Therapeutic foster care for Unaccompanied Refugee Minors and their foster families (FORM)
Erasmus+ (Feb 2022 – Jan 2025)
Co-funded by the Erasmus+ Programme of the European Union

Therapeutic foster care for Unaccompanied Refugee Minors and their foster families - Literature and practice review

(Update October 2022)

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Contact FORM:
Jos.sterckx@odisee.be - +32 (0)477 44 97 14
katja.fournier@odisee.be

FORM is an initiative of
Odisee
UNIVERSITY OF APPLIED SCIENCES

Note on this update

In section 3 of this document, we select existing models of therapeutic foster care (TFC) that seem relevant for our project. We provide summaries of therapeutic foster care for UMR, "general" therapeutic foster care model and "general foster care for UMR and we express our intention to regularly update this section of the document, based on new discovered literature and the feedback of the partnership. This 2nd version of the document contains a first update and some important corrections.

Thanks to all critical readers and writers of this update!

(A document containing the track changes compared to the first version is available on simple request).

1. Background of the project

Europe and its member states are facing a challenging asylum crisis. Not only adults and families with children try to reach Europe to start a better life. But also, youngsters and even children arrive in Europe without the guidance of an adult. National authorities are extremely challenged by the question how these unaccompanied minor refugees (UMR) must be taken care of, according to national and international standards of childcare and children's rights. UMR are often taken care of in the context of buddy projects or residential settings, where they are followed-up on an individual basis by a trustee that acts from a certain distance, or, in the context of a group that is guided by different rotating educators. Foster family care (not to be confused with adoption!) for UMR is a different and more recent trend in guiding this subgroup of 'looked after youngsters'.

All over Europe, 'normal' families are accepting a UMR as a 'normal' member of the family. Within this new trend of foster family care for UMR, foster care services are mentioning complexities and problematic situations that require a specialized guidance, taking into account exile-specific influences (f.e.: the effects of cumulative losses and life-threatening situations on the development of these youngsters), developmental phases specificities (f.e.: multi-layered crises in identity formation), complex and multiple trauma-related dynamics (f.e.: the breakdown of the relationship with primary attachment figures and with later caretakers, a breakdown that can hinder the establishment of trust in the foster parents), and, migration-related factors (f.e.: being confronted with cultural differences).

Foster care services (all over Europe) report an enormous need to offer therapeutic – in the broadest sense of this word: 'healing and development oriented' - care for these youngsters and their foster families. (Therapeutic foster care is also often called 'treatment foster care'). Foster care services also mention the need to share, within learning networks, about the difficulties these youngsters, their foster parents and the guidance networks are confronted with and about the tools and approaches they have at their disposal to work therapeutically with these families.

In our project "*Therapeutic foster care for Unaccompanied Refugee Minors and their foster families (FORM),* we want to bring together knowledge and experiences in this context and we want
(a) to work out a model - to be used by professional foster care workers - for the delivery of therapeutic care for this group of minor refugees and their foster families; a model that is based on research and that is very practice oriented), a model that can be shared with all foster care actors in the EU.
(b) A training on this model, addressed to professional foster care workers, will also be produced.
(c) a 'knowledge base on research and best practices in the field of foster care for UMR' will be developed (on which the model and the training will be based on) and
(d) 'policy and implementation recommendations' will be formulated.

This document is a summarized review of the scientific literature and practice on therapeutic foster care for UMR which will serve as inspiration for the objectives on the project (a), (b) and (d) mentioned above.

2. Methodology for the review

2.1. Objectives

The review has looked into three knowledge resources:

- research through a literature review
- existing guidance practices in the context of foster care for families with UMR in (European) countries through research review but also a questionnaire that has been submitted to the partners and other relevant organizations (Youth Care Platform).
- an overview of the needs and the difficulties that are reported by foster families with UMR and by the foster care professionals and the supportive networks that surround them, described in the research but also through a brainstorming session with the partners (FORM steering group meeting 7th - 8th of March 2022 in Gent), the advisory board meeting (during the Youth Care Platform 22th of January 2022 – online meeting) and the written input by other relevant organizations (answering the questionnaire that was sent out by the Youth Care Platform and ENSA). See also below.

