GUIDELINES FOR IMMIGRANT HEALTH

Appendix 12: Child maltreatment: evidence review for newly arriving immigrants and refugees

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ABSTRACT

Background: Child maltreatment is a significant worldwide public health problem. We conducted an evidence review on the screening, prevention, and treatment primary care practitioners can offer to prevent or reduce morbidity and/or mortality from child maltreatment in newly arriving immigrants and refugees. We also examined culturally specific clinical and equity issues.

Methods: Using the GRADE approach, we systematically assessed evidence on screening, prevention, and intervention for child maltreatment. We then examined the benefits, harms, applicability, clinical considerations, and implementation issues relevant to recently settled immigrants and refugees.

Results: Ethnic minority children in Canada and the United States (US) are over-screened and over-reported for child maltreatment, as compared to general population children. Screening instruments for child maltreatment are based on risk assessment and have unacceptably high false positive rates, which are associated with significant harms because of the risk of mislabeling parents for child maltreatment. Trauma-focused Cognitive Behavioral Therapy and theoretically-driven parenting programs may help reduce maltreatment or alleviate consequences related to it. Nurse home visitation programs with families living in disadvantaged conditions can reduce risk, child injuries, and trauma related to maltreatment and improve child developmental outcomes.

Interpretation: Evidence against routine screening for child maltreatment outweigh benefits of screening because of harms from false labeling. Home visitation preventive strategies, however, may be effective for recently-settled immigrant and refugee families who live in high risk conditions and need support.

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Box 1: Recommendations on child maltreatment from the Canadian Collaboration for Immigrant and Refugee Health

Screening for Child Maltreatment:

Do not conduct routine screening for child maltreatment. Be alert to signs and symptoms of child maltreatment during physical and mental examination and further assess when reasonable doubt exists or after patient disclosure.

Basis of recommendation

- **Balance of benefits and harms:** The Guideline Committee recommends against routine screening due to poor performance of screening instruments and potential harms because of the very high false positive rates. Sensitivity ranged between 25% and 100%; specificity ranged between 16.5% and 94.3%; and positive predictive value (when available) ranged between 1.7% and 28.2%.
- **Quality of evidence:** Low
- **Values and preferences:** The Guideline Committee attributed more value to evidence on the negative effects of screening in relation to the high potential for harms. Harms could result from false positives leading to inappropriate labeling, psychological distress, inappropriate family separation, impaired clinician-patient rapport, potential less use of general medical services and legal ramifications associated with child protection services involvement.

Prevention for Child Maltreatment and Associated Outcomes:

A home visitation program encompassing the first 2 years of life should be offered to immigrant and refugee mothers living in high risk conditions including teenage motherhood, single parent status, social isolation, low socioeconomic status, living with mental health or drug abuse problems.

Basis of recommendation

- **Balance of benefits and harms:** Nurse home visitation programs for high-risk mothers reduced days in hospital for children (P<.001). Harms from surveillance and reports to child protection services were not clearly demonstrated.
- **Quality of evidence:** Moderate
- **Values and preferences:** The Guideline Committee attributed more value to supporting high-risk mothers with an offer of a home visitation program to provide practical support for families and the program's potential to improve health outcomes for children, than to the potential risks associated with increased reports to child protection services.

The cases

A 13-year-old Colombian teenager, Sara, who recently migrated with her family, attends her usual paediatric appointment accompanied by a friend. Upon examination, the paediatrician notices two bruises on Sara's back.

A seven-year old Muslim Algerian boy, Basem, is brought to a physician by a child protection services worker who received a phone call from school. Basem arrived to school one morning with bruises on his legs and arms. The worker suspects the father of maltreating the child because he is described by school personnel as aggressive and the mother as submissive. Basem is placed in foster care for 48 hours until the investigation can be completed.

How would you approach these patients?

Introduction

Child maltreatment is a significant public health problem worldwide[1-5] that has been associated with a wide range of short and long-term health consequences.[3,6-8] The Canadian incidence study of reported child abuse and neglect (2003) estimates an incidence rate, for the year 2003, of 21.71 per thousand for child maltreatment.[9] Of these cases, 15% involved emotional maltreatment, 28% involved exposure to domestic violence, 24% involved physical abuse, 30% involved neglect and 3% involved sexual abuse.

Rates of maltreatment in recently-settled immigrant or refugee children in Canada are unknown. However, surveys conducted with non-representative ethnic minority samples (that likely included immigrants and refugees) have yielded higher rates of maltreatment, compared to official reports, though rates vary widely in Canada and the US (from 11% to 62%),[10] as well as worldwide (3% to 33.8%).[1] Comparing worldwide prevalence of child maltreatment through official reports and empirical surveys is of limited value, because many countries do not have equivalent laws or legal and social systems that record child maltreatment statistics; as well, studies use different definitions of abuse and have various methodological limitations.[3,11-12] This review aims to clarify reports of child maltreatment in ethnic communities and determine whether existing tools and approaches to screening for child maltreatment can be appropriate for immigrant and refugee children and to recommend strategies that may improve quality of care for these populations.

