

MENTAL HEALTH CONSULTATION IN STATE GOVERNMENT: A PROGRAM
EVALUATION

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ABSTRACT

The Clinical Consultant position was established by the New Jersey Division of Child Behavioral Health (DCBHS) to provide clinical guidance to caseworkers from the Division of Youth and Family Services (DYFS) tasked with the job of managing the complex needs of the children and families under their supervision. Due to the urgency of the need for this service the Clinical Consultant position was created and implemented with a loose job definition while an extensive needs assessment and program evaluation was conducted that would form the basis for an informed, comprehensive and detailed training manual. This needs assessment and program evaluation was carried out by the author eighteen months after the position was formally implemented, with the goals of a) identifying the most critical issues that the clinical consultants face, b) clarifying and refining the organizational conceptualization of the position, c) providing a resource for the clinical consultants to assist them in carrying out their duties effectively and efficiently and d) standardizing practice. The methods used in carrying out this program evaluation were modeled on those described by Hepburn, Kaufmann, Perry, Allen, Brennan and Green in *Early childhood mental health consultation: An evaluation tool kit*, and involved an extensive review of the consultation and organizational diagnosis literature, semi-structured interviews with involved personnel, and observation. A qualitative database was created from the semi-structured interviews identifying important themes and analyzing them within the larger context of the theoretical foundations of mental health consultation. Specific duties and tasks associated with these dimensions were isolated and examined in light of these theoretical foundations and within the framework of practical and logistic considerations. Presentations of findings

were made to major stakeholder groups. The significant themes that arose from the evaluation included differing organizational understandings of the Clinical Consultant position, varying conceptions of the important dimensions of the position and associated tasks, and significant inter-system dynamics influencing communication and utilization of the position at large. These are considered with relevant observations from the author's own experience serving as a consultant to the larger system in which the Clinical Consultants operate.

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CHAPTER I

Introduction

Statement of the Problem

A training manual for the clinical consultant position. The Clinical Consultant position was established by the New Jersey Division of Child Behavioral Health (DCBHS) to provide clinical guidance to caseworkers from the Division of Youth and Family Services (DYFS) tasked with the job of addressing the mental and behavioral health needs of children and families on their caseload, who do not have the necessary clinical background or training to evaluate and determine the most needed, appropriate, and potentially effective interventions. Due to the urgency of the need for this service, and the variability in the needs of DYFS by office and by region, the Clinical Consultant position was created and implemented with a loose job definition, while an extensive needs assessment and program evaluation was conducted that would form the basis for an informed, comprehensive and detailed training manual.

This needs assessment and program evaluation was carried out by the author eighteen months after the position was formally implemented, with the goals of a) identifying the most critical issues that the clinical consultants face, b) clarifying and refining the organizational conceptualization of the position, c) providing a resource for the clinical consultant to assist them in carrying out their duties effectively and efficiently and d) standardizing practice. The program evaluation took place over four months, after which the author compiled a detailed training manual and offered feedback sessions. The

program evaluation and subsequent training curriculums impart fundamental information about the position and establish a clear model of consultation that will help guide practice. A clear model of practice is necessary in order to prevent role confusion between consultants and consultees, to support the consistency of service delivery across fifteen CMO/UCM organizations, fifteen individual clinical consultants, and forty-seven DYFS offices, and to provide the foundation for future evaluation efforts. In both government-based programs and the mental health field at large, increasing attention is being paid to the effectiveness of interventions. The program evaluation and training manual are the first steps in creating a product that is standardized and thus able to be evaluated for effectiveness.

The Clinical Consultant Program

History and philosophy. The clinical consultant position, a collaboration among DCBHS, CMO/UCM and DYFS, provides mental health consultation to DYFS employees regarding DYFS-involved youth with behavioral health issues. The position was established in 2008 to provide on-site consultation services to DYFS offices located in the catchments area of the hiring organization, the CMO/UCM, through one individual who would be deployed as a remote employee to the local DYFS offices. Clinical consultants are licensed mental health professionals who receive regular supervision from a member of the CMO staff. This is usually either the Director of Operations, who reports directly to the Executive Director, or, in some cases, from the CMO Executive Director themselves, placing the Clinical Consultants immediately below hierarchically high-ranking members of their own organization. Since its inception, the position has been an evolving one, responding to the needs of the consumer, DYFS, in accordance

with the principles identified in the theoretical and empirical literature on consultation, and in response to the logistical and practical limitations of a single individual attempting to serve what may be an expansive and high demand area comprised of several different local DYFS offices.

Mission and goals. The goals of the position are to bring clinical information to case planning, to link children and families with appropriate interventions in a timely manner, to encourage a deep, informed, proactive and longitudinal view of the mental health situations of the children and families of New Jersey, and to weave together the service delivery systems of the System of Care and DYFS Case Practice. The position was designed to provide DYFS line staff with access to expertise and guidance with regards to issues of mental or behavioral health that would inform their case planning so as to effectively and efficiently improve the overall functioning of child and family.

Organizational location. The Clinical Consultant is a unique cross-systems position that bridges several different organizations, specifically, a) the Division of Child Behavioral Health (DCBHS), b) Care Management Organizations and Unified Care Management organizations (CMO/UCM), and c) the Division of Youth and Family Services (DYFS). Their organizational home is as employees of the Care Management Organization or Unified Case Management, organizations that fall under the auspices of the Division of Child Behavioral Health.

Both DCBHS and DYFS are members of the larger Department of Children and Families. The organizational structure in which the Clinical Consultant is embedded is described in greater detail below, so as to further examine the unique aims, processes, directives, limitations and functioning of each organizational entity, as well as to

explicate the intersections and overlaps as relevant to a cross-systems position such as the Clinical Consultant.

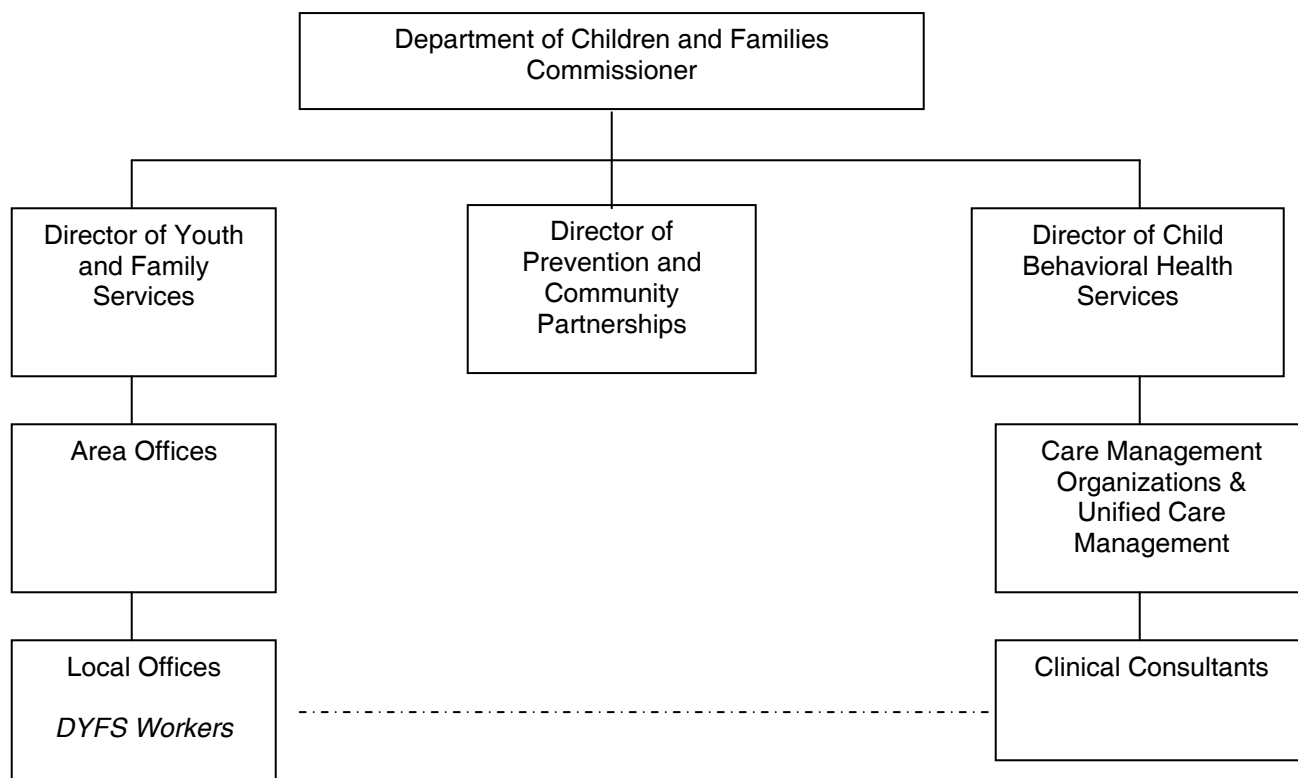


Figure 1. Organization of the Department of Children and Families.

The department of children and families. The Department of Children and Families was established in July of 2006 as part of an effort to reform the child welfare system in the state of New Jersey. Following a class action lawsuit brought against the state by Children’s Rights, in which Children’s Rights alleged that New Jersey was violating the constitutional rights of the children in its custody, a modified settlement agreement (MSA) was reached which laid out the specific reforms and milestones that

New Jersey was required to meet, and established federal oversight and monitoring (Charlie and Nadine H., et al v. Corzine 2006).

The Department of Children and Families is New Jersey's first Cabinet-level agency devoted exclusively to serving and safeguarding the most vulnerable children and families in the state. It has as its aim the strengthening of families, and achieving safety, well-being and permanency for all New Jersey's children (Department of Children and Families [DCF], 2009). The Department of Children and Families consists of three operating divisions, the Division of Youth and Family Services (DYFS), the Division of Child Behavioral Health (DCBHS), and the Division of Prevention and Community Partnerships (DPCP). Also under the purview of DCF is the child abuse and neglect hotline, the State Central Registry (SCR) (Department of Children and Families [DCF], 2009). Each division is responsible for a discrete segment of the work that forms the ultimate goals of DCF; the safety, well-being and permanency of the children of New Jersey. Each division is summarized briefly below.

Division of Youth and Family Services (DYFS). DYFS is the division of DCF responsible for child protection and welfare. Its duties include investigating allegations of child abuse and neglect, arranging for the child's protection and the family's treatment, and executing the appropriate disposition of cases under DYFS supervision, including timely reunification, or alternatively, timely adoption or kinship legal guardianship placements in situations in which reunification is not possible, in compliance with the Adoption and Safe Families Act (ASFA). These duties are carried out by employees at ten area offices and 47 local offices spread around the state, organized by county and judicial vicinage (Department of Children and Families [DCF], 2009). In addition to

local office managers, area managers, and DYFS caseworkers and supervisors, 13 specialized DYFS employees, designated as “Team Leaders,” serve as a “liaison and communication link between local children’s behavioral health system partners and DCBHS” (Armstrong, Blase, Caldwell, Holt, King-Miller, Kuppinger, Obrochta, Policella & Wallace, 2006. p 28). That is, they “share information from the local level with the state level governance and to bring information from the state level back down to the counties/vicinages” (Armstrong et al. 2006. p 28). The Team Leaders fulfill an important function with regards to the Clinical Consultant, as they have direct communication with the Clinical Consultant’s home organization, DCBHS, and institutional authority within DYFS, the consultee agency. These 13 individuals may therefore have a great impact on how well the Clinical Consultants are integrated into the DYFS culture, and how well utilized they are as a result.

State Central Registry (SCR). The State Central Registry (SCR) is the centralized call center to report child abuse and neglect - 1-877 NJ ABUSE. The SCR sits under the auspices of DYFS, is toll free, and operates 24-hours per day, 7 days a week, and 365 days per year. SCR is staffed with professional screeners who attempt to obtain relevant information from callers and forward reports requiring field response to the appropriate Division of Youth and Family Services (DYFS) Local Office, Institutional Abuse Investigation Unit (IAIU), or after-hours response workers. The role of the screener includes conducting background checks and searching existing databases to provide accurate and thorough information to the assigned field worker (“About the Division of Youth and Family Services,” n.d.). Once the report is generated and forwarded to the appropriate Local Office, an investigator from DYFS must initiate an

investigation within 24 hours of receiving the complaint. Thus, the SCR may serve as an important “entry point” into the Clinical Consultant’s services, either during the investigation phase, or after the case has been transferred for ongoing supervision.

Division of Child Behavioral Health (DCBHS). The Division of Child Behavioral Health Services was established as an extension of the vision put forth in the *Children’s Initiative Concept Paper* (State of New Jersey, 2000) in an effort to create a unified statewide system of child behavioral health services with a single point of access. The mission of DCBHS is to provide youth and their families an avenue through which to access community-based behavioral health services with the aim of keeping children at home, in school and in their own community. The system is based on public-private partnerships where local service providers contract with DCBHS to provide services that are need-driven, strength-focused and guided by the youth and families themselves (Department of Children and Families [DCF], 2009). DCBHS administers mental health benefits through the New Jersey System of Care, serving children, adolescents and their families across child-serving systems by coordinating services and developing a single, individualized service plan in conjunction with the child and family. DCBHS does this with the help of several systems partners, including the Contracted Systems Administrator (CSA), Care Management Organizations (CMO) and Unified Care Management Organizations (UCM).

Contracted Systems Administrator: PerformCare. PerformCare is the Contracted System Administrator (CSA), the system partner contracted by DCBHS and tasked with administering the New Jersey System of Care. They provide the central point of access to the System of Care through a centralized phone number, which is staffed and

operational 24 hours a day, 7 days a week. Their duties include authorizing services, maintaining electronic records for children receiving services, and monitoring the quality of behavioral health treatment plans and assessments to assure the appropriateness of services. Services Accessed through PerformCare include mobile response and stabilization services (MRSS), needs assessments and treatment planning, and intensive in-community services (IIC). As an important systems partner with DCBHS, and a significant referral source for DYFS, PerformCare is also an important resource for the Clinical Consultants in their efforts to recommend effective interventions for children and families in need.

Care Management Organizations/Unified Care Management (CMO/UCM). Care Management Organizations were conceptualized and implemented as part of the newly created DCBHS in 2000. They were designed to address the needs of the children evidencing the most serious mental and behavioral health challenges, with Youth Case Management Services (YCM) designated to handle cases with more moderate needs. Recently, Unified Care Management (UCM) organizations have been rolled out in three vicinages, and combine case management and youth case management services into one organization, thereby serving both the most serious, and more moderate mental and behavioral health needs for children and families in their catchments areas. CMO/UCMs do not provide direct services, but rather function as service brokers, assisting families in “accessing, maintaining and adjusting services” (Armstrong et al. 2006, p 91). Care managers employed by the CMO/UCMs provide ongoing, individualized care coordination partnering with formal and informal community supports mobilized around the strengths of the children and families they serve.

The CMO/UCMS are solely contracted to DCBHS, placing them in a subordinate position hierarchically with DCF, though they maintain their position as privately-operating non-profit organizations. The Clinical Consultant position was created by DCBHS, which allots funding to the CMO/UCMs to hire and execute the position based on the loose job description provided. Thus, the Clinical Consultants are employees of the CMO/UCMs, and report directly to their supervisors in these organizations.

Division of Prevention and Community Partnerships (DPCP). DPCP focuses on the primary prevention of child abuse through the creation of a continuum of child abuse prevention and intervention programs that are culturally competent, strength-based and family centered (“Prevention,” n.d.). DPCP is distinguished from DCBHS and DYFS in that its services are intended to address issues of abuse and neglect in the *general* population and *before* any abuse or neglect has occurred. The services offered through DYFS and DCBHS are activated subsequent to a challenge or issue being identified. DPCP focuses on four main prevention priorities: early childhood services for pregnant women, parents and young children up to age five, school-linked services for school-aged children, teenagers and their families, family support services for any families in need of neighborhood center-based services, and domestic violence services for adults and families impacted by intimate partner violence. The DPCP has a deployed Domestic Violence Consultant position to DYFS, similar to the Clinical Consultant. Because of the frequent overlap between issues of domestic violence and child behavioral health needs, the Domestic Violence Consultant is an important partner for the Clinical Consultant within the DYFS offices.

Summary of the organizational location of the clinical consultant. The Clinical Consultants therefore straddle three major organizations; DCBHS, the “parent” organization of the Care Management Organization/Unified Care Management entities who hire and supervise them, the CMO/UCMs themselves, and the DYFS organization to which they are deployed. All of these organizations fall under the purview of the Department of Children and Families, with DCBHS and DYFS being hierarchically equal but with separate and distinct responsibilities and resources, and CMO/UCM placed subordinate to DCBHS, but with a great deal of organizational independence as necessary to remain effectively able to tailor services to local needs.

The reforms instituted by the MSA were designed to render the care of the children and families of New Jersey more efficient and effective by carving out the mental and behavioral health responsibilities from the safety and physical health responsibilities. The clinical consultant position was designed to serve as a link between the agencies responsible for each portion of child and family care by bridging the worlds of behavioral health and child welfare. The cross-systemic location of the Clinical Consultant position is deliberately designed with an aim towards strengthening the System of Care. However, this unique organizational location creates a situation in which the Clinical Consultant must navigate competing systemic needs and demands on a regular basis. Each system will predictably push on the limits of the position to obtain what they feel they need from the Clinical Consultants, and each will differ in the specific duties they see as necessary and appropriate to the position. Therefore it is critically important that the position of the Clinical Consultant be clearly defined so as to allow its occupants to discharge the purpose of the role.

The Present Study

The methods used in carrying out this program evaluation involved an extensive review of the consultation and organizational diagnosis literature, interviews with CMO/UCM personnel, the clinical consultants themselves, DYFS personnel, DCBHS personnel, observation of clinical consultant activities, attendance at various meetings and participation in the UBHC training academy's Wraparound Training. A qualitative database was created from the semi-structured interviews. Organizational perceptions of the position were described, and important dimensions of the job were identified and placed in the larger context of the theoretical foundations of mental health consultation. Specific duties and tasks associated with these dimensions were isolated and examined in light of these theoretical foundations and within the framework of practical and logistic considerations. Presentations of findings were made to major stakeholder groups, including the clinical consultants, the CMO/UCM executive directors, DYFS team leaders and DYFS local and area directors. At each step feedback was invited and considered.

What follows in this paper is an examination of the program evaluation project itself. It is comprised of several sections representing specific elements of the program evaluation process and the resultant findings. Theoretical approaches to consultation and organizational diagnosis are explored, and the relevant literature utilized both in designing the program evaluation project itself, and in formulating a theoretical context from which to describe the Clinical Consultant position are summarized. Next, the methods and process through which this needs assessment and evaluation were conducted are described. A detailed description of the findings from the evaluation follows,

summarizing the various conceptualizations of the position, including the identified important dimensions of the role. Also discussed are specific identified tasks and duties of the clinical consultant, including the rationale for these duties as based in the consultancy literature, and issues associated with being an outside consultant at the nexus of three major organizations.