The final output of this review process will be:

- a 'knowledge base on research and best practices in the field of foster care for UMR' (this document)
- the 'architecture' of the model and the training (that will be developed in the next project phases): concept, contents, maybe a concrete model that can serve as bases for the model, …

2.2. Questionnaire for the partners

One of the challenges with regards to therapeutic foster care for unaccompanied minor refugees is that there are quite some examples of therapeutic foster care but those are often developed for children with extensive trauma and/or extensive behavioral issues and/or in contact with the law or the juvenile justice system. On the other hand, there are quite some practices with regards to foster care of UMR but those often do not have a "therapeutic specificity". In order to have an extensive view on existing literature and interesting practices we have asked the partners to answer the following questions:

- *Is there specific literature that you would like to recommend us?*
- *Do you know about examples of therapeutic foster care for UMR in your country (or another country) that you find promising?*
    - *Can you describe the strengths of those practices?*
    - *Can you send us references to those practices?*
- *If there are no specific projects of therapeutic foster care for UMR:*
    - *Could you describe interesting practice of "general" therapeutic foster care? Please describe the strengths of those projects and give us references.*
    - *Could you describe interesting practices of "general" foster care for UMR? Please describe the strengths of those projects and give us references.*

During the steering group meeting on 7 – 8 of March 2022 in Ghent we held a brainstorming session to analyze deeper the following questions:

- What definition of therapeutic foster care do we want to use for the project?
- What are the needs, challenges and needed support mechanisms for the foster care agencies?
- What are the needs, challenges and needed support mechanisms for the unaccompanied child?
- What are the needs, challenges and needed support mechanisms for the foster care parents?
- What are the needs, challenges and needed support mechanisms for the other members of the foster care families (children, extended family….)?
- How can/should the (extended) family (in the country of origin) of the unaccompanied child be involved in the therapeutic foster care placement?
- What are the needs, challenges and needed support mechanisms for the guardian of the unaccompanied child?

Both the literature review and the different expertise sharing moments within the project led to the (non-exhaustive) following listing of existing models and the specific and transversal needs to consider when designing a model for therapeutic foster care.

3. Models for therapeutic foster care for unaccompanied minor refugees

In this section, we will reference existing models of therapeutic foster care (TFC) that seem relevant to our project. Again, since the small amount of literature on existing practices of specific therapeutic foster care models for UMR we will provide short summaries of therapeutic foster care for UMR, "general" therapeutic foster care model and "general foster care for UMR. We will (try to) update this section regularly, based on new discovered literature and the feedback of the partnership.

3.1. Definition

The term 'TFC' is used in the contexts of foster care practices, policies and research. By consequence, the term can have a different meaning regarding the context or even country it is used in.

"*TFC is out-of-home care provided by foster parents with specialized training. It is intended to serve children who would otherwise be placed in residential, institutional, or group homes due to significant behavioral, emotional, medical, or mental health care needs*". (McGuinness, T. M., & Dyer, J. G., 2007). Sometimes, it is offered as a specific 'type' of foster care (amongst others, and delivered by a foster care service providers who offers different 'types' of foster care situations' (this is the case in Belgium). In other countries, it is a 'standalone care type', often even offered by specialized services (the case of the Netherlands and the US).

In the literature around TFC, this is combined with the notion that TFC can or even has to be supported by evidence-based or evidence-informed research. Since there is still a lack of research on the topic of (therapeutic) foster care of UMR this will have to be a longer-term goal of the model that will be developed: allow evidence based or evidence -informed research about the added value of therapeutic foster care for UMR.

For this project, we will use a broad vision and definition of therapeutic foster care. Foster care, as in living and developing within a family context, is therapeutic in itself (though this does not mean that the therapeutic context is effective enough in all the cases). The focus is on safeguarding and promoting resilience. This means that there is a large spectrum of preventive action and limitation of risk factors. The idea is that the attention provided within families is therapeutic and that a personal or tailored approach is needed.

3.2. Models for therapeutic foster care for UMR

Those models still need to be identified or designed (which is a target of FORM, see 1. above). Certain foster care projects do have elements of therapeutic foster care (see 3.4.3) but cannot be qualified as therapeutic foster care as a whole.

3.3. Model for therapeutic foster care that are not specific to UMR

Therapeutic foster care models have been quite developed in the United States and Canada. Therapeutic foster care, or treatment foster care as it is often called there, had been developed for very traumatized children, children with severe behavioral issues of children who came into contact with the law/juvenile justice system. In Flanders, the thresholds to start therapeutic foster care are less high and TFC is given as additional support upon the 'regular' guidance of foster care workers.

3.3.1. TFC-model-USA

3.3.1.1. The general model

When a state child welfare entity believes a youth is appropriate for TFC and that child meets the medically necessary requirements of the state Medicaid authority, the process of entry to TFC begins. Each child is assessed on the basis of his/her developmental stage, trauma experiences, current physical and emotional health, educational and behavioral deficits, and individual strengths and interests. This assessment is then compiled to make a match for that child with a specific TFC home and TFC parents whose training, experience, and professional competence maximize an appropriate fit for the youth's success and healing.

