A PROGRAM EVALUATION OF A UNIVERSITY-BASED MENTAL HEALTH

PROGRAM FOR FOSTER CARE CHILDREN AND FAMILIES

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ABSTRACT

Young children who enter the foster care system may have an increased risk emotional, behavioral, and developmental disorders when compared to the general population (Leslie, Landsverk, Ezzet-Lofstrom, Tschann, Slymen & Garland, 2000). This dissertation documents the process of planning and conducting a program evaluation of a university-based counseling program that provides therapeutic services for children in the foster care system. The Foster Care program addresses the psychological and social problems of being involved in the foster care system through therapy and consultation. The program evaluation that was planned and conducted used Maher's (2012) program planning and evaluation framework. The first research task was the creation of a Program Design document. This document put the program into an evaluable format using Maher's model (2012). The second research task was to determine the extent in which the program was being implemented as designed. Data were collected through interviews with stakeholders, survey responses of graduate student therapists, and a review of program related documents. The intent of the Program Design Document and evaluation of program implementation was to determine strengths of the program and make recommendations to key stakeholders involved in the Foster Care program. Recommendations were offered about the development, improvement and ongoing evaluation of the Foster Care program.

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Chapter I: Introduction

Brief History of Foster Care

The foster care system in the United States grew exponentially within the 1980's and 1990's (Mallon & McCartt-Hess, 2013). In 1995, it was estimated that there were more than 500,000 children in out of home placements in the United States (Mallon & McCartt-Hess, 2013). Between 1982 and 1995, the number of children living in foster care in the United States increased 63 percent from 435,000 to 710,000 (Smith & Merkel-Holguin, 1996). The number of children in child protective services increased between 2008 and 2012 (Mallon & McCartt-Hess, 2013). According to the most recent statistical publications, an estimated 415,000 children currently live in foster care in the United States (USDHHS, 2014a). Despite data indicating that the number of children in foster care has declined in the recent years, those children who enter the system continue to have substantial service needs (Mallon & McCartt-Hess, 2013). The federal foster care system as it now exists has difficulty meeting the complex and multiple needs of the high number of children entering the system. The foster care system in this country was intended to provide protection and shelter for dependent children. It was designed to be a temporary solution with a goal of family reunification or adoption into a suitable family. However, children involved in the current foster care system face a bureaucratic system that is burdened by a lack of coordinated resources and limited trained professionals (Mallon & McCartt-Hess, 2013).

The 2013 data from the New Jersey Kids Count report suggests that the prevalence rate has plateaued in the last few years (Advocates for Children of New Jersey, 2013). The New Jersey Kids Count report indicates that the number of children

entering foster care in New Jersey has remained at approximately 48,000 children in the foster care system between 2010 and 2012, while the number of children exiting care has increased. The state division has attributed this progress to an increased reliance on kinship placements, shorter placements, and an emphasis on timely termination of parental rights and adoption proceedings (Advocates for Children of New Jersey, 2013).

In 2012, 7,474 of the 51,255 children who were under Division of Youth and Family Services supervision in New Jersey lived in out-of-home placements (Advocates for Children of New Jersey, 2013). Out of these children who were removed from their biological families, 3,929 children lived in non-kin resource families, 2,667 children lived in kinship care, 723 lived in group homes and residential settings, and 155 children lived in independent living facilities. The amount of time spent in foster care demonstrates that a majority of children (70.4%) stay in foster care for less than one year. Approximately 19.9 percent of children stay between one and two years, and five percent of children remain in foster care for two to three years (Advocates for Children of New Jersey, 2013).

Mental Health of Children in Foster Care

Children who enter into the foster care system usually have experienced some form of maltreatment- whether it is neglect, physical, emotional, or sexual abuse (Clausen, Laudsverk, Ganger, Chadwick & Litronwnik, 1998; Cohen, Mannarino & Deblinger, 2006). In 2014, approximately 3.2 million children were the subjects of reports, or referrals, for an investigation into maltreatment. 702,000 children of the 3.2 million were found to be victims of maltreatment or abuse (Center for the Study of Social Policy, 2014). From the years 2010 through 2014, the national victimization rates

remained at approximately 9.3 per 1,000 children (Center for the Study of Social Policy, 2014).

Current research indicates that as many as 80 percent of adolescents involved with child welfare agencies have behavioral or emotional disorders, developmental delays, or other issues requiring mental health interventions (Landsverk, Garland & Leslie, 2002). Prevalence in mental health disorders in foster care children ranges from 40 to 80% (Burns et. al., 2002). These statistics are in stark comparison to community samples where disorders in children range from 14 to 25% (Burns et. al., 2002). A national study of children in the foster care system indicated that almost half of children in the sample (*N*=462) required mental health services (Leslie, Hulburt, Landsverk, Barth & Slymen, 2004).

Children in foster care are exposed to a number of environmental, social, biological, and psychological risk factors that can explain a foster children's vulnerability to psychological disorders (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006). The high risk for physical and mental health problems stems from the maltreatment they have experienced, the separation from their families of origin, and the frequent disturbances to their everyday lives (Newton, Litrownik & Landsverk 2000). Children experience trauma associated with dysfunctional family settings and the reactions to traumatic experiences of being placed in foster care and being separated from parents and often siblings (Thorpe & Swart, 1992). Children in foster care commonly report feelings of rejection, anger, guilt, shame and abandonment in response to the loss of their family and neighborhood (Pasztor, Hollinger, Inkelas & Halfon, 2006). Similarly, frequent placement changes and the ambiguity surrounding the stability of foster care placement make it difficult for

children in foster care to develop appropriate attachment to caregivers and have been hypothesized to also promote susceptibility to psychological disorders (Pasztor, Hollinger, Inkelas & Halfon, 2006).

Recent studies that investigated the mental health of children in out-of-home placements showed that these children display multifaceted psychopathology, characterized by attachment difficulties, relationship insecurity, unsafe sexual behavior, trauma-related anxiety, conduct problems, defiance, inattention/hyperactivity, self-injury and food maintenance behaviors (Clausen, Laudsverk, Ganger, Chadwick & Litronwnik, 1998; Cohen, Mannarino & Deblinger, 2006; Garwood & Close, 2001; McMillen, Zima, Scott, Auslander, Munson, Ollie & Spitznagel, 2005). Furthermore, most children in foster care come from impoverished environments, where they are vulnerable to the myriad of risks associated with poverty, such as inadequate access to prenatal care, homelessness, and limited educational opportunities (Pilowsky, 1995). Biological parents of children in foster care have experienced more changes in marital status and criminal charges than other parents of similar socioeconomic status (Clausen, Landsverk, Ganger, Chadwick & Litronwnick, 1998). In addition, high proportions of children in foster care come from families with histories of mental illness or drug or alcohol abuse (Lockwood, Friedman & Christian, 2015).

Mental Health Service Program Evaluations

Due to the plethora of mental health needs of children in foster care, there is a need for the examination of available services for children in foster care. Rigorous evaluations of the implementation and effectiveness of interventions designed to treat the foster care population are important to improve child and family outcomes. Research has

indicated that there are several modalities that are empirically supported to treat children with complex trauma and behavioral issues (Weiner, Schneider & Lyons, 2009).

The current research on programs serving foster care youth is focused on providing large-scale national, state, or multi- site demonstrations of outcome data (Framework Workgroup, 2014). These programs have focused on large-scale foster care youth programs that were designed to provide information regarding whether the services were effective as applied to the population. This large-scale approach is in contrast to a single-site agency specific evaluation. Although there have been some documented efforts to evaluate child welfare services, the results have limited utility for individual organizations who wish to examine the program for qualities such as implementation integrity. Thus, the methods and procedures in the current body of research are not easily translatable to smaller sites providing mental health services to foster care youth.

Dissertation Task

The purpose of this study was to provide constructive and relevant information to the personnel of a university-based Foster Care counseling program in New Jersey. The Foster Care program provides mental health services to foster care children and families. Data were collected through informal consultation (i.e., clarification of items on program related documents or program policies and procedures), with the program director, survey responses from graduate students involved with the program, and a review of program related documents.

Two tasks were completed using a systematic program evaluation approach as described by Maher (2012). *The first task was the creation of a Program Design document*. This document put the program into an evaluable format using Maher's model

of Program Planning and Evaluation (2012). Putting a program into an evaluable format, through the creation of a Program Design document, serves as a means to provide stakeholders with information to further develop and alter program goals, components, and activities (Maher, 2012). This was developed through collaboration with key stakeholders from the program. The documentation of the program evaluation planning process provides formative information to mental health professionals who may wish to incorporation program evaluation into a similar organization or to consult with this type of program in the future. The product of this dissertation was a program evaluation plan, which included a protocol for addressing whether the program is being implemented as designed.

Literature on mental health services for children in the foster care system indicates that there are interventions and practices that are empirically supported (Weiner, Schneider & Lyons, 2009). These methods have been shown to improve the mental health of children in the foster care population (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2006). Minimal research has been conducted in the field of program evaluation for single site mental health services targeting the foster care population (Framework Workgroup, 2014). To add to this body of research, the second dissertation task was to evaluate the standards of practice in the Foster Care program. *The second research task was to answer the following program evaluation question: To what extent is the Foster Care program being implemented as designed?*

The Program Design document and best practice findings provides information to the stakeholders who are involved in the Foster Care program, enabling sound decisions to be made about the program and contributing to program development and

improvement. The current study has also implications for mental health professionals,

administrators, and others in the field that work with this target population.

Chapter II: Literature Review

Historical Context of Foster Care

The foster care system in the United States is connected to a historical child welfare initiative that is characterized by increasing awareness, attention and support for children's wellbeing and family preservation (Trattner, 1989). Beginning in the early 20th century, with the use of "orphan asylums", a reform movement took hold, which focused on the removal of children and recognized their needs as different from those as adults (Smith & Merkel Holguin, 1996; Trattner, 1989). In 1853, Reverend Charles Loring Brace became involved with the Five Points Mission in New York to aid orphaned and abandoned children. He founded the Children's Aid Society of New York as a way to "place out" and protect children from their environment and sever ties with parents who were found to be incapable of caring for their children (Trattner, 1989). This "placing out" model was the first model of family foster care (Trattner, 1989). The Children's Aid Society moved children ages 7-17 years old to farm communities in the Midwestern United States. Carloads of "orphan trains" were transported to families where the children were expected to earn their keep by labor. Younger children were typically taken in and cared for as members of the family. However, older children were expected to perform a considerable amount of work on the farms where they were placed (Trattner, 1989). Between 1853 and 1929, various reports suggest that Brace's organization transported up to 200,000 children (O'Neill Murray & Geisreich, 2004; Smith & Merkel-Holguin, 1996; Trattner, 1989).

In 1935, Aid of Dependent Children and Child Welfare Services Program (ADC) was created as part of Title IV of the Social Security Act (O'Neill Murray & Gesireich,

2004). Under ADC, federal funds provided support to keep nuclear families together (O'Neill Murray & Gesireich, 2004). The ADC provided payments to orphaned children (O'Neill Murray & Gesireich, 2004). The Social Security Act of 1935 resulted in federal government increasing its involvement in the child welfare system (Smith & Merkel-Holguin, 1996). Families could rely on federal assistance instead of turning to asylums or child placement agencies, but federal involvement led to a dramatic increase in the number of children removed from their homes (Smith & Merkel-Holguin, 1996). The number of children in out of home placements reached at an all time high in the 1930's when it was estimated that an excess of 144,000 children were in institutions and an additional 100,000 were in other forms of out of home care (Trattner, 1989). In the 1940's and 1950's, the use of asylums and institutional care for children declined. By 1950, more children were in in foster homes than in institutions. By 1968, there were three times as many children in foster care as in institutions. With this decline in the use of asylums, there was an increased need for foster families for children removed from their homes (Curtis, Dale & Kendall, 1999).

In the 1960 and 1970s, there was a major increase in reports of child abuse. This was caused, in part, by the publication of "Battered Child Syndrome". The publication by Dr. C. Henry Kempe (Kempe, Silverman, Steele, Droegemueller & Silver, 1962) outlined the symptoms of a condition in young children who have received serious physical abuse from a biological or foster parent. By the late 1970's, child protection professionals and the public at large began to attend to the symptoms of child and sexual abuse in children more acutely (Trattner, 1989; Mallon & McCartt-Hess, 2013). The increased demand for the foster care placements was also due to the increased federal funding for foster care

children through the Aid To Families with Dependent Children (AFDC) (Mallon &
McCartt-Hess, 2013). Although AFDC was created during the Social Securities Act of
1935, it wasn't until the Social Security Act of 1935 was amended that allowed an
extension of funds through the program AFDC to children in foster care. This extension
of AFDC was additionally expanded to include payments for children placed in private,
non-profit institutions. By 1969, the law was amended to increase federal funding of
foster care payments and to require all states to establish Aid To Families with Dependent
Children foster care programs (Mallon & McCartt-Hess, 2013).

The Child Abuse Prevention and Treatment Act of 1974 (PL93-247) formalized
the mandate requiring states to provide avenues for reporting child abuse and neglect
(Mallon & McCartt-Hess, 2013; O'Neill Murray & Gesireich, 2004). With the passage of
this legislation, the number of children reported for abuse and neglect grew
exponentially. This resulted in an increased rate of new children into the foster care
system. By 1977, eight out of every 1,000 children were in foster care placements
(Mallon & McCartt-Hess, 2013). In response to increasing numbers, Congress passed the
Adoption Assistance and Child Welfare Act in 1980 (O'Neill Murray & Gesireich, 2004).
This act attempted to shift policy toward family maintenance and enabled the
reunification of children their families as quickly as possible if temporarily removed. The
legislation was also implemented to prevent unnecessary placement of children in foster
care. The act also required that all efforts would be made to find a permanent adoptive
home for the child (O'Neill Murray & Gesireich, 2004). As a result of this act, the
number of out of home placements decreased between 1980 and 1982 (Curtis, Dale &
Kendall, 1999).

