Quality Assurance Evaluation of an Interagency Consultation Service Provided by a Children’s Assessment Clinic to a Child Welfare Agency

By

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ABSTRACT

In Canada, approximately 76,000 children are in Foster Care (Farris-Manning & Zandstra, 2003). Many of these children have significant social, emotional, and behavioural problems and foster parents are often overwhelmed with the extent of the needs of children in their care. This stress leads to extremely high attrition rate of foster parenting which can cause additional adverse effects on the child. In order to reduce the attrition rate of foster parents, specialized support is essential. Unfortunately, available resources are scarce and studies show that once proper mental health care is found, there are often long waiting lists for assessment and treatment. An alternative to assessment and therapy may be consultation. Consultation services have been shown to lower costs for families needing mental health help while increasing the availability of resources and quality of services (Catron & Weiss, 1994). Although there is support for the use of mental health consultation, the research that exists has several methodological flaws which make it difficult to assess the quality of consultation services. The purpose of this study was to develop a clear empirical process for quality assurance evaluation and to use this method to evaluate the quality of a consultation service provided by a Children’s Assessment Clinic to foster parents and a Child Welfare Agency. The results of the study support the value of interagency consultation. Clients who use the service do find the consultation service to be empowering and would use it again.
ACKNOWLEDGMENTS

Thank you to my agency supervisor who gave me the opportunity to explore this little researched topic of Quality Assurance in mental health consultations. It is also a topic that is of interest but I have not had the opportunity to explore it in-depth. Most of all, thank you to Dr. Sheelagh Jamieson, C.Psych., who supervised this placement and spent many hours helping me create this thesis. This thesis was developed to its fullest potential with her understanding, dedication, and loyalty to seeing her students succeed and develop into assets of the Behavioural Psychology field.
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Introduction

Seventy six thousand Canadian children are in the custody of Child and Family Services according to Child Welfare Canada (2000) (as cited by Farris-Manning & Zandstra, 2003). In Ontario alone, there are 17,876 children in care and of those, 67% of children in Ontario are living with foster families or kin arrangements (Ontario Association of Children’s Aid Societies, 2010). The needs of these children in care can be much more demanding than the needs of children not in care. Approximately 48% to 80% of children in care have moderate to severe emotional and behavioural problems (Farris-Manning & Zandstra, 2003). In Ontario, 82% of children in care have special needs (e.g., developmental and/or emotional disabilities) and 49% of children in care have behavioural issues (Ontario Association of Children’s Aid Societies, 2010). With these alarming statistics, it is obvious that foster parents are faced with many difficult obstacles related to the physical and mental healthcare of foster children. The need for professional help for foster parents is important. Unfortunately, available resources are scarce and psychiatrists and psychologists often have long waiting lists for assessment and therapy. Although assessment and therapy is needed, an alternative way to increase the number of clients seen for less severe problems is through use of consultation.

Consultation is a quick and reliable way of getting expert advice and solutions (Leslie, 2001). It occurs when a specialist or expert is sought out by another professional, such as a nurse, manager, clergy, general practitioner, etc. for advice, course of action, or suggestions. Consultation can be a direct or indirect method of service delivery. The consultant may directly assess a client or the consultant may help a consultee, who would in turn help a third party, which would be the client (Caplan, 1970; Kratochwill & Bergan, 1990; Reschly, 1976). The consultation process can take place in a wide variety of settings, such as hospitals, schools, or community agencies (Dworkin & Dworkin, 1975). Consultation is widely used by mental health professionals, but few agencies offer set standards of practice for a consultation to follow. Although consultation may be an effective treatment option, it can be difficult for child mental health agencies to define the model of consultation, measure, assess, and compare the quality of the consultation since there are few standards to compare and a thorough investigation of quality can be very time consuming. This thesis will look at a consultation service an Ontario Child Assessment Clinic provides for an Ontario Child Welfare Agency, describing the nature of the consultation and assessing the reactions of the clients and workers who have participated in this service.

The goal of this study will be to provide a community Children’s Assessment Clinic with knowledge about the quality of consultation it provides to a Child Welfare Agency. Questions that will be asked in this study are: 1) What model of consultation does the clinic follow? 2) What is the clinic supposed to deliver according to the contractual agreement between the agencies? 3) Does the clinic achieve the goals it has set out to achieve in each session? 4) Is the child welfare agency satisfied with the service delivery the clinic provides? 5) Are the foster parents who use the clinic’s services satisfied with the service the clinic delivers? This will be examined by reviewing the consultation contract, observing and evaluating the present consultation process, and gathering quality assurance data from past and present consultation service users. These questions will aid the Children’s Assessment Clinic in understanding how to improve the consultation service.
Literature Review

The Foster Care System

**Foster children’s needs.** Foster children often come from homes which are economically or socially disadvantaged. They may have been exposed to emotional, physical, or sexual abuse or their physical, medical, or social needs have been neglected (Dryfoos (1990); Prince & Austin (2005) as cited by Catron & Weiss, 1994; Hochstadt, Jaudes, Zimo, & Schater, 1987). These children are considered at high risk for developing behavioural, emotional, and mental health problems (Aricleus, Bellerby, & Vostanis, 1999; Golding, 2004; Hochstadt et al., 1987). Children who do not receive any help may continue the cycle of maladaptive behaviours, such as dishonesty, neglect, or abuse, that they were exposed to (Catron & Weiss, 1994). Additionally, once children have entered into the foster care system, they may sometimes move around multiple times before finding a suitable placement, making consistent and quick mental health care difficult to access (Hochstadt et al., 1987; Philips 1997). Studies show that the professional workers involved with the child’s welfare may not be aware of the possible resources, and once proper mental health care is found, there are often long waiting lists or misunderstanding and miscommunication between the case workers and mental health professionals (Aricleus et al., 1999; Philips, 1997).

**Foster parents’ needs.** Just as the children may have a hard time adjusting, foster parents can also be overwhelmed in dealing with the special needs of foster children and foster adolescents who usually present with different difficulties than the foster parents’ biological children (Golding, 2004; Maluccio, Fein, & Olmstead, 1986). Foster parents are people who are appointed by a family court to take care of the day to day needs of children in the foster care system. Foster parents are seen as a temporary placement until a permanent placement can be found for the foster child (Farris-Manning & Zandstra, 2003). Nixon (1997) mentions the extremely high attrition rate of foster parents. He suggests that because of the demanding role a foster parent takes on, additional support, such as respite care, other foster parents’ support, and specialized care from health, psychological, and educational resources can increase the effectiveness of the foster parents’ job. Support is found to be one of the most important elements to reduce the attrition rate of foster caregivers. Golding (2004) states that, “specialized professionals can dramatically increase a foster parent’s abilities to deal with the exceptional problems a foster child may present.” The United Kingdom’s Primary Care and Support Project (Golding, 2004) helps foster parents find support. It is a service for foster parents that connects them to the specialized professionals. The foster parents are able to consult with mental health or educational specialists who help the foster parents increase their skills, knowledge, confidence, and coping capabilities with specific problems encountered with their foster child. Entering into the consultation, foster parents often felt like the problems of the foster child were due to an incapability of parenting and questioned their parenting skills. After consultation, foster parents reported feeling understood, listened to, and that their expertise in parenting was appreciated and encouraged. The foster parents also realized that they are capable of good parenting; however, the foster children are often dealing with extraordinary circumstances. Fostering is a difficult task and can bring about many insecurities (Nixon, 1997), but having solution-focused support that is readily available, such as the support found in the consultation process, can increase the confidence in foster parents (Golding, 2004; Nixon, 1997).
It is the job of the child welfare agency to help the child and family cope with the changes and understand the difficulties. The consultation process is a time to focus on their needs and what they find challenging. The professional support that can help foster parents cope with the challenges of fostering can be found in a consultation with a professional.