Best practice dictates that only one or two youth in TFC are placed in a home unless special consideration is made for sibling groups or other unique circumstances. TFC foster parents in most states receive at least two times the initial training of traditional foster parents, as well as required continuing education training throughout the year. TFC foster parents are the change agent. They are available to the youth in foster care 24/7 for support, treatment intervention, crisis stabilization, and connection to the community and school. TFC foster parents are considered to be professional participants of the clinical treatment team. Their role includes conducting specific life skills and social skills training, daily interventions, and recording those interventions in the youth's treatment log. TFC parents receive specialized training in various mental health and trauma disorders as well as in cultural sensitivity as is appropriate for each child. Key to the success of the TFC foster parents is the 24/7 supervision and support available to the foster family by the contracting TFC agency. The TFC therapist supports the child and the foster family. He/she contacts or meets with the TFC family weekly and can be called upon at any time.

Agency staff create and monitor the youth's treatment plan. These state-licensed mental health professionals provide crisis intervention if necessary and they encourage respite for TFC foster parents. Creation of the treatment plan is the responsibility of the staff of the TFC agency. The treatment plan is specific to the needs of each youngster. It is monitored regularly for compliance and is subject to on-going assessment and evaluation. Authorization of the treatment plan by state auditing bodies occurs no less than every 90 days.

TFC agency staff provide individual and family therapy for the foster family and the biological family when possible. Group therapy may also be provided, especially with sibling groups. Consultation and collaboration with child welfare workers, Court Appointed Special Advocate volunteers, and other invested professionals in designing, implementing, and evaluating the clinical treatment plan is also a best practice of care. This model is based on an assessment of parents and child/young person, on the basis of which a match is assumed. then a treatment plan is established that must be followed at short intervals (and possibly repeated or extended).

3.3.1.2. The Needs assessment or 'rating sheets'

Several foster care agencies in the US function on the basis of a needs assessment to identify which minor might be best suited for therapeutic foster care. For more detailed information please go to: https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/

We will here summarize a certain number of domains that are being analyzed and who could serve as an inspiration for a needs analysis within TFC for UMR and potentially also as a base for adequate matching with the foster family.

Overall, the needs analysis is a sort of rating system where needs are being evaluated on a scale from 0 to 3:

0: no need identified
1: a need that is identified and needs to be monitored
2: a need where action is required
3: a need where immediate and/or intensive action is required

There are different domains that are looked at, each subdivided in smaller needs. The broad categories are the following:

- Life functioning in general
- Developmental needs
- Individual strengths. To give an insight of the subdivision in smaller categories this section will be detailed:
    - Family strength
    - Interpersonal
    - Optimism
    - Educational setting
    - Vocation
    - Talents & interests
    - Spiritual/religion
    - Community life
    - Relationship permanence
    - Resilience
    - Resourcefulness
    - Cultural identity
    - Natural support
- Cultural factors
- Caregiver resources and needs
- Behavioral and emotional needs
- Trauma module
    - Traumatic / adverse childhood experience
    - Traumatic stress symptoms
- Substance use
- Risk behavior
- Violence module
- Sexually aggressive
- Runaway module
- Juvenile System module
- Fire setting module

Such a needs assessment needs to be identified to the specificities of this target group but might be an interesting tool to assess needs, identify what is known or not about the UMR and which needs to be addressed within the foster care placement.

3.3.2. TFC in Flanders

3.3.2.1. Flemish foster care

Flanders consist out of five provinces, each with their own foster care agency (Agentschap Jongerenwelzijn, 2013). There are four forms of foster care placements in Flanders: supportive, short-term, long-term and therapeutic foster care. Supportive foster care offers a short-term break or a part-time stay (i.e. during weekends or holiday's) in a foster family to support the family, or offers short-

term emergency care. During short-term foster care (maximum duration of 1,5 y), the possibility of reunification with the birth parents is examined. If reunification cannot be realized, another perspective for the child (i.e., long-term foster care or residential care) is sought. Long-term foster care aims at creating permanency for the foster child. Children and families in short- and long-term foster care can get additional support through therapeutic foster care. Therapeutic foster care is treatment and/or support for foster child, foster parents and/or parents, additional to the regular guidance by the foster care worker (Van den Bruel, 2012).

