The Changing Face of the Unaccompanied Alien Child: A Portrait of Foreign-Born Children in Federal Foster Care and How to Best Meet Their Needs

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EXECUTIVE SUMMARY

In June 2011, the United States Conference of Catholic Bishops/Migration and Refugee Services (USCCB/MRS) began an analysis of children placed in the Unaccompanied Alien Children (UAC) and Unaccompanied Refugee Minor (URM) foster care programs. To explore the changing face of the children coming into care, USCCB/MRS considered children referred for foster care services from the Department of Health and Human Services (DHHS)/Office of Refugee Resettlement (ORR) between October 1, 2007, and June 1, 2011. Of the 279 children referred to USCCB/MRS, the sample size for this paper included 98 children from across the study years. The goal of this paper is to inform ORR and other stakeholders about the profile of unaccompanied children entering foster care and how to better serve them and their needs. Through a greater understanding of the changing face of the UAC/URM population, all stakeholders can better shape their organizational capacity development to meet the increasingly complex needs of these children.

This paper provides an in-depth analysis of the profile of children coming into federal foster care and how that profile has changed over the years. Across all study years, male referrals dominated, accounting for 65 percent, while 35 percent of the referrals were females. However, in fiscal year 2010, the number of female referrals more than doubled compared to previous years. The average age of children arriving in the United States and being referred to foster care was 16.02 for UAC and 16.38 for URM. The majority of children coming into care migrated from Honduras, Guatemala, and El Salvador. Children from these countries also reported a high incidence of violence in their home country as a reason for migration. Other reported reasons for migrating remained constant over the study years and included escaping violence in their homes, escaping abusive situations, reuniting with family, and seeking better educational and employment opportunities. However, children also have begun presenting with more complex needs and higher incidences of trauma, mental health issues, and substance use histories. Therefore, it was not surprising to find that about 85 percent of children in the study sample reported having some type of traumatic experience prior to entering ORR custody.

Although the majority of trauma experiences occurred when children were in their home country, the number of children who experienced trauma, such as kidnapping or sexual or physical assault, during their journey to the United States increased throughout the study period. Consequently, it was not surprising to find that youth are coming into care with higher incidences of mental health and substance abuse problems. Although the specific mental health disorders remained consistent across the study years, the number of children in the sample with a diagnosed mental health disorder steadily increased, from 13 percent in fiscal year 2008 to 38 percent in fiscal year 2011. Interestingly, half the children identified with a mental health disorder at the time of referral came from Honduras; a majority of those children were male. The study also found a steady increase in reported substance use from 17 percent of the study sample in fiscal year 2008 to 33 percent in fiscal year 2011. Children reported using substances to alleviate mental health symptoms such as depression; however, none of the children received a formal diagnosis of substance abuse or dependence. Further, the study found that the average length of stay for youth in ORR-funded facilities decreased from almost eight months in fiscal year 2008 to less than six and a half months in the beginning months of fiscal year 2011.

Children reported alarming stories about witnessing violence or being victims of crime while in their home country or during their journey to the United States. The common diagnoses of post-traumatic stress disorder, depression, and adjustment disorder demonstrate that the children had difficulty processing their trauma. Further, while the incidences of children with criminal histories and gang associations coming into care varied over the study period, it appears that children were more likely to be victims of crime and gang violence than perpetrators.

Recommendations

- ***Ensure foster care referral documentation includes all pertinent case information.***

Reviews of documents provided to USCCB/MRS during the foster care referral process revealed that the quality and quantity of information collected varied greatly across ORR-funded facilities and staff. Having a sound understanding of the child's background and trauma history, along with any current behavioral, mental health, or legal immigration case considerations, is vital to ensuring a successful foster care placement.

- ***Plan for placements for children close to age 18.***

The majority of children not placed into foster care were those approaching their eighteenth birthday. When children turn 18 without immigration relief or foster care placement, they are at risk of becoming homeless, exploited, and/or deported. Child welfare standards encourage the use of concurrent permanency planning that involves identifying and working toward a child's primary permanency goal (that is, legal relief) while simultaneously identifying and working on a secondary goal (that is, alternatives to detention if legal relief is not obtained).

- ***Increase availability of legal services across UAC foster care network.***

Consistently over the four years of the study, a number of UAC were not placed in foster care because they were so close to 18 at the time of referral. The availability of legal services for all UAC would ensure they have early representation to pursue immigration relief well before they reach the age of 18, which is especially important for those with complicated cases.

- ***Develop continuum of care, including therapeutic and group home options to increase placement match.***

Developing a continuum of care—particularly creating more therapeutic and group home options—is critical in meeting the varying needs of this population and ensuring placement availability for children with high needs. A number of children were not placed due to their behavioral and/or mental health issues. Therefore, it is crucial that ORR and the states support and provide resources for higher levels of care within the URM network.

- ***Conduct further research on UAC population.***

Although trauma, mental health, and substance abuse issues are commonly addressed with children in foster care in the United States, few scholarly articles address points raised in this paper. Similarities exist among children in domestic and federally funded foster care; however, risks associated with the migration journey to the United States add multiple layers for consideration when working with UAC. In particular, further study is recommended on the outcomes of these children once they have transitioned out of ORR custody.

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I. INTRODUCTION

Unaccompanied Alien Children (UAC) are among the most vulnerable populations in the United States. With the passage of the *Homeland Security Act of 2002*, the federal Department of Health and Human Services (DHHS)/Office of Refugee Resettlement (ORR) was given the responsibility of providing protection, care, and placement of UAC.[1] The act defines UAC as "children who have no lawful immigration status in the United States; have not attained 18 years of age; have no parent or legal guardian in the United States; or no parent or legal guardian in the United States is available to provide care and physical custody."[2] Many UAC, generally from Mexico and Central American countries, are apprehended while attempting to cross the U.S.-Mexican border, while others are identified as unaccompanied undocumented children after being detained for involvement in illicit activity while residing in the United States. Based on the accounts of the children examined in this study, the most common reasons that UAC come to the United States are to seek employment or educational opportunities, reunite with family already in the United States, or escape abusive situations or violence in their home country.

ORR funds a variety of shelters and agencies to provide placement and care to UAC. The number of UAC placed in ORR care has varied over the past few years, ranging from 7,120 to 8,302 per federal fiscal year (FY) between FY 2008 and FY 2011.[3,4] Along with the variance in numbers of UAC entering ORR care over the past several years, USCCB/MRS has seen a change in the demographic profile of the UAC as it has implemented family reunification and foster care programs throughout the United States for this population. Children are presenting with increasingly complex mental health needs, more frequent exposure to violence and traumatic events, history of substance abuse, and gang and criminal involvement. In FY 2012, an unprecedented number of UAC entered ORR care compared to the previous years that were evaluated as part of this study. It is expected that this dramatic increase in UAC arriving in the United States will continue; therefore, continued advocacy around the thoughtful long-term planning for UAC must be a priority of all entities involved with caring for this population.