Consultation

Models of mental health consultation. Consultation is a common term used by many professionals and contains a different meaning depending on the profession and the person (Caplan, 1970; Reschly, 1976). Consultation usually refers to the act of an expert in a particular area seeking out help from an expert in a different area to gain insight, suggestions, or advice (Caplan, 1970; Maddux, 1955). Caplan (1970) divides mental health consultation into four main categories; client-centered case consultation, consultee-centered case consultation, program-centered administrative consultation, and consultee-centered administrative consultation. A client is considered to be the person who is the focus of the consultation, whether it is directly or indirectly. The consultee is the person who sought the advice of the professional. The models’ main differences and features are summarized in Table 1. As Table 1 shows, the main feature of client-centered case consultation is that the focus of the consultation is on helping the client directly. The consultant will often interact with and assess the client to discover the problem, and then develop a plan to help the client. In contrast, the consultee-centered consultation focuses on teaching and developing the consultee’s skills, which in turn, helps the client. The consultant does not interact with the client nor does the consultant assess the client to develop a hypothesis of the problem. The consultee provides an explanation of the problem. The consultant uses his or her expertise in clinical skills, behavioural knowledge, observational skills, objectivity, and interviewing skills to assess the consultee’s problem; for example, the consultee may lack knowledge, skill, or self-confidence, or may be too emotionally subjective with problems pertaining to the client. The consultant’s task, in this case, is to give the consultee advice or suggestions, offer new insight, and improve the consultee’s understanding of the problem. The secondary goal of consultee-centered consultation is to instill the concept of self-worth in the consultee and empower the consultee with the confidence to generalize the learned skills to other clients and similar situations (Dworkin & Dworkin, 1975). Meyers (1975) looked at a consultee-centered consultation between a new grade three teacher and a psychologist. The teacher initially sought out help to manage two particular students, but upon observation the psychologist thought she would benefit from a consultee rather than client-centered consultation. With focusing on the teacher’s attitudes and beliefs, rather than assessing the individual students, the teacher showed a marked improvement in effective classroom management.

Program-centered administrative consultation is similar to client-centered consultation, but instead of assessing an individual, the consultant assesses the overall problem of a service system and develops strategies for the group of people who deliver the service, for example the interactions between workers in an organization. Consultee-centered administration consultation is similar to consultee-centered cases but, again, rather than looking at an individual, the consultant has been sought out by a group of managers who are seeking ways they can improve
<table>
<thead>
<tr>
<th>Feature</th>
<th>Client-Centered Case Consultation</th>
<th>Consultee-Centered Case Consultation</th>
<th>Program-Centered Administrative Consultation</th>
<th>Consultee-Centered Administrative Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who does the consultant directly help?</strong></td>
<td>The client</td>
<td>Another professional</td>
<td>Administration program or improve an existing program</td>
<td>Management of a service delivery administration</td>
</tr>
<tr>
<td><strong>Whose behaviour is targeted to directly change?</strong></td>
<td>The client</td>
<td>The consultee</td>
<td>The group of people who deliver the services directly</td>
<td>Management of program deliverers</td>
</tr>
<tr>
<td><strong>How does the consultant help the client?</strong></td>
<td>Directly</td>
<td>Indirectly</td>
<td>Directly</td>
<td>Indirectly</td>
</tr>
<tr>
<td><strong>How is a plan or hypothesis developed?</strong></td>
<td>Through direct assessment of the client</td>
<td>Through what the consultee says about problems</td>
<td>Through direct assessment of the group and program</td>
<td>Through assessing management’s shortcomings</td>
</tr>
<tr>
<td><strong>The process the consultant follows</strong></td>
<td>Collect and analyze data to develop a plan for the client using the specific skill set he possesses</td>
<td>Teach the consultee about how to analyze and problem solve using his objectivity, knowledge, and skill set</td>
<td>Collect and analyze data using knowledge about program administration, social systems, and mental health theory and process</td>
<td>Address the problems in management and teach management to work through problems</td>
</tr>
<tr>
<td><strong>What does the consultant address?</strong></td>
<td>How the client can be helped concerning the presented problem</td>
<td>Help consultee develop objectivity, increase knowledge and skill set, and develop self-confidence</td>
<td>Areas of the program that are causing problems</td>
<td>Lack of leadership and authority, communication problems, role confusion</td>
</tr>
</tbody>
</table>
the work environment. After any consultation, the advice and suggestions given are carried out by the consultee if he or she chooses to. The consultant is not responsible for implementation or follow-up of the treatment (Caplan, 1970).

**Benefits and challenges of consultation.** Consultation services have been shown to lower costs for families needing mental health help while increasing the availability of resources and quality of services (Catron & Weiss, 1994). For example, schools and rural areas have benefitted greatly from the work of mental health consultations. Froese, Dwyer-Sepic, and Parker (1997) introduced a consultation service to three rural mental health agencies. The consultation service was greatly used and appreciated by the agencies, especially when cases were more complex than usual. The consultants found it important to know what resources were available in each area. The consultation service developed a close working relationship and collaboration between the rural communities’ resources. The service promoted interagency communication and provided a cost-effective service for mental health treatment in areas that otherwise do not have a wide array of resources.

Regardless of what consultation model is being used, consultation is a personalized way of getting quick access to information about a problem (Leslie, 2001). McGarry et al. (2008) assigned children and adolescents with non complex cases from a referral list to either a treatment as usual group or a brief consultation and advisory session. The treatment group went through assessment after at least three months on the clinic’s waiting list, waited for formulation and diagnosis, and then were given a treatment plan. The consultation group was seen within four weeks of opting into this study and were sent a letter about what to expect in the consultation. The consultation was with a psychologist or psychiatrist and lasted 1 to 2 hours. The dropout rates were higher among the treatment group, while parents in the consultation group found that the consultation was empowering and helped with the problem almost immediately. Consultation was seen to be more effective than treatment after a 6 month follow-up because the consultation was problem-focused while the treatment process was slow and not problem-focused. Moreover, 41% of treatment group parents would have rather received consultation services based on the description from other parents after the study.

The previous study takes place within one clinic. However, consultation is often a process between two or more agencies. The United Kingdom Department of Health (as cited by Cottrell, Lucey, Porter, & Walker, 2000) states that interagency consultation is an important process in child and adolescent mental health because drawing from different professions increases the likelihood of receiving the best possible help for the children and adolescents. Prince and Austin (2005), Quinn and Cumbald (1994), and Bradford (1993) found child welfare agencies and the mental health professionals involved with child care have similar perspective on interagency and interprofessional collaboration. Both child welfare agencies and mental health agencies acknowledged how important it is for children and adolescents, especially in the foster care system, to receive help from different professions that can help solve individual and unique problems that may arise. The agencies involved also acknowledged that although interagency collaboration is important, it is hard to achieve.

