What is mental health consultation?

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This paper provides an overview of the state of the art in consultation at the close of the third decade of its existence as a major form of delivering mental health services in the United States of America, and its somewhat later introduction in Victoria, Australia. Gallessich's framework for consultation (1983, 1985), amongst others, is compared with the Victorian model. Issues raised include the need for consultants to understand the boundaries of consultation, its limitations, the state of its knowledge base and the uniquely Victorian contribution of a framework of several levels which enables an integration of the knowledge borrowed from a range of sources to assist in the improvement of its practice. A later paper to be published in 'Children Australia' looks at the steps in the consultation process.

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> What is all the fuss about? We all know what consultation is. It is whatever we do when we want a prestigious designation for professional activities different from the more routine diagnostic and intervention services performed as part of our daily work (Bardon 1985, p.355).

Do we *really* know what consultation is? Do we know what we mean when *we* use the term and does our understanding concur with what others mean when they use it? Over the last thirty years much of what has been written on the topic has been confusing and contradictory. This paper attempts to summarise the more important ideas and describe several models in current mental health practice. In particular, the paper describes the framework commonly used in Victoria in this field and shows how concepts developed further afield can fit comfortably into what may be called the Victorian model of mental health consultation.

THE KNOWLEDGE BASE OF CONSULTATION

To consult competently requires two kinds of knowledge: expertise in a content knowledge area, and expertise in the capacity to share that content knowledge with others. Content knowledge expertise varies widely and includes such diverse topics as the care and treatment for people with chronic schizophrenia, family therapy skills, child sexual abuse and the needs of autistic children. Prospective consultees seek help from a particular consultant because of their reputation, and although essential, such expertise alone is insufficient. In common with other vehicles for sharing knowledge such as teaching and supervision, consultation has a 'how to do it' component which needs to be mastered to provide an effective service. This paper expands on some aspects of this 'how to' knowledge base.

DEFINITIONS AND DIMENSIONS

The term *consult* is used across professions which subscribe to a common understanding captured by the Shorter Oxford English Dictionary's definition: 'to ask advice of; to have recourse to for instruction or professional advice'. The implication is that the process is voluntary and initiated by the person seeking assistance. Applying these ideas to the mental health field, Gallessich (1983) describes consultation as a tripartite interaction in which

> the consultant (a specialised professional) assists consultees (agency employees who are also professionals) with work related concerns (the third component) (p.6).

Problems presented may involve concerns about an individual client or groups of clients. They may focus on the consultee's needs for increased knowledge and/or skill, or extend to issues of organisational structures, processes, programs and policies (ibid).

Steinberg (1989) makes similar points but focuses on strengths rather than deficits. He says:

> Consultation is joint exploration partly of the question at hand, partly exploring the alternatives for managing it, and partly exploring what there is in oneself, in the consultative relationship and in the work setting that helps the work advance (p.122).

Although not specifically stated in these definitions nor in others (Caplan & Caplan, 1993; Wynne, McDaniel &

Weber, 1986), certain assumptions underlie the concept. These include a belief that:

- consultees have the capacity to solve most work problems and the aim of consultation is to extend this capacity further by *providing emotional or cognitive support* ... rather than seeking to take over case management (Gallessich 1983, p.152). Steinberg (1989), who sees the consultant as an enabler and a facilitator, says:
  'Consultation is the sort of talk undertaken when one person (the consultant) helps another (the consultee) to work effectively, but without taking the work over in any way' (p.1).
- effective consultation occurs within the context of a trusting relationship between two parties whose skills are different but equal;
- consultees are free to accept or reject the consultant's suggestions and can terminate the contact when they see fit;
- consultees have the capacity to generalise the input gained in discussion about one problem to others of a similar nature. The consultant can provide assistance congruent with the consultee's practice. The consultant also needs to understand the impact of the consultees' work environment on them and their clients. In order to facilitate this, sessions are held at the consultee's workplace;
- the consultees' perceptions, understanding, skills and methods rather than those of the consultant, are primarily used to deal with the matters at hand;
- discussions with an outsider enables consultees to widen their perspective and reframe ideas and attitudes.