UAC with the potential for legal immigration relief may be referred for long-term foster care provided through a number of ORR-funded programs, one of which is through USCCB/MRS's national network of Unaccompanied Refugee Minor (URM) programs. Although in community-based foster and group homes, these UAC remain in the federal government's custody while pursuing their immigration cases. Due to changes in legislation, specifically the *Trafficking Victims Protection Reauthorization Act of 2008*, Special Immigrant Juvenile Status (SIJS) is now the most commonly pursued form of immigration relief for UAC identified as abused, neglected, or abandoned by one or both parental caregivers. Once UAC obtain immigration relief or are

[1] Within ORR, the Division of Children's Services (DCS) is responsible for the care, custody, oversight, and services for children in federal foster care.
[2] *Homeland Security Act of 2002*, Public Law 107-296, 6 U.S.C. (November 25, 2002), section 462.
[3] U.S. Department of Health and Human Services, Report to Congress on the Refugee Resettlement Program for FY08, http://www.acf.hhs.gov/sites/default/files/orr/annual_orr_report_to_congress_2008.pdf (accessed February 6, 2012).
[4] Tanzeena Shireena and Shannon McGhee, Office of Refugee Resettlement, e-mail messages to USCCB/MRS, December 30, 2011 and January 3, 2012.

issued an eligibility letter as a victim of trafficking,[5] the children can enter the URM program and transition from federal custody to state or local custody. The funding for their care changes as well, funneled from ORR to the state, with the state overseeing the administration of the URM program. Whether the child is in UAC foster care or is receiving URM-funded care, the foster care provider ensures safety, permanency, and well-being by providing assistance and care that is comparable to services offered to all foster children in the state. The URM program provides intensive case management, therapeutic services, vocational and independent living training, and assistance adjusting immigration status, while supporting and maintaining each child's ethnicity and religious and cultural heritage.

For the past thirty years, USCCB/MRS and the Lutheran Immigration and Refugee Service (LIRS) have been the only two national organizations providing placement into the national network of URM foster care programs. Since it began serving UAC through its URM network close to ten years ago, USCCB/MRS has found that children now are presenting with more complex needs; as a result, placement of children into its URM network has become increasingly challenging. USCCB/MRS conducted a study to develop a profile of children referred to both UAC foster care and URM-funded foster care to obtain a deeper understanding of their needs and to address national capacity.

II. GOALS OF ANALYSIS

In June 2011, USCCB/MRS began an analysis of UAC and URM-eligible children referred by ORR for foster care services between the beginning of federal FY 2008 and the first eight months of federal FY 2011 (October 1, 2007 to June 1, 2011) to explore the changing face of the children coming into care. The goals of this analysis were as follows:

1. Identify and examine patterns and trends among UAC- and URM-eligible children referred for long-term foster care placement.
2. Inform ORR, USCCB/MRS, the URM program network, State Refugee Coordinators, and other stakeholders about the current population of children transitioning from ORR-funded facilities to the URM program.
3. Provide greater understanding of how the changing demographics of the UAC and URM populations may increase the challenges of foster care placement.
4. Inform organizational capacity planning and development with USCCB/MRS partners to address the therapeutic and behavioral needs of these children.

III. METHODOLOGY

To develop a profile of the UAC referred for foster care, USCCB/MRS analyzed the records of UAC and URM-eligible children referred from ORR to USCCB/MRS for foster care between October 1, 2007, and June 1, 2011. Twenty-eight categories of information were collected from the children's records to develop the profile report (see Appendix). These records were retrieved from referral documents submitted to USCCB/MRS, including individual intake and assessments

[5] Child victims of human trafficking do not need immigration relief to be eligible for URM care; they only need an eligibility letter provided by ORR's Anti-Trafficking in Persons Program.

of children conducted at ORR-funded facilities. In addition, case notes entered by USCCB/MRS Children's Services staff were reviewed along with legal documents from attorneys and the Department of Homeland Security.

Sample

USCCB/MRS received 385 UAC and URM-eligible referrals for foster care from ORR between the start of FY 2008 through the first eight months of FY 2011. USCCB/MRS received approximately 50 percent of all URM-eligible referrals;[6] therefore, the sample studied represents a significant sample size. Of all the referrals received, 279 were placed into foster care or group care through the URM network of USCCB/MRS. A sequential list of children placed into foster care was developed and separated by fiscal year. Using systematic random sampling with an interval of 3, 98 children were selected as the sample population, providing a margin of error of 8 with a confidence level of 95 percent. The final sample population consisted of 65 UAC and 33 URM-eligible referrals representing 35 percent of referrals placed into the USCCB/MRS foster care network during the study period.

In addition to the profile of children placed into foster care, a separate analysis was conducted of the 106 children referred but not placed into the USCCB/MRS foster care network. To find common themes, an analysis of factors associated with nonplacement of the 106 children was conducted that used the information posted in the USCCB/MRS foster care placement database.

Limitations

Some limitations must be considered in the development of this UAC profile. In a minority (five) of records reviewed, some categories of information needed for this study were not present in the referral documents. Therefore, it was noted for these cases that there was inadequate information in the children's records to be included in data analysis.

IV. FINDINGS

Gender, Country of Origin, and Referral Type

Although males dominated the overall sample study, the number of females more than doubled in FY 2010 compared to previous years.

Across all study years, males dominated the population of children referred for foster care. Of the 98 cases selected, USCCB/MRS received referrals for 64 males, making up 65 percent of the referral population during the study period, and 34 females, accounting for 35 percent of the sample. However, in FY 2010, the number of female referrals more than doubled compared to previous years.

According to Migration Policy Institute's Amanda Levinson (2011),[7] in 2009, approximately 80 percent of unaccompanied children migrating to the United States were males between the ages of 15 and 18. Many males begin working around these ages, and they may feel obligated to help support their family, prompting their decision to migrate to the United States for

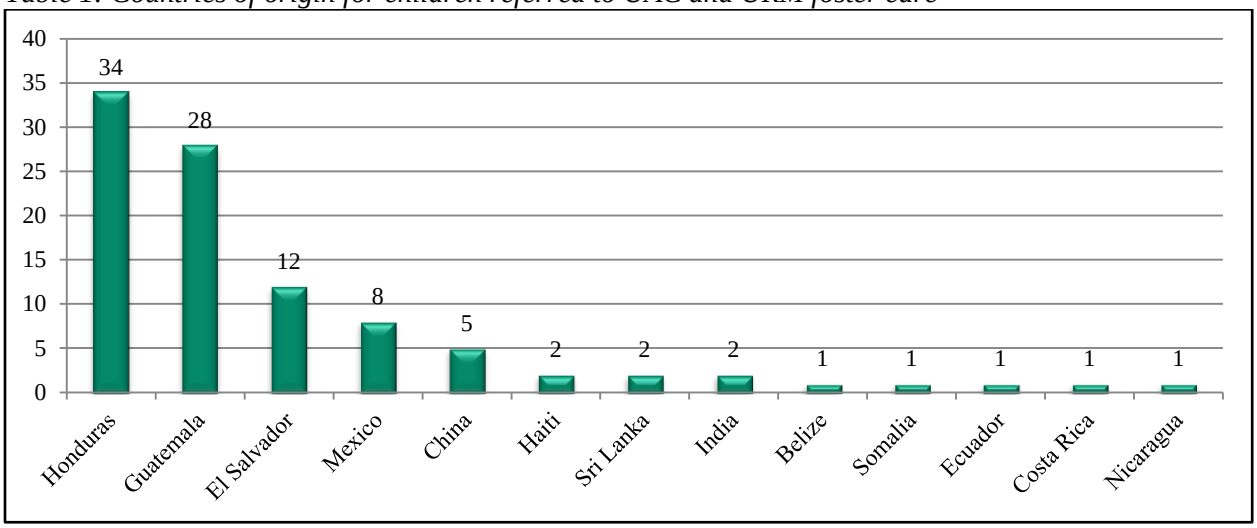
[6] LIRS received the other 50 percent of URM-eligible referrals.

[7] Amanda Levinson, "Unaccompanied Immigrant Children: A Growing Phenomenon with a Few Easy Solutions." Migration Information Source, January 2011. Migration Policy Institute, http://www.migrationinformation.org/Feature/display.cfm?ID=823 (accessed February 6, 2012).

employment opportunities. On a related note, males tend to be more independent and may take more risks than their female counterparts. They are therefore more likely than girls to migrate alone. This factor is reflected in the study sample, because a majority of foster care referrals were males.