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Methods

We used the 14-step approach developed by the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) team.[13] We used a clinician summary table to highlight the populations of interest, the epidemiology of child maltreatment, population-specific clinical considerations, and potential key clinical actions (Appendix 2).

Search strategy for systematic reviews and population-specific literature

We consulted two librarian scientists to identify relevant systematic reviews and guidelines from MEDLINE, PsycLIT, CINAHL, Embase and Cochrane Database of Systematic Reviews. Three independent reviewers selected articles and extracted data. We further hand-searched in websites including the National Guideline Clearinghouse (http://www.guideline.gov/), Public Health Agency of Canada (http://www.phac-aspc.gc.ca), United States Preventive Services Task Force (http://www.ahrq.gov/clinic/USpstfix.htm), Canadian Task Forces on Preventive Health Care (http://www.ctfphc.org/), the Task Force on Community Preventive Services and the National Institute for Health and Clinical Excellence (NICE, UK) (http://guidance.nice.org.uk/CG89/Guidance/pdf/English) and the World Health Organization (WHO) (http://www.who.int/en/). This search covered English and French articles from January 1, 1995 to November 1, 2008. Two reviewers screened the eligible papers and systematic reviews for their relevance to the key question: "Should Canadian primary care practitioners routinely screen for child maltreatment in all immigrant and refugee children, from birth to 18 years, and refer children and/or families at risk or who screen positive to an appropriate intervention program, in order to stop further abuse and reduce its consequences on children and families?" We used the British National Institute for Health and Clinical Excellence (NICE) critical appraisal tool to assess the systematicity, transparency, and quality of methods and relevance of reviews. We appraised relevant guidelines using the Appraisal of Guidelines Research & Evaluation (AGREE) instrument. A reference systematic review was then chosen for each clinically-important outcome. We updated the search (November 1, 2008 to December 31, 2010) to determine if there were any recent publications that would change the position of the recommendation.

Using the same databases as the first search (oldest to June 2009), we conducted a third literature search to identify quantitative and qualitative studies on child maltreatment focusing on the immigrant and refugee populations, discussing the following: 1) baseline risk or incidence and prevalence; 2) risk of clinically important outcomes; 3) genetic and cultural factors (e.g., preferences, values, knowledge); and 4) compliance variation.

Synthesis of evidence and values

We synthesized evidence using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Summary of Findings table format endorsed by the Cochrane Collaboration, which assesses both relative and absolute effects of interventions. We appraised quality of evidence for each outcome using the GRADE quality assessment tool, which assesses study limitations, directness, precision, consistency, and reporting bias across all studies (Box 2). We identified both clinically-relevant considerations and implementation issues relevant to our population. Finally, we identified gaps in the research and evidence-based literature.

Results

The initial and update searches found no systematic reviews or evidence-based guidelines on screening, prevention, or treatment for child maltreatment in recently-settled immigrants or refugees. The literature search focused on the general population identified 180 titles with reference to child maltreatment. Seventeen citations were selected for critical appraisal and reviewers retained five key reviews as background evidence.[14-18] Studies conducted with general population and ethnic minority samples provided evidence that informed our recommendations for clinical actions in the primary care setting for child maltreatment among recently-settled immigrants and refugees (Appendix 1).

What is the burden of child maltreatment in immigrant and refugee populations?

The prevalence and incidence of child maltreatment among immigrant and/or refugee children in Canada are unknown. Furthermore, some risk factors associated with child maltreatment in the general population, such as poverty, unemployment, and social isolation, are associated with the migration experience itself during the first years of re-settlement. As a result, these factors may not correlate with maltreatment in immigrants and refugee populations.

The evidence on maltreatment among ethnic minority children in the US and Canada suggest that some ethnic minority children are disproportionately represented in

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child protection services. Disproportion (over- or under-representation) refers to the fact that the relative presence of ethnic minority children in the child protection system does not reflect their demographic weight in the general population.[19] These children are more likely to be screened for child maltreatment and also more likely to be reported to child protection services. There is also evidence that higher rates result in a higher rate of false positives, i.e., inappropriate referrals to child protection services. Retrospective chart reviews for 388 children less than three years old and hospitalized for skull or long-bone fractures found that ethnic minority children were much more likely to receive medical examinations for suspected maltreatment (OR = 8.75), after controlling for covariates, including injury severity.[20] Ethnic minority children who received medical examinations were twice as likely ($p<.001$) to be reported to child protective services.[20]

The Canadian Incidence Study of Reported Child Abuse and Neglect[9] examined a stratified cluster sample of 9,554 children (<15 years old) investigated by Child Protective Services for suspected maltreatment.[21] Ethnic minority children had a 1.77 times greater likelihood to be over-represented, while whites and Arabs were underrepresented. The higher rates were found among Aboriginals, Blacks, Latinos and Asians (the latter group for only physical abuse). The higher reports of physical abuse in ethnic minority children were not correlated with a greater number of risk factors for these children. This is consistent with previous studies that found racial bias in child maltreatment substantiation decisions. [22-23] This bias may be one explanation why ethnic minority children are disproportionately represented at all levels of the child protection process,[12,24-35] despite the fact that they do not seem at higher risk of maltreatment.[36] Another explanation may refer to the professionals' divergent views as to what should be considered grounds for clinical suspicion of child maltreatment,[37-40] which have been attributed to the recency of their training in child abuse, level of confidence in their ability to manage,[41] prejudices about the perpetrator,[37, 42] age of the child and severity of parental behaviours, [37,43-44] and the professionals' beliefs in the positive or negative consequences of reporting a given family to child protection services.[37,45-48]

Does screening for child maltreatment reduce harm and premature death or disability?

