Youth Mental Health in the Unaccompanied Refugee Minors Program

Findings from a Descriptive Study | March 2021

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Youth Mental Health in the Unaccompanied Refugee Minors Program: Findings from a Descriptive Study

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Overview

Refugee children are often exposed to numerous traumatic experiences and events (Betancourt et al., 2017; Lustig et al., 2004). While individual responses to traumatic events vary widely, sustained exposure can lead to toxic stress and the development of mental health conditions, including post-traumatic stress disorder, depression, and anxiety (Bronstein & Montgomery, 2011; Derluyn et al., 2009; Ellis et al., 2008; Lustig et al., 2004; National Scientific Council on the Developing Child, 2014; Paxton et al., 2011). Research also indicates that refugee children who are separated from their parents/caregivers are at increased risk for development of mental health conditions compared to youth who are not separated (Bean et al., 2007; Derluyn et al., 2009; Lustig et al., 2004). Despite these increased risks, refugee youth are less likely to access mental health services and more likely to have an unmet need for these services than their peers (Bean et al., 2006; Colucci et al., 2014; Lustig et al., 2004).

The Unaccompanied Refugee Minors (URM) Program serves refugees and other eligible youth within the United States who do not have a parent or relative available to care for them. Despite existing research on the mental health of refugee youth in general, there is little research documenting the mental health of youth served through the URM Program, including prevalence of mental health conditions, services provided to the youth, and challenges and successes in providing these services. This report summarizes findings related to mental health from the Descriptive Study of the URM Program. Due to data limitations, this study could not examine actual prevalence of mental health conditions (i.e., via clinical evaluation or symptom measures) nor frequency of use of mental health services. This report summarizes perspectives from program staff, foster parents, and youth on how common mental health conditions and use of mental health services are. These findings are most relevant to those involved in operating the URM Program but may also be of interest to others who serve youth who are recent immigrants or refugees and have experienced traumatic events.

Key Findings

- **URM program staff reported that URM youth have high rates of traumatic experiences and resulting mental health conditions.** Consistent with prior research about refugee youth, particularly those separated from their parents/caregivers, URM program staff perceive high rates of traumatic experiences and resulting mental health conditions among the URM youth they serve. However, URM program staff and foster parents also report that URM youth are highly resilient, adaptive, and skilled at developing coping mechanisms to process and recover from traumatic experiences.
- **URM programs provide a variety of mental health services to help support URM youth mental health.** These services include screenings, individual therapy/counseling, group counseling, psychotropic medication management, substance abuse treatment, and services for victims of torture. URM programs use external partnerships to provide some of these services.

- **URM program staff identified several barriers to mental health service provision, including stigma and lack of culturally and linguistically appropriate services.** However, URM program staff also identified a number of promising approaches for addressing these service barriers, including approaches for developing trust and support to overcome stigma associated with mental health treatment.
- **URM foster parents reported positive changes in URM youths' attitudes and behaviors after participation in mental health services.** Foster parents also described a need for more mental health providers who understand URM youth experiences, as well as challenges overcoming stigma.
- **Some URM youth described positive experiences with mental health services, while others described negative experiences.** Overall, youth described feeling emotionally supported by URM program staff, foster parents, and peers.

Methods

The report draws from qualitative data collected through site visits to six URM programs, in which the research team conducted semi-structured interviews with URM program staff and community partners, as well as focus groups with URM youth and URM foster parents. This report also incorporates findings from our analysis of administrative data and surveys of URM program directors, State Refugee Coordinators, and child welfare administrators.

1. Introduction

The Unaccompanied Refugee Minors (URM) Program serves refugees and other eligible youth within the United States who do not have a parent or relative available to care for them. Refugee children, including those served by the URM Program, have often been exposed to numerous traumatic experiences and events and need services to support their mental health (Betancourt et al., 2017; Lustig et al., 2004). While individual responses to traumatic events vary widely, research indicates that sustained exposure can lead to toxic stress and the development of mental health conditions, including post-traumatic stress disorder, depression, and anxiety (Bronstein & Montgomery, 2011; Derluyn et al., 2009; Ellis et al., 2008; Lustig et al., 2004; National Scientific Council on the Developing Child, 2014; Paxton et al., 2011). Research also indicates that refugee children who are separated from their parents/caregivers are at increased risk for development of mental health conditions compared to youth who are not separated (Bean et al., 2007; Derluyn et al., 2009; Lustig et al., 2004). Despite these increased risks, refugee youth are less likely to access mental health services and more likely to have an unmet need for these services than their peers (Bean et al., 2006; Colucci et al., 2014; Lustig et al., 2004).

There is little research documenting mental health of youth served through the URM Program, including prevalence of mental health conditions, services provided to the youth, and challenges and successes in providing these services. This report summarizes findings related to mental health from the Descriptive Study of the URM Program (see textbox below for more information on the study). The purpose of the report is to describe the mental health needs of youth in the URM Program and the services provided to support their mental health. The report begins with a summary of existing literature on the prevalence of trauma and mental health conditions and risk and protective factors for refugee youth, and specifically for URM youth when possible. The report also summarizes the literature on mental health service provision for refugee youth, including barriers to providing services and promising practices. The report then discusses study findings related to the perceived prevalence of trauma and mental health conditions, services provided to support URM youth mental health, and challenges and successes in providing these services.

In developing the approach for this report, the research team consulted with federal staff, URM program staff, academic researchers, and national refugee resettlement agencies. All pointed to mental health prevalence and services as an important area of interest in the field. In addition, URM program staff, foster parents, and URM youth identified mental health and dealing with trauma as a key, necessary component of URM program services.

> **About the Descriptive Study of the URM Program**
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> The Office of Planning, Research, and Evaluation in the Administration for Children and Families (ACF) awarded MEF Associates and its subcontractor, Child Trends, a contract to conduct a descriptive study of the URM Program to better understand the range of child welfare services and benefits provided through the URM Program. Please see our study overview for more information on the study, including the study's research questions.

1.A. About the URM Program

The URM Program is funded by the Office of Refugee Resettlement (ORR) within the Administration for Children and Families (ACF). The URM Program has served more than 13,000 minors since the federal program was founded in 1980. As of 2020, there were 22 local URM provider agencies in 15 states throughout the country; some of which operate in multiple locations in their state. Local provider agencies operate URM programs[1] and are expected to provide the same range of services to URM youth as provided to youth in the domestic foster care system in the state. URM programs provide out-of-home placements (e.g., foster care, group homes) and other child welfare services to promote youths' well-being. URM programs also include services focused on integrating the youth into their new communities while preserving the youth's ethnic and religious heritage.

1.B. Youth in the URM Program

Youth can enter the URM Program through multiple pathways. Many URM youth come from abroad, where the State Department identifies youth who are refugees who are under 18, and unaccompanied (i.e., without an adult to care for them). These youth are placed in the URM Program once they are resettled in the United States. Others are identified by ORR after arrival in the

URM youth are a diverse group	
50+	Countries of origin
100+	Ethnicities
80+	Languages spoken

United States; these youth are often first identified as unaccompanied alien children (UACs) and referred to the URM Program after an eligibility determination. Currently, eligible youth include refugees, asylees, victims of trafficking, Cuban and Haitian entrants, youth with Special Immigrant Juvenile (SIJ) classification, and youth with U-status.[2] The majority of youth currently in the URM Program are refugees. The next-largest group is youth with SIJ classification. Youth who entered the URM Program from Fiscal Year 2014 to Fiscal Year 2018 represented over 50 countries of origin, over 100 ethnicities, and spoke over 80 primary languages. In this same period, over half of youth entered the URM Program at age 17. Regardless of the age at which youth enter the URM Program, they can receive services including foster placement until they reach age 21, or the age of emancipation from the child welfare system in their state. Youth may also be eligible to receive transition to adulthood services and other education/training benefits beyond (i.e., up to age 23 or 26).

