Child Abuse & Neglect 179 (2026) 108216

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Better together: A priority-setting partnership to identify research priorities for child maltreatment in Canada

Maria Pavlova [a,*], Artina Madani [b], Anara Hopley [c], Ida Dehmardan [d], Lia Norman [c], Katelyn Greer [c,e], Prachi Khanna [f,g], Stephanie Bidoyan [g], Malorie Ashton [b], Anissa Viveiros [b,g,h], Gina Dimitropoulos [c,i], Louise Dunford [j,k], Andrea Evans [b], Jo Henderson [l,m], Anna Karwowska [b], Sheri Madigan [c,i], Naomi Parker [c], Kafui Sawyer [b], Blaine Wolfe [g], Better Together Team, Nicole Racine [b,g]

[a] University of Guelph, Guelph, Ontario, Canada
[b] University of Ottawa, Ottawa, Ontario, Canada
[c] University of Calgary, Calgary, Alberta, Canada
[d] The Hospital for Sick Children Research Institute, Toronto, Ontario, Canada
[e] Alberta Centre for Excellence in Youth Mental Health, Edmonton, Alberta, Canada
[f] University of British Columbia, Vancouver, British Columbia, Canada
[g] Children's Hospital of Eastern Ontario (CHEO) Research Institute, Ottawa, Ontario, Canada
[h] University of Alberta, Edmonton, Alberta, Canada
[i] Alberta Children's Hospital Research Institute, Calgary, Alberta, Canada
[j] University of Warwick, Warwick, United Kingdom
[k] James Lind Alliance, National Institute of Health Research, Southampton, United Kingdom
[l] Centre for Addiction and Mental Health, Toronto, Ontario, Canada
[m] University of Toronto, Toronto, Ontario, Canada

ARTICLE INFO

Keywords:
Youth engagement
Child abuse
Child neglect
Research agenda
Participatory research

ABSTRACT

Background: Child maltreatment research is seldom informed by those with lived experience.
Objective: To identify priority research questions on child maltreatment in Canada from the perspectives of youth, caregivers, and service providers.
Participants and setting: A national priority-setting partnership (PSP) was conducted across Canada. Eligible participants were youth aged 18 to 30 with histories of child maltreatment, caregivers, and service providers working with maltreated youth. A volunteer sample was recruited through social media platforms, national conferences, and community organizations.
Methods: The PSP was carried out between October 2023 and October 2025 using the standardized James Lind Alliance method, which included two cross-sectional surveys, focus groups, and a consensus workshop. Questions generated through the surveys and focus groups were consolidated into 133 summary questions and checked against available evidence. One hundred unanswered questions were circulated for interim prioritization, and the top 20 were discussed at a consensus workshop.
Results: The top 10 priorities included integrating Indigenous Ways of Being and Knowing into systems supporting youth with histories of maltreatment, as well as harm prevention, child maltreatment education, and gaps in services within these systems. Effective approaches to preventing child maltreatment and treating its consequences were prioritized, alongside its

* Corresponding author at: 50 Stone Rd E, Guelph, ON, N1G 2W1, Canada.
E-mail address: mpavlova@uoguelph.ca (M. Pavlova).

https://doi.org/10.1016/j.chiabu.2026.108216
Received 4 February 2026; Received in revised form 2 July 2026; Accepted 3 July 2026
Available online 14 July 2026

impact on brain development and neurodevelopmental disorders. Intergenerational trauma and systemic factors contributing to neglect in Black communities were also among the top 10.
Conclusions: This PSP identified top 10 research priorities for child maltreatment. These priorities can guide researchers toward questions that matter to individuals with lived experience and inform practice and policy.

1. Introduction

Child maltreatment remains prevalent in Canada, with 34.4% of adults reporting childhood experiences of at least one of the following: physical abuse, sexual abuse, or exposure to intimate partner violence, with women, gender diverse individuals, and younger people reporting a greater number of maltreatment types (Afifi et al., 2025; Afifi et al., 2026). Among Canadian youth under age 18, self-reported rates of maltreatment remain high, particularly for emotional abuse (44.9%) and exposure to intimate partner violence (39.4%) (McKinnon et al., 2026). Experiences of child maltreatment have lasting effects throughout the lifespan, including increased risks of mental health disorders (e.g., mood disorders, anxiety, posttraumatic stress disorder, substance use) (Baldwin et al., 2023; Sahle et al., 2022) and poorer physical health (e.g., greater risk of heart disease, stroke, type 2 diabetes, some cancers) (Hughes et al., 2017). Child maltreatment fatalities in Canada occur at a rate of 0.55 per 100,000, and account for 20% of child deaths attributed to homicide or undetermined cause; most occur in children under five (Richmond et al., 2025). Existing research on adverse childhood experiences has focused largely on individual-level associations with mental and physical health outcomes, with only 10% of studies examining treatment and prevention and 29% examining family, community, or system-level factors (Struck et al., 2021). Similarly, half of child maltreatment research examines consequences of abuse and neglect, compared with 19% examining mechanisms, 6% interventions, and 2% prevention (Berthelot et al., 2020). Consequently, child maltreatment is a pressing public health issue that costs Canadian society $20 billion dollars and necessitates both research and policy attention (Dow-Fleisner, 2020). Despite this burden, research on child maltreatment has often been guided by frameworks and priorities set without input from those most affected, leaving important questions unaddressed.

Addressing child maltreatment at the scale and complexity it demands requires research priorities that are responsive to the needs of the communities the research is meant to serve. To date, however, priority- and agenda-setting efforts in child maltreatment have been largely agency- or expert-driven. For instance, the U.S. Centers for Disease Control and Prevention developed child maltreatment prevention research priorities organized around the four stages of the public health model, drawing primarily on internal expertise to guide federal investment (Whitaker et al., 2005).

Using a modified Delphi consensus process, the Preventing Violence Across the Lifespan Research Network reviewed evidence on intimate partner violence and child maltreatment and convened expert discussion to identify research priorities (Wathen et al., 2012). These included examining key elements of effective interventions, integrating violence-related questions into national and international cohort studies, and pooling datasets to analyze which interventions are most effective for specific groups (Wathen et al., 2012). However, most participants were researchers, and although knowledge-user partners were involved, no demographic or lived-experience information about them was reported. While such approaches help align research with public health frameworks, they do not systematically incorporate the perspectives of those with lived experience of maltreatment.

It is well established that placing the priorities of youth and families at the forefront of health research enhances the quality, relevance, and impact of research across the entire research cycle, from co-developing the research questions to knowledge mobilization (Brett et al., 2014; Domecq et al., 2014; Shen et al., 2017). Research becomes more relevant, and outcomes, such as retention rates (Swartz et al., 2004) and treatment compliance (Bender et al., 2011), improve when research is informed by those with lived experience (Bell, 2015; Forsythe et al., 2019; Heffernan et al., 2017; Henderson et al., 2018). Youth and family engagement in research can broaden research questions (Caron-Flinterman et al., 2005; Sharma et al., 2017) and improve the relevance of research findings (Birnie et al., 2019; Lechelt et al., 2018).

Despite this, less than 15% of child maltreatment studies have partnered with youth with lived experience or their families in the research process (Jacquez et al., 2013). A recent review of participatory approaches in European child maltreatment research found only two studies involving youth with lived experience of maltreatment, and engagement was often cursory across the research cycle (Lamela et al., 2025). The limited engagement of youth in child maltreatment research likely reflects several barriers, including insufficient training in youth engagement methods, concerns about re-traumatization, ethical tensions around confidentiality and consent, and system-level constraints such as ongoing court proceedings that preclude research participation (Racine et al., 2023).

This is particularly problematic given that poor or absent research engagement practices can mirror feelings associated with past maltreatment, such as powerlessness and forced silence, highlighting the importance of providing youth with a voice in setting and co-leading the research agenda (Tran et al., 2018). Canada's history of residential schools and the past and ongoing systemic oppression of marginalized communities also provide a distinct context that must be considered for any child maltreatment research agenda (Bombay et al., 2014; Hackett et al., 2016). One approach to engaging individuals with lived experience is through priority-setting partnerships (McCabe et al., 2023; Shen et al., 2017), which facilitate the co-development of research priorities to inform research and policy. For example, Varese et al. (2023) conducted a priority-setting partnership to identify research priorities for adult survivors of sexual abuse. Priorities included improving access to high-quality therapies, identifying optimal supports for marginalized survivors (e.g., people of colour, LGBTQ+ survivors), reducing stigma, and developing trauma-informed services. However, this work was conducted with UK-based adults (68% of participants were 35 years or older) and focused specifically on sexual abuse, leaving

priorities relevant to youth, other forms of maltreatment, and the Canadian context unaddressed.