Children from Honduras, Guatemala, and El Salvador accounted for more than 75 percent of the referrals for foster care in the USCCB/MRS study period sample. The following countries were also represented: Mexico, China, Haiti, Sri Lanka, India, Belize, Somalia, Ecuador, Costa Rica, and Nicaragua. In relation to gender and country of origin, Honduran males consistently represented the greatest number of referrals; a majority of the female referrals came from Guatemala. The Guatemala Human Rights Commission has reported a steady increase in violence against women in Central American countries, especially Guatemala.[8] It is possible that the higher rate of Guatemalan females migrating to the United States is related to the need to escape violence, rape, or torture.

Table 1: Countries of origin for children referred to UAC and URM foster care



Children referred to foster care can be referred for either UAC or URM placements. Placements funded by ORR for children who are in the custody of the federal government and have yet to obtain immigration relief represented 66 percent of referrals for long-term foster care during the study period. In contrast, children with SIJS, grantees of asylum, victims of human trafficking, and Cuban/Haitian entrants accounted for 34 percent of the URM-eligible populations. Referrals for URM placements increased during the sample study years, with the largest spike occurring during FY 2009 and FY 2010 as more children were being referred for foster care with legal relief or eligibility while in ORR shelter care. Among those in the study sample from FY 2008, URM referrals accounted for 9 percent of the referrals compared to 45 percent in FY 2010.

Analysis of the data indicates some correlation with the gender and the types of URM foster care referrals received. Children classified as SIJS and victims of human trafficking were among the

[8] Guatemala Human Rights Commission/USA, 2011, http://www.ghrc-usa.org/Programs/ForWomensRighttoLive/femicide.pdf (accessed July 14, 2011).

most common URM-eligible referrals. In the sample, most of the females referred for URM foster care were victims of trafficking, while all SIJS referrals analyzed were males.

Among the sample children, the most common country of origin of trafficking victims was Mexico, followed by Honduras and Guatemala. Several children were identified as being at risk of being trafficked in their home country, and more than half of the trafficking victims were exploited while they resided in the United States with their perpetrators. Victims who were trafficked in the United States endured forced labor in landscaping/agriculture, housekeeping/ child-care services, and narcotic sales; they most frequently were victims of sexual exploitation. According to the Department of State's Trafficking in Persons Report (2011),[9] Mexico, Honduras, and Guatemala are source, transit, and/or destination countries for persons trafficked for commercial sexual exploitation and forced labor. These countries are also significant transit countries for irregular migrants.

Length of Time in ORR-funded Facilities

The average amount of time children spent in ORR-funded facilities before transitioning to foster care reduced from 7.74 months in FY 2008 to 6.44 months in FY 2011.

Among the sample population, the amount of time children spent in ORR-funded facilities before transitioning to foster care decreased throughout the study period. The reduction in length of stay in ORR-funded facilities may indicate a more efficient referral process for children eligible for foster care or quicker adjudication of immigration relief for children while in shelter care. The average length of time children spent in ORR-funded facilities in FY 2008 was 7.74 months; the length of stay ranged from 4 to 13 months. More than half the children referred for foster care during FY 2008 remained in shelter care longer than the average length of time. During FY 2009, the average length of time children spent in ORR-funded facilities decreased to 7.25 months; the length of stay ranged from 1 to 16 months. About one-third of these children remained housed in ORR-funded facilities longer than the average length of time. In FY 2010, the average length of time was 6.81 months; the length of stay ranged from 2 to 14 months. Approximately 40 percent of the children remained in ORR-funded facilities longer than the average length of stay. Finally, within the first eight months of FY 2011, the average length of time decreased to 6.44 months; the length of stay ranged from 1 to 12 months. About 40 percent of the children remaining housed in ORR-funded facilities longer than the average length of time.

Various factors can explain the discrepancy in longer- or shorter-than-average placement stays. Longer-than-average shelter stays (11 to 16 months) were mainly seen in the following types of cases: (1) attorney and/or shelter waited for grant of asylum before referring child to foster care, (2) children with significant mental health issues or history of significant incident reports (SIRs) while in shelter care needed to "stabilize" before being referred to foster care, and (3) children were awaiting the results of home studies for possible family reunification. Shorter-than-average shelter stays were usually seen in these cases: (1) victims of human trafficking in need of protection who received eligibility letters to enter the URM program, (2) children who entered shelter care close to 18 years of age and needed to be referred quickly to obtain dependency in

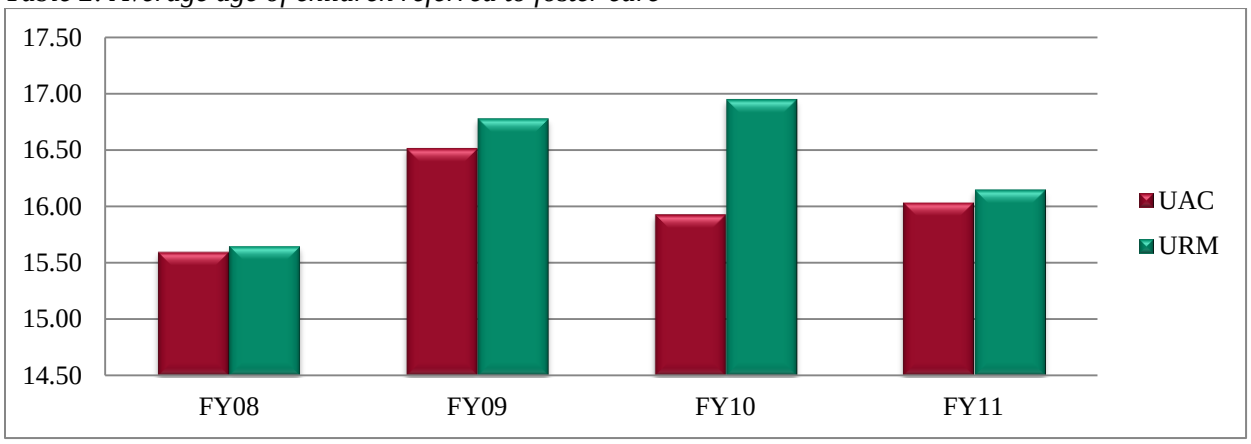
[9] U.S. Department of State, Trafficking in Persons Report, 2011, http://www.state.gov/g/tip/rls/tiprpt/2011/ index.htm (accessed January 6, 2012).

the state where foster care placement was identified, and (3) children who exhibited "exceptional" behavior while in shelter care and were ready for a lesser-restrictive placement.
Longer shelter stays have varying implications for children. When the shelter stay was longer than average because the child was waiting for a final grant of asylum or a decision on family reunification, the child was continuously in an environment away from family, either biological or foster. Further, as children establish relationships with one another while in shelter care, it can affect their mental health and well-being when other children are transitioned out quickly. Although children may understand the need to fully explore family reunification options as well as wait for resolution of legal status, the referral documents of the children in the study sample indicated that children felt more anxious, sad, and hopeless the longer they lived in the shelter. Ultimately, longer shelter stays can have a negative impact on a child's sense of safety, permanency, and well-being.

Age at Time of Referral to Long-Term Foster Care

Among the 98 cases reviewed in the sample population, children referred and placed into UAC long-term foster care were consistently similar in age (within a few months' difference) to children referred and placed into URM foster care. For FY 2008, the study sample included 20 children referred and placed into UAC foster care with an average age of 15.60 years old. Among the FY 2009 referrals, the study sample consisted of 14 UAC referrals with an average age of 16.52 years old at time of referral. Among the FY 2010 sample, the average age of the 22 UAC referrals was 15.93 years old. In FY 2011, the 9 children in the sample population of UAC referrals were an average age of 16.04 years old.