1.C. Study data sources and methods

To understand how the implementation of these services and youths' experiences differ from program to program, this study utilized three research components: (1) surveys of URM program directors,[3] State Refugee Coordinators, and child welfare administrators; (2) analysis of existing program data from ORR; and (3) site visits to six URM programs.

This report relies heavily on qualitative data collected on site visits and the surveys of URM program

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[1] Note that in this report we use "URM Program" with an uppercase "P" to denote the federally administered program. We use "URM program" with a lowercase "p" to denote local providers of services to youth in the URM Program.

[2] There were no U-status recipients in the URM Program at the time of data collection for this study.

[3] While there are only 22 URM programs across the country, two of these programs operate in two different locations in their state. For the purposes of the survey of URM program directors, these two programs were given the opportunity for each location to separately respond to the survey. In total, the research team sought 24 survey responses from URM programs; one did not respond, resulting in a final sample of 23.

directors. The six URM programs visited were selected by the research team and ACF to highlight promising practices and services available to URM youth across diverse programs. During each site visit, the research team conducted semi-structured interviews with URM program staff, community partners, and education service providers. The research team also facilitated focus groups with URM youth and URM foster parents about their experiences with the URM program. While the six sites visited by the research team are

URM programs visited by the research team

- Catholic Charities Community Services (Phoenix, AZ)
- Crittenton Services for Children and Families (Fullerton, CA)
- Lutheran Family Services Rocky Mountains (Denver, CO)
- Bethany Christian Services (Grand Rapids, MI)
- Commonwealth Catholic Charities (Richmond, VA)
- Lutheran Community Services Northwest (Seattle, WA)

not representative of all URM programs, the site visits provided perspectives on the variety of experiences and challenges URM youth and the programs that serve them face related to mental health.

2. Background literature

There is limited recent research available on the youth served through the URM Program. Even fewer studies examine the prevalence of mental health conditions, risk and protective factors, services available to support URM youth mental health, and challenges and successes in providing these services. However, there is a broader field of literature available on the mental health of URM youth resettled in other countries or on accompanied refugee youth resettled in the United States or other countries.[4,5] It is reasonable to assume that accompanied refugee youth, URM youth resettled elsewhere, and youth in the U.S. URM Program have all experienced traumatic events and may have similar experiences. However, there are also likely differences between these populations. Below we briefly summarize the literature on experiencing traumatic events, mental health prevalence, risk and protective factors, and services among refugee youth. We highlight the differences on these topics based on population, where possible.

2.A. Prevalence of trauma and mental health conditions among refugee youth

Migration and trauma exposure. There is a large body of research documenting high levels of traumatic events among refugee youth (Betancourt et al., 2017; Lustig et al., 2004). This literature typically examines the experiences of refugees in three timeframes: pre-, peri-, and post-migration. The textbox at the top of the next page provides broad definitions of each stage.[6] It is possible for

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[4] In the United States, the term URM is typically used explicitly to refer to youth enrolled in the URM Program and receiving the Program's benefits and services. Outside of the United States, where programs similar to the U.S. URM Program do not exist, the term is used more broadly, typically to refer to any youth unaccompanied by their parents who fled their home to escape violence, war, persecution, or any number of negative conditions.

[5] "Accompanied" refers to refugee youth who are not separated from their parents/guardians.

[6] These timeframes are also referred to as pre-flight, flight, and resettlement, respectively, in some literature.

youth to experience traumatic events and have substantial mental health needs as a result of experiences at all stages of migration. However, it is also possible for youth to demonstrate resilience through each of these stages, especially when provided with a safe, supportive environment to adjust and cope.

During each of these stages, youth may experience a multitude of stressors and the individual experiences of youth vary widely. Examples of stressors or traumatic events may include but are not limited to: exposure to war and combat; separation from or loss of friends and family members; witnessing or experiencing trafficking, torture, violence, rape,

> **Stages of migration**
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> - **Pre-migration:** Prior to fleeing country of origin.
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> - **Peri-migration:** Fleeing country of origin; may include transitional placements in refugee camps, temporary housing, or immigration detention facilities.
>
> - **Post-migration:** After resettlement in the United States or, if already arrived in the United States, may be once eligibility for the URM Program is determined.

or harassment; lack of reliable access to water, food, shelter, or medical care; and living in detention facilities (Bean et al., 2007; Ellis et al., 2008; Forrest-Bank et al., 2019; Lustig et al., 2004; National Child Traumatic Stress Network, 2019). A study examining refugee youth in the United States seeking psychological treatment (of which only a small number were unaccompanied) found that on average these youth were exposed to over five different types of traumatic experiences in their lifetimes, compared to over three types for other immigrant youth and U.S.-born non-refugee/non-immigrant youth (Betancourt et al., 2012; Betancourt et al., 2017). The most common traumatic events (present in at least 25 percent of the sample) included traumatic loss or separation, forced displacement, community violence, domestic violence, impaired caregiver, physical maltreatment/abuse, and emotional abuse/psychological maltreatment (Betancourt et al., 2012).

Mental health conditions. Exposure to trauma over a prolonged period can disrupt healthy youth development (National Scientific Council on the Developing Child, 2014). While individual responses vary widely, sustained exposure can lead to toxic stress and serious developmental consequences, including development of mental health conditions such as post-traumatic stress disorder (PTSD), depression, and anxiety (Bronstein & Montgomery, 2011; Carlson et al., 2012; Derluyn et al., 2009; Ellis et al., 2008; Lustig et al., 2004; National Scientific Council on the Developing Child, 2014; Paxton et al., 2011; Pieloch et al., 2016; Weine et al., 2014).

Two systematic reviews have summarized the prevalence of PTSD among refugee children and documented wide ranges across studies. Bronstein and Montgomery (2011) report rates of PTSD ranging from 19-54 percent, while Paxton et al. (2011) documented an even wider range of 3-94 percent. These variabilities are likely due to differences in study populations, measures, and timing of the study within the stages of migration.[7] A small study specifically examining URM youth resettled in the United States in the late 1990s and early 2000s, known as the "Lost Boys of Sudan," found that one year after resettlement, 20 percent had a PTSD diagnosis (Geltman et al., 2005). In a separate small study of these youth, researchers found that 12 to 18 months after resettlement, PTSD symptoms were twice as high among these youth compared to other children who had experienced a traumatic event (Bates et al., 2005).[8]

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[7] For example, a study of unaccompanied Sudanese refugee children in a Kenyan refugee camp found that 75 percent of youth had PTSD symptoms; comparatively, a different study found that 3 percent of Kosovar refugee children resettled in Denmark exhibited PTSD symptoms.
[8] However, the "Lost Boys of Sudan" may not be representative of youth enrolled in the URM Program today because they arrived as a large cohort together, and there have been other changes in the URM population (e.g., country/region of origin) (Evans et al., 2018).

