U.S. Department of Health and Human Services
Administration for Children and Families
Office of Refugee Resettlement
Division of Children's Services

Preventing Child Maltreatment in ORR-Funded Care Programs

Resource Appendices

Developed by Bridging Refugee Youth & Children's Services (BRYCS)
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BRYCS Bridging Refugee Youth & Children's Services

Bridging Refugee Youth and Children's Services (BRYCS), a project of the United States Conference of Catholic Bishops (USCCB), provides national technical assistance to "bridge the gap" between public child welfare and other mainstream organizations, refugee and immigrant-serving agencies, and newcomer communities. BRYCS' overarching goal is to strengthen the capacity of service organizations across the United States to support the safety, stability, and well-being of newcomer children, youth, and their families through targeted training, consultation, resource development, and a Web-based clearinghouse. Please visit www.brycs.org *for more information.*

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ORR/DCS Policies on Confidentiality
(Excerpted from the DCS Policy and Procedures Manual, August 21, 2006, pp. 125–126)

4.06 OTHER POLICIES: CONFIDENTIALITY

Policy
The case files of every UAC [Unaccompanied Alien Child] are the property of the ORR and must be provided to the ORR immediately upon its request.

The care provider must not release information about the child to anyone without prior authorization of the ORR, except as specified below:

a) The care provider and the voluntary agency staff must give the ORR and its designees, as directed by the ORR, unrestricted access to information about the child at all times.
b) The care provider and the voluntary agency staff may provide information about an UAC to the child's educational program, medical, mental health, dental and other service providers to the extent that the information is needed for the child's education, recreation, social development, and medical, dental or mental health treatment.

Procedures

General
Care providers and voluntary agency staff shall have written procedures to ensure the protection of confidential information. These policies shall ensure that persons who collect or have access to UACs' data are trained in confidentiality issues, including the maintenance of information in such a way that confidential information could not accidentally be revealed. These persons must also provide assurances of nondisclosure of confidential information. All care provider and voluntary agency staff must be trained in the ORR and local confidentiality policies and procedures. They must also provide written assurances of nondisclosure of confidential information which should be documented in the personnel file. Confidential files and records shall be properly disposed at the end of the agreement per the directions from the ORR.

Care providers and voluntary agency staff shall establish administrative and physical controls to prevent unauthorized access to both electronic and paper records. These established controls must also address the prevention of the unauthorized disclosure of records and physical damage to or destruction of records. At a minimum, each of the administrative and physical controls shall ensure that:

- Records, both in paper or electronic form, are protected from public access.
- The area in which paper records or electronic equipment are kept is supervised during business hours to prevent unauthorized persons from having access to them.
- Records are inaccessible to unauthorized persons outside of business hours.
- Records are not disclosed to unauthorized persons or under unauthorized circumstances in either oral or written form.

Subcontracts created by the care providers and voluntary agency staff with subcontractors or consultants shall include safeguards that prohibit the subcontractor or consultant from using or disclosing the information for any purpose other than that described in the contract. The care providers must also require that the sub-contractor or consultants return or destroy all information at the completion of the contract.

Attorney-Client Privilege
All conversations between UAC and their attorneys of record may be observed by the care provider staff when safety concerns exist. However, staff are not to record or listen to those conversations in any manner. If the care provider staff suspect that an attorney may be involved with human trafficking, human smuggling or other criminal activities, this suspicion must be immediately reported to the Program Director and submitted in writing with documented concerns to the designated PO and the FFS.

Photographs and Videotapes
Care providers may take photographs and record videotapes of UAC in care for purposes of identification or for the child's personal use. An UAC's personal use may include photographs to send to persons in his or her home country. Such photographs shall depict the child alone or with staff and shall not identify the care provider's site or other UAC in care. Care providers shall not release any photographs or videotapes of any UAC for public use. They may also not use them for any training purposes or promotional materials without prior written authorization from the ORR.

Disposition of Confidential Information
The disposition of the data files created during the term of the agreement between the ORR and the care providers and voluntary agencies will be determined by the ORR prior to the end of the agreement.

Compliance With ORR Requirements Concerning the Collection of Information Containing Personal Identifiers
Care providers and voluntary agencies shall comply with all ORR requirements concerning the collection and maintenance of data that include personal identifiers.

Appendix 1B

Care Provider Program Policies on Professional Ethics, Boundaries, and Conduct

Each ORR-funded residential care provider program is encouraged to insert its own program policies in this section.

Appendix 1C

Excerpts From the National Association of Social Workers (NASW) Code of Ethics[1]

The following excerpts from the NASW Code of Ethics are included for reference purposes only. Please keep in mind that not all of the following may apply to the ORR-funded care provider programs and that few care provider program staff are actually professional social workers and thus bound by this code. Regardless, these guidelines provide an excellent example of professional ethics, boundaries, and conduct for everyone who works with vulnerable populations. In some examples below, notes are included about the relevance of a given standard for ORR-funded care provider program staff.

1. Social Workers' Ethical Responsibilities to Clients

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

Relevance for ORR-funded care provider program staff:
The above discussion concerns limiting one's work to the areas that one is qualified to do. ORR staff at all levels who are naturally warm and friendly may be tempted to "counsel" residents. They need to be careful to be supportive, only, and to leave the professional clinical counseling to the clinicians. Non-clinicians should not try to "treat" residents.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

[1] NASW Delegate Assembly. (revised 2008). *Code of Ethics of the National Association of Social Workers.* Retrieved February 20, 2013, from www.socialworkers.org/pubs/code/code.asp

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

Relevance for ORR-funded care provider program staff:
Staff should learn about the cultural and national backgrounds of the residents. They should work to create environments in which the residents can feel safe, "at home," and appreciated as cultural beings.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

Relevance for ORR-funded care provider program staff:
Staff members should not establish personal or professional relationships with residents during or after the youth are in the residences. Similarly, staff should not establish personal relationships with family members or foster family members of youth that might affect their professional work with residents.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

Relevance for ORR-funded care provider program staff:
ORR-funded care provider program staff need to be careful to protect residents confidentiality and the privacy of their information. Care needs to be taken in conversations held in person or on the phone, and through electronic communication. Utmost care must be taken to protect resident written and electronic records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers--not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers--not their clients--who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

Relevance for ORR Provider Programs:
ORR-funded care provider program staff should not engage in sexual activities or contact with current or former residents or their family members.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

Appendix 2

Goal 2: Defining Child Maltreatment

A. Definitions[2]

What is the definition of child maltreatment?

Federal Child Abuse Prevention and Treatment Act (CAPTA), defines child abuse and neglect as:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm.

What are the major types of child maltreatment?

Each state is responsible for providing its own definitions of child abuse and neglect. Most states recognize four major types of maltreatment, which may be found separately, but often occur in combination :

- Neglect
- Physical abuse
- Emotional abuse (psychological maltreatment)
- Sexual abuse

How do you define neglect, physical abuse, sexual abuse, and emotional abuse?

As definitions vary by state, the below examples are for general informational purposes only. Your local Child Protective Services (CPS) office will be able to give specifics on state laws and definitions.

Neglect is failure to provide for a child's basic needs. Neglect may be:

- Physical (e.g., failure to provide necessary food or shelter, lack of appropriate supervision, abandonment)
- Medical (e.g., failure to provide or unwarranted delays in providing necessary medical or mental health treatment)
- Educational (e.g., failure to educate a child, failure to attend to special education needs, permitting or causing a child to miss too many days of school)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)

Sometimes cultural values, the standards of care in the community and poverty may be contribute to child neglect. Some youth in DCS care may have been inadequately cared for (neglected) in their home country, which is part of the reason they and/or their families wanted them to immigrate to the United States.

Physical abuse is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child.

Emotional abuse is usually a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding support or guidance. Emotional abuse is often difficult to

[2] The information on definitions of and types of abuse in this section is adapted from the Child Welfare Information Gateway. (n.d.). *What is child abuse and neglect?* Retrieved February 7, 2013, from www.childwelfare.gov/pubs/factsheets/whatiscan.pdf

prove, and it can range from a simple repeated verbal insult to an extreme form of punishment. The following are examples of emotional child abuse:[3]

- Threatening,frightening or bullying
- Negative comparisons to others
- Belittling; telling the child he or she is "no good," or "worthless"
- Habitual blaming
- Ignoring or disregarding the child
- Using extreme forms of punishment
- Corrupting the child by encouraging him or her to engage in criminal acts
- Exposing the child to abuse or violence by others.

Child sexual abuse is defined as "inappropriately exposing or subjecting a child to any sexual contact, activity, or behavior."[4]

Sexual abuse includes both touching offenses and nontouching offenses and can involve varying degrees of violence and emotional trauma. The following activities are considered sexual abuse:[5]

- Fondling a child's genitals, breasts or buttocks
- Enticing a child touch an adult or another child in a sexual way
- Oral, anal, or genital contact or penetration
- Exhibitionism or indecent exposure
- Use of a child in prostitution, pornography, Internet crimes, or other sexually exploitative activities.
- Taking sexual pictures of a child
- Exposing a child to pornography

B. Discipline vs. Abuse

How can you tell the difference between discipline and abuse?

Many states define abuse in terms of outcome rather than intent. From this perspective, physical discipline is considered abuse if it leaves injuries. Injuries can mean a lasting mark such as a bruise or a lasting soreness.

Most jurisdictions do not care about the intentions of a caretaker when they assess for abuse. Whatever the caretaker's intentions, if the caretaker leaves a mark or lasting soreness on a child, it is considered abuse. All too often, caretakers who mean to educate a child or correct his or her behavior end up abusing the child, with lasting consequences for all. Caretakers may be found guilty of abuse even when they have good intentions.

