trauma-informed, attending to the child's safety, emotional state, developmental needs, and the risks that led to supervision; safe, separate exchanges can also prevent contact between adults when needed. (<https://www.ontario.ca/document/2025-2026-mccss-service-objectives-child-welfare-and-protection/2025-2026-services-38>)

Agree? Supervised Visitation and the Reality

In practice, supervision is not automatically protective or therapeutic. Research cautions that some children experience supervised contact as distressing and that poorly supported visits can undermine safety, security, or placement stability; services may lack sufficient trauma-informed skill to help adults respond constructively to a child's needs. Access can also be constrained by limited capacity, staff availability, waiting lists, restricted hours, and inconsistent program quality. Ontario's standards acknowledge that scheduling depends on facility and staff availability and that families may wait when space is unavailable. Further concerns include overly vague orders, insufficiently trained supervisors, inconsistent enforcement of rules, use of relatives who may be unable to remain neutral, and visits that become an avenue for coercion, intimidation, or continued control rather than safe contact. (<https://link.springer.com/article/10.1007/s10615-023-00862-6>)

A Response Pathway – Attendees Describe Scenarios in Their Work?



Follow local law, your organization's procedures, supervisory direction, and emergency protocol at every stage.



Sidebar Case Scenario: What Would You Do?

During a scheduled supervised visit, an 8-year-old who is usually talkative becomes quiet, repeatedly asks whether the visit must continue, and says, “Please don’t tell Dad I said anything.” The child has recently resisted attending visits and arrives with a new phone the caregiver says was a “special surprise.”

Discuss/notate in pairs or small groups (sidebars):

- What do you observe and document?
- What immediate safety questions or steps are appropriate—and what should you avoid?
- Who do you consult or report to under your local protocol?
- How do you preserve the child’s dignity and avoid leading questions?



On a Piece of Paper: Organizational Readiness

Mark each as:

- Ready (R)
- Needs strengthening (N)
- Not yet in place (T)

- ☐ We have a current, accessible child-protection reporting procedure and contact list.
- ☐ Staff know their role when a concern, disclosure, allegation, or escalation arises.
- ☐ Our documentation templates support objective, timely, secure records.
- ☐ We provide regular training, supervision, consultation, and debriefing.
- ☐ We maintain survivor-centred, culturally safer referral pathways.
- ☐ We review whether our policies unintentionally silence children, survivors, or non-offending caregivers.

Same Paper - Call to Action: One Change Within 30

Days

**Identify one personalized, written action step
you can implement within 30 days.**

My action step is:

It will strengthen safety, access, trust, or accountability by:

My first concrete step and completion item is:

People or resources I will involve:

How I will know it is complete:





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Key Canadian Resources

Justice Canada — Divorce Act: best interests of the child and family violence.

Government of Canada — National Action Plan to End Gender-Based Violence.

Provincial / territorial child protection authority — local duty-to-report requirements.

Ontario Association of Children's Aid Societies — Ontario duty-to-report guidance.

Canadian Child Welfare Research Portal — reporting and child protection resources.

Your organization's reporting procedure, emergency plan, court-order protocol, and local referral directory.

Training note: This deck provides education, not legal advice. Follow local law, agency policy, court orders, and supervisory direction.



ACEs/CSA Impact and Supervised Visitation, Part 3:

Canadian Policies, Procedures, Standards, Practices

Canadian policies, procedures, and standards guiding responses in a supervised visitation environment

Pamela Pine, PhD, Director, Stop the Silence®
- A Department of the Institute on Violence, Abuse and Trauma (IVAT)



HELLO, Welcome, Who's Who, Taking Care, and a Story



Learning Objectives

- Describe key Canadian legal, policy, and practice considerations in an SV setting.
- Recognize concerns and be able to respond without conducting an investigation.
- Able to apply trauma-informed, survivor-centred, culturally safer practice.
- Can use documentation, reporting, consultation, and referral pathways appropriately.
- Able to identify one realistic policy or practice improvement within 30 days.