Prince and Austin (2005), Phillips (1997), and Maddux (1955) noted that interagency collaboration may be difficult because the goals, needs, and expectations of each agency may not
be communicated or may not be understood by the other. Collaboration efforts and communication are key elements to the success of interagency consultations (Prince & Austin, 2005). To address these issues, the Department of Health in the United Kingdom has implemented several training programs across the nation that unite pertinent professionals involved in the protection of children together for inter-agency child protection training (Glennie & Horwath, 2000; Arcleus, Bellerby, & Vostanis, 1999). The Leeds Model (Cottrell, Lucey, Porter, & Walker, 2000) implemented a prioritizing committee that would prioritize cases from children’s services and send them to the appropriate referrals. Prior to this, children’s services were referring most cases for full assessments to mental health agencies, which, in turn, made waiting lists longer. A formal consultation process was also added to the sequence; a social worker would present a case to fellow social workers and the consulting psychiatrist and psychologist. The group would discuss the case and what action needed to be pursued. The consultation sessions also include briefing and teaching components from the consulting psychiatrist or psychologist. The agency found the interprofessional collaboration to be extremely useful and the social workers found it to be a valuable tool. The referral committee and consultation process allowed more priority children to be seen quickly for full assessments, while less complex cases could be referred more appropriately.

The previous studies demonstrate that consultation can be a useful service delivery model and the professionals and parents accept the process and find the information useful. Although the literature supports the use of consultations in mental health, it is virtually impossible for someone to replicate the consultation studies described above. Very few pieces of literature actually describe what the consultation process is. There are few guidelines as to how a consultation should go in mental health. The issues raised by consultations, such as lack of communication, may be able to be addressed if there is a structure to follow. Measuring the quality of consultation is useful because it would further support the use of consultations as an appropriate method to supplement assessments and therapy.

Quality and Effectiveness in Consultation

Quality assurance in health care. Over the past couple of decades, quality assurance in the service delivery systems has become an important element in the health care system. The quality assurance model began in business as a way for businesses to be accountable for their actions and provide better services. Health organizations have become a business and must account for their actions like a business must. Hospitals, practitioners, and mental health providers do not only have to report to themselves and their respective colleges, but must be accountable to their patients and in some cases third-party providers like Medicare (Shimokawa, Lambert, & Smart, 2010). A general goal of quality assurance in health care has been defined as ensuring that the standards for care set out by the profession are followed. This is done by using evidence-based treatments. If mistakes are made, actions are taken to correct them and lessons are learned from the mistakes. Overall, quality means to assure that the process and the achieved outcome are what the process and the achieved outcome should be according to the professional standards (Library of Congress, 1992; Wilson 1998). Speller, Evans, and Head (1997), and Goodman, Goodman, McGrath, and Goldsmith (1987), identified several major steps that were taken by different health organizations to implement a quality assurance evaluation of the service being delivered. This process can ensure that a quality service is provided to the clients. First,
one must identify the key areas for review (i.e., the consultation process). The next question in the series is related to standards of practice set out by individual affiliations and associations. After the standards are known, the task is to measure, compare, and analyze the selected elements to the set standards and, possibly, other similar services that are offered. When these questions are answered it is time to implement a plan for preventative or corrective actions. Once in place, the quality assurance cycle starts again. The quest for quality is an ongoing cycle. There are continuous research questions which are answered, new technology is introduced, and professional standards change (Ellis & Whittington, 1993).

Defining and measuring quality. Parasuraman, Zeithaml, and Berry (1985) found that defining quality in service delivery is difficult for clients and professionals. They found that service quality is best described as the discrepancy between the client’s expectation and the actual service delivery. Quality in service delivery is not only based on the outcome as product quality is. Quality assurance in the service delivery sector also includes the communication process and interactions during the service. In a meta-analysis, Zeithaml, Berry, and Parasuraman (1988) further support using discrepancies in service delivery to describe service delivery quality by identifying four gaps in the delivery that affect a client’s perception of quality. Gap one is the difference between the client’s expectations and what the company believes the client’s expectations to be. Factors that cause a discrepancy between client and management perception include poor market researching and limited or no interaction between the employees performing the service or management-client contact. Gap two is the difference between what management perceives the client as expecting and the type of service that is delivered. The management knows what to deliver, but there are insufficient resources available to deliver the service, therefore the quality is diminished. Gap three is the service delivery details specified by a contract, for example, and what is actually delivered. This gap occurs when the service is ready to be delivered to a certain standard, but the employees do not perform up to the specified standards. This may be due to unclear job titles and roles or a simple incompatibility between employee and job. The fourth and final gap identified is the difference between what service is expected to be by the clients and what is actually delivered. Simply put, what is communicated to the clients as what to expect with the service is not what is delivered. One goal of quality assurance in service delivery is to minimize these gaps of expectancy and perception. There is multitude of criteria used to evaluate these gaps and the criteria can greatly differ depending on the evaluator, but certain criteria of a consultation are perceived to be more important by a client. The client’s perceived quality of service delivery compared to the expected service delivery usually depends on ten evaluation criteria (Berry, Zeithaml, & Parasuraman, 1985; Parasuraman et al., 1985) shown in Table 2.

With respect to health care, the literature also suggests other ways to measure quality assurance as in consultation, such as patient satisfaction, patient enablement, and goal attainment. For example, Schoenwald, Sheidow, and Letourneau (2004) measured quality assurance by assessing expert multisystemic therapy (MST) consultants’ adherence to treatment through the consultee’s written reports. In this case the consultee was the therapist providing treatment to children with behavioural issues. They further assessed the therapists’ adherence to MST treatment integrity through caregiver pre- and post-treatment reports of the child’s behaviour and functioning. They found that the expertise advice and suggestions of the MST consultant had a positive impact on therapist adherence to MST; however, continued support
Table 2
Evaluation Criteria Commonly Used by Clients to Evaluate Service Delivery

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>What the Criteria Represents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability</td>
<td>Is the service consistent and predictable?</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>How willing are the employees to deliver the service? Is the service provided in a timely</td>
</tr>
<tr>
<td></td>
<td>manner?</td>
</tr>
<tr>
<td>Competence</td>
<td>Are the employees educated and qualified to deliver the service?</td>
</tr>
<tr>
<td>Access</td>
<td>Is the service easy to contact, approach, and locate?</td>
</tr>
<tr>
<td>Courtesy</td>
<td>Are the employees polite, respectful, non-judgemental, etc?</td>
</tr>
<tr>
<td>Communication</td>
<td>Is the language used understood by the client?</td>
</tr>
<tr>
<td>Credibility</td>
<td>Is the service really benefitting the client?</td>
</tr>
<tr>
<td>Security</td>
<td>Is the service confidential and are there limited risks involved?</td>
</tr>
<tr>
<td>Knowing the customer</td>
<td>Does the service provider listen to the individual needs?</td>
</tr>
<tr>
<td>Tangibles</td>
<td>Is the appearance of the facilities, personnel, and other clients acceptable?</td>
</tr>
</tbody>
</table>