Finally, the results are discussed in light of the varying responses by the stakeholders to the author's presentation of the findings. The author's use of self throughout the process of the evaluation and feedback processes is examined with reference to Embedded Intergroup Relations theory as a vehicle through which to understand the different responses and to evaluate the overall success of the program evaluation project.

CHAPTER II

Theoretical Foundations of Mental Health Consultation

Introduction

The role of the consultant is a unique one in the world of mental health service provision. While professional training primarily focuses on direct service provision with a personally known client, consultation is a critically important intervention with the potential for the widespread improvement of community behavioral and mental health, and prevention (Caplan & Caplan, 1993). Yet consultation as a professional practice is less emphasized and frequently learned “on the job” (Brown, 1993).

Consultation is distinct from other professional activities along several dimensions. Clarifying these differences is important to understanding the ways in which consultation is most effectively and meaningfully conducted. The model of consultation upon which the Clinical Consultant program is based is grounded in Caplan’s Consultee-Centered Consultation (Caplan & Caplan, 1993) approach, and draws from the consultation literature listed in the references section. Consultation can be generally defined as an indirect intervention aimed at improving the mental and behavioral health of a client through the relationship between the consultant, who has specialized knowledge, and the consultee, who bears the ultimate responsibility for the client’s well-being and development (Brown, 1993; Caplan & Caplan, 1993; Glasser, 2002). That is, the consultant provides specialized guidance and recommendations arising from his or her particular expertise, within the context of a non-hierarchical, non-coercive,

collaborative relationship with the consultee (Reinhiller, 1999). It is important to note that in this model, as is true of the Clinical Consultant position, the consultant is external to the organization that he or she is serving, and consultee participation in the process is voluntary, with the consultee free to accept or reject the consultant's recommendations (Brown, 1993; Caplan & Caplan, 1993).

Consultation occurs within a specific ecological context comprised variously of the client's unique situation, the community, the consultee organization and the consultant organization. The total sphere of the client's situation includes influences at various ecological levels from a micro level consisting of significant individuals in a client's day-to-day life, to a macro level consisting of the various overarching systems with which the client must interface (Davis & Sandoval, 1991). The consultant must take a systemic view of the challenges identified by the consultee, and must maintain an awareness of the multiple and simultaneous organizational factors that shape and direct his or her own professional activities.

The Importance of Consultation

Consultation provides the opportunity to exert an influence over a much larger sphere, and consequently, to positively impact a larger number of clients than is possible via direct, individual service provision (Caplan & Caplan, 1993). The practice of mental health consultation arose out of a pragmatic need to reconcile the overwhelming demand for mental health services following World War II with the limited number of providers and restricted organizational capacity. Gerald Caplan, upon whose seminal work in community psychology and mental health consultation this model is based, and his team at the Lasker Mental Hygiene and Child Guidance Center in Jerusalem found that they

were able to more efficiently utilize their expertise to effect an improvement in child functioning and well-being through consultation, rather than trying to provide individual therapy to the large volume of immigrant children whom they were referred (Caplan & Caplan, 1993). They discovered that through consultation, “a relatively small number of consultants can exert a widespread effect through the intermediation of a large group of consultees, each of whom is in contact with many clients” (Caplan & Caplan, 1993, p. 12). Mental health consultation has always had as its goal the maximizing of expertise for the benefit of a client when the need for intervention is great. This too is the goal of the Clinical Consultant position with regards to the needs of the DYFS population.

Because of its potential to impact a wide-ranging number of clients, consultation serves an important preventative function, by allowing for early and focused, proficient intervention (Caplan, Caplan & Erchul, 1994). There is evidence that mental health consultation can increase cost-effective intervention, improve services, increase client satisfaction and raise quality of life (Badger, Geleberg, & Berren, 2004). Although the primary roles of many consultees, such as the DYFS employees in question, do not directly relate to mental health, all of them will frequently encounter individuals and families struggling with mental and behavioral health challenges (Caplan & Caplan, 1993). Raising the level of awareness of potential red flags increases the likelihood that individuals and families who may not previously have been offered mental or behavioral health services will benefit from early consultation and intervention, thus preventing the development of additional, more significant impairments in functioning and symptom expression down the road.

The importance of the preventive aspect of the consultation process means that consultation must be conceptualized as “help plus education” (Caplan & Caplan, 1993, p. 14). The goal of any consultant is not only to assist the consultee with the specific problem for which they are seeking guidance, but also to increase the consultee’s understanding, knowledge, insight, sensitivity and skill in order to inform their future handling of similar situations. The consultant is training the consultee to recognize the need for, and to quickly seek, consultation when appropriate. Educating the consultee results in a greater understanding of the value of consultation, and thus raises the demand for consultation (Caplan & Caplan, 1993). Therefore, a consultant not only intervenes in cases with active or acute mental health needs, but also works to improve rates of early identification of potential mental health issues and proactive intervention, particularly the increased seeking of consultation.

How is Consultation Different from Other Clinical Activities?

Given the potential impact of the consultant role on the well being of individuals and families and the effective functioning of the social services system, it is important to consider the distinguishing factors that make consultation a unique professional role.

One of the primary distinguishing factors of consultation, as referenced above, is the indirect nature of consultation as an intervention (Brown, 1993; Caplan & Caplan, 1993; Knoteck & Sandoval, 2003; Reinhiller, 2000). The consultant has little or no direct client contact and must rely on the consultee to put the consultant’s recommendations into practice, and ultimately ameliorate the client’s situation. The improvement in the client’s mental health situation is accomplished almost exclusively through the mediating relationship between the consultant and the consultee. Thus, while the working

arrangement involves a dyadic interaction between consultant and consultee, the true ecological field is, as Wallace and Hall describe, “an intricate network of relationships between and among consultants, who are external to the situation; consultees, who engage consultants; and clients, who are the end users or ultimate beneficiaries of the services provided by the consultee” (as cited in Glasser, 2002, p.28). The total relationship in consultation is thus triadic in nature, rather than the more common dyadic relationship encountered in the individual therapy setting.

In this manner, consultation is similar to supervision. In a supervisory relationship, the supervisor guides the handling of a client’s case not by working with the clients themselves, but by working with their direct service providers to enhance and improve the provider’s conceptualization and intervention skills. The overall goal is to help the client, but the intermediate goal is to enhance provider functioning (Caplan & Caplan, 1993). In consultation, similarly, the consultant works to improve the client’s situation not through direct intervention with the client, but by guiding the consultee to more effectively identify, target and intervene in areas where help is needed, and to more skillfully enact the advice and recommendations provided by the consultant.

Consultation is distinct from supervision along several important dimensions, however. In supervision the relationship most often occurs between two members of the same profession, while in consultation, the interaction occurs between two individuals of different disciplines. That is, rather than being a subordinate in the same field as the consultant, the consultee is instead an expert in his or her own field of professional practice (Caplan & Caplan, 1993). The consultant and consultee are equal, but different in this respect (Schulte & Osborne, 2003). It is critical to note that, because of the

different professional spheres in which the consultant and consultee operate, the consultant must rely on the consultee's expertise in his or her own specific arena in order to most effectively respond to the referral question and craft recommendations for intervention (Brown, 1993; Caplan & Caplan, 1993; Reinhiller, 1999; Schulte & Osborne, 2003).

The likelihood that a recommendation will be implemented, and successful, depends on how realistically it fits into the professional world of the consultee (Green, Everhart, Gordon & Gettman, 2006). If a recommendation is impractical from the consultee's viewpoint, the consultee will either disregard it and leave the consultation with a negative view of the process, or will implement it ineffectively and become frustrated with its failure (Caplan & Caplan, 1993). In either situation the consultation has been unsuccessful in achieving its end goal of improving the mental health of the consultee's clients. The consultant must respect the consultee's expertise with regards to his or her own professional duties, abilities and limitations.

This reciprocal respect allows for the formation of a coordinate and non-hierarchical relationship between the consultant and the consultee, a factor that has important implications for the outcome of the consultation process (Green et al., 2006). Given that consultee participation in the consultation process is voluntary, the relationship between the consultant and consultee assumes added importance (Glasser, 2002). The consultee must feel free to approach the consultant with the knowledge that there will be no coercive mandates following the consultation.

As in the therapy relationship, there is evidence that the most important factor in successful consultation is the relationship between consultants and consultees (Benes &

Gutkin, 1995; Knoff & Hines, 1995). Frequency of contact between consultant and consultee appears to be significant only in how much and how well contact facilitates the relationship (Green et al., 2006). That is, it is not the number of consultation activities that are important, but rather the activities themselves are only as effective as the positive nature of the individual relationship that exists between consultant and consultee. Both in therapy, and in consultation, building rapport determines the efficacy of all future interventions by laying the groundwork of trust and respect upon which the process can build.

The reciprocal and non-hierarchical relationship between the consultant and the consultee is made further possible by the fact that the consultant bears no responsibility for the outcome (Caplan & Caplan, 1993). Because of this, the consultee is free to accept or reject advice the consultant's advice, and the consultant is able to feel comfortable with this arrangement. In the case of the Clinical Consultant, the responsibility for the well-being of the client remains with the DYFS worker as much as it did before the consultation, or as if no consultation had taken place.

The divesting of the consultant of responsibility for outcome is the result of the fact that consultants are external to the organization to which they are consulting. They maintain their home base in another organization. The consultant therefore does not have any administrative authority over the consultee, but also does not bear professional responsibility for the client's well-being. The consultant does not have the responsibility to ensure that recommendations are followed or implemented. The role of the consultant is to provide the recommendations when asked, and any follow up support that is requested. An obvious limitation to this stricture would be if the consultant believes that

the behavior of the consultee is placing the client in imminent danger of self-harm or is a risk of causing harm to others. When that situation occurs the consultant must be bound by the ethical and legal code of his or her own profession and bring the matter to the attention of the consultee's supervisor or the appropriate authority.

Key Factors in Effective Consulting

The consultant's task is to identify and highlight critical information regarding the client's situation and to consider multiple viewpoints and levels of intervention (Davis & Sandoval, 1991). The main consulting service is the provision of expertise (Uliva, 2000), and the main product of consultation services are recommendations, born out of the consultant's particular expertise as distinct from that of the DYFS worker. It is incumbent on the consultant to craft these recommendations in a way that is maximally helpful for the consultee, in this case, the DYFS worker requesting the consultation. In order to perform this specialized function, however, a consultant must be able to effectively penetrate the consultee organization. The consultant must, as per Busche & Gibbs, "enter an ambiguous power-control situation, simultaneously develop empathy for and maintain objective distance from the key players, provide the required services, and exit when the consultation is concluded" (as cited in Glasser, 2002, p.31).

Several important skills make this task possible: interpersonal skills, effective communication skills, problem solving skills, an understanding of the consultation process and its application, ethical and professional comportment, and clear and consistent communication of boundaries and limitations (Brown, 1993; Glasser, 2002; Green et al., 2006; Knoff & Hines, 1995; Schulte & Osborne, 2003; Uliva, 2000). It is likely that a consultant will already possess some of these skills upon entering into the

Clinical Consultant position, while others will be honed through supervision and practice. These skills all interplay and overlap to influence the ultimate success of the consultation process.

Interpersonal skills and building relationships. A good individual relationship between consultant and consultee is the single most important factor in consultation (Glasser, 2002). Aspects of the consultant's role that render him or her most effectively able to do their job, such as an external position to the consultee organization and lack of administrative authority over the consultee, also create a dependence on the consultee. "Because consultants lack both autonomy and authority in an organization, the only way their recommendations can be implemented is through the commitment of members of the organization" (Glasser, 2002, p. 33). The consultee is a vitally important individual who shares the consultant's ultimate goal of helping the children and families of New Jersey, but who comes from a distinct professional background and perspective that may impede an immediate "meeting of the minds" on how to proceed. Joining with the consultee in the initial consultation and maintaining a positive connection throughout the consultation process helps engender the consultee's commitment to the resulting recommendations (Schulte & Osborne, 2003). Ultimately, mental health consultation can be viewed, not as a technique, but rather as an interpersonal process (Meyers, Parsons & Martin, 1979).

Interpersonal skills with regard to effective consulting practices have been defined as "those behaviors and skills that the consultant uses to build and maintain rapport, trust and positive relationships with their consultees such that the consultation process can ultimately focus on problem solving, intervention development and implementation"

(Knoff & Hines, 1995, p. 486). Attempts to empirically identify characteristics of effective consultants on this dimension have determined the most important factors to be; a demonstration of respect by the consultant for the consultee, acting in trustworthy manner, being approachable, encouraging and pleasant, and demonstrating a positive attitude (Knoff, & Hines, 1995).

The consultant can take a series of steps to promote good working relationships on a day-to-day basis (Caplan & Caplan, 1993; Duran et al., 2009; Glasser, 2002; Green et al., 2006; Schulte & Osborne, 2003; Uliva, 2000):

- 1) Specify the mutual expectations of the consulting process
 - a) Clearly delineate the limitations of the consultant role. For example, be clear that the consultant does not take responsibility for tasks that fall under the purview of the DYFS worker, such as directly linking the client to services, calling the CSA, or arranging emergency housing. The consultant's task is to provide recommendations, not link directly to providers.
 - b) Communicate respect for the DYFS worker's knowledge of the child and family under consideration, the identified challenges, and knowledge of interventions that have been, or are currently being tried.
 - c) Make the collaborative nature of the consultation explicit.

- 2) Initiate frequent informal contacts with the consultee in addition to the agreed upon formal communications
 - a) Make oneself visible. Informally check in, through email or in person, with the individuals who have sought consultation as to the helpfulness of recommendations and the ease or difficulty of implementation.
 - b) Be careful not to overload the consultee. Keep the informal contacts at a level with which the consultee is comfortable.
- 3) Accept people for where they are and who they are
 - a) Remember that readiness for consultation is tied to the success of the consultation.
 - b) Part of consultation work is recognizing where the consultee is along the spectrum of readiness and helping them to become more ready.
 - c) Consultation is “help plus education.” Education will nurture the consultee’s acceptance of consultation as a viable tool for them to accomplish their work goals.
 - d) Emphasize the preventative and cost-efficient benefits of consultation. Early and focused intervention may prevent the development of future symptoms, may

decrease the need for services faster, and may allow the DYFS worker to close a case earlier.

4) Encourage an internal champion

- a) There are many forces within an organization that may resist the implementation of an independent consultant. This resistance may arise from any level of the consultee organization hierarchy and may not be readily apparent to an outside consultant. It may be born out of a reluctance to change long-standing and widely held professional practices, an expectation that outside consultants may hold negative or critical views of their organization, or a suspicion that the consultant may add to the workload.
- b) An internal champion should be an influential member of the consultee organization who can speak to the skills of the consultant and the ease and advantage of consulting him or her, in order to help soften the individual and organizational obstacles to the consultant's integration. This person may vary from DYFS office to DYFS office, but may include individuals such as individual caseworkers, Casework Supervisors, Local Office Managers and Team Leaders. Word of mouth by a trusted individual inside the consultee organization is the most effective way to dispel resistance.

- 5) Make the project visible within the organization and to the relevant professional public
 - a) Make formal and informal presentations at internal meetings and trainings.
 - b) Make yourself personally known and approachable.
- 6) Do not project a “better than” attitude, or come across as “the authority”
 - a) The consultation relationship is collaborative, not coercive.
 - b) The consultant is an “expert,” not an “authority.”
 - c) Honor the consultee’s expertise in their particular domain.
 - d) Project an “equal but different” attitude.
- 7) Find “common ground”
 - a) e.g. “we all want what is best for the child.”
 - b) Frame the consultation as another way to achieve these ends.
 - c) Reiterate that your professional goals are in line with those of the DYFS worker.
- 8) Explore ways to be of further assistance to the consultee

- a) Foster long term relationships with individual consultees. Follow up informally to enquire as to the helpfulness of the consultation or any issues with implementation of recommendations.
- b) Make sure to only offer or agree to activities that are in line with the stated duties of a consultant. Don't be drawn into wanting to provide further assistance to the worker in ways that blur professional boundaries and duties.

These steps are organized around creating reasonable and realistic consultee expectations for the consultation, and then meeting those expectations. The consultant must cultivate these relationships at every level of the consultee-institution hierarchy. Buy in at every level assures effectiveness. Resistance on the part of the caseworker to access the Clinical Consultant may be dispelled by a supervisor who recognizes the value of the consultation service.

Effective communication skills. A centerpiece in creating good relationships is effective communication. Consultants must strive to promote the transparency of their role by communicating frequently and clearly with individuals at all levels of the hierarchy in the consultee organization, as well as with other important stakeholders (Caplan & Caplan, 1993). Important factors in effective communication include (Benes & Gutkin, 1995; Glasser, 2002; Knoff & Hines, 1995):

- Demonstrating empathy
- Genuineness
- Active listening
- Use of clear and straightforward (non-technical) language

- Asking the consultee for input

The role, agenda and purpose of an external consultant is not always clear to all those within a large and complex organization such as DYFS, nor can the consultant assume that the individuals at the higher levels of management and administration have explained the nature of the consultant position to their staff or supervisees (Caplan & Caplan, 1993). Furthermore, given the high rate of turnover in many DYFS offices, new individuals will frequently enter into the system at various levels of the hierarchy, and may or may not be made aware of, or familiarized with the Clinical Consultant's role upon hiring. The consultant therefore may be met by confusion or suspicion that he or she must work quickly to dissolve. The most effective tool in this dissipation is the transparency promoted by effective communication.

Effective communication also ensures that the mental health needs of the client are clearly and accurately delineated in the early stages of the consultation. The consultant must continuously probe, clarify and reframe the identified challenges with the consultee (Davis and Sandoval, 1991) in order to make sure both consultant and consultee are on the same page and in agreement as to what the primary concern is, and where the priority for intervention lies. This contributes not only to managing consultee expectations about the goals of intervention (Brown, 1993; Uliva, 2000), but also guarantees that the consultant and consultee are working syntonically to achieve mutually agreed upon ends, rather than working at cross-purposes.

This is important with regards to other treatment team members as well. The consultant must utilize good communication skills to make sure that members of the DYFS team, such as supervisors and casework supervisors, child health unit personnel

and domestic violence or Certified Alcohol and Drug Counselors (CADC), as necessary and appropriate, are briefed as to the clinical consultant's conceptualization of major problem areas, underlying concerns and suggested interventions. This ensures that the treatment team is aware of what each limb is doing and can work in concert to achieve the mutually agreed upon ends of improving the situation of the children and families under their care.