To address the longstanding absence of lived experience engagement in shaping child maltreatment research priorities, the Better Together project aimed to co-create a meaningful and sustainable partnership between child maltreatment researchers and youth affected by child maltreatment, as well as people who care for and work with them. We aimed to collaboratively produce a list of top 10 research priorities for child maltreatment in Canada following the James Lind Alliance Priority Setting Partnership (PSP) framework (Nygaard et al., 2019).

2. Methods

2.1. James Lind Alliance Priority Setting Partnership framework

The James Lind Alliance (JLA) is a UK-based initiative that identifies research uncertainties and priorities relevant to people with lived experience, carers, and service providers (Partridge & Scadding, 2004). The JLA PSP framework guides the identification and prioritization of research uncertainties, culminating in a top 10 list of research priorities (James Lind Alliance, 2021). The PSP framework has been used to identify top research priorities in over 170 disciplines (James Lind Alliance, 2025), including child health and wellbeing (Jessa et al., 2025). PSPs are guided by equal involvement of researchers and people with lived experience, inclusivity, transparency of the processes, and a commitment to using and contributing to the evidence base (James Lind Alliance, 2021). These guiding values equalize the power imbalances typical for research (Plamondon et al., 2022), and shift the focus from researcher-driven agendas to priorities of youth, their caregivers, and clinicians. JLA PSPs typically follow five phases (Fig. 1). Each PSP is chaired by a JLA Adviser, an independent consultant trained in JLA methodology and experienced in research facilitation, who ensures that the process is conducted fairly and transparently, with equal input from patients, carers, and service providers.

2.2. Better Together PSP, Steering Group, and Youth Consultant Panel (YCP)

The focus of the Better Together PSP, child maltreatment, was defined as the abuse and neglect of children under 18 years of age. Child maltreatment encompasses any form of ill-treatment, abuse, neglect, and exploitation that causes or risks harm in relationships of trust or power (World Health Organization, 2024). Any questions related to the impact, assessment, prevention, and treatment of child maltreatment were considered in scope of the PSP.

The Better Together PSP was conceived and led by the senior author, whose research focuses on child maltreatment. The senior author initiated forming of the PSP Steering Group that would lead PSP activities and decisions. Steering Group members were recruited through two channels: direct invitation of research and clinical collaborators with relevant expertise, and outreach to youth research advisories and child protection services. The Steering Group ($n = 26$) included seven youth, one caregiver, six service providers, and eight researchers. Each Steering Group member contributed expertise in child maltreatment grounded in personal, clinical, and/or research experience. There was lived experience of maltreatment on the committee. Involving youth with lived experience, caregivers, and service providers alongside researchers aligned with JLA values, diversified the expertise represented, and supported the project's overall goal of identifying research priorities that matter to those most affected.

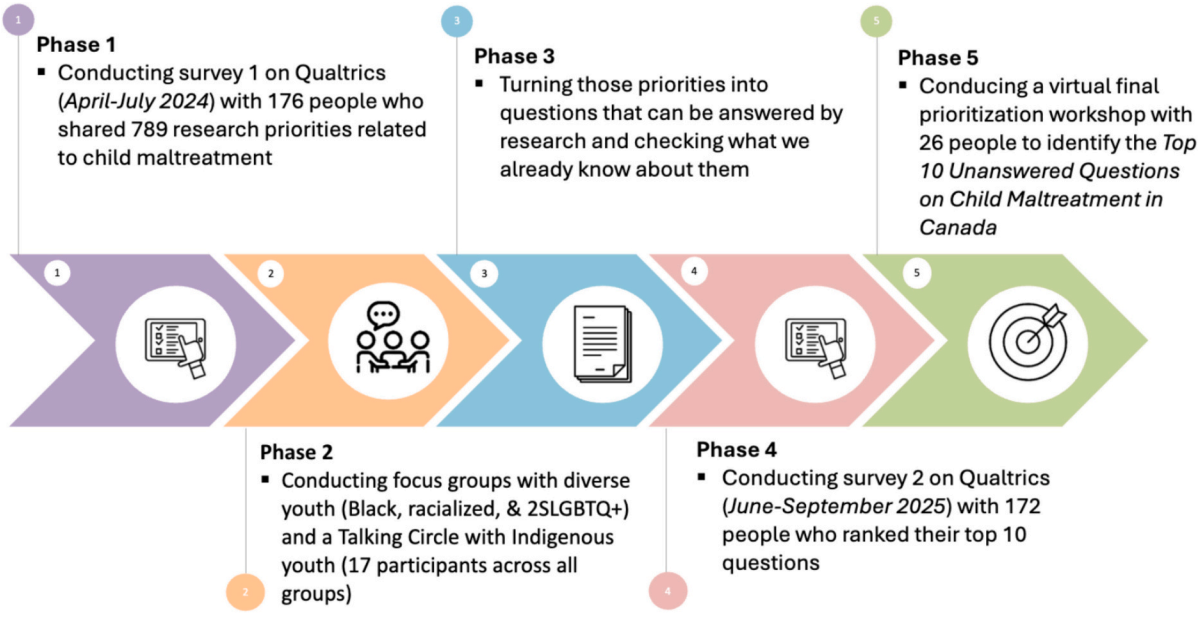

Fig. 1. Overview of child maltreatment Priority-Setting Partnership Process.

In line with trauma-informed care (SAMHSA, 2014) and established models for youth engagement (Darnay et al., 2019), an autonomous group of youth partners, The Youth Consultant Panel (YCP), formed as an equal to the Steering Group to create a safe, egalitarian space (Darnay et al., 2019). The YCP operated in parallel with the Steering Group and seven youth participated in regular meetings led by two peer facilitators. YCP members were equal collaborators, provided input on all PSP phases, and were compensated for their time and contributions to the PSP design and execution.

2.3. Phase 1. National survey

In the first phase, the Steering Group and YCP formulated a survey to gather research questions from youth (18–30 years) with lived experience of child maltreatment, their caregivers, and service providers (Supplemental Table 1). Participants could identify up to 10 research priorities in the survey; they also provided sociodemographic information (e.g., province of residence, languages spoken, age, gender identity; Table 1). Definitions of child maltreatment types were provided at the beginning of the survey. The survey was distributed in English and French using social media platforms, Steering Group and YCP members' networks, national conferences, and through local organizations (Supplemental Table 2) who work with youth. Individuals could enter a draw to win a $100 gift card for their time.

2.4. Phase 2. Focus groups and Talking Circle

To generate questions that are relevant to youth from under-represented groups, we recruited for and conducted additional targeted focus groups with Black, racialized, and 2SLGBTQIA+ youth who experienced child maltreatment. Taking a culturally aligned approach, Indigenous youth participated in a Talking Circle, a traditional First Nations practice for sharing perspectives and experiences to foster a sense of community, safety, and dialogue (Chilisa, 2012). The Talking Circle included three stages: 1) A Smudge (smoke cleansing ceremony) and an Eagle Feather (sacred item) teaching around growing from trauma; 2) Two rounds of introductions and sharing perspectives on trauma, child maltreatment, and impacts on Indigenous health; 3) Circle-Popcorn and Whiteboard session discussing the topics that were shared prior to the circle. The groups lasted up to 90 min and were co-facilitated by at least one YCP member. The Talking Circle was co-facilitated by an Ojibwe research team member using open-ended questions and prompts (Supplemental Table 3). Focus groups and the Talking Circle were recorded and transcribed for processing the questions; all identifying information was removed.

2.5. Phase 3. Processing the questions

In accordance with James Lind Alliance guidelines (James Lind Alliance, 2021), a Steering Group member and a five-member YCP subcommittee processed survey responses into research questions. First, the research team removed out-of-scope questions (i.e., not related to impact, assessment, treatment, and/or prevention of child maltreatment) and separated entries containing multiple questions into single questions. Eligible questions were then grouped into broad categories: impact; assessment; treatment; or prevention. Related questions and duplicates were combined to form summary questions and, when needed, reworded to reflect key aspects of the original entries. Focus group and Talking Circle transcripts were read, and each comment/question was either incorporated into an existing summary question or reformulated into a new summary question. The generated questions were compared against existing literature (i.e., high-quality systematic reviews and meta-analyses) by team members. Whether a question had been answered was judged against several characteristics of the relevant systematic reviews and meta-analyses: overall sample size, representation of diverse gender, sexual, racial, and ethnic identities, socioeconomic diversity, and the proportion of Canadian studies included. Two Steering Group members reviewed the evidence in consultation with the YCP. Questions with evidence limited on any of these dimensions (e.g., predominantly White samples) were considered partially answered and retained for interim prioritization; those deemed fully answered were removed. Any disagreements were resolved through iterative discussions with the Steering Group.