Screening Tools

Most screening methods consist of self-administered questionnaires generally completed by the mother; interviews or checklists completed by the professional who collects information directly from the patient; or clinical judgments by nurse or professional teams.[14,16] All screening methods attempt to predict child maltreatment based either on parents' potential for maltreatment or on the presence/level of risk factors associated with maltreatment, rather than on actual maltreatment occurrences. No studies have assessed physical examination of children as a screening strategy and none have been evaluated for feasibility in the primary care setting (using measures of time and cost).[14]

The Canadian Task Force (2000)[15] and the United States Task Force (2004)[14,49] report on three and six studies respectively on the performance of risk-assessment screening methods, regardless of screening period. Peters and Barlow (2003) report on eight studies on screening tools designed to predict child maltreatment based on risk assessment during the antenatal and postnatal period. The three systematic reviews report that instruments generally tend to have high sensitivity, but poor specificity and false positive rates too high for use in clinical settings.[14-16] Sensitivity ranged between 25% and 100%; specificity ranged between 16.5% and 94.3%;, and positive predictive value (when available) ranged between 1.7% and 28.2%. Although some risk indicators correlate with child maltreatment, the assumption that screening for those risk factors will predict child maltreatment in any one family has not yet been proven. At this point, screening instruments may be more useful for non-punitive or preventive interventions such as identifying high-risk families who may benefit from support in reducing the economic and social disparities that put them at risk for child maltreatment.[16, 50]

Relative benefits and harms from screening

The reviews of the Canadian Task Force [15,51] and the United States Task Force [14,49,52-53] report that unsubstantiated investigations for child maltreatment may be experienced by families as intrusive and invasive,[54] and stigmatization may occur from being labelled at risk.[16] False-positives, which are the most common result in low-risk populations, can lead to a number of negative consequences, such as: inappropriate labelling and punitive attitudes, psychological distress,[50] inappropriate separation of children from family support systems, destruction of family supports, loss of resources, and loss of autonomy for those falsely accused.[49] This may leave parents wary of any subsequent assistance that may be offered,[50] thus reducing their access to care. In a recent British review of nine previous systematic reviews of the performance of screening tests,

Woodman and colleagues (2008) concluded that adding a screening protocol to the clinical encounter yielded additional false-positives that exceeded additional abused children detected.[55]

Compared to the general population, immigrant and refugee families may thus be more likely to suffer from the direct and indirect risks of harms related to screening for child maltreatment. Further, the validity and applicability of screening instruments have not been tested with immigrant and refugee populations, and are less likely to be accurate due to factors including language barriers, different cultural meanings and norms of behaviors and attitudes toward institutional authority.[56] Primary care practitioners working with recently-settled immigrant and refugee families also may face many additional obstacles to screening for child maltreatment due to the fears of: a punitive response, disruption of the family system and separation from child, exclusion and shame from community, and involvement with police, courts and child protection services that may compromise their legal migrant status in Canada.[57] Given the present state of knowledge in recently settled immigrant and refugee populations, potential harms from screening for child maltreatment outweigh benefits, which have not yet been clearly established.

Relative benefits and harms of preventing child maltreatment

Nurse Home Visitation Programs: Nurse home visitation programs aim to prevent child maltreatment by assessing and supporting families. Barlow et al. (2006) reviewed eight studies and Mikton and Butchart (2009) summarized 17 systematic reviews on the effectiveness of home visitation interventions.[58-59] Nurse home visitation programs were effective in reducing risk factors associated with maltreatment. However, evidence for

Table 1: Summary of findings on home visitation by nurses for preventing child maltreatment

Patient or population: pregnant first-time mothers with at least one "sociodemographic risk characteristic"
Settings: US clinic with free prenatal services and private obstetricians' offices (Kitzman); US public system of obstetric care (Olds)
Intervention: home visitation by nurses
Comparison: usual care
Source: MacMillan HL. Preventive health care, 2000 update: prevention of child maltreatment. CMAJ 2000;163(11):1451-8.