However, the number of children in foster care increased in the 1990's and 2000's (Curtis, Dale & Kendall, 1999; Mallon & McCartt-Hess, 2013). This may be attributed to the increase in the urban foster care population. The main demographic for this population is infants under one year of age who are removed from their biological parents. Not only were more children entering foster care, but they were also staying longer (Curtis, Dale & Kendall, 1999; Mallon & McCartt-Hess, 2013).

An additional reason for the increase in placements was the growing popularity in kinship care. By 1990, formal kinship care, or placement with a relative, was an important part of foster care services. At that time, approximately 1.4 million children were living with families or relatives (Duerr-Berrick, 1998). Although informal care with relatives has been historically utilized by many families, the formalization of this option was an important development in child welfare services. The growth in kinship placements may be attributed to the increased number of children in the foster care system in the 1990's and the lack of available resource parents (Duerr-Berrick, 1998).

Current Foster Care System

In the last decade, the U.S. foster care population has undergone a substantial reduction in size and experienced a shift in its racial and ethnic composition. Between 2002 and 2012, there was an approximate 25% reduction in foster care placements. (Administration on Children, Youth and Families, 2013). Federal policies have emphasized increasing permanency for children in the child welfare system through strategies that include family preservation and timely placement (UDHHS, 2015b). According to the Adoption and Foster Care Analysis and Reporting System (UDHHS, 2015b) the primary documented case goal for individuals in foster care for 2014 were:

reunification with primary caregivers (55%), adoption (25%), followed by emancipation (5%).

The Obama Administration's 2013 budget proposal included a number of initiatives designed to improve outcomes for children in foster care and incentivize both systematic reform and individual foster and adoptive parenting (Children's Defense Fund, 2012). These proposals included additional funding for state programs seeking improved performance, increases in adoption tax credits, and a foster care reform incentive program. The pursuit of these strategies coincided with substantial reductions in the number and rates of children in the foster care system since 2002 (Children's Defense Fund, 2012).

In the fiscal year 2014, there were 415,000 children in the U.S. foster care system, with 265,000 entering the foster care system that year (Center for the Study of Social Policy, 2014; USDHHS, 2015a). Of the 265,000 children, some may have entered and exited care multiple times throughout the year. While most children in out of home placement were awaiting reunification with their families, 108,000 were waiting for adoption and 50,600 were adopted before the end of the fiscal year (Center for the Study of Social Policy, 2014).

Between 2002 and 2012, all ethnic groups shared a decline in the rates of children entering the foster care system each year (Center for the Study of Social Policy, 2014). African American children experienced the largest reductions. The change in demographic trends has produced significant changes in the composition of the foster care population. African American children, who once made up over a third (37%) of all children in foster care, are now just over one quarter (26%). Latino/Hispanic children's

proportion of the foster care population has increased from 17% to 21%. While numbers declined among all major non-Latino/Hispanic race groups, reductions among African American children experienced the strongest decline with a 47.1% reduction between 2002 and 2012. In contrast to the general trend, children identified with two or more race experienced substantial growth over this period, increasing to six percent of child in the foster care system (Center for the Study of Social Policy, 2014).

Of the 415,000 children in the foster care system in 2014, 190,000 children (46%) were placed in a non-relative foster family home. Of important note is the 29% of children who were placed in kinship care or with a relative (UDHHS, 2014). Almost 33% of children in kinship placements represent the general trend of placing children with relatives compared to non-relative care. The average length of stay in the foster care system for a child has declined by more than 25% between 2002 and 2012 from 31.3 months to 22.4 months. Declines in the average length of stay were experienced among all race/ethnicity groups (Administration on Children, Youth and Families, 2013).

Foster Care System in New Jersey

Under the Adoption and Safe Families Act (AFSA, 1997), the United States federal government presently grants states funding and independence in developing and administering child welfare program. Thus, a substantial amount of variation exists between foster care programs by state (Mallon & McCartt Hess, 2013). Of particular relevance are the foster care programs in New Jersey. From 1996 to 2012, New Jersey's child protection agency was The Division of Family and Youth Services. In 2012, The Division of Family and Youth Services went under federal government surveillance due to concerns about timely placement and worker negligence (Racioppi, 2014). The

Division of Family and Youth Services became part of The Department of Children and

Families, and were re-named the Division of Child Protection and Permanency

(Advocates for Children of New Jersey, 2013). After several high profile child deaths by

abuse or neglect in the previous years, Division of Child Protection and Permanency

(DCP&P) went under federal monitor to ensure it was meeting certain guidelines

(Racioppi, 2014). In 2012, there were 50,354 children under New Jersey state

supervision. 7,474 of which were in out-of-home placements, which was a 14% decrease

from the previous year. A majority of the children in state protection receive in-home

services, such as parent skills training, in-home child therapy, and behavioral

management services (Advocates for Children of New Jersey, 2013).

Results of a 2013 Monitoring Period Report by the Department of Children and

Families revealed that DCP&P had made improvements on the timeliness of case

planning and increased productivity in family team meetings (Advocates for Children of

New Jersey, 2013). However, there were several areas of identified weaknesses in the

areas of visitation, risk re-assessment, youth exit care, and adoption measures. Also of

worthy note is the percentage of foster children who are victims of "substantiated" abuse

returning to their families. According to the report, 8.5% of children in 2012 were

reunited with their families even after substantiated claims of abuse or neglect were made

(Advocates for Children of New Jersey, 2013).

Critics of the foster care system argue that it "neither prepares [participants] for a

successful future nor even allows them to prepare themselves." Foster children are

usually released from care at the age of majority "with a small stipend and an exit

interview" (Bardzell & Bernard, 2013, p. 33). While the foster care system is intended to

temporarily provide "positive, nurturing family relationships and normal family life in a permanent home," ideally before reunification with biological parents, the reality is that many participants are never adopted or reunited with their biological parents (Bardzell & Bernard, 2013, p. 33).

Mental Health Needs of Foster Care Children

Entering the foster care system itself presents a significant psychological challenge. (Dorsey, Cox, Conover & Berlinger, 2011; Garwood & Close, 2011; Lockwood, Friedman, & Christian 2015). Children must cope with the effects of the events precipitating the placements into foster care, deal with the loss of parental figures, and adjust to new living situations (Dorsey, Cox, Conover & Berlinger, 2011; Garwood & Close, 2011). Children often experience multiple foster placements and the length of each placement is often unclear (Lockwood, Friedman & Christian, 2015). This process often exacerbates pre-existing conditions in the child (Landsverk, Berns, Stambaugh, Rolls Reutz, 2006). Even for children who are severely abused, removal from their homes and separation from their biological families is considered a traumatic experience (Cohen, Mannarino, Deblinger, 2006). Most of these children are exposed to a multitude of psychological and environmental stressors that leave them vulnerable to psychiatric disorders (Newton, Litrownik & Landsverk, 2000).

Research has indicated that children in foster care exhibit a number of mental health issues that far exceed the rates of the comparative general child population (Cohen, Mannarino, Deblinger, 2006; Landsverk, Berns, Stambaugh, Rolls Reutz, 2006; McMillen, Zima, Scott, Auslander, Munson, Ollie & Spitznagel, 2005). Problems identified range from relational and coping difficulties, school problems, emotional and

behavioral disturbances, conduct disorder, attention deficit disorder, aggression, and depression (Garwood & Close, 2001). Rates of behavioral and psychological problems documented in the foster care population are 11% to 25% higher than the normative sample (Newton, Litrownik & Landsverk, 2000). It is not uncommon for children placed in foster care to have experienced sexual or physical abuse in the past (Pilowsky,1995). These children often present with a number of behaviors such as aggression, compulsive behavior, self-mutilation, lying and stealing, running away, suicide threats or attempts, and inappropriate sexual behavior (Cohen & Mannarino, 1996).

McMillen, Zima, Scott, Auslander, Munson, Ollie & Spitznagel (2005) explored the association between maltreatment (physical abuse, physical neglect, and sexual abuse) and mental health disorders. The study sample included foster youth (*N*=473) from eight Missouri counties who were approximately 17 years old and in the custody and care of Child Protective Services. Sixty-one percent of the youths qualified as having at least one psychiatric disorder during their lifetime, such as major depression, disruptive behavior disorder and a co-morbid internalizing (major depression, post-traumatic stress disorder), or mania and externalizing disorders. The number of types of maltreatment experienced was the strongest predictor of psychiatric disorder among several maltreatment variables, such as physical neglect, physical abuse, and sexual abuse (McMillen, Zima, Scott, Auslander, Munson, Ollie & Spitznagel, 2005).

Children in the foster care system are exposed to a number of risk factors, both prior to and during their placement (Thorpe & Swart, 1992). Prenatal risk factors include in utero exposure to alcohol, tobacco and other ilicit substances that are linked to neuro-cognitive and behavioral deficits (Halfon, Berkowitz & Klee, 1992). During

development, children are susceptible to developmental, fine and gross motor delays

(Halfon & Berkowitz, 1992). Children in foster care are frequently removed due to

physical or medical neglect, and come from impoverished environments where they are

vulnerable to risks such as inadequate access to prenatal care, homelessness, and limited

educational opportunities (Clausen, Landsverk, Ganger, Chadwick & Litronwnik, 1998).

A high proportion of children in foster care come from families with histories of mental

illness and drug or alcohol abuse (Garwood & Close, 2001). Children in the foster care

system have described their foster parents as using maladaptive parenting styles that

include punitive punishment, inconsistent rules, verbal aggression and lack of warmth

and attachment. The experience of authoritative parenting is associated with attachment

difficulties and psychopathology in children (Timmer, Urquiza, Herschell, McGrath,

Zebell, Porter & Vargas, 2006). It is not uncommon for children placed in foster care to

have traumatic experiences, such as exposure to domestic violence, physical abuse,

physical neglect, or sexual abuse (Cohen & Mannarino, 1996; Pilowsky, 1995). On

average, children in foster care have more than 14 risk factors (Thorpe & Swart, 1992).

Thus, foster care children require mental health assessment, intervention, and monitoring

at a significantly higher rate than their peers do.

Mental Health Service Usage

It is estimated that 60% of all children in out of home care have moderate to

severe mental health problems, yet less than 33% of those children are receiving mental

health services (Burns, Phillips, Wagner, Barth, Kolko, Campell & Landsverk, 2004;

Halfon, Berkowitz & Klee, 1992). Approximately 3% of children in foster care comprise

Medicaid users, but use 15% of Medicaid-eligible behavioral health series (Raghavan,

Brown, Thompson, Ettner, Clements & Key, 2012). Further, children in child welfare receive psychotropic medications at a rate between two and three times that of comparable children (Raghavan, Brown, Thompson, Ettner, Clements & Key, 2012). Approximately one in seven children in foster care have received a psychotropic drug at a given point in time (Raghavan, Brown, Thompson, Ettner, Clements & Key, 2012).

In consideration of the enormous financial expense and documented need, it would be assumed that foster care children are receiving mental health services. Several studies have indicated that there is a barrier between the documented need for services, and the barriers that prohibit them from accessing them (Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk, 2004; Garland & Besinger, 1997; Leslie, Hurlburt, Landsverk, Barth & Slymen, 2004). A 1995 General Accounting Office report found that a significant proportion of children in the foster care system were not receiving critical services in three evaluated locations: New York City, Los Angeles County and Philadelphia County (US General Accounting Office, 1995).

Results from a study that used a national sample of 3,803 children in the foster care system found that nearly half (47.3%) of children had clinically significant emotional or behavioral problems (Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk, 2004). Using the Child Behavior Checklist, a behavioral rating scale, the study found that half of the children in the study were rated at the clinically significant range by their caretakers and teachers. However, only 15.8% of children had received mental health services one year prior to the study. Among children who exhibited clinically significant behaviors, only 11.7% had received mental health services. (Burns, Phillips, Wagner, Barth, Kolko, Campbell & Landsverk, 2004). In contrast, another

study examined a cohort that had been in out-of-home care for at least 12 months and found that over half of the children age two-15 years had received an outpatient mental health service since the time of investigation leading to placement in foster care (Leslie, Hurlburt, Landsverk, Barth & Slymen, 2004).

Garland, Landsverk and Lau (2003) reviewed the racial and ethnic disparities in court-referred pathways to mental health services among children in foster care. After evaluating a number of studies, they found that differences in referral patterns might be based on perceptions of a family's interest in mental health services. Cultural differences appeared to have an impact on whether families would utilize the referred services, even when controlling for need and insurance status. Additionally important were the caseworker's perceptions of the client's preferences and perceptions of availability to attend culturally sensitive or responsive treatment. Caseworkers would make assumptions about the perceived benefits of therapy for youth of different cultural or racial/ethnic backgrounds (Garland, Landsverk & Lau, 2003).

As previously discussed, New Jersey's foster care system is state managed. The New Jersey Department of Health and Human Services sampled 50 children from five New Jersey offices to determine the extent to which foster care children were receiving timely and appropriate mental health services (Inspector General, 2003). A review of Medicaid claims for the 50 children revealed that 11 of the children had a Medicaid claim submitted on their behalf where a mental health professional worked. The authors found that caseworkers and caregivers were not informed about the Medicaid program and they have received very little training in Medicaid services for foster children. In addition,

most caseworkers and caregivers did not receive their foster child's medical information, and reported difficulty finding Medicaid providers (Inspector General, 2003).