Table 2: Average age of children referred to foster care



Among the sample population for the URM referrals, the average age of the 3 children in FY 2008 was 15.65 years old. In FY 2009, the average age of the 10 children referred and placed in URM foster care was 16.78 years old. The average age of the FY 2010 sample of 13 URM-eligible referrals was 16.95 years old. In FY 2011, the average age of the 7 URM-eligible referrals was 16.15 years old.

Initial referral and placement of children who are close to age 18 is a challenge for the URM foster care programs. They are under a time crunch to assist children who are trying to obtain immigration relief and dependency while simultaneously preparing the child for possible transition into the community. Case reviews among the study sample revealed four children

placed into UAC foster care were at least 17.5 years old at the time of referral. Children in the shelter setting who age out of eligibility for URM-funded foster care may transition to adult detention until their immigration case is resolved. Those children, who are placed in UAC foster care, but age out without immigration relief, often find that there is minimal to no support for them in the wider community and limited resources to meet their special needs. Therefore, it is imperative to transition children out of shelters and into community-based foster care quickly, particularly for those who are nearing their eighteenth birthday.

Reported Reason for Migration

Between FY 2009 and FY 2010, the number of children who reported escaping violence in their home and/or abuse, abandonment, and neglect nearly doubled.

As previously mentioned, according to ORR,[10] unaccompanied children leave their country of origin for many reasons: to reunite with family members already in the United States, escape from abusive family relationships in their home country, search for work to support their families in their country of origin, or improve their education. This study found that youth across all age groups reported the above reasons for their migration to the United States.

Among those in the sample, children reported reuniting with family/friends and obtaining employment as their primary reasons for migrating to the United States. Motivation to seek employment within the United States often depended on circumstances affecting families and communities in their home country. Migration was often prompted by the death of a primary caretaker who was a biological parent or grandparent and usually their sole source of financial and emotional support. Lack of jobs, severely low wages, and threats by cartels are some of the reasons also cited by children seeking better employment opportunities in the United States. Children who lived in their home country with caretakers who were not biological parents were often expected by these caretakers to provide for themselves. Therefore, it is no surprise that many children hoping to reunite with family in the United States knew that there would be familial expectations of them gaining employment upon their arrival. Similarly, children who had experienced abandonment by a primary caretaker were often motivated to migrate for the purpose of finding work, even if they did not have any known relatives in the United States. Several children seeking employment reported relatives or friends already in the United States who planned to connect them with places to obtain work.

In addition to seeking employment and reuniting with relatives and friends, fleeing violence in their home country was another primary reason for migration to the United States and was often cited by older children in the sample population. Violence often took the form of gang and community violence as well as family abuse, including sexual abuse.

Throughout the study period, Honduran males and Guatemalan females most often reported violence as their reason for migration. By FY 2010, *more than 50 percent* of referred children in the study sample from Honduras, Guatemala, and El Salvador reported violence in their home country as influencing their migration to the United States. Honduras, Guatemala, and

[10] Office of Refugee Resettlement, Unaccompanied Children Services, 2011, http://www.acf.hhs.gov/programs/orr/programs/unaccompanied_alien_children.htm (accessed July 14, 2011).

El Salvador are now among the most violent countries in the world.[11] It is not only street gangs that cause the violence in these countries but also the expansion of the drug trade and increase in kidnappings, theft, and domestic abuse. Children from Sri Lanka also cited escaping violence related to civil wars as a reason for their migration.

Lastly, the pursuit of education was reported as another motivator for migration among children in the study sample. The children often reported that their caretakers could not afford to send them to school. Many people in Central American countries cannot afford to continue their children's education past the equivalent of the sixth grade.

Trauma History

Anecdotally, USCCB/MRS recognizes that immigrant and refugee children are at risk for traumatic events prior to, during, and after their migration to the United States. Children migrate from war-torn and economically impoverished countries and have routinely lived in sub-marginal circumstances. Many did not have access to basic utilities, such as electricity or running water. Most lived in homes far from school and frequently faced gangs and violence while on their way to or from school. Furthermore, many children reported an extensive history of physical, sexual, verbal, and emotional abuse and/or neglect by their parents or caretakers.

Sadly, one-third of the children reported witnessing acts of gang violence or deaths of people falling off trains while migrating to the United States.

We found that about 85 percent of children in the study sample reported having some type of traumatic experience prior to entering ORR custody. Although the majority of trauma experiences occurred when children were in their home country, the number of children who experienced trauma such as kidnapping or sexual or physical assault during their journey to the United States increased throughout the study period.

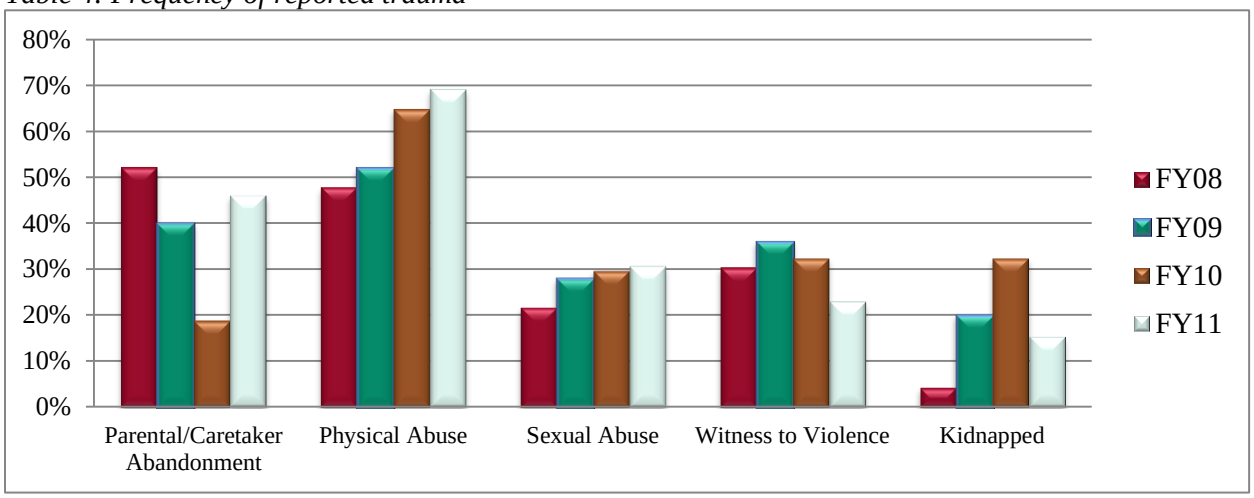
The most mentioned forms of trauma were abandonment by parents or primary caretakers and physical abuse. Across the sample study years, an average of 58 percent of the children reported being physically abused in their home country, often by biological parents and other relatives. Children identified alcohol as a contributing factor in the abusive treatment parents demonstrated toward siblings and others in the home. Abandonment by one or both biological parents in the home country was reported by an average of 34 percent of children throughout the sample study period. Children abandoned by their parents were often put into the care of a paternal or maternal relative or older sibling. More than 50 percent of the children reported abuse while in the care of their non-parental relatives. Honduran children accounted for 42 percent of the children reporting parental abandonment.

In approximately 25 percent of cases reviewed, children reported witnessing violent crimes in their home country. Gun-related crimes were the most dominant form of violence. Children reported witnessing the murders of relatives and friends, which was often gang-related. Gang

[11] Wim Savenije and Chris van der Borgh, "Gang Violence in Central America: Comparing Anti-Gang Approaches and Policies," *The Broker* (April 2, 2009), http://www.thebrokeronline.eu/Magazine/articles/Gang-violence-in-Central-America (accessed July 14, 2011).

membership is estimated to be 10,500 in El Salvador, 14,000 in Guatemala, and 36,000 in Honduras.[12] These countries reportedly have the most severe gang problems among Central American countries. Among the study sample, children from El Salvador, Guatemala, and Honduras reported witnessing most of the violent crimes. Honduran children accounted for about 50 percent of those who witnessed gun- and/or gang-related violence throughout the study period.