Outcomes	Absolute effect		Relative effect (95% CI)	No. of participants (studies)	GRADE quality of evidence	Comments
	Risk for control group	Difference with home visitation by nurses (95% CI)				
Out-of-home placements Follow-up: 16 months	226 per 1000	31 more per 1000 (70 fewer to 201 more per 1000)	RR 1.14 (0.69 to 1.89)*†	197 (1)	Moderate‡§	NNT 32 (not statistically significant)
Mean number of substantiated reports of child abuse and neglect over 15 years	0.54¶	0.25 fewer¶	0.77 (0.34 to 1.19)**	245 (1)††	Moderate	
Mean number of days in hospital for injuries and ingestions over two years	0.16	0.13 fewer	N/A	697 (1)‡‡	Moderate	P<.001
Mean number of health care encounters for injuries and ingestions over two years	0.55	0.12 fewer	N/A	697 (1)‡‡	Low	P=.05

Note: CI = confidence interval, GRADE = Grading of Recommendations Assessment, Development and Evaluation, NNT = number needed to treat, RR = risk ratio.
* Calculated using http://statpages.org/ctab2x2.html
† NNT = not estimable, because RR crosses 0 (not stat. sig.)
‡ Pregnant women with "specified psychosocial risk factors": substance abuse, homelessness, domestic violence, psychiatric illness, incarceration, HIV infection, or lack of social support.
§ "when the recommendation is in favour of an intervention and the 95% confidence interval (or alternative estimate of precision) around the pooled or best estimate of effect includes no effect and the upper confidence limit includes an effect that, if it were real, would represent a benefit that would outweigh the downsides" (grade pro software)
¶ Adjusted for socioeconomic status (SES), marital status, maternal age, education, locus of control, support from husband or boyfriend, working status, and husband or boyfriend use of public assistance at registration.
** Estimate = (comparison log incidence) - (intervention log incidence).
†† Olds et al. Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect Fifteen-Year Follow-up of a Randomized Trial. JAMA. 1997;278:637-643.
‡‡ Kitzman et al. Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing A Randomized Controlled Trial. JAMA. 1997;278:644-652.

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reduction of actual maltreatment occurrences was equivocal.[59] To date, Olds et al.'s 15-year longitudinal study provides the best evidence for the effectiveness of Nurse-Family Partnership Program in reducing actual child maltreatment. The effectiveness of this program is particularly evident for first-time mothers who are younger than 19 years of age, single, or economically disadvantaged (Table 1).[15,17,59-60] Another prevention program (the Early Start Program) has also shown efficacy in reducing hospital admissions for child injuries at 36 months (17.5% vs. 26.3% for control group).[61]

To date, studies on the effectiveness of nurse home visitation programs have been conducted with general population and/or ethnic minority families, and evidence is lacking on their effectiveness with recently-settled immigrant and or refugee families. However, social isolation, socioeconomic disadvantage, and single parenthood may also be present for recently-settled immigrant, and particularly refugee populations, as well as constitute a significant source of stress for them.

Conversely, adverse effects of home visitation programs have also been observed.[59] Bilukha et al. identified seven out of 26 study arms where a surveillance bias was induced.[62] Professional home visitors increased by 70% the likelihood that child maltreatment was observed, as compared to relying solely on child maltreatment occurrences reported in child protection files.[62] Duggan and colleagues (2004) reported no significant positive outcomes for a home visitation program (the Health Start Program) but identified two harms: (1) increased likelihood of hitting the child with an object by mothers who had a higher risk level for abuse; (2) higher likelihood of reporting severe physical abuse by the families who received higher doses of services overall.[63]

Relative benefits and harms of treatment for child maltreatment

Trauma-Focused Cognitive Behavioral Therapy for sexually abused children: Several specific forms of intervention have been devised to reduce the consequences of child maltreatment among children who have experienced such trauma.

In 2006, Cohen et al. reviewed six randomized controlled trials, [64] all of which yielded positive effects of Trauma-Focused Cognitive Behavioral Therapy in reducing sexually abused children's symptoms of anxiety,

Table 2: Summary of findings on cognitive behaviour therapy for sexually abused children

Patient or population: sexually abused children aged 2-18
Settings: US and Australia, communities and hospitals
Intervention: cognitive behaviour therapy for children
Comparison: varied; group information-based approach, cognitive behaviour therapy for parents and children, community control, waitlist control
Source: Macdonald G, Higgins JPT, Ramchandani P. Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database of Systematic Reviews 2006, Issue 4. Art. No.: CD001930. DOI:10.1002/14651858.CD001930. pub2.