Evidence-based Interventions for Children in Foster Care

With respect to the current climate of child welfare services, both in terms of access to mental health services and prevalence of psychological disorders, there is a need to contract with outside agencies to provide valuable interventions and consultation that the child welfare system is unable to provide. Given the increased expenditures of Medicaid funds for services for foster care children, it is necessary to continually evaluate programs the child welfare system aligns itself with (Inspector General, 2003; Raghavan, Brown, Thompson, Ettner, Clements & Key, 2012).

Current literature suggests that there are several mental health interventions that have been designed specifically for the foster care youth population (Baker, Brown, Schneiderman, Sharma-Patel & Berill, 2013; Hambrick, Oppenheim-Weller, N'Zi, Taussig, 2016). The following intervention have been developed for the foster care population and found to be efficacious: Attachment and Biobehavioral Catchup (ABC), Fostering Healthy Futures (FHF), Keeping Foster Parents Trained and Supported (KEEP), Kids in Transition to School (KITS), Short Enhanced Cognitive-Behavioral Parent Training (CEBPT), and Treatment Foster Care Oregon for Preschoolers (TFCO-P) (Hambrick, Oppenheim-Weller, N'Zi, Taussig, 2016).

There are also evidence-based interventions and programs for youth with mental health disorders that have been found effective when applied to the foster care population (Landsverk, Burns, Stambaugh & Rolls Reutz, 2006; Stewart, Lescheid, den Dunnen, Zalamanowitz & Baiden, 2012; Weiner Shneider, & Lyons, 2009). These interventions

include: Incredible Years (IY), Parent-child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavior Therapy (TF-CBT). They have been successfully adapted for the foster care population and yielded successful outcomes (Stewart, Lescheid, den Dunnen, Zalamanowitz & Baiden, 2012; Craven & Lee, 2016).

Baker, Brown, Schneiderman, Sharma-Patel and Berill (2013) reviewed current mental health treatments to determine the extent in which they were appropriate for foster care children. They identified ten essential foster care issues and evaluated the current literature to determine whether they included these components. The treatment components included trauma work, affect regulation, social skills, attachment and relationships, preparation for reunification, family conflict/resolution, parenting skills and case management integration (Baker, Brown, Schneiderman, Sharma-Patel & Berill, 2013).

The authors reviewed treatments specifically designed for foster care, treatments where foster care children were included in the sample, and other treatments that could possibly address relevant issues within the population. Results indicated that the interventions specifically designed for the foster care population, or were evaluated in a randomized controlled design with foster care children were equally able to address the ten core issues. However, both categories of interventions were limited in their ability to address issues such as promoting secure attachment, family work improvement, facilitating reunification and reducing family conflict. Similar gaps in interventions were identified by Craven and Lee's (2006) findings. Craven and Lee (2006) indicated that although many foster care specific interventions recognized behavioral problems such as externalizing and internalizing disorders, they failed to address the attachment, foster

family dynamics and foster family structure within the treatment.

An evidence-based intervention that can address foster family structure and dynamics is Parent-Child Interaction Therapy (PCIT) (Eyberg, Boggs & Algina, 1995; Weiner, Schenider & Lyons, 2009; Landsverk, Burns, Faw Stambaugh & Rolls Reutz, 2006). PCIT is task-oriented and live-coached with both the caregiver and child (Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas, 2006). Caregivers learn skills through didactic sessions that use a transmitter and receiver system. Specific skills are targeted as the caregiver interactions with the child. Generally, the graduate student/therapist provides guidance behind a one-way mirror. Parents learn skills related to communication and behavior management through two phases: Child Directed Interaction (CDI) and Parent Directed Interaction (PDI). The goal of CDI is to provide a positive experience for both parent and child. The goal of PDI is to assist parents in practicing specific behavior management skills (Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas, 2006).

A number of studies have detailed the efficacy of PCIT for reducing behavior problems in children (Eyberg, Boggs & Algina, 1995; Weiner, Schenider & Lyons, 2009; Landsverk, Burns, Faw Stambaugh & Rolls Reutz, 2006). PCIT is indicated to have a long-term impact on the reduction of behavior problems. Studies have indicated that participation in PCIT has lead to reductions in subsequent report of physical abuse or risk for abuse in home environments where parents had child maltreatment histories (Timmer, Urquiza, Herschell, McGrath, Zebell, Porter & Vargas, 2006). Families have reported satisfaction with participation and outcome, which included increase social-emotional

functioning and compliance with parents, and an increase in positive communication (Landsverk, Burns, Faw Stambaugh & Rolls Reutz, 2006)

Engaging and supporting birth and foster parents in the child welfare system are critical for successful child outcomes (Pasztor, Hollinger, Inkelas & Halfon, 2006). KEEP is an additional intervention that focuses on foster parent training (Buchanan, Chamberlain, Price & Sprengelmeyer, 2013). Besides mandated training provided to foster parents through foster care agencies, there are few programs that are designed to specifically assist and support the complex needs of foster care parents (Newton, Litrownik & Landsverk, 2000). Although research indicates that parent management training improves the parent-child relationship and behaviors, few foster parents are able to receive training to address the concerns and barriers they face (Pasztor, Hollinger, Inkelas & Halfon, 2006). The KEEP (Keeping Foster and Kin Parents Supported and Trained) program is an intervention that focuses on foster parent training (Buchanan, Chamberlain, Price & Sprengelmeyer, 2013). KEEP is based on a parent management training philosophy where parents receive 16 weeks of support, training and supervision in behavior management methods. The objective is to educate foster and kinship parents on how to effectively deal with externalizing and other behavioral and emotional problems. Several studies evaluating the effectiveness of KEEP have shown to produce positive outcomes for the treatment and prevention of child and adolescent behavior problems (Buchanan, Chamberlain, Price & Sprengelmeyer, 2013).

KEEP participation is also associated with increased foster parent retention. This is of particular importance considering the difficulty foster care systems face in recruiting foster parents and limiting the drop out rate. Chamberlain, Moreland & Reid (1992)

found that foster parents were more likely to remain as parents in the foster care system after participating in the KEEP program. They cited a 66% reduction in the drop out rate of 31 foster families compared with the control group over a year period (Chamberlain, Moreland & Reid, 1992)

Intervention studies with multiple components proved most consistently effective for behavioral outcomes and showed improved placement stability for children in the child welfare system, a finding consistent with a previous review examining mental health treatment for children in the child welfare system (Craven & Lee, 2006). An example of a multiple component intervention is Multisystemic Therapy.

Multisystemic Therapy is based on the premise that for a treatment to be effective, it must target risk factors concurrently and at multiple levels that include individual, family, school, and community, as well as facilitating interactions between all partners. In Multisystemic Therapy, primary caregivers, therapists, and educators collaborate to deliver a highly individualized, strength-based treatment plan. Multisystemic Therapy therapists teach children behavioral skills, while teaching caregivers how to deliver appropriate positive reinforcement when such skills are used (Henggeler & Schaeffer 2010). The researchers found that there was some inconsistency within multiple component interventions. Some interventions were not effective in reducing behavioral problems and increasing placement stability. They ascribed this to the high levels of trauma found in children in the welfare system. It was recommended to incorporate a trauma-component into treatment to reduce trauma levels before addressing psychosocial functioning (Henggeler & Schaeffer, 2010).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based

treatment that has been found to be effective in reducing trauma related symptoms in the foster care population (Weiner, Shneider, & Lyons, 2009). TF-CBT is a structured individual and parent trauma-focused model that includes initial skills based components followed by more trauma-specific components with gradual exposure integrated into each component. TF-CBT addresses both trauma related emotional and behavioral problems, especially in cases where the behavior problems are prominent (Cohen, Mannarino & Deblinger, 2006). In order for TF-CBT to be effective with children who also have behavior problems, the parenting component is an integral part of the therapy (Weiner, Shneider, & Lyons, 2009). The parenting portion of the therapy consists of application of a standard behavior management and skills training. Parents learn to increase the frequency of positive parent-child encounters, provide reinforcement for wanted behavior, learn to ignore unwanted behavior, and give effective instruction or consequences for behavior. Both the child and parent are taught problem solving and communication techniques that include rehearsal and practice in sessions. (Dorsey, Cox, Conover & Berliner, 2011).

TF-CBT has been compared to other treatment (non-directive play, supportive therapy) for childhood trauma in several randomized, controlled trials. Results indicated that TF-CBT is associated with improved PTSD symptoms, behavior problems, anxiety, depression, sexualized behaviors, and a reduction in shame and guilt (Weiner, Scheider & Lyons, 2009; Dorsey, Cox, Conover & Berliner, 2011). TF-CBT was found to be highly effective in reducing trauma symptoms and placement disruptions (i.e., running away, arrests) in the foster care population (Dorsey, Cox, Conover & Berliner, 2011;Weiner, Scheider & Lyons, 2009).

Need for Child Welfare Program Evaluation

Program evaluation involves collecting information about program components and outcomes in order to improve program effectiveness, inform decisions about the program's future, and make judgments on a program's value or worth (Patton, 1997). Program evaluation is an essential part of the program planning and implementation process, since it provides information about necessary improvements and accountability (Lee & Sampson, 1990). There are various types of program evaluation and they can range from providing judgments about the overall effectiveness of programs, to providing feedback about program content and operation (Patton, 1997). Program evaluation is a means of research to examine the available services for children in foster care. The program evaluations that serve children in foster care enable the continuous improvement and expansion of services in order to ensure that youth receive appropriate services (Testa & Poertner, 2010). Ideally, models would be developed for documenting the programs and treatments provided to foster care children in mental health treatment. However current child welfare policy provides individual states with federal funding and initiatives to develop their own documentation efforts to move children towards adoption (Framework Group, 2014).

A literature search has indicated that the majority of program evaluation efforts in the area of mental health services for children in foster care have focused on large, multi-site outcome evaluations (Casey Family Programs, 2011). These quantitative and qualitative evaluations have focused on whether the services were effective and satisfactory. The U.S. Department of Health and Human Services has funded several evaluations of foster care programs. The evaluations have focused on long term outcomes

of children in the foster care system, and results of training programs for caseworkers. They have also funded several state evaluations that reported on recipients of child welfare services (Office of Planning Research and Evaluation, 2010).

Although these documented efforts provide useful information and valuable considerations, they have less utility for individual organizations that wish to closely examine the program itself (e.g., the services it provides are consistent with the stated mission and logic model). Many of the program evaluations conducted are large scale, complex, costly procedures that cannot be generalizable to smaller sites. In addition, all of the aforementioned examples focused on outcome evaluations.

Chapter III: Description of Program Evaluation Approach

According to Rossi, Lipsey and Freeman (2004), program evaluation is the use of research methods to evaluate the effectiveness, make judgments about the worth or value, need, appropriateness, or implementation of social intervention programs. Program evaluation is a process in which education and training programs are evaluated to determine their quality and provide directions for improvement (Rossi, Lipsey & Freeman, 2004). Program evaluation is not only about understanding and learning about a program. It also provides a framework for making evidence-based decisions and informed judgments about their program. The methods and purpose of an evaluation are individualized to a program's needs at the time of the evaluation. There is no one size fits all approach to program evaluation (Rossi, Lipsey & Freeman, 2004).

Maher (2012) cited several reasons why program evaluation is an important component of human service programs: (1) human service programs require an investment of resources, with the expectation that the program will add value to the target population served; (2) it can be used to gather information on a program's value and how successful similar programs have been implemented in the past; (3) it is a critical means for a human service program and to continuously improve its social value to the target population; (4) it enables outside funders to easily understand and review the program for funding decisions; (5) program evaluation provides an opportunity for personnel to be actively involved in the improvement of the program (Maher, 2012).

Program evaluations can be initiated for many different reasons- to improve programs, support advocacy, and gain knowledge about a program's impact, provide input to decisions about funding, or respond to administrative or political pressure. The

program evaluation's purpose guides evaluation planning, evaluation design and are determined by the needs of the stakeholders. The program evaluation process involves delineating the program model, establishing program performance indicators, examining program operations, collecting data based on information needs of decision makers and predicting the likelihood of meeting objectives (Maher, 2012).

Maher (2012) defines three distinctive activities of this process: planning, evaluating, and revising. Maher (2012) describes the three activities as: "Planning means the using of evaluation information for program improvement. Relatedly, evaluating denotes gather, analyzing, and interpreting information as a basis for program planning. Furthermore, revising refers to purposeful and routine activity that occurs through the planning and evaluating process" (pp. 5).

According to Maher's (2012) model, there are a number of qualities to a sound human service program evaluation. The evaluation should be practical and should be able to be regularly implemented by people in the program in a way that is not disruptive to regular routines. The plan could result in useful information that enables the client to make more effective decisions about the program and how to improve it. The evaluation should be proper, in that it properly adheres to all pertinent legal requirements and ethical standards that are relevant to the program. The program evaluation should also utilize technically defensible methods, procedures and instruments. It should have methods that are reliable and valid (Maher, 2012).

Maher (2012) described a program planning and evaluation approach that provides a structured guide to answering important questions about the worth and merit of a program, and to use the resulting information as a means for making decisions.

These steps assist a program to plan for continuous development and improvement.

The program evaluation plan (Maher, 2012) can be broken down into four phases: (1) Clarification phase, (2) Design phase, (3) Implementation phase, and (4) Evaluation phase. Maher (2012) states a "program can benefit from a sound program design, that is based on a well understood and clarified situation, that is implemented according to design, and that is evaluated routinely, and in a technically defensible manner" (pp. 5).

The Clarification Phase specifies that the program should clarify and understand the current situation of programmatic concern (Maher, 2012). This is accomplished by a series of interrelated and sequential set of activities that result in an understanding of the target population, their needs, and the context in which those needs are embedded. According to Maher (2012), a clear understanding of the present situation is necessary to obtain a controlled predictable program planning and evaluation process, which will result in a plan that has value for the target population.