Table 4: Frequency of reported trauma



Sexual abuse experienced in the home country was reported among 20 percent of the sample population. Parents and relatives were frequently identified as the perpetrator by sexually abused children. Approximately 25 percent of the sexual abuse victims among the sample were Guatemalan females. As noted previously, violence against women has steadily increased in Guatemala, which likely is a major reason for their fleeing to the United States, as was the case reported by one Guatemalan victim of sexual abuse identified in the sample. In addition, at least 10 percent of children in the sample reported being sexually abused during the migration journey. Similar to their adult counterparts, children migrating to the United States are at risk of experiencing physical and sexual assault, robbery, kidnapping, and death while on the migration journey. In cases of the children sampled, the perpetrator was often a smuggler paid to guide the child to the United States.

Twenty percent of children in the sample reported being kidnapped in their home country or during the journey to the United States. The majority of the kidnappings occurred as the children traveled through Mexico in preparation to cross the U.S.-Mexican border. The children reported being attacked and held for ransom by the *coyotes* (smugglers who facilitate the migration of people across the U.S. border), the Zetas gang, or other Mexican gangs. Kidnappers would demand a ransom, which was often paid by relatives living in the United States. Children unable to pay the ransom who reported escaping from captivity were sexually exploited or forced to commit crimes (for example, smuggle/sell drugs). The number of children who reported being

[12] Congressional Research Service Report for Congress, "Gangs in Central America," updated August 2, 2007, http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA471229&LocatioU2&doc=GetTRDoc.pdf (accessed July 14, 2011).

kidnapped peaked in FY 2010, when eight children reported being kidnapped and held hostage. Several children who had been kidnapped were deemed victims of human trafficking.

Mental Health History

Unaccompanied migrating children are vulnerable populations who are at risk for emotional and mental health issues. Their history of trauma, migration journey to the United States, and possible challenges with integration into American culture can exacerbate mental health issues. Further, if they experienced poor relationships with primary caregivers in their home country or even abandonment, it is likely they will develop mental health, attachment, and/or substance abuse issues as they try to cope with their history. Using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[13] children with an Axis I and/or II diagnosis represented 22 percent of the sample referred for foster care. In the FY 2008 sample, 13 percent of children were diagnosed with an Axis I/II disorder; 20 percent of the sample in FY 2009; 24 percent in FY 2010; and 38 percent in the first eight months of FY 2011. Although the specific mental health disorders remained consistent across the study years, the numbers of children with a diagnosed mental health disorder steadily increased.

The vast majority of children reported abuse and neglect by parents and caretakers in their home country.

Children in the FY 2010 and FY 2011 samples demonstrated a higher incidence of suicidal behavior compared to previous study years.

Due to the prevalence of trauma experienced and witnessed, post-traumatic stress disorder was one of the most common diagnoses.

Of the twenty-three children who received Axis I or II diagnoses, twenty-two of them reported a significant amount of trauma (for example, sexual abuse, physical abuse, torture, and neglect). The vast majority of children reported abuse and neglect by parents and caretakers in their home country. These accounts were particularly prevalent in the trauma narrative of Honduran males. Sexual abuse was reported in almost half of females diagnosed with DSM disorders. Studies in *The Journal of the American Medical Association* (*JAMA*), along with many other studies, have successfully correlated the direct association between the exposure of violence and trauma to depression, anger, anxiety, dissociation, post-traumatic stress disorder, and other trauma symptoms.[14, 15] Of these, twelve reported experiencing trauma solely in their home country (abuse, abandonment); six reported trauma instances both in their home country and while on the journey to the United States (sexual assault, kidnapping); and four reported experiencing trauma solely on the journey to the United States (sexual assault, kidnapping, witnessing crimes). Not surprising, due to the prevalence of trauma experienced and witnessed, post-traumatic stress disorder was one of the most common diagnoses.

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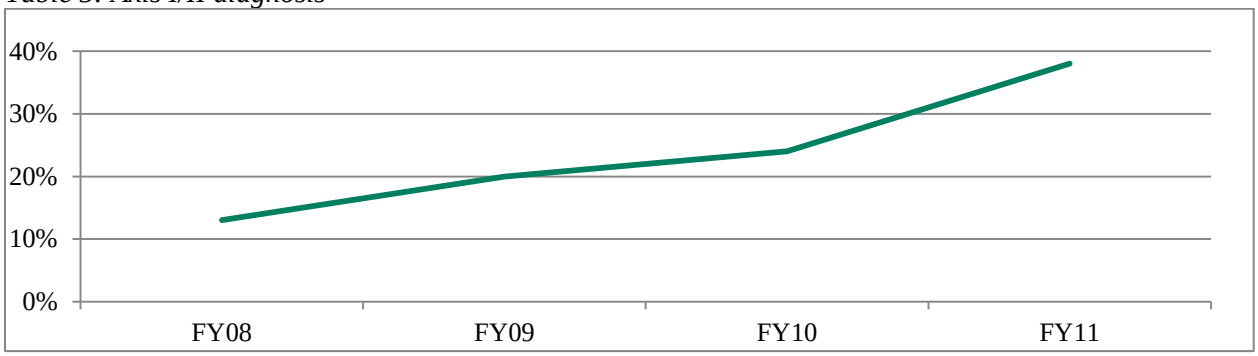
[13] The current version is the DSM-IV-TR (fourth edition, text revision). It is organized into a five-part "axis" system, with the first axis incorporating clinical disorders and the second covering personality disorders and intellectual disabilities. The remaining axes cover related medical (Axis III), psychosocial and environmental factors (Axis IV), as well as assessments of functioning for children (Axis V).

[14] M. Singer, PhD; Menden Anglin, MD, PhD; T. Song, PhD; and L. Lunghofer, PhD, "Adolescents' Exposure to Violence and Associated Symptoms of Psychological Trauma, *The Journal of the American Medical Association* 273, no. 6 (1995): 477-82.

[15] P. Guarnaccia and S. Lopez, "The Mental Health and Adjustment of Immigrant and Refugee Children," *Child and Adolescent Psychiatric Clinics of North America* 7, no. 3 (July 1998): 537-53.

Table 5: Axis I/II diagnosis



The study sample also indicated a number of children presenting mental health symptoms that did not meet the diagnostic criteria for an Axis I or II disorder. Mental health symptoms ranged from anxiety, flashbacks, self-injurious behaviors, emotional dysregulation, aggression, behavioral or emotional issues, as well as past substance abuse. Children in the FY 2010 and 2011 samples demonstrated a higher incidence of suicidal behavior compared to previous study years.

As more children come into care, there will be a need for increased mental health treatment, which subsequently will have a significant impact on the cost of caring for UAC. Currently, few group and treatment foster care options are available for children with long-term mental and behavioral health needs. The consequences of not building the capacity to meet these complex needs include future delinquent and criminal behavior as well as inpatient psychiatric treatment.

Psychotropic Medication Prescribed While in Care

About 55 percent (average across years) of children in the study sample diagnosed with a DSM-IV-TR disorder were prescribed psychotropic medications. Frequently, foster care referral documentation did not indicate the purpose of the prescribed medications. Therefore, it is not possible to conduct a complete assessment on the use of psychotropic medications among children in ORR custody. In addition, the referral documentation for a few children who received medication to aid with mood and sleep disorders did not indicate an official DSM diagnosis. This is concerning for the children who may be released to family in the United States and not receive the appropriate follow-up services after release to assess continued need for prescription psychotropic medication.