Finally, effective communication ensures that the Clinical Consultant's input and perspective can be accurately passed on to the clients, the children and families under DYFS supervision. This communication occurs through the consultee, the DYFS worker who is responsible for face-to-face contact and interaction with the Child Family Team. In order for families to receive accurate information in a sensitive manner likely to promote agreement and cooperation, the DYFS worker must possess it first. Thus, non-technical language must be used and the practical advantages to each intervention must be clear.

In many cases, the consultee may be apprehensive about communicating clinical recommendations to the families. In these instances it is appropriate for the consultant to offer to consult on upcoming meetings with the family, Child Family Team, Child Study Team or other caregivers or providers. Rather than attending these meetings in person, the consultant can help the consultee prepare. This is part of the "help plus education" aspect of consultation work that allows a consultant to assist the consultee in developing the skills to handle, not only the immediate and upcoming meeting, but similar meetings in the future (Caplan & Caplan, 1993). This ultimately allows the consultant to remain in an indirect service provision role, and maximizes his or her ability to remain in the office,

and be available to other workers for consultation. This is an important aspect of clearly and effectively communicating the limits of the consultation role to the consultee, helping them to understand and anticipate the division of labor in the consultation process (Glasser, 2002).

Problem solving skills. Once positive relationships and a clear pattern of communication have been established, the problem-solving aspect of the work can be most effectively entered into. This phase of the consultation allows the consultant to make use of his or her expertly-honed psychotherapy skills in case conceptualization, identification of underlying conditions that give rise to, and maintain, symptom expression or impairments in functioning, and assess the contributing factors of the child's environment as well as strengths and resources that can be marshaled in the service of effecting positive change.

In this phase of the consultation process, the consultant utilizes his or her own knowledge, training, background and theoretical orientation to conceptualize the client's primary issues and to generate a plan for intervention that will most effectively address them. Any number of approaches may suit the particular case under consideration, and the individual approach a consultant takes will necessarily be informed by their training, theoretical orientation, previous experiences, and the nature of the ecological systems in which they are working.

Problem solving skills have been defined generally as "those behaviors and skills that consultants use to identify and analyze referred problems and to develop the consultation momentum that results in the successful implementation of agreed-upon interventions" (Knoff & Hines, 1995, p. 486). Factors that have been shown to contribute

to effective consulting on this dimension include (Duran et al., 2009; Knoff & Hines, 1995):

- Consultant is skillful
- Consultant is a good facilitator
- Consultant is an active listener
- Consultant is effective at establishing rapport
- Consultant is good at problem solving
- Consultant is an astute observer and is perceptive

Many of these skills are neither specific nor unique to the consultation role. The consultant will likely be comfortable with active listening, establishing rapport, engaging in a collaborative problem solving process and utilizing his or her observational skills in a therapy setting. The key lies in being able to manage the consultation process, distinct from a therapeutic process, in a manner which maximizes the likelihood that needed interventions will be successfully implemented.

Understanding the consultation process and application. While identifying underlying issues and generating treatment recommendations are important, these skills can be impacted if the consultation process becomes derailed. “In order to effectively do consultation, the consultant must be able to implicitly and explicitly negotiate the consultation contract and structure the consultation process” (Knoff & Hines, 1995, p. 486). Consultants must utilize their communication skills to clearly educate the consultee as to the overt and covert expectations, roles, and responsibilities involved in the consultation process in which they are the identified experts (Glasser, 2002; Uliva, 2000). The consultee is not necessarily experienced in seeking or participating in consultation,

and the process should be explained to them at the outset, in the same way that the therapeutic process is explained in the initial sessions to a new individual client (Caplan & Caplan, 1993). Empirically supported characteristics of effective consulting along this dimension include (Knoff & Hines, 1995):

- Consultant is willing to get involved
- Consultant evaluates and focuses ideas
- Consultant is active
- Consultant pursues issues and follows through
- Consultant identifies clear goals

The situation that the consultee is seeking help with may be chaotic, frustrating and confusing, and this may be reflected in the initial presentation of the case and the relevant information (Caplan & Caplan, 1993). The consultant's role is to clarify important points as they arise and create a deliberate, thoughtful approach to what was before a potentially overwhelming and confusing situation. The consultant must communicate that the situation is manageable, and that he or she can be helpful in tackling it. At the same time the consultant must make sure to keep the consultee's expectations reasonable, by identifying clear goals and tying recommendations directly to them (Caplan & Caplan, 1993; Glasser, 2002; Uliva, 2000). The consultant must structure the consultation process itself, and the thinking about the child or family under consideration.

Ethical and professional practice skills. Often taken for granted, the ethical and professional comportment of a consultant is a critical factor to the integrity of the consultation process that benefits from concrete identification of empirically supported

factors contributing to its successful execution. Such factors include (Knoff & Hines, 1995):

- Consultant practices in an ethical manner
- Consultant maintains confidentiality
- Consultant is trustworthy
- Consultant is emotionally well-adjusted and stable
- Consultant has a clear sense of identify

Consultation can be a difficult and complicated task, particularly in a cross-systems setting such as the one in which the Clinical Consultant operates. They must manage the demands of covering multiple offices, sometimes over a large geographic area, negotiate and enforce the limits of the consultant position which will frequently be challenged by the systems in which they operate, operate without a true “home,” and manage the complicated and difficult situations encountered by the children and families on whom they consult. Maintaining a sense of balance, emotional adjustment, and clear sense of identity can be difficult under these circumstances, and the Clinical Consultant must make sure to obtain the necessary amount of support for him or herself. One avenue through which to do this is in supervision with the hiring agency, the CMO/UCM. Supervision is discussed more specifically later on.

In addition to the ethical boundaries laid out in the ethical code specific to the discipline of the consultant, there are ethical considerations specific to the consultation process of which the consultant must be cognizant. Ethical boundaries in consulting involve maintain ethically sound relationships by establishing clear boundaries. The consultant bears the ultimate responsibility for delineating and maintaining these

boundaries (Glasser, 2002). The consultant must, as has been mentioned previously, make the limitations of the consultation position clear, and consistently hold to them. If the limitations differ from consultee to consultee, for example if the consultant is regularly willing to engage in direct contact with clients or providers for one consultee, this will surely be noticed by other, potential consultees and will generate resentment when the consultant is ultimately not able to facilitate all such requests. Limits must be clear from the outset.

The consultant must also have a clear understanding of his or her own professional limitations, and limit the scope of their practice to the range of competencies they can realistically claim. The consultant must not assume a level of expertise commensurate with the consultees with regard to the system or organization in which the consultee regularly functions (Caplan & Caplan, 1993; Schulte & Osborne, 2003). That is, the consultee is the expert on DYFS, the child welfare system, and its accepted procedures and hierarchies.

Consultants must not take on the role of doing what the consultee is capable to doing for themselves. Throughout the consultation, consultees should be provided with what is needed and nothing more (Glasser, 2002). The consultee “may be disempowered by doing for them what they can already do for themselves” (Davis & Sandoval, 1991, p. 206). To return to the example utilized earlier, if a consultee requests a consultant’s participation in a face-to-face meeting with the clients, the consultant should emphasize their ability to help the consultee prepare for the meeting, but decline direct participation. This practice allows the limits of the consultant role, defined as an indirect intervention, to be maintained, while helping the consultee to practice skills for future use.

Collaboration and the consultation process. Throughout the consultation literature there are many different definitions of “collaboration” (Schulte & Osborne, 2003). In the context of the Clinical Consultant position, the most appropriate conceptualization of “collaboration” involves a definition best characterized as “equal but different” (Schulte & Osborne, 2003, p. 115). The consultant and the consultee have separate areas of expertise both critical to the success of the consultation process. Working collaboratively does not require the ceding of expertise or authority within one’s own domain, but rather acknowledging that the consultants own perspective must dovetail with the consultee’s. Johnson and Brinamen describe this position by stating that the consultant “is neither shy to offer her expertise nor to receive it from the consultees, but she integrates these perspectives to make them most useful” (Johnson & Brinamen, 2006, p. 15).

Summary

Mental health consultation is an indirect service aimed at improving the mental or behavioral health of a third party, the client, through the consultee. Consultation occurs between two professionals, one, the Clinical Consultant, who provides expertise in mental health, and the other, the DYFS workers, who understands the setting in which the proposed interventions must occur. The relationship between the Clinical Consultant and the DYFS worker is collaborative, non-hierarchical, and entered into voluntarily by the DYFS worker. Thus, the DYFS worker is free to accept or reject the recommendations of the Clinical Consultant, and the Clinical Consultant bears no responsibility for the outcome.

Because consultation has as its goal the maximizing of the consultant's influence across a wide range of clients, the Consultant must be careful to set and maintain limits to their role that allows them to consult on as many children and families as possible. Thus, part of the Consultant's role is "help plus education," helping DYFS workers to prepare for off-site or face-to-face meetings with the clients, but rarely attending these meetings in person. Another aspect of "educating" the DYFS worker involves helping them to recognize potential mental and behavioral health challenges quickly, thus allowing for earlier intervention and the prevention of future, more serious mental health struggles.

The role of the mental health consultant is a unique one. Since, as Caplan notes, the consultation setting "rarely provides the consultant with the clear set of mutual expectations to which he has become accustomed in his traditional work as a teacher, psychotherapist, clinical psychologist or agency caseworker, he [or she] must develop an internal conceptual map that he carries into the sphere of consultation operations" (Caplan & Caplan, 1993, p. 18). The theory presented in this chapter is not meant to provide exhaustive or definitive answers to all the situations that will arise as a Clinical Consultant deployed to a DYFS office, but rather to provide a way of thinking about consultation that should inform and guide future decision making.

CHAPTER III

Methods

Introduction

This project was undertaken eighteen months after the Clinical Consultant position was formally implemented. The goal of the project was to examine the process of position implementation across the various and varied geographic areas of the state, and to examine the perceived outcome of the position on the target populations of both the consultee (the DYFS staff) and the client (the child and family in question). The project had four specific primary objectives:

- 1) Extensively survey the position as it is being carried out across the state
- 2) Synthesize the assorted experiences and perspectives of the clinical consultants, their employers, and their consumers
- 3) Develop a comprehensive training manual addressing the most critical issues that the Clinical Consultants face, clarifying and refining the conceptualization of the position, and assisting them in carrying out their duties effectively and efficiently
- 4) Facilitate consistency of service provision across the state and thus provide the standardization that will allow for future effectiveness evaluations consistent with evidence-based practice

In order to accomplish these objectives, the project sought to understand what specific duties and tasks the Clinical Consultants were performing, whether these

activities met the objectives identified by the model of consultation under which they were operating, how the position was conceptualized by the various agencies with a stake in its execution, whether the position was successfully meeting its goals, and where further study, development and improvement were necessary. In the service of achieving this understanding, a detailed evaluation process was designed and carried out, following the model put forth in *Early Childhood Mental Health Consultation, an Evaluation Tool Kit* (Hepburn, Kaufman, Perry, Allen, Brennan, & Green, 2007). This model calls for meeting with stakeholders, identifying a evaluation strategy, determining the program theory of change, developing a logic model, writing a program description, collecting data, and determining a strategy for disseminating and implementing findings.

Meeting with Stakeholders

This project was instituted by the Division of Child Behavioral Health with the goal of understanding and furthering the position of the Clinical Consultant. Prior to the evaluation and data collecting process the various stakeholders were consulted to identify key issues, questions and concerns. This process included meetings with representatives of the Unified Care Manager and Care Management Organizations who assume organizational ownership of the position, representatives of the Division of Youth and Family Services Team Leader group, who represent the consumers of the Clinical Consultant services, a select group of volunteer Clinical Consultants, who occupy the position in question, and the Director of the Division of Child Behavioral Health, the agency which oversees the position. Standardized questionnaires were developed in consultation with these stakeholders for use in data collection.

Evaluation Strategy

The overarching strategy of evaluation was determined to be one of “process evaluation,” divided into two phases following the model identified by Dagenais, Briere, Gratton & Dupont (2009). Under this model, the project attempted to a) capture the specific activities being implemented and to determine whether the program was being executed as originally intended, and b) and to examine the factors affecting program implementation and execution from the perspective of the practitioners involved with the position. It is important to note that the project did not attempt to examine impact of the position on the client (the child and family in question) in terms of changes in behavior or other measures of functioning. The focus was rather on the position as it is being carried out with regards to the consultee, the DYFS staff member.

The interview forms were therefore designed to include questions aimed at capturing both the process and the outcome, specifically gathering information on how the position was implemented, what specific duties were being carried out, what each organizational entity expected and desired from the position, how frequently utilized the position was, and how it was advertised and understood. Interview forms were also developed for use with each domain in which the Clinical Consultant functioned, a) their home agency of the UCM/CMO and b) the DYFS organization to which they were deployed.

Program Theory of Change

The program theory of change, as defined by Hepburn et al. (2007), is “the pathways through which the effects of the intervention would manifest” (p 18). The primary mechanism of change was determined to be the consultation meeting itself,

during which the DYFS worker, having identified a child or family in which mental and behavioral health challenges play a role in their current situation, meets with the Clinical Consultant. The Clinical consultant, through a collaborative exchange with the DYFS worker, makes individualized recommendations for services and interventions appropriate for the unique situation of the child and family in question. Secondary pathways through which the Clinical Consultant can achieve the goals of their position include, but are not limited to, trainings for the DYFS staff to increase their familiarity with, and ability to quickly identify, mental and behavioral health issues and challenges, and acting as a “translator” and communication link between service entities.

The Logic Model

The theory of change, once identified, can be incorporated into a “logic model,” which helps to inform the evaluation process. A “logic model” is a graphic depiction of the program under evaluation, identifying the connections between a need and the set of actions to be undertaken to address it (Hepburn et al. 2007). One of the goals of the program evaluation carried out by this author was to more clearly articulate a model of consultation that would guide practice. The preliminary logic model identified during early meetings with the various stakeholders was instrumental in identifying areas that required further development in order to fully elaborate the model design. The logic model consists of four major components; the target population, the program theory of change and guiding assumptions, program activities, and outcomes (Hepburn et al. 2007).

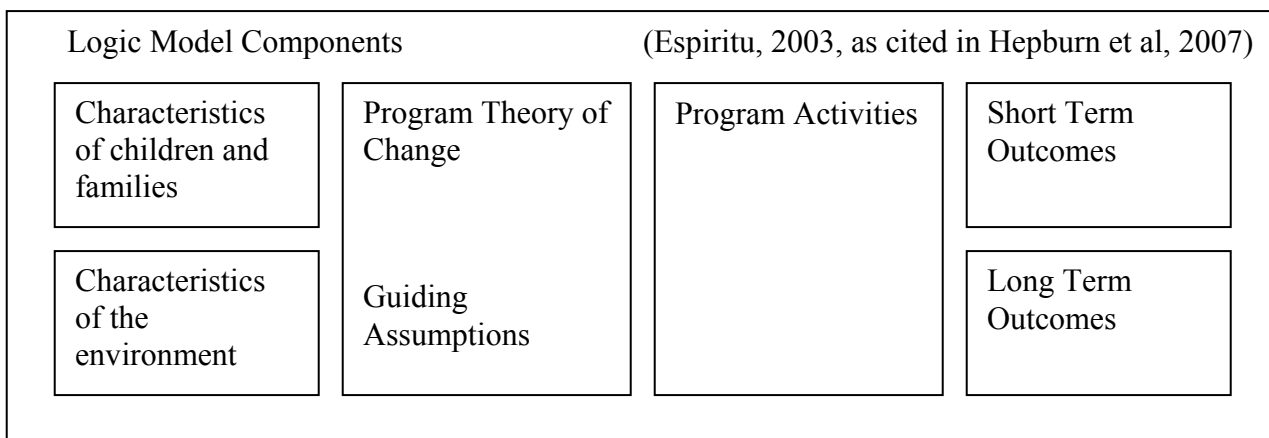


Figure 2. Logic Model.

Target population. The children and families under the auspices of the Division of Youth and Family Services.

Guiding assumptions and theory of change. Achieving service plan individualization through consultation utilizing the values of the New Jersey Wraparound model; increased choice and family independence, individualized interventions, building on strengths to meet needs, best fit with culture and family preferences, community-based responsiveness, care for children in the context of families.

Program activities.

- Provide consultation to DYFS staff members
- Provide training on mental and behavioral health for DYFS
- Meet with UCM/CMO supervisor for ongoing supervision
- Market services and solicit referrals
- Meet together with other Clinical Consultants at Monthly Meetings
- Provide monthly report to DCBHS detailing consultation activities

Outcomes.

- Link children and families with appropriate services
- Improve functioning of children and families
- Increase referrals

Program Description

Clear model design is an essential component of an effective mental health consultation program. A clearly defined program model must include; a theoretical approach to consultation, guiding principles, purpose of the consultation, the target population, the roles and responsibilities of the consultant and consultees, and methodology or protocol for service delivery (Duran, Hepburn, Irvine, Kaufman, Anthony, Horen & Perry, 2009). The original program description for the Clinical Consultant position had been designed to be purposefully loose, so as to allow for the development and refinement of the job definition as the position developed, and systematic evaluation enhanced the understanding of what was needed and effective. The position of the Clinical Consultant was originally defined by the following: “Under supervision, performs work involved in providing clinical expertise regarding youth within the auspices of a Care Management Organization in tandem with the Division of Children and Families, does other related duties as required” (Memo DCBHS, 2008).

Utilizing the logic model developed during the preparation phase, three key areas were identified as requiring further investigation and articulation to achieve a clear model design: the theoretical approach to consultation, the roles and responsibilities of the consultants and consultees, and methodology and protocol for service delivery. While the underlying values of the program, those of New Jersey Wraparound, were clear, the

theoretical basis for determining what activities were the rightful domain of the consultant versus the consultee was less clear, and not universally defined. This lack of definition, which would guide further decision-making, thus led to varying execution of the role, confusion as to what activities were specifically required or discouraged, and the absence of a clear rationale for these distinctions.

Collecting Data

The data collection plan was developed as a result of meetings with various stakeholders. Six separate interview forms were developed, for use with a) the Clinical Consultants themselves, b) Unified Care Management/Care Management Organization executive directors, and c) the Care Coordination Supervisor at PerformCare, the Contracted System Administrator for the Division of Child Behavioral Health. The final three were developed for use with members of the Division of Youth and Family Services and were designed to elicit feedback from individuals at differing organizational levels of the consumer entity, specifically d) DYFS staff members, including workers, supervisors and casework supervisors, e) Team Leaders, and f) local and area office managers. These questionnaires were developed in collaboration with a select group of volunteer Clinical Consultants, representatives of the UCM/CMO executive staff, and with oversight from the Division of Child Behavioral Health Services.