3.3.2.2. Flemish TFC

Therapeutic foster care was developed to help with specific psychological, emotional or behavioral problems of foster children by providing additional treatment or training for the foster child, foster family or parents. In order to qualify as TFC, the treatment has to be clearly described, foster care specific and have a theoretical (and scientific) background. There are currently 18 different types of TFC in Flanders , but every foster care agency offers their own selection of these 18 types. Therapeutic foster care can be offered to all children in short- and long-term foster care. The treatment or training is given by a trained foster care worker. Before the start of some of the types of TFC, questionnaires are used as tools to estimate whether that specific type of TFC is useful.

The most common themes are:

- Trauma of the foster children
- Quality of attachment between foster children and foster parents
- Behavior problems of foster children
- Shared parenthood between parents and foster parents
- Groups with specific support needs, f.e. grandparents that are fostering, kinship foster carers (F. Van Holen, personal communication, June 15, 2022).

On the last day of 2021, they were 8643 children in foster care, 776 (9%) of them received TFC at that moment (Opgroeien, 2022). It is also interesting to look at the percentage of TCF received during a whole year. The last data regarding this are dating from 2019. In 2019, there were 8272 foster children. 2037 (24.6%) of these foster children (or their foster parents and/or parents) got additional support through TFC (Pleegzorg Vlaanderen, 2019).

3.4. Models of "general" foster care for UMR

3.4.1. The Fostering Across Borders

The Fostering Across Borders (FAB) project aimed to improve the quality and expand the availability of family-based care for unaccompanied migrant children in six EU Member States: Austria, Belgium, Greece, Luxembourg, Poland, and the United Kingdom.

In this project a training manual was developed for foster care families (training does not target the foster children) consisting of 6 modules:

- Module 1: goals and overview of the training
- Module 2: the experiences of UMR (why do they leave, why are they unaccompanied, which risks have they encountered, ….)
- Module 3: Rights and procedures and their impact (arrival, reception, age assessment, asylum, other protection possibilities, leaving reception, impact of living in uncertainty)

- Module 4: Overview of the needs of UMR (complexity of their experience, renegotiating of interpersonal relationships, adolescence and its impact, identity, expectations, mental health, concept of resilience...)
- Module 5: Responding to the needs (integration as a 2-way process, how to prepare, why UMR can provide unreliable information, making a difference, …)
- Module 6: care for foster families (recognize stress factors, secondary traumatization, selfcare, …)

3.4.2. ALFACA

Within the ALFACA project a manual is developed for staff working with reception families and unaccompanied children living in reception families.

Module 1 shines a light on the general approach for supporting unaccompanied children. It focuses on the particular situation of these children and their need for guidance, and on working in an intercultural environment. The website includes in-depth material written primarily for specialized professionals. This is targeted training for those interested in supporting unaccompanied children with personal development issues. Module 2 provides specific information on recruiting, screening, and matching families, and on placing a child in a reception family

3.4.3. Culturally sensitive Foster Care-Pleegzorg Oost-Vlaanderen

Foster Care-Pleegzorg Oost-Vlaanderen (PZ OVL) provides culturally sensitive foster care guidance to UMR foster families and to UMR itself. This implies several things:

- Supervisors are trained internally and externally to provide culturally sensitive assistance.
- There is an intervision group that meets every 2 months for half a day. One person from each team from PZ OVL takes part in this group. The participants gain expertise through small workshops (e.g. about racism, how to work with interpreters...), feedback on trainings is given, cases are discussed... Subsequently, they are the culture-sensitive ambassadors of their team.

PZ OVL's culturally sensitive care consists of:

- Knowledge about cultures, religion, migration, ...
- Skills:
    - Basic attitude: open, honest, authentic, respectful, empathy...
    - Interest and eagerness to meet the cultural other

In addition to a culture-sensitive basic attitude, knowledge about and experience with UMR is also important. Some examples:

- They do not ask for the UMR's story about the flight, in order not to give them the feeling that they have to do another interview (as with the Immigration Department for the residence procedure). They work on a relationship of trust. These are young people in vulnerable situations who simply need help, whether they are in Belgium legally or not.
- Foster care as an institution is unknown to most of them. We regularly repeat (with an interpreter!) what Foster Care can do for them.

We involve parents from the start of the placement. We ask their permission for foster care AND involve them as much as possible in raising their children (many video calls).

Protective factors on success for UMR in foster care:

- Contact with parents (UMR, foster family and foster care supervisor)

- Contact with their ethnic origin and culture (language, food, people from the community, religion...)
- Cooperation with guardian.
- Cooperation with interpreters.
- Collaboration with the Integration and Inclusion Agency (authorities)
- Enhancing their autonomy and independence skills

They have an adapted screening for candidate foster families for UMR. We have adapted the regular training in a culturally sensitive way, and it is geared towards foster care for UMR.