More controversial is the view that the greatest learning occurs at times of high stress when entrenched ways of coping are discarded as no longer effective (Caplan, 1964). Steinberg (1989), for example, suggests that subscribing to the crisis model of learning downplays the versatility of consultation. He proposes a spectrum of learning ranging from crisis intervention (in a specific case) through problem solving (indicating something amiss in the structure/functioning of the agency) to unstructured teaching which increases new learning exponentially.

WHY CONSULT?

Although mental health resources have significantly increased in recent years, they will never be sufficient to provide quality one-to-one mental health services to all those seeking help. On the other hand, in the child and adolescent field at least, not all those who are emotionally disturbed actually need to be seen in a specialised service. Many quite serious problems can be handled by non-mental health personnel when provided with adequate support.

The policy of establishing satellite clinics will make access to Child and Adolescent Mental Health Services (CAMHS) easier, but the fear and stigma associated with mental health services means that clients prefer to obtain help from universal services (schools, neighbourhood houses, community health centres, general counselling agencies, etc). This is particularly true with families from non-English speaking backgrounds (Luntz, 1998; Stolk, 1996; Trauer, 1994). Consultation, especially secondary consultation, enables mental health services to be delivered in culturally congruent ways.

Mental health services generally, and CAMHS in particular, are much more expensive to fund than locally based or generalist facilities. Providing consultation to locally based services as a way of reducing costs has not been evaluated, but common sense would indicate that, when working effectively, it *must* be cheaper than referring all clients to CAMHS for direct work. This said, consultation is not a panacea. It is a useful tool when used in conjunction with other tools as part of a service delivery package (Mannino & Shore, 1985).

While effective consultation may make service delivery cheaper to the taxpayer overall, it increases the cost in the consultees' own agency, especially in the short term. This is so for two reasons. First, consultees take more time thinking about and working on a case about which they wish to consult. They then continue working with the client for whom the help was sought instead of referring on and ceasing contact. Less tangible benefits, eg, increased consultee confidence and client preference for locally based services, are more difficult to measure, but consultees frequently express satisfaction about the consultation received.

DISTINGUISHING CONSULTATION FROM RELATED PROCESSES

By the time mental health workers' skills are sufficiently well-honed to assume the role of consultant, they have usually worked as therapists, case managers, supervisors and educators. Some of the skills used in these other processes can enhance consultative practice. Others require modification to be useful, and still others are actually unhelpful. In order to sort out what is useful from what is not, it is necessary to be clear about the differences between consultation and related processes.

DISTINGUISHING CONSULTATION FROM SUPERVISION

Consultation and supervision are frequently confused because in both cases, one person receives help from another who is competent to give it. Differences include an *unequal* supervisory relationship. It occurs between a person more skilled and experienced and one who is less so. Supervisors are responsible for those whom they supervise in three ways – administratively, educationally and supportively (Kadushin, 1977). Administrative responsibility includes the authority to insist on compliance. Supervisors are able to direct and evaluate work done and to raise matters they perceive need attention (Gallessich, 1983). Those supervised have little choice in the allocation of their supervisor. The goal of supervision is to enhance the confidence and competence of those supervised, and is provided until the supervisor considers that it is no longer required. Mostly, but not always, supervision is an *intra-disciplinary* activity.

Mental health consultation, on the other hand, ideally occurs between people whose expertise is different but *equal.* Consultants provide support and education but consultees are not accountable to them for the work done. Consultees are free to ask or not to ask for assistance. Once given, they may accept or reject it as they see fit.

High quality consultation mostly occurs within the context of an ongoing relationship, but it is different from supervision because consultees take responsibility for setting the agenda and raise matters with which they want help. The problems presented at each session may well be different, and there is rarely the continuity in content characteristic of supervision.