Site visits and in-person interviews were conducted when possible with the Clinical Consultants, UCM/CMO executive directors and DYFS Team Leaders. In addition, emails with the interview forms attached were sent to every Clinical Consultant, UCM/CMO executive director and DYFS Team Leader. Individuals were asked to fill

out the form and email it back if an in-person interview was not scheduled. A follow-up a conference call was also held with DYFS Team Leaders.

DYFS workers, supervisors and casework supervisors individually identified by the Clinical Consultants were contacted via email, asked to fill out the interview form and to return it via email. An interview form was distributed to all Local and Area Office Managers at a monthly Statewide Meeting. An in-person interview with the Care Coordination Supervisor at PerformCare was held. In addition, the project was advertised via email and at regular meetings by the Director of the Division of Child Behavioral Health.

Analysis of Information

After completion of the data-gathering stage, all interview forms were sorted by geographic location, assigned a random number known only to the author, and placed into one of three categories; DYFS, Clinical Consultant, or CMO/UCM. This level of identification was necessary in order to isolate organizational differences in the conceptualization of the position and the resultant organizational demands placed on the Clinical Consultant. The anonymity of the respondents was protected both in adherence to standards of good practice, and because DCBHS had no interest in linking specific statements to specific individuals. The purpose was the evaluation of the Clinical Consultant program, not the individuals administering or executing it.

The interviews were then closely examined by the author, and key dimensions of the position, and specific job tasks were identified, coded and placed in a database. The frequency with which each dimension appeared, and the specific context in which it was mentioned and by whom were noted. Once the most frequently mentioned dimensions

across data sources were identified, specific tasks were coded, and assigned as relating to one of more of the key dimensions. Both the dimensions and tasks were examined as to their appropriateness within the identified consultation model informing the Clinical Consultant position. They were then: 1) incorporated into the training curriculum; 2) discouraged, with an explanation of the rationale behind their exclusion; or 3) placed into a category that left the decision as to whether or not to perform these tasks up to the Clinical Consultant, with considerations as to time, practicality, and theory.

Disseminating and Implementing Findings

According to Hepburn et al. (2007), once the evaluation process is complete and a clear model of theory and service delivery is delineated, it must be disseminated to all systems partners in order to achieve the desired ends of clarifying roles and duties, supporting service delivery consistency, providing a theoretical rationale to guide day-to-day decision making and to provide a foundation for ongoing evaluation efforts. This project was designed to produce a training curriculum that could clarify some of the issues leading to variability in service delivery, enhance the job description and provide more guidance, standardize some aspects of the role, provide clarification of the purpose of the position and the rationale behind its inception and implementation, and ultimately be disseminated across the system to major service partners in order to provide a universal understanding of the position.

Several strategic steps were identified to accomplish this goal. First, presentations were made to each group of stakeholders summarizing findings and providing answers to key questions and issues raised. This included presentations to the UCM/CMO executive directors, the Clinical Consultants themselves, and the DYFS

Team Leaders. During each presentation feedback was invited and discussed, with the goals of providing transparency into the process, reinforcing the model design and clarifying confusion, and encouraging and supporting ongoing discussion and clear communication around complex issues.

Second, after each presentation was complete the presentation materials were distributed with the approval of the Director of the Division of Child Behavioral Health via email to every member of the group, so as to provide information for future reference. This step also accomplished the goal of providing everyone, regardless of whether they were able to attend the presentation, the opportunity to review the information and to respond via email with any feedback.

Following the completion of the initial presentations, a training manual was compiled containing relevant information regarding the project, the process, the theory of consultation being utilized and model design for the execution of the clinical consultant position. This curriculum is to be distributed to systems partners.

Finally, it is intended that the manual be converted into a training curriculum that will lay out the fundamentals of the position, to be universally transmitted to the Clinical Consultants during a formalized in-person training conducted by University Behavioral HealthCare (UBHC) of the University of Medicine & Dentistry of New Jersey (UMDNJ) Behavioral Research and Training Institute, the agency responsible for all DCBHS curriculum development, training and technical assistance activities statewide. This will ensure that all current and future Clinical Consultants receive consistent instruction and information regarding their specific role and associated duties upon entering the system.

Conclusion

This project was designed in accordance with the model of evaluation identified in *Early Childhood Mental Health Consultation: An Evaluation Tool Kit* (Hepburn et al, 2007) in order to most effectively assess both the process and the outcome of the mental health consultation program designed by the Division of Child Behavioral Health and embodied in the Clinical Consultants. Data was collected through in-person interviews and the use of collaboratively created standardized interview forms administered to various sources with a stake in the clinical consultant position. This data was subsequently analyzed with an eye towards identifying important dimensions of the clinical consultant role, agency variability in their understanding of the role, specific duties being carried out and the frequency with which they appeared, and their conformity with the overall guiding theory of consultation. The results were disseminated via in-person presentations, distribution of presentation materials, and the creation of a training manual and training seminar.

CHAPTER IV

Results

Introduction

Model design. As mentioned previously, a well-defined program model is essential to the success of mental health consultation, as it allows for standardized service provision across multiple and separate sites, prevents role confusion, and creates a basis for future evaluation efforts (Duran, F. et al 2009). The clinical consultant functions in a unique cross-systemic setting, where the demands and expectations of his or her role are less clear and less well understood by those with whom he or she must interact than in a traditional psychotherapy role. Within the DYFS setting in particular, consultation cases are frequently unstable, constantly changing, highly complex, influenced by a multitude of different sources and limited in potential resources. The clinical consultant, therefore, must develop an internal conceptual map (Caplan & Caplan, 1993) that can guide decision-making. A clear model design can provide such a map, and a rationale upon which to base future choices. Program model design consists of several key elements (Duran et al, 2009):

- Philosophy or theoretical approach to consultation
- Guiding principles
- Purpose of consultation
- Service Population
- Roles and responsibilities of the consultant and consultees

- Methodology or protocol for service delivery

Of these key elements, the theoretical approach to consultation and the guiding principles underlying the DCF system and the Clinical Consultant position were identified, and universally agreed upon prior to the initiation of this program evaluation project, as was the purpose of consultation, and the service population. Therefore, the purpose of the project was to clarify the remaining facets of clear model design, specifically the roles and responsibilities of the consultants, and methodology of service delivery, to facilitate the development of an agreed-upon conceptual map to guide practice. Prior to examining the findings of the project with regards to these domains, the theoretical approach to consultation and guiding principles are elaborated upon below, in order to place the subsequent data in the appropriate context.

Model design for the Clinical Consultant position

Philosophy and theoretical approach to consultation. The theoretical approach to consultation has been laid out in the literature review chapter of this project. Based on Caplan's Consultee-Centered Consultation model (Caplan & Caplan, 1993), the consultation is considered to be an indirect intervention aimed at improving the mental and behavioral health of a client through the relationship between the consultant, who has specialized knowledge, and the consultee, who bears the ultimate responsibility for the client's well-being and development. Specific ways in which this approach influences the day-to-day functioning and decision-making process of the Clinical Consultant position under examination will be described in greater detail as the dimensions and tasks of the role are elucidated.

Guiding principles. The guiding principles of the clinical consultant's program model are the values identified by the System of Care, and found in New Jersey Wraparound. It is beneficial to explore these principles more thoroughly so as to provide a strong understanding of the service model out of which clinical consultancy in the DYFS setting is born.

Principles of the New Jersey System Of Care (SOC). The system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.

The system of care was founded on the recognition that children with complex needs reside in multiple entities and organizations, and that their care has the potential to become fractured and uncoordinated across these disparate systems. The system of care addresses the whole child across all domains of functioning and areas of life, focusing on individual, family and community strengths and resources that support emotional and physical well-being. The aim of the system of care is to maintain children and families in their communities by developing a single, individualized, focused treatment plan. The values of the System of Care represent a fundamental realignment of the manner in which children and families are conceptualized and interacted with.

The philosophy for how to work with children and families is called Wraparound. The values of Wraparound form the basis for the System of Care itself, and provide a common language and a common foundation from which to work. The goal is to have all members of the System of Care, including the Clinical Consultant and the DYFS staff

members to whom they consult in agreement as to the aim of their work and the language they use.

The Wraparound value base, and therefore the value base for the Clinical Consultant program model, emphasizes:

- Increased choice and family independence

The family knows what is best for them. Family members are the experts in what they need, and what they can provide. They have the right to choose the interventions and treatments they enact and participate in.

- Build on strengths to meet needs

Strengths are the building blocks of change, and the focus is on “what children and families can do”, not “what they can’t do.”

- Best fit with cultural preferences

Language, religion, ethnicity, race, food, community, rituals, age, gender and interest all inform the interventions that are likely to be the best fit and thus the most successful.

- Community-based responsiveness

The focus is on keeping children in the community, in home, or, at a minimum, close to family and the environment that they know. The setting should be the least restrictive as is possible while still maintaining safety.

- Care for children in context of families

The belief is that children should grow up in a family, and so the emphasis is on permanency planning, not simply crisis management.

- One family – one plan

One service plan is designed to oversee all the different interventions and goals of all the different team members. The emphasis is on continuity and consistency. One road map is created that bridges providers and leads everyone to the same end goals.

Summary. The overall mission of the Clinical Consultant position informs the identified dimensions of the role, and the various related duties that the consultant will be expected, or asked, to perform. As has been stated previously, the overall mission of the program consists of several primary objectives:

- To link children and families with appropriate services in a timely manner
- To encourage an informed, proactive and longitudinal view of the mental health situations of the children and families of New Jersey
- To weave together the principles of the System of Care with the DYFS Case

Practice model and case planning

This mission is discharged through the activities of a licensed mental health professional, employed by a Care Management Organization or a Unified Case Management entity, and deployed in the local DYFS offices located in his or her catchments area. The Clinical Consultant provides expertise and guidance with regards to potential mental or behavioral health issues present in the caseloads of the DYFS staff to which he or she consults. This guidance may take the form of reviewing or recommending psychological or psychiatric evaluations, crafting referral questions for evaluation, performing record reviews and ultimately making recommendations and providing advice as to potential and appropriate interventions to improve the functioning of the child and family, and to ameliorate struggles and achieve positive outcomes from a behavioral and mental health perspective as well as a case resolution perspective.

Results

Central Dimensions of the position. Throughout the interview process outlined earlier, a central objective was to identify and isolate the primary dimensions of the multi-faceted and cross-systemic position of the Clinical Consultant. Seven primary dimensions were identified via theme analysis across four data sources, DCBHS, CMO/UCM, DYFS and the Clinical Consultants themselves. Each of these dimensions is discussed in greater detail below, in the context of the theory of consultation outlined earlier, and with an eye to the overall goals of the position. This discussion is meant to provide a conceptual outline for the Clinical Consultant in the discharge of their duties, and in anticipating and navigating the cross-system demands exerted on the position. The Clinical Consultant is universally seen as an expert, a translator, an educator, and a link to the system of care. Each of these is discussed below.

Expert. All sources identified the Clinical Consultant as an expert, and it was the most frequently cited dimension across the stakeholder groups who were interviewed. The domains of his or her expertise were seen to encompass several critical areas. The clinical consultants were believed to be able to utilize their expertise in psychological, and behavioral health, as well as clinical intervention, in order to relieve DYFS workers from that responsibility. The Clinical Consultants identify mental health concerns early on and propose interventions to address the underlying needs and challenges of the clients in question, thus more quickly and effectively improving the situations of the children and families under the purview of DYFS. Because of their specialized knowledge, the Clinical consultant is able to address the “well-being” of children and families as distinct from “health and safety” which is the appropriate realm of the DYFS

worker. This division of labor allows for a more focused and informed approach to case planning.

The Clinical Consultant was also seen as an expert as to the services available through the System of Care and other independent sources, able to help the worker to link children and families with the behavioral health system in the most appropriate and efficacious way. In addition to crisis management, they are understood to provide assistance with long-term case planning from a clinical standpoint.

Translator. The Clinical Consultant was thought to serve as a translator in multiple capacities. Interviews revealed that they are seen as able to provide translation of clinical documents and information into user-friendly language for consumption by non-psychological professionals such as the DYFS worker, the children and families themselves, and other formal and informal supports. They also act as translators between systems, translating the CMO/UCM perspective and dynamics to DYFS and vice versa, to address and minimize conflicts within and between systems partners. Much of the tension between organizational entities frequently occurs as a result of a lack of understanding of each group of the other's perspectives (Green et al 2006). Finally, they are liaisons, joined with DYFS from the Wraparound perspective, translating System of Care principles and values into case practice and planning, and helping to ensure that the Wraparound philosophy is carried out true to form in case practice. All interested stakeholders agree that this is a primary function of the Clinical Consultant.

Educator. The Clinical Consultant's role was perceived to involve educating DYFS staff regarding his or her specialized function in their office, when to access the services offered by the Clinical Consultant, and how to recognize mental and behavioral

health issues and concerns. The educational mission of the Clinical Consultant is in line with the overall goal of the position, in that more informed DYFS workers are more likely to recognize the need for, and subsequently seek consultation that may result in quicker and more effective interventions. This education may occur on a one-on-one basis with individual workers, supervisors or office managers, or on a larger scale in office-wide trainings or presentations at staff meetings.

Link to the System of Care. The Clinical Consultant position was born out of the principles of the overall System of Care, the implementation of which is still in flux across the state of New Jersey. The establishment of the System of Care was an unprecedented reformation on a state-wide level begun in 2000 following the Modified Settlement Agreement, with the goal of transforming the approach to safeguarding the health, safety and well-being of the children and families of New Jersey, and moving away from a hierarchical and authoritarian approach to child welfare to a collaborative, community-centered, family-focused, needs and strengths driven one (Armstrong et al, 2006). Thus, the implementation of the values and practice of the System of Care is still occurring.

The Clinical Consultant serves as a link to the System of Care, working in concert with the CMO/UCM/YCM entities, traditional and non-traditional service providers, and families themselves to achieve positive outcomes for the youths and families about whom they are consulted. They are familiar with the behavioral health network, and local and community resources and can help the DYFS staff navigate the complicated behavioral and mental health systems, particularly when most of the staff is unfamiliar with this discipline.

However, serving as a link to the System of Care is in many ways a secondary benefit of the Clinical Consultant position. The Clinical Consultant's primary objective is to provide focused case planning advice. This advice may include referrals to therapeutic resources not contained in the System of Care as accessed through PerformCare, but rather referrals to independently DYFS-contracted resources. This may be particularly true for the 0-5 population, whom the DCBHS-contracted providers do not serve. The Clinical Consultant must utilize all available options in providing referral advice in collaboration with the DYFS worker with whom he or she is consulting, not just those contained within the System of Care.

Potential and Perceived Philosophical Dimensions of the Role. The functions of expert, translator, and educator are all widely agreed upon by systems partners and stakeholders, and are in line with the values and purpose of the model of mental health consultation that informs the Clinical Consultant position. The following dimensions of the perceived role of the Clinical Consultant were identified less globally, and primarily reflect the specific interests of one or another of the stakeholders. These dimensions must be examined carefully through the lens of the theory of consultation, the overall mission of the Clinical Consultant position, and the pragmatic question of how these dimensions may limit Consultant effectiveness.

Support for staff. The first such dimension is as practical support for DYFS staff. This dimension was identified twice as much by DYFS sources as by CMO/UCM or Clinical Consultant respondents. This discrepancy highlights the differing systemic needs of the systems partners, and the consequent demands placed on the Clinical Consultants. It also highlights the previously identified need to manage the expectations

of the consultee, in this case the DYFS employees, and specify the distinct roles of the consultant and consultee from the beginning.

The specific ways in which this dimension is concretely conceptualized are important in understanding how each system partner perceives this aspect of service provision, and from where some of the inter-system tensions arise. “Support for staff” was described variously as: the design of more efficient and effective interventions, helping workers identify when PerformCare or Case Management is needed, helping to identify services that may enable a worker to close a case if safety, abuse and neglect issues are not present, having familiarity with various services, speaking with children and families and participating in off-site meetings and visits, speaking directly with providers, and finally, helping workers connect children and families to these services and navigate the system of care in a practical manner.

Some of these services are in line with the model of consultation in use, and with the overall goal of the Clinical Consultant position, while others should generally be avoided or rarely performed in exceptional circumstances where the rationale is clear. The Clinical Consultant can act as a support for staff in so far as he or she functions in the design of an intervention plan, but must be careful to avoid performing duties more appropriately understood as case management responsibilities. That is, the model of consultation in use defines consultation as indirect service provision, in which the primary products of the consultation meeting are advice, information, guidance and recommendations. Thus, support activities such as the design of more efficient and effective interventions, helping workers identify when PerformCare or Case Management is needed, helping to identify services that may enable a worker to close a case, and

having a familiarity with various services available are appropriate consultation activities, and within the purview of the Clinical Consultant.

Support activities that involve the direct interaction with the child and/or family or other service providers, except in rare instances, are more appropriately conceptualized as case management activities and therefore within the purview of the DYFS worker.

The consultant can consult with the worker on these interactions, helping the worker to prepare for these meetings and debriefing with them after, but should only participate directly in rare instances, when the purpose of their participation is explicit and unable to be satisfied by any other member of the team. Finally, their participation must be endorsed by the family in accordance with the principles of the Wraparound model that empowers the family to accept or decline specific interventions as they desire.

The reasons for these limitations are largely practical. The Clinical Consultants are a limited resource. Many Clinical Consultants are responsible for providing clinical guidance to several DYFS offices over a large area, and the demand for their services is high. Time spent out of the office in direct service provision activities detracts from the Clinical Consultant's ability to be available to other DYFS employees and, ultimately, to provide assistance to more children and families. The ultimate goal of consultation activities is to provide high quality services to a wide population, and thus the relative time demands of tasks outside the immediate and obvious purview of the Consultant must be carefully considered.

How to address these requests. The fact that this dimension was identified so often by DYFS sources means that the Clinical Consultant can expect to be asked to fill this role frequently in his or her interactions with DYFS employees. Therefore, the

Consultant must be prepared to clearly and consistently explain and maintain the limits of his or her role, and redirect the consultation meeting in a direction that allows the consultant to be of maximal help to the DYFS employee within these bounds. For example, the Clinical Consultant may address a request to attend a provider meeting in the following way: “I understand that this has been a challenging and frustrating case, and that this is an important meeting coming up. I think I can be helpful to you in preparing for this meeting and explaining our proposed plan of intervention to the team. I think you would be the best person to represent our perspective because you know the family the best, and you have a connection with them. Let’s figure out what we can anticipate from this meeting and talk about how to handle it now, and then we can meet afterwards to discuss how it went. If it is still an issue after this meeting we can talk about where to go from there.”