Rates of symptoms of internalizing mental health conditions (e.g., withdrawal, somatic complaints, and depression/anxiety) and externalizing mental health conditions (e.g., delinquent or aggressive behaviors) also vary widely across studies of refugee youth (Levesque, 2011). Bronstein and Montgomery (2011) report that across seven studies examining internalizing and externalizing symptoms, four of these studies found that refugee youth in the study sample had collective scores above the clinical cutoffs for internalizing and externalizing symptoms.[9] Specifically examining depression, Bronstein and Montgomery (2011) report rates of 3-30 percent of refugee youth experiencing depression across studies, while Paxton et al. (2011) report a wider range of 4-47 percent. Paxton et al. (2011) also report a wide range in anxiety of 3-96 percent. As with PTSD, these variabilities are likely due to differences in study populations, measures, and timing of the study within the stages of migration.

Though not examining clinical diagnosis, a recent, small (n=30) pilot evaluation of youth who had exited the URM Program found that many of the youth had trouble sleeping and relaxing, had experienced fearfulness, or felt they had little or no control over decisions in their lives (Evans et al., 2018). A small number of these youth reported taking medication for a psychological diagnosis (Evans et al., 2018). However, on the positive side, more than three in four youth reported that they currently felt happy or very happy, nearly all reported a positive outlook for their future, and no youth reported being hospitalized for psychological reasons (Evans et al., 2018).

Long-term outcomes. Most research on refugee youth mental health uses a cross-sectional research design where studies assess youth at just one point in time. Few studies use a longitudinal design where youth are followed over time in order to assess changes in mental health outcomes (Lustig et al., 2004). There is some research that indicates that mental health conditions may develop months or years after resettlement. For example, Smid et al. (2011) found that among URM youth resettled in Norway, 16 percent of youth surveyed exhibited late onset PTSD. They exhibited no PTSD symptoms on an initial assessment but did demonstrate PTSD symptoms two years later. In a review of literature, El-Awad et al. (2017) concluded that URM youth mental health tends to improve over time, but it may take nine years or longer before these improvements are evident. Overall, there is only limited literature examining long-term mental health outcomes for refugee youth, therefore, drawing overall conclusions is not possible.

2.A.1. Risk factors

Refugee youth broadly. Among refugee youth, certain factors are associated with an increased risk of developing mental health conditions. Youth who reported a higher number of traumatic experiences pre-migration were at increased risk for adverse mental health outcomes (Bean et al., 2007; Bronstein & Montgomery, 2011). Youth who were older at the time of resettlement were also at increased risk (Bean et al., 2007; Bronstein & Montgomery, 2011).[10] Gender varies as a risk factor based on condition. Females report higher internalizing problems, including depression, and males report higher

> **Risk and protective factors—defined**
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> - **Risk factor:** Variables or characteristics that are associated with an *increased* chance of developing a mental health condition.
>
> - **Protective factor:** Variables or characteristics that are associated with a *decreased* chance of developing a mental health condition.

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[9] Internalizing and externalizing symptoms are both not reported as a percentage.
[10] Bean et al., 2007 posit that age may be associated with increased risk because older youth have more emotional challenges and greater exposure to stressful life events.

scores for externalizing problems, including conduct problems (Bronstein & Montgomery, 2011). Studies vary on whether males or females were at greater risk of PTSD (Bronstein & Montgomery, 2011).

Notably, post-migration and resettlement factors are also associated with increased risk of mental health conditions. These factors include limited skills in youths' new country's language, shorter time in the resettled country, financial difficulties, greater perceived discrimination, post-resettlement stress (such as housing, financial, or interpersonal challenges), and acculturative stress (such as stress due to school, peers, or language) (Bronstein & Montgomery, 2011; d'Abreu et al., 2019; Ellis et al., 2008).

URM youth. Among literature specifically examining URM youth, research also indicates that URM youth are at increased risk for developing mental health problems, compared to other youth who are not separated from their parents/guardians (Bean et al., 2007; Derluyn et al., 2009; Lustig et al., 2004). URM youth resettled in Europe report significantly higher depression scores, PTSD scores, and avoidance and hyperarousal symptoms than their accompanied peers (Derluyn et al., 2009). Female URM youth resettled in Europe exhibit PTSD or depressive symptoms more often than males (Mohwinkel et al., 2018).

Among URM youth in the United States, researchers found that pre-migration factors associated with an increased risk of PTSD included separation from immediate family members, direct personal injury or torture, and head trauma (Geltman et al., 2005). After resettlement, feeling lonely or isolated where they live, living in a group home or being in foster care alone with an American family,[11] and less participation in and satisfaction with group activities were also associated with increased risk of PTSD (Geltman et al., 2005).

2.A.2. Protective factors and resilience

Refugee youth broadly. Despite high rates of experiencing traumatic events and mental health problems, many refugee youth are resilient through their experiences (Carlson et al., 2012). Some mental health conditions may be less prevalent among refugee youth than other populations. For example, Betancourt et al. (2017) identified that among samples of youth in the United States who had visited a mental health practitioner for therapy or other treatment, refugee youth had lower rates of sexual behavior problems (e.g., hypersexual or compulsive sexual behaviors), oppositional defiance disorder, and substance abuse than their non-immigrant/non-refugee peers.

A number of protective factors are associated with reduced risk for adverse mental health outcomes. Among refugee youth these include a positive outlook, hope, social support, having basic needs met, attending school, feeling school is a safe place, valuing education, a sense of belonging, perceived community support, maintaining a strong connection with their culture and cultural identity, having foster caregivers or guardians of the same ethnic-origin, and religious faith (d'Abreu et al., 2019; Lustig et al., 2004; Marshall et al., 2016; Pieloch et al., 2016). Maintaining a strong connection with cultural identity can be a protective factor many years after resettlement for some refugee children (d'Abreu et al., 2019).

URM youth. Within literature focused on either URM youth living in the United States or Europe, a few additional possible protective factors have been identified. These include being younger at the time of resettlement, easy temperament, feeling a sense of belonging, having a well-functioning family prior to migration, a sense of attachment with at least one parent, having another family

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[11] It is unclear from this study whether the researchers meant that URM being "alone" referred to being in a foster home without siblings, without other youth in foster care, without other URM youth from their country of origin, or some other definition of "alone."

member living in the country in which they were resettled, and attachment to other adults or other community organizations like schools or churches (Bean et al., 2006; Bean et al., 2007; Carlson et al., 2012).

Overall, many researchers have pointed to a lack of high-quality, large-scale research focused on the strengths of URM youth and the factors that contribute to their resilience (Carlson et al. 2012, Lustig et al. 2004, Marshall et al., 2006, Pieloch et al., 2016). Much of the literature focuses instead on mental health conditions and contributing factors, without examining the protective factors that have kept many youth from developing mental health conditions.

2.B. Mental health services

2.B.1. Need for mental health services and barriers in service provision

Given high rates of traumatic events and mental health conditions in refugee and URM youth as a result of their migration experience, the need for high-quality mental health services is evident. However, refugee youth are less likely to access mental health services and more likely to have an unmet need for these services than their non-refugee peers across different countries (Bean et al., 2006; Colucci et al., 2014; Geltman et al., 2008, Lustig et al., 2004). Bean et al. (2006) found that nearly half (49 percent) of URM youth in the Netherlands surveyed stated that they needed mental health services but had not obtained them, compared to only five percent of their non-URM peers.