Outcomes	Absolute effect		Relative effect (95% CI)	No. of participants (studies)	GRADE quality of evidence
	Risk for control group	Difference with cognitive behavior therapy (95% CI)			
Depression Child Depression Inventory	The mean depression score was 5.47*	The mean depression score was 1.8 lower (3.98 lower to 0.38 higher)	-33% (-73%, 7%)	443 (5)	Moderate†
Anxiety Various scales	The mean anxiety score was 27.76*	The mean anxiety score was 0.21 lower (0.40 to 0.02 lower)	-0.8% (-1.4%, -0.1%)	456 (5)	High
Post-traumatic stress disorder Various scales	The mean post-traumatic stress disorder score was 2.32	The mean post-traumatic stress disorder score was 0.43 lower (0.69 to 0.16 lower)	-19% (-30%, -7%)	464 (6)	High
Sexualized behaviour	The mean sexualized behaviour score was 8.2	The mean sexualized behavior score was 0.65 lower (3.53 lower to 2.24 higher)	-8% (-43%, 27%)	451 (5)	Very low†‡
Externalizing behaviour	The mean externalizing behaviour in the control groups was 13.82	The mean externalizing behavior score was 0.14 lower (0.44 lower to 0.15 higher)	-1% (-3%, 1%)	560 (7)	Moderate§

Note: CI = confidence interval, GRADE = Grading of Recommendations Assessment, Development and Evaluation, NNT = number needed to treat, RR = risk ratio.
* Representative study chosen based on sample size
† 95% confidence interval includes no effect and the upper or lower confidence limit crosses the minimal important difference (MID), either for benefit of harm (Note: "if the MID is not known or the use of different outcomes measures required calculation of an effect size (ES), we suggest downgrading if the upper or lower confidence limit crosses an effect size of 0.5 in either direction" grade pro software).
‡ Test for heterogeneity p = 0.02
§ Test for heterogeneity p = 0.01

depression and sexual behavior problems[64] in the general population and ethnic minority children. Positive impacts are also reported in longitudinal follow-up studies.[65-66] Macdonald, Higgins, and Ramchandani (2006) (Table 2) systematically reviewed ten randomized controlled trials on the outcomes of cognitive behavioral interventions with samples composed of general population and ethnic minority children who have been sexually abused.[18] Contrary to some earlier reviews, however, the authors conclude that the quality of the evidence on the efficacy of trauma-focused cognitive behavioral therapy in reducing negative child outcomes is poor.

Parent/child- and parent-focused programs: Barlow et al. (2006) systematically reviewed evidence from seven randomized controlled trials on individual and group-based parenting programs with general population and ethnic minority parents who are physically abusive and neglectful[17] (Table 3).[17,67-68] Only Parent-Child Interaction Therapy[67] showed a reduction in repeated reports of physical abuse in treatment as compared to control groups (standard psychoeducational program) (19% vs. 49%). Most other studies failed to achieve statistically significant outcomes

Table 3: Summary of findings on parent-child interaction therapy for preventing physical abuse

Patient or population: physically abusive parents and their abused children
Settings: child welfare system[67]
Intervention: parent-child interaction therapy
Comparison: standard community-based parenting group[67]; standard family preservation services[68]
Sources: Barlow J, Johnston I, Kendrick D, Polnay L, Stewart-Brown S. Individual and group-based parenting programmes for the treatment of physical child abuse and neglect. Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD005463. DOI: 10.1002/14651858.CD005463.pub2.
Chaffin et al. Parent-Child Interaction Therapy With Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. Journal of Consulting and Clinical Psychology. 2004, Vol. 72, No. 3, 500-510.
Terao SY. Treatment Effectiveness of Parent-Child Interaction Therapy with Physically Abusive Parent-Child Dyads [EdD]. Stockton, California: University of the Pacific, 1999.

Outcomes	Absolute effect		Relative effect (95% CI)	No. of participants (studies)	GRADE quality of evidence	Comments
	Risk for control group	Difference with parent-child interaction therapy (95% CI)				
Re-reports of physical abuse Follow-up: median 850 days	486 per 1000	295 fewer per 1000 (392 fewer to 112 fewer per 1000)	RR 0.39 (0.19-0.77)	77 (1)	Low *†	NNT 4 (95% CI 3-9)
Child Abuse Potential Child Abuse Potential Inventory	The mean child abuse potential score was 227.06	The mean child abuse potential score was 110.69 lower. The mean child abuse potential score was 0.99 standard deviations lower (1.71 to 0.27 lower).§	Not estimated	34 (1)	Low †‡	
Parental stress Parental Stress Inventory	The mean parental stress score was 257	The mean parental stress score was 23.62 lower. The mean parental stress was 0.36 standard deviations lower (1.04 lower to 0.31 higher).§	Not estimated	34 (1)	Low †‡	
Child behaviour - intensity Eyberg Child Behaviour Inventory	The mean child behaviour - intensity score was 127.65	The mean child behaviour – intensity score was 27.24 lower. The mean child behaviour - intensity score was 0.72 standard deviations lower (1.41 to 0.02 lower).§	Not estimated	34 (1)	Low †‡	
Child behaviour - problem score Eyberg Child Behaviour Inventory	The mean child behaviour - problem score was 15.82	The mean child behaviour - problem score was 12.70 lower. The mean child behaviour - problem score was 1.81 standard deviations lower (2.63 to 1.00 lower).§	Not estimated	34 (1)	Low †‡	

Note: CI = confidence interval, GRADE = Grading of Recommendations Assessment, Development and Evaluation, NNT = number needed to treat, RR = risk ratio.
* The group described in this study is not comparable to the population seen in primary care (multiple past child welfare reports, severe parent-to-child violence, low household income, and significant levels of depression, substance abuse, and antisocial behavior.")
† Less than 300 events.
‡ Allocation concealment is unclear
§ Standardized mean difference

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but showed a consistent tendency in favour of treatment programs.