- Individual screening by 2 screeners, and
- Digital group training of 3 evenings.
- Direct placement module: we try to place as many UMR under 15 years as possible in a foster family (who has been specifically screened for this) within a few days after arrival in Belgium. There the screening consists of the digital training, but the individual screening has been adjusted: 1 screener from Foster Care and 1 screener from Minor Ndako (Youth protection). In this, it starts as a rapid placement which means that they start in crisis foster care (max 14 days) and then switch to perspective seeking or offering foster care.
    - During the first 3 months, Minor Ndako will provide intensive guidance (they have received funds from the government for this). Foster care starts administratively and is involved from the sidelines. The foster care supervisor visits every month together with the supervisor of Minor Ndako and in the meantime stays informed through a logbook. If all goes well, the foster care supervisor takes over after 3 months.
    - Unique to this placement in very special youth care: buffer bed in Minor Ndako remains free in case things go wrong in the foster family (during the first 3 months).

4. Needs and challenges

(Therapeutic) foster care for UMR brings a certain amount of attention points and potential needs for support. UMR, the foster families, the foster extended family (siblings, grandparents), the family of the UMR (if applicable), the guardian and the foster care agencies all face specific challenges and needs for support.

In order to be able to develop an adequate training programme it is important to have an overview of those needs and challenges. This section is and will be updated on the basis of literature and the feedback of the partners (through the questionnaire or other). In the literature and during exchange of expertise between the partners of the projects several specific needs were mentioned that need to be considered in (therapeutic) foster care.

It is important to note that there is little research of foster care of UMR and on therapeutic foster care for this target group. Existing research therefore might present limitations and current conclusions could be challenged and /or improved by more extensive research.

4.1. What are the needs, challenges and needed support mechanisms for the unaccompanied child?

Unaccompanied minor refugees (UMR) are considered in the literature as a specific and particularly vulnerable group due to their exile journey, their isolation from family, their age and their exposure to traumatic events. Several studies show that they have a higher risk of severe psychological and

psychiatric problem (Derluyn & Broekaert, 2007, Vervliet et al., 2014) but several other studies show the high levels of resilience and strengths present within these youngsters (Bates et al. 2015; Van Holen et al., 2019).

When considering adequate care for UMR the suitable living situation is one of the first elements to consider. UNHCR (United Nations Refugee Agency, 2008) recommends that care within extended family, the child's community or foster care should be preferred to residential care.

Only a limited amount of research has been done on UMR in foster care. Studies found that UMR in foster care reported better affective bonds with their caregivers, better material circumstances, better outcomes in terms of mental health, usually had a better perception of their education, and received more support and felt more a sense of belonging to the host society, though among other more autochthonous friends (Van Holen et al., 2019; Kalverboer et al., 2017; Bronstein et al. 2012. Hodes et al., 2008, Hollins et al., 2007). An important question that remains with regards to a potential bias within the research is whether UMR with a better mental health are placed within foster care of if the improved mental health can be (directly) attributed to the living environment of foster care (Van Holen et al., 2019).

4.1.1. Needs of the UMR in general

Throughout the brainstorming sessions in the project several general needs UMR (in foster care) were mentioned that need to be addressed within foster care. First a sense of safety and a time to rest were a precondition to develop a warm relationship. After months or years of situation where trust has been abused, the needs to have time and space to develop a relationship of trust is key.

Within a broader perspective, they also need quick and predictable procedures and a sense of inclusion from a societal and institutional perspective to create a sense of stability. School is an important partner with regards to the well-being of the minors, but the schools need to be aware of the context of the youngsters, the challenges relating to language (learning) and the fact that they might not been used to the school rhythm (due to unschooling because of the flight or little or no schooling in the country of origin). This can compromise (temporarily) the learning capacity of the UMR.

The partners of the FORM project observed that the high of (growing levels) of expectations of the UM do not coincide with the grief process and this can have different impacts on well-being, social relationships, and school. In general, allowing the UMR to have time to adapt, to grieve, to understand is fundamental. In regard to well-being is the presence of accessible and adequate mental health (preventive and curative) a must.

General and specific access to information on their rights and the functioning of the system and foster care is crucial to reinforce their agency and participation capacity.

4.1.2. The individual personality

In important attention point is to ask each UMR what its expectations and needs are. Each UMR has its own personality, wishes, habits, family history, attachment mechanisms. Those need to be considered. UMR are not a homogeneous group, even though policy and practice tend to deny this.