Note for ORR-funded care provider program staff: Because young people who live away from their families are so vulnerable to mistreatment, in most jurisdictions physical punishment of

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[3] The examples of emotional child abuse are from HelpGuide.org. (2013). *Child abuse and neglect: Recognizing, preventing, and reporting child abuse.* Retrieved February 4, 2013, from www.helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm

[4] Prevent Child Abuse America. (n.d.). *Fact sheet: Sexual abuse of children* (p. 1). Retrieved February 4, 2013, from http://member.preventchildabuse.org/site/DocServer/sexual_abuse.pdf?docID=126

[5] The examples of sexual abuse are adapted from RAINN (2009) . *Child sexual abuse.* Retrieved February 4, 2013, from http://www.rainn.org/get-information/types-of-sexual-assault/child-sexual-abuse

children is prohibited in foster homes and in all institutions. No physical punishment is permitted in ORR/DCS residences.

C. Recognizing Abuse and Neglect[6]

How can I recognize if a child is being abused and/or neglected?

Sometimes children will say that they are being abused or neglected. Often, however, children will not disclose abuse. Caregivers need to be aware of signs that may signal the presence of abuse and neglect.

The presence of a single sign does not prove child abuse is occurring; however, when the signs appear repeatedly or in combination, you should take a closer look at the situation and consider the possibility of child abuse. Remember, also, that some of these signs are typical of young people who are experiencing stress of all kinds. Therefore, the presence of some of these signs in young people in DCS care may *not* be indicative of abuse or neglect.

Signs that a child might be abused or neglected:

- Shows sudden changes in behavior or school performance.
- Has not received help for physical or medical problems brought to the caregivers' attention.
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes.
- Is always watchful, as though preparing for something bad to happen.
- Lacks adult supervision.
- Is overly compliant, passive, or withdrawn.
- Comes to school or other activities early, stays late, and does not want to go home.
- Has unexplained injuries
- Touches him or herself or other children in a sexual way and seems unable to control this behavior
- Hoards or steals food
- Hoards or steals possessions.

Signs that a caregiver may be abusing or neglecting a child:

- Shows little concern for the child.
- Denies the existence of—or blames the child for—the child's problems in school or at home.
- Asks teachers or other caretakers to use harsh physical discipline if the child misbehaves.
- Sees the child as entirely bad, worthless, or burdensome.
- Demands a level of physical or academic performance the child cannot achieve.
- Looks primarily to the child for care, attention, and satisfaction of emotional needs.
- Interferes with the child developing relationships with people outside the family.

Remember, adults who seem like loving, responsible caretakers may also abuse a child in private.

What are specific signs of which type of abuse or neglect a child may be experiencing?

[6] The text about signs of abuse and neglect is adapted from Child Welfare Information Gateway. (n.d.). *Recognizing child abuse and neglect signs and symptoms.* Retrieved February 4, 2013, from www.childwelfare.gov/pubs/factsheets/signs.cfm

The following are some signs often associated with particular types of child abuse and neglect. It is important to note, however, these types of abuse are more often found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

Signs of Neglect

Consider the possibility of neglect when the child:

- Is frequently absent from school.
- Begs or steals food or money.
- Lacks needed medical or dental care, immunizations, or glasses.
- Is consistently dirty and has severe body odor.
- Lacks sufficient clothing for the weather.
- Abuses alcohol or other drugs.
- States that there is no one at home to provide care.

Consider the possibility of neglect when the parent or other adult caregiver:

- Appears to be indifferent to the child.
- Seems apathetic or depressed.
- Behaves irrationally or in a bizarre manner.
- Is abusing alcohol or other drugs.

Signs of Physical Abuse

Consider the possibility of physical abuse when the child:

- Has unexplained burns, bites, bruises, broken bones, or black eyes.
- Has fading bruises or other marks noticeable after an absence from school.
- Seems frightened of the parents and protests or cries when it is time to go home.
- Shrinks at the approach of adults.
- Reports injury by a parent or another adult caregiver.

Consider the possibility of physical abuse when the parent or other adult caregiver:

- Offers conflicting, unconvincing, or no explanation for the child's injury.
- Describes the child as "evil," or in some other very negative way.
- Uses harsh physical discipline with the child.
- Has a history of abuse as a child.

Signs of Emotional Maltreatment

Consider the possibility of emotional maltreatment when the child:

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression.
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example).
- Is delayed in physical or emotional development.
- Has attempted suicide.
- Reports a lack of attachment to the parent.

Consider the possibility of emotional maltreatment when the parent or other adult caregiver:

- Constantly blames, belittles, or berates the child.
- Is unconcerned about the child and refuses to consider offers of help for the child's problems.

- Overtly rejects the child.

Signs of Sexual Abuse

Consider the possibility of sexual abuse when the child:

- Has difficulty walking or sitting.
- Suddenly refuses to change for gym or to participate in physical activities.
- Reports nightmares or bed wetting.
- Experiences a sudden change in appetite.
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior.
- Becomes pregnant or contracts a venereal disease, particularly if under age 14.
- Runs away.
- Reports sexual abuse by a parent or another adult caregiver.

Consider the possibility of sexual abuse when the parent or other adult caregiver:

- Is unduly protective of the child or severely limits the child's contact with other children, especially those of the opposite sex.
- Is secretive and isolated.
- Is jealous or controlling with family members.

D. Reporting[7]

Who is required by law to report child maltreatment?

All States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands have statutes identifying mandatory reporters of child maltreatment. A mandatory reporter is a person who is required by law to make a report of child maltreatment under specific circumstances. Approximately 48 States, the District of Columbia, Puerto Rico, and the territories have designated individuals, typically by professional group, who are mandated by law to report child maltreatment. Individuals typically designated as mandatory reporters have frequent contact with children. Such individuals may include:

- Social workers
- School personnel
- Health care workers
- Mental health professionals
- Childcare providers
- Medical examiners or coroners
- Law enforcement officers

Other professions frequently mandated across the States include members of the clergy, commercial film or photograph processors, substance abuse counselors, and probation or parole officers. Eleven states (California, Hawaii, Louisiana, Maine, Nevada, New York, Ohio, Oregon, Vermont, Virginia, and West Virginia) require staff and volunteers at programs that provide organized activities for children, such as camps, daycares, and youth or recreation centers to report. Seven states (Alaska, Arizona, Arkansas, Connecticut, Illinois, Maine, and South Dakota) include domestic violence workers on the list of mandated reporters.

[7] The text on reporting is adapted from Child Welfare Information Gateway. (2012). *Mandatory reporters of child abuse and neglect.* Retrieved February 4, 2013, from www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

Approximately 18 States and Puerto Rico require all citizens to report suspected abuse or neglect, regardless of profession. In all other States, territories, and the District of Columbia, any person is permitted to report. These voluntary reporters of abuse are often referred to as "permissive reporters."

To find out what your state requires, ask your local Child Protective Services (CPS) office. You can search for additional information on your state's statutes online at www.childwelfare.gov/systemwide/laws_policies/state/

If I'm a mandatory reporter of child maltreatment, when should I make a report?

The standards used to determine under what circumstances a mandatory reporter should make a report vary from state to state. Typically, a report must be made when the reporter, in his or her official capacity, suspects or has reasons to believe that a child has been abused or neglected. Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child. Permissive reporters follow the same standards when electing to make a report.

But what if I've promised confidentiality to the youth I'm working with?

Again, this depends on your state and whether or not you are a mandatory reporter. It is important to be aware of your state's statutes regarding reporting. Mandatory reporting statutes also may specify when a communication is privileged. "Privileged communications" is the statutory recognition of the right to maintain the confidentiality of communications between professionals and their clients or patients. To enable States to provide protection to maltreated children, the reporting laws in most States and territories restrict this privilege for mandated reporters.

All but 3 States and Puerto Rico currently address the issue of privilege within their reporting laws, either affirming the privilege or denying it, that is, not allowing privilege to be a reason for failing to report. The physician-patient and husband-wife privileges are most commonly denied by States. The attorney-client privilege is most commonly recognized. The clergy-penitent privilege is also widely recognized, although that privilege is usually limited to confessional communications and, in some States, is denied altogether.

The bottom line is that you have an obligation to keep the youth in your care safe. You should let youth know that you cannot keep confidential any matters that concern their safety or the safety of other residents. If you have mistakenly made a promise of confidentiality, you should break it to keep a young person safe. If you fail to report suspected abuse or neglect, you may be subject to legal penalties.

I don't want the youth or the caregiver I'm reporting of suspected child abuse to know that I made a call to Child Protective Services (CPS). Can I make an anonymous call?

Most States maintain toll-free telephone numbers for receiving reports of abuse or neglect. Reports may be made anonymously to most of these reporting numbers, but States find it helpful to their investigations to know the identity of reporters. A report made anonymously will be less effective.

Approximately 18 States, the District of Columbia, American Samoa, Guam, and the Virgin Islands currently require mandatory reporters to provide their names and contact information, either at the time of the initial oral report or as part of the written report.

All jurisdictions have provisions in statute to maintain the confidentiality of abuse and neglect records. The identity of the reporter is specifically protected from disclosure to the alleged perpetrator in 39 States, the District of Columbia, Puerto Rico, and the territories of American Samoa, Guam, and the Northern Mariana Islands. This protection is maintained even when other information from the report is being disclosed.