DISTINGUISHING CONSULTATION FROM THERAPY

Once again the processes are sufficiently similar for confusion to occur. In both consultation and therapy one person has a problem for which they seek help from someone who is trusted. The main differences lie in the goals and material discussed. Therapy deals with *personal problems* which may or may not be job related. Consultation focuses only on *job related problems.* Even when consultees are under stress, consultants are concerned with problem identification and resolution and they focus on strengthening coping skills (Gallessich, 1983). Therapists help clients become better people, consultants assist consultees to become better workers.

DISTINGUISHING CONSULTATION FROM IN-SERVICE TRAINING OR STAFF DEVELOPMENT

The trainer makes decisions about the content and presentation of in-service training sessions, although participants' preferences are sometimes sought. Training occurring at the more formal end of the spectrum requires participants to produce evidence of learning which is evaluated.

In consultation, consultees determine the topic and the ways in which the consultant is used. Consultants are not involved in evaluating consultees' work.

> ... teaching is content-oriented; consultation uses the content as a vehicle for a process orientation (McDaniel et al, 1986, p.20).

In in-service training the relationship between trainer and trained is less hierarchical than in formal education, but there remains a distinction. A fundamental strength of consultation is that it is a relationship between peers.

MODELS OF CONSULTATION

Several models of mental health consultation are described in the literature (Caplan 1964, 1970; Caplan & Caplan 1993; Gallessich 1983, 1985; Heller & Monahan, 1977). Gallessich (1985) attempts to create a meta-theory by integrating the following models into an overall framework: clinical consultation; consultee-centred consultation; behavioural consultation; organisational consultation; and program consultation.

GALLESSICH'S FRAMEWORK

Clinical consultation

Clinical consultation comes from medicine where a GP (the consultee) seeks a diagnosis and treatment plan from a specialist physician (the consultant). This prototype has been adopted by the wider psychiatric field, by education and other human service areas. Like the form from which it is derived, it is triadic in that the consultant is asked to assess the consultee's patient/client in order to make recommendations concerning how best to proceed. In the education and human service fields the term *client* is sometimes extended from an individual to a work unit, a team, an organisation, etc. The relationship is hierarchical with the consultant viewed as the expert who provides advice. Its weakness is that it has established principles and practice but no theory (Gallessich, 1985).

Consultee-centred consultation

The main goal is to increase the primary worker's ability to ameliorate or prevent mental illness. In contrast to clinical consultation it has an elaborate theoretical framework, where the consultant is conceptualised as a peer within an egalitarian relationship. The client is the focus *but the problem is formulated in terms of the consultee's deficits in understanding, remedying, or preventing client problems* (Gallessich, 1985, p.338). Such deficits may include lack of knowledge, skill, self-confidence or objectivity (Caplan, 1964, 1970; Caplan & Caplan, 1993). The consultant assists the consultee to overcome cognitive or affective barriers to effective problem solving by providing *information, perceptions, concepts, principles, skills, suggestions or emotional support... Roles include educator and facilitator* (Gallessich 1985, pp.338-339). The most sophisticated descriptions of this approach can be found in Caplan, (1970), and Caplan and Caplan (1993).

Behavioural consultation

Behavioural consultation is useful in settings where a high degree of uniformity is required, eg, schools and prisons. It is based on learning theory and techniques. The problem is conceptualised as the client's dysfunctional behaviour which the consultee seeks to modify by reinforcing that which is desirable and ignoring what is unacceptable. Behavioural consultation has no *central theory of consultation,* the focus being on the client's behaviour and the client-consultee relationship. Because there is no information about appropriate *consultant behaviour* the relationship tends to a supervisory style with the consultant directing the consultee as to what to do (Gallessich, 1985).

Organisational consultation

Organisational consultants are interested in personnel assessment, leadership style, motivation, group dynamics and quality of life at work. There is a lively concern about the importance of worker morale on the level of productivity. The knowledge base is drawn from social-psychological, cognitive-behavioural, ecological, psychodynamic and systems theory. It also includes statistical models and methods (Gallessich, 1985).