4.1.3. Family dynamics with the family of origin

An UMR is a minor who arrived without its parents, but he still remains a minor with a family context. The family from the UMR might seem invisible, but is still (very) present in the life of the UMR. Foster care deals here with so-called *collective world*: a transnational family setting. Attention should go to how to communicate and work (if applicable) with the parents in the country of origin. Within the family dynamics of origin of the UMR several questions can emerge relating to attachment, (conflicts

of) loyalty, projected expectations and mandate that are on the UMR shoulders and the UMR can be confronted with feelings of loss or ambivalence. The way the minor has left and the family's implications (or not) within the flight can also impact the UMR. For example, in cases where the parents have contracted a lot of debt or send the minor the activate family reunification this can lead to amplified pressure on the UMR. Other situations can also include the situation where the minor tried to escape certain (toxic) family dynamics. In those cases, the way communication is set up with the biological family needs to be even more carefully evaluated.

Two recurring topics show up in the occurring discussions: the loyalty conflict and the different forms of attachment. There are a variety of situations in which the UMR can find him/herself for example in a situation where his/her two worlds do not mix and where the minor has almost two different personalities. This can lead to (internal) identity conflicts. Also (both positive and more problematic) dynamics of parentification may arise.

4.1.4. The experience of exile

UMR are prone to exile specific dynamics. Their experience of violence, loss and grief is very specific. The question of the identity development will also have added challenges as maintaining a link to the culture of origin, the language, beliefs, and traditions might be under pressure as well as having to learn about a new culture and language. It is important to have a broad view of culture and not only to consider the general culture from the country of origin but also the more specific culture of the family of origin.

4.1.5. Mental health and resilience (strategies)

Research shows that there are high levels of war trauma and risks for PTSD within this group. This affects the UMR but also can add extra challenges in the foster care relationship. It has been suggested that mental healthcare should be standard care for UMR (Luster et al., 2009). When considering therapeutic foster care there is a presupposition that the UMR has extra needs and this raises the question of how (and who) assesses the extra (mental health) needs? This means also that some existing taboos around mental health need to be addressed, that the mental health services have to be adequate and tailored to this target group. Culturally sensitive mental health services should be developed, where there is an openness to work with interpreters is key. It has also been noted that individual care does not always have the best results (because of stigma around mental health among others) and that group support mechanisms might also be an interesting support tool (Bates et al.,2005). A broad spectrum of mental health support mechanisms needs to be available.

There is extensive documentation on mental health needs of UMR in this toolkit: https://guardianstoolkit.eu/wp-content/uploads/2018/10/In-dept-material-on-trauma.pdf. This toolkit discusses the following topics:

- Problematic attachment with explanations on the theory of attachment; attachment from an intercultural perspective and screening and treatment of problematic attachment.
- Psychological issues with information on ideas about health from an intercultural perspective; post-traumatic symptoms; depression; suicidal behavior and non-suicidal self-harm; destructive or inappropriate behavior and psychological guidance and treatment of unaccompanied children.

Besides the specialized mental health care, there is also a need to identify how to support daily the psycho-social needs of the UMR. Reinforcing existing resilience mechanisms and supporting the development on new resilience strategies are significant tools.

4.2. What are the needs, challenges and needed support mechanisms for the foster care parents?

In the existing literature we find the following aspects to consider (Van Holen et al., 2019):

The literature has identified 8 cluster of needs and characteristics of successful foster parenting.

4.2.1. Parenting skills and a good fit of the UMR into the foster family.

Several elements raised here general parenting skills, but also specific skills as "empathy, patience, realistic expectations of the UMR, mutual respect, good communication, the ability to not distinguish between the UMR and the biological children and a good relationship with the UMR" (Van Holen et al., 2019)

4.2.2. Good parenting conditions and personal skills.

Here the need for "a good partner relationship, being prepared to foster a UMR, having enough time, having the possibilities for respite and being appreciated and respecting as a foster parent". Promoting the self-development of the UMR, sufficient resilience, commitment, resilience, flexibility and using common sense are also important factors.

4.2.3. Tolerant society and information about options for family reunification

Living in the context of society that is open to the UMR and tolerant towards (minor) refugees is important. A sense of inclusion and belonging to the broader society also can be a powerful support mechanism for the UMR and also for the foster care family hosting the UMR. On the contrary experiences of racism and exclusion care have a negative impact on the UMR and on the foster care placement. Information and support for family reunification is needed as well so that the foster care family can have the adequate information and orient the UMR.

4.2.4. Support (material, medical, psychological, school) for the UMR and certainty about the future

This clutter mentions sufficient material conditions but also the need for guidance at school, medical care, and specialized psychological support as well as cultural translation.