According to research that looks at multiple countries, refugee youth are less likely to access mental health services due to:

- Lack of linguistically or culturally appropriate providers in their community
- Lack of providers with expertise in their types of trauma and experiences
- Cost of services or challenges with insurance coverage
- Lack of understanding of what mental health services are
- Under-recognition of their own psychological distress
- Prioritization of other needs such as food and housing
- Distrust of authority figures (which a mental health therapist can be perceived as)
- Different cultural understandings or stigma of mental health conditions (Colucci et al., 2015; Colucci et al., 2014; Ellis et al., 2011; Lustig et al., 2004; Marshall et al., 2016)

In addition to these individual barriers to service provisions, some research finds that identification of need for services may also be a barrier, including culturally appropriate assessments and identification by other adults. Specifically, providers in the United States working with refugee children and families have reported that assessment tools available for identifying signs and symptoms of mental health conditions often lack interpretations and adaptations for this population (Forrest-Bank et al., 2019). These providers report feeling that the assessment tools they have are of little benefit, because they are not culturally appropriate and ask questions in a way that creates shame or a desire to give the 'right' answer (Forrest-Bank et al., 2019). However, one study also found that a lack of recognition of the need for services by guardians or teachers could also contribute to refugee youth underutilizing mental health services (Bean et al., 2006). Among URM youth resettled in the Netherlands who self-reported that they felt they needed mental health care, only about three in ten of these youth were also identified by their teachers or guardians as needing mental health supports (Bean et al., 2006).

2.B.2. Promising approaches in service provision

Several qualitative studies and systematic literature reviews have examined strategies for addressing barriers to service provision for refugee youth. These approaches can be roughly grouped into two main areas: 1) approaches focused on the individual and family or 2) approaches focused on systems.

Individual- and family-focused approaches. There are several recommendations from the literature on how providers can broadly strengthen mental health approaches with individual youth. First, using a strengths-based approach focused on building youth resiliency and self-efficacy is believed to improve the quality of mental health services for refugee youth (Forrest-Bank et al., 2019; Hettich et al., 2020; Marshall et al., 2016). Building trust and a relationship between the youth and provider is reported to help youth overcome the stigma around mental health conditions and services, particularly if it promotes the feeling that youth have a safe space to talk about their lives (Forrest-Bank et al., 2019; Hettich et al., 2020; Marshall et al., 2016). Part of building trust may include inviting family members or other important community members to participate in counseling sessions or programs (Ellis et al., 2011; Marshall et al., 2016). In addition to building on family connections, another promising approach identified in the literature is to focus on bolstering youth's connectedness to other social networks (e.g., with peers) (Hettich et al., 2020). However, with all approaches, there must be attention placed on cultural competency with respect and awareness of cultural norms and strengths, and attention to trauma-informed approaches to ensure a supportive post-migration environment that minimizes re-traumatization (Forrest-Bank et al., 2019; Hettich et al., 2020; Marshall et al., 2016). Marshall et al. (2016) also recommends considering new and innovative online or mobile approaches to engage youth in mental health services. Given that mobile approaches are often more anonymous, this may be particularly helpful if youth have a history of mistrust in government services or authorities.

Forrest-Bank et al. (2019) also found that providers in the United States working with refugee children and families felt that certain therapeutic interventions may be helpful, such as Cognitive Behavioral Therapy, Play Therapy, and Eye Movement Desensitization and Reprocessing Therapy. However, the providers interviewed by Forrest-Bank et al. (2019) also noted that these interventions may not be culturally relevant and that more research is needed to assess whether cultural adaptations are necessary for the therapeutic intervention to be effective. Additional research examining the effects of trauma-focused therapeutic treatments (e.g., Narrative Exposure Therapy, Community Implemented Trauma Therapy, and Culturally Modified Trauma-Focused Cognitive Behavioral Therapy) found promise for reducing PTSD, depression, anxiety, suicidal ideation, and feelings of guilt, and increasing functioning and prosocial behavior among refugee youth (von Werthern et al., 2019).

Systemic approaches. At the organization or system level, there are a few promising approaches identified in the literature for overcoming barriers to receiving mental health services. The first approach is to embed mental health services within existing service systems that refugees are already familiar with and trust, such as schools (Ellis et al., 2011). Another approach is to form partnerships between mental health service providers and cultural experts to ensure that services are appropriate (Ellis et al., 2011; Forrest-Bank et al., 2019). This could include forming a stable working alliance with interpreters and having them serve also as cultural translators (Hettich et al., 2020).

3. Original study findings related to URM mental health

Within the current study, the research team included questions during its information collection related to mental health concerns and treatment. As described above, the team conducted site visits to six URM programs where the team interviewed URM program staff and partners and conducted focus groups with URM foster parents and URM youth. Key themes regarding mental health from these interviews and focus groups fall within four primary areas: perceptions of URM mental health; services provided to youth; challenges to providing services; and successes in providing these services, including strategies to overcome challenges. When possible, we integrated data from the study surveys and analysis of existing ORR data. Given the nature of the study's data, we were not able to examine youth mental health outcomes. Rather, this report adds to the literature by providing in-depth qualitative data and narrative descriptions of *perceptions* of mental health.

3.A. Perceptions of URM mental health

URM program staff described URM youth as highly resilient and said that the youth typically adjust and cope after multiple traumatic experiences in their lives. However, URM program staff reported that dealing with past trauma is a major challenge for URM youth, which sometimes results in mental health conditions such as adjustment disorder, PTSD, and depression. Foster parents also described the way this trauma manifests in the home through youth behaviors. URM youth provided insight on the stressors they experienced prior to the program and the challenges to adjusting after entering the program, which affects their mental health.

While some of the information collected from URM program staff, foster parents, and youth was explicitly related to mental health conditions, other information was broader and focused on emotional well-being, adjustment to the United States, and stressors that impact daily life. When possible, this section provides details explicitly on mental health conditions, but this section also provides broader information that is contextually relevant.

3.A.1. URM program staff perceptions

Across interviews and surveys, URM program staff emphasized youth resiliency. Youth were described as adaptive, hardworking, quick learners, family/community-minded, goal-oriented, and big-hearted. Program staff emphasized that youth are skilled at building community and developing connections with other people, focusing on goals, advocating for themselves, and developing mechanisms to cope with the trauma they have experienced. As one URM program staff described, "Their biggest strength is just their resiliency. They made it here and have overcome so much already. They know so much and have so many skills."

However, URM program staff also reported that prior traumatic experiences are common. Staff noted that most youth have experienced some type of significant traumatic event in their lives, such as torture, rape, harassment, or witnessing people they were close to be killed. Program staff noted that traumatic experiences, and how recently those experiences occurred, vary based on population characteristics, such as country of origin or eligibility status. On the survey of URM program directors, respondents were asked to rate on a scale of 1 to 5 (1=not a challenge, 5=serious challenge) how serious of a challenge certain factors are for URM youth. Of these challenges, program directors rated dealing with past trauma as a 4 or 5 more frequently than other challenges such as financial resources, English language acquisition, and access to employment opportunities. As shown below in Figure 1, over half of program directors rated past trauma as a serious challenge for URM youth.