The current equivocal state of evidence on the efficiency of treatment programs and the lack of evidence on their efficacy with recently-settled immigrant or refugee children make extrapolation of the findings to immigrant and refugee children impossible.

Clinical considerations

Does screening for child maltreatment occur during the migration process?

Child maltreatment is not routinely investigated during the migration process.

What are potential implementation issues?

Defining maltreatment and related domains such as parent-child relations, parental authority, aggression and discipline vary considerably across social and cultural contexts.[50,69-71] Some milder and legal forms of child discipline may be atypical, unusual, or outside the dominant group's social norms, but not dysfunctional, pathological,[72] or dangerous for the child. However, the tolerance level for these practices appears to be low among practitioners.[21]

Practitioners may face significant dilemmas as some immigrant or refugee families may resort to disciplinary behaviors (e.g., hitting a child with an object) that are condoned in their cultural context of origin but that contravene child protection laws in Canada. In situations where child maltreatment has been established or is disclosed following assessment, the practitioner must take action in accordance with the child protection law in his/her region, in accordance with the evidence on prevention and treatment programs and their availability, as well as the specific clinical considerations for immigrant or refugee children and families. Some cultural practices (e.g. scarification as part of life cycle rituals among some African children or cupping, a common traditional healing method in some Asia cultures that leaves circular ecchymoses) may be misinterpreted as signs of child abuse by clinicians without sufficient cultural competence. Some other culture-specific practices (e.g., female genital cutting), contravene to child protection and civil laws in Canada.

As a preventive strategy, clinicians may want to provide families with or direct them to sources of information about their province's child protection law, their legal rights, and their obligations regarding children, in addition to addressing the social causes and physical and mental health consequences of child maltreatment. Recent research is showing promising results for primary care interventions such as the SEEK (safe environment for every kid) model in terms of the reduction in maltreatment reports to child protection services and of parent use of severe physical punishment, as well as in terms of increase in adherence to medical care.[73]

Recently-settled immigrant and refugee children/youth may be aware of the diverging discipline norms between their culture of origin and the host society. On some occasions, disclosure of physical punishment or maltreatment may be an overt symptom of an underlying intergenerational conflict. Failure to investigate thoroughly the family dynamics and the intergenerational conflicts may further disempower the parents and attribute greater power to the child, consequently aggravating his/her conduct problem. Immigrant and refugee children placed in foster care may suffer significantly from loss of contact and connection with language of origin and religious, familial and cultural traditions.

Fear of punitive institutional power, fear of deportation, and fear of not accessing Canadian citizenship may constitute major barriers to disclosure of child maltreatment and to adherence with interventions. These fears are nourished by: (1) lack of knowledge of the professional's and institution's role and the state's laws on child maltreatment in relation to parents' obligations and rights; and (2) possible negative past experiences with institutions who have power in their country of origin (e.g. war, torture) and their host country (e.g. discrimination in access to work).

Language barriers can impede accurate assessment, isolate some family members from clinical engagement and treatment planning and thus jeopardize effective intervention.[74] Establishing rapport and getting to know patients and their families through history-taking (medical, developmental and psychosocial) remain the keystone of effective care, and have the best chances of bringing any maltreatment to light in a context that allows appropriate intervention.[26]

Recommendations from other groups

The United States Preventive Services Task Force concluded that there is insufficient evidence for or against routine screening of child abuse and neglect in primary care.[49] The Canadian Task Force on Preventive Health Care concluded that there is fair evidence to exclude screening for child maltreatment from the periodical health examination.[51] The American Academy of Paediatrics[75] and the American Medical Association[76-77] do not support universal screening, but recommend

that physicians be alert for signs and symptoms of child maltreatment during routine physical examination. The Task Force on Community Preventive Services recommends early childhood home visitation for the prevention of child maltreatment in high-risk families and families with low birth weight infants.[78]

The cases revisited

The paediatrician's examination shows that Sara's bruises do not seem accidental and that the probability of them having been induced by physical punishment is high. During the examination and upon further questioning from the paediatrician, Sara states that "Colombian parents hit their kids" and that's normal for her but that she wants to be placed in a foster care family because she is "fed up" with her "old-fashioned" parents, who are "still in Colombia in their minds," while she now feels Canadian and wants to live like Canadian teens. However, a meeting with Sara and her parents revealed strong positive family attachments, the cultural normative use of physical discipline, evidence of intergenerational conflict, and the family's willingness to address these issues. The practitioner consequently referred Sara and her parents to family mediation to strengthen family ties and work on alternative methods of discipline while addressing generational issues.

