SYSTEMS-BASED PRACTICE
CONSULTATION

SYSTEMS-BASED PRACTICE: CONSULTATION OBJECTIVES*

Knowledge
The resident will demonstrate an adequate knowledge of:
1) Systems/providers to which child and adolescent psychiatrists can provide consultation. (1,5,7)
2) Reasons why child and adolescent psychiatrists often work in consultative relationships. (1-12)
3) The different types of consultation relationships, including 1) case-based client-centered, 2) case-based consultee-centered, 3) administrative program-centered and, 4) administrative consultee-centered and internal consultation. (1,2,5,7)
4) Elements of a successful consultative relationship. (1-7)
5) The role of the consulting CAP in promoting access to safe, quality treatment. (1-7)

Skills
The resident will demonstrate the ability to:
1) