

## **Foster Care Mentorship Program Proposal**

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## **Foster Care Mentorship Program Proposal: Section A**

### **Social Problem**

The social problem we will be addressing is the lack of support for foster children (5-12 y.o.) that have a clinical diagnosis and behavioral issues. There are limited-to-no mentorship programs in our area that work with this age group and demographic. The problem arises from the trauma prevalent in foster children's experience (Carrera, et al., 2024; Stewart, et al., 2023). Clinical diagnoses and behavioral issues often manifest in disruptive ways at home, at school, or at other public locations (ibid.).

Trauma-related clinical diagnoses and behavioral problems in foster children are important to address due to the prevalence of trauma experienced by this group and the lack of support to process those traumas and the resulting behavioral issues that manifest. The lack of mentorship programs presents a clear challenge to foster children, foster families, schools, and the public that have occasion to interact with these children. Helping children process their trauma with a mentor has been shown to improve outcomes for these foster children. It can also help to improve behaviors and reduce the frequency of being placed in a new home due to foster parents' inability to manage trauma-related behaviors. Additionally, working to solve this problem helps to prevent the spread of negative behaviors among other foster children in a foster home by helping children learn how to overcome poor behavioral patterns, gain coping skills for clinical diagnoses, and achieve better lifetime outcomes. In turn, these children will teach each other what they learn about appropriate ways to manage stressors.

According to the FY22-23 DCS Annual Report, statewide, 7,862 children received services from residential childcare and/or foster care in Tennessee during fiscal year 2023. On average, children remained in foster care for 291 days (FY22-23 DCS Report, 2024). In the

Tennessee Valley Region, which includes this project's target population in Hamilton County, there were 1,261 children placed in custody of DCS during the 22-23 fiscal year. 341 of these children were 5-12 years old (FY22-23 DCS Report, 2024).

Current statistics show that nationally, 9.6-10.1% of children aged 3-17 years old receive mental health services, and 7.8% of children take medication for mental health issues (Bitsko et al., 2022). The most common mental health disorders that these children experience are ADHD, anxiety, and depression (Bitsko et al., 2022). These national statistics provide a broad perspective of the prevalence of mental and behavioral health diagnoses in children. Looking broadly at the state of Tennessee, the situation reflects a high prevalence of behavioral health diagnoses with 23.2% of the general population of children 3-17 years old having one or more reported mental, emotional, developmental, or behavioral (MEDB) problems (CAHMI, 2024).

Analyzing the data reveals a relationship between environmental factors such as poverty, family structure, and the number of ACES a child experiences, and the rate of behavioral health diagnoses. For example, 20% more children in a grandparent or other family type home structure are reported to have an MEDB problem than a child from a two-parent household (CAHMI, 2024). Additionally, the percentage of children who have a score of two or more ACEs and qualify for an MEDB problem is 46.5%. Because foster children have higher exposure to ACES, poverty, and various family structures they are at even higher risk than the general population for poor physical and mental wellbeing (Turney et al., 2017).

According to an interview with a case worker at DCS in Hamilton County, Tennessee, 91 children have been placed in foster care in the county during 2024, and 59 (64.8%) of those children had a behavioral health diagnosis (H. Hancock, personal communication, September 4, 2024). The average number of placement disruptions in this county for a child with behavioral

problems is three times per year (H. Hancock, personal communication, September 4, 2024). These frequent placement disruptions further destabilize the lives of the children placing them at risk for compounded mental health diagnoses such as Reactive Attachment Disorder, Disinhibited Social Engagement Disorder (DSED) and Disorganized Attachment (Oleviera et al., 2022).

It is evident from this statistical data that further investigation of the usefulness of a mentorship program for children with behavioral health diagnosis in the Hamilton County foster care system is needed.

### **Target Population**

The target population will be children with behavioral problems ages 5-12 in foster care in the Hamilton County community. Our program will look at children with clinical diagnosis currently in foster care. Our program will be working with children that speak English and Spanish. The dispersion area will be within the Tennessee Valley Region specifically Hamilton County. Our program will be proposing to start this program under Partnership due to them working with foster kids already in other established programs.