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Why This Conversation Matters

Supervised visitation (SV) can be a critical safety intervention—not simply a neutral exchange or contact service.

Children's **safety, security, and well-being** must remain central.

A concern, disclosure, allegation, or observed change may require **action**—even when staff do not have all the facts.

Our role is not to investigate or decide guilt; it is to **notice, respond, document, report, consult, and support safety.**



Safety, Contact, and Power – What Would Have Happened in the story IF the **focus** was on...

Child safety

Physical, emotional, and psychological safety are the starting point.

Caregiver safety

A non-offending caregiver's fear or safety concern may affect a child's safety.

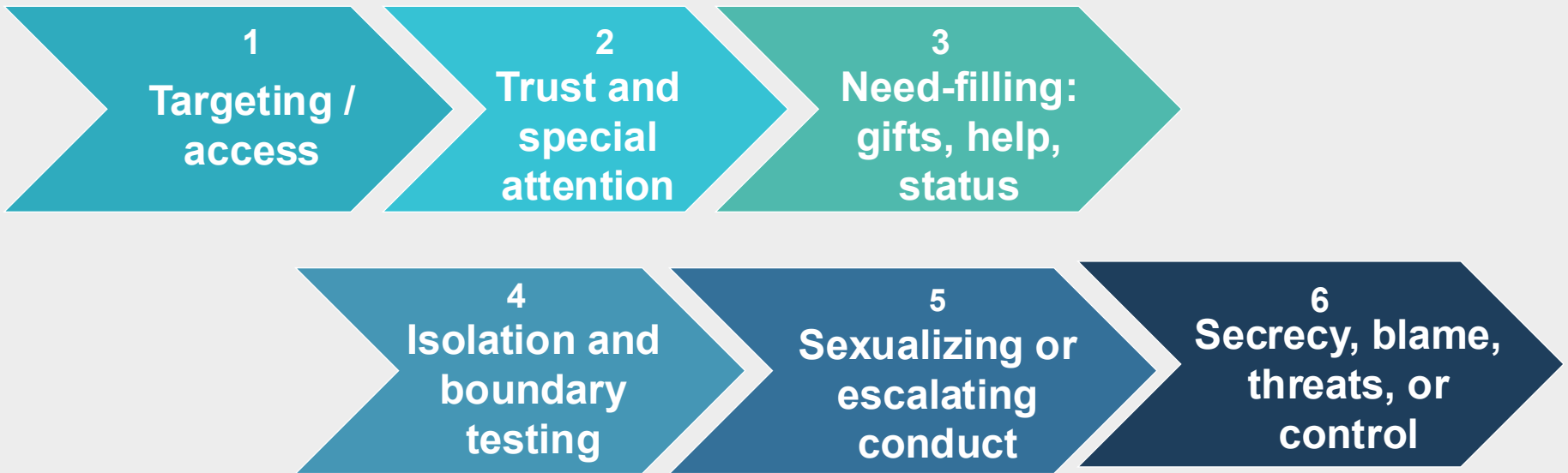
Service response

Clear boundaries, documentation, consultation, and escalation protect everyone.

Contact arrangements do not eliminate risk; they require active, informed safety practice.



Grooming and Coercive Control: Look for Patterns



Focus on behaviours, access, boundary violations, isolation, secrecy, and control—not stereotypes about who may cause harm.



Family Violence Is Also a Child-Safety Issue

Family violence can include patterns of coercive and controlling behaviour, violent or threatening conduct, and behaviour that causes fear for safety.

Children can be affected by violence even when they are not directly targeted.

Exposure may shape fear, behaviour, attachment, health, school functioning, and the ability to speak freely.

Risk assessment must consider patterns, context, and safety—not only a single reported incident.

Warning Signs in Kids: A Signal to Respond, Not Proof

No single sign confirms abuse. Changes, patterns, and context are reasons to notice, consult, and respond.