The second phase of Maher's (2012) program planning and evaluation framework is the Design Phase. The purpose of the Design Phase is to provide a clear understanding of the program to be provided to the target population. According to Maher (2012), a clear understanding of the program's design is necessary so that sound judgments may be made about how the program was implemented and the extent to which it added value to the target population. The Design Phase provides clarity about the purpose, goals, and activities of the human services program. It is also when those involved in the program receive assistance in the program evaluation plan. This is when the program implementers and administrators receive guidance regarding how to proceed in a timely and economical manner. Without a well-developed program design, there is a risk that

implementers and other stakeholders will become disinterested in the program plan, which will result in a reduction of desired outcomes. The four major activities of the Design Phase are to describe the program purpose and goals, consider program design alternatives, create the program, and document the program design. Each activity guides the next, and changes in one activity may result in changes to the next (Maher, 2012).

The third major phase is the Implementation Phase. The major activities of the Implementation Phase are to review the program design, facilitate the program implementation, and monitor the program process (Maher, 2012). The purpose of this phase is to ensure that the program is implemented as it was designed. Maher (2012) noted several reasons why this phase is important. First, it is anticipated that the program will result in value for the target population if it is implemented as designed. Second, if the program is not implemented as intended there is a risk that worthwhile outcomes for the target population will be decreased. Third, when a program is implemented as designed there is a greater ability to make informed decisions about how to improve the program as it operates. Finally, proper documentation of the implementation of the program is necessary to determine how the program added value to the target population (Maher, 2012).

The final phase of Maher's (2012) program planning and evaluation framework is the Program Evaluation Phase, which was the focus of the dissertation. The purpose of the Program Evaluation Phase is to gather and analyze data so that sound judgments about the value of the program may be made. There are several reasons why the Evaluation Phase is very important (Maher, 2012). First, a sound program evaluation may assure that use of resources adds value to the target population. Second, a sound program

evaluation may contribute to program development and improvement. Third, other program planning decisions may only be made based on important information about the program's worth and how it was implemented. In addition, a sound program evaluation that addresses outlying concerns such as external funding sources, may contribute to continued financing for the program. Finally, a sound program evaluation may facilitate the involvement of key stakeholders for continued program improvement. Understanding the gestalt of the program is important so that the program can continue to operate, if appropriate, and it can be adapted as needed to better meet the needs of the target population (Maher, 2012).

There are twelve major activities in the Program Evaluation Phase. These activities are sequential, interrelated, and reflexive. Although the steps were created to be applied in order, it may be necessary to return to earlier activities so that changes can be made as deemed appropriate. The first step is to identify the client for the evaluation of the program. Maher (2012) poses the following questions to consider when identifying the client: who is the individual within the organization that is directly responsible for the program design and implementation; who is the individual within the organization who is directly responsible for overseeing the program; who is the external individual, group, or agency that is interested in the design, implementation, and outcomes of the program (Maher, 2012). The answers to these questions will aid in the identification of the primary client and place additional clients into appropriate perspectives or time frames (Maher, 2012).

The second step is to determine the client's need for a program evaluation (Maher, 2012). A determination must be made as to whether or not the needs of the client

can be met via a program evaluation. There are three tasks that assist with determining the client's needs for program evaluation. Next, determine the reasons that the client desires this knowledge regarding the program. Finally, assess how the client expects program evaluation information to be obtained (Maher, 2012).

The third task is to place the program in evaluable form (Maher, 2012). A human services program must be placed into an evaluable form. An evaluable program reflects a program design that meets the criteria of clarity, compatibility, and development status. A fundamental task of the program planning and evaluation process is to facilitate the continuous development and improvement of human service programs. This task cannot be accomplished without a program that is clearly understood by all stakeholders. In order to make sound judgments about the program and the target population prior to and during the time that the program was implemented, the program must be in an evaluable form. Moreover, human service programs must be fully understood so that a determination can be made as to whether or not a program can and/or should be replicated. Finally, placing a program into an evaluable form is important because the designing and development of a program utilizes a range of resources. Given such an expenditure of resources, it is necessary to know what value the program is expected to bring to the target population so that these expectations can be used as a basis for the program evaluation (Maher, 2012).

The fourth step is to delineate program evaluation questions. These are questions about some element of the program's design, implementation, or results that will facilitate program planning and evaluation actions to be taken (Maher, 2012). These actions include making judgments about the following: the merit of the program for

serving the needs of the target population; the worth of the program in adding value to the

target population; the ability of the program to be implemented as designed; and the

program's contributions to the organization (Maher, 2012). The program evaluation

questions may also aid in making decisions about the following: how to use the

evaluation information to make revisions in the program design; whether and to what

extent the program can be replicated in other settings; whether elements of the program

should be eliminated; and whether the entire program should be terminated. Several tasks

can be carried out to delineate program evaluation questions. These tasks are: specify

what needs to be known about the program; generate a list of program evaluation

questions; and select the most important questions to be answered. Once the final

program evaluation questions are identified they should be placed into a SMART

program evaluation form. The acronym SMART (specific, measurable, answerable,

relevant, time framed) refers to characteristics of human service program evaluation

questions that increase the likelihood that data will be gathered specifically relating to the

question that the stakeholders will use to take effective program planning and evaluation

actions (Maher, 2012). Each program evaluation question is placed into a Program

Evaluation Protocol Worksheet.

The fifth step is to define the data collection variables. This refers to some item or

matter that needs to be measured to assist with answering the program evaluation

question (Maher, 2012). There are two tasks that must be taken for each program

evaluation question. First, a list of variables on which data can be collected is generated.

Second, each variable must be operationalized so that clarity will be reached as to what

types of data need to be collected. This in turn will serve to guide decisions about

methods, procedures, and instruments for data collection.

The sixth task is to describe the data collection methods, instruments, and procedures (Maher, 2012). This will help determine how data will be collected on each program question variable so that each question can be answered. Data collection variables for each question must be reviewed to identify the most important ones. Once the most important data collection variables are identified, decisions are made about the method and sources for data collection. For each program evaluation question, a decision is made for procedures for data collection for each variable. Once procedures for data collection have been identified, the final task is to select and/or develop instruments. In either circumstance, instruments should meet the following qualities: practicality, usefulness, propriety, and technical defensibility (Maher, 2012).

The seventh step is to define the methods and procedures for data analysis (Maher, 2012). This step defines how the data is analyzed so that program evaluation questions can be answered. It is important to analyze and interpret the data in a systematic manner so that program evaluation questions can be answered in a way that informs the client and other relevant stakeholders. There are several tasks that will allow data to be analyzed and interpreted using practical and technically sound methods and procedures (Maher, 2012). These tasks include: selecting the unit of analysis; organizing and displaying the data; identifying frames of reference; and determining statistical procedures (Maher, 2012).

The eighth step is to specify program evaluation personnel and responsibilities (Maher, 2012). This task requires the evaluator to identify the people who will be involved in the program evaluation and to clarify their roles and responsibilities relevant

to the program evaluation. The purpose of the activity is to increase the likelihood that the program evaluation will occur as planned. There are several tasks that must be completed for each program evaluation question, which will facilitate completion of this step. These tasks are: identify the evaluation responsibilities and timelines; determine the people who will be responsible; and discuss the timelines and responsibilities with the designated people (Maher, 2012).

The ninth task is to delegate guidelines for communication and the use of the program evaluation information (Maher, 2012). The guidelines are developed regarding how to communicate and use program evaluation information for program planning. Delineating guidelines for communication and use of program evaluation information increases the likelihood that program planning actions will contribute to the continuous development and improvement of the program. The following tasks need to be completed for each program evaluation question: target the audiences for receipt of evaluation information; specify the evaluation information to be communicated; determine how to involve the audience in the use of evaluation information; and pinpoint program planning actions (Maher, 2012).

The tenth step is to construct the program evaluation protocol (Maher, 2012). The program evaluation protocols are developed and placed into a written form as a program evaluation plan document. This activity is readily accomplished via successful completion of the first nine activities, during which information was placed onto respective Program Evaluation Protocol Worksheets for each question (Maher, 2012).

The eleventh task is to implement the program evaluation (Maher, 2012). The program evaluation is implemented based on the information provided in the program

evaluation protocols. The aim is to ensure that the process of the evaluation is controlled as expected based on the following indicators presented by Maher (2012) for each program evaluation question: data are collected on variables specified in the protocol; methods, procedures, and instruments designated in the protocol are used; data analysis and interpretation are based on the methods and procedures articulated in the protocol; and evaluation results are communicated to the target audiences and used by them for program planning. If it is necessary to modify the evaluation process and revise one or more protocols, a rational for such changes must be made clear (Maher, 2012).

The final step is to evaluate the program evaluation (Maher, 2012). The program evaluation that has been implemented is itself evaluated in the final step. This step is important so that relevant stakeholders may determine how to improve future program evaluations as well as the entire program planning and evaluation process (Maher, 2012).

Considering the level of mental health concerns for children in foster care, and the lack of continuity in program evaluation protocols for mental health programs, foster care programs providing mental health services should be continuously evaluated and improved in order to enhance child outcomes. The current dissertation task utilized Maher's Program Planning and Evaluation Framework (2012) to put a foster care program into an evaluable format, which is a task that must be accomplished prior to evaluating a program. This format can be achieved through carrying out activities in Maher's design phase in the program evaluation plan. The creation of a Program Design document will serve as a means to develop and improve the foster care program that is under study.

Chapter IV: Evaluable Program Design

Procedures for Placing the Foster Care Program into Evaluable Form

In order to conduct a program evaluation, the Foster Care program needed to be placed into evaluable format (Maher, 2012). The evaluable format allows the program's design elements to be delineated in a clear and logical manner, such that someone who is unfamiliar with the program would be able to understand it.

Data Collection Variables

There are several data collection variables that were used to document the design of the Foster Care program. This description included who is served by the program, what needs are served, the program goals, methods, eligibility standards and criteria, policies and procedures, materials, equipment, facilities, components and activities of the program, personnel, the budget of the program, incentives, the overall mission or purpose of the program, and a program evaluation plan (Maher, 2012).

Data Collection Methods, Instruments, and Procedures

In order to document the design of the Foster Care program, data were taken from program documents and informal consultations with the program director. Informal consultation consisted of clarification of items on program related documents or program policies and procedures. The program director gave permission for the evaluator to have access to these data sources. All information gathered was kept confidential. No information was collected that identified clients in the program (see Appendix A).

Methods and Procedures for Data Analysis

In order to create a Program Design document for the Foster Care program, informal consultations with the program director and review of program documents were

utilized to gather information to fill in items on the Program Design Instrument. Director

responses and information in program documents were condensed and described, which

resulted in the Program Design document for the Foster Care program.

Program Design Personnel and Responsibilities

The evaluator was responsible for administering a confidential online survey to

graduate students and conducting informal consultations with the program director. The

evaluator collected program related documents from the Director. The evaluator

conducted observations of programmatic activities.

Guidelines for Communication and Use of Program Design Information

Results were communicated to the Director upon completion of the evaluation.

Dissemination of the evaluation information to other stakeholders was at discretion of the

Director.

Chapter V: Program Evaluation Plan

Program Evaluation Question

To what extent is the Foster Care program being implemented as designed?

Data Collection Variables

The data collection variables that were used to evaluate the implementation of services in the Foster Care program included creating operational definitions of the variables on the data collected so that the measures are clear to all involved. The variables that were used to evaluate the implementation of the Foster Care program included: target population, length of therapy, current therapeutic practices, and graduate student/therapist training and supervision in the Foster Care program. These variables were selected because they best captured the programmatic elements of the program. "Implemented" is defined as how the service provided by the program as described by the director and graduate student/therapists across four dimensions. "Design" is defined as the way the program has been implemented in comparison to the way the program is described in the most recent grant proposal documents. The four variables that were evaluated are:

- Population Served: The description of the target population as reported in grant proposals. This was compared to information reported on the description of their clients from graduate student/therapists. This is in response to the survey question, "Describe the cases you work with in terms of what type of placement your clients are in. Who is involved in the treatment?" on the *Graduate Student Online Survey* (See Appendix B).

- Services Provided: Information about the services provided by the program was gathered from the most recent grant proposal document. This information was

compared to the responses to the survey questions, "What services do you

provide?"   on the *Graduate Student Online Survey*.

- Length of Contact: Information about the amount of clients receiving short-term

  individual therapy, long-term individual therapy, and short-term group therapy was

  summarized from grant proposals. This was compared with the responses to the

  question, "How long you have been involved in each case?" on the *Graduate*

  Student Online Survey.

- Training and Supervision: Information was gathered from grant proposals

  regarding the amount of training and supervision graduate student/therapists

  receive. This information was compared to the responses to the survey questions,

  "What training have you received through the program? Do you feel it has been

  adequate? If so, in what ways has it met your needs? If not, in what ways has it

  been lacking?   Describe the supervision you receive through the program? Do you

  feel it is adequate? If so, in what ways?   If not, how is it lacking?" on the

  Graduate Student Online Survey.

Data Collection Methods, Instruments, and Procedures

The program's 2015-2016 grant proposal documents were reviewed to gather

information about the intended program implementation. Grant renewal documents were

used because it was the only available source of information on the program.

Information on the program's implementation was collected along the following

variables: (1) population served; (2) services provided; (3) length of contact; and (4)

training and supervision.

The director of the project provided the current PI with the number of graduate students who participated in the program during the years 2013-2014, 2014-2015 and 2015-2016. A total of *N*=20 students participated in those three years. The breakdown of participants is as follows: seven unduplicated graduate students participated in 2013-2014; six unduplicated graduate students participated in 2014-2015 (one of which participated in both 2013-2014 and 2014-2015); seven unduplicated graduate students participated in the year 2015-2016 (one of which also participated in the year 2015-2016). The online survey was sent to the 20 current and past graduate students in the form of an email notification (See Appendix C). The graduate student/therapists were surveyed through a questionnaire that had open-ended questions, which required a narrative form of response. The survey was made available to students online for a period of four weeks. Students were able to submit their responses electronically and anonymously.