Upon examination, Basem states that he does not understand why he cannot go back home, and fears he will not see his family again. He also complains that the foster family eats pork and does not give him something else to eat if he refuses to eat it. He reports that his parents sometimes punish him, but "not strong and it does not hurt." He kept repeating that he got the bruises after playing soccer with his friends. Although Basem's statements were suspicious, further tests showed that he suffered from hemophilia which increased his tendency to bruise. The practitioner arranged for the aid of an interpreter and met with the parents to inform them about Basem's medical condition. This reassured the family and strengthened the parent-practitioner trust relation. The parents expressed significant fear of Child Protection Services and school personnel. The placement decision for the child was consequently revised and youth protection offered follow-up at home by a psychoeducator, in order to assist parents in caring for their child's condition. This gave the psychoeducator the opportunity to further assess and address potential physical punishment, as well as to re-establish the family's alliance with the school.

Conclusion and research needs

This review highlights the lack of evidence on the prevalence and incidence of child maltreatment for immigrant and refugee children, as well as the lack of evidence on the effectiveness of screening and interventions for child maltreatment. Research is also needed on the impact of migratory and post-migration re-settlement stressors on the incidence of child maltreatment. Research on the cultural systems of meaning and the explanatory models of child maltreatment and of its causes may be particularly informative. Because of the diversity between and within migrant groups, epidemiological surveys and quantitative studies must be supplemented with qualitative research and case studies. Qualitative research is also essential to examine the interactions between migrant families and the various institutions involved in detecting and responding to child maltreatment (e.g. police, youth courts, criminal, courts, Child Protection Services).

Finally, promising interventions such as Nurse-Family Partnership programs need to be adapted to high-risk families within the immigrant and refugee population, and assessed for their effectiveness in reducing child maltreatment and other related health outcomes.

Key points

- Ethnic minority children, possibly including recently-settled immigrants and/or refugees are: disproportionately over-screened (up to 8.75 times more likely), over-reported (up to four times more likely) for child maltreatment, and over-represented (up to 1.77 greater odds) among child protection service clients.
- Immigrant and refugee families may be particularly vulnerable to potential harms consequent to false positive screens.

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Box 2: Grading of Recommendations Assessment, Development and Evaluation Working Group grades of evidence (www.gradeworkinggroup.org)

High quality: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and could change the estimate.
Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low quality: We are very uncertain about the estimate.

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Clinical preventive guidelines for newly arrived immigrants and refugees

This document provides the review details for the CMAJ CCIRH Child Maltreatment paper. The series was developed by the Canadian Collaboration for Immigrant and Refugee Health and published at www.cmaj.ca.

More detailed information and resources for screening, assessment and treatment of depression can be found at: www.mmhrc.ca.

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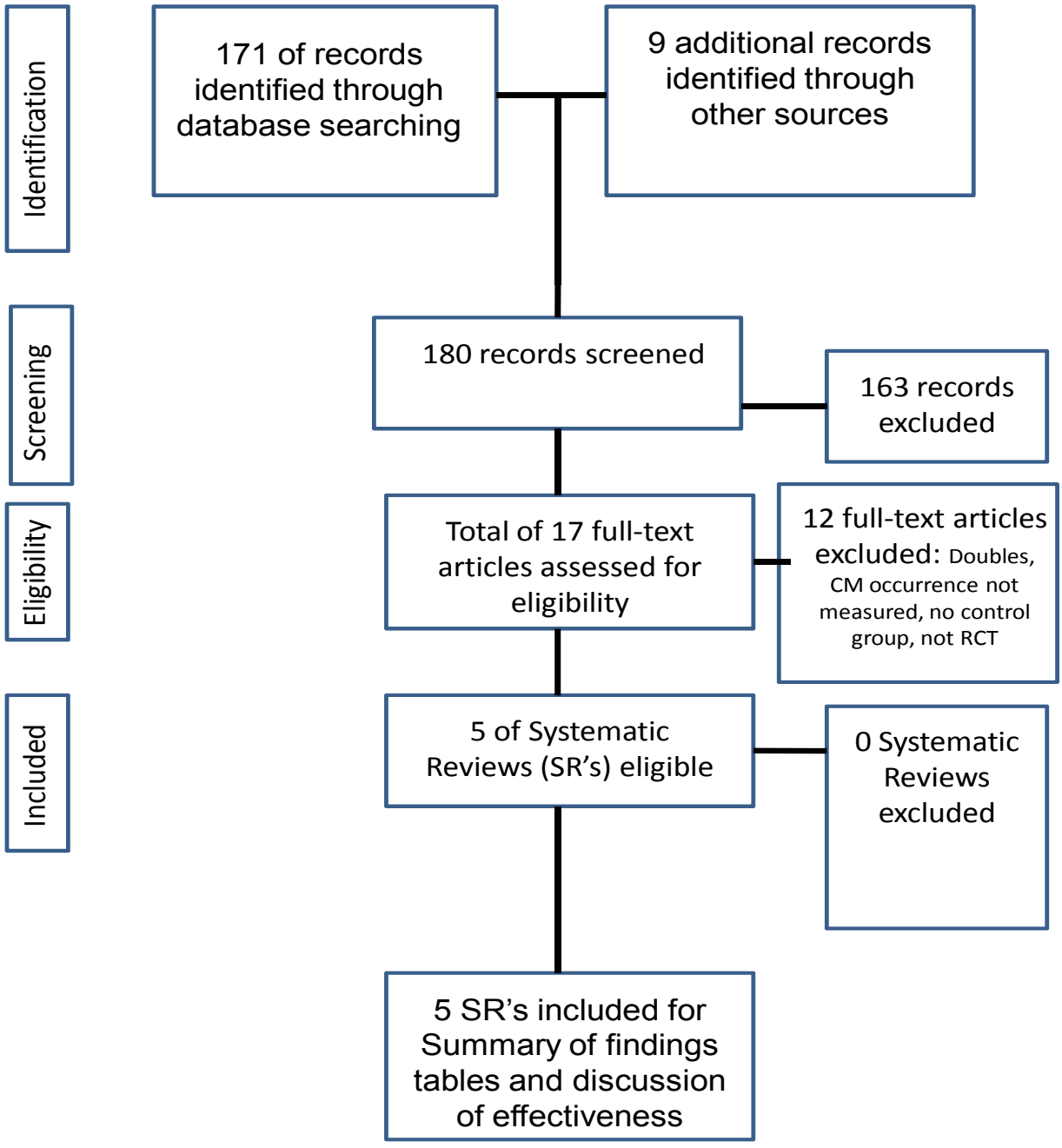
Appendix 1: Figure 1