4.2.5. Information on and an open attitude for the background and friends of the UMR

The need for information and openness about the background, culture, religion, language, and friends of the UMR.

4.2.6. Preparation of the UMR and reassuring contacts with the biological family and others

A good preparation of the UMR for foster care is a necessity. Contacts, if possible, with the UMR's biological family is an often-expressed need. The UMR needs the reassurance that his/her family is doing well.

4.2.7. Support and fellow contacts for the foster parents

Foster care families have a broad need for support. This support can be given through contacts or talking groups with other foster parents. More specialized support is also needed from the foster care agency and specialized services. The need for contact with 1 expert person and good contact with the guardian is a necessity.

4.2.8. Support from the context

Foster care families need to feel that they, as foster parents, and their foster child are receiving emotional, social and practical support from their broader family (grandparents, aunts/uncles, ….) but also from their larger social context (friends, colleagues…).

Preparation, training, supervision, continuous and emergency support is fundamental to be adequately supported for therapeutic foster care.

4.3. Transversal needs and challenges

4.3.1. Prevention of breakdown of foster care placements

Research shows 4 groups of factors influencing the success of family foster care placements: a) the foster family characteristics, b) expectations of foster families and UMRs, c) culture and d) contextual factors (Van Holen et al., 2019). We added a 5th factor: the question of silencing, sharing, and 'lying'.

4.3.1.1. The foster family characteristics

In the research of Van Holen (2019), the question of the cultural background of the foster family is mentioned. Within the very limited research on this topic, we see that US studies tend to see a favorable correlation between culturally matched placements and better health outcomes, smaller likelihood of PTSD and depression and better academic performance (Van Holen et al., 2019). Studies from the UK found more nuanced results with advantages and disadvantages with culturally matched families. The most important element was the quality of the relationship with the foster family. Maintaining a link with the mother tongue and culture is important but not decisive and the fact that non culturally matched foster families respected their cultural background was an important factor, combined with the personality of the foster parents linked to satisfaction within the foster family. With regards to language, communication was easier with culturally matched foster families, but non culturally matched foster families were seen as advantageous to learn the language of the country quicker.

The literature review of Van Holen (2019) showed that other characteristics, like patience, interest in other cultures, flexible thinking, good communication skills and a sense of humor were found important by the UMR.

During the expertise exchanges during the FORM project other "sub-type" of foster care families emerged: the non-kinship - non culturally matched foster care family, the non-kinship – culturally matched foster care family and the kinship (extended family) foster care family. Within the kinship families you can have families with different experiences and levels of settlement. On this topic research is severely lacking. The following considerations are based on exchanges during expert meeting.

We can also identify a difference within the kinship families due to the difference of ''level' of settlement in the host society. Some kinship foster families have been settled since a long time with clear perspective with regards to stay, knowledge about the institutions and the language. Other families are still in the stress of the procedure and have a limited knowledge of the system, language, and culture. There might be a lack of (support) network. More settled kinship families will not have the added stress of the procedure and might give more a feeling of safety with that regard. Some kinship foster families will not be parents themselves. This can also raise the need for support with regards to developing parentings skills. Kinship families (or culturally matched foster families) have the cultural know-how and the experience in migration and integration. Their intimate knowledge or the identity processes this creates can be very helpful for the UMR.

Non kinship foster families can simultaneously have more and less information or comprehension of the situation of the UMR. The exile and the impact of the procedure can be lesser known. Often, they do have more access to and knowledge about the societal system and the possibilities for the minor. There might be a certain shyness or avoidance to discuss traditions, sexuality, gender, religion and other sensitive topics (though that might also be the case in kinship foster families). Without an open mind and curiosity about the personality, background, and culture of the minor there might be a risk of misunderstandings or generalizations. It also raises the question if non kinship foster families have the awareness (or not) of what it means for the UMR to be part of a minority.

The building of a sense of home is quite key. It raises the question of: what is home? Is foster care an address/a home/ housing with a set of rules and habits/a additional family that creates a sense of belonging? This really raises the question of how the UMR is treated compared to the biological children of the foster family.

All 'type' of foster care families, deal with potential avoidance dynamics or taboos on topics like religion, culture, sexuality, or mental health and even though the 'taboo' might differ this needs to be addressed by the foster care agencies.

Overall, all foster families need to be supported in their parenthood and its specific challenges with a child/youngster growing up under the pressure of vulnerabilities of the psychodynamics of exile.