Figure 1. Program staff perceptions of how serious a challenge past trauma is for URM youth

Dealing with past trauma	3	6	14

■ 1 to 2: Not a challenge   ▨ 3   ■ 4 or 5: Serious challenge

Data source: Survey of URM program directors (n=23). Note: Response categories for this survey item are collapsed from 5 categories to 3.

On the survey and in interviews, URM program staff named a few common mental health diagnoses among URM youth, including adjustment disorder, PTSD, and depression. Staff also reported that these mental health conditions may take time to manifest and diagnose. They described a "honeymoon" period when youth first arrive where they are often quiet and adjusting to their new environment. After this initial period, youth may start to exhibit new behaviors; sometimes these behaviors are positive (e.g., opening up and discussing their feelings), and sometimes they are negative (e.g., showing signs of PTSD, anxiety, or depression). Additionally, URM program staff discussed that because youth have often lived independently with little supervision in other places, they may "rebel" after being placed in a foster family with household rules and restrictions.

3.A.2. Foster parent perceptions

The research team held six focus groups with foster parents at different URM programs and heard similar perceptions of URM youth experiences with trauma. Parents did not typically describe or disclose actual mental health diagnoses among URM youth. Rather, the parents discussed understanding that youth may have experienced traumatic events and that as a result of this trauma exposure, URM youth may exhibit concerning behaviors. One foster parent described that some URM youth have "seen people killed in their presence" and that youth may exhibit "survivor's guilt" once living with foster parents. One foster parent described behaviors at home as a result of trauma:

> "They're three, they're 30, and they're 80 at the same time. It's a full-time job, to figure out whether I'm talking to my three-year-old or my 30-year-old today."
>
> *- URM foster parent*

"They're three, they're 30, and they're 80 at the same time. It's a full-time job, to figure out whether I'm talking to my three-year-old or my 30-year old today." This sentiment, that youth are mature in some ways, while still young in other ways was reiterated across focus groups. Parents described some youth as silent and withdrawn, while other youth expressed emotions strongly. One parent described seeing emotions manifest as a part of everyday life and as an important aspect of getting to know her youth: "We eat dinner with them seven nights a week. We sit in our pajamas together. We watch them cry. We see their hormonal changes throughout the month." According to two foster parents, their role is to help youth learn to cope with what they have been through and adjust to their new environment. One parent stated, "[It is] trying to get them to recognize that just because you were a survivor there, doesn't mean you have to be that here." The second foster parent elaborated, "It's going from surviving to living." Parents also recognized that establishing trust with youth may be a long process and that they need to give youth time to adjust. As one parent reflected, "It's been three years, I think he just started trusting me a month ago."

3.A.3. Youth perceptions

The research team held six focus groups with URM youth, focusing on their experiences with URM program services more broadly. Youth did not discuss or disclose actual mental health conditions during these focus groups. Rather, they described the stressors they experienced prior to or immediately after entering the URM program. These stressors are informative in understanding youth mental health and emotional well-being.

One youth reflected on life in a refugee camp, stating that people suffered there:

> "Because of the endless waiting nobody knows what is going to happen to them. They can't go back, they can't come here [United States]… It's really hard to live in a place like that and be healthy. People who are mostly strong will survive. So [after resettlement] it was really good to have a person to talk to."

Another youth provided their perspective on adjustment to life in the United States, "I used to live by myself… I was responsible for myself… I eat what I eat when I eat, I sleep when I sleep. It's different to come here and have these rules. It's not difficult, but sometimes you struggle." Another youth described what it was like to live with a foster family stating that it was "awkward" at first, but that after living there for a while it became "normal."

The research team also asked youth for advice to offer new youth entering the URM program. The advice reflected the same message that adjustment to a new place and new people took time and elicited many feelings. One youth stated, "Trust the people. At first, I didn't trust anyone. I was just scared. I didn't open myself up until months later." Another youth normalized confusion and emotional reactions, stating that entering a foster home and understanding American culture can be "confusing" and generate many emotions, but went on to say that these emotions are due to "misunderstanding," implying that once youth understand more about life in a foster home and American culture, they will be more comfortable.

> "…at first I didn't trust anyone. I was just scared. I didn't open myself up until months later."
>
> *- URM youth*

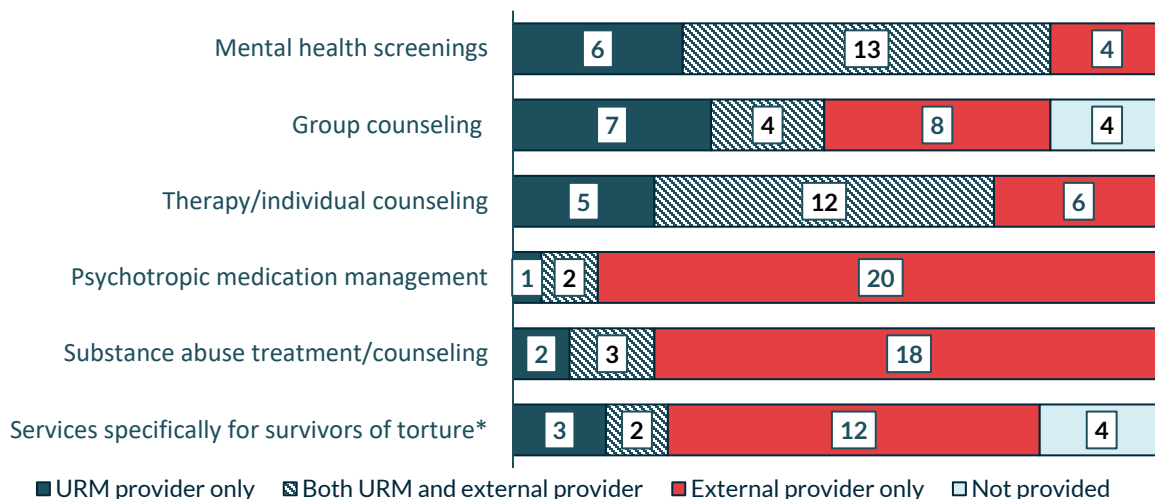## *3.B. Mental health services provided to URM youth*

ORR policy requires URM programs to address the mental health needs of URM youth and provide appropriate services for URM youth to develop the skills necessary for social, emotional, and economic self-sufficiency. To meet these needs, URM programs offer multiple types of mental health services to URM youth, either internally or through partnerships with external providers. All URM programs visited by the research team provide mental health assessments soon after a youth enters the program. If necessary, URM programs can typically provide living arrangements that offer more intensive therapeutic care. Programs also use a wide variety of interventions or service models designed to support youth mental health.

3.B.1. Available services

URM programs offer a wide variety of mental health services to meet the mental health needs of youth. As shown in Figure 2, in the survey of URM program directors, all programs responded that they offer mental health screenings, individual therapy/counseling, psychotropic medication

management, and substance abuse treatment/counseling, either internally or through external partnerships. Services specifically for victims of torture and group counseling were not offered in as many programs as other mental health services, but they were still offered by most programs.

Figure 2. Mental health services available in URM programs and who provides them

Data source: Survey of URM program directors (n=23). Note: *2 responses missing.