Release of the reporter's identity can be allowed in some jurisdictions under specific circumstances or to specific departments or officials. For example, disclosure of the reporter's identity can be ordered by the court when there is a compelling reason to disclose (in California, Mississippi, Tennessee, Texas, and Guam), or upon a finding that the reporter knowingly made a false report (in Alabama, Arkansas, Connecticut, Kentucky, Louisiana, Minnesota, South Dakota, Vermont, and Virginia). In some jurisdictions (California, Florida, Minnesota, Tennessee, Texas, Vermont, the District of Columbia, and Guam), the reporter can waive confidentiality and give consent to the release of his or her name.

E. Resources on Child Maltreatment

Highlighted Resources in English

- *Training on Recognizing Child Abuse:* www.childwelfare.gov/can/identifying/
- *Physical and Behavioral Indications of Abuse:* www.nationalcac.org/families/for_workers/abuse_indicators.html
- *Behaviors to Watch for When Adults Are Around Children:* www.stopitnow.org/behaviors_watch_adult_with_children
- *Risk Factors by Type of Abuse:* www.childwelfare.gov/can/factors/risk/

Highlighted Resources in Spanish

Los siguientes recursos y materia se encuentra en la página “En Español” en el sitio web de Child Welfare Information Gateway: www.childwelfare.gov/espanol/#one

- *Que es la negligencia y abuso de menores? (What is Child Maltreatment?):* www.childwelfare.gov/pubs/factsheets/ques.pdf
- *Terminos del bienestar de menores—Del español a ingles (Child Welfare Terms—from Spanish to English):* www.childwelfare.gov/glossary/terms_spanish_english.pdf
- *Recursos para la prevención del abuso y la negligencia de menores (Resources for the prevention of child maltreatment):* www.childwelfare.gov/espanol/prevencion_recursos.cfm
- *Como funciona el sistema de bienestar de menores? (How does the Child Welfare System Work?):* www.childwelfare.gov/pubs/factsheets/spcpswork.pdf

F. Resources on Bullying[8]

Another issue of concern for DCS care provider programs related to child maltreatment is the possibility of child-on-child abuse or bullying. The following information aims to further increase skills in preventing, identifying, and intervening when bullying occurs.

What is bullying?

Bullying is aggressive behavior that is intentional, repeated over time, and involves a real or perceived imbalance of power or strength. A child who is being bullied has a hard time defending him- or herself. Some bullying is physical: for instance, when the bully pushes or hits another person repeatedly, or interferes with the other person's movements or belongings. Some bullying is psychological; for instance, when one person repeatedly mocks another and may organize their peers against the target.

What are common characteristics of children who bully?

- Have less parental involvement or have issues at home;
- Aggressive or easily frustrated;
- Lack empathy;
- Have difficulty following rules;
- View violence in a positive way;
- Have friends who bully others.

What are signs that a child is being bullied?

The following are signs that the child <u>may</u> be experiencing bullying:

- The child suddenly appears with torn, damaged, or missing pieces of clothing, books or other belongings
- The child has unexplained bruises, cuts or scratches;
- The child suddenly loses friends or seems afraid of taking part in organized activities with peers;
- Difficulty sleeping or frequent nightmares
- The child has frequent headaches, stomachaches, or fakes illness; exhibits changes in eating habits, such as binging or skipping meals.
- The child frequently appears anxious and/or suffers from low self-esteem.
- The child exhibits self destructive behaviors like running away, harming themselves, or talking about suicide.

What are the best practices in bullying prevention and intervention?

- **Focus on the social environment of the care provider or foster care program.** To reduce bullying, it is important to change the social climate of the care provider program and the social norms regarding bullying. This requires the efforts of everyone in the care provider program—youth workers, administrators, clinicians, teachers, and the youth themselves.

- **Assess bullying at your program.** Adults are not always good at estimating the nature and prevalence of bullying in youth-serving organizations. As a result, it can be quite useful

[8] This section is adapted from Health Resources and Services Administration.(n.d.). *Stop bullying now!* Retrieved February 6, 2013, from http://www.stopbullying.gov/index.html

to administer an anonymous questionnaire or have staff ask youth about bullying in a discreet manner.

- **Obtain staff buy-in and support for bullying prevention.** Bullying prevention should not be the sole responsibility of any single person at a care provider program. To be most effective, bullying prevention efforts require buy-in from the majority of the staff. However, bullying prevention efforts should still begin even if immediate buy-in from all isn't achievable.
- **Form a group to coordinate the bullying prevention activities.** Bullying prevention efforts seem to work best if they are coordinated by a representative group with staff of different backgrounds (administrators, youth workers, clinicians, teachers, etc.).
- **Provide training for program staff in bullying prevention.** In-service training can help staff members understand the nature of bullying and its effects, how to respond if they observe bullying, and how to work with others at the care provider program to help prevent bullying.
- **Establish and enforce program rules and policies related to bullying.** Developing simple, clear rules about bullying can help ensure that youth are aware of adults' expectations that they not bully others and that they help youth who are bullied. Appropriate positive and negative consequences should be developed.
- **Increase adult supervision in "hot spots" for bullying.** Bullying tends to thrive in locations where adults are not present or are not watchful. Staff should look for creative ways to increase adult presence in locations that youth identify as hot spots.
- **Intervene consistently and appropriately when you see bullying.** Observed or suspected bullying should never be ignored by adults. All program staff should learn effective strategies to intervene on the spot to stop bullying. Staff members also should be designated to hold sensitive follow-up meetings with youth who are bullied and (separately) with youth who bully.
- **Devote some educational time to bullying prevention.** Young people can benefit if program staff set aside a regular period of time to discuss bullying and improving peer relations. These meetings can help staff keep their fingers on the pulse of young people's concerns, allow time for discussions about bullying and the harms that it can cause, and provide tools for youth to address bullying problems. Antibullying messages also can be incorporated throughout the program. Young people should learn about the role of bystanders in preventing bullying.
- **Continue these efforts.** There should be no "end date" for bullying prevention activities. Bullying prevention should be continued over time and woven into the fabric of the agency's environment.

Appendix 3

Goal 3: Responding to and Reporting Suspected Child Maltreatment

Appendix 3A

ORR/DCS Reporting Policies and Procedures

Current as of March 3, 2013.

Staff should know and follow the most recent ORR/DCS Policies and Procedures at all times. If you have any questions, contact your ORR Project Officer for guidance.

Reporting Child Abuse and Neglect

POLICY

Many UAC have histories of child abuse and neglect and may not have sufficient understanding themselves of appropriate treatment to be able to identify situations of maltreatment. As some of the UAC may not be able to recognize child abuse and neglect, the Care Provider shall have policies in place to teach children about child maltreatment and reporting.

The Care Provider **must immediately** report the allegation to the local child protective services (CPS) hotline, any local or state law enforcement agency, and as appropriate, other state agencies that operate, license, certify, or register the program in which the alleged abuse or neglect occurred.

For a list of child abuse reporting phone numbers, please go to ACF's Children's Bureau, Child Welfare Information Gateway at http://www.childwelfare.gov/responding/reporting.cfm

The Care Provider staff must immediately report the allegations to the Program Director, or the Program Director's supervisor if the Program Director is the subject of the allegations.

Reports of suspected child abuse or neglect involving anyone including Care Provider staff, or UAC shall be immediately reported to the ORR/DUCS emergency SIR hotline at any time, day or night, seven days a week. Failure to report these incidents could be grounds for termination of the grant or contract.

Acknowledgment of Reporting Responsibility

All Care provider staff are mandated reporters by virtue of their employment and shall sign statements acknowledging that they are mandated to report suspected child abuse and neglect. The statement shall be on a form provided by the employer. The statement shall be signed before beginning employment and shall be retained by the employer as a permanent part of the personnel record. The form must include the following statement: "Failure to report these incidents could be grounds for termination."

Interference with Reporting Prohibited

Care provider staff who report instances of child abuse or neglect, may also notify the person in charge or designee of the care provider that a report has been made. However, the person in charge or designee may not exercise any control, restraint, modification or other change in the report or the forwarding of such report to ORR.

Notification

Care Providers will follow state licensing standards for notifying immediate family members or confirmed sponsors of the UAC.

Written Confirmation of Reports

Within 48 hours of the oral report to CPS or state licensing, Care Provider staff shall follow-up with a written report to CPS or State Licensing.

Consequences of False Reporting

Any person who knowingly transmits a false report to ORR, CPS and/or state licensing shall be terminated.

Written Notices of CPS (State Licensing) Determinations

The Care Provider shall provide ORR a complete copy of the written CPS final determination within 24 hours. The Care Provider shall provide the FFS with timely updates of all verbal communication with CPS, State Licensing and law enforcement.

Child Abuse and Neglect Reports on UAC

When a UAC is reported as being abused or neglected while in a DUCS-funded facility, the Care Provider shall promptly notify the following persons when the report has been made, when an investigation is pending, and when the report has been indicated or unfounded:

1) Immediate family members or confirmed sponsors of the UAC, per state licensing procedures;

2) All Care Provider case managers/clinicians responsible for the UAC involved in the alleged incident;

3) Those persons designated by the Care Provider as responsible for evaluating the investigation and the disposition of the report; and,

4) Care Provider staff responsible for licensing and accepting placements with the facility.

FFS must [9]notify the FBI in writing of any allegations of abuse by Care Provider staff committed against a UAC while in ORR's care.[10]

[9] Certain professionals who work in federally operated (or contracted) facilities have an obligation to report child abuse. The US Code at 42 USC 13031 states that "a person who, while engaged in a professional capacity or activity described in subsection (b) of this section on Federal land or in a federally operated (or contracted) facility, learns of facts that give reason to suspect that a child has suffered an incident of child abuse, shall as soon as possible make a report of the suspected abuse to the agency designated under subsection (d) of this section."
[10] Refer to section 2.17.4 "Abuse of UAC While in ORR's Care."