The most-often prescribed medication among the sample of children was sertraline, which is commonly used to treat symptoms of depression and post-traumatic stress disorder. The second-most prescribed medications were Seroquel and Celexa, which are routinely used to treat symptoms of schizophrenia and bipolar disorder, and depression, respectively. Several children were prescribed medication to treat symptoms of schizophrenia or bipolar disorder, although referral documents did not indicate whether they were suffering from these symptoms. Rather, they were formally diagnosed with adjustment disorder, acute stress disorder, post-traumatic stress disorder, conduct disorder, and attention deficit hyperactivity disorder. Additional commonly prescribed psychotropic medications for children included Remeron, Wellbutrin,

Trazodone, Lexapro, Klonopin, Ativan, Abilify, Zoloft, Prozac, and Intuniv.[16] It is important to note that all children released from ORR custody to community-based UAC and URM foster care who received psychotropic medication while in shelter care are evaluated to assess continued need for psychotropic medication.

Substance Use History

The percentage of children reporting the use of controlled substances increased from 17 percent in FY 2008 to 33 percent in the first eight months of FY 2011 alone.

Throughout the study period, an increased percentage of the sampled children reported having a history of substance use. During the FY 2008 referral period, 17 percent of children in the sample reported substance use. The percentage of children reporting the use of controlled substances increased to 25 percent in FY 2009, 37 percent in FY 2010, and 33 percent in FY 2011. The majority of children with a history of substance use reported that they started using controlled substances in their home country around 14 years of age; however, a few children reported that they started using substances as early as 9 years old. Children who reported tobacco or alcohol use once or alcohol consumption only during a special occasion, such as Christmas or a family party and/or while under the supervision of an adult caretaker, were not identified as having a history of substance use.

Although a majority of children with a history of substance use reported being social users, a small number of the children reported daily use. Several children who reported frequent use of controlled substances conveyed that consumption helped manage their feelings of depression and stress. Approximately 66 percent of the children diagnosed with a DSM mental health disorder and prescribed psychotropic medication had a history of substance use. Alcohol was the most common substance consumed, followed by marijuana. The use of inhalants, cigarettes, and cocaine was also reported among substance users. Interestingly, none of the children who reported daily use of controlled substances, or who used them to alleviate mental health symptoms, were diagnosed with a substance abuse disorder.

Criminal History and Gang Association

Children were more likely to claim victimization by gangs than gang membership. About 20 percent of children among the sample were identified as victims or witnesses of gang violence.

Among the sample population, 10 percent[17] were identified as having a criminal history prior to entering ORR custody. A majority was charged with drug-related offenses. After the detention of three children charged with drug offenses, it was later determined the children were victims of human trafficking. One child was arrested after the home where he was held hostage by smugglers was raided by police. He was transferred from an adult detention facility to ORR custody after authorities determined he was a juvenile.

[16] Remeron, Wellbutrin, Trazodone, Lexapro, Zoloft, and Prozac are routinely used to treat symptoms of depression. Klonopin is routinely used to treat symptoms of seizures, panic disorder, and manic symptoms of bipolar disorder. The remaining medications are prescribed to treat anxiety disorders (Ativan), schizophrenia or bipolar disorder (Abilify), and attention deficit hyperactivity disorder (Intuniv).

[17] Two in FY 2008, two in FY 2009 (one minor's referral information did not indicate if he had a prior criminal history), five in FY 2010, and one in the first eight months of FY 2011.

During the ORR shelter intake process, three Central American males reported past involvement in criminal activities in their home country. These children, who were all referred for foster care in FY 2010, reported participation in robberies and thefts. One child disclosed that police in his home country were searching for him due to his crimes. Another child reported fleeing his country to come to the United States to escape retaliation for the thefts he committed.

Regarding gang association, children were more likely to claim victimization by gangs than gang membership. During the study period, only three children disclosed membership in gangs: a 15-year-old Guatemalan male, a 13-year-old El Salvadorian female, and a 16-year-old Honduran male. About 20 percent of children among the sample were identified as victims or witnesses of gang violence. Gang victimization generally involved physical assaults by gang members. Several children reported witnessing gang members shooting and killing their family members. In addition, children reported being kidnapped and beaten by gang members for refusing to join local gangs. At least two children reported dropping out of school due to constant assaults from gang members. Although Hondurans made up the majority of those reporting gang victimization, children from Guatemala and El Salvador were also commonly identified as victims. The fear of gangs was reported by several children as the factor influencing them to migrate to the United States.

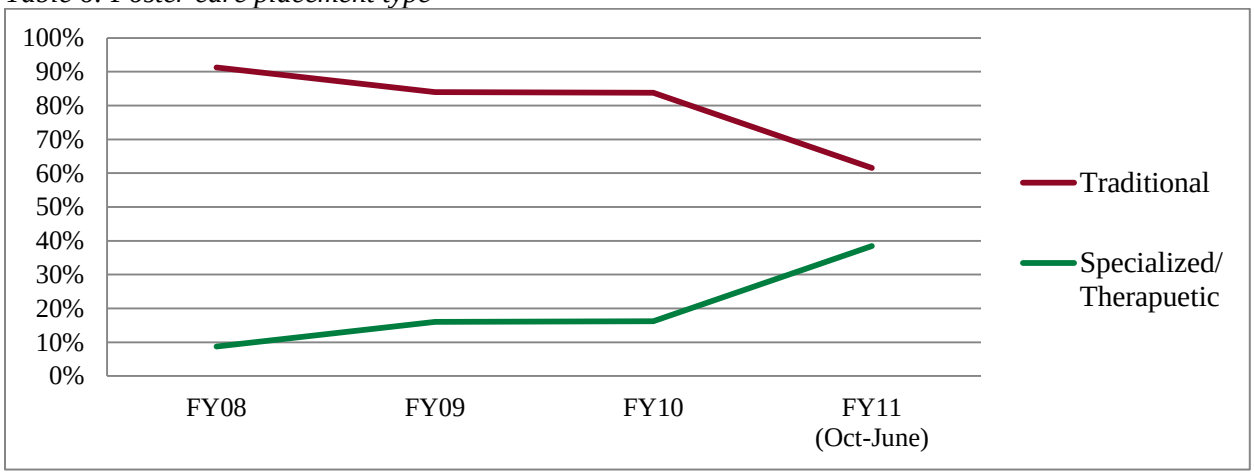
Significant Incident Reports While in Shelter Care

An SIR is a form used to formally document significant, out of the ordinary, and/or emergency incidents that involve or are disclosed by children in ORR custody. SIRs may be mental health, behavioral, or medical related and can potentially affect level of care or type of foster care placement. Approximately 20 percent of children among the study sample demonstrated emotional or behavioral issues leading to SIRs. The majority of SIRs were from the FY 2010 referral period. Physical altercations, disruptive behavior, refusal to follow directions, and suicidal ideation were the most common types of behaviors noted in SIRs. Further, SIRs for three children were documented for demonstrating sexualized behavior by displaying genitals to other children and inappropriately touching other residents and staff. About 50 percent of children whose behaviors were reported in SIRs also had a DSM-IV-TR diagnosis, and at least half of these children were prescribed psychotropic medications. With the exception of three children who were placed in a residential treatment center, a group home, and a specialized foster home, the remaining children referred for foster care who exhibited the most challenging behaviors while at ORR shelters were transitioned to traditional foster care settings.

Foster Care Placement Type

The URM network has a variety of level-of-care options available to youth in foster care. Ranging from traditional, therapeutic, group, or residential treatment, children have access to programs that will adequately meet their needs. Cases referred for foster care are reviewed at USCCB/MRS staff meetings to determine best placements based on information provided by ORR. Currently, USCCB/MRS works with twelve URM foster care programs in ten states, including Arizona, California, Florida, Michigan, Mississippi, New York, Texas, Utah, Virginia, and Washington.