from the consultant had a negative effect on therapist adherence. As well, more experienced consultants lead to therapists closely following MST treatment guidelines, which in turn had a more positive outcome on child’s behaviour. Less competent consultants resulted in fewer adherences to the MST model by the therapist, and in turn MST treatment had less of an effect on child’s behaviour. Kopel, Nunn, & Dossetor (2001) sent questionnaires to workers and families who used telepsychiatry for consultation in a rural area to gather data about satisfaction to monitor and measure quality with the new service. They found that both the workers and patients were highly satisfied with the consultation provided. Howie, Heaney, Maxwell, Walker, and Freeman (2000) introduced a potential questionnaire called the ‘consultation quality index’ (CQI) for patients to measure the quality of general practitioners consultations. The different constructs included are patient enablement, the length of the consultation, and knowing the doctor. Patient enablement was found to be one of the important aspects for the perceived success of a consultation. Patient enablement was defined in this study as patients being helped to understand their problems and how to manage them. The use of the CQI self-report also supports the use of this study’s self-report responding methods as the patient’s answers were found to be reliable and valid.
Present Study

Quality assurance and mental health consultation. Although the medical model for consultations has pulled information from the business model of quality assurance, a quality assurance business model has not been used in the evaluation of mental health consultation. Although literature supports the use of mental health consultation, practically no evaluation method or consultation process is replicable. The purpose of this study was to apply a quality assurance business model to evaluate the consultations between a Children Assessment Clinic and a Child Welfare Agency due to the methodological limitations described previously. By providing a methodology for the consultation and the evaluation method, more adequate methods and data may be produced for replicability and stronger reliability and validity results.

Consultation process of the Children’s Assessment Clinic. The Children’s Assessment Clinic is a training clinic for master’s and doctoral students studying to become clinical psychologists. The Children’s Assessment Clinic started the consultations with the child welfare agency in March of 2009. The consultations take place on the last Friday of each month at the child welfare agency in a board meeting room. Three one hour consultations are available each month. The foster parents or parent, the in-care case worker, the resource case manager, the clinic’s psychologist, and a graduate student from the clinic are always present at the consultations. Occasionally, the resource case worker may attend. The Child Assessment Clinic provides a consultation contract to the Child Welfare Agency in which the head psychologist attends consultations and provides advice, suggestions, support, and guidance to foster parents experiencing difficulties with their foster children. The Child Welfare Agency sends the clinic the foster child’s file along with a referral sheet that notes the concerns and questions that the foster parents were interested in discussing in the consultation. Concerns brought forward included violence, “bad attitude”, mental retardation, Autism Spectrum Disorder, how to help a foster child’s transition, drug use, sexual assault, stealing, attachment issues, and non-compliance. The clinic’s psychologist and graduate student then review the files and generate hypotheses before going into the consultation. To begin the consultation, the foster parents present the problems or concerns they are experiencing with the foster child, other information about the foster child that may be helpful, and the techniques they have used. Based on the presentation of the foster parents, the psychologist presents his understanding of what the foster parents are seeking and hypotheses previously thought of or new hypotheses that better fit with the problems the foster parents are experiencing. The psychologist provides positive feedback to the foster parents and uses lay language to explain developmental psychology, child psychology (e.g., attachment theory), and suggest behavioural techniques to help with the problem. Suggestions included in past consultations included the implementation of reward programs, modeling, goal setting, and explanations of the importance of boundaries for foster children. The psychologist does not follow-up with the foster parents but does send a letter with an overview of the problems presented and the outcome of the consultation, such as goals proposed for the child. The letter always reminds the foster parents that the knowledge provided from the psychologist is limited as he did not meet or assess the child and that they do not have to follow his advice; they may choose to do what they wish. The graduate student listens throughout the consultation and takes notes based on what the foster parents have said and what the psychologist has said. The student then drafts the letter for the foster parents and the graduate student and psychologist review the letter together to make updates or changes.
**Roles of the consultees.** The foster parents are referred to the consultations by either the in-care case worker or the resource case worker. Any foster parent may participate in the consultation service. A *resource case worker* is the child welfare agent that determines best matches for foster parents and foster children, assures the foster home is acceptable, and aids foster parents in dealing with the needs and for foster children and provides resources to the parents. A resource case worker may be present during the consultation, but it is not necessary. The *in-care case worker* is a child welfare agent that interacts and communicates with the foster child regarding the placement and progress in the foster homes. Since the in-care case worker represents the child’s best interests they are always present on behalf of the foster child.

**Evaluation of the consultation process.** To evaluate the consultations the evaluator used Speller et al. (1997) and Goodman et al. (1987) steps to quality assurance to identify the evaluation process for this study. The area identified for review is the consultation process. The standards of practice for the consultation process are the guidelines set out by the Ontario College of Psychologists regarding confidentiality and competence and the goals the clinic sets out to achieve in each consultation. This study will then measure, compare, and analyze the results to develop the next actions needed to improve the consultation service.

To measure and analyze the consultation process Berry et al. (1985) and Parasuraman et al. (1985) key evaluation areas as quality indicators of service delivery according to clients will be used. The study will also address and evaluate discrepancies three (the gap between service delivery details specified and what is actually delivered) and four (the difference between what the service is said to be to the clients and what is actually delivered) identified by Parasuraman et al. (1985) and Zeithaml et al. (1988). Finally, this study will also use aspects of consultation that health care has found to be helpful in identifying quality in medical consultation. These will be goal attainment and client empowerment. It should be noted that client empowerment is parallel to Howie et al. (2000) patient enablement defined as helping the client understand their problems and how to manage them.
Methodology

Design

The research for past and present consultations, which took place between October 2009 and August 2010, was completed using archival study and quality assurance client questionnaires. For the present consultations, which took place between September 2010 and November 2010, additional qualitative data was collected using the evaluator’s observations of the present consultations. The independent variable is the consultation process. The dependent variable was the responses received from the foster parents and case workers on the feedback questionnaires. An ethical review was not required for this quality assurance project.

Participants

Thirty people were asked to participate in this study. The head psychologist, who is also the consultant, was asked questions about the goals of the consultation. Twenty-nine consultees were asked to participate in the feedback questionnaire. Overall, 37.93% (11/29) of people approached did respond to the feedback questionnaire. Of the 29 consultees approached, 41.38% (12/29) were female case workers who participated in at least one consultation since October 2009. Of the 12 in-care and case workers that participated in at least one consultation, 25% (3/12) completed the feedback questionnaire. The remaining 58.62% (17/29) of consultees asked to participate were all foster parents who participated in at least one consultation between October 2009 and December 2010. A response rate of 41.18% occurred within the foster parents. Seven foster mothers who completed the questionnaire received consultations between October 2009 and August 2010, while the remaining two were from present consultations.

Quality assurance evaluator

All observations and interviews were conducted by the present author. She is 4th year student in the Bachelor of Applied Arts in Behavioural Psychology completing a full-time 14 week field placement at the Children’s Assessment Clinic. She has completed courses in Applied Behaviour Analysis, Behavioural Consultation, counselling, research methods for behavioural sciences, and statistics. She completed an exhaustive review of quality assurance literature over her 14 week field placement.