PROCEDURES

- After making the appropriate **immediate** state and licensing notifications as stated above, the Care Provider must also **immediately** notify the ORR/DUCS Hotline at 202-401-5709.
- The Care Provider shall prepare a SIR as outlined in Section Program Management, Incident Documentation, Reporting, and Follow-Up of the ORR Policies and Procedures Manual.
- The Care Provider shall send an email notification of the SIR immediately summarizing the nature of the incident to the following parties:
    - Project Officer.
    - Federal Field Specialist.
    - Immigration attorney of record, if any.

- The Care Provider shall notify the sponsor of the SIR within 24 hours of the incident
- The FFS shall contact the local FBI agency and report any abuse committed against a UAC by a Care Provider staff.

Appendix 3B

ORR-Funded Care Provider Program or Foster Care Program Policies on Documentation and Reporting

Each ORR-funded residential care provider program is encouraged to insert its own program policies in this section.

Appendix 3C

State Licensing and Reporting Policies:

Each ORR-funded residential care provider program is encouraged to insert their state licensing and reporting policies in this section. They may be found at:

https://www.childwelfare.gov/systemwide/laws_policies/state/can/reporting.cfm

Appendix 4

Goal 4: Preventing Abuse and Neglect

Appendix 4A

CDC Recommendations for Preventing Child Sexual Abuse Within Youth-Serving Organizations[11]

What can you do to prevent child abuse?

1. Learn to differentiate between appropriate and inappropriate verbal communication and physical behavior in yourself and other staff. Alert your supervisor, in private without the presence of other co-workers, to any interactions that seem inappropriate.

   Verbal communication
   Appropriate:
   - Praise
   - Positive reinforcement for good work/behavior
   - Teaching

   Inappropriate/harmful:
   - Sexually provocative or degrading comments
   - Risqué jokes

   Physical behavior
   Appropriate:
   - Pats on the back or shoulder
   - High-fives

   Inappropriate/harmful:
   - Patting the buttocks
   - Hugging
   - Intimate/romantic/sexual contact
   - Corporal punishment
   - Showing pornography or involving youth in pornographic activities

2. Limit one-on-one interactions between staff and youth.
   - If you find yourself to be physically or sexually attracted to a youth, ensure that you avoid being alone with that young person and ask a supervisor for assistance.
   - Whenever possible have at least two adults present at all times with youth.
   - Encourage employees/volunteers to interact with the youth to maintain adequate supervision and monitoring. Even with a satisfactory ratio of employees/volunteers to youth, the youth are not being monitored if all of the employees/volunteers are immersed in their own conversations in a corner of the room.

[11] Adapted from Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2007). *Preventing child sexual abuse within youth-serving organizations: Getting started on policies and procedures* (pp. 9–15). Atlanta, GA: Author. Retrieved February 6, 2013, from http://www.cdc.gov/ViolencePrevention/pub/PreventingChildAbuse.html

3. Do not give young people your personal contact information unless instructed by a supervisor and authorized to do so. Let supervisors know when co-workers share personal contact information with children.

4. Be careful with hugging children. Hugging may be appropriate and positive in some circumstances, but it can also be inappropriate if the child is not receptive, if the employee/volunteer is hugging too often or for too long, or if the contact is romanticized or sexually intimate. When in doubt, do not hug.

5. Ensure an appropriate level of visibility in the facility. Spaces that are open and visible to multiple people make it more difficult for abusive behaviors to occur.

   Use the following methods to increase visibility:
   - Landscape to ensure open visible spaces with no possible concealment.
   - Have clear lines of sight throughout the building.
   - Secure those areas that are not used for program purposes to prevent youth from being isolated (e.g., lock closets and storerooms).
   - Install windows in doors.
   - Institute a “no closed door” policy.
   - Install bright lighting in all areas.

6. Make sure children and youth have privacy when showering, changing clothes, and toileting.

7. When you become overwhelmed, talk with your supervisor and take time out for a few moments, if possible. Taking time out will help you to regain your perspective and to make sure your response to the situation is as appropriate as possible.

Appendix 4B

Positive Behavior Management Strategies

ORR/DCS Policies on Behavior Management
(Excerpted from the DCS Policy and Procedures Manual, August 21, 2006, p. 109)

3.20 SERVICES
BEHAVIOR MANAGEMENT

Policy

Care providers shall implement a behavior management system that meets child welfare standards of best practice. Behavior management strategies shall be based on a system of privileges and should not be punitive in nature.

Procedures

Care providers shall have written policies and procedures regarding the behavior modification program used at the care provider program or foster care program. All staff shall be trained in effective behavior modification techniques. The behavior management system shall be implemented uniformly and explained to arriving UAC in a language that he or she understands. Each UAC shall receive a copy of the behavior management system in writing during intake. Behavior management shall be positive in its development, implementation and outcome. Behavior management strategies shall include staff-child interactions that are proactive in nature rather than reactive. Non-restraining procedures (such as verbal interventions, loss of privileges and time out) should always be the first methods of management.

Mechanisms shall be developed to reinforce positive behavior. Clinicians shall assist in identifying the antecedents of the UAC's negative behaviors in order to develop appropriate treatment and staff intervention plans. Those antecedents may include trauma, neglect, poor modeling or socialization, poor attachments, attention seeking and learned helplessness. Staff shall discuss with UAC ways to meet behavioral needs in a productive way and, when possible, ways to address or alter antecedents to assist in appropriate behavior.

The behavior modification program shall include rules for the program, rewards and consequences, a list of minor and major behavioral infractions and systemic feedback from staff to each child. Care providers shall have written rules that specify acts prohibited while residing at the program and consequences that may be imposed for various degrees of violation. The written rules shall be posted in a common area, reviewed at least semi-annually and updated when necessary. The rules are to be written in a way that is easily understandable by children and should be provided in the languages of the majority of UAC in care. When a literacy or language problem prevents a child from understanding the written rules, a staff member or interpreter shall assist the child in understanding them. Care providers shall ensure that the standards for rules and discipline are formulated with consideration for the range of ages and maturity and are culturally sensitive to the needs of UAC in federal custody.

The remainder of this appendix consists of handouts compiled from several sources. BRYCS extends special thanks to Deb Westveer and Laurie Tibble at Bethany Christian Services, Grand Rapids, MI, for compiling and sharing the handouts with us.

Unplugging Power Struggles[12]

I. Introduction
   A. Power struggles are emotional battles between caregivers and children over who is in control
   B. The caregiver's job is to teach, train, influence, and to guide
   C. Children are inclined toward independence.
   D. Lying at the root of every power struggle is the natural inclination of children to be under their own power and to control their own lives.

II. Why Children Need Power and Control
   A. Children have the natural tendency to want to direct their own lives—it's imbedded in their drive for self-esteem.
   B. The healthy course of action is for adults to turn power and control over to children gradually in ways that are appropriate to their developmental age.
   C. Offering choices provides them with a personal sense of power and control over themselves and their environment.
   D. Offering choices is a good way to sidestep power struggles.
   E. The drive for power and control is so strong that if they can't get it in positive ways, children will seek it in negative ways:
      1. Misbehavior
      2. Sabotage—passive/aggressive behaviors
      3. Rebellion—"You can't make me"
      4. Revenge—"get backs"
      5. Overcompliance—refusing to make any decisions on their own.

III. Sometimes You Just Have to Hold On
   A. Don't waver, remain steadfast.
   B. This option is most appropriate when child's safety is an issue or when something is absolutely non-negotiable.

IV. Choices, Negotiation, and Compromise
   A. Turn over a little control to the child—share the power.
   B. Use this option when the child is able to take on more responsibility.
   C. Allow children to know the consequences of their choices—positive and negative.
   D. Help the child think through a variety of options and consequences.
   E. Consequences must not be presented as a threat.
   F. Be sure you can live with what the child has decided.

V. Letting Go of a Power Struggle
   A. Use this option when you have no control over the outcome or when the child is capable of having the control over this issue.

[12] Adapted from Faull, J. (2000). *Unplugging power struggles: Resolving emotional battles with your kids ages 2 to 10.* Seattle, WA: Parenting Press.

B. Letting go is not giving up.

VI. Power Struggles You Will Always Lose

A. Attitude—you can't make a child have a good attitude.
B. Thinking—you can't control what the child is thinking.
C. You can't make a child eat, sleep, or poop.

VII. Intervention Strategies

A. Prevention
- Stop it before it starts.
- Start each day with no left over emotional agendas with the child, leave the resentment and anger at the door.
- State your expectation up front, expressed in positive terms, what you expect from the child and what the child can expect from you.
- Offer choices, "Would you like to carry your backpack to school or wear it on your back?" "Would you like to talk now or take some time to think about it and talk later? (teaches coping strategies).
- Catch the young person doing good, "I like the way you spoke with Randy. You had a smile on your face and you stated exactly what you needed from him." "When I was speaking on the phone, I really appreciated that you waited quietly until I was finished."
- Honor their feelings, recognize their hidden agenda, honor their values, (and be aware of your own).
- Maintain consistent routines.
- Focus on the areas where you find agreement—understand what they are saying first.

B. Early Intervention—Avoid taking the bait; know the youth and what will work best for him or her.
- Ignore the behavior.
- Give time and space.
- Redirect to another activity.
- Set a limit.
- Offer choices.
- Ask questions to understand better.