The basic template for addressing such a request is the same as in most therapeutic situations; affirming and reflecting the feelings and fears of the consultee, agreeing to provide assistance, affirming the consultee’s ability to manage the situation, helping him or her to practice the skills that will allow them to be successful, and agreeing to meet afterwards and offer further help if needed. In this way the consultant is not refusing to directly intervene in the future if necessary, but is maintaining their role as a consultant first and foremost. The Clinical Consultant should always remember that one of the goals of consultation work, as identified earlier, is to provide “help plus education” (Caplan & Caplan 1993, p 14). Preparing the DYFS employee to take the lead with the family in clinical issues is one of the educational tasks of the consultation meeting. In addition, this type of conversation helps the consultee to become familiar

with the consultation process, and establishes reasonable expectations on the part of the consultee, a key to consultation success.

Ambassador. The dimension of “ambassador” is one of the most widely discrepant dimensions of the Clinical Consultant role in terms of how frequently, and by whom, it is understood to be important. 86% of the CMO/UCM data sources identified this aspect of the role as important, understanding the Clinical Consultant’s ambassadorial duties to mean providing a necessary link between the CMO/UCM and DYFS, joining with staff of both agencies, helping to craft an experience of CMO/UCM employees as a supportive resource for DYFS, and helpful in resolving conflicts as they arise. In some respects, there is overlap along this dimension with the dimension of “translator” as described above. However, the “ambassador” dimension goes further than the provision of insight into the functioning of these two agencies, positing that an important aspect of the Clinical Consultant’s role is to actively shape a positive relationship between these two entities. Reflecting this belief, 100% of the Clinical Consultant’s interviewed identified duties associated with acting as an ambassador as important functions of their role, emphasizing communication and building positive connections. In contrast, only 25% of DYFS data sources identified “ambassador” as an important function of the position.

While the bulk of the responsibilities of the Clinical Consultant position should be on providing concrete advice and recommendations to DYFS staff members with the best interests of the child and family in mind, the Clinical Consultants also occupy a unique space at the nexus of overlap between DCBHS, DYFS and CMO/UCM that allows them to act as a point person for all parties and facilitates greater connection and

communication between all three organizations. This in turn may help in the discharge of collective and joint missions with regards to the health and well-being of the children and families of New Jersey. While there are few specific duties that make up this aspect of the job, an ambassadorial stance and attitude may facilitate the carrying out of this feature of the Clinical Consultant's role. That is, the Clinical Consultant can actively foster positive relationships between the three agencies by utilizing the consultation skills identified earlier in this manual regarding relationship building and transparency. The Clinical Consultant should not get overly caught up in this aspect of the role, but should take advantage of naturally occurring opportunities within their workday to bolster this connection when possible. Again, this aspect of the position is a secondary benefit, not an overt goal, but something that occurs naturally as the Clinical Consultant forms positive relationships with the consultee base and provides effective consultation services.

Advocate. The dimension of “advocate” for the child and family in question is one that must be thoroughly parsed to distinguish between the general goal of obtaining appropriate and helpful services for the client and practically and concretely performing advocacy actions. Practical and concrete advocacy actions must be carefully considered with the consultation model in mind before being engaged in. They may include participating in discharge and permanency planning meetings, speaking on a clinical level with providers and PerformCare, facilitating communication with Case Management entities, and participating in Child Study Team meetings or Family Team Meetings.

An understanding of general advocacy responsibilities includes the idea that a primary responsibility of the Clinical Consultant is to review the needs of the child and

identify the services necessary to meet those needs, encouraging early intervention at an appropriate level of intensity and duration. These duties can be discharged within the model of consultation in use, avoiding direct service provision such as attending off-site meetings and participation in Child Study Team meetings or Family Team meetings. Advocating for the child and family within the consultee organization and advocating for them with external agencies are two separate situations. In this way the “advocacy” dimension of the Clinical Consultant’s work overlaps with the “support for staff” dimension identified earlier. In some instances, the clinical authority of the consultant may be needed at the table, but these instances should be rare, and should occur only after all other indirect methods of intervention have been tried.

Summary

The Clinical Consultant is often perceived as occupying many dimensions central to their role as a resource to the children and families of New Jersey. These perceptions often reflect the distinct and differing perspectives and needs of the various organizations involved with this position, and place many demands on the Clinical Consultants themselves. The Clinical Consultants must anticipate these demands and be prepared to respond to them in a manner which allows them to maintain their role as a specialized, indirect service provider with the ultimate goal of improving the mental and behavioral health of as many children and families as possible. The Clinical Consultant should engage primarily as an expert, a translator, an educator, and a link to the system of care, framing their consultation activities along these dimensions. The most efficient way to act as a “support for staff” is to provide useful and clinically relevant recommendations,

and support the worker in discharging them. In this way the Clinical Consultant can avoid “doing for” the consultee.

Concrete Duties of the Clinical Consultant

Basic and Expected duties

The following are the basic and expected duties of the Clinical Consultant. These are tasks that all Clinical Consultants should expect to perform.

Record review. An extensive review of the file available on the child or family in question, including the history of the primary presenting problem and reason for DYFS involvement, the family’s social and functional history, treatment and intervention history, and a review of any clinical documents contained in the file. This will allow the Clinical Consultant to identify significant events, patterns and interactions that will inform the treatment plan and subsequent recommendations.

Clarifying diagnoses. Review any diagnoses the child, parent, or caregiver may have been given, and the presenting problems and symptoms informing the diagnosis. If the diagnoses are out of date, or poorly supported by the accompanying clinical documentation, the Clinical Consultant may wish to recommend new evaluations. The Clinical Consultant may also need to explain the diagnosis to the DYFS employee in order to foster a greater understanding of the child’s presentation, and how his or her recommendations are tailored to address it.

Reviewing and explaining evaluations. Many children involved with DYFS have undergone previous evaluations. DYFS workers do not have experience or expertise in reading and translating these evaluation reports into practical terms. The Clinical

Consultant should review the evaluations carefully with the consultee and explain the findings.

Recommending new evaluations and crafting referral questions. Evaluation reports should be carefully reviewed for their recentness, relevancy to the referral question, and with an eye towards how they are being utilized in case planning. If the evaluations are out of date, uninformative, or do not answer the referral question, the Clinical Consultant may wish to recommend new evaluations. In this case the Clinical Consultant should work with the DYFS employee to craft a specific referral question that they would like the evaluation to answer. The Clinical Consultant should then review the resultant evaluation to ensure that the referral question was appropriately answered in the report, and help the DYFS employee to follow up if not.

Helping DYFS to obtain accurate and informative evaluations greatly assists the efficient and effective functioning of the DYFS system, and reduces the amount of money and time wasted by unfocused and unhelpful evaluations. It also reduces the strain on the child and family in question experienced in participating in stressful and time-consuming evaluations. DYFS utilizes evaluations in their court process, especially with regards to Termination of Parental Rights (TPR). The Clinical Consultant should actively shape these evaluation requests with the consultee.

Making recommendations for services and interventions. This is the main product of the consultation services. During the consultation meeting, recommendations for services and interventions related to the primary needs and challenges of the child and family in question should be collaboratively crafted with the consultee. While the

Clinical Consultant is the expert in mental and behavioral health, they are constrained by the realities of the DYFS system, in which the consultee is the expert.

Preparing workers to meet with families and providers. In place of direct service provision, part of the Clinical Consultant's duties include helping consultees to take charge of the communication with the child, family, other team members and providers, and the explanation and implementation of recommendations. Empowering the consultee to take on this role allows the consultant to remain in a consultation role, to more efficiently utilize their time in consultation activities, and builds the consultee's skill base for similar future situations.

Attend monthly statewide Clinical Consultant's meeting. Once a month the Clinical Consultants meet as a group with representatives from DCBHS. The purposes of this meeting include opportunities to meet as a peer group for peer supervision and to trouble shoot, to provide direct communication with DCBHS, especially around institutional difficulties encountered, and to receive training around group-identified topics.

Additional and Potential Duties

The following are tasks that some Clinical Consultants may be asked to perform. This list also includes activities that may be discouraged in general, but that the Clinical Consultant may elect to pursue if the rationale is clear and unable to be fulfilled by any other member of the treatment team.

Psychotropic medication review meetings. The Clinical Consultant may be asked to sit in on these meetings regularly, or on an ad hoc basis to confer with consultees on the intervention strategy, including the medication plan. While the Clinical Consultant may be able to offer a helpful perspective on the child's presentation that may have

implications for medication regimen or adjustments in psychiatric medication profiles, this activity may be most helpful as an opportunity to follow active cases and build relationships with consultees. The cost of time in attending these meetings should also be carefully weighed.

Carrying out trainings for DYFS staff. In addition to working with individual consultees, the Clinical Consultant can provide valuable training services to DYFS at large. Topics of these training can include clarifying common diagnoses, identifying “red flags” that should prompt a referral to consultation, discussing different services that may or may not be recommended, education about the System of Care, and orientations to the Clinical Consultant position itself. Trainings help to build institutional recognition and memory regarding the Clinical Consultant position, demonstrate its utility, and help raise the clinical savvy of the DYFS employee.

Home visits. These visits should occur on an exceedingly rare basis, and only in situations where the rationale for such a visit is clear and necessary. The consultant should be sure to confer with his or her supervisor at the CMO/UCM prior to participating in such an activity. While a frequently requested service, it falls under the rubric of direct service provision, and as such should be avoided whenever possible. A more helpful consultation activity, as previously mentioned, is to offer to help the consultee prepare to conduct the home visit themselves, and to identify and address their concerns regarding it.

Following up to ensure recommendations are implemented. The consultant should not perform any follow-up to ensure that recommendations are implemented by the consultee. Follow-up contact with the consultee is encouraged in order to inquire as to

the success of the intervention, the helpfulness of the consultation meeting, and ways in which the consultant may be of further use to the consultee, but the consultant has no administrative right or responsibility to ensure recommendations are carried out. The consultee is free to accept or reject the consultant's recommendations, and the ultimate responsibility for the well-being of the client remains with the DYFS employee in the same way as if no consultation had taken place (Caplan & Caplan, 1993). Given the multiple demands and limited resources of the Clinical Consultant position, attempting to enforce implementation is not practical, nor does it encourage collaborative and cooperative relationships between consultants and consultees. Should the Clinical Consultant feel that the lack of follow up on their recommendations places the child or others in imminent danger, the Consultant should of course act appropriately to ensure safety.

Contacting providers. At times the Clinical Consultant may be asked to speak to service providers directly. The Consultant generally may wish to provide guidance to the DYFS employee in helping them identify his or her concerns and the reason for the call, assist them in planning how to address it directly with the service provider, and follow up afterward to see how it went. The Clinical Consultant may also wish to consider reaching out to the provider with the consultee, and allowing the consultee to take the lead in directing the conversation, providing input as needed. If possible, the Clinical Consultant should try to avoid speaking to individual service providers without the consultee present. This allows the consultant to remain in a consultation role to the consultee, to help the consultee build his or her skill base, and to allow the consultee to receive information

relevant to the case directly, rather than relying on the consultant to communicate the outcome of the conversation to them later.

Attending Family Team Meetings (FTM). This duty has been discussed previously. In general, the consultant should offer to help the consultee prepare for the meeting and debrief with them afterwards. The DYFS employee is the primary point person for the child and family in question, and will be the consistent member of the treatment team, rather than the clinical consultant. Therefore it is important that the consultee adopt the recommendations as his or her own, and take charge of communicating them to the child and family in question. There may be exceptions to this guideline, but they should be relatively rare, and occur only in consultation with the consultant's and consultee's supervisors and for an identified, specific reason.

Bridging communication between CMO/UCM and DYFS/Consulting on co-managed cases. Because the Clinical Consultant is employed by CMO/UCM but deployed to DYFS, they are often relied upon to facilitate communication between these two systems. This can occur particularly frequently when a child and family are co-managed by CMO/UCM and DYFS. When co-management is in place, the Clinical Consultant should remain involved only in rare instances, and in a specific capacity that cannot be fulfilled by the case manager. The Clinical Consultant should have only the most peripheral of roles on these occasions. This guideline is designed to avoid service duplication and to support the principles of the System of Care by encouraging case planning only within the confines of the Family Team Meeting. The Clinical Consultant may be called upon to help the important individuals from each system identify each

other and make an initial connection, but should then remove him or herself from direct involvement.

Common Referral Questions

There are many “points of entry” into the Clinical Consultant’s services. Two of the more concrete and established referral questions arise when a psychological evaluation is completed, or a child is hospitalized. In some DYFS offices, Administrative Assistants, workers, supervisors, or casework supervisors, funnel evaluations directly to the Clinical Consultant upon receipt. The Clinical Consultant then reviews the evaluation and seeks out the worker to confer about the results and to collaborate on the treatment plan.

Evaluations and hospitalizations are two objective measures by which a DYFS worker can easily and quickly determine that a consult is needed. Other important referral questions may require a greater familiarity with mental health needs, and DYFS employees may often need additional guidance to seek out consultation. Other referral questions reported by DYFS employees include:

- Caregiver mental health issues
- Acting out behaviors at home or school
- When a case feels “stuck”
- If current services are not resulting in improved functioning

Outreach duties

The Clinical Consultant is only as effective as he or she is utilized. Therefore, the Clinical Consultant may need to perform some outreach duties in order to “drum up business” for themselves within the consultee organization. The Clinical Consultant

position is relatively new, and may not yet be a service that many DYFS workers think to avail themselves of when faced with difficult or challenging situations. In addition, as noted above, the need for a mental health consultation meeting may not always be readily apparent. In order to effectively penetrate the consultee organization, the consultant should be prepared to perform the following duties to educate DYFS workers as to when, and why, to access mental health consultation, and advertise the position.

Cultivating relationships with referral sources. As noted earlier, there are many “points of entry” into the Clinical Consultant’s services. Unlike other specialized consultants deployed to, or employed by, DYFS, there is no set protocol for when to access clinical consultation. Therefore the clinical consultant depends on his or her individual connections with various people in order to receive steady referrals. These potential referral sources may vary from office to office, but include:

- Individual Workers, Supervisors and Casework Supervisors
- Team Leaders
- Resource Development Specialist (RDS)
- Case Practice Specialist
- The Child Health Unit
- Domestic Violence and Substance Use Consultants
- Court Liaison

Any and all of these individuals may be important in gaining entry to the consultee base that will form the body of the Clinical Consultant’s work. In addition, there may be other key individuals in the various DYFS offices who may be able to support the Clinical Consultant in gaining referrals and advertising his or her services.

The Clinical Consultant should attempt to identify these individuals and maintain frequent contact with them.

Advertising the position. Because the Clinical Consultant position is relatively new, as yet not fully integrated, and located in an agency in which there is a great deal of turnover, the Clinical Consultant must frequently advertise the position and his or her services. Some ways of doing this include creating marketing materials such as fact sheets and brochures that describe the position and establish accurate expectations, cold calls and drop-ins to introduce the consultant position, and attending and presenting at site meetings, forums and trainings.

Educating DYFS workers and staff as to roles and responsibilities. The DYFS employees are unlikely to utilize a service they do not understand, or whose value to their case planning is not clear. Therefore, clear and consistent education as to the nature of the services provided and the advantages of utilizing the consultant's expertise must occur on a regular basis. Clinical Consultants should communicate early and often with consultees about what services will be provided and what to expect. At the beginning of a consultation meeting, the consultant should ask consultees, "What are your expectations?" and clarify any issues as needed (Duran et al, 2009). Thus the education process begins with advertising the position, and continues throughout the consultation itself.

Variability

The Clinical Consultant position is a highly variable role, with many complex dimensions, job duties, and competing organizational demands. This variability is one of the primary challenges for the Clinical Consultant. While variation allows for specially

tailored, and context specific, problem solving, too much variability may impact model fidelity and erode the core defining characteristics of the position. Too much variation may lead to the position being carried out in vastly different ways across the board.

The program evaluation and training manual attempted to address this issue by providing general guidelines, and a way of thinking about consultation activities to scaffold the Clinical Consultant in his or her everyday decision-making. However, some variability between systems will remain, and the Clinical Consultant must be able to anticipate from where competing and differing demands may arise, and understand how this process impacts his or her functioning. Two major sources of variability must be examined in greater detail: regional variability and organizational variability.

Regional Variability. A large portion of the variability across the Clinical Consultant position arises from the geographical location of the Clinical Consultant. There are fifteen Clinical Consultants, each with his or her own discrete catchments area. These areas are distinct along innumerable axes, from ethnic, racial, economic, and social dissimilarities, to variations in size and scope, population density, rural and urban concentrations, and the centrality and accessibility of services. In addition, as much as the culture of each particular county varies, so does the culture of the service entities within them.

Regional needs are unique and important, and all local service entities, from CMO/UCM to DYFS and the Clinical Consultant, must have the flexibility and adaptability to respond to regional needs as they arise and in a timely manner. The Clinical Consultant must be able to function in a manner most effective to his or her specific context, which is by design and definition, variable. Each catchments area has

its own strengths, resources, needs, challenges and limitations within which the Clinical Consultant must function, and the recommendations that he or she issues will necessarily depend on these factors. The Clinical Consultant's role will differ depending on the environment in which he or she is operating. In this sense, it is not in the best interest of the Consultant, nor of the consultee, to over standardize what must be a highly flexible role. Regional variability allows for tailored service provision, increased effectiveness, is in line with values of the System of Care, and allows for the utilization of the individual clinical consultant's particular skills.

Organizational Variability. Organizational intersection is the source of a large amount of variability in every system, and a great deal of the challenge of a cross-systems position such as the Clinical Consultant comes from the differing systemic needs of the involved entities. Cross-systems interaction is, at large, both the strength and the challenge of the System of Care within which the Clinical Consultants, the CMO/UCMs and DYFS are operating. The goal of the System of Care is to bring together the multiple individuals and organizations involved with a youth or family in order to coordinate care. The more such entities that come together, the more perspectives are represented, the more resources for care and intervention are mobilized, and, the greater the opportunity for arising communication issues, competing agendas, and differing organizational needs.

The clinical consultants are located at the nexus of three separate and large organizations; DCBHS, CMO/UCM and DYFS. There is variability within each organization and in the relationships between each organization.

Within CMO/UCM organizations, the Clinical Consultant is conceptualized differently from establishment to establishment. There is a great deal of variability

around how much ownership the CMO/UCM takes of the Clinical Consultant position, that is, how much the CMO/UCM feels the consultant to be a securely connected member of their organization. This sense of ownership is reflected in the level of consultant involvement with CMO/UCM. The Clinical Consultant position was originally designed by DCBHS to remain connected to the home organization by requiring that one day a week be spent physically at the CMO/UCM. This was to address some of the challenges inherent in offsite employment for both the Clinical Consultant and the CMO/UCM. It was intended to ensure that the Clinical Consultant remained steeped in the culture of Wraparound and the System of Care embodied by the CMO/UCMs, that they received the necessary support and supervision, and that they were able to attend relevant staff meetings, trainings, and in other ways interact with members of their home organization. The goal was to provide ample opportunity for the Clinical Consultant, who in many ways operates “without a home,” when deployed to DYFS, to be practically and concretely connected to the organization that employs them, and for the CMO/UCM to remain connected to their activities.