### **Current Service Programs**

The Greater Chattanooga area has various mental health services and organizations. Youth Villages provides foster care services and mental health interventions for foster children (Youth Villages Mentoring Program, 2024). Partnership for Families, Children, and Adults hosts Camp Hope which provides weekly interventions and a summer camp for children and parents who have experienced trauma (Camp Hope, n.d.). Parkridge Valley Child and Adolescent Program offers inpatient and outpatient mental health services for children in the Chattanooga area (Parkridge n.d.). Erlanger Behavioral Health Hospital has a mental health treatment center,

but they only provide services to children over the age of twelve (Adolescent Psychiatry, 2024). Helen Ross McNabb Behavioral Health Center provides medicine management, counseling, and case management for children and youth (McNabb Center, 2024). Centerstone provides outpatient counseling services, parenting classes, and therapeutic foster care services (Centerstone, n.d.). Camelot, another foster care agency, provides case management, foster training, and therapeutic services to foster children (Southeast, n.d.).

### **Target Need**

This mentorship program's goal would be to reduce negative behaviors of foster children by providing social learning, academic role models, and social role models. Another implicit goal would be to lessen the burden on foster parents and thus reduce placement instability through this program.

### **Program Proposal**

#### ***Planned Program***

Our program aims to address the behavioral issues often reflected in foster care children by offering a mentorship program. We will be serving Hamilton County elementary children ages five and twelve that exhibit behavioral health challenges and have been or are currently in foster care. Many of the behaviors exhibited by foster children are trauma-related (though biological sources are also relative to behavioral issues in children). Research shows that mentorship-type programs are the most effective means of impacting the foster child and their behaviors in a positive manner.

Addressing behavioral issues in foster children is an important issue to address due to the prevalence of traumas experienced by foster children and the lack of support children face in trying to process their traumas and address the resulting behavioral issues that manifest. Helping

children process their behaviors will help improve those behaviors and reduce the frequency of new placements due to foster parents not feeling able to manage the behaviors of the foster children in their home (Sarkar, 2024). Additionally, mentorship prevents the spread of negative behaviors among children in the home by helping children learn how to overcome poor behavioral patterns (Sarkar, 2024).

### ***Environmental Scan***

The Greater Chattanooga area houses several behavioral health programs for children and adolescents. The programs provided are clinically based and open to the general population. There are several foster care-specific organizations that provide in home and residential services for children in foster care, but there are few programs specifically designed for mentoring foster children specifically. Youth Villages has a mentoring program in Tennessee and Georgia in which a child in foster care is paired with an adult and provided mentorship. This program is open to anyone who is interested in mentoring. Mentors spend four to six hours per month one-on-one with the child. The mentors receive training and access to group activities and tickets to local events, when available. The program is not specific to mental health or behavioral issues and is only provided to foster children in the Youth Villages program (Youth Mentoring Program, 2024). Formerly Partnership for Families, Children, and Adults supported the I.A.M. READY Center which provided mentorship for foster youth. This program is no longer available (Resource Links, n.d.). Partnership now offers Camp Hope, which provides year-round mentoring and a summer camp for children and teens who have experienced trauma. The goal of this program is to increase a child's sense of hopefulness (Camp HOPE, n.d.). Parkridge Valley Child and Adolescent Program provides clinical mental health services for children in the Chattanooga area (Parkridge n.d.). Erlanger Behavioral Health Hospital has an adolescent treatment center focused

on clinical interventions. They only serve children twelve and over (Adolescent Psychiatry, 2024). Helen Ross McNabb Behavioral Health Center provides mental health services and case management for children in crisis. Their outpatient program provides medicine management, counseling, and case management (McNabb Center, 2024). Centerstone provides outpatient counseling services, parenting classes, and therapeutic foster care services but no mentorship opportunities (Centerstone, n.d.). Camelot provides medical management, case management, foster care training, counseling, and outpatient therapy (Southeast, n.d.).

### ***Uniqueness of Program***

The program will provide mentorship and peer support for children aged five to twelve who are currently in foster care with clinical diagnoses and negative behaviors in the Greater Chattanooga area. The program provides services for ages five to twelve, whereas existing programs provide services to teenagers and adolescents.

## **Literature Review**

### ***Foster care***

Children in foster care are seven times more likely to experience trauma and to require trauma-informed interventions (Stewart, et al., 2023). Foster children also experience more traumas compared with clinically referred children for mental health services who are not in the foster system (Shdaimah & Zhao, 2024, Stewart, et al., 2023). Being a child within the foster system, thus, predisposes young people to a range of additional traumas that will compound the areas of treatment they will require. Trauma impacts the whole child. And in so doing, creates disorganized attachments and behavioral problems (West, et al., 2023). In addition, some children in the foster system have been previously adopted with a subsequent dissolution of the

adoption. This practice creates greater breakdown of attachments and increased trauma for children within the foster system (Brown, 2022).

### ***Mental Health in Foster Children***

Children in foster care require more services for mental health treatment than children not residing in foster care (Stewart, et al., 2023, Hambrick, et. Al., 2023). Over fifty percent of children in foster care meet the criteria for a mental health disorder. Yet, children in foster care experience barriers to receiving mental health treatment due to frequent moves and overwhelmed caregivers (Hambrick, et. Al., 2023). Foster children are statistically more likely to require behavioral health services than their peers, with an average of sixty-percent receiving a primary mental health diagnosis. They are more likely to undergo services in restrictive settings such as inpatient and residential treatment centers and are more likely to experience overprescribing of psychotropic medication (Chorniy et al., 2024).

### ***Resiliency***

Children aged five to twelve years old in foster care exhibit negative behavioral problems that have several impacts on resilience (Fischer et al., 2023). The foster care environment, which can often be harsher than those of their peers, contributes to increased negative behavioral outcomes which can influence overall development (Fischer et al., 2023). Children in foster care typically experience more mistaken judgments, feelings of inferiority or superiority, and reduced resilience which can lead to higher rates of mental health diagnoses later as well as negative behaviors (Fischer et al., 2023). Another factor impacting resilience includes age, as research indicates that children between seven and twelve years old tend to have lower resilience compared to those younger than 7 or older than 12 (Fischer et al., 2023). Specifically, children in the concrete operational stage, seven to twelve, show lower resilience due to developmental



changes and the increased importance of peer approval, which can lead to maladaptive behaviors (Fischer et al., 2023). During the preoperational stage, two to seven years old, children often use fantasy play to manage emotions, which can support psychological resilience (Fischer et al., 2023). In contrast, during the concrete operational stage, children face greater challenges as they seek peer approval and their cognitive and emotional development evolves (Fischer et al., 2023). Males in foster care are generally found to be less resilient compared to females (Fischer et al., 2023).

Risk factors affecting resilience include age, sex, race, maltreatment history, and placement type (Fischer et al., 2023). Protective factors, such as placement stability and social support, are important but may not fully counteract the risks (Fischer et al., 2023). Mental health services, while crucial, may be accessed after behavioral problems have developed, thus their impact on resilience can be limited (Fischer et al., 2023). This suggests a need for targeted interventions that address the specific risks faced by foster children, including their developmental stage, trauma history, and social context (Fischer et al., 2023). Interventions should also consider the child's perception of their environment and themselves. While the literature doesn't give a specific recommendation, our mentorship program can help improve a child's perception of their situation (Fischer et al., 2023). In conclusion, children aged five to twelve in foster care who exhibit negative behavioral problems face unique challenges related to their developmental stage and the harshness of their environment (Fischer et al., 2023). Their resilience is influenced by a complex interplay of age and gender, and both risk and protective factors (Fischer et al., 2023). Effective interventions need to be age-appropriate, address trauma, and focus on improving the child's perception of their situation (Fischer et al., 2023).

### *Negative Behaviors in Foster Care*

The outcome of trauma experienced by foster children often leads to substance abuse and behavioral disorders associated with abandonment and neglect. Children who grow up in foster care have higher rates of substance abuse and behavioral problems in later life. Similarly, they are more likely to be involved with the justice system than those who do not have an association with foster care. Reactive Attachment Disorder (RAD) is a common diagnosis for children who have been abused and neglected. Children with RAD do not readily form attachments to a specific caregiver resulting in negative behaviors such as: “misery, huddling, clinginess, an inappropriate lack of response, aggression, unexplained fearfulness, or irritability” (Bruce et al., 2019). Negative behaviors from diagnoses such as RAD are shown to be preventable if the child experiences positive social-emotional connections (Haggerty, et. Al., 2023). One-third of foster children are not well adjusted across major domains of behavior including social and mental competence, adversity factors, and behavioral, emotive, and attachment regulation and stabilization (Carrera, et al., 2024).

In conclusion, trauma related to foster care exacerbates social problems of child mental health, behavioral health, and resiliency. Children in foster care have higher rates of mental health diagnoses and behavioral problems than children who do not have experience in the foster care system. Many of their mental health diagnoses are related to attachment issues and neglect resulting in difficulty establishing healthy social connections. Foster children are in need of social support that can help them develop healthy attachments and overcome negative behaviors. The social support that foster children require includes positive interventions to help them overcome negative and harmful behaviors. The literature provides evidence that mentorship programs provide positive outcomes for children by establishing healthy social connections and

opportunities for interpersonal learning. Mentorship programs are uncommonly offered to younger children but could help prevent the development of more severe negative behaviors in adolescence. Children benefit from older mentors and peer-based mentorship programs.

### ***Mentorship for Foster Children***

Behavioral problems are often due to the lack of a healthy social and emotional development. Social and emotional development in children is dependent upon children forming healthy connections and relationships with adults. Mentorship provides a safe environment for children from traumatic backgrounds to form healthy connections (Poon, et al., 2021; Haggerty, et. Al., 2023). Mentorship has been shown to improve behaviors and mental health over time for foster children (Poon, 2021; Weiler, et. Al., 2022). In a meta-analysis of 55,561 foster children Poon and associates (2021) found that mentorship had a positive outcome for children in the foster system throughout their lives (Poon, 2021). The impact of preventative programs such as mentorship or caregiver guidance may not become evident until the child reaches an age where they are exposed to more risk-taking opportunities, but the intervention will prove its worth over time. Mentorship early on in life can provide a framework for creating healthy patterns and preparing foster children for adolescence and adulthood (Haggerty, et. Al., 2023).

### ***Mentorship Methods***

Three types of mentoring programs are commonly utilized when working with foster children. The first, is a supportive mentorship model in which the relationship serves as the intervention and the success or failure is determined based on the reported quality of the relationship (Cavell et al., 2021). This model requires the mentorship relationship to be built over a long period of time and allows the mentor to become an integral part of the mentee's long-term support system. This model is widely criticized for its weaknesses because it is most likely to be

terminated prematurely if the mentor-mentee relationship is not well matched (Cavell et al., 2021). One example of successful mentorship for children in schools showed that even when mentors didn't specifically do anything, simply showing up at the school lunchroom to sit with their mentee benefited children who were chronically bullied in school (Cavell et al., 2021). Though longevity of the relationship is sometimes difficult to maintain, Youth who choose their own mentor tend to have more enduring relationships, which predicts better outcomes (Cavell et al., 2021).

The second mentorship model is problem-focused mentoring, which utilizes the mentor relationship as a means to undertake activities to address a specific behavioral or practical problem that the mentee is experiencing. The purpose is to provide extra support for a child who is working on a particular behavioral problem as a supplement to professional support (Cavell et al., 2021). This model has proven especially successful when combined with weekly skills groups. A study by Weiler and associates (2022) found that amongst 426 children, mentorship programs significantly improved children's outcomes for quality of life and decreased trauma behaviors (Weiler et al., 2022). The third mentorship model is transitional mentoring, which supports the mentee through a specific vulnerable transitional period in their life. This type of mentorship is time-limited, and its purpose is to help the child feel safe and supported as they navigate specific changes in their lives (Cavell et al., 2021).

### ***Teaching Relational Skills***

A study on Video-feedback Intervention revealed that teaching positive relational skills to caregivers of foster children improved overall child behavior. In the quantitative random controlled trial of 100 Flemish foster children, it was discovered that children whose foster parents received sensitive discipline training experienced less insecure attachments when the

child was under 30 months of age and experienced reduced external behavior problems among all children in the intervention group. The strategies employed in sensitive discipline training could be applied to training methods administered to mentors within a proposed program. These teaching methods provide adults with skills to establish secure attachment through sensitive discipline, which thus reduces negative behaviors (West, et al., 2023).