Figure 1: Search and Selection Flow Sheet 1999 to 2008 and 2008-2009



Appendix 2: Child Maltreatment Evidence Based Clinician Summary Table

Screening for Child Maltreatment

Do not conduct routine screening for child maltreatment. Be alert to signs and symptoms of child maltreatment during physical and mental examination and further assess when reasonable doubt exists or after patient disclosure.

Prevention for Child Maltreatment and Associated Outcomes

A home visitation program encompassing the first 2 years of life should be offered to immigrant and refugee mothers living in high risk conditions including teenage motherhood, single parent status, social isolation, low socioeconomic status, living with mental health or drug abuse problems.

Prevalence: Prevalence and incidence rates of child maltreatment among the general population are 2.15%. Studies with non-representative samples of ethnic minority populations (possibly including recently settled immigrants or refugees) report prevalence rates that range between 11% and 62%.

Burden: Ethnic minority children (possibly including recent immigrants or refugees) are disproportionately over-screened (up to 8.75 times more likely) and disproportionately over-reported (up to 4 times more likely) for child maltreatment, as well as they are over-represented (up to 1.77 greater odds) among child protection services clients.

Access to Care: Barriers to disclosure of child maltreatment and access of care include: issues of confidentiality and fear of stigma, shame, fear of separation from child, exclusion from community, language difficulty, economic strain, diversity of cultural values around acceptable child rearing practices and physical discipline, lack of knowledge of Canadian child protection laws, possible negative past experiences with institutions who have power in their country of origin and with host country, as well as potential involvement with police or criminal proceedings, which may put immigrant and refugee parents at risk of loosing their sponsorship agreements, being deported to countries of origin or having their access to Canadian citizenship refused.

Key Risk Factors for Child Maltreatment: No specific family profile can predict the occurrence of any type of child maltreatment. Risk factors include a combination of: single parenthood, teenage mother, low socioeconomic status, social isolation from formal and informal family and community networks, parent mental health or substance abuse problems.

Screening Test: Instruments generally tend to have high sensitivity, but poor specificity and false positive rates too high for use in clinical settings.

Prevention of outcomes related to child maltreatment:
Home visitation by a nurse or qualified mental health professional, (e.g. The Nurse Family Partnership) starting prenatally or shortly after and, ideally, continuing until child reaches his/her third year, have shown efficacy in reducing hospital admissions and injuries in children living in high-risk families (a combination of: single parenthood, teenage mother, low socioeconomic status, social isolation from formal and informal family and community networks, parent mental health or substance abuse problems).

Treatment for mental health consequences of child maltreatment
Treatment for mental health consequences of child maltreatment may include individual psychotherapy for children or theoretically driven parent-child and parent programs. Do not refer a non-symptomatic child for therapy.

Special Considerations:

- Cultural variations in definitions of maltreatment and related domains such as parent-child relations, parental authority, aggression and discipline vary considerably across social and cultural. Many parenting behaviors (disciplinary strategies, cultural healing practices, ceremonies) may be dysnormative (outside the social norm) but not dysfunctional.
- Some culture specific practices (e.g., female genital cutting) or disciplinary behaviors contravene to child protection and civil laws in Canada. In situations where child maltreatment has been established or is

disclosed following assessment, the practitioner should take action in accordance with the child protection law in his/her province.

- The place of disclosure of physical punishment or maltreatment by the child may also be an overt symptom of an underlying intergenerational conflict. Immigrant and refugee children placed in foster care may be at risk of loyalty conflicts and suffer significantly from the disruption of contacts with their siblings and other extended family members, and/or from loss of practice of language of origin and religious, familial and cultural traditions.