2.6. Phase 4. Interim prioritization

An interim prioritization survey was used to further reduce the number of questions for the final workshop. Participants were invited to choose the 10 most important questions to them. First survey participants were invited to complete this phase. Additionally, the survey was distributed across social media platforms and community organizations.

Participants were asked to vote for up to 10 questions, with each vote contributing one point. Responses were collected in English and French and combined within youth, caregivers', and service providers' groups. Questions were then ranked by total votes, with ties retained. To generate the overall ranking, each question's rank position was summed across the three groups to produce a total score, ensuring that each group contributed equally to the final ranking regardless of differences in participant numbers.

2.7. Phase 5. Priority-setting workshop

The final workshop was held over the course of two days via Zoom. The workshop brought together youth with lived experience of child maltreatment, caregivers, and service providers. The Steering Group and YCP members, as well as new participants recruited through social media and targeted outreach, were invited to ensure equal representation from under-represented groups. Participants became familiar with the final 20 questions prior to the first workshop day. JLA facilitators led the workshop and used an adapted

Table 1
Participant demographic characteristics for phases of the Priority Setting Partnership.

	Phases 1 and 2: National survey ($n = 176$) combined with focus groups ($n = 17$) No. (%) or M (SD)	Phase 4: Interim prioritization ($n = 172$) No. (%) or M (SD)	Phase 5: Priority-setting workshop ($n = 26$) No. (%) or M (SD)
Participant groups			
Youth with lived experiences	82 (42.5)	95 (55.2)	14 (54)
Caregiver with child with lived experiences	17 (8.8)	23 (13.4)	1 (4)
Service providers with clinical practice with youth with lived experiences	94 (48.7)	51 (30.0)	11 (42)
Two or more groups	–	3 (1.7)	–
Average age, yrs			
Youth	23.90 (4.24)	24.16 (3.47)	24.10 (4)
Caregivers	41.75 (7.92)	43.61 (11.36)	40s[b]
Service providers	38.99 (11.59)	35.24 (10.73)	43.14 (11)
Province/territory			
British Colombia	11 (5.7)	14 (8.1)	–
Alberta	22 (11.4)	14 (8.1)	6 (23)
Saskatchewan	2 (1.0)	5 (2.9)	–
Manitoba	9 (4.7)	6 (3.5)	–
Ontario	88 (45.6)	83 (48.3)	11 (42)
Quebec	23 (11.9)	40 (23.3)	–
Atlantic provinces: New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador	13 (6.7)	5 (2.9)	1 (4)
The Territories: Yukon Territory, Northwest Territories, and Nunavut	5 (2.6)	5 (2.9)	–
Prefer not to say	3 (1.6)	–	1 (4)
Missing	17 (8.8)	–	7 (27)
Language			
English	136 (70.5)	132 (76.7)	–
French	21 (10.9)	30 (17.4)	–
Other	10 (5.2)	10 (5.8)	–
More than one language	8 (4.1)	–	–
Prefer not to say	1 (0.5)	–	–
Missing	17 (8.8)	–	–
Residence			
Urban	113 (58.5)	109 (63.4)	12 (46)
Suburban	37 (19.2)	34 (19.8)	5 (19)
Rural	26 (13.5)	29 (16.9)	1 (4)
Prefer not to say	–	–	1 (4)
Missing data	17 (8.8)		7 (27)
Gender identity			
Cisgender male	14 (7.3)	14 (8.1)	3 (12)
Cisgender female	153 (79.3)	123 (71.5)	12 (46)
Another gender identity	8 (4.7)	20 (11.6)	2 (8)
More than one gender identity	1 (0.5)	9 (5.2)	–
Prefer not to say	–	4 (2.3)	1 (4)
Missing data	17 (8.8)	2 (1.2)	8 (31)
Sexual orientation			
Asexual	–	5 (2.9)	
Bisexual	–	16 (9.3)	
Gay	–	5 (2.9)	
Lesbian	–	5 (2.9)	1 (4)
Pansexual	–	3 (1.7)	
Queer	–	7 (4.1)	1 (4)
Straight	–	117 (68.0)	12 (46)
Questioning	–	1 (0.6)	
1+ sexual orientation	–	11 (6.4)	2 (8)
Prefer not to answer	–	2 (1.2)	2 (8)
Missing data	–	–	8 (31)

(*continued on next page*)

Table 1 (*continued*)

	Phases 1 and 2: National survey ($n = 176$) combined with focus groups ($n = 17$) No. (%) or M (SD)	Phase 4: Interim prioritization ($n = 172$) No. (%) or M (SD)	Phase 5: Priority-setting workshop ($n = 26$) No. (%) or M (SD)
Ethnic identity			
Black (e.g., African, Afro–Caribbean, African Canadian descent)	19 (9.8)	26 (15.1)	4 (15)
East Asian (e.g., Chinese, Korean, Japanese, Taiwanese descent)	9 (4.7)	9 (5.2)	–
Indigenous (e.g., First Nations, Métis, Inuk/Inuit descent)	12 (6.2)	7 (4.1)	1 (4)
Latino (e.g., Latin American, Hispanic descent)	2 (1.0)	3 (1.7)	–
Middle Eastern (e.g., Arab, Persian, Iranian, Lebanese, Turkish, Kurdish descent)	1 (0.5)	3 (1.7)	1 (4)
South Asian (e.g., Indian, Pakistani, Bangladeshi, Sri Lankan, Indo–Caribbean descent)	6 (3.1)	6 (3.5)	1 (4)
South–East Asian (e.g., Thai, Cambodian, Indonesian, Vietnamese, Filipino descent)	4 (2.1)	1 (0.6)	–
White (e.g., European descent)	117 (60.6)	103 (60.0)	8 (31)
More than one ethnic identity	12 (6.2)	13 (7.6)	2 (8)
Another race/ethnicity category	1 (0.5)	–	–
Prefer not to say	2 (1.0)	–	1 (4)
Missing data	8 (4.1)	1 (0.6)	8 (31)
Clinical capacity (for clinicians only, n = 94)[a]			
Counsellor	21 (22.3)	–	–
Nurse	4 (4.3)	–	–
Peer support/youth worker	20 (21.3)	–	–
Physician	8 (8.5)	–	–
Psychologist	8 (8.5)	–	–
Social worker	38 (40.4)	–	–
Teacher	7 (7.4)	–	–
Other	25 (26.6)	–	–
Prefer not to say	1 (1.1)	–	–
Missing	8 (8.5)	–	–
Type of abuse experienced (for youth only, n = 82)[a]			
Sexual	36 (43.9)	–	–
Physical	42 (51.2)	–	–
Emotional/psychological	56 (68.3)	–	–
Racialized	3 (3.7)	–	–
Religious	8 (9.8)	–	–
Emotional neglect	32 (39.0)	–	–
Physical neglect	10 (12.2)	–	–
Prefer not to say	1 (1.2)		
Missing data	17 (20.7)	–	–
Age when trauma occurred (for youth only, n = 82)[a]			
0–5 years	–	–	–
6–12 years	6 (7)	–	–
13–18 years	3 (4)	–	–
0–5 and 6–12 years	2 (2)	–	–
0–5 and 13–18 years	1 (1)	–	–
6–12 and 13–18 years	18 (22)	–	–
From 0 to 18 years	35 (43)	–	–
Missing data	17 (21)	–	–

[a] Types of abuse categories and ages of abuse for youth are not mutually exclusive.
[b] One caregiver participated in the workshop; including their exact age could be potentially identifying information. An approximate age is reported instead.

Nominal Group Technique (James Lind Alliance, 2021) with two 90-minute small group discussions and within-group rankings, followed by two whole-group reviews to agree on the top priorities. Small groups were pre-set to balance youth, caregivers, and service providers. The final list of top 10 priorities was identified based on cumulative scores obtained during the workshop. Following the workshop, the participants completed the Public and Patient Engagement Evaluation Tool (Abelson, 2018; Abelson et al., 2016) to evaluate their experience by rating statements on a 5-point Likert scale (1 = Strongly disagree; 5 = Strongly agree).