C. Diffusion Strategies—spitting out the bait once we've been hooked
- Back off for a minute—take two steps back, take a deep breath, use a noncombative stance, sit down.
- Affirm their feelings—"I understand you are upset."
- Take responsibility for your part in the struggle.
- Use humor—not sarcasm—to diffuse the tension.
- Acknowledge that you are stuck in a power struggle and this is a "lose–lose." situation—"How can we compromise?"
- Stop repeating your point, stop dwelling on the problem, stop talking altogether, "I'm going on and on here, aren't I? I need to stop. I need to listen to you more carefully. You talk now and I'll listen."

Behavior Management Techniques[13]

- **Managing the Environment**
  Where we choose to talk with a youth, whether we sit or stand and who we sit next to are all part of structuring the environment. This structuring can be used to set a warm, informal, friendly tone (such as when shooting hoops with a youth) or it can set a cold, businesslike, authoritative tone (such as in a court room setting). Staff can manage environments to make everyone feel included by paying attention to seating arrangements and making sure they include everyone in conversations.

- **Prompting**
  Prompting involves signaling to the youth to either begin a desired behavior or stop an inappropriate action. It is simple, noncritical direction given when the youth needs help in taking the next step. A prompt could be something as simple as a shaking of the head, or the word "no," or a smile and nod in response to a young person doing something that is helpful.

- **Caring Gesture**
  Like praise, showing caring can help increase a youth's self-esteem. Patting a youth on the shoulder, giving a high five, and remembering to ask about events in a youth's life are all ways of showing caring. Knowing that someone in a residence cares about him or her can help the youth cope with difficult times.

- **Hurdle Help**
  When we know a youth is not able to begin a task without some assistance, we can provide the help he needs to get over the first hurdle and on to success.

- **Redirection**
  Changing the activity may be enough to help the youth calm down and return to normal functioning. Diverting the youth's energy and attention to another activity can de-escalate the situation and help the youth regain control.

- **Proximity**
  Often the mere fact of having an adult close by will be calming for a youth.

- **Planned Ignoring and Positive Attention**
  Ignoring harmless, attention-seeking behavior withholds the reinforcement a youth gets from our attention. Along with ignoring the undesired behavior we have to praise the child for the appropriate behavior.

- **Directive Statement**
  As a youth's behavior escalates, his ability to make rational decisions decreases. Directive statements tell a youth in specific terms what is expected. For instance, "It's time to go into your room and cool off" or "back away from the table now."

- **Time Away**

[13] Adapted from the "Therapeutic Crisis Intervention" training developed by the Family Life Development program at Cornell University.

Requesting that a youth go to a quiet, neutral area when upset and overwhelmed can help the person calm down and regroup.

Managing Noncompliant Behavior

- Actively listen and problem solve.
- Remove others from the area.
- Give choices and time to decide.
- Let rules and consequences stand.
- Redirect the young person to a more attractive activity.
- Appeal to the young person's self-interest.
- Use your relationship with the young person.

Crisis Development[14]

Phase of Crisis	Adult Attitude/Response
1. Triggering Phase • Anxiety • Agitation • Change in behavior	**1. Be Supportive** • Empathic • Active listening • Nonjudgmental
2. Escalation Phase • Defensive • Aggressive • Verbal defiance • Beginning to lose reason • Challenging authority • Power struggles • Pushing "buttons" • Testing limits	**2. Be Directive** • Set limits that are clear, reasonable, and simple • Nonthreatening • State directive positively • Remind the young person of positive consequences to compliance • Offer choices • Avoid power struggles • Remain calm
3. Outburst Stage • Violent • Acting out • Total loss of reason • Dangerous to self/others • Physically aggressive	**3. Provide Safety** • Call 911—police • Notify director
4. Recovery Stage • Release of physical and emotional tension • Young person calms down • Regaining physical control • Regaining reasoning skills	**4. Life Space Interview (see below)** • Allow some time to regain control • Deep breathing to relax • Reestablish therapeutic relationship • Empathic, supportive • Active listening • Nonjudgmental

Life Space Interview

Have the conversation in a quiet place without distractions.

Allow the youth to tell his or her perspective.
- Listen actively
- Be nonjudgemental, polite, attentive, concerned
- "Tell me more?"
- "What happened next?"

Let the youth know you heard and understand what he or she has said.
- Summarize his or her point of view.
- Don't argue.

[14] Adapted from the "Therapeutic Crisis Intervention" training developed by the Family Life Development program at Cornell University.

- Don't try to convince the young person of your perspective.
- Don't get sidetracked if the young person tries to blame others, doesn't take responsibility, or minimizes the importance of the event.
- At this point your goal is to understand what the young person is saying and thinking, not convince him or her of right or wrong.
- "Kids don't care what you know until they know that you care."

Connect behaviors and feelings.
- "It seems to me that when you feel (angry, overwhelmed, disrespected, anxious, frustrated, etc.) you usually respond by (being defiant, yelling at me, swearing, pounding your fist through the wall)

Brainstorm alternative options
- What are some other things you can do when you get angry?
- Brainstorm—everything is an option.
- How do you think that will work out for you?
- Would you like to know what other kids have done in similar situations?
- Appropriate ways to manage stress/anger.
- Improve social skills.
- Teaching opportunity.
- How to problem solve.

Plan for next time
- So, when you get angry next time, what will you do?
- How can I help you?
- Write some options on a 3x5 card to review daily as a reminder

Enter back into the routine
- Review consequences of behavior (pay for broken window, do an additional chore)
- Restore relationship—"I'm sorry it turned out this way. I know you can do things differently next time." "I'm glad we could talk." I hope this was helpful for you."

Appendix 5

BRYCS Cultural Profiles

A. **Youth From Mexico and Central America: El Salvador, Guatemala, Nicaragua, and Honduras**
B. **Youth From China**
C. **Youth From India**
D. **Youth From Haiti**

BRYCS Bridging Refugee Youth & Children's Services

Appendix 5A

Youth From Mexico and Central America:

El Salvador, Guatemala, Nicaragua, and Honduras

Background

Within the DCS system, youth from Latin America tend to make up over 95% of the population. In 2012, the DCS population by country of origin was: Guatemala (35%), El Salvador (27%), Honduras (25%),Mexico (8%), Ecuador (2%), and other (2%).
The vast majority of Mexican youth apprehended in the U.S. are immediately sent back to Mexico. Mexican children in the DCS system usually have been apprehended in the interior of the U.S. by Immigration and Customs Enforcement (ICE) or identified through involvement with the juvenile justice system and then referred to ICE. Some Central American youth also come into DCS care in this manner. In some cases youth were brought to the U.S. by family when they were much younger; these children may have less affinity for their "home" culture and may speak limited Spanish. Unlike youth who recently came from their country of origin, these youth tend to be more acculturated to the U.S., present more risk factors, and their families may be less likely to come forward as sponsors.

Central American and Mexican youth in DCS care who travel unaccompanied to the United States come for a variety of reasons. Most come for economic reasons, often with the intention of sending money back to their home country to support their family. Other children come for better educational opportunities, to reunite with a parent or other family in the U.S., to escape abuse and violence in their home country, or for a combination of these reasons.

This profile will focus on the youth from El Salvador, Honduras, Guatemala, and Mexico because they make up the largest percentage of those in care. While many of these youth share a common value system and face similar challenges in their journey to the United States, it is important to learn about the diversity among them. Special considerations for Mayan language–speaking youth are shared later in this profile. Refer to the Resources section below for additional information about cultural differences in the populations and potential points of contention between youth.

Cultural Considerations

Religion: The people of El Salvador, Honduras, Nicaragua, Guatemala and Mexico are predominately Catholic, with small but growing populations of evangelical Christians. In Guatemala, an estimated 30-40% of the population is evangelical. There is sometimes tension and distrust between Catholics and evangelical Christians in Central America that could potentially surface in a DCS shelter. In each country, Catholic traditions have been combined with indigenous traditions, resulting in unique beliefs and practices. Youth may wear crosses or amulets which they believe will keep them safe.

Family and Social Roles: Central American and Mexican cultures typically place a high value on family. Family is a source of pride, strength, identity, and help. Non-related or "fictive kin" are often included as family members; for example, *primos* or cousins may or may not be related by blood. Children are usually raised to respect adult authority (particularly male) at home, at school, and in the world at large. For example, children who respect their elders are often described as being *well-educated* or *bien educado*, which is also a compliment to their parents and guardians. Whereas in the United States education is seen as coming predominately from schools, Central American and Mexican families often have a wider definition that includes purposeful instruction in the home towards respectful and appropriate social interactions.

Especially in rural areas, teenagers may take on adult responsibilities earlier than is common in the United States. Therefore, teenage residents may be accustomed to working to support their families, and some may have married and started families of their own in their countries of origin. It is important to remember that, although they may be viewed as adults in their countries, youth under 18 are of minor age under U.S. law.

Youth are often urged by their parents and guardians to go along with whatever is happening and not make a fuss as an individual; they are encouraged to be agreeable or *amable*. For this reason, some Central American and Mexican youth in DCS care may hesitate to make their needs known and may "go along with" what others are pressuring them to do, whether it be adults or other youth. This tendency may make these youth vulnerable to abuse and exploitation and may diminish the likelihood of a child reporting abuse.

Education: Central Americans and Mexicans tend to value education highly, but may not have had access to much schooling. Sometimes fees for uniforms and books or the distance to school can keep these children from attending. In some locations, public schooling ends with elementary school, and only those families who can afford private tuition can continue to send children to school. Some youth may not have completed elementary school, and some may have been working in their country of origin for many years prior to coming to the United States.