Setting

All consultations took place at the child’s welfare agency in a board room.

Measures

Interview. An informal interview with the head psychologist was completed to identify the goals the clinic sets out to achieve in each of the consultations.

Foster parent’s questionnaire. The foster parent’s questionnaire (Appendix A) used the clinic’s original quality assurance questionnaire devised by Parker (2009). The original scale was a 5-point scale which rated 1-poor, 2-weak, 3-adequate, 4-good, and 5-excellent. The foster parent’s questionnaire included five likert-scale questions from the original questionnaire. Four
‘yes’ or ‘no’ questions and one open-ended question were added to the questionnaire. The questions are related to Berry et al. (1985) and Parasuraman et al. (1985) service delivery areas that client’s use to rate quality. Questions 2 and 5 are also related to the notion of client empowerment. The final question will be used to identify any discrepancies between what is expected from the service and what is delivered. Table 3 presents the questions and areas of quality of service delivery they are related to.

Table 3
**Quality indicators Among the Foster Parents’ Questionnaire**

<table>
<thead>
<tr>
<th>Question</th>
<th>The Areas it Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chance to speak about your issues</td>
<td>Knowing the customer, courtesy, communication</td>
</tr>
<tr>
<td>2. Gain new perspectives into your issues</td>
<td>Communication, knowing the customer, client empowerment</td>
</tr>
<tr>
<td>3. Feeling that you were heard</td>
<td>Courtesy, knowing the customer</td>
</tr>
<tr>
<td>4. Usefulness of the enclosed consult letter</td>
<td>Communication, client empowerment</td>
</tr>
<tr>
<td>5. Sense that you can make the difference</td>
<td>Client empowerment</td>
</tr>
<tr>
<td>6. Do you feel the consultation was a worthwhile investment of your time?</td>
<td>Responsiveness, reliability</td>
</tr>
<tr>
<td>7. Did you use any of the techniques suggested?</td>
<td>Credibility, competence</td>
</tr>
<tr>
<td>8. If yes, were they helpful?</td>
<td>Credibility</td>
</tr>
<tr>
<td>9. Would you use the consultation service again?</td>
<td>Overall experience</td>
</tr>
<tr>
<td>10. Did you know what to expect in the consultations?</td>
<td>Discrepancies</td>
</tr>
</tbody>
</table>

**Case worker’s questionnaire.** The case worker’s questionnaire (Appendix B) included four open-ended questions used on the previous quality assurance questionnaire. The first question (What did you tell the client to expect from the consultation?) relates to determining any discrepancies in what the case workers expect with the consultation and what is delivered. This question also serves as a probing question for future questions related to the use of the service. Question two (Do you feel confident that a consultation is a worthwhile investment of the foster parent’s time and your time?) was added as measure of general satisfaction of the consultation process and outcome and competence of the psychologist. The remaining questions
for the case workers were concerning the process of the consultation (What worked well during the consult meeting? What went poorly during the consult meeting? What didn’t happen during the consult that should have? What did happen during the consult that didn’t need to happen?) Case workers were only asked questions about the process and outcome because the consultations are provided to help the foster parents and the workers have different knowledge. It is thought that the case workers may better understand the process from a professional and objective view.

**File review and observations.** The content of 14 letters to foster parents from past consultations was reviewed to determine the information provided in previous consultations. The present consultations were evaluated to observe the process and listen to the information provided in the consultations. Observations were made using the case workers questionnaire to write down observations about the consultation process. The consultation process was observed and evaluated by the evaluator because she was aware of the technical process and outcome of different consultation models. Only questions three through six were answered, while questions one and two were omitted from her observations. These happen prior to the consultation and were not observed. Finally, she assessed whether or not the psychologist empowered the client and reached his goals set out for the consultations (address the concerns of the foster parents using his expertise to the best of his ability; enable foster parents to carry on the good work they are already doing, with less stress, anxiety, and doubt; help develop the skills of the foster parents to better help then in caring for the foster child). This was compiled from her knowledge of consultation process, research on quality assurance in service delivery, and the comments of the foster parents and case workers. All notes were written in point form on a blank caseworker’s questionnaire sheet.

**Procedure**

**Quality assurance for past and present consultations.**

*foster parents.* The resource case manager sent an e-mail (Appendix C) to all the foster parents who had a consultation since October 2009. Foster parents who responded to the resource case manager’s e-mail were included in the questionnaire. For present consultations verbal consent was obtained from the foster parents for the evaluator to contact them regarding the consultation at the prior to beginning the consultation. If verbal consent was received the resource case worker in charge of the consultation forwarded the foster parent’s home phone numbers to the evaluator in an e-mail.

The evaluator contacted the foster parents within one week of receiving their phone numbers. All foster parents were contacted in the late afternoon or early evening. If a foster parent was home, the evaluator followed the phone script (Appendix D) for foster parents and then explained that they were to give a rating from 1 (poor) to 5 (excellent) or a ‘yes’ or ‘no’ for the questions. The evaluator then read the questions for foster parents and circled the responses. The open-ended question was asked and the evaluator wrote the response in point form. A scripted message was left to contact the clinic between 9:00 am and 4:30 pm if no one answered. If the foster parents did not call back within four business days, they were contacted again by the
observer. The previous procedure was followed. The evaluator telephoned the foster parents a maximum of three times and left a maximum of two messages.

**In-care case workers and resource case workers.** The phone numbers of each case worker who attended at least one consultation between October 2009 and August 2010 were forwarded in an e-mail to the evaluator. For present consultations, verbal consent was received at the beginning of the consultation to contact the case worker. If consent was received, the resource case manager forwarded the work phone extensions to the evaluator in an e-mail.

The evaluator contacted the case workers within two weeks of receiving the case workers work phone numbers. The evaluator followed a phone script to interview the case workers. The phone script explained the feedback questionnaire, what the feedback would be used for, and a reminder that the responses will be shared but no identifying information will be given. In-care case workers and resource case workers that did attend the consultations were asked six open-ended questions. If the worker attended more than one consultation, they were asked to give an overview of their thoughts, and if a consultation was found particularly good or particularly bad to explain in as much detail as possible. The evaluator copied each response down in point form. If no one answered the telephone, a scripted message was left. If the case worker did not call back within two business days, he or she was contacted again. The previous procedure was followed. The evaluator telephoned each case worker a maximum of three times and left a maximum of two messages.

**Evaluator.** The evaluator sat in on the consultations that took place while on placement at the Children’s Assessment Clinic. The evaluator attended the consultation as an observer and filled out questions three through six on blank caseworker’s questionnaire form from observations. Point form notes were also made related to the quality service delivery indicators (Berry, Zeithaml, and Parasuraman, 1985; Parasuraman, Zeithaml, and Berry, 1985) and the goals of the consultation through observations about the process and the content of the consultation. No inter-observer reliability data was obtained.
Results

Data Analysis

Qualitative data for all consultations between September 2009 and November 2010 was gathered using the answers to the open-ended questions from the case worker’s and the comments from the foster parents. Quantitative data for all consultations was collected using the ratings on the likert scale questions. The mean, range, and standard deviation, was calculated for the likert-scale questions.