The data were collected on the variables by reviewing online survey responses on the *Graduate Student Online Survey* submitted by the graduate student/therapists. The program was evaluated through questionnaires for the graduate student/therapists found in the *Graduate Student Online Survey*.

Methods and Procedures for Data Analysis

The units of analysis were the responses of graduate students to the items on the online survey. Out of 20 possible responders, *N*=12 students participated in the survey (60% response rate).

The following is a breakdown of the number of responders by participation year:

- 2013-2014: four graduate student/therapist

- 2015-2016: four graduate student/therapist

- 2014-2015: two graduate student/therapist

- 2013-2014 and 2014-2015: one graduate student/therapist

- 2014-2015 and 2015-2016: one graduate student/therapist

Information from grant proposal documents were organized by the four dimensions of the program (population, services, contact, training and supervision) to answer the program evaluation question. Survey responses were thematically analyzed by response theme for each of the dimensions described in the data collection above. The responses were reviewed for recurrent, unifying concepts or statements about each survey question (Bradley, Curry & Devers, 2007). A set of categories were derived from the data, and formed after the data were collected. Thematic narrative analysis was completed for all data collection from the survey. The data was inductively analyzed across participants and organized into common concepts and themes (Braun & Clarke, 2006). Inductive thematic analysis strives to explore what participants are communicating by identifying patterns of experience found in the narratives (Patton, 2002).

There were several procedures for inductive coding of data. The data set was read multiple times until a familiarity with the data developed. Then, actual coding of each data subset began. Initial categories were created from actual phrases or meanings in specific text segments of responses. Categories across the data subsets occurred several times, as additional themes evolved in additional readings of the data. Text segments that had been assigned a code were compared to each other to confirm whether they reflected the same concept. To arrive at a system, a list of possible themes was examined to identify groups of patterns of responses, and a final list of themes was designated for each

group of responses (Thomas, 2006). The data and classification system were verified for

meaningfulness and accuracy by testing each theme for "utility, salience, credibility,

uniqueness, heuristic value and feasibility of the classification schemes" (Patton, 2002, p.

466).

Program Design Personnel and Responsibilities

The evaluator was responsible for administering a confidential online survey to

graduate students and conducting informal consultations with the Director. The evaluator

collected program related documents from the Director.

Guidelines for Communication and Use of Program Design Information

Results were communicated to the Director upon completion of the evaluation.

Dissemination of the evaluation information to other stakeholders was at discretion of the

Director.

Chapter VI: Evaluable Program Design Document

The Foster Care Program, which began in 1989 as a contracted service provider for the Division of Child Protection and Permanency (DCP&P), provides services for DCP&P-referred children in resource care (foster and relative care) in Middlesex and Somerset Counties in New Jersey. Over the past twenty-six years, the project made changes to its service delivery to reflect the changing needs of the population served. This current Evaluable Program Design document reflected these changes and described the program, as it currently exists. The Program Design document components are based on Maher's (2012) framework for Planning and Evaluating Human Service Programs. These components placed the Foster Care Program into evaluable format, which allowed for the program to be evaluated continuously over time, and for improvements to be made. Additionally, the information created a comprehensive document that assisted stakeholders of the program to be aware of all program components and efforts, which could have the potential to lead to a more efficient and effective service delivery (Maher, 2012).

Information to compose this document was gathered by the evaluator through informal consultations with the program director and program-related documents.

Target Population

The target population is children, within two specific counties in New Jersey, who are in the foster care system. The target population served by the Foster Care Program includes referrals from three Middlesex county Division of Child Protection and Permanency (DCP&P) local offices and one Somerset county office. The children must currently be in resource care (foster or relative homes) or may have recently reunited with

their biological parents after spending time in their care. They must be under eighteen years of age. These children have been identified as requiring therapeutic care for a variety of reasons including removal from their biological parent's care or difficulty adjusting to a resource care placement. The graduate student/therapist's primary client is the child, but also work closely with the foster and/or biological parents. Graduate student/therapists also collaborate with school personnel or behavior therapists. The program carries approximately thirty cases at any time. At the time of the evaluation, approximately 22 of those cases were from Middlesex County. The remaining eight cases were referred from Somerset County. Over the course of a fiscal year, approximately 40 unduplicated individuals receive services from the program, with approximately 30 of those from Middlesex County and ten cases from Somerset County.

Program Purpose and Goals

The Foster Care program provides home-based and clinic-based mental health counseling and preventative services to children involved in the foster care system. The program has evolved from short-term adjustment-focused individual interventions into a comprehensive multi-systemic collaborative treatment approach to address not only adjustment but also mental health and developmental problems stemming from trauma and child maltreatment. When a child is first referred to the program, the assigned graduate student/therapist conducts an assessment at the beginning of treatment. This involves 2 to 3 sessions of meetings with the Division of Child Protection and Permanency (DCP&P) caseworker, caregivers, child, family, and school consultation. The purpose of this assessment is to gather information and assess areas such as presenting problem, current and past functioning, placement history, family composition

and relationships, history of exposure to trauma, academic and social functioning, developmental delays/deficits, and psychiatric treatment history. The Ohio Youth Problem, Functioning and Satisfaction scale (Ogles, Melendez, Davis & Lunnen, 1999) are administered to caregivers, caseworkers, and children older than 12. The Resiliency Scales for Children and Adolescents-A Profile of Personal Strengths: RSCA (Prince-Embury, 2008) are administered to children over the age of nine. The graduate student/therapists collaborates with the resource family and school to provide therapeutic environments while the child is with them. If children are to be reunified with biological parents, the parents are included in the treatment process when appropriate. This model provides continuity of care and maximizes chances for a successful reunification and optimal child functioning. The stated mission of the program at the time of the evaluability assessment, as cited in the most recent grant renewal document was "to meet the needs of the children, caregivers, caseworkers, and therapists it works with" (Lang, 2015a). A secondary goal is that the program will demonstrate that youth participants have improved self-esteem, and commitment to education (Lang, 2015a).

Clients are evaluated quarterly on their therapeutic milestones and goals. Client's goals are written in measurable and attainable language. Clients are administered pre and post rating scales on the Ohio Youth Problem, Functioning and Satisfaction Scale (Ogles, Melendez, Davis & Lunnen, 1999) and Resiliency Scales for Children and Adolescents-A Profile of Personal Strengths: RSCA Scale (Prince-Embury, 2008) to assess growth and progress. Individualized primary treatment goals (i.e., self regulatory capacities, greater sense of mastery, greater sense of relatedness to others) are assessed pre-treatment and post-treatment to determine the skills and goals gained in individual counseling. The

assessment results are shared with the program funders. Client satisfaction is assessed through feedback questionnaires from Division of Child Protection and Permanency (DCP&P) caseworkers, resource parents and child clients. Staff satisfaction is evaluated on an ongoing basis throughout the year. Graduate student/therapists are encouraged to report their training needs and critique of training provided, both during staff meetings and individual supervision. Senior staff is responsible to respond to staff's expressed needs.

Eligibility Standards and Criteria

All referrals for services through the Foster Care program must come through Division of Child Protection and Permanency (DCP&P) caseworkers. The children must currently be in resource care (foster or relative homes) or may have been recently reunited with their biological parents after spending time in their care. They cannot be more than eighteen years of age. If children have significant substance abuse issues, they are referred to a substance abuse treatment facility. If children have severe psychiatric issues requiring more intensive treatment, they are referred to an inpatient or intensive outpatient treatment program. If they are acutely suicidal or homicidal, they are referred to an emergency treatment service.

Program Policies and Procedures

There are four overarching bodies of regulations that govern the client: Rutgers University policies (Secretary of the University, 2016), New Jersey Department of Children and Families policies (State of New Jersey, 2016), Foster Care program policies (Lang, 2016), and psychologist ethical policies (American Psychological Association, 2010). The Foster Care program is part of Rutgers University Center for Applied

Psychology. As part of the University system, the program must adhere to certain rules and regulations. The Division of Children and Families requires the program to submit program-wide and client specific progress notes and reports on a regular basis. There are also requirements of what is contained in each progress note and type of outcome data that is submitted to the Division of Children and Families. Required documents for graduate student clinicians are made available online on RU Sakai and at the Center for Applied Psychology office.

The director is responsible for disseminating information regarding programmatic policies and procedures. A summer orientation is held for graduate students to provide them with information about the program and their role within the program. During this orientation, graduate students also learn about relevant policies and procedures. A "Getting Started" manual is also provided for graduate student/therapists. These topics include behavior management, therapeutic, and consultative techniques.

One hour to two hours of weekly individual supervision, and one hour of weekly group supervision is provided for graduate students. A two-hour didactic session is held weekly with both undergraduate and graduate students in attendance to provide exposure to therapeutic techniques. Finally, graduate students are encouraged to attend additional conferences and workshops. Undergraduate students receive training and supervision through their enrollment in the undergraduate Field Work in Foster Care course.

Methods and Procedures

The program is comprised of four primary components: (1) evaluation and referral services; (2) individual and family therapy; (3) group therapy; and (4)

undergraduate driving and mentorship. These services are utilized to meet service provision goals and will be described in further detail below.

1. In meeting the goal of facilitating reunification with the biological family, or preparing the child for adoption, graduate student/therapists maintain regular contact with the child's caseworker. Maintaining communication with the client's caseworker is important to remain aware of the current plans for the case and to ensure therapeutic goals are in alignment with the goals for the case.

2. In order to increase the ability of caregivers to understand the needs of this population of children and respond in a more therapeutic manner, both individual and family systems therapy is utilized. Therapeutic interventions were applied based upon a number of factors such as the graduate student's skill set and the graduate student/therapist's interest in gaining experience in applying a particular therapeutic strategy. Grant application documents revealed the following procedures related to family systems work:

   a. Parents are invited to be involved in the therapeutic process to provide a consistent, reliable adult presence in the child's life. Clinicians work with the parents to train them in therapeutic parenting strategies. Family systems therapy can include an adaption of parent-child interaction therapy, specific parent skill training, or family subgroup dyadic training to facilitate positive interactions.

Grant application documents revealed the following procedures related to individual

therapy:

    b. Individual psychotherapy is additionally utilized to improve emotional and

        behavioral regulation and process trauma narratives. Therapeutic techniques

        include trauma-focused cognitive behavioral therapy (Cohen, Mannarino &

        Deblinger, 2006), play therapy (Landreth, Homeyer, Glover & Sweeney,

        1996), and psychodynamic therapy (Lieberman & van Horne, 2005).

        Depending on the needs of a child, skills are taught to improve the child's

        ability to manage emotions and process traumas in a manner that is safe and

        developmentally appropriate.

3. Group therapy sessions are offered at the program for adolescents in foster care.

    Information on the guiding platform of the group was not available. Groups are

    catered to by gender, with female and male groups offered. A "safe and supportive

    therapeutic environment" (Lang, 2015a) is provided for adolescents to share their

    experiences in the foster care system. Each group meets weekly for 90 minutes and

    addresses topics such as: self-advocacy, developing support systems, goal

    development, and regulating emotions and feelings.

4. The program offers transportation services to the university-based clinic for some

    families. The offer of transportation to families with barriers to transportation is to

    increase the likelihood that regular sessions are attended. Undergraduate students are

    paired with a graduate student/therapist and transport the client to and from sessions.

    In addition, undergraduate students act as "mentors" for the clients and are

encouraged to develop relationships with the client and participate in activities approved by the graduate student clinician.

Program Materials

The following material is used in order to contribute to the counseling process: rating scales, permission forms, progress notes, play therapy materials, treatment manuals, and worksheets. The "Permission for Consultation form" is signed by Division of Child Protection and Permanency (DCP&P) caseworkers and resource caregivers to initiate therapy. A "Consent to Release Information form" is required for biological parents, children over 14, and in some cases relative caregivers to sign prior to releasing any information to Division of Child Protection and Permanency (DCP&P). An "Initial Evaluation and Treatment Plan" and a "Performance Target Tracking Form" are required to be completed by the third session with the client. "Quarterly Reports" that provide client updates on progress and attainment of goals are required every three months thereafter. Entries are made on "Progress Notes" after every contact, either face to face, or by phone. At pre, six month, and post-treatment intervals, the clients, caregivers and caseworkers complete the Ohio Youth Problem, Functioning and Satisfaction Scale (Ogles, Melendez, Davis & Lunnen, 1999). The Resiliency Scales for Children and Adolescents-A Profile of Personal Strengths: RSCA Scale Scales (Prince-Embury, 2008) are also completed for children over nine years old. An "Assessment of Services Form" is provided to clients for feedback at the termination of therapy. A "Termination Report" is completed within a month of the case being closed. Table 1 depicts the forms and checklists that are used by the program. These checklists and forms are used to assess client progress in meeting program and individual goals.

Table 1

Description of Forms/Checklists used by Foster Care program

Name	Purpose	How Used	Expected Results
Initial Evaluation and Treatment Plan	Record review on client and identifies treatment goals	Record review on client and identifies treatment goals	Clinician assists client in attaining goals developed in plan
Quarterly Reports	Brief written update on client's progress	Provides progress update to case worker on progress	To facilitate communication on client's progress
Performance Target Tracking Form	Identify program participation milestones, including goals and objectives for therapy	Develop goals and objectives for therapy and projections for when goals will be attained	Helps clinician and supervisor clarify and track goals and objectives for treatment
Ohio Scales for Youth	Brief measures on mental health and functioning	Caretakers, case workers, and youth complete form at beginning and at termination of treatment	Identifies possible areas for treatment target and clinical improvement from receiving services
Resiliency Scales for Children and Adolescents	Brief measure of emotional mastery, relatedness and emotional reactivity	Caretakers, case workers, and youth (9 and older) complete form at beginning and at termination of treatment	Identifies possible areas for treatment target and clinical improvement from receiving services
Termination Report	Summary of treatment and report of therapy termination	Provides summary of treatment and documentation of case termination to case worker	Case is closed following termination report
Assessment of Services Form	Feedback and satisfaction form	Caretakers, case workers, and youth complete form at termination of treatment	Provides client feedback for services

Equipment

The following equipment is used to help support program operations and methods: computers, printers, and fax machine. Clinicians use computers, and printers to print various items such as therapy activities, progress notes, treatment summaries, etc. Therapy materials include toys, books and games.