Strategies include collection and feedback of survey data, personnel assessment, human relations training and conflict resolution. Consultant roles span action-researcher, teacher, trainer, diagnostician, participant-observer, coach and facilitator. Like behavioural

consultation there is no coherent integrated theory, although some effort has been made to conceptualise the consultant's role and relationship to the consultee and to evolve principles and techniques (Gallessich, 1985).

Program consultation

The consultant assists the agency to design, implement and evaluate new or existing programs. This may involve reviewing the functioning of the entire agency or just one section of it. A program is defined as a *systematic and coordinated activity designed to benefit a particular target group in a particular way* (Gallessich 1983, p.224). Mental health consultants are sometimes invited to contribute to the overall development or evaluation of a particular program. For example, a CAMHS worker may provide a child mental health perspective to the development of accommodation units for mentally ill mothers with dependent children. Less common would be involvement as regards the whole program. Although program consultation is currently experiencing a boom with the health/welfare dollar under scrutiny, this type of consultation appears to be the least well conceptualised of all (Gallessich, 1983).

THE VICTORIAN MODEL

Although the Victorian model did not arise in response to Gallessich's challenge to develop a meta-theory, it has some of the required characteristics. For example, it enables the flexible borrowing of concepts and practices from any of Gallessich's models as well as from other knowledge areas. The model was used widely in mental health circles in Victoria in the past. It fell into disrepute during the mid 1980s but has recently been revived and is now enshrined in policy documents (see *Victoria's Mental Health Services: The Framework for Service Delivery, 1993;* and *Victoria's Mental Health Service, The Framework for Service Delivery: Child and Adolescent Mental Health Services 1996)* amongst others. Its greatest weakness is that, aside from some unpublished papers (see, for instance, Luntz, 1987,1991), little has been written about it. In consequence, understanding of terminology and methods of practice vary widely across facilities, making evaluation and monitoring difficult. This may well have been a factor in it losing favour as a method of service delivery for nearly a decade, a time during which skills were lost and are now needing to be relearned.

The Victorian model is usually described as occurring at one of three levels – primary, secondary or tertiary consultation.

Primary consultation

In primary consultation the consultant is briefed by consultees on what is known about their client's circumstances prior to that consultant meeting those clients/patients. Management decisions are based on a combination of the information provided by the consultees as well as the consultant's assessment. The following alternatives are possible:

1. The problem is of such mental health complexity or severity that management should be transferred from the consultees's agency to the consultant's agency. In such instances referral processes are set in motion.
2. It is appropriate for case responsibility to remain with the consultee agency provided consultees have access to guidance and support from the consultant.
3. The problem lies beyond this consultant's expertise and the client needs referral elsewhere.

Superficially, primary consultation appears similar to Gallessich's clinical consultation. There is, however, a difference in intent. Clinical consultation provides a service to the consultee's client. Primary consultations on the other hand have several aims, the main one being to assist the consultee to learn how to prepare for and conduct assessments which take account of the mental health dimensions of their client's functioning. A second aim is to use a discussion of this client's problems to enhance and extend the consultee's practice overall. The consultant's modelling of how to make an assessment helps increase the consultee's understanding of the client's bio/psycho/social functioning.

Ideally, primary consultations occur more frequently in the early stages of the consultative relationship. Later on they are rarely conducted unless the client's difficulties have been found through a secondary consultation to need a mini-assessment.

Secondary consultation

In secondary consultation the consultant does not actually see the client/patient. The consultee collects the information, makes an assessment and presents the material in a case conference format. Consultant and consultee(s) discuss the problem and consider management strategies which consultee(s) are free to implement as they see fit.

Secondary consultation draws heavily on the principles and practice of consultee-centred case consultation (Caplan & Caplan, 1993). The major difference is that consultee-centred case consultation is derived from and dependent on a psychodynamic approach (Caplan & Caplan, 1993) whereas secondary consultation is not tied to a particular theoretical perspective.