Table 6: Foster care placement type



Among the study sample, the percentage of children placed in traditional foster care settings decreased during the study period. During the FY 2008 referral period, 91 percent of children were placed in traditional foster care homes compared to the first eight months of FY 2011, when traditional foster care placements were provided for 62 percent of children.

Case records reveal that the decrease in the number of referrals for traditional foster care placements is due to the increased mental health needs of children referred to foster care. Approximately 71 percent of children referred to nontraditional foster care settings during the study period were children diagnosed with DSM-IV-TR disorders. Therapeutic family placements were the most common level of care provided to children diagnosed with mental health disorders. Although residential treatment and group home placements are considered therapeutic, they were less frequently used for children with DSM-IV-TR disorders, because the preference is to place children in more traditional, homelike environments. Despite the shift to less restrictive environments, it is important to ensure families are equipped to address the children's mental health needs. Therapeutic family homes and group homes were provided for pregnant children, children who were medically fragile, victims of human trafficking, and children who demonstrated significant behavioral challenges while at ORR-funded facilities.

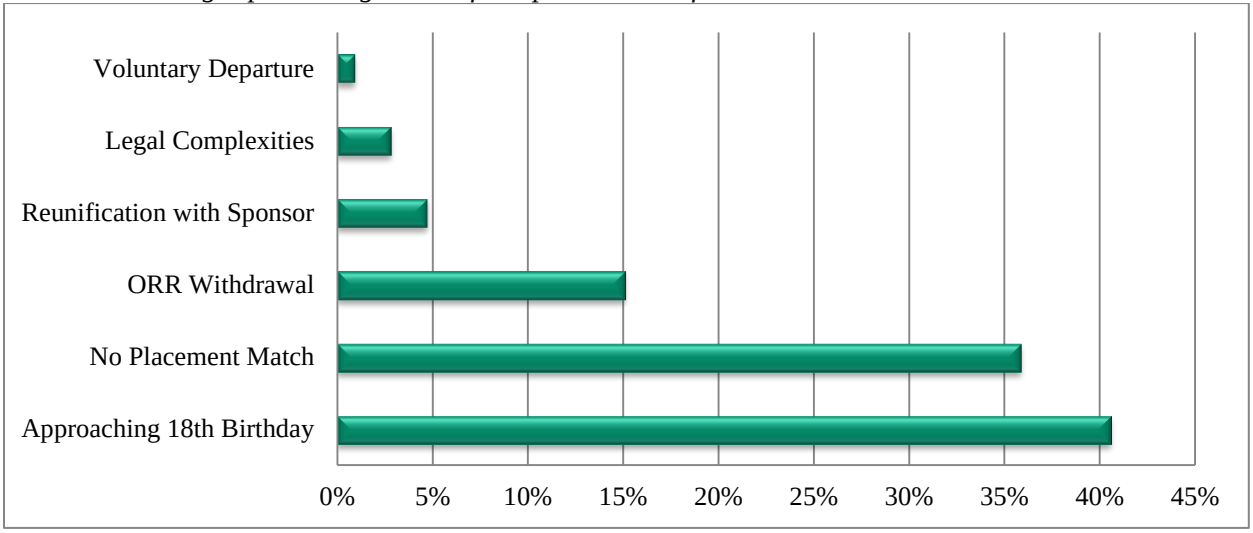
Analysis of Children Referred but Not Placed into the USCCB/MRS Foster Care Network

Over the four-year study period, USCCB/MRS received 385 referrals for both UAC and URM foster care. Of the 385 referrals, about one-quarter (106) were not placed in the foster care network. USCCB/MRS reviewed each of the 106 referrals to identify the challenges affecting the placement of children. Common challenges resulting in the non-placement of children for foster care services included children's proximity to their eighteenth birthday, mental health and behavioral needs, and no placement match to meet complex needs.

Children who would reach their eighteenth birthday a short time after being referred to foster care accounted for about 41 percent of children not placed into the URM foster care network. URM-eligible children who were not placed typically had the least amount of time to enter into foster care at time of referral—anywhere from a couple of months to only a few days before reaching their eighteenth birthday. Children with SIJS status were the most common type of URM referral that had the least amount of time to enter into foster care, with the time of referral

usually less than two weeks before they turned 18 years of age. Children referred for UAC foster care and who were not placed generally had four to five months before their eighteenth birthday at the time of referral. Legal challenges, such as identifying pro bono attorneys and length of time to establish dependency before final grant of SIJS (required for URM designation), were identified as problems for several children approaching their eighteenth birthday. In addition, the complex mental health and behavioral needs of a few children approaching age 18 further complicated program entry.

Table 7: Challenges preventing minors from placement in foster care



Throughout the course of the study period, children referred to foster care had increasingly higher mental health and behavioral needs. Addressing the needs of these children has become a greater challenge for the URM programs. No placement match, including the lack of high therapeutic placements, to meet the needs of children contributed to approximately one-third of referrals not being placed into foster care during the study period. During the FY 2008 and FY 2009 referral periods, the lack of therapeutic placements was generally related to the URM program's inability to place children with complex mental health and behavioral needs. During the FY 2010 and FY 2011 referral periods, more referrals were sought for children in need of placement in secure settings, group homes, and residential treatment, in addition to therapeutic homes within specific states. These placements were needed for children identified as flight risks, as well as children with complex mental health needs. Further, during FY 2011, several referrals were not placed due to the inability to identify placements available to accept children with sexual victimization and criminal histories. Lastly, a case review for the children not placed due to "Legal Complexities" indicated that children aged out of UAC long-term foster care and were not able to transition to URM foster care due to several preventable factors. Two youths' SIJS petitions were not approved prior to their eighteenth birthday. For a third, the local judge did not sign the dependency order in the state the youth was placed. Although it is difficult to assess the exact details as to why an SIJS petition was not adjudicated or why a judge decided not to grant dependency, they are significant examples illustrating the importance of referring youth to foster care as soon as they are determined eligible to allow sufficient time to process adjustment of legal status and/or establish county or state dependency.

In summary, the findings provide an in-depth analysis of the profiles of children coming into federally funded foster care and how these profiles changed over four years. Children are migrating to the United States due to continued violence in their home countries, to escape from abusive situations, to reunite with family members, or to seek better educational and employment opportunities. The largest number of children coming into care migrated from Honduras, Guatemala, and El Salvador. Children from these countries also reported a high incidence of violence in their home country, as compared to other countries, as a reason for migration.

The analysis showed, however, that while the reasons for migration remained consistent over the study years, children presented more complex needs and higher incidences of trauma, mental health problems, and substance use histories. Children reported alarming stories about witnessing violence or being victims of trauma while in their home country or during their journey to the United States. The common diagnoses of post-traumatic stress disorder, depression, and adjustment disorder demonstrate that the children had difficulty processing their trauma. Further, although the incidences of children with criminal histories and gang associations coming into care varied over the study period, it appears that children were much more likely to be victims of crime and gang violence than gang members themselves.

V. RECOMMENDATIONS

Over the past several years, the needs of unaccompanied children referred for foster care services have become more complex and require special attention. A review of this population and analysis of the data have led to the following recommendations:

- ***Ensure foster care referral documentation includes all pertinent case information.***

Reviews of documents provided to USCCB/MRS during the foster care referral process revealed that the quality and quantity of information collected varied greatly across ORR-funded facilities and staff. A discrepancy often existed between the level of information provided by the ORR-funded facility and the level of detail needed to initiate the foster care placement process, most often regarding a child's mental health and behavioral needs. Of particular concern is the fact that foster care referral documentation often did not indicate the purpose of the prescribed medications. Pertinent information on a child's background related, but not limited, to migration journey, trauma history, and need for psychotropic medication is necessary to place the child in an appropriate care setting in a timely manner. Having a sound understanding of the struggles a child has endured prior to and during the journey to the United States, along with any current behavioral, mental health, or legal immigration case considerations, is vital to ensuring a successful foster care placement.