Facilities

The Foster Care Counseling Project primarily operates in the Center for Applied Psychology building on Rutgers University-Livingston Campus. The office has several private offices, administrative and office area, conference room, and kitchen. The clinicians see the clients at the Rutgers University Psychological Clinic located on Busch Campus. Clinicians book the private play therapy or individual therapy rooms at the clinic when a client is scheduled.

Components, Phases, Activities

Clients in the program have the potential to attend the Foster Care Program as long as their case is open through Department of Children and Families. Clients are typically seen for at least six months, while many cases stay open for 12 months or longer. Graduate student/therapists have a commitment with the program for one year. If a child requires services for more than one year, they are transferred to a new graduate student/therapist. Duration of time in the program is affected by a client's progress in achieving their therapeutic milestones and whether the case remains open. If a child is over the age of 18 at the time of the initial referral, they are unable to be seen by the program. Components and activities of the Foster Care Program are individually tailored to each client's unique needs.

Budget

Foster Care Program receives in-kind assistance from Rutgers University such as the use of Center of Applied Psychology facilities. DCP&P provides funding for staff salaries, materials, facilities and part of the graduate student stipend. United Way has provided supplemental funding for the past five years. The New Jersey Psychological Association has provided additional funding for the past three years for the graduate student stipend.

Personnel

The following are the core program personnel as described in the most recent grant renewal document.

Director: Administration of Project and coordination of day-to-day Project business; liaison between Project and Center for Applied Psychology, Graduate School of Applied and Professional Psychology, Rutgers University, Division of Child Protection and Permanency, outside consultants and community agencies; fund raising and grant writing; recruitment, training and supervision of graduate student/therapists; supervision of support staff; oversees recruitment and training of undergraduate students.

Clinical Trainer: Teaches the undergraduate course Fieldwork in Foster Care. The trainer also trains and supervises undergraduate students and consults with the director on training and clinical matters.

Secretarial Assistant: The assistant provides clerical and support services professional staff that includes typing of reports, monitoring charts, handling phone calls and working with the Director on administrative issues.

Graduate Student/Therapists: Their primary duties include the assessment of the mental health needs of referred clients, provision of individual and family therapy, crisis intervention, telephone consultation, and serving as a liaison between the program and the child's case worker.

Undergraduate Paraprofessionals: They are junior and senior Psychology or Social Work majors who are enrolled in the Field Work in Foster Care course. Primary duties of the position include transportation of selected children/families to therapy sites and ancillary mentoring activities with clients (i.e. recreational activities, social skills training, etc.).

Incentives

No additional salary/monetary reward, in additional to their contractual salary, is given to the Director, Clinical Trainer, Administrative Assistant, or Undergraduate Paraprofessionals for their involvement in the program. The graduate students receive a stipend for their participation.

Program Evaluation Plan

A formal procedure for ongoing evaluation was not developed; therefore an evaluation of the current program had not occurred.

Chapter VII: Assessment of Program Implementation

Program Evaluation Question: To what extent has the program been implemented as designed?

This program evaluation question sought to provide a description of how the program was executed and the extent to which the implementation adhered to the program design. This information is valuable toward making sound judgments about the program's ability to be implemented as designed, thus contributing to continuous program development and improvement. Answers to this question may also assist with making judgments about the program's ability to attain program and departmental goals. In order to answer this question, data were collected about the population to which services are provided, the nature of services, length of contact, as well as on supervision provided by the director to graduate student/therapists. These data were collected via permanent product review of grant proposal documents. Survey questions were posed to *N*=12 graduate student/therapists on an online survey.

Population Served

The most recent grant renewal documents (Lang, 2015a; Lang, 2015b) were reviewed along the following dimensions: current home placement and those involved in treatment. A 2015-2016 grant proposal document (Lang, 2015b) describes placements as "children in resource care (foster and kinship care)" that are "referred by the Division of Child Protection and Permanency (DCP&P) and their families. We provide services for children who are in the custody or under supervision of DCP&P and who have been removed from their biological parent's care and placed with resource families (either with relatives or foster parents)" (Lang, 2015b). Grant proposal data suggest that all children served are in either kinship or relative care placements or traditional foster homes. Grant

renewal documents did not reveal supporting information for clients residing with biological parents.

Results from graduate student/therapist responses revealed that most clients were residing in resource or kinship placements. Out of the twelve survey participants, ten (n=10) graduate student/therapists responded to the item, "describe the cases you work with in terms of what type of placement your clients are in?" The remaining two responders chose to leave the question blank. Responses revealed that 100% of graduate student/therapists had at least one client that resided in a resource home. Graduate student/therapists responses indicated that 90% had at least one client that lived in kinship care or with a relative. A total of 30% of respondents indicated that their clients lived with their biological parents.

Grant proposal documents were reviewed to determine individuals involved in treatment. The following individuals were noted in proposals that collaborate during treatment: "collaborate with the resource family and school", "bring the biological parents into treatment", "consult with DCP&P workers", "consult with law guardians, DAG, CASA workers, other treating professionals". In informal consultations with the project director, emphasis was placed on open lines of communication between all parties involved with a particular child.

The following themes emerged from the graduate student responses: (1) resource parents (2) DCP&P case workers and supervisors (3) extended family (grandparents, aunts, uncles, etc) (4) biological parents (5) law guardians (6) CASA workers (7) school personnel. Other personnel indicated include siblings, co-therapists, family therapists, behaviorists, and undergraduate mentors.

Services Provided

The 2015-2016 grant proposals (Lang, 2015a; Lang, 2015b) list several categories of services provided by graduate student/therapists. These are reported as follows: (1) evaluation and referral services for clients whose clinical needs cannot be adequately met by Foster Care program staff; (2) short-term individual and family interventions- usually less than 6 months- for those clients whose clinical needs can be met by problem-focused counseling (e.g., bereavement issues, symptom reduction intervention, social skills training, parent skills training, problem focused groups, etc.); (3) intensive interventions for children with more complex and pervasive problems; and (4) group interventions focusing on social skills building and relationship development, emotional expression and regulation, separation and loss issues, trauma processing, self-esteem building and empowerment, and adolescent life skills.

The grant proposal describes the theoretical orientation of the project as "multi-systemic" and "trauma and attachment informed" that is not "governed by a single intervention or technique". The center "draws on a number of training and therapeutic skills" such as "trauma-focused cognitive behavioral therapy, trauma systems therapy, dyadic developmental psychotherapy, parent-child interaction therapy, and the attachment, self-regulation and competency (ARC) treatment framework" (Lang, 2015a; Lang, 2015b).

Results from the graduate student/therapist survey on services provided in therapy revealed the following themes: (1) play therapy/creative arts interventions; (2) talk therapy; (3) psycho-education/social skills training; (3) cognitive-behavioral therapy; (4) behavioral interventions; (5) parent-child interaction therapy/parent management training.

Additional themes included: therapeutic story telling, narrative therapy and game-based cognitive-behavioral therapy. There were notable discrepancies between the graduate student responses and grant renewal documents. The grant renewal documents indicated usage on trauma systems therapy and attachment, self-regulation and competency (ARC) framework. Graduate students did not endorse utilizing these theoretical frameworks in their cases.

Length of Contact

Grant renewal documents (Lang, 2015a; Lang, 2015b) were reviewed to summarize descriptions of length of client participation in the project. The documents indicated that short-term and family therapy cases whose "clinical needs are met through problem-solving interventions" are typically seen for "less than six months" (Lang, 2015a; Lang, 2015b). Grant documents did not provide information for the length of contact in more intensive cases. Graduate student/therapists participate in the program for one calendar year and carry caseloads between three and six clients each. Without more data from grant renewal documents, it was difficult to ascertain the intended length of contact for clients.

Graduate student/therapists were surveyed on the length of their cases. Results (n=10) revealed a large range in length of contact. Two responders chose to not answer the question. Responses varied from seeing clients, "once or twice" to "eighteen months". Figure 1 displays the results indicating frequency of survey responses demonstrating length of client contact.

Figure 1
Frequency of Contact with Clients
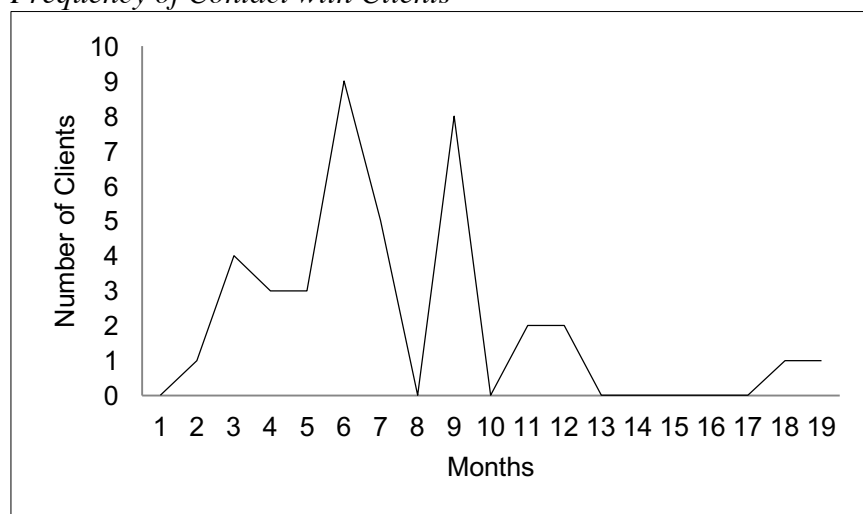
The most frequent duplicated response to the length of contact seen for a client is

"six months" (n=9 responses) followed by "nine months" with n=8 graduate

student/therapists endorsing this length of time. Three responders chose not to respond to

the question. As indicated by the survey responses, a majority of cases remained with the

project for 6-9 months of time. It appeared that long-term interventions comprised a large

percentage of the services offered more than any other intervention, though this remained

an imprecise comparison due to the fact that the grant proposal document did not indicate

a specific percentage and length of service for long-term interventions.

Knowledge and Supervision

Grant renewal documents (Lang, 2015a; Lang, 2015b) were reviewed for

descriptive information on its supervisory practices. Results indicated that the project was

self-described as "serv[ing] the same purpose as the teaching hospital of a medical

school" (Lang, 2015a). The agency's mission to staff training and development is to

"train future psychologists in the clinical needs of and therapeutic interventions for

children in resource care" (Lang, 2015a). Trainings are described as "intensive, weekly

in-service trainings on topics such as multi systemic treatment, trauma, child maltreatment, attachment, separation and loss, [and] assessment and intervention strategies" (Lang, 2015b). Special speakers have presented on a variety of topics including game-based cognitive behavioral therapy for child sexual abuse, adolescent sexuality and relationships and trauma and attachment (Lang, 2015a; Lang, 2015b).

Surveys were administered to graduate student/therapists to also gain more information on their experiences and reactions to the supervisory and educational components of the project. In order to assess the reactions of these individuals, data were collected for the following variables: type of training received, type of supervision offered, and satisfaction with supervision, knowledge, skills and abilities.

Graduate student responses revealed the following themes to the survey question, "What training have you received through the program?": (1) training for treating children in the foster care system; (2) play therapy; (3) parent-child management skills; (4) cognitive-behavioral therapy; and (5) family systems theory. Additional themes that emerged include: group process skills and personal control training.

Graduate students were asked to respond to the following questions "Do you feel [training] was adequate? If so, in what ways has it meet your needs? If not, in what ways has it been lacking?" to gather more information on their training experiences at the project. The following themes emerged: (1) disappointment in brief exposure to modalities (e.g., TF-CBT, PCIT, play therapy); (2) desire to gain more knowledge in modalities (e.g., TF-CBT, PCIT, play therapy) and develop a treatment plan; (3) supported to pursue modalities of interest; (4) lack of directive supervision; (5) lack of treatment planning.

Graduate student responses to the survey question, "describe the supervision you receive through the program" indicated the following themes: (1) knowledge in the areas of trauma, DCP&P and family systems; (2) specific behavioral strategies and interventions; and (3) empathic and supportive supervisor. It is important to note that several students indicated that they felt "lost" and "frustrated" by the lack of long-term treatment planning and case conceptualization. The supervisor's "non-directive" style was described as "not helpful" and resulted in some students feeling "overwhelmed by [their] cases".

Graduate students were asked to respond to the following questions "do you feel [supervision] was adequate? If so, in what ways has it meet your needs? If not, in what ways has it been lacking?" to gather more information on their supervision experiences at the project. Results revealed the following themes indicating a positive experience: (1) empathic supervisor; (2) supportive supervisor; (3) available supervisor; (4) supervisor is knowledgeable in DCP&P systems. The following themes emerged indicating a negative experience: (1) supervision was unfocused or unstructured; (2) indirect supervisory style; (3) supervisor appeared overwhelmed; (4) no treatment planning; (5) supervisor had limited knowledge of manualized treatments.