In some instances, programs may partner with an external provider to provide certain types of mental health services to URM youth. For example, one program visited by the research team reported that their own URM case managers provide therapy directly to the youth, but they may also make referrals to community providers for group or individual therapy. They discussed having a psychiatrist onsite one day a week for youth who would benefit from that level of service. Most programs that offer psychotropic medication management, substance abuse treatment/counseling, and services specifically for survivors of torture provide these services only through an external provider. Mental health screenings, group counseling, and individual therapy/counseling all vary in whether they are offered internally, externally, or through both. Overall, many programs rely solely on external partners or supplement their approach with external partners for most mental health services.

3.B.2. How services are provided

Services to support URM youth mental health are available at all programs, but programs vary in how they provide these services.

Initial referral to the URM program. During interviews, URM program staff explained that when a URM program receives a referral for a new URM youth, they use their own discretion in determining whether to accept the referral.[12] One of the factors programs consider is whether they can meet the mental health and therapeutic needs of the youth. However, prior to a youth's arrival, programs sometimes know very little about the youth's mental health needs, particularly if they enter the program as a refugee. This is because refugees are referred while they are still outside of the

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[12] In many cases, when one URM provider agency chooses not to accept a referral, the youth may still enter the URM Program as another provider agency may accept the referral instead. There are two ways in which youth who are referred to the Program do not enter the Program: (1) Youth turn 18 and age out of eligibility before a provider agency can identify an appropriate placement for them, or (2) for youth who are in the United States when referred to the Program, ORR may determine that a referred youth needs a higher level of care than the community-based care provided through the URM Program and determines the referral is not appropriate. Both scenarios occur infrequently.

United States, and the documentation available at the time of referral may not fully describe the youth's experiences and current circumstances. If the youth was first a UAC, the URM program staff may have a better understanding of the youth's mental health needs prior to the youth officially being placed in their URM program because the youth is already in the United States and may even be in a UAC program operated by the same agency.

Initial Living Arrangements. Based on what they know about a youth, staff determine the most appropriate initial living arrangement. If they feel a family-based foster home would be appropriate, the program will share information with the prospective family to help them decide whether the youth is a good fit for their home. Many URM programs acknowledge the likelihood that youth will enter the program with significant trauma, therefore they offer therapeutic foster care living arrangements for youth. Foster parents who are certified to provide therapeutic foster care have additional training to meet the needs of youth in foster care with severe mental, emotional, or behavioral health needs.

In the survey of URM program directors, as shown below in Figure 3, all but two program directors surveyed stated that their program offers therapeutic foster care living arrangements. Other living arrangements that may include more intensive mental health support include group homes or residential treatment facilities. Residential treatment facilities are available in all URM programs surveyed, and group homes are available in all but three programs. Sometimes, these living arrangements are offered through external partnerships. In particular, nearly all URM programs only offer residential treatment facilities through external providers.

Figure 3. Select living arrangements available in URM programs and who provides them
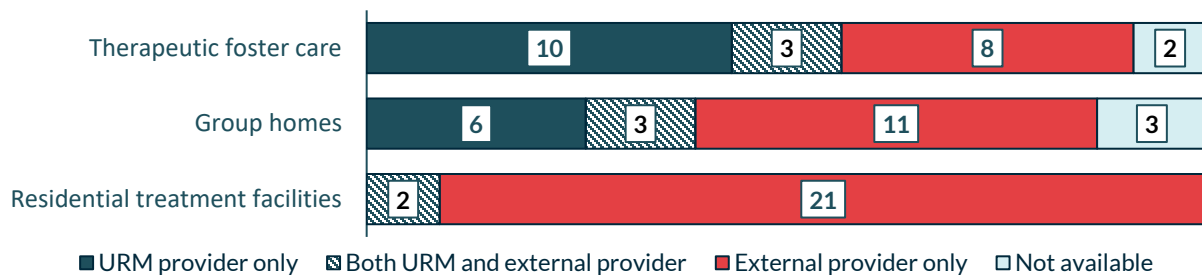
Data source: Survey of URM program directors (n=23).

However, while therapeutic living arrangements or treatment facilities are widely available, youth are not often placed in such arrangements. As shown in Figure 4, our analysis of administrative data collected by ORR (referred to as ORR-3) found that 11 percent of youth were initially placed in a therapeutic foster home, 12 percent of youth in a group home, and nine percent in a residential treatment facility.

Figure 4. Initial living arrangements for URM youth, as reported in ORR-3
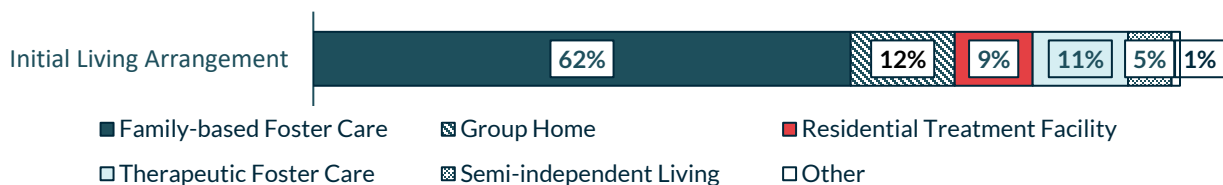
Data source: This figure is based on original analysis of data from ORR's Refugee Arrivals Data Systems (RADS) of youth who entered the URM Program in federal fiscal years 2014-2018 (n=1,950 youth).

Initial assessments and services. All sites visited by the research team reported conducting initial mental health assessments for all URM youth soon after the youth's arrival. Program staff reported

that this assessment is done anytime between the first few days to the first 90 days of arrival. The exact timing of this assessment varies among programs based on each program's intake procedures and local or state child welfare requirements. Only two programs reported the specific tools used for mental health screening. One site stated that they use the Refugee Health Screener 15. Another stated that they use the Adverse Childhood Experiences questionnaire, the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-V) definition of trauma symptoms, and occasionally, the UCLA Post-Traumatic Stress Disorder Reaction index.

After the assessment, youth are not required to attend therapy or other mental health services. URM program staff discussed that youth who entered the program through the UAC pathway were often familiar with therapy because it is a requirement for youth in UAC care facilities to attend therapy. As described more in the challenges and successes sections below, URM program staff use a variety of approaches to encourage youth to participate in therapy and to destigmatize mental health conditions and services. Two of the programs visited by the research team noted that all of their case managers are licensed clinical social workers, which implies that all youth have some type of therapeutic treatment, even if they are not receiving one-on-one therapy. One site provided detailed information on how they identify the need for services beyond a youth's initial arrival in the program. The staff discussed asking parents to keep a behavioral log that aligns with a state mandated assessment tool. They use this information to determine if additional supports (e.g., a higher level of care) are necessary.

3.B.3. Use of interventions and service models

Across all mental health social service providers, one method providers use to increase program quality is to use therapeutic interventions and services models. On the survey, URM program directors were asked to indicate what interventions or service models they use in their work with URM youth, many of which are related to mental health. Program directors were asked to 'check all that apply' when answering this question. Overall, as shown in Table 1, program directors reported that programs use either trauma-focused cognitive behavioral therapy or other trauma-informed care models relatively frequently. Dialectical behavior therapy and the Sanctuary Model® are used relatively infrequently. Three program directors reported that they do not use any of the interventions or models that were listed.