The Children’s Assessment Clinic Goals

The clinic’s goals are set by the head psychologist. The goals he sets to achieve in consultation are: 1) address the concerns of the foster parents using his expertise to the best of his ability; 2) enable foster parents to carry on the good work they are already doing, with less stress, anxiety, and doubt; 3) help develop the skills of the foster parents to better help them in caring for the foster child. These goals are related to an overall goal of client empowerment. Therefore, if the psychologist reaches his goals in the consultation, it is expected that client empowerment will also be achieved.

Consultation Model Used by the Clinic

Through file reviews and observation it was determined that the clinic follows a consultee-centered case consultation according to Caplan’s mental health consultation models. As illustrated in Table 4, the clinic clearly falls into a consultee-centered case consultation model.

Foster Parents’ Evaluations of the Consultation

The mean, range, and standard deviation for questions 1 through 5 are displayed in Table 5. Responses from both the past and present the foster parents were combined into a single table for data analysis due to the small sample size and each foster parent used the same questionnaire. All foster parents felt the consultation was a worthwhile investment of time. 62.5% (5/8) of the participants tried the suggestions received in the consultation. Of those that tried the suggestions, 80% (4/5) of the foster parents said the suggestion worked. Foster parent 4 and foster parent 6 rated the “sense that they could make a difference” as a 1- weak. Foster parent 4 also rated “gain new perspective into your issues” and “usefulness of the enclosed consult letter” as a 2-poor. All foster parents said they would use the service again; however, two of the foster parents would prefer less people in the room, while one foster parent would use the service for a different issue, not the original issue brought to attention. All foster parents felt that the consultation process was what they expected. See Appendix E for each foster parent’s answers.

Case Workers’ Evaluations of the Consultations

All case workers were confident that the consultation was a worthwhile investment of everyone’s time. All case workers felt that the psychologist’s input and advice worked well
Table 4

Features of Caplan’s Mental Health Model as Applied to the Child Assessment Clinic’s Consultation Service

<table>
<thead>
<tr>
<th>Feature</th>
<th>Client-Centered Case Consultation</th>
<th>Consultee-Centered Case Consultation</th>
<th>Program-Centered Administrative Consultation</th>
<th>Consultee-Centered Administrative Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who does the consultant directly help?</td>
<td>The client</td>
<td>Another professional</td>
<td>Administration program or improve an existing program</td>
<td>Management of a service delivery administration</td>
</tr>
<tr>
<td>Whose behaviour is targeted to directly change?</td>
<td>The client</td>
<td>The consultee</td>
<td>The group of people who deliver the services directly</td>
<td>Management of program deliverers</td>
</tr>
<tr>
<td>How does the consultant help the client?</td>
<td>Directly</td>
<td>Indirectly</td>
<td>Directly</td>
<td>Indirectly</td>
</tr>
<tr>
<td>How is a plan or hypothesis developed?</td>
<td>Through direct assessment of the client</td>
<td>Through what the consultee says about problems</td>
<td>Through direct assessment of the group and program</td>
<td>Through assessing management’s shortcomings</td>
</tr>
<tr>
<td>The process the consultant follows</td>
<td>Collect and analyze data to develop a plan for the client using the specific skill set he possesses</td>
<td>Teach the consultee about how to analyze and problem solve using his objectivity, knowledge, and skill set</td>
<td>Collect and analyze data using knowledge about program administration, social systems, and mental health theory and process</td>
<td>Address the problems in management and teach management to work through problems</td>
</tr>
<tr>
<td>What does the consultant address?</td>
<td>How the client can be helped concerning the presented problem</td>
<td>Help consultee develop objectivity, increase knowledge and skill set, and develop self-confidence</td>
<td>Areas of the program that are causing problems</td>
<td>Lack of leadership and authority, communication problems, role confusion</td>
</tr>
</tbody>
</table>

*bolded items are features that the clinic applies in consultation*
Table 5

<table>
<thead>
<tr>
<th>Question</th>
<th>M</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chance to speak about your issue</td>
<td>4.6</td>
<td>3-5</td>
<td>.74</td>
</tr>
<tr>
<td>2. Gain new perspective into your issues</td>
<td>3.9</td>
<td>2-5</td>
<td>1.13</td>
</tr>
<tr>
<td>3. Feeling that you were heard</td>
<td>4.8</td>
<td>4-5</td>
<td>.46</td>
</tr>
<tr>
<td>4. Usefulness of enclosed consult letter</td>
<td>4.4</td>
<td>2-5</td>
<td>1.06</td>
</tr>
<tr>
<td>5. Sense that you can make a difference</td>
<td>3.6</td>
<td>1-5</td>
<td>1.77</td>
</tr>
</tbody>
</table>

_M= mean, SD= standard deviation. Rating scale: rating scale 1- poor, 2- weak, 3- adequate, 4-good 5- excellent_

during the consultation. Comments made were that the psychologist “makes sense of the problem”, “does not put himself above the foster parents”, “uses good language”, “uses a strength based approach”, and “gives the foster parents a voice”. One case worker thought there was nothing poor about the consultation. One case worker felt that the foster parents were “all over the place” but the letter was really helpful to organize the information the consultation. The last case worker did not agree with one of the answers the psychologist gave as she felt it did not match the agency’s philosophy. All case workers felt that everything that needed to happen did and everything that did happen was necessary. See Appendix F for each case worker’s responses.

Evaluator’s Observations of the Consultations

The contract between the Children’s Assessment Clinic and the Child Welfare agency was unavailable during this process. Therefore, the evaluator was unable to determine if there were any discrepancies between the contract and what was being delivered.

The psychologist has been a registered member of the College of Psychologists of Ontario for 26 years in children, adolescence, adult, and family psychology. He has been participating in these consultations for two years. He follows regulations set by the College of Psychologists of Ontario regarding confidentiality. The psychologist took the time to thoroughly review the cases sent by the Child Welfare Agency and develop hypotheses. He was also very interested in the foster parents’ explanation of the problem and previous courses of action that had been taken. The psychologist used lay language and was able to explain a concept in many different ways. He showed respect for the foster parents’ by introducing himself, letting them speak, and interacting with them rather than speaking at them.

In the three consultations that were observed by the evaluator, the psychologist appeared to reach each goal he sets out to achieve in each consultation. The psychologist asked the foster
parent for his or her view of the problem to begin all consultations and would then summarize and give his understanding of what was explained. He would then share his hypotheses concerning the child’s behaviour using explanations such as, learned or modelled behaviour. This addressed the concerns of the foster parents using his expertise to the best of his ability. If the foster parents agreed with the hypotheses, the psychologist would then teach and develop the skills of the foster parents (second goal of the consultation). Finally, based on comments made by foster parents during and after the consultation and accepting and approving body language from the foster parents, it appeared that the psychologists enabled the foster parents to carry on the good work they are already doing, with less stress, anxiety, and doubt (third goal of the consultation). The third goal was also evident in the language the psychologist used. He used sayings such as, “the apple did not land far from the tree” referring to the fact that the foster child’s behaviour is similar to the biological father’s behaviour. In consultations where the foster parents had raised biological children, the psychologist would point out that those children have grown up into healthy adults. When these comments were made the foster parent would nod her head or the foster parent’s body would become relaxed rather than rigid. All the information given and received was pertinent to understanding and helping the consultee. There did not appear to be any missed steps or miscommunication inside the consultations.