In reality, the level of the Clinical Consultant’s involvement with CMO/UCM varies by organization along a spectrum, from being tenuously connected, to occupying the role of a primary employee on the level of a supervisor. The actual amount of time a Clinical Consultant spends at his or her home organization varies, from the recommended one day a week, to a half day per week, to two days per month, or less. The Clinical Consultant may be lightly overseen, with few supervisory requirements or check-ins, or highly managed. The amount of paperwork required by each CMO/UCM varies, from the minimum monthly report submitted to DCBHS, to daily activity forms. The supervisory

relationship varies, from focusing on systems issues, to clinical guidance, depending on the background of both consultant and supervisor. Each CMO/UCM operationalizes this relationship differently.

Similarly, every DYFS office incorporates the Clinical Consultant differently. In some local offices the Clinical Consultant is regularly invited to staff meetings and is seen as a regular member of the DYFS employ, while in other offices, the Clinical Consultant is held apart as an employee of CMO/UCM, and therefore not allowed access to DYFS-only staff meetings. Correspondingly, in some offices the Clinical Consultant is regularly called on to consult on cases, while in other offices the consultant may have to spend more time reaching out to directly obtain referrals and offer assistance. In some DYFS offices the Clinical Consultant will have a dedicated space, while in others he or she may “float” from cubicle to cubicle depending on the day. The environment may differ, not only between county and region, but from office to office within the same catchments area. The Clinical Consultant must be adept at recognizing where on the spectrum they are located in each environment in which they must function.

Part of the difficulty of navigating organizational overlap results from the fact that consultants are asked to assume many different group memberships (Alderfer, 2010) in the carrying out of their duties. The consultants are simultaneously members of their parent organizations, the CMO/UCMs, members of their consultee organizations (DYFS), which differ by region and sometimes by office, and members of the peer group of clinical consultants with direct connection to, and interaction with, DCBHS. In the monthly meetings and through the submission of monthly reports, the fifteen clinical consultants receive more attention from DCBHS than other CMO/UCM employees,

which can set them apart in their home organizations. This heightened level of interaction is intended to support the Clinical Consultants, and is due to DCBHS recognition of the distinct and unique nature of their role, and their relative professional isolation from other individuals who share their job duties. Because the Clinical Consultants are a point of contact between all three of these organizations, ongoing dynamics and tensions between DCBHS, CMO/UCM and DYFS at an organizational level will come to bear on the Clinical Consultants themselves.

Navigating Organizational Overlap. The nature of the consultant role requires that he or she straddles and navigates the intersection of the three major entities involved with the position. This can be confusing and difficult, and there are specific consultancy skills needed to meet this challenge. These skills were touched on in the literature review, but include clear, consistent and transparent communication about the expectations, goals, and limits of the consultant role, strong interpersonal skills and the ability to form positive relationships throughout all three organizations, and a clear sense of professional identity as an employee of the CMO/UCM, and a consultant to DYFS.

In addition to the stated consulting skills mentioned above, there are specific ways to maintain a consultative stance that allows the Clinical Consultant to navigate the demands placed on them by organizational overlap. Emotionally and cognitively, it is helpful for the Consultant to recognize that each organization is committed to the health, safety and well being of the children and families of the state of New Jersey. Each organization has its own piece of the mission of improving the well-being of the members of the communities in which they operate; local, county and statewide. While the

relationships between DYFS and CMO/UCM or CMO/UCM and DCBHS, or DYFS and DCBHS may vary, each organization has as this as their ultimate goal.

Conflicts and tensions frequently stem from the coming to a head of the different visions and agendas for realizing this goal. These organizations may speak different languages, embrace different approaches, and have differing understandings of each other's responsibilities, abilities and limitations, but each is attempting to achieve something for the well-being of children and families. It is helpful to attempt to place the conflict in question in this context and to examine subsequent actions, tensions and requests of the various parties from this perspective. In no way does this stance imply that the Clinical Consultant bears the responsibility for resolving these conflicts or acceding to these requests, but merely allows the Clinical Consultant to understand the conflict as arising from outside of him or her, and as a reflection of the systemic nature of the problems the Clinical Consultants confront, and the context in which they work.

With this in mind, there are several concrete actions the Clinical Consultant can take to minimize or address the conflicting demands their position at the center of these three entities places on them. Again, this does not imply that it is in any manner the role of the Clinical Consultant to act as a peacemaker between organizations or to solve every issue or conflict that arises among any three of the major organizations with which he or she interacts. However, it is likely, given the cross-systemic location of the Clinical Consultant and many group memberships that they are asked to assume, that the Clinical Consultant will need to navigate these situations in order to fulfill his or her primary function of providing clinical recommendations and advice for case planning and intervention.

Of primary importance for the Clinical Consultant is maintaining open communication routes between themselves, their consultees, and their employers.

Specifically:

- Ask clarifying questions to isolate the crux of the issue when it arises. Identify what is being asked, by whom and of which organization or individual.
- Hold multiple perspectives and communicate them to alternate parties as needed. If it is apparent that DYFS is requesting something of the CMO/UCM that they are unable to provide, such as emergency housing, etc, address the misunderstanding with DYFS from a systemic view.
- Access support and guidance up the organizational hierarchy as necessary. Make use of the supervisory support available from the CMO/UCM if conflicts persist. If ongoing inter-organizational tensions persist and regularly interfere with the Clinical Consultant's ability to effectively function within his or her role, their employer at the CMO/UCM may need to speak at a higher level with supervisors at DYFS to address the issue. The Clinical Consultant must know his or her limits, and recognize that when navigating intersystemic issues interferes with his or her ability to be clinically useful to the consultee organization, it is time to step back and request help from supervisors.
- Address the level of connection and involvement with a CMO/UCM supervisor if it feels problematic, in order to attempt to move in one direction along the spectrum. The majority of CMO/UCM supervisors recognized the new and developing nature of the Clinical Consultant position, and indicated that they would be open to a conversation of this nature.

These steps, while not exhaustive, function to preserve transparency at all levels of the multi-systemic environment in which the Clinical Consultants function, and to reinforce the hallmark guiding principles of consultation work in general, communication, transparency, shaping of role expectations, and relationship building.

Summary

The Clinical Consultant is asked to do a multitude of things in the course of their duties. While no list could address every request that may arise, the preceding discussion has explored the main requests that were found to occur during the course of this project. While some tasks are appropriate and necessary parts of the Clinical Consultant's work; such as conducting record reviews, reviewing, explaining or recommending psychological evaluations, recommending services, and working with DYFS employees to prepare to communicate with families and providers, others do not fit as cleanly into the established model of consultation, and must be carefully considered. A key task of the Clinical Consultant will be to navigate competing requests and demands, and maintain open, transparent, and consistent communication with all involved parties in order to maintain the integrity of the position and their own effectiveness in being able to offer assistance. The Clinical Consultant's own judgment and clinical skills will play a crucial role in this aspect of their work.

CHAPTER V

Discussion

A Change in Culture

In a state agency, employees serve at the pleasure of the governor. Thus, turnover, especially in leadership roles, is a regular part of the rhythm and nature of government work. Leadership is responsible for carrying out the vision of the governor, and in times of administration change it is most frequently the people at the head of major organizations who leave and are replaced. This can result in large shifts in culture, priorities, and understanding of what is most important and deserving of investments of the limited resources of time, people and funding.

The Clinical Consultant program evaluation project was envisioned and implemented between October of 2009 and June of 2010, a nine month span during which New Jersey elected a new Governor, and ushered in a new majority political party. Thus, by the end of the author's project, several of the individuals who had envisioned, championed and enacted the program evaluation had moved on from their positions. The original intention of the project was to produce a training manual for the Clinical Consultant position that would additionally be made into a training curriculum disseminated by the state training agency to educate new Clinical Consultants upon their hiring. It may be that the manual will fulfill these original goals, but it is also possible that with a change in leadership, attention is shifted to other projects and the momentum to implement a formal training process is lost.

Given these conditions, it is possible that the true work product of this project will manifest rather as a shift in the organizational culture surrounding the Clinical Consultant position. The individuals who participated in the project and who are responsible for the daily operation of the position (the clinical consultants themselves, their supervisors at the CMO/UCMs, the DYFS Team Leaders and the Service Line managers at DCBHS), remain largely the same. These individuals, by virtue of having participated in the collaborative program evaluation process, have helped to mutually shape, with the author, an evolution in the organizational understanding of the position, which may result in lasting change.

Culture change is not a process that can be externally forced on a system; it requires the participation and endorsement of those within an organization. The author's "self," as the figure responsible for penetrating the boundaries of different organizational groups enough to complete the tasks of the project, is an important entity. Becoming temporarily incorporated into a system in a way such that the individuals and groups involved are able to assume ownership of the project, rather than to simply tolerate it, is a critical task with implications for how the project may proceed and what lasting change may occur as a result. The relationship between author and system is a mutually determined one that is enacted at every stage of the program evaluation. It is therefore important to explore the process of the program evaluation, in order to understand the potential impact this project had on the system in question, that of the Department of Children and Families.

Embedded Intergroup Relations Theory

In examining how multiple groups within a system mutually influence each other and the overall functioning of the whole, it is first important to examine who and what comprises a group, and under what conditions. In the most basic terms, a psychological “group” is “any number of people who 1) interact with one another, 2) are psychologically aware of one another, and 3) perceive themselves to be a group” (Schein, 1965, p. 67). However, this definition is highly weighted towards an internally oriented and self-determined definition of a group, and neglects to capture the external dynamics acting on groups located within a system. To remedy this, Alderfer (1977a) proposes a description of a “group” as defined both by how individuals within the group view each other, and by the ways in which group boundaries are recognized from both inside and outside.

A human group is a collection of individuals 1) who have significantly interdependent relations with each other, 2) who perceive themselves as a group, reliably distinguishing members from nonmembers, 3) whose group identity is recognized by nonmembers, 4) who, as group members acting alone or in concert, have significantly interdependent relations with other groups, and 5) whose roles in the group are therefore a function of expectations from themselves, from other group members, and from non-group members. (as cited in Alderfer, 1986, p. 202)

Alderfer’s definition incorporates the concept of “nonmembers” as influencing the crystallization of group identity. That is, not only do the members of the group recognize

themselves as belonging to the group, but others outside the group also recognize a group membership, and their exclusion from the group in question.

Embedded intergroup relations theory distinguishes between two types of group memberships: identity groups and organization groups. Identity groups are those groups that one belongs to by virtue of birth, and are relatively unchanging and inescapable. These groups include gender, race, ethnicity, generation, family, sexual orientation, etc. Organizational groups are transitory or temporary group memberships determined by the type of work one does and one's place in the organizational hierarchy. Both types of group memberships are salient in all interpersonal interactions, to varying degrees and depending on a number of factors. These factors include which groups the other person or persons involved represent, how each party relates to the group memberships they hold, the relationship between the groups being represented, and how the groups are embedded in the system in which the exchange occurs (Alderfer, 2011).

Intergroup relations refer to “activities between or among groups” (Alderfer, 1986, p. 190). These activities are both official and unofficial, in that “Every relationship – between individuals, within small groups and within large groups as well as between groups – has the characteristics of an intergroup relationship” (Rice, 1969, p. 342). Every person is simultaneously a group representative for multiple groups, and may experience a different group memberships as more salient at different times. Alderfer states that “which group memberships are evoked depends on the other people with whom a given group representative is dealing,” (Alderfer, 2011, p. 145) indicating that the context in which an individual is operating influences the group memberships they are most likely to be influenced by at the moment.

Alderfer (2011) uses the term “embedded” to acknowledge the fact that, within a given organization, multiple groups exist, are encompassed by the overarching system, and must interact with each other. Groups form and operate in a specific context that shapes how they react to themselves, with themselves, and with each other.

Summary and Relationship to the Current Study

Multiple identity and organization groups, fulfilling both formal and informal functions, exist within the ecological systems under study. Which group memberships are at the forefront for a given individual at a given time depends on a multitude of factors, including their own relationship to these group memberships, the group memberships of the individuals with whom they are interacting, and the environment in which the interactions are occurring.

Given the fundamental nature of group membership, it is inescapable that investigators will participate in intergroup relationships that will shape the nature of their work and findings. As Alderfer notes,

The predisposition of consulting team members to enact client system dynamics begins with the memberships they bring to the team and to the subgroups within the team to which they belong. Both classes of group memberships affect where in the client system they are likely to undertake work, and in turn which aspects of the client system they are likely to absorb (Alderfer, 2011, p. 159).

That is, a consultant’s identities impact how they enter the system, and how they understand and react to it. The consultant’s actions, in turn, impact the system which they are studying, and influence the information they get, from whom, and how. The author’s identity and organizational group memberships were activated to differing

extents throughout every stage of the program evaluation and heavily influenced the final product in a variety of ways.

Partial System Engagement

The most notable manner in which the author's "self" impacted the program evaluation was in her lack of success in engaging the entire DCF suprasystem in which the Clinical Consultants were operating. She succeeded much more in entering the DCBHS-CMO/UCM-Clinical Consultant subsystem than in engaging the DYFS subsystem. There are likely several reasons for this, all of which shed important light on the process and success of this project, as well as its limitations.

As noted, in entering a system, even if only temporarily, an outside consultant necessarily becomes part of that system, influencing and being influenced by that system in equal turns. The consultant herself brings to the work a number of identity and organizational group memberships, (Alderfer, 1986) any and all of which may be activated at any time throughout the process of the program evaluation. The author's own group memberships therefore shaped her work on the Clinical Consultant program throughout the three stages of the project: entry, data collection, and feedback. This was manifested during the feedback phase of the evaluation, which consisted of the author's presentation of her data and a subsequent discussion with the individuals present. As Alderfer (1980) states, the feedback stage is significant in that,

All the work that the consultant has done (or has failed to do) to develop effective working relationships with the client system will come to fruition (or frustration) during feedback. If this work has been good enough, the system will be able to tolerate learning about itself (p. 466).

Given this, it is notable that the feedback sessions with DCBHS, CMO/UCM and Clinical Consultants were much more successful in this regard than the feedback session conducted with the DYFS Team Leaders. Though no formal evaluations were conducted after feedback sessions, the author observed that representatives from DCBHS, CMO/UCM and the Clinical Consultant groups were active participants in the feedback presentation and discussion, voiced feelings of being understood, verbalized an increased understanding of the system at large, and stated that they felt the process had been “helpful.” In contrast, DYFS Team Leaders voiced feelings of frustration with the proposed vision for the position, feeling that their needs in the system were not understood or supported, and openly disagreed with the conclusions presented.

This contrast points to an important observation about the program evaluation itself; the author was more able to successfully penetrate, understand and identify with the groups represented by DCBHS, CMO/UCM and Clinical Consultants, than with the groups represented by the DYFS Team Leaders (DYFS local office managers, area managers, supervisors and line workers). Viewed through the lens of Embedded Group Theory, the fact that the author found herself more closely aligned with one group over another is not surprising, and certainly not novel. Alderfer describes the beginning of the dissolution of the “neutral and unbiased observer” stance in social science research over forty years ago with Howard Becker’s seminal 1967 paper “Whose Side Are We On?”. In that paper, “Becker proposed that social scientists inevitably take sides when they study organizations. For him, the issue was not whether investigators take sides, but rather, whose side they take” (Alderfer, 2011). Whose side investigators take is primarily determined by two major factors; their own group memberships and biases, and a parallel

process reflecting some aspect of the operation of the larger system. An examination how these two factors contributed to the discrepancy in reactions to feedback sessions between DCBHS-embedded groups and DYFS is important in further illuminating and understanding this process as it operated in this study, and “whose side” the author took, unawares.

Significant Identity and Organizational Group Memberships Held By the Author

The author, as a student of the Graduate School of Applied and Professional Psychology, had experience in recent years heavily weighted towards clinical practice. As a direct service provider, the author had worked with traditionally underserved populations, where the clinical and case management needs of the children and families were numerous and difficult to address. The author had also worked as a directly contracted clinician serving DYFS-involved children and families, through the Rutgers Foster Care Counseling Project. In this position, she had frequent interactions with DYFS workers, supervisors and local office managers. These experiences generated the author’s interest in the intersection of government and psychology, as the impact of the government systems within which her clients were embedded became clear. Therefore, the author has had experience working in the DYFS system, while not being a part of that system, in a similar, though not identical, manner as the Clinical Consultants.

In this position, furthermore, the author’s belief as to the clinical needs of her clients often fell into opposition with the resources that DYFS was practically able to make available to the children and families with whom they worked. This is not to imply that the DYFS workers with whom the author interacted were anything else than professional and competent, but merely to indicate that their perspectives were different.

The author had previously been embedded in a system, therefore, where, from her perspective, DYFS remained an “out-group.”

This was significant, as the Clinical Consultants were all licensed mental health providers, each with a background in direct clinical work. For many, their role with DCBHS was in addition to a continuing private practice. They were also “outsiders” to the DYFS system; in, but not of, this system, and struggling to balance their clinical recommendations with the practicalities of a state-funded system with limited resources.

Generationally, the author was closer in age to the majority of the Clinical Consultants, as opposed to the CMO/UCM directors and the DYFS Team Leaders, who were usually older. The Clinical Consultants, by virtue of their age and profession, were able to identify with experiences of graduate school and early career considerations, which the author was immersed in, and to see the author as a peer. Furthermore, as a female, the author was in a majority group with regard to the Clinical Consultants, as is typical in the profession, but not so with the CMO/UCM Directors, who had significantly more males in their membership, and the DYFS Team Leaders, who were also more evenly split. It is also noteworthy that the leadership team at DCBHS, with whom the author worked closely, was also entirely female. Professional background, age and gender were all salient group memberships that influenced the author’s initial ability to connect with the Clinical Consultants, and with the DCBHS team.

The Organizational Location of the Author

In addition to the identity based group memberships mentioned above, the author was also organizationally located to more successfully penetrate the DCBHS-CMO/UCM-Clinical Consultant system than the DYFS system. Her affiliation with

DCBHS leadership influenced how she was able to permeate the boundaries of that system, and how she fell short of equally joining the DYFS system. This organizational location may have joined the author's other pre-existing biases and resulted in the "taking sides" referred to earlier. In doing so, much was revealed about the functioning of the suprasystem in which both DYFS and DCBHS were themselves embedded.