Table 1. Mental health interventions and service models used by URM programs

Intervention or model	Programs that use intervention/model # (%)
Trauma-focused cognitive behavioral therapy	15 (65%)
Other trauma-informed care model	11 (48%)
Wraparound service model	6 (26%)
Dialectical behavioral therapy	3 (13%)
Sanctuary Model®	1 (4%)
Other promising practices and approaches	4 (17%)
Training for foster parents*	4 (17%)
None of the above	3 (13%)

*Data source: Survey of URM program directors (n=23). Note: *This response was not presented on the survey; it was created during recoding from open-ended responses to "other promising practices and approaches." It is possible that if had been presented as a response option more respondents would have selected it.*

Examples of 'other trauma-informed care models' mentioned by program directors included Eye Movement Desensitization and Reprocessing, Trust-Based Relational Intervention®, Trauma Informed Parenting, Together Facing the Challenge, Motivational Interviewing, Therapeutic Crisis Intervention, crisis prevention and intervention, harm reduction model, as well as other general trauma-informed approaches. Examples of 'other promising practices and approaches' mentioned by URM program directors included family systems approach, Nurtured Heart Approach®, host home model, Structured Analysis Family Education (SAFE) Home Study model, and a psycho-social support group for girls. However, the research team did not collect information on which staff members implement these therapeutic interventions and service models.

3.C. Challenges in providing mental health services

URM program staff and foster parents described several challenges in providing mental health services. In particular, staff and foster parents described limited resources and challenges in engaging youth or overcoming stigma. Some URM youth reflected on their experiences receiving therapy and expressed that they preferred to use other methods or supports, such as talking with friends.

3.C.1. URM program staff perspectives

When asked about challenges in providing mental health services to URM youth, URM program staff identified challenges in two primary areas: 1) available resources and 2) youth engagement.

Resource challenges.

On the survey of URM Program Directors, respondents were asked to rate on a scale of 1 to 5 (1=not a challenge, 5=serious challenge) how serious of a challenge certain factors are in providing services to URM youth. As shown in Figure 5, many program directors reported that availability of mental health service providers and culturally competent providers are serious challenges.

Figure 5. Challenges in providing services related to mental health to URM youth
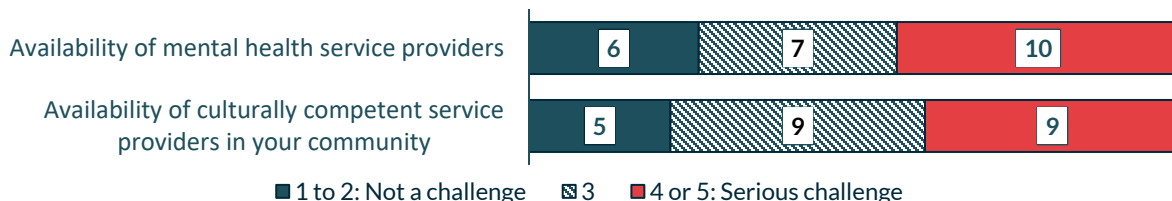
Data source: Survey of URM program directors (n=23). Note: The response categories for these survey items are collapsed from 5 categories to 3.

Several sites visited by the research team reported a lack of mental health providers in their area who can meet the needs of URM youth. Specifically, there are limitations based on language, cultural competency, and acceptance of Medicaid. One site also described that if they cannot find a provider who speaks the youth's language, they often use an interpreter. However, URM program staff stated that it is important that youth feel comfortable with the interpreter in such situations, so that youth are comfortable participating in mental health services.

Some of the URM programs visited also described limitations in their own budget and capacity to provide mental health services. One site reported that they do not license therapeutic foster homes and have to rely on partner agencies for these placements; however, the partner agencies rarely have a placement available. Therefore, this site went on to say that they do not accept referrals for youth with high therapeutic needs. However, this proves challenging if high therapeutic needs are

identified after the youth's arrival. Another site described having a limited budget for group home placements, supervised independent living, or higher need placements in their contract with their state; as a result, they stated that they only consider these types of placements in extreme circumstances.

Challenges in engagement. URM program staff also frequently identified stigma or youths' misunderstanding of mental health conditions or therapy as a challenge in providing services. For some youth, therapy may be a completely new concept. URM program staff said youth may express beliefs that therapy is for "crazy people" or that it means there is something wrong with them. Case managers noted that it can take a long time for a youth to accept a diagnosis and decide that it is in their best interest to engage in counseling and treatment. They reflected that it may take years before a youth engages in treatment.

3.C.2. Foster parent perspectives

Foster parents echoed many of the challenges described by program staff. Parents discussed the need for more mental health providers, including more in-house therapists at URM programs to ensure the provider is trusted by youth and understands URM youth experiences.

Challenges with stigma were also discussed. One foster parent described one youth's strong reaction when the case worker arranged an appointment with a local mental health provider: "She went to one session and was furious…She said, 'I'm not crazy,'… Culturally, [therapy] wasn't a thing. She didn't want anyone to think she was crazy." Another parent expressed disappointment that she and the URM program had not more strongly encouraged her foster son to attend therapy. The parent stated that the youth was "happy and healthy" when they first arrived but that more serious issues started to show up years later. The foster parent said she realized later that there had been signs of mental health needs earlier on that she did not notice, and said, "We should have recognized it."

3.C.3. Youth perspectives

Overall, focus groups with URM youth did not include extensive conversations about challenges with or thoughts on mental health services. A few of the URM youth, however, expressed that they did not enjoy therapy or did not feel it was "for me." As one youth explained, "Having a therapist was not something I really liked…Sometimes it's hard, and it can be good to have someone to talk to, but I have self-confidence and like to handle things myself... If I feel I need someone to talk to, I use the therapist but that does not happen much." Similarly, another youth described that they prefer to use other supports in their life, "The therapist is good for someone who trusts them. But it is their job. I don't like to talk about my problems, but if I want to vent, I talk to my best friends or my caseworker because me and my caseworker have a really good relationship. Therapy is just not my thing."

> "The therapist is good for someone who trusts them. But it is their job. I don't like to talk about my problems, but if I want to vent, I talk to my best friends or my caseworker because me and my caseworker have a really good relationship. Therapy is just not my thing."
>
> *- URM youth*

Finally, one youth expressed having a negative experience with therapy. The youth stated that their therapist, "Said I could talk about anything, so I trusted [the therapist]." However, the youth noted

that something they said in therapy was shared with their case manager and then with their foster parents; as a result, the youth lost trust in the therapist.[13]

3.D. Successes in providing mental health services

URM program staff identified many approaches that they use to overcome challenges in providing mental health services to youth, including approaches to overcome stigma and build rapport. Foster parents reflected on the positive changes they have observed in youth behaviors over time or after receiving services. Some URM youth described positive experiences with therapy and feeling safe or supported as a result of the program.

3.D.1. URM program staff perspectives

During interviews and in open-ended survey responses, URM program staff described many successful approaches to overcoming challenges to mental health service provision.

Overcoming stigma. URM program staff identified a few helpful strategies in overcoming stigma of mental health services. The first was to encourage group therapy. One program described that it is helpful for youth to hear others express similar experiences and sentiments so that they do not feel like they are singled out. As one staff member described, when youth are in a group of people from all around the world, they realize that the other youth are describing similar challenges even though the other youth may not look like them. The staff member stated that it makes the youth feel like, "There is nothing wrong with me." The staff also described that they felt group therapy provided youth with language to describe their feelings.

Another approach identified by program staff is to normalize therapy by explaining to youth that it is similar to checking in with their case manager and even offering to do a mock therapy session. One program described offering to have foster parents attend therapy with youth to help them feel more comfortable and model how to talk about feelings and experiences. This program also consulted with cultural leaders who gave a recommendation to refer to therapy as a "doctor for the heart" or "for feelings."