### ***Peer Mentorship***

Peer support programs are another effective means of improving child well-being cognitively, behaviorally, socially, and emotionally (Poon, 2021; Mitchell, et. Al. 2024; Friesem and Greene, 2020). Children who have experienced emotional abuse respond more positively to peer-based mentorship as opposed to mentorship from older mentors (Poon, 2021). Peer mentors are often close in age to mentees, have shared experiences, and, as a result, are seen as credible messengers. Additionally, there are benefits of transference when a peer without mental health challenges models their regulated, healthy cognitive and social functioning for a foster child lacking in that area. Children enrolled in a peer support program reported that the program kept their interest by helping them feel empowered, providing opportunities to build connections with a supportive person, and provided a space where they felt safe (Mitchell, et. Al. 2024).

In conclusion, mentorship provides a relational intervention for foster children experiencing negative behavioral and mental health problems. Mentorship may be offered in various formats depending on the needs of the child enrolled in a program. Peer mentorship also provides a unique opportunity for children to develop positive behaviors by connecting with a trusted individual with similar experiences.

Children in foster care between the ages of five and twelve often exhibit behavioral issues as a result of the traumas that they have experienced in their lives. Further, we know that if these

children are provided with mentorship, especially a peer-based mentorship program, they are more likely to experience positive results. Additionally, sensitive parenting training for foster parents will help to improve the behaviors of children placed in foster care and can be incorporated into mentor training, as well, due to its effectiveness. However, we do not know the needs of the foster parents and children in the Chattanooga area that can be addressed through a mentorship program. For that reason, it is important for us to explore the needs of mentorship within the Chattanooga area more specifically.

## **Needs Assessment**

### ***Sources of Data***

The sources of data for the needs assessment will be gathered through a combination of surveys from foster parents, interviews with older youth who have aged out of foster care, and existing DCS records in the Greater Chattanooga area of children 5-12 years old who have behavioral problems. Additionally, records will be gathered from existing peer mentorship programs in the state of Tennessee to determine the effectiveness of their efforts. A survey and interview guide will be created to match the needs assessment.

### ***Statement of Purpose***

The purpose of this needs assessment study is to determine the social and mental health needs of foster youth ages five to twelve with behavioral problems in the Chattanooga area.

### ***Research Questions***

The research questions that we will be exploring include:

1. What are the social needs of children in foster care in the Chattanooga area?
2. What are the mental health needs of children in foster care in the Chattanooga area?

3. What are the educational needs of children in foster care of foster children in the Chattanooga area?

### *Hypotheses*

Null hypothesis (H0):

1. There are no specific, identifiable, social needs that impact only foster children with negative behaviors in the Greater Chattanooga area.
1. There are no specific, identifiable mental health needs that impact only foster children with negative behaviors in the Greater Chattanooga area.
2. There are no specific, identifiable educational needs that impact only foster children with negative behaviors in the Greater Chattanooga area.

Alternate hypothesis (H1):

1. There are specific social needs that impact foster children with negative behaviors in the Greater Chattanooga area.
2. There are specific mental health needs that impact foster children with negative behaviors in the Greater Chattanooga area.
3. There are specific educational needs that impact foster children with negative behaviors in the Greater Chattanooga area.

Independent variable/s (IV): The independent variables in the study have been identified as the child's experience within foster care such as length of stay, age at entry, number of placements, number of siblings, etc.

Dependent Variable/s (DV): The dependent variables have been identified as mental health, behaviors, attachment formations, and education.

Controlled variable/s (CV): The controlled variables have been identified as age, gender, income, grade, and other demographic information.

Extraneous Variable/s (EV): The extraneous variables have been identified as ability to understand language, child being moved to a new placement during the study, and the ability and willingness to consistently participate in the study.

This study will include mixed-methods research because it includes both quantitative information (surveys) and qualitative data (interviews) (Hales et al., n.d). This methodology is the most appropriate because it would provide more in-depth information than other studies in our area (Hales et al., n.d). Mixed-Methods studies utilize triangulation of data which is a variety of data sources which help strengthen conclusions in findings and reduces the risk of false interpretations (Hales et al., n.d).