- ***Plan for placements for children close to age 18.***

The majority of children not placed into foster care were those approaching their eighteenth birthday. When children turn 18 without immigration relief or foster care placement, they are at risk of becoming homeless, exploited, and/or deported. Child welfare standards encourage the use of concurrent permanency planning that involves identifying and working toward a child's primary permanency goal (that is, legal relief) while simultaneously identifying and working on

a secondary goal (that is, alternatives to detention if legal relief is not obtained).[18] The use of concurrent permanency planning is recommended for all UAC to ensure that multiple options are sought upon immediate entry into ORR-funded facilities, so that when they reach the age of 18 they have concrete options and durable solutions for their future.

Additionally, for those children with potential immigration relief, foster care programs reported difficulty placing children close to 18 because foster families want younger children or children who will live with them for many years. Foster care programs can target recruitment strategies for families who are willing to foster older children or desire to foster a youth who will live with them for only a short period of time. Another challenge for foster care programs is related to county- or state-specific time frames on establishing dependency. Length of time to establish dependency for UAC pursing SIJS varies by location, but ranges from ninety days to one year. USCCB/MRS and other partners could provide education and training to family court judges on the UAC population arriving in the United States and the trends related to their age, family history, and mental health needs.

- ***Increase availability of legal services across UAC foster care network.***

Consistently over the four years of the study, a number of UAC were not placed in foster care because they were so close to 18 at the time of referral. The availability of legal services for all UAC would ensure they have early representation to pursue immigration relief well before they reach the age of 18, which is especially important for those with complicated cases. Currently, children in ORR custody are provided an orientation explaining their legal rights and screened for potential immigration relief. However, pursuit of long-term relief depends on the strength of the child's case as well as availability of legal representation. URM foster care programs are encouraged to continuously establish and maintain relationships with law firms that offer pro bono services in their local jurisdictions and are interested in assisting this population. Further, URM foster care programs can network with local law schools to recruit law students to provide legal services under the supervision of licensed attorneys in exchange for hours toward their clinical experience.

Additionally, ORR has contracted with the VERA Institute of Justice to fund coordination of pro bono legal services for children who are detained at ORR-funded facilities and after they have been reunited with their family or referred to foster care. However, VERA-funded attorneys are primarily located only in areas that detain a high concentration of children (for example, Texas and Arizona). To ensure that all children have equal access to legal representation, funding and VERA representation should be distributed equally throughout locations where UAC are in foster care.

- ***Develop continuum of care, including therapeutic and group home options to increase placement match.***

Developing a continuum of care—particularly creating more therapeutic and group home options—is critical in meeting the varying needs of this population and ensuring placement availability for children with high needs. A number of children were not placed due to their

[18] U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway, http://www.childwelfare.gov/permanency/overview/concurrent.cfm (accessed February 6, 2012).

behavioral and/or mental health issues. Therefore, it is crucial that ORR and the states support and provide resources for higher levels of care within the URM network. Since therapeutic and group care models are inherently more expensive than traditional foster care placements, URM programs need the additional resources in place to fund and establish these placements within their own programs. Other options for creating therapeutic levels of care include foster care programs exploring the feasibility of training all foster families at a therapeutic level, resulting in the program's increased capacity to place children with more complex mental health and behavioral needs.

Further, establishing subcontracts and memorandums of understanding with psychiatrists, other mental health professionals, local residential treatment centers, group homes, therapeutic foster care agencies, and agencies in the community with experience working with children with complex needs should continuously be explored and established by the URM programs to increase their placement capacity and provide children with the ability to move within various levels of care as their mental health and behavioral needs increase or decrease. That said, this has proven to be challenging as more states de-institutionalize their group home models of care and congregate care as a non-preferred placement option. Therefore, subcontracting with existing group home providers may not always be possible. The URM programs network may consider developing its own group homes to meet the special behavioral and mental health needs we identified in this population.

- ***Conduct further research on UAC population.***

Although trauma, mental health, and substance abuse issues are commonly addressed with children in foster care in the United States, few scholarly articles address points raised in this paper. Similarities exist among children in domestic and federally funded foster care; however, risks associated with the migration journey to the United States add multiple layers for consideration in working with UAC. The analysis of the study sample found the majority of children who were diagnosed with mental health disorders and who had a history of substance use were prescribed psychotropic medications. Therefore, further study on the relationship between substance use history and psychotropic medication use among UAC in long-term foster care may help improve emotional and behavioral stability within this population. Referrals for foster care peaked in FY 2010, and the number of referrals for females doubled during the study period. It would be interesting to conduct further research to examine the trends occurring in the home countries, and in the United States, contributing to higher rates of female referrals to foster care. Initial analysis showed the majority of children have significant family-related problems. In addition to trends affecting migration, it is important to understand the capacity of countries to provide family preservation and social support services to children who may migrate alone.

Lastly, the sample showed an increased number of referrals for children who were quickly approaching their eighteenth birthday and were subsequently not placed in foster care. Further study is recommended on the outcomes of these children once they have transitioned out of ORR custody. Little information is presently available on the percentage of children who turn 18 without immigration relief: the numbers detained and removed or the numbers who opt for voluntary departure. To ensure the safety and development of children upon repatriation, it would be beneficial to determine the services of support available to them in their countries of origin. Further information and study on these issues can assist the development of programs and community resources that can address the complex needs of these children.

VI. APPENDIX

Categories of UAC Profile Research

1. Alien number
2. Name
3. Date of birth
4. Country of origin
5. Gender
6. Referral type
7. Age of U.S. arrival
8. Age at entry into shelter
9. Length of time between U.S. arrival and entry into shelter
10. Child's activities between U.S. arrival and entry into shelter
11. Reported reason for migration
12. Connection to biological parents
13. Family relationships
14. Language comprehension
15. Education status
16. Trauma history in home country
17. Trauma history experienced during journey to the United States or while in the United States
18. Chronic medical conditions
19. Significant incident reports/sexualized behavior while at shelter
20. Mental health history
21. Psychotropic medications
22. Substance use
23. Gang association
24. Criminal history
25. Religious and spiritual affiliation
26. Foster care referral history
27. Foster care program placement
28. Length of stay in ORR shelter

About USCCB/MRS

The United States Conference of Catholic Bishops/Migration and Refugee Services (USCCB/MRS) is the largest nongovernmental refugee resettlement agency in the world. In addition to its work with more than 100 local refugee resettlement programs to provide reception and integration services to approximately 20,000 refugees each year, USCCB/MRS has been collaborating with a national network of Unaccompanied Refugee Minor (URM) programs to place and serve unaccompanied foreign-born children into specialized foster care settings for more than thirty years. Refugees, victims of trafficking, Cuban/Haitian entrants, grantees of asylum, grantees of special immigrant juvenile status (SIJS), and unaccompanied alien children (UAC) in federal custody are populations eligible for long-term foster care through the URM program. USCCB/MRS also coordinates family reunification services for children who are released from federal custody.

USCCB/MRS assists its various programs through monitoring for compliance and quality assurance, national case placement coordination, technical assistance and training, program analysis, and capacity building assistance. A particular focus of USCCB/MRS is to research and write papers addressing key issues affecting the populations served through its programs. These papers include analysis of programmatic trends that can suggest or affect policy and program development and highlight practice shifts and recommendations. We focus in particular on using the information unique to USCCB/MRS—information within our programming—that benefits both an external and internal audience to achieve continual quality improvement in our work.

Learn more about USCCB/MRS at http://www.usccb.org/mrs/

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