Understanding the youth and building rapport. In our survey of URM program directors and State Refugee Coordinators, multiple respondents emphasized that a strength of URM programs is the staff's understanding of trauma experienced by youth. URM program directors reported that their staff have strong expertise in working with this population and are dedicated to the youth. One survey respondent wrote, "Relationship building is the ONLY sure way to reach our youth and build trust. We use lots of models, but our being available, consistent, and involved in their lives speaks volumes to a youth from cultures that are about connection and trust."

In interviews during site visits, program staff described that therapists use many strategies for building rapport with youth, including creating a sense of safety, helping the youth understand that information is confidential, allowing them to move at their own pace, and using attentive and reflective listening. Program staff also

> "Sometimes we're planting the seeds as soon as they get here and four years later they are like, 'I think it'd be a good idea to go to therapy.'"
>
> *- URM program staff*

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[13] It is unclear to the research team what the exact situation was; per study confidentiality procedures, the team did not ask URM program staff about this comment for more information. Regardless, the youth's perception of the situation and their negative opinion of therapy is important to understand the youth's experience.

described staff being trained on cultural competence as vital to building rapport and providing youth with high quality care. They also acknowledged that youth may take time to open up. As one staff member stated, "Sometimes we're planting the seeds as soon as they get here and four years later they are like, 'I think it'd be a good idea to go to therapy.'" One site also described that when they have to use an interpreter, they try to give youth choice of the gender of the interpreter to increase comfort and to stick with the same interpreter over time.

Certifying foster parents. Three of the programs visited by the study noted that they certify all of their foster families as therapeutic foster placements. This means that if the program staff identify that an incoming youth would benefit from this level of care, they have a larger number of potential homes they could place the youth in. Additionally, this reduces the need to change a youth's placement over time if additional behaviors develop that require therapeutic placement. This may also help ensure that all youth have foster parents with high levels of training on therapeutic approaches, implying that all youth receive a high level of care.

3.D.2. Foster parent perspectives

Conversations with foster parents on successes primarily focused on the positive changes they observed in youth over time or after the youth received therapy. One foster parent described their foster daughter's experience with therapy: "She was in counseling for five years, and the first year it was just about how to talk and tell people what happened to you… and then the next year was about writing her trauma story. But the bottom line is that the difference that made in her life…to see the change!" Another parent described that while the youth in their home is still cognizant of the trauma she experienced, she is focused on other experiences: "She kind of has this mentality of, 'I know what happened to me, but I want to focus on getting an A right now or running track.'" Later, this parent also explained that her foster daughter now feels empowered to tell her story and that the youth tells her foster parent that she will "change the world with my story."

> "She was in counseling for five years, and the first year it was just about how to talk and tell people what happened to you… and then the next year was about writing her trauma story. But the bottom line is that the difference that made in her life…to see the change!"
>
> *- URM foster parent*

Two parents spoke about giving youth time to adjust to life in the United States or to the idea of therapy as one successful strategy. One stated that they had to let their youth come to the decision on their own to seek treatment, "We were told by our social worker that, 'If you want counseling, let us know,' and he came eventually and said, 'It's time.' He went for five months. It helped with his nightmares, but he knew what he needed and then he said, 'I'm done.'" Another parent described that the youth in their home came to understand that feelings of sadness are normal in his circumstances:

> "Before he came to the United States, they had him thinking that Americans are all nice—and we are like the Stepford wives and we smiled all the time and were never upset, always happy. Then he said when he got here and realized people aren't always happy…. It changed his demeanor… I said, 'Well no, we're human, you can't be happy all the time. It's okay to be depressed, it's okay to be sad some days'… when we were talking about that, it was like a lightbulb came on. I said, 'What you're

feeling—that anxiety, that separation from your country, you don't see your family anymore—of course you need therapy.'"

Parents also touched on the high quality of services available to support youth, "They have a behavioral therapist here too, and she is *beyond* excellent. She worked with [URM youth's name] and it made such a difference." Another parent spoke about the excitement of finding a therapist who spoke the same language as the child they foster, stating that the youth was seeing the only therapist in their city who spoke the same language; the parent described this as "amazing."

3.D.3. Youth perspectives

A few of the youth described positive experiences with therapy and the supports available through the URM Program. One youth described their trust in their therapist and the way the therapist helped them process emotions:

> "The therapist helps me out… I trust him and felt he was good. Everybody has their own situations and their own stories. He helps me to understand what I was not understanding about the way I was feeling. He helps me to understand that I need to be myself to do what I need to do, and that I am not just my past."

Another youth described the tools they gained through therapy to better process challenging emotions; the youth stated that seeing a therapist was "pretty good" and helps "a lot to get through traumas from the past, and to be more social with other people." The youth continued by describing the way art therapy helps with emotion regulation: "When you go to therapy to work on self-control, like when you're angry, you can do what you like the most. Like if you like music, then you can play some music; if you like to draw or paint you can do that. You take the anger and make some art instead."

> "When you go to therapy to work on self-control, like when you're angry, you can do what you like the most. Like if you like music, then you can play some music; if you like to draw or paint you can do that. You take the anger and make some art instead."
>
> *- URM youth*

Other youth described the supportiveness they now feel in their lives due to the program, "I have never felt that I'm by myself—there's always someone to talk with, always feel like you have support. Sometimes there are no words to describe how you feel, but it's been pretty amazing to be in this program." In the simplest of terms, one youth stated, "I feel safe."

4. Conclusion

Overall, the findings from this study complement prior research on refugee youth mental health and related services. URM program staff perceive high rates of trauma and resulting mental health conditions among the youth they serve, similar to prior research for refugee youth, particularly among those separated from their parents/guardians (Bean et al., 2007; Betancourt et al., 2017; Derluyn et al., 2009; Lustig et al., 2004). This descriptive information builds a foundation for future research to explore these questions further. Future research should use longitudinal research designs in order to better understand changes in URM youth mental health over time.

URM programs provide a variety of mental health services to help support URM youth mental health. Stigma and lack of affordable or culturally and linguistically appropriate services are

perceived as barriers to service provision within URM programs. This echoes existing literature on barriers for refugee youth more broadly (Colucci et al., 2015; Colucci et al., 2014; Ellis et al., 2011; Lustig et al., 2004; Marshall et al., 2016). URM program staff have begun identifying promising approaches for addressing these barriers and building rapport with the youth. Many of their approaches have also been reported as promising for other refugee populations in other literature (Ellis et al., 2011; Forrest-Bank et al., 2019; Hettich et al., 2020; Marshall et al., 2016). Future research could build on this by formally evaluating different approaches for effectiveness, including approaches to engage youth in mental health services.

Focus groups with foster parents and URM youth provided nuanced perspectives on their experiences with mental health services in URM programs. Future research could explore their perspectives further, including a deeper understanding of whether youth feel these services are beneficial or suggestions for how to improve services. Additionally, given that some URM youth expressed a desire to rely on other social supports for mental health (e.g., peers), research could further explore how youth support each other. Additional research could explore the way that foster parents or group home staff support URM youth mental health on a daily basis. Finally, research could further explore the trainings or supports provided to URM program staff or foster parents on mental health and if these trainings meet needs and improve services.

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