Chapter VIII: Evaluation of the Program Evaluation

The final program planning and evaluation activity is to evaluate the program evaluation. According to Maher (2012), evaluating the program evaluation allows key stakeholders to use evaluation information for judging the program's worth and to make subsequent program planning decisions. Evaluating the program evaluation provides information so that decisions may be made as to how future program evaluations and the entire program planning and evaluation process can be improved. The evaluation of the program evaluation can be facilitated by exploring the four qualities of a sound human services program evaluation. The four qualities are practicality, utility, propriety, and technical defensibility (Maher, 2012) The following four questions, which are based on these qualities, are:

1. To what extent was the program evaluation conducted in a way that allowed for its successful accomplishment? (Practicality)

2. In what ways was the resulting program evaluation information helpful to people? Which people? (Utility)

  3. Did the program evaluation occur in a way that adhered to legal structures and ethical standards? (Propriety)

4. To what degree can the evaluation be justified with respect to matters of reliability and validity? (Technical Defensibility)

Responses to these questions can be obtained from a variety of people who have been involved in the evaluation and through sources of data. In order to evaluate the Foster Care program evaluation, these four questions were addressed during a meeting with the director of the Foster Care program, through observations of the program, and

through review of data obtained from the program evaluation. This chapter discusses each of the four questions.

Practicality

This question examines whether or not the program evaluation was conducted in a manner that allowed for its successful accomplishment. A program evaluation plan should be designed in a way that is not disruptive to the organizational routines of the program (Maher, 2012).

The information generated from the creation of the Program Design Document will be useful to the Foster Care program's stakeholders because prior to its creation, a Program Design Document did not exist. The evaluable format will allow for further program development and improvement and it will help stakeholders to perform program activities in a coordinated manner. The information generated from the analysis of the program's best practices will be useful to the Foster Care program's stakeholders because it will provide guidance to program stakeholders who are interested in taking steps to improve the program.

One program evaluation instrument was used for this program evaluation. The instrument, *Graduate Student Online Survey,* surveyed the experiences of past and current graduate student/therapists at the project. The graduate students were asked to respond to an open-ended survey that would take approximately 20 minutes to complete. The format of the survey was designed to be brief and easy to navigate. The survey was accessed online, so that the gradate students could complete it at a time that was convenient for them. The online format of the survey was practical to engage the graduate student/therapists since their schedules and availability varied. The director of

the project expressed her support in receiving feedback directly from the graduate students, which allowed current graduate student/therapists to use the time during group supervision or didactics to complete the survey. The current graduate students also indicated that completing the survey was a worthy use of their time and verbally expressed their support for both the program evaluation and online survey. Although the surveys resulted in a 60% response rate, the response rate of the current graduate student/therapists resulted in an 83% response rate. This high response rate can be attributed to the support received from graduate students for the program evaluation. The procedure for the questionnaire completion did not present any disruptions to the daily operation of the Foster Care program, and was embraced by all key stakeholders.

Utility

The purpose of asking and answering this question is to determine whether the information that was generated as a result of the program evaluation plan allowed the stakeholders to make more informed decisions about the program (Maher, 2012). Information obtained from the program evaluation could be helpful toward the future development of the Foster Care program. The supervisor will be able to refer to the program evaluation information as a tool to guide future decisions when improving the program. The director could use the information to guide the training and supervisory aspects of the program. The supervisor indicated that the information obtained highlights the need for ongoing program evaluation. The supervisor planned to refer to the program evaluation information to modify the Foster Care program implementation and to inform future program evaluations.

The program evaluation information is also useful to other Rutgers University

faculty members, graduate student/therapists, and other key stakeholders. The objective information resulting from the program evaluation can improve service delivery to foster care children. Foster care children can be provided with more effective services, and the process of implementing the project can be revised to meet both the children and graduate student/therapist's needs.

Propriety

The purpose of asking and answering this question is to ensure that the program evaluation occurs in a way that adheres to ethical and legal standards (Maher, 2012). Legal and ethical concerns were openly discussed prior to implementing the program evaluation process. The program evaluation plan was thoroughly reviewed and approved by the director of the program and the chairperson of this dissertation. Data for the program evaluation was collected and reported in a manner that protected the confidentiality and anonymity of all participants. The current evaluation adhered to guidelines set by the IRB and staff was surveyed by the evaluator read and signed the IRB's "*Consent Form for Anonymous Data Collection*" (see Appendix C).

Technical Defensibility

The final question for the evaluation of the program evaluation addresses the reliability, validity, and accuracy of the methods, procedures, and instruments of the program evaluation (Maher, 2012). The methods and procedures used for evaluation of the foster care counseling program evaluation were deemed to be justifiable based on the context within which the program evaluation occurred. The Program Design Instrument that was used was developed by the evaluator based on information and suggested questions provided in Maher's (2012) Resource Guide, Planning and Evaluating Human

Services Programs.

One instrument was designed and used to evaluate the Foster Care program. Caution needs to be taken when considering the reliability and validity of the instrument. The *Graduate Student Online Survey* was accessed and completed online via SurveyMonkey. Results obtained from this instrument must be considered in light of the context in which they were administered. Although every precaution was used to ensure confidentiality and anonymity, and these precautions were thoroughly explained to graduate students prior to completing the questionnaire, it is possible that graduate students currently participating in the program felt pressured to respond to questions in a manner that would be most flattering to themselves and the center in which they worked. The instrument was examined by the director of the project and the chairperson of this dissertation prior to use in the program evaluation process, and deemed to have adequate levels of content and face validity. It is important to emphasize, however, that this evaluation was formative in nature and the research design lacked a comparison program. Thus, it is difficult to ascertain how other programs adhere to a program model. Results are only valid within the context of the Foster Care program and the specific population served.

The final program planning and evaluation activity was to evaluate the program evaluation so that subsequent program planning and evaluation decisions could be made. Four questions were developed based upon the four qualities of a sound human services program that are delineated by Maher (2000). These qualities are practicality, utility, propriety, and technical defensibility. Responses to these questions were obtained from informal consultation the program director, and by review of data obtained from the

program evaluation. First, the evaluation of the program evaluation determined that the implementation of the evaluation was conducted in a practical manner. Second, key stakeholders indicated that the program evaluation was useful in that it provided objective information that will allow effective decisions to be made about foster counseling project program development and implementation, as well as future program evaluations. Third, it was determined that adherence to legal and ethical concerns was strictly maintained. Finally, it was determined that results of the program evaluation were reliable and valid only within the context of the program and the specific population served. Results could not be generalized to other foster care counseling programs and settings.

Limitations

Limitations should be considered when interpreting the findings of the current program evaluation. One limitation was the qualitative design used for the review of program-related documents, data collection and data analysis. Qualitative designs have many benefits, particularly in the context of program evaluation where the goal is to extract meaning from raw data (Rossi, Lipsey, & Freeman, 2004). Qualitative approaches are oriented towards discovery of new information and interpret meaning within the context of which the data is found, which has significant utility for program decision makers (Rossi, Lipsey, & Freeman, 2004). Qualitative analysis can be conducted in a manner that obtains psychometric information on the reliability and validity of the coding (e.g., inter-rater agreement). A limitation of this study was that I was the sole coder of the qualitative data and did not obtain such psychometric information (Rossi, Lipsey, & Freeman, 2004). Thus, it is recommended that the Foster Care program's future program evaluations either apply reliable and valid qualitative methods, such as inter-rater

reliability, or use quantitative methods as part of their program analyses.

Utilizing a second independent coder to confirm the credibility of the coding and categorization of the survey responses could have further reduced imbedded bias. When making judgments based on qualitative data, it is common to rely on personal constructions that may introduce bias or random error (Patton, 2002). The evaluation of inter-coder reliability and agreement as part of the development of coding schemes helps to confirm that the data is reliable. It is recommended that future evaluations utilize a second coder to reduce the possible error and bias generated when processing text-based data. This can be accomplished by a team collaborating on the process of coding the data, calculating inter-rater agreement, identifying disagreement, modifying the codebook as needed, and recoding the data (Bradley, Curry & Devers, 2007).

An additional limitation that should be considered is the subjectivity and imbedded researcher bias. The evaluator was a current graduate student/therapist in the Foster Care program while conducting the program evaluation. The current evaluator took measures to reduce bias, such as self-evaluating for evaluator influence and consultation with the director of the project. However, it would have been beneficial to have someone who was not part of the system or the program conduct the evaluation.

Another limitation that should be considered is the sample used in the study. A small number of responders (N=12) participated in the study. The 40% non-response rate resulted in a sample size. In addition, demographic data of the participants were not gathered at the onset of the study. Therefore, it is difficult to ascertain whether there is a selection bias, or if the participants hold unique characteristics that might have skewed the results. In addition, the participants reflected responses over the past three years of the

program. The students might have had different experiences as the program and University evolved over time. These considerations impact the reproducibility of the findings and negatively affect the validity of the study (Patton, 2002). Future program evaluations of the Foster Care program could focus on collecting more demographic data and increasing the sample size to ensure a more accurate representation of the graduate student/therapists.

Chapter IX: Recommendations For Program Implementation

In Chapter VII, the Foster Care Counseling Program was evaluated on how the program implementation adhered to its initial design. The evaluation used graduate student responses to determine how the program operated on the following variables: target population, nature of services, length of client contact, and graduate student supervision. In this current chapter, the results of the survey will be analyzed in terms of strengths of the program design as well as recommendations for improvement. Recommendations in this chapter are meant to provide guidance to program stakeholders who are interested in taking steps to improve the program. Recommendations should be considered within the goals, context, and resources of the program.

Population Served

The target population identified in grant renewal documents was described as children in resource care or recently reunified with their biological parents that were referred by the Department of Child Protection and Permanency (DCP&P) aligned with responses from graduate students/therapists. 90% of graduate student/therapists indicated that at least one of their clients were in resource care. 30% of graduate student/therapists had at least one client who was residing with their biological parent. Additional treatment providers who are involved in a child's therapy were consistent across grant documents and graduate student/therapist responses.

Recommendations. Although it appears that the client population corresponds with grant renewal documents, it would be beneficial for the program to clarify what constitutes an appropriate referral. Because DCP&P caseworkers are responsible for referring clients to the program, it would be helpful to have an ongoing discussion with

referral sources, stakeholders, and graduate student/therapists about what presenting

problems and referrals are appropriate for the center.

Services Provided

Grant proposal documents described a "multi-systemic" and "trauma-informed" approach

to therapy that is "not governed by a single intervention or technique". This flexibility in

theoretical orientation was reflected in the results of the graduate student responses.

Graduate student/therapists endorsed a wide range of services in therapy, varying from

play therapy to behavioral interventions.

 Recommendations. Grant documents described utilizing therapeutic skills in

"trauma-focused cognitive behavioral therapy, trauma systems therapy, dyadic

developmental psychotherapy, parent-child interaction therapy, and the attachment, self-

regulation and competency (ARC) treatment framework" (Lang, 2015a; Lang, 2015b).

graduate student/therapists did not endorse utilizing trauma systems therapy or the

attachment, self-regulation and competency (ARC) treatment framework. It appears that

the flexibility and adaptability of the theoretical orientation of the program has resulted in

discrepancies between proposed therapeutic approaches and what graduate

student/therapists are doing with their clients. There are several treatments that have been

designed specifically for children in foster care or have been deemed effective with

children in foster care. These include TF-CBT, PCIT, KEEP, and a multiple component

framework such as Multisystemic Therapy (Chamberlain, Moreland & Reid, 1992;

Eyberg, Boggs & Algina, 1995; Landsverk, Burns, Faw Stambaugh & Rolls Reutz, 2006;

Stewart, Lescheid, den Dunnen, Zalamanowitz & Baiden, 2012; Weiner, Shneider, &

Lyons, 2009). It appears that Multisystemic Therapy would be a beneficial framework for

the Foster Care program, as it uses the same concepts of collaborative decision-making that the Program employs. Although Multisystemic Therapy does not specifically address trauma, attachment or parenting, this could be addressed by selecting an evidence-based manualized intervention such as TF-CBT or PCIT that best fits the client's needs. These considerations and changes would help make the services and treatment both empirically-supported and also address the unique mental health and environmental needs found in foster care children.

Length of Contact

Grant documents described contact with a short-term or family therapy client as, "less than six months" (Lang, 2015a). Grant documents did not provide information for the length of contact in more intensive cases. Responses from graduate student/therapists ranged from one therapy session to continuous involvement for over eighteen months. The most common length of time for a client seen at the program is between six and nine months. It should also be noted that several graduate student/therapists also felt that they had difficulty confining their placement to a certain number of hours per week. Many indicated that instead of spending the prescribed one or two days focused on their work for the program, they spent a part of each work-day on Foster Care program related responsibilities. Although the survey did not directly address this question, several graduate student/therapists provided this information anecdotally.

Recommendations. To reduce the variability in client contact, stakeholders may consider re-evaluating the referral process. Changes can be made either in the communication to caseworkers and supervisors regarding which cases are appropriate for referral or how the project accepts or rejects cases. This could help reduce the amount of

cases that are an inappropriate length for the program. The program and program director can also assist graduate student/therapists in creating healthy and professional boundaries with their clients to restrict the time they are actively working. It may be beneficial for this issue to be addressed as a standard part of professional psychology training, in addition to students receiving training from individual supervisors.

Another future direction would be to implement a screening procedure or use the pre-referral data collected from DCP&P in a systematic manner to determine whether the client is an appropriate fit. It could be beneficial to use a screener to provide a preliminary assessment of a client to ascertain their fit into the program. The program could also consider using the results of the Ohio Youth Problem, Functioning and Satisfaction Scale (Ogles, Melendez, Davis & Lunnen, 1999) to inform decisions as to whether the client could benefit from the services offered at the Program. The scales include a 20-item Problem Severity scale and 20-item Functioning scale that can be completed by the youth, parent and social worker's perspective (Ogles, Melendez, Davis & Lunnen, 1999). The information gleaned from both the Problem Severity scale and the Functioning scale could be used to inform program enrollment or whether to refer out to a more appropriate source.