Given that the goal of mental health consultation is to enable consultees to extend their work skills, the more active the role taken by the consultees the more successful the outcome. In the most successful examples, consultees have a great commitment to learn about the mental health aspects of their client's dilemmas and difficulties, and the consultant has wide-ranging skills, knowledge, patience and the desire to share the benefits of their experience with the consultees.

Tertiary consultation

At this level the focus is less on client/consultee interactions *per se* and more on agency structure and functioning and the unintended, but often negative consequences which impinge on client/consultee relationships. Such consultations may include administrative and planning staff as well as those in direct contact with clients.

Gallessich's organisational and program consultations, Caplan's program-centred administrative consultation and consultee-centred administrative consultation, can all fit comfortably within the boundaries of tertiary consultation.

KNOWLEDGE, SKILLS AND VALUES IN CONSULTATION

Gallessich draws together *currently scattered and heterogeneous concepts* (Gallessich 1985, p.336) from the models which she describes. This section expands on that author's work and adds the contributions of family therapy, a relative newcomer to the application of consultation in their repertoire of intervention strategies. We can now look again at each model described by Gallessich, albeit from a slightly different perspective.

Clinical consultation

The main assumption underlying this model is that the client's emotional disturbance is beyond the expertise of the consultee. The consultant's role is to assess in order to make an *authoritative diagnosis* and treatment plan for the consultee to implement (Gallessich 1985, p.337). This assumption may be simplistic. It is just possible that while there is something about *this* client which leads the consultee to feel concerned about them now, the main problems actually lie with the consultee rather than the client. If this is so, such personal difficulties may prove to be a barrier to the consultee implementing a management plan proposed by the consultant. Alternatively, the plan may be implemented in a partial or distorted way resulting in minimal (if any) improvement in the client's difficulties.

Consultee-centred consultation

Some consultants became frustrated because their carefully devised treatment plans were not followed through. They began seeking explanations. One such was to consider the role played by the unconscious in human interactions generally, and in the consultant-consultee-client paradigm, in particular. Concepts such as transference and counter-transference; mechanisms of defence, eg, splitting, denial, projection of unwanted feelings onto others in response to feeling threatened; the importance of understanding an individual's past in order to make sense of the present, are used by consultants to make sense of why an apparently eager consultee does not follow through with action. Also important are ideas like envy and gratitude and their role in the resistance to, or ambivalence about seeking, giving and receiving help; the value of self-understanding and the use of concepts like *containing* and *holding* as tools in helping relationships (Pearson et al, 1988).

Using such concepts to give meaning to what on the surface appears to be inexplicable behaviour can aid the consultant's understanding. Where this model becomes controversial is the ways in which this understanding can then be used. Caplan and Caplan (1993) propose a technique they call theme-interference reduction. This uses analogies, parables and other indirect methods of intervention in preference to confronting defensiveness directly.

Heller and Monahan (1977) question the ethics of using what overtly appears to be a discussion of the client's problems to covertly deal with the consultee's problems. They have no solution to the dilemma which led Caplan and Caplan to develop their technique in the first place. We are left to ponder the conscientious consultant's dilemma when confronted with lapses in professional objectivity in consultees who are resisting change and who occupy important positions in the care-giving networks of a community!

Behavioural consultation

This model stresses the importance of clarifying the problem, setting performance goals and developing tools which measure the extent to which these goals have been realised. Establishing contracts, modelling desired behaviour, and the use of role plays are important tools. The belief that all behaviour, normal as well as abnormal, is learned and can therefore be unlearned, provides the consultant with an alternative way of looking at problems presented by consultees from one based on psychopathology within the consultee (Gallessich, 1983). This strength needs to be balanced against the ethics of an approach which, while priding itself on its neutrality, is open to abuse since the consultant is in a position to exert power and control over the behaviour of both consultee and client. It is the power over the latter which is of concern, because the client is unlikely to have been informed about the consultant's existence and role (Heller & Monahan, 1977).