- Sudden changes in behaviour, mood, sleep, eating, or school functioning
- Age-inappropriate sexualized knowledge or behaviour
- Regression, withdrawal, self-harm, aggression, or increased fear
- Reluctance to be alone with, see, or travel to a particular person or place
- Unexplained gifts, money, devices, or special attention from an adult or older youth
- Physical symptoms or disclosures that raise concern



When Violence Is Alleged: Use a Risk Lens

Nature, seriousness, frequency, and pattern of violence

Coercive control, threats, fear, stalking, or intimidation

Direct or indirect exposure of the child

Risk of physical, emotional, or psychological harm

Ability and willingness to meet the child's needs safely

Evidence of accountability, change, and compliance with conditions

Allegation Is Not Proof—But It Is a Safety Signal

A concern should prompt a safety-focused response. It does not require staff to determine credibility or guilt.

Do

Listen • document • consult
• report • safety-plan

Do not

Investigate • confront • mediate
• promise secrecy • dismiss

The aim is a timely, proportionate response that protects safety and preserves the integrity of any formal process.



When a Child or Adult Discloses

Helpful responses

“I believe you.”

“It is not your fault.”

“Thank you for telling me.”

Listen calmly; explain next steps and limits of confidentiality.

Use the person’s words; document and report/consult as required.

Avoid

Leading or repeated questions

Promises you cannot keep

Confronting the alleged person

Pressuring a disclosure

Blame, disbelief, or minimizing language



Document What You Saw, Heard, and Did

OBSERVE

Record objective behaviour, condition, context, date, time, and who was present.

RECORD

Use exact words when possible.
Distinguish facts from interpretation.

ACT

Record report, consultation, safety action, referral, and follow-up.

Document facts, not conclusions. Use your organization's approved recordkeeping system.



Child Protection: Duty to Report

Across Canada, suspected child abuse must be reported under provincial or territorial child-protection law.

Report when the legal threshold is met—do not wait for proof.

Follow the reporting process in your jurisdiction and your organization's protocol.

Do not assume that someone else has reported.

When danger is immediate: use emergency procedures and contact emergency services as required.



Practice Point: Report Promptly and Directly

For example, in Ontario, every person who has reasonable grounds to suspect a child is or may be in need of protection must **promptly report to a Children's Aid Society.**

Reasonable grounds

Concern based on information, observation, disclosure, or circumstances—not proof.

Prompt reporting

Do not delay while trying to verify, interview, mediate, or resolve the concern.

Direct responsibility

A person cannot simply rely on another person to make the report.

Canadian Framework: Layered Responsibilities

Federal law

Criminal law and the Divorce Act

Provincial / territorial law

Child protection, family law, reporting duties,
professional regulation

Organizational practice

Policies, safety procedures, documentation,
supervision, referral agreements

**Exact duties and procedures vary by jurisdiction, agency mandate,
court order, and role.**



Legalities: Best Interests of the Child - Safety First

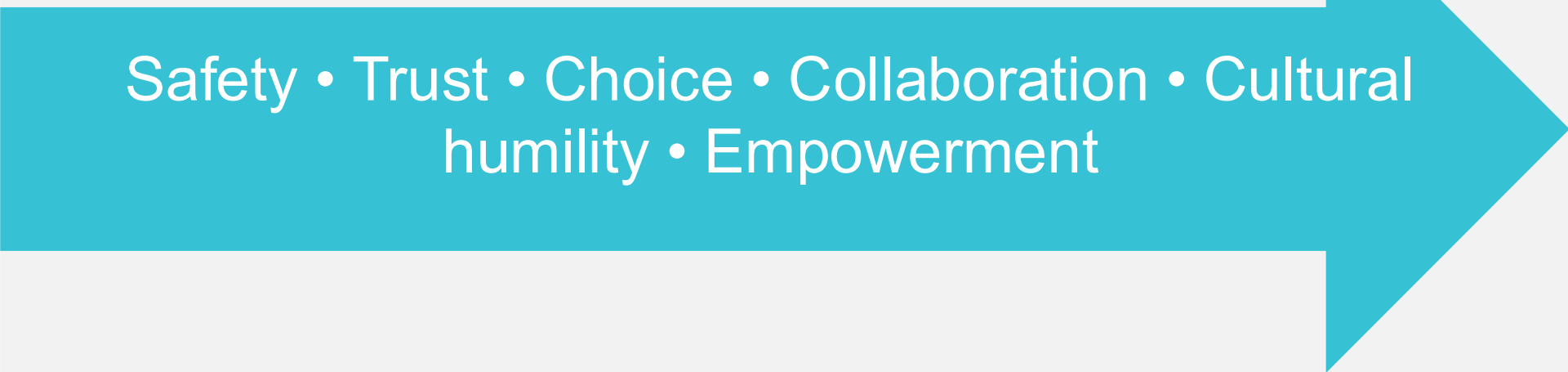
The child's physical, emotional, and psychological safety, security, and well-being are the primary consideration.