One comment that stood out from the rest is when foster parent 6 mentioned she had to wait almost two months for the consult as the previous month’s consultations were cancelled. This may suggest dissatisfaction with the responsiveness of the agencies because the issue was not addressed in a timely manner. This may also suggest a reason as to why she rated “sense that you can make a difference after the consult” as a 1-weak. The consultations also tended to begin slightly late as gathering all the individuals for the meeting was a challenge.
Discussion

The goal of this study was to provide a community Child Assessment Clinic with knowledge about the quality of practice it provides on a consultation contract. Questions that were asked are: 1) What model of consultation does the clinic follow? 2) What is the clinic supposed to deliver according to the contract? 3) Does the clinic achieve the goals it has set out to achieve in each session? 4) Is the child welfare agency satisfied with the service delivery the clinic provides? 5) Are the foster parents who use the clinic’s services satisfied with the service the clinic delivers? Through observation of the present consultations and quality assurance questionnaires from past and current consultation service users, the clinic was provided with information about the strengths and weaknesses of the consultation service offered.

From this evaluation, the consultation service provided by the Children’s Assessment Clinic follows a consultee-centered case consultation model according to Caplan’s (1970) mental health consultation models. The service adheres to all the indicators and outcomes of a consultee-centered consultation. A prominent and important feature of a consultee-centered case consultation is the goal of client empowerment. This allows the consultee to understand the problem and develop a skill set to decrease the problem. An overall goal of client empowerment overarches each goal set by the psychologist to achieve in the consultations. Therefore, if the psychologist reaches his goals in the consultation, it is expected that client empowerment will also be achieved. From the evaluator’s observations, it appears that the psychologist has clear goals set to achieve in each consultation and he does adhere to completing these goals in each consultation. The only items that had a large variability in ratings were questions 2 and 5. Question 2 (gained new perspective into your issue) and question 5 (sense that you can make a difference), which are related to client empowerment, both received rating of 1-poor and/or 2-weak, while the highest was a 5-excellent. Upon further follow-up, one of the foster parents who rated question 5 poorly seemed to feel hopeless about the foster child’s situation. The other foster parent did not agree with any information given in the consultation, but did indicate she would use the service for a different issue. Both the foster parents who rated question 5 as 1-poor did not try any suggestions made by the psychologist. These evaluations may suggest that there are problems that require a more in-depth evaluation of the problem.

The Children’s Assessment Clinic follows most indicators of quality in service delivery and client empowerment seems to be achieved in almost all consultations as reported by the foster parents. Although some foster parents did not agree with the psychologist’s point of view, all foster parents reported that the consultation was a good investment of time. The case workers were also all confident in suggesting the consultation as a tool for foster parents. There do not seem to be discrepancies between what the foster parents and case workers expect the service to provide and what is provided in the consultations. However, the contract was unavailable for review so it is unclear if the Children’s Assessment Clinic delivers a service up to the standards of the contract.

From the results, a major question that arises is, “Why is the consultation service offered by the Children’s Assessment Clinic not used to its fullest potential?” Only three consultations were observed over a period of three months. However, over three months there was a possibility for up to nine consultations. This question can be answered with a few possible explanations.
The case manager who handles the communication between the clinic and the agency is not providing enough promotion to the case workers. The case workers may not be providing accurate or any information to the foster parents or foster parents are uncertain of the consultation method. The case workers understand what the consultation process is meant for and correctly relay this to the foster parents. Highlighting the multiple aspects of what a consultation can provide, rather than simply stating the consultation will provide support and behavioural solutions, may increase the number of foster parents who use the service.

**Multilevel Challenges**

**Client level.** One of the most obvious challenges at the client level is determining how to increase the small percentage of usage of the consultation service. Both foster parents and case workers are, more often than not, quite busy. It may be difficult for foster parents to get an afternoon off work, find a babysitter, or a multitude of many other things. Because both clients are usually quite busy, it also made it difficult to contact both the foster parents and case workers by phone.

**Program level.** The consultation service had not been evaluated since its beginning, which was nearly two years ago. Although a questionnaire was mailed to foster parents with the consultation letter to evaluate the service, very few had actually been filled out and returned. Because very little constructive feedback was offered, the consultation had no way to maintain a quality assurance cycle. The evaluator had time to call the case workers and foster parents to complete this study, but future ways to obtain feedback may need to be altered.

**Agency level.** Receiving evaluation of the quality of consultations from case workers’ point of view was difficult. Although this would be ideal, the Children’s Assessment Clinic is a small teaching clinic that is burdened by a long waiting list. As well, because it is a teaching clinic students are often passing through the clinic at high rates which may make it difficult for one of them to take on a quality assurance task.

**Society level.** As mental health agencies become more and more burdened due to increase in patients and a lack of funding and awareness, a consultation service may become more pertinent for the delivery of good service. Unfortunately, managers and directors may not understand multiple and diverse benefits of a consultation service in mental health services field until more studies demonstrate proper consultation processes and its practicality. When use of a proper consultation service is understood and supported by higher level management, more clients may be able to benefit from choosing a consultation service.

**Strengths**

The results from this study may help hesitant foster parents to recognize that the consultation process is useful. As Nixon (1997) noted, advice and support from other foster parents has a significant impact on foster parent attrition rates. If foster parents are aware that a useful and specialized resource is available, other foster parents have found it helpful, and a quick and simple consultation may help with certain problems, foster parents may be more inclined to use the service.
A goal of developing an empirical study was accomplished in this research. The present consultation process and evaluation methods can be replicated by other studies. Most of the current literature on the evaluation of consultations has neglected to describe the details of the process of the consultation service provided, nor has it gone into details pertaining to the model of consultation used, goals, and evaluation tools, among other things. Furthermore, the current research has developed an evaluation of quality assurance based on literature from the business model to provide the reader with the areas and methods of evaluation. This includes areas such as what aspects of the consultation are being evaluated and specifically what questions were asked to clients and the rating system he or she used to rate the service. Consultation services have been found to be accepted and useful by clients; however the evaluation method has not been described nor has it been shown to be based on quality assurance literature. By having data that shows the consultation service is used and accepted may be used to encourage a consultation service at other agencies.

Limitations

The number of consultations reviewed was very small, especially consultations that were directly observed. The response rate of all the participants, especially case workers, was small. Less than 50% of the people approached to participate in this study responded. As well, the evaluations of the consultations from the past year are retrospective. The evaluations are relying on recall memory, which may become influenced by other factors (e.g., comments of others) over time.

Future Recommendations

Although this study united both mental health and a business quality assurance model, much more research and refinement is needed. It is suggested, to get better data, case workers questionnaires be turned into likert scales as the open-ended questions did not provide sufficient detail. A ‘yes’ or ‘no’ answer was most often given by the case workers to the open-ended questions. This did not provide any information for ways to improve or definite aspects of the consultations to keep. If more specific questions are asked of the case workers, the information provided may be more useful. To obtain more specific details from the consultations observed, it is suggested that the evaluator use a formally operationalized rating system rather than point form notes. This will guarantee that all areas needed for evaluation will be noted and covered in greater detail in the present moment. This will also create more consistency within the evaluations. As well, it is suggested that the contract be revisited. This may identify any discrepancies in what the service is set out to be in the contract and what is delivered (Zeithaml et al., 1988). Since the beginning of the consultation process new ideas or changes to the contract may have risen. New negotiations may be beneficial and further evaluation may improve the consultation service. Further study about the consultation process and developing an evidence based quality assurance rating system for mental health consultations would greatly benefit the practice.