Reason for migration: Many, but not all, parents/guardians in the country of origin were involved in the decision for the youth to migrate to the United States. In order to pay for the journey and the services of a smuggler (often called a *coyote* or *pollero*), the parents/guardians must come up with thousands of dollars for the youth to be taken to the Rio Grande on the Mexican side of the U.S./Mexico border. One cost estimate is $3,000 and for longer trips, such as from Ecuador and Peru the fee can be up to $10,000. Going with a smuggler is often perceived as safer for children than sending them alone. Though many smugglers have abused, abandoned, and held children for ransom (until the family sends still more money), parents often take the gamble, hoping that such accompaniment will protect the children from predators on the journey. Many parents, guardians, and migrating youth must borrow money from family in the U.S., take out a second mortgage on their agricultural land, and/or take out a loan at a high interest in their home country to pay the smuggling fee. This creates a situation where the youth in the U.S. may feel that they must start earning money as soon as possible to pay back those who financed their travel to the U.S. Obviously, in this kind of situation they are vulnerable to exploitation of all kinds.

Youth sent to the United States with the intention of providing economic support for those left behind go with the expectation that they will first pay off the loan for the smuggling; generally, once the debt is paid they begin sending money back to support their parents, guardians, siblings, and other family members left behind. Thus, these youth often perceive themselves as adults and family providers rather than children who need to finish their formal education. They may view themselves as failures for being detained by ICE, especially when they are told by parents or guardians of how their detainment has caused the family's financial situation to become even more precarious. Even if the youth came to reunite with family members and/or receive an education and do not owe money to a smuggler, the youth may struggle with a sense of failure and have a deep fear for their family's well-being and safety.

Interactions with program staff: When youth enter the DCS care provider programs, they go through a process of adaptation and assess the safety of the setting, usually through talking with other youth who are detained. While some children may openly discuss their history of abuse or neglect, whether in their home country or on the journey to the United States, other children are hesitant to share this information until a trusting relationship is built. Instead of verbalizing past abuse, these children may give indications of abuse or neglect through extreme behavior such as being very withdrawn or acting out wildly, though it is important to note that these are not necessarily indicators of abuse or neglect.

If youth feel uncomfortable with a member of the shelter staff, they will often verbalize this discomfort through speaking with a member of the staff they trust or through using the grievance procedures at the shelter. Thus it is important that the grievance procedures and reasons for using them are clearly stated to the youth. However, some youth will not verbalize their discomfort because they do not want to challenge authority. These young people are often not assertive on their own behalf but may demonstrate drastic behavior changes. For example, a participant who is always well-behaved may become withdrawn or violent.

Medical issues: Central American and Mexican ideas about health and illness differ from those of the U.S. mainstream. Some of the youth in DCS care provider programs have never had contact with the Western medical system, including vaccinations. They may be more accustomed to meeting with traditional healers who offer them herbs, potions, and prayers for healing. Central Americans and Mexicans explain various kinds of pain and discomfort using terms which are not recognized in the United States. They may be initially suspicious of Western medicine. For this reason, all procedures, recommended medications, and other regimens should be explained with great care.

Mayan Language–Speaking Youth

The Mayan language–speaking youth who come into the DCS system have many of the same needs and strengths described above. However, because of their often limited understanding of Spanish, shelter staff could benefit from recognizing some particular needs and challenges derived from these youths' background, culture, and language differences. Though there are Mayan-language speakers in the DCS system who come from southern Mexico, the following description focuses on Guatemalan youth.

Background: In Guatemala, about half the population is of Mayan descent, and many people speak a Mayan language exclusively. There are 23 distinct Mayan languages. Mayan families have been persecuted and pushed off their lands by various governments and commercial interests throughout Guatemalan history. Some of the Mayan Guatemalans who enter the United States are literally running for their lives. Though the civil war is over, many youth may come from families where there is a strong memory ofviolence, especially in communities which are still healing as mass graves are being exhumed. Land reclamation continues so any loss of land can be very traumatic to a child. Youth may have been taught not to trust Spanish speakers. For more information about Guatemalan history and the massacres of indigenous people, see the Resources section below.

Many of the Mayan-language speaking youth in the DCS system come from the rural Western Highlands of Guatemala where the predominant languages and people groups are K'iche, Q'anjobal, Chuj, Mam, K'akchiquel, and Ixil (pronounced "Eeshil"). Most of the youth have no more than an elementary school education, with many having less than 1–2 years of school, which also served as their only formal exposure to Spanish. Some youth have had traumatizing experiences because of their lack of Spanish speaking ability. Others have learned Spanish through working construction or other jobs but may still feel more comfortable in their native language.

Most Mayan youth have family members in the U.S. but may not know the exact relation. Adults in Guatemala may have put pressure on the youth to go to the U.S. because of limited opportunities in the rural home setting. The majority of these youth have had a smuggler (coyote) bring them through part of their journey.

Cultural Considerations for Mayan Language–Speaking Youth: Many of the Mayan-language speaking youth may have experienced trauma before reaching the DCS system of care; in some cases the trauma is specific to their lack of Spanish. For example, border authorities in Mexico or the U.S. may have spoken to the youth in Spanish and thought the child was being evasive because of the lack of response or a confused response. The young person may have felt humiliated. When youth discuss past trauma, these types of experiences in their journey to the U.S. will likely surface more quickly in an assessment than experiences of abuse or trauma in their home country.

Some Mayan-language speaking youth have expressed that other Central American youth bully them, which may be due to their lack of Spanish, physical appearance, individual temperament, or the history of discrimination against indigenous peoples.

Assessing Whether a Youth Speaks a Mayan Language Better Than Spanish:

- It is often difficult to assess whether a young person speaks another language because Mayan speakers often try to blend in and not show their lack of understanding.
- Sometimes Mayan language–speaking youth will be well-behaved except when following rules that have only been explained to them verbally (e.g, youth are told not to touch certain things but the Mayan language–speaking youth touch the object repeatedly—typically not with an attitude of defiance—and show confusion when reprimanded).
- If youth answer the questions in Spanish with confusing answers or do not make eye contact, ask youth if they understand the words. For example in an assessment, ask if the youth understand concepts of *miedo* or *temor* or *violencia*.
- Ask youth if they speak another language. Remember that Mayan languages are actually distinct languages, but they are often referred to as "dialects" in Mexico and Guatemala, so even asking this question may not elicit a direct response from the youth. Nevertheless, it is more respectful to refer to these tongues as languages rather than dialects. Ask for the name of

a youth's language and what town/area they are from. Use linguistic maps as a tool (www.larutamayaonline.com/history/idiomas2.html), but be aware that locations of languages can still vary from the locations described on these maps.
- It often helps to suggest the name of a language when trying to discover which the youth speaks. For example say "Do you speak Mam? (*Habla usted Mam?*)" or point to different regions on the linguistic map until a child gives a positive response.

Tips for Working With Mayan Language–Speaking Youth

- Use body language to explain important rules when an interpreter is not available and, if possible, explain a Spanish or English word with non-verbal communication to help the youth begin to understand the other language. However, it is important to be aware that non-verbal communication varies across cultures.
- Utilize community resources and national networks to find interpreters. Interpreters are available through the Language Line, and court interpreters may be another resource.
- Use interpreters not only for assessments but also to make sure the Mayan language–speaking youth know the grievance procedures and their right to be free from harm in the shelters.
- Avoid yes/no questions when trying to solicit important information from the youth. They have been taught to comply with authority figures, and if asked *"sí o no,"* they will often answer in order to please the authority figure rather than admit their confusion about the question. Give them a chance to say that they are unsure or "I don't know."
- Ask how they are doing. These youth are often unlikely to express discomfort or concerns on their own. They may only do so if asked directly—either through an interpreter or in Spanish if they speak it adequately. Be alert to signs of isolation and keep an eye out for children being taunted by other youth in the shelter.
- When asking questions about past experiences with abuse, be careful to ask one question at a time. Youth will likely recall experiences of intimidation and/or abuse by border patrols as it is fresher than abuse they may have been fleeing in their country of origin. Furthermore, abuse experienced within the DCS system may be difficult for these youth to discuss if they fear such a disclosure will lead to confronting an authority figure.
- Keep in mind that these youth may be eligible for forms of relief from deportation such as those related to labor and/or sex trafficking and forced marriages.
- Many youth learn Spanish quickly while they are in the DCS system of care. Praise the youth for their progress as they are learning. When possible, take time to teach them key words. As you are able, ask children to teach you and other Spanish-speaking youth words from their language. This allows youth to connect their past to the present and fosters pride in their Mayan heritage.
- It is also important to educate other youth in the shelter about cultural differences and to teach tolerance in a way that indigenous youth and others are not singled out.

BRYCS thanks Servando Barrera, LIRS, Aileen Moore, LIRS, and Aryah Sommers, Florence Immigrant and Refugee Rights Project, for their work with these youth and their insights on these issues; Rebecca Trego, USCCB, for development of this profile; and Lisa Fontes, Consultant, for her research and training information on Central American immigrant families.

Further Reading

Some of the following resources are from the www.brycs.org Clearinghouse. Type a country name or "Central America" in the Search box on the BRYCS home page for additional resources.

Also see the BRYCS and BRYCS Trainer publications list in Appendix 6 for general resources on child abuse and culture.