2.8. Statistical analysis

Descriptive statistics were used to analyze the data.

2.9. Ethics approval

The institutional research ethics board approved the study (CHEOREB#23/82X). Participants provided informed consent. Due to mandatory reporting requirements (i.e., legal obligations to report maltreatment of youth under the age of 18 year) (Public Health Agency of Canada, 2019), all study participants were 18 years or older.

3. Results

The flow of participants and questions through the study are reported in Fig. 2.

3.1. Phases 1 and 2. National survey and focus groups

In total, 176 people (82 youth, 17 caregivers, 94 service providers; Table 1) completed Survey 1 and generated 789 questions. On average, there were 4.5 questions (range 1 to 10) per participant, with youth and caregivers contributing 4.7 questions each and service providers 4.2. The majority (61%) of Survey 1 respondents were White. Although Black, racialized, Indigenous (First Nations, Inuit, and Métis), and 2SLGBTQIA+ youth are overrepresented in child welfare systems (Cénat et al., 2023; Ma et al., 2019), the initial

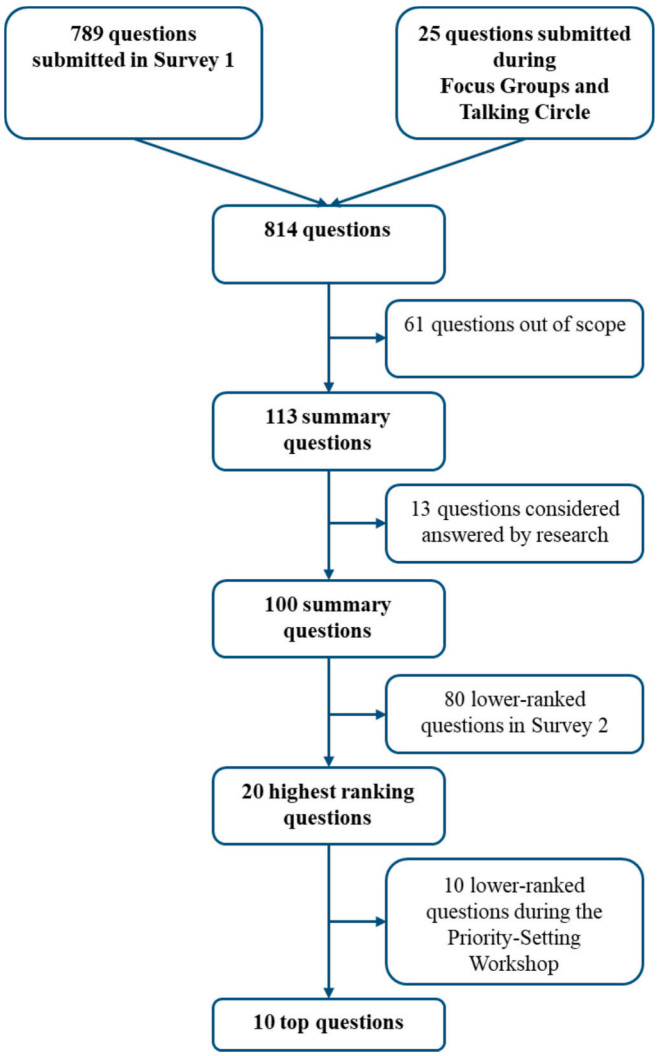

Fig. 2. Flow diagram of research questions.

demographic breakdown indicated that these groups were underrepresented in our sample (9% of youth in Survey 1 identified as Black; 4% identified as Indigenous). To address that, we conducted three focus groups for Black ($n = 7$), racialized ($n = 2$), and 2SLGBTQIA+ youth ($n = 5$) and a Talking Circle for Indigenous youth ($n = 3$). The groups generated additional 25 research questions.

3.2. Phase 3. Processing the questions

Sixty-one questions out of 814 generated in the Phases 1 and 2 were considered out of scope and/or unclear. The remaining 753 questions were combined into 113 summary questions. Following an evidence check, 13 questions were considered answered by the existing research (Supplemental Table 4).

3.3. Phase 4. Interim prioritization

A total of 172 people (95 youth, 23 caregivers, 51 service providers; Table 1) ranked the 100 summary questions in order of

Table 2
Interim rankings of the top 20 questions identified by respondents in survey 2.

Combined rank	Summary question	Youth rank	Caregiver rank	Service provider rank
1	How can we tell the difference between the effects of child maltreatment and the symptoms of other mental health or neurodevelopmental disorders (like anxiety or ADHD) that can occur at the same time?	3	1	1
2	How does child maltreatment impact brain development, and how the brain works? (For example, memory, attention, language processing, critical thinking, decision–making, creative thinking, and problem–solving, etc.)	1	4	6
3	How does child maltreatment affect emotional functioning? This includes things like feeling negative emotions like shame or guilt, feeling positive emotions like happiness, showing emotions, understanding emotions, and feeling emotionally open or vulnerable.	8	2	4
4	How does child maltreatment happen alongside, contribute to, or lead to the development and diagnosis of mental health problems (like eating disorders), and neurodevelopmental disorders, like ADHD?	4	9	2
5	How effective are specific therapies—like positive psychology, trauma–focused cognitive behavioural therapy (TF-CBT), play therapy, mindfulness–based therapies, EMDR (eye movement desensitization and reprocessing), internal family systems (IFS), emotional freedom techniques, emotion focused therapy (EFT), group therapy, and parenting interventions—in treating youth who have experienced child maltreatment?	5	9	9
6	How does child maltreatment affect attachment (meaning the ways children and youth form emotional bonds and trust others) throughout life?	10	4	12
7	In Black communities, how do socioeconomic challenges (e.g., poverty) and related mental health issues (e.g., depression) contribute to unintentional or system–driven neglect (e.g., when a caregiver must work multiple jobs and has limited time for their child)?	10	4	19
8	Does disconnection from Indigenous cultural roots, identity, or traditions contribute to childhood trauma? And how might connection or reconnection to these cultural roots support trauma recovery?	9	16	9
9	How can we improve education about childhood maltreatment and trauma–informed practices in services that support youth who have experienced maltreatment (e.g., healthcare, schools, child welfare, and mental health)?	10	16	9
10	Which Indigenous Ways of Being and Knowing can be included in trauma- and violence-informed care in systems like healthcare, education, mental health, and justice to create safer and more supportive environments for Indigenous youth who have experienced trauma?	28	9	6
11	How can systems such as the justice system, legal proceedings, healthcare, and child protective services sometimes cause harm or make things worse for youth who have experienced maltreatment? What steps can be taken to prevent these harms?	22	16	12
12	How can people who experienced child maltreatment be protected from further violence, exploitation, committing violence, or involvement in criminal activity?	13	9	30
13	How does child maltreatment impact a person's relationships, including friendships, romantic partnerships, parenting, family dynamics, authority figures, and other social interactions?	2	55	3
14	What are the most effective ways to prevent child maltreatment, and how can these strategies be applied in Canada?	16	39	6
15	How can schools better support 2SLGBTQIA+ students experiencing maltreatment?	22	24	19
16	How can we address intergenerational trauma and support the whole family during treatment?	42	9	19
17	Is medication an effective treatment for youth who experienced child maltreatment?	59	4	16
18	Which parenting programs are effective at preventing child maltreatment in families at risk, such as when parents have experienced maltreatment themselves?	22	55	4
19	What are the gaps in the systems that support children and youth who have experienced maltreatment, and how can these systems be improved?	50	2	30
20	How does childhood trauma affect how people understand, express, or feel connected to their sexual orientation and/or gender identity?	5	24	55

ADHD = Attention-Deficit/Hyperactivity Disorder.

importance to them.

3.4. Phase 5. Priority-setting workshop

Twenty-six participants (14 youth, one caregiver, and 11 service providers; Table 1) participated in the final workshop. The interim rankings of the top 20 questions that were discussed in the workshop are presented in Table 2. The top 10 questions are presented in Table 3. Participant engagement evaluations were consistently high (Supplemental Table 5).

4. Discussion

The Better Together PSP identified the top research priorities for child maltreatment in Canada. To our knowledge, this is the first study to identify research priorities in child maltreatment grounded in the lived experiences of youth and caregivers and the clinical realities of service providers. The final list focused on systems transformation, social and intergenerational determinants of maltreatment, evidence-based culturally responsive treatments, and developmental and neurobiological impacts of child maltreatment. Together, these priorities offer a roadmap for a child maltreatment research agenda in Canada that is grounded in the perspectives of those most affected.