Location within the DCBHS framework. The author, as has been noted, was assigned to evaluate the Clinical Consultant program by the Director of the Division of Child Behavioral Health, and introduced to the other members of the DCBHS – CMO/UCM – Clinical Consultant – DYFS system as an outside consultant working for DCBHS. This established the author, from the initiation of the project, as having direct access to hierarchically the most powerful member of the system. "Because only management can authorize consultation on behalf of the whole organization, an agreement for consultants to provide professional services inevitably aligns them with management" (Alderfer, 2011, p. 325). Physically, the author was located in the main offices of DCBHS in Trenton, in geographic proximity to both the Director of DCBHS and the Service Line Manager in charge of CMO/UCM. Though the author was not a permanent employee, nor paid by the Division of Child Behavioral Health, her direct supervisors were highly ranking members of the organization with significant influence and power over the other members of the system being studied.

Using Alderfer's (1986) definition of organizational groups as those "whose members share (approximately) common organizational positions" (p. 204), the author functioned as a result of these associations as a member of the organizational group embodying the most authority. This was evidenced by the author's access to resources

that eased the progress of the project, such as the quick designation of a state government email address, something the Clinical Consultants were unable to obtain due to their position as employees of CMO/UCM organizations, and the immediate approval from the Director of the Division of Youth and Family Services for access to DYFS offices for interviews and observations. Due to the sensitive nature of the information located at DYFS offices, the Clinical Consultants underwent extensive background checks before being allowed access, and their lack of state email addresses meant that they frequently did not receive important information such as notifications of staff-wide meetings at the DYFS offices, or closures due to weather.

These practical difficulties subtly enforced their “out-group” status with regards to DYFS, frustrated the Clinical Consultants’ attempts to gain entry into the DYFS system, and impacted the access they had to their client base. The author, by virtue of her access to the Directors of both DBCHS and DYFS, did not have to contend with these practical difficulties, reinforcing her membership in a separate organizational group. In this case, the author’s organizational membership helped her to gain access where she needed it, and she went on to successfully build working relationships that allowed her to complete the program evaluation in a manner that allowed the DCBHS system to own it and approve of it. This was not the case with the DYFS system, despite the fact that the author’s organizational membership in the upper echelon of DCBHS allowed her to gain access to the physical locations and members of the DYFS system.

Author’s organizational location outside of the DYFS system. As has been noted already, the Division of Child Behavioral Health, and the Division of Youth and Family services are administratively separate and equal branches within the larger

Department of Children and Families. DCBHS, in order to carry out its responsibilities to the children and families of New Jersey, independently contracts with and funds Care Management Organizations and Unified Care Management agencies to provide specific services within their catchments areas. As part of their contractually obligated services, CMO/UCMs employ the Clinical Consultants. Therefore, the author's affiliation with the Director of DCBHS embedded her within the intra-systemic context of DCBHS-CMO/UCM-Clinical Consultants. By nature of the purposeful organizational separation between DCBHS and DYFS, the author's standing within the DCBHS system did not translate to the same standing within the DYFS system. The author was able to make use of her relationship with the Director of DCBHS to gain entry to the DYFS system, but this physical access did not result in access to the group itself. From the DYFS perspective, the author remained organizationally a member of the "out-group" of DCBHS.

This dynamic reflected some of the difficulties the Clinical Consultants themselves experienced in attempting to penetrate the DYFS system. Organizationally, they were located in a different system, which was continually reinforced in small ways as noted above (the lack of a state email address, not being informed of important meetings or changes in access codes to the building, lack of dedicated office space, etc.) Thus, it is fair to hypothesize that at least part of the difficulty the author experienced in building relationships with the consultee agency was reflective of a parallel process occurring with the Clinical Consultants. This will be discussed further in a case example.

Summary

The author participates in both identity and organizational group memberships that facilitated her incorporation into the DCBHS-CMO/UCM-Clinical Consultant system. However, this alone is likely not enough to account for the entirety of the variance in her ability to effectively penetrate the system under examination. It is likely that a parallel organizational process reflecting internal divisions between the DCBHS-DYFS systems took place in combination with which the author's inherent group memberships shaped the project in significant ways. A closer examination of case examples from the entry, data collection and feedback phases of the project is necessary to account for the author's partial system entry as revealed by the differing reactions to the feedback sessions.

The Entry Stage

"Entry is an intergroup transaction by which a professional outsider negotiates with the system and its subsystems for the temporary membership necessary to complete mutually agreed upon diagnostic work" (Alderfer, 2011, p. 350). During the entry stage of the author's work with DCBHS, her primary focus was on gaining admission to the Clinical Consultant and CMO/UCM groups. This is noteworthy, since DYFS, as the "consumer" entity with regards to the Clinical Consultant, certainly could have been considered a prime focus for study. There were several ways in which the author's investment in the DCBHS system members over DYFS members was enacted.

To begin with, the author's position as a member of a specific hierarchical group within DCBHS rendered her, at least nominally, a member of the "out-group" with

regards to the Clinical Consultants, the CMO/UCMs and DYFS. Alderfer reflects the difficulties inherent in this position, stating

Because consultants are outsiders, they can easily be prevented from understanding crucial elements of the system. Therefore, the consultant must establish some type of liaison system to manage the relationship between consultant and those elements of the system where diagnosis will take place (Alderfer, 1980, p. 461).

The author planned to make use of a liaison system containing members of each organizational location of the system under examination, CMO/UCM management, Clinical Consultants, and representatives of DYFS. How the liaison system actually came together, however, reveals important biases of which the author was not initially aware.

Immediately following her initial introduction at several large group meetings, the author solicited volunteers for help in planning and executing the evaluation. Following these requests, she held individual, unstructured meetings with a CMO executive director, a DYFS Team Leader, and a small group of Clinical Consultants. This liaison system therefore technically contained members of each level of the system to which the author needed access. These relationships were crucial in helping the author develop an understanding of the lived experience of different members of this complex system, as they discharged their various responsibilities with regards to the Clinical Consultant position. In addition, these relationships granted the author credibility with other members of each level of the system, allowing her to permeate group boundaries by

demonstrating a connection to a member of each “in-group,” without which she would have remained, solidly, an outsider.

However, it is important to note that the author’s liaison system was heavily weighted towards the Clinical Consultants, with five members to represent them, versus one for DYFS and one for the CMO/UCMs. The manner of selection of these individuals was also significant. The Clinical Consultants were recruited by the author, in person at a group meeting, as was the CMO/UCM representative. All of these individuals were volunteers who elected to serve as liaisons and assume an active role in shaping the evaluation. The DYFS Team Leader was selected for convenience; his office was located one floor above the author’s location in Trenton with DCBHS. This made it easy to consult with him; however, as a result the call for volunteers was not opened up to the group of DYFS Team Leaders as a whole.

This likely had several ramifications; the individual selected may not have been someone who would have volunteered otherwise, volunteers who may have actively wished to participate were not recruited or accessed, and a message may have been communicated to the DYFS system at large that their opinions, input and assistance were not highly valued. Alderfer (2011) notes that “Being aware of one’s nonverbal messages aids valid interpretation of initial observations” (p. 331). What may have appeared to the author to be “resistance” or disinterest on the part of DYFS system members may have in fact been a response to the author’s own consultative stance. From the outset, the author influenced the system by unwittingly declaring a firm allegiance to the DCBHS system partners, rather than the DYFS partners. This, in all likelihood, had an impact on the participation of DYFS system members later on during the process.

A case example from the entry phase. A case example from the entry phase demonstrates how the author was able to navigate entry tasks in order to negotiate temporary membership with the DCBHS system. During the entry phase, a critical moment arose during a monthly meeting between the Clinical Consultants and representatives from DCBHS that illuminated some of the differing organizational needs with which both the author, and the other members of the system, were contending. At issue was how to track data measuring the monthly utilization of the clinical consultants by the DYFS offices to which they were deployed. At the time, each Clinical Consultant was tracking their time differently; some were tracking the number of hours spent in consultation, some were tracking the number of cases on which they consulted, and others were tracking the time spent per various tasks (contact with DYFS workers, training, paperwork or administrative responsibilities, outreach work, research exploring available resources, etc.) Clinical Consultants were being asked to submit records of their work to both their home agency (CMO/UCM) and to DCBHS. This meant that, at the State level, the data was functionally meaningless, as there was no basis upon which to compare utilization. DCBHS wished to standardize a metric for data collection across all monthly reports submitted by the Clinical Consultants.

This was a complicated issue that tapped into several key areas of potential conflict within the system. First, the Clinical Consultants were organizationally straddling two power systems in this issue – their employer, the CMO/UCM for whom they worked, and DCBHS, the organization to whom the CMO/UCM was the sole-contracted employee. Boiled down, the Clinical Consultants were caught between their boss (CMO/UCM), and their boss's boss (DCBHS). The struggle as to who had the

right to exercise supervisory control over the Clinical Consultants was therefore being activated. The CMO/UCMs have the responsibility to supervise their remote employees and to hold them accountable for their work, and wanted to do so in the manner they deemed most useful for their particular agency. DCBHS has a responsibility to monitor the implementation and utilization of a program designed and funded by the State, and required statistics that allowed them to understand the progress of the position and to identify areas that needed additional attention. Both agencies had a legitimate claim on the data being requested, and the format in which it was to be rendered.

The monthly meeting itself was a cause of tension between DCBHS and the CMO/UCMs. The meeting was initially born out of recognition by DCBHS that the Clinical Consultant position was a unique one, and largely carried out in isolation. The monthly meeting was conceived as a way to provide additional support for the Consultants by creating a space and time in which they could come together and process obstacles, difficulties and successes in the carrying out of their duties. The CMO/UCMs viewed the meeting as a “stepping outside the chain of command” on the part of DCBHS by meeting with their employees without supervisors (the CMO/UCM directors) in the room. The Clinical Consultants were therefore caught in the unenviable position of being asked, during this discussion, to represent the organizational view of their own agency, without the power to alter it or to compromise its demands, and to comply with the organizational needs of DCBHS.

Furthermore, while both agencies were asking the Clinical Consultants to account for their time, the Consultants themselves were unsure as to the purpose of the data-tracking, concerned that it might be the basis for performance evaluation or dismissal,

without a clear understanding as to what was expected of them. Therefore, the Clinical Consultants were experiencing, and voicing, feelings of suspicion, scrutiny, a loss of agency, and defensiveness, feeling as though they were being asked to account for their time in various ways by various “others” to justify their employment.

During the conversation as to how best standardize data collection, the Clinical Consultants requested that the author, as the “outside authority,” weigh in on the subject. The author was sitting in on the meeting in a purely observational capacity, attempting to familiarize herself with the various agencies through document review, individual meetings and observation. The attention in the room was immediately focused on the author as an active participant with some level of perceived influence to exercise. It was a watershed moment, with implications for future working relationships with members of three of the system’s crucial participants; DCBHS, who could reasonably expect support in their vision for standardized data from their consultant, the Clinical Consultants, who were attempting to understand the author’s standing, the location of her loyalty, her potential to be trusted, and her ability and willingness to understand and empathize with their position, and the CMO/UCMs, who were not in the room, but would understandably be frustrated if an outside consultant rendered an opinion that infringed on their supervisory rights over their employees. It was also the first overt test of the author’s purported “expertise” and, as such, had implications for how future feedback by her would be received by the system.

“During entry period, diagnosticians, while physically inside the system, are experienced by organization members as outsiders who are nonmembers and whose roles remain to be determined” (Alderfer, 2011, p. 331). The author experienced the request

on the part of the Clinical Consultants to weigh in on what was clearly an ongoing, highly charged, and controversial issue as an attempt to clarify what her role would be. The request contained within it elements of the tacit concerns of the Clinical Consultants regarding the program evaluation; could the author be trusted to hear and understand the Clinical Consultant's concerns? Would she be merely a tool of management? How would she navigate the competing systemic pressures to which they themselves were subject? These questions had important implications for how safe the consultants would feel during the evaluation process, and how much they would be willing to cooperate and engage with the author during the active data-gathering portion of the project.

The context in which this question was posed and the underlying anxieties and questions it implied required that the author accomplish several things in her response. The author's immediate reaction was a strong feeling that it would be important not to take a position on this issue. To do so would have, from the outset, aligned her with some parties and not with others, compromising her ability to work collectively with the group. There was an intense pull in the room to answer directly, to take up one of the many proposed solutions to the problem and to champion it, which the author interpreted as an unspoken desire on the part of the consultants to have the author declare a position and thus dispel the anxiety of remaining an unknown, potentially dangerous quantity. The author was experiencing the collective transference of the clinical consultants towards authority and an immediate, strong countertransference against declaring herself specifically on this issue.

Utilizing this information, the author responded by initially acknowledging her "outsider" status, stating that as a newcomer to the system, she was not in a position to

take a definitive stance on this issue. However, the author felt that to leave it at that would be unsatisfying, both for herself and for the audience. It felt important not to “dodge” the issue, and to leave the consultants with the same unresolved anxiety over her role and position as existed before. The author also felt a pull to assert and demonstrate her expertise, and her potential ability to help the system resolve the frustration generated by issues such as this. Furthermore, the question felt like a confrontation, such as Alderfer describes in his own work as “an event from which the beginning relationship could move forward or backward” (Alderfer, 2011. P. 336). The author wished to communicate that, if necessary, she and the consultants could discuss issues of authority, expertise and influence directly and explicitly.

Therefore the author went on to interpret a portion of the underlying issue at play as she hypothesized it – that while everyone could agree the data should be meaningful, there seemed to be confusion as to what the data was being used for, which made it difficult to determine how best to track their work, and created a great deal of anxiety. The author also acknowledged that the Clinical Consultants were being asked to satisfy two supervisory bodies, which contributed to feelings of scrutiny, and created extra work for them that took up time and detracted from their ability to ultimately serve their clients. Finally, the author stated that the lack of a communal conceptualization of the position seemed to create this type of situation, where competing beliefs about the position, its purpose, value and operation, contributed to organizational disagreement and difficulty resolving these issues. She voiced her hope that the project would help clarify some of these difficulties, and ruefully reminded the collective audience that she had no

authority to influence any request coming from DCBHS, which garnered laughter in response.

After the author finished speaking, there was a palpable change in the atmosphere in the room, individuals relaxed, and the issue was ultimately resolved by a temporary edict from DCBHS on how to track data, to be revised as necessary. Following the conclusion of the meeting, several of the Clinical Consultants who had not expressed interest in the project or responded to the authors attempts to engage them prior, approached the author and volunteered to meet with her and be interviewed.

It was an important moment in negotiating entry into the DCBHS system, which was successful for several likely reasons. In her response the author was able to use humor to diffuse a tense situation while at the same time setting boundaries on her role, communicating to both the Clinical Consultants and to DCBHS representatives that she would not attempt to infringe on any established lines of authority. Furthermore, she was able to communicate understanding, empathy, a willingness to learn and a desire to be helpful. All of this helped to clarify her position and to render her less threatening to the individuals present.

The Data Collection Phase

A similarly significant moment occurred during the data collection phase of the project, in relation to a CMO/UCM Director and her staff. Alderfer (1980) describes the three stages of organizational diagnosis as overlapping and recursive in nature. That is, “there is some data collection and some feedback during entry, some entry and some feedback in data collection, and some entry and some data collection at feedback” (p.

460). The case example that follows is a good demonstration of how entry was required during data collection, as a condition of successful and meaningful information gathering.

Transference of the system towards authority figures. The author's organizational home within the upper levels of DCBHS, in combination with the author's designation as an "evaluator," and therefore "authority" from outside the system, made the author the recipient for "feelings that organization members have for authority figures inside their system" (Alderfer, 1980, p. 461). That is, the author, as a result of her affiliation with DCBHS, the overall system authority, was naturally and organically the object of transference feelings of system members towards authority in general. This phenomenon was particularly evident during the data collection phase of the program evaluation.

In particular, the question of authority was the most pertinent to, and therefore the most in evidence with, the Executive Directors of the CMO/UCMs. The Executive Directors of the CMO/UCMs viewed themselves as independently operating non-profit organizations, while DCBHS viewed the CMO/UCMs as solely contracted service providers of the State of New Jersey, supervised by and accountable to DCBHS. This distinction in perspective resulted in a great deal of systemic tension that became focused on, and discharged around the discussion of the Clinical Consultant position.

The author became aware of this dynamic early on in the entry phase, and the opportunity to engage directly in it presented itself during the data collection phase. The manner in which the author was given the opportunity to engage with this dynamic led, as in most transference/countertransference interactions, to invaluable information about the system that all individuals concerned were working within, and enriched the program

evaluation to such an extent that without this engagement the project would have been much less successful.

As Alderfer observes, “Each data collection episode begins by establishing the bases of the client-consultant relationship and, as such, is like entry. These unstructured events provide the consultant with a continuing basis for revising or confirming hypotheses about the organization” (Alderfer, 1980, p. 462). This process was evident in one of the first interviews the author conducted with the steering committee of a CMO/UCM, during which the author had to negotiate entry and experience systemic tension.

A case example from the data collection phase. The author was wondering why the interview was not proceeding smoothly. The conversation was stilted, and though there were three members of the CMO/UCM steering committee in the room, only one, the director, was speaking at any notable length. The author was working off a semi-structured interview form, developed and vetted with the help of her liaison system, but felt that she was not succeeding in opening up the dialogue or establishing an effective rapport with the individuals present. The author was feeling frustrated and confused by the lack of engagement, and hypothesized that the CMO/UCM representatives were feeling guarded, suspicious, and careful. While the author reflected on how to shift the feeling in the room the CMO/UCM director took the reins and bluntly asked the author to explain the origin and purpose of her project.

Though the origin and purpose of the project had been mentioned during the author’s initial introduction to all CMO/UCM directors at a separate meeting at the start of the program evaluation, this was an example of the necessity of negotiating entry into

the system at multiple locations and stages of the project. The author was initially caught off guard, and her immediate response was to feel defensive. What became evident in the discussion that followed was that the author and the CMO/UCM steering committee were acting out an important dynamic that existed, to varying degrees, between all CMO/UCM directors and DCBHS. The program evaluation project was a project that had been foisted on the CMO/UCMs by the external authority of DCBHS. As a result they did not own it, feel invested in it, or understand how it would benefit them. They felt their institutional sovereignty was being intruded upon, and in many ways this reflected the feelings they had about the Clinical Consultant program at large.