Aguirre International. (May 2001). *No longer children: Case studies of the living and working conditions of youth who harvest America's crops.* Retrieved February 21, 2013, from www.lhc.ca.gov/lhcdir/immigrant/T4KissamMay01.pdf

Gammage, S. (July 2007). *Despite end to civil war, emigration continues*. Retrieved February 22, 2013,
, from www.migrationinformation.org/Profiles/display.cfm?ID=636

Hernandez, M. (2005). Central American families. In M. McGoldrick, J. Giordano, & N. Garcia-Preto (Eds.), *Ethnicity and family therapy* (pp.178–191). New York: Guilford Press.

Nazario, S. (2007). *Enrique's journey*. New York: Random House.

Smith, J. (2006, April). *Guatemala: Economic migrants replace political refugees.* Retrieved February 21, 2013, from www.migrationinformation.org/Profiles/display.cfm?ID=392.

Murguia, A., Peterson, R., & Zea, M.C. (2003, February). Use and implications of ethnomedical health care approaches among Central American immigrants. *Health and Social Work*. 43–51. Retrieved February 21, 2013, from http://hsw.oxfordjournals.org/content/28/1/43.short

Ethnologue: Languages of the World is a website that contains information on thousands of languages. Information on languages spoken in Guatemala can be found at www.ethnologue.com/show_country.asp?name=GT

Video Resources
The following videos may help staff members understand the situations of the young people in the residences. They should not be shown to residents because their graphic violent content may be upsetting.

Feature Films:
Enrique's Journey
Which Way Home
The Harvest (La cosecha)
Innocent Voices
Sin Nombre

BRYCS Bridging Refugee Youth & Children's Services

Appendix 5B

Youth From China

Background

Within the DCS system, Chinese children tend to make up 1–2% of the population. Most come from Fujian province and speak Fujianese; they are sent by family members in China to earn money to support the family. The vast majority of Chinese children in DCS custody have been smuggled into the U.S. by smugglers called snakeheads. The smuggling debts these children owe are staggering—currently about $74,000. Due to the size of the debt, there is enormous pressure on these children to leave DCS custody and begin working to pay off what the family owes. When they do begin working, the money they make will go to their family in China who then pay the snakeheads. In addition to paying off the smuggling debt, these youth are expected by their family to provide financial support.

Cultural Considerations

Social roles: Confucianism has informed the long history of China and is the touchstone of how children are reared. Within this belief system, social roles are rigid; highly defined; and part of a male-dominated, top down society. In this society, children are socialized to be subservient, quiet, docile, compliant, and deferential to those in positions of authority—a category which includes most adults.

Family: The Chinese children in DCS care provider programs typically come from very traditional backgrounds and the concept of family includes extended family members. Family loyalty is of utmost importance. Chinese children are expected to be obedient and subservient to their elders, particularly parents. Most often the decision for the child to come to the U.S. is made by the parents or other relatives. In many cases the child is not consulted and may only learn of the trip a day or so before they depart. Nevertheless, due to the cultural value placed on obedience and family loyalty, most Chinese children would not consider questioning the family's decision to send them to U.S. While in the DCS system, they may feel a strong need to begin earning money to support the family and pay off the smuggling debt. They may have legitimate concerns about their family's safety and well-being and feel that they are failing their family if they are unable to earn money.

Safety issues: Due to the large debt Chinese children owe, they face significant safety issues. Typically, once a child leaves a DCS care provider program, the snakehead expects the family to begin paying off the debt. Additional precautions are taken before releasing Chinese children to family members to ensure that the sponsors are genuine relatives and not snakeheads. Facilities and foster care programs also may more closely monitor phone calls and in other ways try to protect this group of children from the snakeheads who may be looking for them. Often, attorneys or DCS care provider programs will request that DHS suppress children's A#s from the DHS Immigration Information Line, to ensure that snakeheads cannot track when a child will be in court or when a child has moved to DCS foster care.

Interactions with care provider program staff: Due to Chinese children's socialization, it may be particularly difficult for them to discuss past or ongoing abuse. They have been taught to comply, conform, not question, and acquiesce when things do not go their way. Staff members in care provider programs will be seen by this group of children as authority figures who merit obedience and deference. In addition to cultural taboos against speaking with strangers about physical and sexual abuse, they are likely to hesitate to report an authority figure to another authority figure. If abused, their negative feelings may be turned inward and manifest themselves in somatic complaints: physical ailments, pains, inability to sleep.

The children's smuggling debt and desire to be released from custody to begin working complicate the situation. Children may fear that reporting abuse or maltreatment might hurt their chances for release or slow down the process. Furthermore, experiences with corrupt government figures in China may have taught them that complaints about mistreatment will be ignored.

Tips for Working With Chinese Youth

When interviewing Chinese children or completing assessments, it may help not to try to get complete information all at once. If the child has been abused or maltreated, it will take time for the story to come out. If abuse is suspected, the child may confide in friends in the program before confiding in a caseworker. Chinese caseworkers who speak Fujianese are likely to receive greater trust from the children than caseworkers from other backgrounds or caseworkers who require interpreters. Children are also sensitive to hierarchies within agencies and may be less likely to report abuse to a person they believe does not have power or is not valued within the agency.

Staff members should also remember that lack of direct eye contact may not mean a child is guilty or trying to avoid answering questions. Generally Chinese children make only limited eye contact with authority figures out of respect. They may also avoid eye contact due to shame or confusion when asked to give direct, precise answers when they have been trained to be subtle and indirect, particularly around sensitive topics.

BRYCS thanks Minh Martinez, USCCB, for her work with these youth and her insights on these issues; Margaret MacDonnell, Consultant, for development of this profile; and Roger Chow, Consultant, for his research and training information on Chinese immigrant families.

Further Reading

The following resources are from the www.brycs.org *Clearinghouse. Type "Chinese" in the Search box on the BRYCS home page for additional resources on youth from China. Also see the BRYCS and BRYCS Trainer publications list in Appendix 6 for general resources on child abuse and culture, as well as articles on serving Chinese immigrants by Roger Chow, LCSW.*

Cooper, C. R., Baker, H., Polichar, D., & Welsh, M. (1993, Winter). Values and communication of Chinese, Filipino, European, Mexican, and Vietnamese American adolescents with their families and friends. *New Directions for Child Development*. Retrieved February 21, 2013, from http://www.bridgingworlds.org/pdfs/paper4.pdf.

Futo, K. T., Hsu, E., & Hansen, D. J. (2001, Summer). Child sexual abuse in Asian American families: An examination of cultural factors that influence prevalence, identification, and treatment. *Clinical Psychology: Science and Practice*. Retrieved February 21, 2013, from http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1100&context=psychfacpub.

Zhang, S., & Chin, K.-L. (2004, August). Characteristics of Chinese human smugglers: A cross-national study. *Research in Brief*. Washington, DC: National Institute of Justice. 18 pages. Retrieved February 21, 2013, from https://www.ncjrs.gov/pdffiles1/nij/grants/200607.pdf.

BRYCS Bridging Refugee Youth & Children's Services

Appendix 5C

Youth From India

Background

Indian children make up a very small portion of those in DCS care—less than 1%. Most entering DCS custody are 16 or 17 year old boys, though some coming to join parents are younger. Those who come are mainly from poor, remote villages in Gujarat and Punjab, India. While these two groups of children are similar, there are some differences in their backgrounds. The majority of Punjabi youth come to the U.S. to reunite with family members—usually a parent or close relative. In a few cases they report coming for better educational opportunity or due to political harassment in India. Gujarati youth tend not to have close family in the U.S. and often intend to join distant relatives or family friends.

Indian children who enter the U.S. often are brought by family acquaintances, rather than through organized smuggling networks. Their family members pay for the travel, which is typically much less expensive than the smuggling fees charged to Chinese children. While the children are generally not expected to pay the smuggling fee themselves, older youth and those coming to join distant relatives or friends of the family may still want or need to work in the U.S.

Cultural Considerations

Family: Punjabi and Gujarati children entering DCS care provider programs generally come from a traditional, close-knit, patriarchal family structure which includes extended family members. Children are often seen as the property of their parents and are expected to be obedient and show respect for elders, both within their family and in the community at large. They are likely to be obedient and deferential to extended family members, including the people they are coming to the U.S. to join.

Indian children are often not consulted by adults on decisions that affect them, including the decision to come to the U.S. They may be told that they are going to the U.S. but frequently do not know who they are coming to join or what the plan for them is when they arrive. Most of these children place great trust in their family. Their obedience often stems from the belief that their parents have their best interests at heart.

Within Indian communities, there is often a strong cultural taboo against speaking about abuse, particularly sexual abuse. The Indian children in DCS care provider programs may feel the need to deny that abuse could happen in their family. Their sense of loyalty to the family as well as an unwillingness to discuss sexuality may combine to prevent these children from disclosing any history of abuse.

Interactions with care provider program staff: Indian children in DCS care are likely to see care provider program staff as authority figures who merit deference and obedience. However, familial loyalty and obedience take precedence. If these children are told by parents or other family members not to reveal information to care provider program staff, they will not. In many cases, families do instruct their children not to share information with care provider program staff. Often families have been told by their attorney or by the person who brought the child to the U.S. that the child will quickly be released from federal custody. They also may have been warned that if the child shares information it could damage their legal case.

This group of children is very likely to be reluctant or unwilling to talk to care provider program staff about any history of abuse, within or outside the family. In their home country, a small number of these children might be willing to disclose abuse to family or a friend, but most will not even do that. However, if abuse were to happen within the care provider program, it is possible that a child would disclose the abuse to a trusted caseworker or other staff member.