4.3.1.2. The expectations of foster families and UMRs

One of the most crucial elements with regards to the success of foster care placement that the UMR and the foster family have similar expectations (Van Holen et al., 2019). Information about Foster care for the UMR is utmost important as studies show that there is a lack of knowledge about what foster care is (often does not exist in the country of origin) which can lead to confusion and studies also show that UMR often have negative connotations associated with foster care with among others fears of discrimination and abuse (Van Holen et al., 2019) is key.

The first encounter plays also an important role is how the UMR is going to perceive the foster care placement. A house tour, sharing a meal, explanations around how the household functions (Sirriyeh, 2013) are important starting point. To increase the sense of belonging and create a feeling of reciprocity the involvement in decision making but also giving them responsibilities and chore are important (Van Holen et al., 2020).

In the literature, the most successful foster care parents were those who had "few expectations on the foster child, were open to new ideas and flexible in thinking. Those with rigid rules and expectations about how the foster child should behave and how the family should function had a higher risk of problems" (Van Holen et al., 2019). The assumption of foster families that the foster child would easily become part of the family was often contradicted with the fact that the UMR needed more time. Several UMR have been taking decisions on their own for a long time and might have difficulties to adjust to situation where the foster family takes more decision for them.

Certain difficulties can arise when expectations are unfulfilled or disappointed due to the (perception) of lack of respect, oppositional behavior, and slow acculturation, where clothing and hygiene can be tension points (Van Holen et al., 2019).

There are three relationship models distinguished (Sirriyeh, 2013) in the literature around foster care of UMR. First a 'like family" relationship where foster families and the UMR form a new family bond that translates in the expectation that the bond will last after placement and the wording used to address each relates to family bonds (for example mom, auntie, son). In de second model the UMR is

considered as a quest with which there is mutual respect but not a very close bond. The last model is bases on the idea of a "lodger" model where there is no sense of belonging and a certain distance between the UMR and the foster family. The sense of belonging in the foster family and the broader context are key in successful placements. This brings the attention to the need of clarifying expectations and having an appropriate matching procedure.

4.3.1.3. Culture

When foster families take into consideration the cultural background (food, religion, certain tradition or celebration) the sense of belonging is strengthened (Van Holen et al., 2020). Cultural tension points can arise (more or less and among others) around differences with regards to clothing, hygiene, punctuality, privacy, authority, boundaries, autonomy parent-child and gender roles (Van Holen et al., 2020). Also, non-verbal communication can lead to misunderstanding (for example looking in the eyes or looking away). The fact that UMR often do not speak fluently the host language can contribute to non be able to explain habits or feelings. In the ALFACA training guide there is an extensive overview of culturally related misunderstandings that may arise for example or the guilt versus shame culture of the question of vision and beliefs around health.

4.3.1.4. The (broader context)

Having a wide support network, in the broader context of the foster family (other family members, friends, …) and within the larger community is also very important. School and the foster agency are key supportive relationships (Van Holen et al., 2020)

The way the guardian fulfills his or her role is also important as this might lead to constructive working relationship where there is a clear understanding of who takes care of which administrative of psychosocial need. To the contrary, an absent guardian can lead to extra burdening of the foster care family.

The legal status of the UMR also has an impact as this might impact the possibilities and rights of the UMR but also impact the perspectives for the future. Not only the future of the UMR of itself but also the duration of the foster care relationship.

4.3.1.5. Silencing, sharing and 'lying'

Within all family dynamics, but certainly with regards to an exile story the question of what is shared and what is silenced can be very complex.

A potential source of conflict can be misunderstandings on the spectrum of "Truth-Lying". There is a need for a higher understanding of why a UMR might not tell the factual truth. It might also be related to (culturally)different of the notion of sharing. What you need to know within a family might not be similar to that of another family. Often telling 'the truth' is seen as a question of interpersonal respect. However, UMR have spent months or sometimes years just surviving. Surviving that included sometimes to lie to be able to survive (the border crossing, interrogations, to protect family members). Lying can therefore become a coping strategy of (self) protection.

5. To conclude

Therapeutic care can be a crucial added value in the development of UMR. This however implies that the needs of all actors involved are thoroughly analyzed with tools that might not yet exist in all countries or that are insufficiently adapted to the specificities of UMR. The needs and challenges listed in this section needs to be proactively addressed in the development of therapeutic foster care. Information, preparation, and support for the UMR needs to be organized. Foster care families

need to be carefully selected, trained, and supported (materially, emotionally, by access to general and emergency (mental health) services, support groups and respite). The matching and first encounters are key to the future success of the placement. A model should allow for evidence based or informed research, which now is still partial and quite severely lacking (for sure for certain type of foster care families).

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