In family-law decisions, courts consider the impact of family violence.

The purpose of supervised contact is not to override safety concerns; it is to implement safe, accountable arrangements within a defined mandate.

Staff observations and documentation can be important safety information.

Trauma-Informed, Survivor-Centred Practice



Safety • Trust • Choice • Collaboration • Cultural
humility • Empowerment

Equity Matters in Credibility and Access

Indigenous women, girls, and 2SLGBTQQIA+ people face the continuing crises and require Indigenous-led, culturally grounded pathways.

Black women may encounter systemic disbelief when reporting pain, racism, harassment, or safety concerns.

Immigrant and refugee women may face language barriers, immigration-related fear, economic dependence, and isolation.

People with disabilities may encounter dependency, communication, transportation, and accessibility barriers.

Ask: Whose disclosure is most likely to be minimized, misunderstood, or excluded by our systems?



Culturally Safer and Accessible Responses

- Use qualified, confidential interpreters—not children, relatives, or alleged perpetrators.
- Ensure private, accessible ways to report concerns and receive information.
- Build referral relationships with Indigenous-led, Black-led, newcomer-serving, disability, and culturally specific organizations.
- Ask about accommodation and communication needs; do not make assumptions.
- Use names, pronouns, and family definitions respectfully; explain processes in plain language.



Trauma-Informed Supervised Visitation

Safety Predictable procedures, clear boundaries, privacy, and immediate-risk planning.

**Trustworthi-
ness** Explain roles, limits, documentation, and next steps honestly.

**Choice
and
voice** Offer meaningful options whenever possible; avoid unnecessary control.

**Collabor-
ation** Work with caregivers, children, advocates, & partners within role boundaries.

**Cultural
humility** Recognize culture, racism, colonialism, disability, language, immigration realities.

**Empow-
erment** Notice strengths, validate concerns, support informed decision-making.



Survivor-Centred Does Not Mean Neutral About Safety

Respectful, nonjudgmental care and firm safety action belong together.

Survivor-centred

Listen, validate,
explain options,
respect autonomy,
reduce harm.