### ***Population***

The population of the interview study would include adults who were in foster care from ages 5-12 in the Tennessee Valley geographical area. The survey population would include foster parents who are currently caring for children in foster care ages 5-12 in the Tennessee Valley geographical area.

### ***Inclusive Criteria***

All people in the study will be from the Tennessee Valley geographical region. They will have been in the foster system between the ages of 5-12 while in foster care.

### ***Exclusive Criteria***

This study will exclude individuals who are non-verbal. The study would not include adults who have not been in foster care during the ages of 5-12, and individuals who are outside of the Tennessee Valley region.



### ***Sample Selection***

The sample for the survey will be collected by randomly selecting foster parents from the Department of Children's Services foster care enrollment list. DCS will provide a list of all foster parents whose foster children meet the age requirements. The provided list will exclude names, and each person will be assigned a number. Two hundred individuals will be drawn at random from the list for the survey. The sample for the interviews will be collected by contacting former foster youth who are adults and enrolled in the extension of foster care program. Twelve individuals will be recruited for the interviews.

### ***Rationale***

The population for the study was chosen to most accurately represent the population that the program intends to serve. Foster parents were chosen for the survey because they regularly interact with foster children who may have behavioral concerns. Adults who were formerly in the foster system were chosen for the interviews because they would be able to provide narrative information about their experiences in the foster system.

### ***Permission***

Permission for the study will be sought from the Director of Training at the Department of Children's Services, Rhonda Faulkner. This person oversees research for the department. To conduct the study, the research team will need to receive permission from the state and informed consent documentation for all participants in the study.

### ***Data Collection***

The data collection process for the surveys to be completed will include the creation of the surveys by LCSWs. The questions will be free of bias and leading questions, will respect

diversity, will be written in a clear manner so that the questions they ask and the answer choices they offer are without ambiguity. They will also be asked in an empathetic manner in order to gain trust and will include a page involving their consent to participate in the survey and the promise of confidentiality to all participants at the outset. To find foster parents willing to share their perspectives on the behavioral challenges of the foster children they are caring for, we will ask DCS to hand out surveys to interested persons during their visits. We will also keep a locked box at the location where participants can drop their completed surveys, which will be collected by the research team by a certain date. Additionally, we will visit the Chambliss Center for Children, Omni Family of Services, Youth Villages, Ridgedale Baptist Church, and Kidlink Community Services to provide surveys to foster parents and encourage participation in the survey. Locked boxes to collect completed surveys will be available at each location. All surveys will be collected at the end of the survey period from each secure location and will be kept in a locked compartment to ensure the integrity of the data is maintained. The surveys would then only be available to researchers who would work to integrate the results of the surveys into a spreadsheet for analysis. No rewards would be offered for the completion of the surveys.

The data collection process for the interviews conducted will include the creation of potential interview questions, with special concern that no bias or discrimination are reflected in the questions and that they are culturally relevant to all participants. Next, letters will go out to transitional foster youth still receiving state funding requesting their participation in an interview for those who were in foster care during age 5-12, aimed at improving the social, emotional, and behavioral health of foster children. Additionally, billboards and posters will be displayed throughout Chattanooga with information regarding how transitional foster youth or aged-out foster youth from age 18-25 can sign up to participate in an interview regarding their foster care

experience during the ages of 5-12, aimed at improving the social, emotional, and behavioral health of foster children. Both letters and public advertisements would list \$20 gift cards for those who participate in the interview process. The interview would cap at the first 12 people who responded and were verified as being eligible to participate. Permission to secure a given location for the interview would be granted. Then, the interview date and time would be announced and begin with the signing of consent forms. Following the signing of consent forms, the semi-structured interview would be conducted by an LCSW that will be prepared to show empathy as she records the experiences of these transitional or aged-out foster children, now aged 18-25). Following the interview, counselors would be on staff to assist participants privately with potential triggering that may occur during the course of the interview and may cause some level of distress in the participant. And finally, consent forms and any notes or recordings taken during the course of the interview would be placed in a locked cabinet or box to ensure that all information connected to the interview will be secure. The information collected would only be available to researchers connected to the interview and not to be available in an unsecure fashion and with an understanding that the identities of the participants would be secured.