The CMO/UCM director began to voice the organization's confusion and frustration with regards to the creation of the Clinical Consultant position, which they had not been a part of. She described the mandate handed down to the CMO/UCM Directors to create and implement the Clinical Consultant position without a clear job description, which she (and evidently others) felt was unnecessary micromanaging by DCBHS. She felt that she and her colleagues were able to judge for themselves what employees they needed to do the job laid out in their contracts, and would have preferred to be given the money allotted to the Clinical Consultant salary to invest in program expansion as they saw fit. Furthermore, she voiced anger with the confusing supervisory structure with regards to the position. The CMO/UCM did not understand DCBHS's level of involvement with the Clinical Consultants (such as the request for monthly data), and in particular felt "disrespected" by the fact that representatives from DCBHS met with the Clinical Consultants independently of their direct supervisors, the CMO/UCM directors. There was pronounced confusion and resentment about the boundaries of this position,

and, more largely, the boundaries of the relationship in general between DCBHS and CMO/UCM.

The author, for her part, was acutely aware that she was feeling defensive on behalf of herself and, particularly DCBHS, feeling misunderstood, and wanting to defend the current system. In this moment and in this specific context, the author's group membership with the leadership of DCBHS was being activated. Also likely is that the author's identity as a "student" was being activated as well, in feeling called to explain herself to a much higher ranking, more experienced and seasoned professional in her own field. Feelings of anxiety and potential inadequacy contributed to the feeling of defensiveness.

This defensiveness, however, was likely functioning to some degree on an organizational level as well. If the CMO/UCMs felt frustrated with and disrespected by DCBHS, it could be assumed that DCBHS was experiencing some counter reaction of their own, quite possibly in line with the defensiveness the author was experiencing. If so, then the author's initial impulse to withdraw, push away the challenge to her authority and take cover in pulling rank (the CMO/UCM directors had been instructed meet with her, after all) mirrored the institutional reaction of DCBHS, to varying degrees. The author's emotional response clearly communicated something important about the DCBHS/CMO/UCM dynamic, since the basic premise of the director's argument, that the Clinical Consultant position remained unclearly defined and inconsistently administrated and executed, was also the position of DCBHS, and the impetus for the project. Why then, did it feel as though the author and the director were adversaries? The author hypothesized that perhaps the tension between CMO/UCM directors and

DCBHS resulted in DCBHS withdrawing from the relationship and, as a result, declining to explain itself perhaps as fully and transparently as was possible. Accordingly, the present moment was therefore an opportunity for the author to test this hypothesis by attempting to address the director's concerns, provide information and be as transparent as possible.

The author acknowledged the confusing and abrupt nature of the Clinical Consultant position's creation and implementation, and stated that her current project arose out of DCBHS's recognition of the problem and desire to provide some clarity for all concerned. She voiced some of the difficulties the position entailed for the CMO/UCM directors as she saw it based on her experience so far, and expressed a desire to learn from the director if they had also experienced those difficulties, and if she could point to others as well. The author also stated that, as an employee of DCBHS she was less well equipped to understand the daily operations of administering to an off-site employee such as the Clinical Consultant, and that she hoped to gain insight from what the CMO/UCM directors had to tell her.

Following this response the Director began to speak more candidly about her concerns about the position, ways in which she felt some of her concerns could be addressed, and her previous attempts to get them addressed. As the conversation continued, with the author attempting to reflect what she was hearing and contribute supportive statements, the other members of the steering committee began to actively participate. The interview concluded on a positive note.

In recognizing the CMO/UCM director's questions as a form of resistance on the part of the system to intrusions of authority, the author was able to better explore her

concerns, provide an honest response, and build a positive relationship. At subsequent group meetings this director frequently approached the author to say hello, and to enquire about her progress both on the project, and in school. During the final feedback session she was one of the most vocal in contributing questions and comments, and expressed pleasure with the final product, stating that she felt the author had “already helped” improve the situation.

These are two examples of instances in which the author was able to successfully negotiate entry with the Clinical Consultants and the CMO/UCM directors, strengthening working relationships and permeating boundaries more effectively. This was possible because of the author’s organizational location, group identities, and an awareness of the parallel processes occurring within the DCBHS suprasystem. This success on the part of all parties to negotiate entry was evident in the feedback stage, while the author’s failure to similarly engage with DYFS system was also evident.

The Feedback Phase

As noted earlier, the feedback phase is where the consultant’s success or failure to enter, gather data, and compile a clear and accurate picture of the system that they are studying is revealed. The feedback phase is a unique part of the process because, as Alderfer (1980) describes,

Through entry and data collection, the consultant has been primarily *taking* from the client system. Entry gives permission to conduct the diagnosis, and data collection provides information and the hope of understanding. Feedback is the time for the consultant to be *giving* to the client system (p. 467).

The opportunity to present the fruits of long and dedicated labor is an exciting one, and signals the conclusion of an involved and extensive project that has benefited from the sacrifice of time and work on the part of many individuals. However, it is also a time when unresolved dynamics and intra-systemic tensions can be enacted, as the content and process of the feedback re-creates patterns that maintain those tensions.

A case example from the feedback stage. The feedback sessions conducted with the CMO/UCM directors and the Clinical Consultants, with DCBHS representatives present, were both successful. The feedback was well received, participants were actively involved, asking questions, voicing agreement, stimulating discussion and making recommendations. At varying points members from each group expressed feeling heard, feeling that the author had “really got it,” and feeling that their viewpoint, concerns, strengths and needs were accurately represented. Furthermore, individuals felt empowered to know that their perspectives had been accurately represented to other members of the system, their supervisors, co-workers and others. The feedback occurred first with the Clinical Consultants themselves, then with the CMO/UCM directors, and the final feedback session, scheduled near the end of the author’s time with DCBHS, was scheduled with DYFS Team Leaders.

Walking into the third and final feedback session with DYFS, the author felt fairly confident in her presentation and its anticipated reception. The manual had largely been written, two presentations had been successfully completed, and her time with DCBHS was almost at an end. There was no reason, as yet, to doubt that this presentation would go similarly well.

Throughout the first part of the presentation, during which the study was summarized and the model of consultation in use was explained, the DYFS Team Leaders seated around the table were quiet, asking few questions and contributing few comments. As the presentation shifted into describing the findings, outlining the differing institutional conceptions of the position and defining the basic duties, tasks, and limits of the position, the audience began to speak up, challenging the conclusions and voicing disagreement. The primary source of disagreement stemmed from the Team Leaders feeling that the Clinical Consultants should be more directly involved as a “support for staff,” in the ways outlined earlier. They argued that Clinical Consultants should speak with providers, attend treatment team meetings, facilitate the family’s direct connection to services, etc. They felt frustrated with the limits placed on the system, and devalued what they felt the position would come to be, as a result. There were strong implications that the Clinical Consultants would not be working as hard as the rest of the DYFS team, and that they were getting “special treatment.”

In many ways, this response makes institutional sense. The DYFS Team Leaders were employed by DYFS, and actually served a similar function as the Clinical Consultants, that is, as a “liaison and communication link between local children’s behavioral health system partners and DCBHS” (Armstrong et al., 2006. p 28). In practice, however, these Team Leaders did much more. According to the Independent Assessment carried out by the Louis de la Parte Mental Health Institute in 2006, Team Leaders were found to have many roles and responsibilities, including: personal case management of high risk or high profile cases in concert with the assigned worker, overall systems “problem solver,” attending multiple meetings (sometimes up to 30) with

system partners every month in order to receive and pass on information, and being available at all times to assist on calls (p. 28).

During a focus group held by this team, Team Leaders spoke of “‘having to be responsible for everything,’ and of being overwhelmed with the number of tasks” (p. 28). Because of the nebulous conception of the Team Leader position, they were experiencing “model drift” in the same way that the Clinical Consultants had been. That is, with no clear formulation of what their role was, they had been asked to take on more and more tasks until they felt besieged. Where DCBHS had stepped in to support its employees, define and clarify their role and reinforce boundaries, the Team Leaders were still struggling with the difficulties of the vague limits around their role. In this sense, the Clinical Consultants were receiving “special treatment” as compared to the Team Leaders.

In addition, part of the project was to place the responsibility for carrying out the recommendations of the Clinical Consultant back on DYFS. Team Leaders saw this as creating even more work for them. They felt the Clinical Consultants were free to make recommendations without concern for feasibility, to subsequently document their recommendations, and then walk away from the consultation without culpability should the recommendations fail to become implemented or should a tragedy befall the family in question. Though the findings presented to them placed heavy emphasis on the responsibility of the Clinical Consultants to jointly craft recommendations that were realistic and practical with the DYFS worker, the Team Leaders were correct that legal responsibility for the case remained with DYFS as an agency.

The interaction between the author and the DYFS Team Leaders was also an enactment of the limit testing that necessarily follows such a system wide re-orientation to an existing program. The Clinical Consultants had largely been doing what had been asked of them, and, similarly to the Team Leaders, had voiced feeling overwhelmed and “spread too thin.” Now that the program evaluation project had clarified more specifically what they were expected to do, and, perhaps more importantly, what they were discouraged from doing, the Clinical Consultants would be in a position to set limits with the DYFS workers, caseworkers, supervisors and Team Leaders, and to have those limits be enforced by the CMO/UCM directors, and by DCBHS. The introduction of new limits around a position that had been previously “limitless” would necessarily lead to limit testing. The author, as the in-room representative of the Clinical Consultant group (at least, when viewed through the perspective of the Team Leaders), was the recipient of initial boundary testing in the form of arguments, disagreements and displeasure. Additionally, the fact remains that the author did not form the same kind of working relationships with representatives from the DYFS subsystem as she did with DCBHS. Despite the fact that questionnaires were sent out to all Local and Area Office Managers, a conference call was held with the Team Leaders, and several specially selected DYFS workers designated by the Clinical Consultants as “high-end” utilizers of the position completed questionnaire forms, it remains that the author spent significantly less time with these representatives than with individuals from DCBHS.

One difference can be seen in that, with this group, many more questionnaires were used, rather than the more time-consuming but also more intimate semi-structured interview used in other instances. The author conducted only three semi-structured

interviews with DYFS Team Leaders, and none with DYFS workers or supervisors. Part of this was due to practical considerations; time was limited and the author was working alone. However, it is also true that with limited time and resources the author chose to focus on one population of respondents over another, and the reasons for that choice deserve examination.

One reason is that the author was, as has been noted, organizationally located within DCBHS. This affiliation likely functioned to cognitively and emotionally orient the author more towards the members of the DCBHS system. Also, as has been noted, the author was more able to identify with the Clinical Consultants, and was more naturally disposed to be interested, as a result of her own professional experiences, in their work, rather than the work of the DYFS Team Leaders. Both personally and organizationally, the author was biased towards DCBHS in ways which likely would have benefited from earlier recognition and examination.

However, what is also clear is the remaining systemic divide between DCBHS and DYFS. It was disclosed to the author, towards the beginning of the project, that there has historically been tension between DCBHS and DYFS, dating back to the creation of DCBHS in 2000. When DCBHS was created following several tragic and high profile cases of child deaths and severe abuse that garnered national attention and resulted in a class action lawsuit and national oversight, DYFS believed that the funding allotted to the new agency was carved out of their existing budget. Though representatives from DCBHS denied this, the belief persists among DYFS employees, particularly those who have been employed with them for many years. The actual facts of this remain unclear to this author, but the truth of the matter is less relevant than the perspective it informs. The

DCBHS representative who described the tension to this author went on to state that DYFS has always believed that they should have maintained control over behavioral health as well as physical health and safety, and that additional money should have been allotted to them for this purpose, rather than creating a new division. Acknowledging that this information was received from a source connected with DCBHS, it nevertheless illuminates some of the dynamics resulting from the long-standing tension between the two agencies.

It indicates that there has always been disagreement about the limits of the responsibilities and powers of each agency. If DYFS believes that the behavioral and physical health of the children of New Jersey should remain under their purview, they will resent any intrusions into that sphere by DCBHS representatives. This would be primarily true for DYFS employees who pre-date the creation of DCBHS. Furthermore, if DYFS as an institution views the creation of DCBHS as a “punishment” for their perceived failure to protect the children under their care, they may feel that DCBHS is there to “keep an eye on them,” and to point out what they are doing wrong in their management of difficult cases. Support for this hypothesis is found in the behavior of DYFS employees at every level, when a child in their care died. A Clinical Consultant who was present in the DYFS office where the case was assigned stated that the DYFS employees “closed ranks,” holding closed door meetings without her, gathering to speak to each other far away from her desk, and failing to include her on any of the email communications regarding the case. Her “outsider” status during this time became even more pronounced than usual. Viewed with this in mind, the DYFS Team Leaders

reactions to the limits set on the Clinical Consultant position through the program evaluation project can be more thoroughly understood.

It is interesting to note that the systemic divide described above did not extend to the individuals at the top echelons of DCBHS and DYFS. The author's direct supervisor, the Director of DCBHS, had a positive and collaborative relationship with the Director of DYFS, and worked with her to gain access to the DYFS system for this author. In addition, the Director of DCBHS consistently encouraged the author to more proactively seek out DYFS views. She was committed to the conception of the DYFS employees as the "consumer" of the position, and, as such, important sources of information for the project. Both directors were women, in the same age group, who had entered the system following the creation of DCBHS, and who were able to work collaboratively together. This relationship between the two directors, however, was not enough to overcome the deep-seated systemic divide between their two agencies. The author, with greater immersion in the lower ranks of both the DCBHS and DYFS system, seems to have taken on the more systemic distance, rather than the director's more collaborative attitude. This speaks to the lingering difficulty posed to any single position that is designed to bridge the divide, such as the Clinical Consultant.

Conclusion

The author entered the DCF system, comprised of DCBHS, DYFS and the DCPC, with her own group memberships and identities. These identities, in combination with her organizational location and the ecological setting in which the program evaluation project took place, resulted in a specific "taking sides" with the DCBHS system in the manner described by Becker and Alderfer. This, in and of itself, revealed important

information about the system under study, illuminating lingering divides, disagreements, and boundary issues.

In the same way that the boundaries of the Clinical Consultant position were initially vague, the boundaries within the DCF system also remain somewhat unclear, resulting in boundaries between the system that are either too rigid (i.e. excluding the Clinical Consultant from important DYFS office issues, or the author's actions in positioning DYFS as "outside" the DCBHS system, and therefore allotting less time to understanding their perspective during the study), or too permeable (asking the Clinical Consultant to do tasks that are clearly in the purview of the DYFS worker.) Attempts to clarify limits within the system were, therefore, unsettling to the system, and experienced as threatening.

This is not unusual, given the unprecedented and massive reorganization of the child welfare system in New Jersey in the recent past. New Jersey has confronted the question of how to best organize services for the children under their care in a way few states have before. This struggle has resulted in many innovations and interventions that are still relatively new, and continuing to evolve and to become integrated into the understandings of those who work in this field. The author experienced the system in a way that was informed and colored by her own experiences and perspectives, and that, in turn influenced the system as she studied it.

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APPENDIX A

Questionnaire for DYFS Users

- 1) What are the clinical consultant's most valuable functions with regards to your work?
- 2) What is happening in a case or referral that makes you seek out the clinical consultant?
- 3) How did you become aware of the clinical consultant as a resource?
- 4) How do you communicate with the clinical consultant? (for example, email, face to face, phone contact, notes?)
- 5) How do you document your consultation with the clinical consultant? (in SPIRIT or not? Anywhere or not?)
- 6) Any other thoughts on this position?

APPENDIX B

Questionnaire for DYFS Team Leaders

- 1) How do you see the role of the Clinical Consultant as it is being carried out in your office?
- 2) What do you want from this position in terms of services?
- 3) How were they introduced to you and to your staff? How were you and your staff educated as to the services they are able to provide?
- 4) How have they been integrated into your office? Do they have dedicated space, attend regular meetings, etc?
- 5) How do you and your staff communicate with your Clinical Consultant?
- 6) How has the position developed? What were some obstacles to their integration? What aided the process of their integration?
- 7) How do the workers know when to bring the Clinical Consultant in on a case?
- 8) How well utilized are they?
- 9) What do you see as their most valuable function in your office?
- 10) Is there anything you would like to see changed?

APPENDIX C

Questionnaire for Clinical Consultants

- 1) How do you get referrals?
- 2) What are the main referral questions?
- 3) How do you define a consultation for the purposes of data collection?
- 4) What other data do you keep track of on a regular basis, and how do you track it?
- 5) What paperwork are you responsible for, and for whom do you complete it (i.e. DYFS, CMO, DCBHS)? What other administrative duties do you have?
- 6) How do you document your work?
- 7) What meetings do you attend on a regular basis?
- 8) What activities form the main part of your consultancy responsibilities as you see them?
- 9) Who are your main contact people at your office? Who are the important DYFS employees with whom you interact?
- 10) How many offices do you cover, and which ones do you spend time in? How do you divide your time? Do you have regular hours at each or does it vary?
- 11) What is your typical work load and how do you manage it, in terms of accepting new referrals?
- 12) How do the DYFS workers find and communicate with you when you are both in and out of the office?
- 13) How much time have you spent, or do you spend, reaching out to the DYFS workers in these offices and educating them about your services? How do you do that?
- 14) Are you involved with co-managed cases (with YCM/CMO/UCM)? How do you handle co-managed cases that come to your attention?
- 15) Have you experienced any roadblocks or challenges to performing your role as a Clinical Consultant? When faced with such challenges how have they been resolved, or, do the concerns remain?
- 16) How do you interact with the CMO?

17) Any additional thoughts?

APPENDIX D

Questionnaire for CMO Directors

- 1) What do you see as the primary duties of the Clinical Consultant?
- 2) What do you view as the most important aspect of the Clinical Consultant's role?
- 3) What paperwork do you require your Clinical Consultant to submit, if any?
- 4) What meetings do you require your Clinical Consultant to attend on a regular basis?
- 5) What is the supervisory process?
- 6) What was the process of implementation of this role in your own organization and with DYFS?
- 7) What successes or positive outcomes have resulted from the implementation of the Clinical Consultant position?
- 8) What difficulties or obstacles have you encounter in terms of implementing this innovative role? How have you addressed these obstacles?
- 9) What aspects of the Clinical Consultants role do you see as being unique and specific to your region or community (ie in terms of the kind of referrals received, the services needed, or what kind of interaction occurs with DYFS?)
- 10) Any other comments on this position?

APPENDIX E

Questionnaire for PerformCare

- 1) What is the role of the dedicated DYFS unit at PerformCare and how does it function?
- 2) What is the process when a DYFS worker accesses PerformCare?
- 3) How does PerformCare communicate with the DYFS worker or the Clinical Consultant once a referral has been made?
- 4) What is your role in facilitating relationships between PerformCare and DYFS?
- 5) What has your interaction been with the Clinical Consultants, if any?
- 6) How do you see the role of the Clinical Consultant?
- 7) How, if at all, should the Clinical Consultant utilize you and your expertise?
- 8) What do you think is the primary value of the Clinical Consultant role?
- 9) Are there any ways that the Clinical Consultant could be more useful to you?