Safety-centred

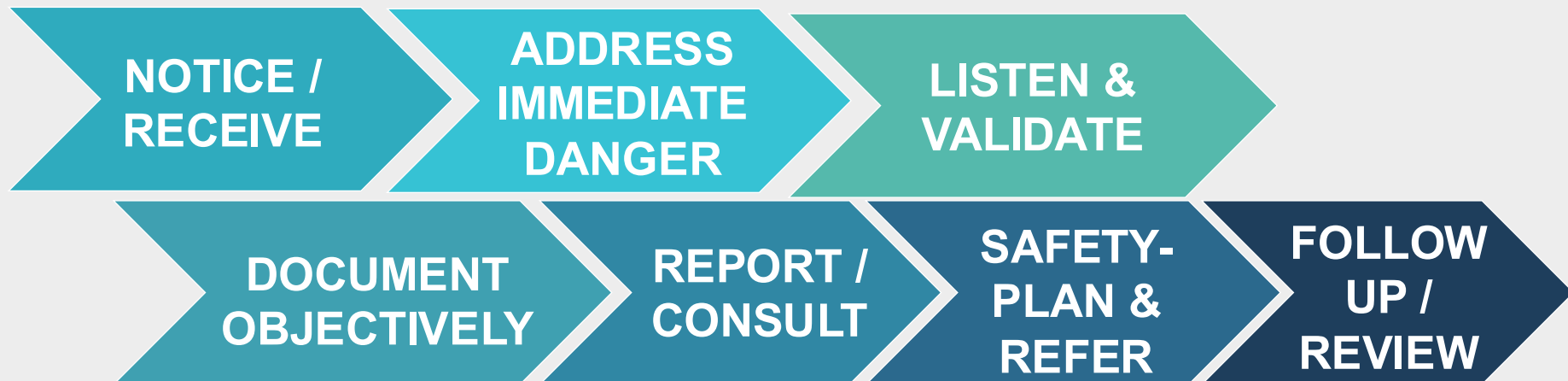
Escalate
concerns, follow
policy, report as
required, manage
access risks.

Accountability- centred

Document, consult,
follow court/agency
conditions, review
practice.



A Response Pathway – Attendees Describe Scenario in Your Work?



Follow local law, your organization's procedures, supervisory direction, and emergency protocol at every stage.



Remember...

“If you are concerned, respond calmly, listen, and document... You do not need proof to act on a reasonable concern.

Your role is to recognize, respond supportively, and report—not to investigate.

And you do not have to manage it alone.”



Sidebar Case Scenario: What Would You Do?

During a scheduled supervised visit, an 8-year-old who is usually talkative becomes quiet, repeatedly asks whether the visit must continue, and says, “Please don’t tell Dad I said anything.” The child has recently resisted attending visits and arrives with a new phone the caregiver says was a “special surprise.”

Discuss/notate in pairs or small groups (sidebars):

- What do you observe and document?
- What immediate safety questions or steps are appropriate—and what should you avoid?
- Who do you consult or report to under your local protocol?
- How do you preserve the child’s dignity and avoid leading questions?



On a Piece of Paper: Organizational Readiness Check

Mark each as:

- Ready (R)
- Needs strengthening (N)
- Not yet in place (T)

- ☐ We have a current, accessible child-protection reporting procedure and contact list.
- ☐ Staff know their role when a concern, disclosure, allegation, or escalation arises.
- ☐ Our documentation templates support objective, timely, secure records.
- ☐ We provide regular training, supervision, consultation, and debriefing.
- ☐ We maintain survivor-centred, culturally safer referral pathways.
- ☐ We review whether our policies unintentionally silence children, survivors, or non-offending caregivers.

Same Paper - Call to Action: One Change Within 30 Days

**Identify one personalized, written action step
you can implement within 30 days.**

My action step is:

It will strengthen safety, access, trust, or accountability by:

My first concrete step and completion item is:

People or resources I will involve:

How I will know it is complete:





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Discussion and Closing

Safety, dignity, and accountability are practices—not aspirations.

1. Where might our current practices unintentionally silence a child, survivor, or non-offending caregiver?

2. What one policy, procedure, partnership, or training change would most strengthen safety in our setting?

3. What will you take forward in the next 30 days?

Core resources: Justice Canada • Government of Canada / Women and Gender Equality Canada • Provincial / territorial child-protection authorities



Key Canadian Resources

Justice Canada — Divorce Act: best interests of the child and family violence.

Government of Canada — National Action Plan to End Gender-Based Violence.

Provincial / territorial child protection authority — local duty-to-report requirements.

Ontario Association of Children's Aid Societies — Ontario duty-to-report guidance.

Canadian Child Welfare Research Portal — reporting and child protection resources.

Your organization's reporting procedure, emergency plan, court-order protocol, and local referral directory.

Training note: This deck provides education, not legal advice. Follow local law, agency policy, court orders, and supervisory direction.





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THANKS FOR YOUR PARTICIPATION