4.1. Transforming systems to be trauma-informed and culturally safe

A top-ranked research priority centers on Indigenous Ways of Knowing and supporting Indigenous youth, who are overrepresented in Canadian child welfare systems (Quinn et al., 2022). In the Canadian context, more research is needed on how Indigenous Ways of Knowing can transform existing colonial systems to better support Indigenous and other youth with experiences of maltreatment. Some promising work is already underway. For example, the Making Our Hearts Sing initiative in Alberta brought together Indigenous communities and local child welfare agencies to innovate support systems grounded in Indigenous worldviews and build community capacity, with key outcomes including a focus on kinship, relational responsibility, self-determination, and the integration of traditional spiritual beliefs through Elder-led programming, intergenerational storytelling, and education for young parents (Lafrance, 2006; Lafrance & Bastien, 2007). Expanding such initiatives, and rigorously evaluating their efficacy and implementation, remains a critical direction for future research and practice.

The second and third top research priorities focused on how various systems (e.g., health, justice) may cause further harm to youth who experienced child maltreatment, and how these systems can be transformed to better support their needs. Further research is needed on how systems may harm maltreated youth and on how they can become more trauma-informed and culturally safe. Indeed, only 10% of child maltreatment research has addressed legal or organizational issues (Berthelot et al., 2020), a gap that is echoed in the priorities identified here.

4.2. Strengthening prevention by addressing social and intergenerational determinants of maltreatment

Several identified research priorities addressed prevention of maltreatment. Although a considerable body of research has explored antecedents and interventions to prevent child maltreatment (Little et al., 2026; van IJzendoorn et al., 2020), there remain some gaps in the practice and implementation of this knowledge to prevent maltreatment in Canadian context. Several recent Canadian studies illustrate both the promise and the limitations of implementation research in child welfare. In Manitoba, a home visiting program

Table 3
Top 10 priorities for child maltreatment research among youth with histories of child maltreatment, caregivers, and service providers working with maltreated youth.

Rank	Research priority
1	Which Indigenous Ways of Being and Knowing can be included in systems like healthcare, education, mental health, and justice to create safer and more supportive environments for Indigenous youth who have experienced trauma?
2	How can systems such as the justice system, legal proceedings, healthcare, and child protective services sometimes cause harm or make things worse for youth who have experienced maltreatment? What steps can be taken to prevent these harms?
3	What are the gaps in the systems that support children and youth who have experienced maltreatment, and how can these systems be improved?
4	How can we address intergenerational trauma and support the whole family during treatment?
5	In Black communities, how do socioeconomic challenges (e.g., poverty) and related mental health issues (e.g., depression) contribute to unintentional or system–driven neglect (e.g., when a caregiver must work multiple jobs and has limited time for their child)?
6	What are the most effective ways to prevent child maltreatment, and how can these strategies be applied in Canada?
7	How effective are specific therapies—like positive psychology, trauma–focused cognitive behavioural therapy (TF-CBT), play therapy, mindfulness–based therapies, EMDR (eye movement desensitization and reprocessing), internal family systems (IFS), emotional freedom techniques, emotion-focused therapy (EFT), group therapy, and parenting interventions—in treating youth who have experienced child maltreatment?
8	How can we improve education about child maltreatment and trauma–informed practices in services that support youth who have experienced maltreatment (e.g., healthcare, schools, child welfare, and mental health)?
9	How does child maltreatment happen alongside, contribute to, or lead to the development and diagnosis of mental health disorders (like eating disorders), and neurodevelopmental disorders, like Attention-Deficit/Hyperactivity Disorder (ADHD)?
10	How does child maltreatment impact brain development, and how the brain works? (For example, memory, attention, language processing, critical thinking, decision–making, creative thinking, and problem-solving, etc.)

delivered in First Nations communities was associated with lower rates of maltreatment-related indicators, including children being taken into care and maltreatment-related injuries (Chartier et al., 2020). In Ontario, a parenting intervention for resource parents improved knowledge and beliefs about trauma-informed parenting, though the evaluation did not consider diversity-related factors (e.g., gender identity, ethnic identity, socioeconomic status) (Stenason & Romano, 2022).However, several broader gaps in the implementation of Canadian child welfare programs persist. Many of the concerns raised by Flynn and Bouchard (2006) remain timely nearly two decades later, including the need for more high-quality impact evaluations and for the implementation and evaluation of evidence-based interventions. Trocmé et al. (2019, 2016) have echoed these points, noting limited research capacity in Canadian child welfare and emphasizing the ongoing need to evaluate new policies and evidence-based programs adapted to the diverse needs of Canadian families, most notably Indigenous families.

The impact of intergenerational trauma and systemic inequalities (e.g., poverty) were identified as research priorities. While burgeoning research has focused on intergenerational trauma (Racine et al., 2025) and social determinants contributing to child maltreatment (Sawyer et al., 2025), comparatively less research has focused on how to break cycles of maltreatment, particularly in under-represented communities (Sawyer et al., 2025).

4.3. Improving evidence-based, culturally responsive treatment and supports

The need for evidence on specific therapies for youth who have experienced maltreatment was prioritized. Recent work from the VEGA (Violence, Evidence, Guidance, Action) project, which systematically reviewed and contextualized existing evidence for the Canadian setting, recommends case finding for the identification of child maltreatment, as well as trauma-focused cognitive behavioural therapy (TF-CBT) and parent-child interaction therapy for children who have experienced physical abuse or neglect; other interventions were not recommended due to low certainty of evidence (VEGA Project, 2016). Consistent with these recommendations, strong evidence supports the effects of certain therapeutic modalities (e.g., TF-CBT) (Bennett et al., 2021; Gillies et al., 2013; Thielemann et al., 2022) for youth exposed to maltreatment. However, evidence for other approaches identified as priorities by youth, caregivers, and service providers (e.g., eye movement desensitization and reprocessing, emotion-focused therapy, play therapy) remains mixed or inconclusive, with adequately powered trials and implementation and fidelity research particularly lacking (Dorsey et al., 2017). Structured cultural adaptations of treatment content and modes of delivery are also needed. For example, within the Canadian context, understanding how Indigenous-led and adapted approaches could be implemented in Indigenous communities is an important future direction. Existing work offers guidance for cultural adaptation. For example, the Strong Communities program, designed to shape community attitudes about child safety to prevent maltreatment, was originally developed in the United States and successfully adapted for delivery in Israel at both deep structural (e.g., identifying religious and secular organizations that could serve as family resources) and surface levels (e.g., translation of the materials) (McLeigh et al., 2017).

4.4. Advancing knowledge on developmental and neurological impacts of maltreatment

The final priorities focused on the role of maltreatment in mental health and neurodevelopmental disorders and its impact on brain development and cognition. It is well established that maltreatment disrupts psychological, emotional, and cognitive development (Afifi et al., 2014; Hong et al., 2018; Nico Trocmé et al., 2005). However, there is a shortage of research examining how maltreatment co-occurs or interacts with the emergence of mental health and neurodevelopmental disorders, leaving the developmental pathways linking these processes insufficiently understood. As a result, it remains difficult to determine whether maltreatment precipitates these difficulties, whether early vulnerabilities increase susceptibility to maltreatment, or whether both processes unfold reciprocally across development. Additionally, there is a shortage of longitudinal, mechanism-focused studies that map how early maltreatment leads to altered neurodevelopment or cognitive functioning over time, rather than relying on cross-sectional or correlational findings (Berthelot et al., 2020). Addressing these questions is crucial to identifying where and when intervention can be most effective.

The priorities identified through this PSP both overlap with and meaningfully extend those developed by earlier expert- and agency-led efforts. Similar to the CDC's child maltreatment prevention agenda (Whitaker et al., 2005) and the PreVAiL Research Network's Delphi-based priorities (Wathen et al., 2012), our findings reaffirmed the need to advance prevention and evaluate effective interventions. However, centring the perspectives of youth, caregivers, and service providers brought up priorities that past efforts have not identified. Most notably, the integration of Indigenous Ways of Knowing into systems supporting youth, the transformation of health, justice, and child welfare systems to be trauma-informed and culturally safe, the role of intergenerational trauma and systemic factors contributing to neglect in Black communities, and the need for culturally responsive treatments. These priorities reflect concerns that are particularly salient in the Canadian context, shaped by the legacy of residential schools, ongoing systemic oppression, and the overrepresentation of Indigenous and Black youth in child welfare. These priorities may be less visible in expert-driven work that is not co-led by affected youth. Priority-setting partnerships that centre lived experience do not displace expert-identified priorities but expand the agenda to include questions that the field has historically overlooked.