Graduate Therapist Training and Supervision

The Foster Care Program partially serves as a training program for psychology doctoral students to gain exposure in therapeutic strategies with children and adolescents (Lang, 2015a). Grant documents describe the training and supervision component as "serv[ing] the same purpose as the teaching hospital of a medical school" (Lang, 2015a). Documents indicated that graduate students are trained in trauma-informed therapy,

attachment, child abuse, separation and loss, and assessment and intervention strategies (Lang, 2015a). Students revealed that they were exposed to trauma-focused cognitive behavioral therapy, play therapy, and behavioral strategies.

However, themes of responses revealed a sense of incompetence in applying these skills, and disappointment in the brief trainings. Themes of the graduate students indicated that they required increased structure in supervision to help them be more effective in their clinical work. Several respondents commented on the lack of a unitary approach for service provision and lack of evidence-based treatment planning and conceptualization.

Recommendations. Though the incorporation of diverse modalities may benefit the unique referrals that the program provides services to, it would be beneficial to determine how the training and supervision process can be streamlined so that the graduate student/therapist's and director are making evidence driven decisions about treatment planning and therapeutic strategies.

Graduate student/therapist responses indicated that supervision was unstructured and did not assist them in their treatment planning and case conceptualization. The program has developed a number of data collection tools that could be used throughout the therapeutic process to provide this requested structure. The Performance Target Tracking Form is used to develop goals and objectives for therapy. The purpose and utilization of this document could be expanded so that it is referred to more frequently throughout the client's case. The Form can serve as a guide for the case conceptualization and treatment planning when determining how the client will achieve the indicated goals.

The graduate student/therapists also indicated an overall lack of self-efficacy in conducting therapy. Although it appears that there are several factors for their lack of confidence, one reason could be how clients are assigned. If clients are assigned to graduate student/therapists that are more aligned with their experience and interests, this may improve their confidence. The Ohio Youth Problem, Functioning and Satisfaction Scale (Ogles, Melendez, Davis & Lunnen, 1999) and the Resiliency Scales for Children and Adolescents-A Profile of Personal Strengths: RSCA Scale (Prince-Embury, 2008) is used to help identify areas for treatment and clinical improvement. The results of these scales could not only help inform referral decisions, but also aid in the "match" between graduate student/therapists and clients. Graduate student/therapists with more experience can be matched with children who revealed higher scores on the scales, and vice versa.

In response to the graduate student/therapist's concerns over "vague" and "non-directive" supervision, the client's treatment plan during the assessment phase could include SMART (specific, measurable, answerable, relevant, time framed) goals (Maher, 2012). The treatment plan can include case priorities and tasks, specific techniques to use, etc. The treatment plan may also include graduate student/therapist goals, including training in a specific therapeutic technique. Supervision could be oriented around this treatment plan so that it is more structured and organized.

The graduate student/therapist goals could also be oriented in the SMART goals (Maher, 2012) format so that the graduate student/therapist and supervisor can closely monitor their progress. For example, a graduate student/therapist could have a client that is engaging in externalizing behaviors. One of his/her goals is to reduce incidences of outbursts and shouting. To incorporate graduate student/therapist's training goals, the

treatment plan would specify that the graduate student/therapist improve his/her ability to de-escalate verbally aggressive behavior. This could be monitored by a graduate student/therapist self-rating system that occurs throughout treatment to track progress. The incorporation of graduate student/therapist goals can help to measure the therapist's perception of self-efficacy and provide him/her with the ability to track his/her goal development. This may reduce concerns over incompetence in the therapeutic environment and improve the graduate student/therapist's self-confidence.

Chapter X: Recommendations For Implementation of the Evaluation Plan

The following recommendations are made based on the evaluation of the evaluation plan of the Foster Care program. In order to continue to successfully evaluate the Foster Care program, the following recommendations are made. First, stakeholders should designate an evaluation consultant to be responsible for ongoing evaluation of the program. The stakeholders will need to provide future evaluation consultants with the appropriate resources necessary to execute a successful program evaluation. The evaluation consultant is responsible for ensuring that all aspects of the program evaluation are conducted appropriately, including data collection, data analysis, and communication of the results of the evaluation. A designated evaluation consultant, in conjunction with access to all necessary resources, will increase the likelihood that future program evaluations will be conducted successfully.

Second, consideration should be made for the improvement of the data collection instrument used during the evaluation process. Improvements can be made to the *Graduate Student Online Survey,* as well. Consideration should be made to revise this instrument so that open-ended questions align more accurately with questions in which graduate student therapists are asked to assess experiences and perceptions as they correspond to the goals of the program. This will increase the ability of the instrument to identify improvements in which the program is executed so that aligns with the desired results of the Foster Care program. Accordingly, the data obtained from the evaluation plan will be more likely to provide the director of the Foster Care program and other key stakeholders with more meaningful and valuable information about the merit and worth of the Foster Care program.

Third, one of the findings of the evaluation indicated that decisions for selecting a therapeutic intervention were not evidence-based. The current evaluation plan did not address the reasons for the necessity of choosing therapeutic interventions based on the referral. Consideration should be made to include examination of this phenomenon in future program evaluation plans so that meaningful information can be obtained about how to improve the delivery of therapeutic interventions.

Fourth, improvements for communicating results of the program evaluation must be considered. Original guidelines for communicating the results of the evaluation included disseminating results to the supervisor of the Foster Care program. To date, however, communication of program evaluation information has not occurred. It is recommended that a plan to share evaluation information with all key stakeholders of the program be revised to ensure that all interested parties are informed about the results of the program evaluation. This revision may include a change in designation of which stakeholders will participate in the initial dissemination of evaluation results with the consultant and the supervisor of the Foster Care program. Additional participants in this meeting may serve to alleviate the supervisor of the Foster Care program from having the sole responsibility of disseminating evaluation information to other key stakeholders. Regardless of how the plan to communicate evaluation information is revised, it is important to maintain the integrity of the plan to communicate evaluation results. Sharing evaluation information properly and thoroughly contributes to the abilities of all key stakeholders to make decisions about the development and improvement of the Foster Care program and improvements to the evaluation plan.

Finally, program evaluation is an ongoing process of gathering, analyzing,

interpreting, and using information so that judgments can be made about the worth of the program (Maher, 2012). Therefore, it is important to emphasize that program evaluation plans are not intended to be constant or fixed. Rather, program evaluation plans must remain fluid. There are principles and procedures that structure the process of program evaluation, but program evaluation is intended to be an ongoing process. As the Foster Care program continues to develop, it should be continuously evaluated so that sound decisions could be made as to whether or not it is adding value to the target population.

Chapter XI: Implications for School Psychology Training

The current dissertation's methods, assessment and analysis of the Foster Care Program have implication for other child welfare initiatives, mental health workers, psychologists and educators. The graduate student/therapist responses to training have several implications for training in professional psychology. School psychologists are in a unique position to provide both school-based and social-emotional support for those who lack permanent families (McKellar, 2010). To effectively prepare and train future school psychologists to work with this population, students should be exposed to the unique circumstances that surround each child in foster care (McKellar, 2010). Though there is a commonality that a child in foster care has a parent that is unable or unwilling to care for their child, these children present with various backgrounds and presenting mental health issues (Leslie, Hurlburt, Landsverk, Barth & Slymen, 2004).

School psychologist training should prepare students for the academic and behavioral challenges that face many foster care youth. This includes achievements gaps in basic skills, frequent changes in school placements, high incidences in externalizing and internalizing disorders and stigmatization by peers. School psychologists should be aware of school-based intervention services that support these students. These can include individualized instruction, arranging for a mentor and referring for mental health care when needed (McKellar & Cowan, 2011).

School psychologists are also fluent in developing educational plans where program goals and objectives are used to track progress (McKellar, 2010). Training in school psychology can include training in program evaluation in addition to their existing evidence-based consultation skills. Rossi, Lipsey, and Freeman (2004) identified several

requisite skills needed for program evaluators. These include: (1) Training in social

science methodology, (2) Knowledge about target problem area addressed by the

program, (3) Findings related to problem area and previous evaluations, and (4)

Understanding of context in which the program is situated. School psychologists

frequently have these above mentioned skill sets. Yet, they might benefit from additional

training in program evaluation, which can build upon their skill set in student evaluation

and progress monitoring (McKellar, 2010).

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Appendix A
IRB Approval

RUTGERS

Office of Research and Regulatory Affairs   orra.rutgers.edu/artsci
Arts and Sciences IRB
Rutgers, The State University of New Jersey   732-235-9806
335 George Street / Liberty Plaza / Suite 3200
New Brunswick, NJ 08901

December 22, 2015

Emily Kurlansik

P.I. Name: Kurlansik
Protocol #: E16-357

Dear Emily Kurlansik:

This project identified below has been approved for exemption under one of the six categories noted in 45 CFR 46, and as noted below:

Protocol Title: "A Program Evaluation of a University-Based Mental health Program for Foster Care Children and Families"

Exemption Date: 12/21/2015   **Exempt Category:**   2,4

This exemption is based on the following assumptions:
- **This Approval** - The research will be conducted according to the most recent version of the protocol that was submitted.
- **Reporting** – ORSP must be immediately informed of any injuries to subjects that occur and/or problems that arise, in the course of your research;
- **Modifications** – Any proposed changes MUST be submitted to the IRB as an amendment for review and approval prior to implementation;
- **Consent Form (s)** – Each person who signs a consent document will be given a copy of that document, if you are using such documents in your research. The Principal Investigator must retain all signed documents for at least three years after the conclusion of the research;

Additional Notes:

- HSCP Certification will no longer be accepted after 7/1/15 (including for anyone previously grandfathered). CITI becomes effective on July 1, 2015 for all Rutgers faculty/staff/students engaged in human subject research.

Failure to comply with these conditions will result in withdrawal of this approval.
Please note that the IRB has the authority to observe, or have a third party observe, the consent process or the research itself. The Federal-wide Assurance (FWA) number for the Rutgers University IRB is FWA00003913; this number may be requested on funding applications or by collaborators.

Sincerely yours,

Farah Omvar

Acting For--
Beverly Tepper, Ph.D.
Professor, Department of Food Science
IRB Chair, Arts and Sciences Institutional Review Board
Rutgers, The State University of New Jersey

cc: Dr. Kenneth Schneider

(MW:nh)

Appendix B
Graduate Student Online Survey

1. Describe the major activities or components of the program
    a. (I.e. activities you perform and what percentage of time you spend on each?)
2. Describe the cases you work with in terms of:
    a. Type of placement your clients are in
    b. Who is involved in the treatment
    c. What services you provide
    d. How long you have been involved in each case
    Please refrain from including any identifying information.
3. Describe any products that you have produced during your work with your clients (i.e., reports, notes, worksheets)
4. What training have you received through the program?
    a. Do you feel it has been adequate?
        i. If so, in what ways has it meet your needs?
        ii. If not, in what ways has it been lacking?
    b. What knowledge, skills and abilities have you gained as a result of working with the program?
5. Describe the supervision you receive through the program?
    a. Do you feel it is adequate?
        i. If so, in what ways?
        ii. If not, how is it lacking?

Appendix C
Consent Form for Participation

You are invited to participate in a study of the Foster Care Counseling Project (FCCP). The purpose of this study is to gather information about FCCP in order to put the program into evaluable format and to evaluate how the program is being implemented in terms of products, services, and activities. This program evaluation is being conducted for FCCP by Emily Kurlansik of Rutgers Graduate School of Applied and Professional Psychology as part of her dissertation project. You were selected as a participant in this study because of your involvement and knowledge of FCCP.

If you decide to participate, Ms. Kurlansik may request that you complete confidential survey questions on surveymonkey.com to find out more information about the activities of the Foster Care Counseling Project. Surveymonkey.com is a 100% confidential and anonymous tool.

Ms. Kurlansik will also conduct observations of the program and review program documents. Observations will take place in the Rutgers University Center for Applied Psychology building where the program is housed. You may complete the survey online at a time and place that is convenient for you. Observations and survey administration will begin once IRB approval is granted and will continue until April 2016.

Your participation in this study is part of the program evaluation process. The survey questions and observations are not about individual graduate student clinicians, but about the program itself. The director has approved the program evaluation process. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and anonymous. All information, when aggregated, will not show who said what. No one will be identified by name and the program itself will not be identified in the dissertation. This is a program evaluation of the Foster Care Counseling project and not an evaluation of personnel.

Your participation in this study is voluntary. There are no alternatives to participating in this study. There are few foreseeable risks to participating in this study. Individuals who choose to participate in the survey and observations will increase the knowledge of the Foster Care Counseling project's current activities and practices. Information and resources related to facilitating and improving the program will be shared with the director at the completion of the evaluation. Your decision whether or not to participate will not prejudice your future relation with the Foster Care Counseling project or with Rutgers University. If you decide to participate, you are free to discontinue participation at any time without prejudice.

This informed consent was approved by the Rutgers University Institutional Review Board for the Protection of Human Subjects on December 22, 2015. Currently, there is no expiration on the approval of this form.

 If you have any questions, please do not hesitate to contact Ms. Kurlansik. If you have

any additional questions later about the study, please contact Emily Kurlansik at (908) 303 5371 or edk25@scarletmail.rutgers.edu who will be happy to answer them. If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Institutional Review Board
Rutgers, The State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Email: humansubjects@orsp.rutgers.edu
(732)235-9806

You may withdraw at any time without penalty or loss of any benefits to which you may be entitled after signing this form should you choose to discontinue participation in this study.

Please retain a copy of this form for your records. By participating in the above stated procedures, then you agree to participation in this study.

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, click on the "I Agree" button to begin the survey/experiment.   If not, please click on the "I Do Not Agree" button which you will exit this program.

I Agree   I Do Not Agree