Tips for Working With Indian Youth

This group of children may need to hear repeatedly that staff members are there to listen to them and are willing to help. It may be helpful to explain why certain questions are being asked and that the intent of seeking information about abuse is to determine how the care provider program staff can help. Most likely, though, it will simply take time—often a lot of time—before these children will develop the trust needed to overcome their culturally conditioned reluctance to share information, particularly about sensitive topics. Many Indian youth are Hindu and therefore may have certain dietary restrictions, such as being prohibited from eating beef or perhaps all meat. Be sure to ask Indian youth about possible dietary restrictions.

BRYCS thanks DB, LIRS, for her work with these youth and her insights on these issues; Margaret MacDonnell, Consultant, for development of this profile; and Roger Chow, Consultant, for his research and training information on Indian immigrant families.

Further Reading

The following resources are from the www.brycs.org *Clearinghouse. Type "India" or "South Asia" in the Search box on the BRYCS home page for additional resources on youth from India.*

Also see the BRYCS and BRYCS Trainer publications list in Appendix 6 for general resources on child abuse and culture.

Ministry of Women and Child Development, Government of India. (2007). *Study on child abuse: India 2007.* Retrieved February 21, 2013, from http://wcd.nic.in/childabuse.pdf

Save the Children Sweden. (2007). *A toolkit on positive discipline with particular emphasis on South and Central Asia.* Retrieved February 21, 2013, from Child Rights Information Network: www.crin.org/docs/Toolkit%20on%20Positive%20Discipline%20final.pdf

BRYCS
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Appendix 5D

Youth From Haiti

Background

Haiti is a small Caribbean country, about 700 miles southeast of Florida. It shares the island of Hispaniola with the Dominican Republic. Most Haitians are descendents of African slaves and have lived in dire poverty for hundreds of years. Today, Haiti is the poorest country in the Americas, and much of its population suffers from political violence, malnourishment, and underemployment and lacks the most basic resources, including clean water, medical care, and safe shelter. In 2010, Haiti suffered a devastating earthquake which left many people in desperate condition.

Haitian youth make up less than 1% of the children in DCS care. Aside from the rare situations of Haitians who first travel to Mexico and then enter the U.S. by land, Haitians who migrate to the United States typically journey by boat. Under the Cuban/Haitian entrant program, Haitians who arrive by boat must touch land in order to avoid immediate repatriation. Smugglers currently charge about $2,000 to bring a Haitian youth to the United States—an enormous sum in a country in which 78% of people live on less than $2 a day (The World Bank 2007). Many Haitian youth in DCS care arrive at the shelters in poor physical health due to being severely sun burnt and having had limited or no food and clean water on their journey to the United States.

Haitian youth in DCS care have immigrated to the United States for a myriad of reasons, including one or more of the following: to earn money and provide for family left in Haiti; the desire to reunite with family members in the United States; and to escape political violence, crime, excruciating poverty, and/or lack of educational opportunities.

Cultural Considerations

Language: Most Haitians speak Haitian Creole (or Kreol) at home and with their friends. Some school instruction occurs in French. The young Haitains in DCS custody are unlikely to speak French, although they may understand a bit more than they can speak.

Religion: Most Haitians are Roman Catholic, although Protestant religions have been growing in Haiti. Much of the population combines their Catholicism with the practice of voodoo or vodou, which has African roots and which requires regular rituals and prayers by its adherents. Many Haitians wear religious medallions or amulets and believe these will keep them safe.

Family: In Haiti, families typically feel a strong obligation to take care of each other, even across generational lines. Extended family members often take responsibility for raising children. It is not uncommon, therefore, for families to send a youngster to live with a relative in the U.S. to gain better access to opportunities. Alternatively, sometimes parents will leave their children in Haiti to be cared for by extended family members while they pursue opportunities in the United States and send money home.

Often, family members will make the decision to send a child to the United States in order to support the family. Some children have been working and giving money to their family since they were quite young, and DCS youth with this background will often have unrealistic expectations about their ability and access to work in the United States. Like youth from Central America, these youth may be struggling with the tension between their role as child and their role as family provider. In Haitian culture, close friends are often considered family and this may make it difficult to determine the relationships of DCS children.

Education: Poverty makes it difficult for Haitian families to send their children to school, where they are required to pay for textbooks, uniforms, and other supplies. Often, children are pulled out of school to work in order to help families overcome their extreme poverty. Frequently, the youth who come into DCS care have had little formal schooling and may not be able to read or write in any language.

Those youth who were formally educated in Haiti are usually accustomed to a strict, formal learning environment in which children are typically addressed by their last names, the teacher has absolute authority, and students only speak when they are called upon. Haitian youth are taught not to make eye contact with their teachers and other authority figures as a sign of respect and deference. Haitian youth in DCS care might benefit from explanations that eye contact is usually viewed as a sign of respect and honesty in American culture.

Challenges while in custody: It is often difficult for shelter staff to gather appropriate documentation for Haitian youth for reasons usually related to poverty. For example, many youth do not have birth certificates in Haiti and their parents/guardians in Haiti do not have phones. Often Haitian youth in DCS care feel tension with youth from Mexico and Central America. Shelter staff can ease tensions by talking openly about differences and similarities in the cultures and histories of their countries; encouraging cultural exchanges such as playing Haitian music in addition to Latin music can build cultural bridges.

Interactions with shelter staff and history of abuse: Haitian youth in DCS care may be unfamiliar with adult/child interactions in the United States, which they may see as more informal than Haitian adult/child interactions. If they are uncomfortable with shelter staff, it is unlikely that they would disclose their discomfort. Due to having to endure harsh conditions in Haiti, many have learned to accept treatment that would be considered child maltreatment in the United States. Many of the girls in DCS care will have experienced sexual abuse in their home country but likely will not admit it even if asked. These young women typically think that they would be seen as prostitutes and that the abuse was their fault.

Medical issues: Many Haitians believe in the power of prayer to heal the body and that certain spirits can make them sick. If given a choice, they may prefer turning to a voodoo spiritual leader rather than a Western doctor for healing. They may also believe that certain foods will upset their natural balance and make them sick.

BRYCS thanks Yasmine Malebranche, LIRS, for her work with these youth and her insights on these issues; Rebecca Trego, USCCB, for development of this profile; and Lisa Fontes, Consultant, for her research and training information on Haitian immigrant families.

Further Reading

Some of the following resources are from the www.brycs.org *Clearinghouse. Type "Haiti" in the Search box on the BRYCS home page for additional resources. Also see the BRYCS and BRYCS Trainer publications list in Appendix 6 for general resources on child abuse and culture.*

Ballenger, C. (1998). *Teaching other people's children*. New York: Teacher's College Press.

Colin, J. (2005). Haitians. In J. G. Lipson & S. L. Dibbles, *Culture and clinical care* (pp. 221–235). San Francisco: University of California–San Francisco School of Nursing Press.

Cultural Orientation Resource Center. (2004, February). *Haitians: Their history and culture.* (Refugee Fact Sheet No. 10). Retrieved January 18, 2008, from www.cal.org/co/haiti/htoc.html.

Menos, J. (2005). Haitian families. In M. McGoldrick, J. Giordano & N. García-Preto (Eds.), *Ethnicity and family therapy* (pp. 127–137). New York: Guilford Press.

World Bank. (2007, October). *Haiti country brief*. Retrieved January 18, 2008, from http://go.worldbank.org/55NM6X1VQ0.

Appendix 6
Additional Resources

A. Resources on Cultural and Ethnic Groups

- BRYCS Targeted Resources for Professionals: http://www.brycs.org/publications/index.cfm
  - Cultural and Ethnic Groups: http://www.brycs.org/publications/index.cfm#populations
  - Multilingual Resources: http://www.brycs.org/refugee-portal/index.cfm

- Center for Applied Linguistics: www.cal.org
  - Cultural Profiles (Refugees): www.cal.org/topics/ri/profiles.html
- EthnoMed.org (see culture-specific pages): www.ethnomed.org/
- National Center for Cultural Competence: www11.georgetown.edu/research/gucchd/nccc/
- Refugee Health—Immigrant Health (see Populations): http://bearspace.baylor.edu/Charles_Kemp/www/refugees.htm

B. Selected BRYCS Publications (available for free download)

- Cultural Competency in Child Welfare Practice: A Bridge Worth Building www.brycs.org/brycs_spotwinter2007.htm
- Refugee Resettlement and Child Welfare: Collaboration for Child Protection www.brycs.org/brycs_spotnov2006.htm
- Raising Children in a New Country: An Illustrated Handbook www.brycs.org/documents/RaisingChildren-Handbook.pdf
- Cultural Perspectives on Child Rearing http://www.brycs.org/aboutRefugees/parenting_interviews.cfm

C. Resources by BRYCS Staff and Trainers

Adkins, M. A., Birman, D., Sample, B., Brod, S., & Silver, M. (1999). *Cultural adjustment, mental health, and ESL.* Available at www.springinstitute.org/Files/culturaladjustmentmentalhealthandesl.pdf

Birman, D. (1999). *Mental health of refugee children: A guide for the ESL teacher.* Available at www.springinstitute.org/Files/mentalhealthrefugeechildren3.pdf

Birman, D. (2005). *Refugee children with low literacy skills or interupted education.* Available at www.springinstitute.org/Files/refugeechildrenbehavior3.pdf

Birman, D. and Morland, L. (2013). Immigrant youth. In D. Dubois & M. Karcher, *Handbook of Youth Mentoring, Second Edition.* Thousand Oaks, CA: Sage Publications, Inc.

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Appendix 7

Evaluation Forms and Instructions