A notable proportion of the questions raised by youth, caregivers, and service providers concerned topics that have been substantively addressed in the existing literature — for example, the short- and long-term consequences of different types and severities of maltreatment, and the intergenerational impacts of childhood maltreatment. Indeed, Berthelot et al. (2020) cite the latter as a prime example of the persistent lag in translating child maltreatment research into child welfare practice. That such well-studied questions continue to be raised by those most affected and by the providers who support them suggests a failure of the field to translate existing knowledge to youth, caregivers, and the wider network of service providers working with them. MacGregor et al. (2014) identified three core gaps in knowledge translation (KT) for child maltreatment and intimate partner violence research: established KT strategies

are underused, evidence on what works and for whom is sparse, and claims of ineffectiveness often go unsubstantiated. They proposed a KT framework specific to this field that emphasizes goal setting, the selection and evaluation of appropriate KT strategies, and attention to barriers unique to child maltreatment (e.g., the discomfort or potential re-traumatization that may arise when individuals are reminded of traumatic experiences). That a meaningful proportion of the priorities surfaced by this PSP have already been at least partially answered in the literature underscores the urgent need for sustained KT work, ideally led by youth themselves (Racine et al., 2023).

4.5. Strengths and limitations

The PSP had several strengths. First, it built on rigorous JLA methodology by explicitly prioritizing the voices of people from underrepresented groups to ensure their perspectives were reflected in the research priorities. Given the overrepresentation of Indigenous and Black youth in Canadian child welfare systems (Cénat et al., 2023; Ma et al., 2019), we purposefully increased the representation of these groups in the surveys and the final workshop. We acknowledge, however, that this approach may have introduced certain biases. For example, some questions, such as those concerning system changes, may have resonated more strongly with youth experiencing marginalization. Second, this PSP followed trauma-informed principles (SAMHSA, 2014) to ensure the safety of PSP participants, the YCP, and Steering Group members. Through sustained mentorship and peer support, YCP members were equipped to participate fully and confidently throughout the process. Limitations of the current project include the exclusion of youth under the age of 18 years to avoid mandatory reporting if maltreatment was disclosed. The decision to introduce the age limit was influenced by trauma-informed considerations and the above-mentioned legal obligations. Additionally, focusing on youth aged 18 and older also allowed us to center the priorities of individuals with a longer retrospective view of how child maltreatment has shaped their lives. Second, many important research questions were not discussed or ranked in the final workshop. It is possible that some of these questions would be particularly relevant and resonating to some individuals with lived experience. Third, some questions were considered answered by existing research and excluded from interim prioritization. Although we followed a structured protocol for reviewing high-quality evidence, this was not a formal systematic review, and it is possible that some questions classified as answered remain only partially resolved, yet they were not carried into the final workshop. Finally, a key limitation of the study was arriving at top research priorities shared by youth, caregivers, and service providers, as opposed to top priorities for each group. For example, youth ranked the question on treatment effectiveness higher than service providers or caregivers, reflecting their priority to address maltreatment consequences on an individual level. Service providers and caregivers prioritized understanding and mitigating system-level harms. The focus on shared research priorities, as opposed to priorities endorsed by youth only, is in line with JLA methodology that emphasizes shared decision-making to identify priorities that resonate across all three groups. Future priority-setting partnerships and youth engagement projects may need to clarify priorities that are particularly relevant to youth.

5. Conclusion

The Better Together Priority-Setting Partnership brought together youth, caregivers, and service providers to collaboratively identify the top 10 research priorities for child maltreatment in Canada. These research priorities offer a roadmap to a new research agenda that is relevant and beneficial for youth with experiences of maltreatment, as well as for people who support and work with them. The list will be used to inform relevant policies, funding decisions, and organizational and systemic change.

Research funding

This research was funded by the Canadian Institutes of Health Research (487488) Patient-Oriented Research Priority Funding.

CRediT authorship contribution statement

Maria Pavlova: Writing – review & editing, Writing – original draft, Visualization, Investigation, Data curation, Conceptualization. **Artina Madani:** Writing – review & editing, Visualization, Project administration, Formal analysis, Data curation. **Anara Hopley:** Writing – review & editing, Project administration, Data curation. **Ida Dehmardan:** Writing – review & editing, Data curation. **Lia Norman:** Writing – review & editing, Data curation. **Katelyn Greer:** Writing – review & editing, Data curation, Conceptualization. **Prachi Khanna:** Writing – review & editing, Data curation. **Stephanie Bidoyan:** Writing – review & editing, Data curation. **Malorie Ashton:** Writing – review & editing, Data curation. **Anissa Viveiros:** Writing – review & editing, Data curation. **Gina Dimitropoulos:** Writing – review & editing. **Louise Dunford:** Writing – review & editing, Resources, Project administration, Methodology, Formal analysis. **Andrea Evans:** Writing – review & editing. **Jo Henderson:** Writing – review & editing. **Anna Karwowska:** Writing – review & editing. **Sheri Madigan:** Writing – review & editing. **Naomi Parker:** Writing – review & editing. **Kafui Sawyer:** Writing – review & editing. **Blaine Wolfe:** Writing – review & editing, Resources, Methodology, Data curation. **Nicole Racine:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no conflicts of interests.

Acknowledgement

We are grateful to all study participants who shared their perspectives and ideas regarding child maltreatment research priorities. We would also like to acknowledge the support and contributions of the Better Together Steering Group and Youth Consultant Panel.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.chiabu.2026.108216.

Data availability

Data will be made available on request.

References

Abelson, J. (2018). *Public and Patient Engagement Evaluation Tool (PPEET)*.

Abelson, J., Li, K., Wilson, G., Shields, K., Schneider, C., & Boesveld, S. (2016). Supporting quality public and patient engagement in health system organizations: Development and usability testing of the Public and Patient Engagement Evaluation Tool. *Health Expectations, 19*(4), 817–827. https://doi.org/10.1111/hex.12378

Afifi, T. O., MacMillan, H. L., Boyle, M., Taillieu, T., Cheung, K., & Sareen, J. (2014). Child abuse and mental disorders in Canada. *Cmaj, 186*(9), E324–E332. https://doi.org/10.1503/cmaj.131792

Afifi, T. O., Mathews, B., Salmon, S., McCarthy, J.-A., Sandhu, G., Osorio, A., … Taillieu, T. (2026). Prevalence of child maltreatment types in Canada. *Child Abuse & Neglect, 175*, Article 107985. https://doi.org/10.1016/j.chiabu.2026.107985

Afifi, T. O., McCarthy, J.-A., Osorio, A., MacGowan, L., Taillieu, T. L., Stewart-Tufescu, A., … Edwards, J. (2025). Child abuse prevalence estimates in Canada; comparisons of nationally representative data from 2012 to 2022: A population-based study. *The Lancet Regional Health – Americas, 45*. https://doi.org/10.1016/j.lana.2025.101072

Baldwin, J. R., Wang, B., Karwatowska, L., Schoeler, T., Tsaligopoulou, A., Munafò, M. R., & Pingault, J.-B. (2023). Childhood maltreatment and mental health problems: A systematic review and meta-analysis of quasi-experimental studies. *American Journal of Psychiatry, 180*(2), 117–126. https://doi.org/10.1176/appi.ajp.20220174%M36628513

Bell, E. (2015). Young persons in research: A call for the engagement of youth in mental health research. *The American Journal of Bioethics, 15*, 28–30.