Organisational consultation

In almost all instances mental health consultation occurs within an organisational context and an understanding of organisational structure and function is important even when the actual contract is for case-focussed consultation. Especially useful is research on human service organisations which highlights the common threads of uncertainty of status and discrepancy between responsibilities and authority (and pay) of personnel (Gallessich, 1983) which occurs almost universally within these organisations. The anomalies arise, at least in part, from the ambivalence with which the dominant values in our society view helping those perceived as less fortunate. On the one hand, caregivers are seen as altruistic and, on the other, terms like 'the welfare industry' anticipate that the work done will result in the production of a successful product, eg, well-adjusted foster children, or people with schizophrenia attaining better levels of functioning. Success is anticipated in spite of cost-cutting, downsizing, and emphasis on greater efficiency while staff contend with poor working conditions and uncertainty about their own future employment (Imber-Black, 1986). Stress and burnout are common consequences resulting in high staff turnover which in turn leads to lack of service continuity for clients.

Systems theory as applied to organisations provides useful concepts like open and closed systems, entropy and negative entropy. It alerts us to increased specialisation among human service providers and the resulting demand for new training, increased technology and greater autonomy for workers and their work units. At the same time this greater specialisation makes workers more interdependent on each other's expertise in order to provide the client with an adequate service (Imber-Black, 1986). This in turn leads to increased competence in such processes as inter-agency co-ordination and collaboration. Bion's (1961) theories on dependency which develops in groups (eg, fight and flight, pairing, waiting for the Messiah) have been applied to work groups by Turquet and others from the Tavistock group in the United Kingdom and the Institute

for Social Analysis in Victoria. This knowledge increases the consultant's understanding of the way in which organisations impinge on individuals at work and how vulnerable workers are to such group pressures, myths and fears which then affect clarity in the definition of tasks, choice of leadership, relationship between leader and followers and the implicit contract between them. This contribution also owes its origins to psychodynamic thinking and provides a balance to the use of these theories in understanding the consultee's problems as being created by theme-interference.

Program consultation

An important lesson to be learned from program consultation is that a program frequently fades once the consultant leaves. This is often because those expected to continue its running in the long term were not involved in the initial planning and development stages. Gaining the support of staff expected to implement a new program may seem time-wasting and fruitless, yet without their commitment the exercise could prove to be a greater waste of time, effort and money. A conflict of values in this type of consultation may be more problematic and intractable than with other types because values may lie at the heart of the development of new programs. In program consultation, the consultant may feel frustrated about having a contract to change only part of the whole system, when other facets may be equally (sometimes more) dysfunctional.

Knowledge from family therapy

Family therapy has only recently addressed consultation as a strategy for delivering service (Wynne et al., 1986). One consequence of this is that the overall knowledge base of consultation has not yet been able to benefit from the principles and practice developed by family therapy. Another is that family therapy has not yet realised the importance of distinguishing between consultation and therapy.[1] Nonetheless several concepts appear to have potential. These include *joining, mirroring, scapegoating, triangulation, viewing figure and ground and circular causality*; and the techniques of *paradoxical interventions, reframing and circular questioning* may prove useful tools for consultants. It is interesting to note that some family therapists have struck the problem of theme -interference. Penn and Scheinberg (1986) talk about the need to identify the *isomorphic problems in the clients' family system and in the therapist's own family system* (pp.115-131). They address this through family of origin work. This solution has the merit of honesty in alerting the consultee to the consultant's view of where the problem lies, but it raises awkward questions about the goals of consultation and the framing of contracts. Real solutions to this fundamental issue are far from being at hand. □

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[1] Wynne et al describe assessment of family functioning as consultation. Even while making their arguments they acknowledge some confusion (Wynne et al, p.20). By trying to place direct service to families within the context of mental health consultation they lose important strengths of the process, eg, the emphasis on work-related problems and the process' triadic nature. This naivety is a flaw in an otherwise thoughtful and comprehensive volume which makes an exciting contribution to the literature on consultation.