Areas for Further Study

Previous researchers (e.g., Maddux, 1955; Phillips, 1997; Prince & Austin, 2005) mentioned the difficulty with communication between agencies. The communication between
the Children’s Assessment Clinic and the Child Welfare Agency may be a beneficial area to examine. This aspect was not thoroughly looked at, but it may provide further knowledge as to how to improve the quality and usage of the whole consultation. If both the clinic and the agency are involved in the quality assurance evaluation, the service as a whole could benefit.

**Benefit to the Behavioural Psychology Field**

This study will benefit the Behavioural Psychology field because consultations are becoming more and more prominent in the behavioural field in settings, such as schools. It provides further support for the use of an interagency consultation model to be used when professionals have questions they cannot answer. This study has taken the first steps in developing a scientific method for a somewhat previously unstructured process that can be of great benefit.

Finally, the Behavioural Psychology Field is centered around improving the quality of living for our clients. Through developing and implementing a quality assurance model for mental health professionals to use in their practice, we can improve the quality of treatment and outcome for our clients.
References


APPENDIX A

Foster Parent Questionnaire

Using a scale of 1 to 5 (1- poor, 2-weak, 3-adequate, 4-good, 5-excellent) please rate the following aspects of the service you received.

1. Chance to speak about your issue 1 2 3 4 5
2. Gain new perspective into your issues 1 2 3 4 5
3. Feeling that you were heard 1 2 3 4 5
4. Usefulness of enclosed consult letter 1 2 3 4 5
5. Sense that you can make a difference 1 2 3 4 5
6. Do you feel the consultation was a worthwhile investment of your time? YES NO
7. Did you use any of the techniques suggested? YES NO
8. If yes, were they helpful? YES NO
9. Would you use the consultation service again? YES NO

10. Did you find you knew what to expect in the consultations or would an information sheet or brochure about the consultations be useful? What would you want to see on them?
APPENDIX B

Case Worker Questionnaire

Please fill in the questions below with your comments on the service provided.

1. What did you tell the client to expect from the consultation?

2. Do you feel confident that a consultation is a worthwhile investment of the foster parent’s time and your time?

3. What worked well during the consult meeting?

4. What went poorly during the consult meeting?

5. What didn’t happen during the consult that should have?

6. What did happen during the consult that didn’t need to happen?
APPENDIX C

E-mail Memo to Foster Parents

MEMO: PHONE INTERVIEW POST CONSULTATION

Hi,

I am contacting you as sometime over the past year, you have had a consultation session with Dr. [redacted] in regards to one of the adolescent foster youth in your home.

Dr. [redacted] currently has a student, Lauren, conducting a quality assurance project for these consultation services. I would like to give her your phone number for a follow-up phone interview with you in order to find out what you thought about the process. The phone interview will take approximately 15 minutes. The results will be shared with Dr. [redacted] and [redacted], but no identifying information will be given. Your help is much appreciated and will aid in the improvement of the consultations.

Please let me know if you would be willing to take part and if so, what number you would like Lauren to use to call you.

Thanks…
APPENDIX D

Phone Script

Case Workers

message left.

Hi this is Lauren from the [Queen’s Psychology Clinic]. I was calling to see if you could answer a few questions regarding your consultation with Dr. [redacted] that took place in the past year. If you could call the clinic between 9 and 4:30 at your earliest convenience, the number is 613-533-6021. Thank you, have a good day.

administer questionnaire.

Hi (insert name) this is Lauren from the [Queen’s Psychology Clinic]. Do you have a couple minutes to answer some questions about the consultations you have had with Dr. [redacted]? It will take about 5 minutes. Your answers will be shared with [redacted] and Dr. [redacted] but no identifying information will be given.

Foster Parents

message left.

Hi, this is Lauren from the [Queen’s Psychology Clinic]. I was calling to see if you could answer a few questions regarding the consultation you had with Dr. [redacted] in the past year. If you could call the clinic between 9 and 4:30 at your earliest convenience, the number is 613-533-6021. You can also reach me in the evenings at 613-453-4754. Thank you, have a good day.

administer questionnaire.

Hi (insert name) this is Lauren from the [Queen’s Psychology Clinic]. Sandy had contacted you about answering a couple questions about the consultation you had with Dr. [redacted]. Do you have about 5 minutes now? Just a reminder that the answers will be shared with [redacted] and Dr. Parker but you will not be identified. The questions are a rating scale from 1 to 5. 1- poor, 2- weak, 3- adequate, 4-good 5-excellent.
# APPENDIX E

## Foster Parents’ Answers to Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Foster Parent 1</th>
<th>Foster Parent 2</th>
<th>Foster Parent 3</th>
<th>Foster Parent 4</th>
<th>Foster Parent 5</th>
<th>Foster Parent 6</th>
<th>Foster Parent 7</th>
<th>Foster Parent 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chance to speak about your issues</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2. Gain new perspectives into your issues</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>3. Feeling that you were heard</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4. Usefulness of the enclosed consult letter</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>5. Sense that you can make the difference</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>6. Do you feel the consultation was a worthwhile investment of your time?</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>7. Did you use any of the techniques suggested?</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>8. If yes, were they helpful?</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
<td>yes</td>
<td>n/a</td>
<td>yes</td>
<td>n/a</td>
</tr>
<tr>
<td>9. Would you use the consultation service again?</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>10. Did you know what to expect in the consultations?</td>
<td>yes</td>
<td>Sort of, but better define the role of the foster parent</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

*rating scale 1- poor, 2- weak, 3-adequate, 4-good 5-excellent.*

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<table>
<thead>
<tr>
<th>Question</th>
<th>Worker 1</th>
<th>Worker 2</th>
<th>Worker 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What did you tell the client to expect from the consultation?</td>
<td>Support for foster parents, suggestions for behaviour, and insight into child’s behaviour</td>
<td>Gives behavioural strategies</td>
<td>Consultation is optional for foster parents to get support to develop strategies with specific issues</td>
</tr>
<tr>
<td>2. Do you feel confident that a consultation is a worthwhile investment of the foster parent’s time and your time?</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>3. What worked well during the consult meeting?</td>
<td>Everything</td>
<td>Everything</td>
<td>Everything. Can tell that the psychologist really listened</td>
</tr>
<tr>
<td>4. What went poorly during the consult meeting?</td>
<td>Nothing</td>
<td>Psychologists response about the child leaving if he breaks the rules again</td>
<td>Foster parents were all over the place, there was no structure but the letters are really helpful and provide a nice summary</td>
</tr>
<tr>
<td>5. What didn’t happen during the consult that should have?</td>
<td>Nothing</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
<tr>
<td>6. What did happen during the consult that didn’t need to happen?</td>
<td>Nothing, on track</td>
<td>Nothing</td>
<td>Nothing</td>
</tr>
</tbody>
</table>