Bender, B. G., Dickinson, P., Rankin, A., Wamboldt, F. S., Zittleman, L., & Westfall, J. M. (2011). The Colorado Asthma Toolkit Program: A practice coaching intervention from the High Plains Research Network. *Journal of American Board of Family Medicine, 24*(3), 240–248. https://doi.org/10.3122/jabfm.2011.03.100171

Bennett, R. S., Denne, M., McGuire, R., & Hiller, R. M. (2021). A systematic review of controlled-trials for PTSD in maltreated children and adolescents. *Child Maltreatment, 26*(3), 325–343. https://doi.org/10.1177/1077559520961176

Berthelot, N., Garon-Bissonnette, J., Lemieux, R., Drouin-Maziade, C., & Maziade, M. (2020). Paucity of intervention research in childhood maltreatment contrasts with the long known relation with mental health disorders: Is trauma research translational enough? *Mental Health & Prevention, 19*, Article 200189. https://doi.org/10.1016/j.mhp.2020.200189

Birnie, K. A., Dib, K., Ouellette, C., Dib, M. A., Nelson, K., Pahtayken, D., … Stinson, J. (2019). Partnering For Pain: A Priority Setting Partnership to identify patient-oriented research priorities for pediatric chronic pain in Canada. *CMAJ Open, 7*(4), E654–E664. https://doi.org/10.9778/cmajo.20190060

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcult Psychiatry, 51*(3), 320–338. https://doi.org/10.1177/1363461513503380

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C., & Suleman, R. (2014). Mapping the impact of patient and public involvement on health and social care research: A systematic review. *Health Expectations, 17*(5), 637–650. https://doi.org/10.1111/j.1369-7625.2012.00795.x

Caron-Flinterman, J. F., Broerse, J. E., Teerling, J., & Bunders, J. F. (2005). Patients' priorities concerning health research: The case of asthma and COPD research in the Netherlands. *Health Expectations, 8*(3), 253–263. https://doi.org/10.1111/j.1369-7625.2005.00337.x

Cénat, J. M., Noorishad, P.-G., Farahi Moshirian, S. M. M., Darius, W. P., & Flynn, R. J. (2023). Reasons for admission to service and overrepresentation of Black youth in the child welfare system in Ontario, Canada: Does race matter? *Child Abuse & Neglect, 140*, Article 106157. https://doi.org/10.1016/j.chiabu.2023.106157

Chartier, M., Enns, J. E., Nickel, N. C., Campbell, R., Phillips-Beck, W., Sarkar, J., … Brownell, M. (2020). The association of a paraprofessional home visiting intervention with lower child maltreatment rates in First Nation families in Canada: A population-based retrospective cohort study. *Children and Youth Services Review, 108*, Article 104675. https://doi.org/10.1016/j.childyouth.2019.104675

Chilisa, B. (2012). *Indigenous research methodologies*. SAGE Publications.

Darnay, K., Hawke, L. D., Chaim, G., Henderson, J., & the INNOVATE Research Team. (2019). INNOVATE research: Youth engagement guidebook for researchers. https://foundrybc.ca/wp-content/uploads/2020/06/E.12-INNOVATE-Research-Youth-Engagement-Guidebook.pdf.

Domecq, J. P., Prutsky, G., Elraiyah, T., Wang, Z., Nabhan, M., Shippee, N., … Murad, M. H. (2014). Patient engagement in research: A systematic review. *BMC Health Services Research, 14*, Article 89. https://doi.org/10.1186/1472-6963-14-89

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., … Amaya-Jackson, L. (2017). Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 46*(3), 303–330. https://doi.org/10.1080/15374416.2016.1220309

Dow-Fleisner, S. (2020). Impacts of child maltreatment in Canada: Examining the social consequences and economic costs. https://ok-socialwork-research.sites.olt.ubc.ca/files/2022/12/UBCO-Case-for-support-report_SDF.pdf.

Flynn, R. J., & Bouchard, D. (2006). Randomized and quasi-experimental evaluations of program impact in child welfare in Canada: A review. *The Canadian Journal of Program Evaluation, 20*(3), 65–100.

Forsythe, L. P., Carman, K. L., Szydlowski, V., Fayish, L., Davidson, L., Hickam, D. H., … Anyanwu, C. U. (2019). Patient engagement in research: Early findings from the patient-centered outcomes research institute. *Health Aff (Millwood)., 38*(3), 359–367. https://doi.org/10.1377/hlthaff.2018.05067

Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2013). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents (Review). *Evidence-Based Child Health: A Cochrane Review Journal, 8*(3), 1004–1116. https://doi.org/10.1002/ebch.1916

Hackett, C., Feeny, D., & Tompa, E. (2016). Canada's residential school system: Measuring the intergenerational impact of familial attendance on health and mental health outcomes. *Journal of Epidemiology and Community Health, 70*(11), 1096–1105. https://doi.org/10.1136/jech-2016-207380

Heffernan, O. S., Herzog, T. M., Schiralli, J. E., Hawke, L. D., Chaim, G., & Henderson, J. L. (2017). Implementation of a youth-adult partnership model in youth mental health systems research: Challenges and successes. *Health Expectations, 20*(6), 1183–1188. https://doi.org/10.1111/hex.12554

Henderson, J. L., Hawke, L. D., & Relihan, J. (2018). Youth engagement in the YouthCan IMPACT trial. *Cmaj, 190*, S10–S12.

Hong, S., Rhee, T. G., & Piescher, K. N. (2018). Longitudinal association of child maltreatment and cognitive functioning: Implications for child development. *Child Abuse & Neglect, 84*, 64–73. https://doi.org/10.1016/j.chiabu.2018.07.026

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., … Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health, 2*(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4

Jacquez, F., Vaughn, L. M., & Wagner, E. (2013). Youth as partners, participants or passive recipients: A review of children and adolescents in community-based participatory research (CBPR). *American Journal of Community Psychology, 51*(1–2), 176–189. https://doi.org/10.1007/s10464-012-9533-7

James Lind Alliance. (2021). James Lind Alliance guidebook on priority setting partnerships. https://www.jla.nihr.ac.uk/jla-guidebook.

James Lind Alliance. (2025). Rounding up 2024…. https://jla.nihr.ac.uk/news/rounding-2024.

Jessa, J. S., Zhang, M., Bonhomme, J., Richards, D. P., Lorenzetti, D. L., Chambers, C. T., & Birnie, K. A. (2025). Identifying common patient-oriented priorities for child and adolescent health research and care: A systematic review of priority setting partnerships. *Health Expectations, 28*(4), Article e70349. https://doi.org/10.1111/hex.70349

Lafrance, J. (2006). Leadership development forums in aboriginal child welfare: Making our hearts sing in Alberta. https://cwrp.ca/sites/default/files/publications/en/MOHS2006.pdf.

Lafrance, J., & Bastien, B. (2007). Here be dragons! Reconciling Indigenous and Western knowledge to improve Aboriginal child welfare. *First Peoples Child and Family Review, 3*(1), 105–126.

Lamela, D., Nurmatov, U., Alfandari, R., Söderlind, N., Crous, G., Roth, M., … Korhonen, L. (2025). A scoping review of participatory approaches in child maltreatment research across Europe. *Child Abuse & Neglect, 162*, Article 107229. https://doi.org/10.1016/j.chiabu.2024.107229

Lechelt, L. A., Rieger, J. M., Cowan, K., Debenham, B. J., Krewski, B., Nayar, S., … Neck Cancer Priority Setting Partnership Steering, C. (2018). Top 10 research priorities in head and neck cancer: Results of an Alberta priority setting partnership of patients, caregivers, family members, and clinicians. *Head & Neck, 40*(3), 544–554. https://doi.org/10.1002/hed.24998

Little, M. T., Butchart, A., Massetti, G. M., Hermosilla, S., Wittesaele, C., Pearson, I., Jochim, J., Swingler, S., Schupp, C., Böhret, I. A., Neelakantan, L., Backhaus, S., Martin, M., Mase, M., Page, S., Janowski, R., Blackwell, A., Bernstein, K. T., Rakotomalala, S., & Cluver, L. (2026). Interventions to prevent, reduce, and respond to violence against children and adolescents: A systematic review of systematic reviews to update the INSPIRE framework. *The Lancet Child & Adolescent Health, 10*(1), 49–61. https://doi.org/10.1016/S2352-4642(25)00214-7

Ma, J., Fallon, B., & Richard, K. (2019). The overrepresentation of First Nations children and families involved with child welfare: Findings from the Ontario incidence study of reported child abuse and neglect 2013. *Child Abuse & Neglect, 90*, 52–65. https://doi.org/10.1016/j.chiabu.2019.01.022

MacGregor, J. C. D., Wathen, N., Kothari, A., Hundal, P. K., & Naimi, A. (2014). Strategies to promote uptake and use of intimate partner violence and child maltreatment knowledge: An integrative review. *BMC Public Health, 14*(1), Article 862. https://doi.org/10.1186/1471-2458-14-862

McCabe, E., Amarbayan, M., Rabi, S., Mendoza, J., Naqvi, S. F., Thapa Bajgain, K., … Santana, M. (2023). Youth engagement in mental health research: A systematic review. *Health Expectations, 26*(1), 30–50. https://doi.org/10.1111/hex.13650

McKinnon, B., MacMillan, H. L., Vandermorris, A., Georgiades, K., Nolan, E., Catley, C., … Tonmyr, L. (2026). Child maltreatment in Canada: Prevalence and gender differences among youth. *Health Promotion and Chronic Disease Prevention in Canada, 46*(2), 61–66. https://doi.org/10.24095/hpcdp.46.2.02 (La maltraitance envers les enfants au Canada : prévalence et différences entre les genres chez les jeunes.)