### ***Data Analysis***

The data gathered from surveys of foster parents, interviews with older youth who have aged out of foster care, and existing DCS records in the Greater Chattanooga area will be analyzed using a mixed methods approach, incorporating both quantitative and qualitative data analysis procedures. For the quantitative data from the surveys, statistical analysis will be conducted using descriptive statistics with nominal and ordinal measurements described using frequencies, percentages, mode, median, and ranges depending on the data. Ratio and interval data will be described using means, standard deviation, and ranges. When making comparisons

such as social needs and placement types among groups T-test and ANOVA testing will be utilized.

For the qualitative data collected from the interviews, a thematic analytic approach will be applied. Video recordings of the interviews, as well as transcripts, will be reviewed. A one-page summary of each transcript will be written, highlighting major themes and identifying patterns. An emergent coding method will be used to label these patterns. Memos will be created to define each code and explain its construction, and a codebook will be developed from this information. The SAS, 9.4 software program will be utilized for quantitative data analysis, while NVivo 14 will assist in the analysis of qualitative data.

***Research Questions:***

1. What are the social needs of children in foster care in the Chattanooga area?

The results will likely show that the major social needs of children in foster care in Chattanooga would reflect those found throughout Tennessee, including foster care instability and poor access to mental health treatment (Fite, 2023). Without adequate foster care homes and services, children will continue to struggle with a sense of stability which impacts attachments and ability to manage the mental health needs that have arisen from the abuse they have experienced. Additionally, food instability is likely to be a social concern for children in Chattanooga, as well, since 40% of Tennessee children live in homes that experience food instability (Lowary, 2024).

2. What are the mental health needs of children in foster care in the Chattanooga area?

The mental health needs of children in foster care in Chattanooga will likely include services to assist with depression, ADHD, anxiety, ODD, conduct disorder, PTSD, and reactive attachment disorder (Fite, 2023; Mason, 2024).

### 3. What are the educational needs of children in foster care in the Chattanooga area?

The educational needs of children in foster care in Chattanooga will likely include tutoring with tutors that are able to work with children with mental illness or behavioral problems, as foster children are more likely than their peers to experience mental health challenges (Mason, 2024). Also, educational needs occur due to frequent home and school placement changes which put children behind academically. With each move, children lose about four to six months of academic progress (Lahey, n.d.) In fact, 8/10 foster children have maladaptive educational trajectories (Melkman, 2020). Additionally, they need surrogate parents who will monitor children's educational progress with interest and actively note needs to be filled to assist child toward educational success. Finally, children need to experience stable school enrollment throughout a school year, which is difficult since Tennessee has one of the worst unstable housing experiences for foster children in the country (Fite, 2023).

#### ***Ethical Considerations***

It is to be considered that participating in this study for some participants could cause them to recall traumatic events or what might have been an uncomfortable time in their life when they were involved with foster care. These memories may evoke a psychological response such as anxiety, sadness, regret, etc. With these potential responses, participants will be offered available debriefings, if needed. Participation will be voluntary, and they can withdraw without penalty. While collecting the data, surveyors will allow the families time to thoroughly read the informed consent and sign before completing the survey. Once the survey is completed, to ensure anonymity, the participant will place his/her survey in an envelope to be transported back to the office to be placed in a designated area where only designated persons may be allowed to access the data. While analyzing the data, only designated persons will have access to the analysis of the

data. The participants names and identifying markers will not be visible to the individuals analyzing the data, thus, keeping the survey completely confidential. After data is collected, designated persons will have up to one year to refer to the data. All data will be kept up to one year after which the paper surveys will be shredded and disposed of. Any data we do store online or on a computer will be password protected with two factor authentication and then it will be deleted from the hard drive. Data will be stored in designated locked areas where only designated persons will have access. This is to ensure that confidentiality is kept.

### ***Plan to Mitigate Ethical Concerns***

The needs assessment research plan will utilize culturally informed, anti-racist, and anti-oppressive strategies such as utilizing random sampling and inclusive language. The informed consent form and survey/interview guide will use inclusive language, anti-racist/anti-oppressive terminology for gender identity and ethnicity by providing multiple options for ethnicities as well as gender (male/female/non-binary/other). The forms and guide will use culturally appropriate language for the demographic surveyed by using language that is educationally on par for the sampling region.

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