McLeigh, J. D., Katz, C., Davidson-Arad, B., & Ben-Arieh, A. (2017). The cultural adaptation of a community-based child maltreatment prevention initiative. *Family Process, 56*(2), 393–407. https://doi.org/10.1111/famp.12193

Nico Trocmé, F., B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., … Cloutier, R. (2005). *Canadian incidence study of reported child abuse and neglect – 2003: Major findings*.

Nygaard, A., Halvorsrud, L., Linnerud, S., Grov, E. K., & Bergland, A. (2019). The James Lind Alliance process approach: Scoping review. *BMJ Open, 9*(8), Article e027473. https://doi.org/10.1136/bmjopen-2018-027473

Partridge, N., & Scadding, J. (2004). The James Lind Alliance: patients and clinicians should jointly identify their priorities for clinical trials. *The Lancet, 364*(9449), 1923–1924. https://doi.org/10.1016/S0140-6736(04)17494-1

Plamondon, K., Ndumbe-Eyoh, S., & Shahram, S. (2022). Equity, power, and transformative research coproduction. In *Research co-production in healthcare* (pp. 34–53). https://doi.org/10.1002/9781119757269.ch3

Public Health Agency of Canada. (2019). *Provincial and territorial child protection legislation and policy*. Government of Canada. https://www.canada.ca/en/public-health/services/publications/health-risks-safety/provincial-territorial-child-protection-legislation-policy-2018.html.

Quinn, A., Fallon, B., Joh-Carnella, N., & Saint-Girons, M. (2022). The overrepresentation of First Nations children in the Ontario child welfare system: A call for systemic change. *Children and Youth Services Review, 139*, Article 106558. https://doi.org/10.1016/j.childyouth.2022.106558

Racine, N., Deneault, A.-A., Thiemann, R., Turgeon, J., Zhu, J., Cooke, J., & Madigan, S. (2025). Intergenerational transmission of parent adverse childhood experiences to child outcomes: A systematic review and meta-analysis. *Child Abuse & Neglect, 168*, Article 106479. https://doi.org/10.1016/j.chiabu.2023.106479

Racine, N., Greer, K., Dimitropoulos, G., Collin-Vezina, D., Henderson, J. L., & Madigan, S. (2023). Youth engagement in child maltreatment research: Gaps, barriers, and approaches. *Child Abuse & Neglect, 139*, Article 106127. https://doi.org/10.1016/j.chiabu.2023.106127

Richmond, N., Ornstein, A., Tonmyr, L., Dzakpasu, S., Nelson, C., & Pollock, N. J. (2025). Child maltreatment mortality in Canada: An analysis of coroner and medical examiner data. *Child Abuse & Neglect, 159*, Article 107127. https://doi.org/10.1016/j.chiabu.2024.107127

Sahle, B. W., Reavley, N. J., Li, W., Morgan, A. J., Yap, M. B. H., Reupert, A., & Jorm, A. F. (2022). The association between adverse childhood experiences and common mental disorders and suicidality: An umbrella review of systematic reviews and meta-analyses. *European Child & Adolescent Psychiatry, 31*(10), 1489–1499. https://doi.org/10.1007/s00787-021-01745-2

SAMHSA. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*.

Sawyer, K., Barriault, S., Williams, M. T., Vitoroulis, I., & Racine, N. (2025). Intergenerational transmission of child maltreatment among Black families: A scoping review. *Child Abuse & Neglect, 170*, Article 107746. https://doi.org/10.1016/j.chiabu.2025.107746

Sharma, A. E., Knox, M., Mleczko, V. L., & Olayiwola, J. N. (2017). The impact of patient advisors on healthcare outcomes: A systematic review. *BMC Health Services Research, 17*(1), 693. https://doi.org/10.1186/s12913-017-2630-4

Shen, S., Doyle-Thomas, K. A. R., Beesley, L., Karmali, A., Williams, L., Tanel, N., & McPherson, A. C. (2017). How and why should we engage parents as co-researchers in health research? A scoping review of current practices. *Health Expectations, 20*(4), 543–554. https://doi.org/10.1111/hex.12490

Stenason, L., & Romano, E. (2022). Evaluation of a trauma-informed parenting program for resource parents. *International Journal of Environmental Research and Public Health, 19*(24), Article 16981. https://www.mdpi.com/1660-4601/19/24/16981.

Struck, S., Stewart-Tufescu, A., Asmundson, A. J. N., Asmundson, G. G. J., & Afifi, T. O. (2021). Adverse childhood experiences (ACEs) research: A bibliometric analysis of publication trends over the first 20 years. *Child Abuse & Neglect, 112*, Article 104895. https://doi.org/10.1016/j.chiabu.2020.104895

Swartz, L. J., C., K., Butz, A. M., Rand, C. S., Kanchanaraksa, S., Diette, G. B., … Eggleston, P. A. (2004). Methods and issues in conducting a community-based environmental randomized trial. *Environmental Research, 95*(2), 156–165.

Thielemann, J. F. B., Kasparik, B., König, J., Unterhitzenberger, J., & Rosner, R. (2022). A systematic review and meta-analysis of trauma-focused cognitive behavioral therapy for children and adolescents. *Child Abuse & Neglect, 134*, Article 105899. https://doi.org/10.1016/j.chiabu.2022.105899

Tran, B. X., Pham, T. V., Ha, G. H., Ngo, A. T., Nguyen, L. H., Vu, T. T. M., … Ho, R. C. M. (2018). A bibliometric analysis of the global research trend in child maltreatment. *International Journal of Environmental Research and Public Health, 15*(7), Article 1456. https://www.mdpi.com/1660-4601/15/7/1456.

Trocmé, N., Esposito, T., Nutton, J., Rosser, V., & Fallon, B. (2019). Child welfare services in Canada. In L. Merkel-Holguin, J. D. Fluke, & R. D. Krugman (Eds.), *National systems of child protection: Understanding the international variability and context for developing policy and practice* (pp. 27–50). Springer International Publishing. https://doi.org/10.1007/978-3-319-93348-1_3.

Trocmé, N., Roy, C., & Esposito, T. (2016). Building research capacity in child welfare in Canada. *Child and Adolescent Psychiatry and Mental Health, 10*(1), 16. https://doi.org/10.1186/s13034-016-0103-x

van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Coughlan, B., & Reijman, S. (2020). Annual research review: Umbrella synthesis of meta-analyses on child maltreatment antecedents and interventions: Differential susceptibility perspective on risk and resilience. *Journal of Child Psychology and Psychiatry, 61*(3), 272–290. https://doi.org/10.1111/jcpp.13147

Varese, F., White, C., Longden, E., Charalambous, C., Meehan, K., Partington, I., … Majeed-Ariss, R. (2023). Top 10 priorities for sexual violence and abuse research: Findings of the James Lind Alliance sexual violence priority setting partnership. *BMJ Open, 13*(2), Article e062961. https://doi.org/10.1136/bmjopen-2022-062961

VEGA Project. (2016). Child maltreatment systematic review summary. https://vegaproject.mcmaster.ca/app/uploads/2022/11/vega-cm-systematic-review-summary.pdf.

Wathen, C. N., MacGregor, J. C. D., Hammerton, J., Coben, J. H., Herrman, H., Stewart, D. E., … Pre, V. R. N. (2012). Priorities for research in child maltreatment, intimate partner violence and resilience to violence exposures: Results of an international Delphi consensus development process. *BMC Public Health, 12*(1), Article 684. https://doi.org/10.1186/1471-2458-12-684

Whitaker, D. J., Lutzker, J. R., & Shelley, G. A. (2005). Child maltreatment prevention priorities at the Centers for Disease Control and Prevention. *Child Maltreatment, 10*(3), 245–259. https://doi.org/10.1177/1077559505274674

World Health Organization. (2024). Child maltreatment. https://www.who.int/news-room/fact-sheets/detail/child-maltreatment.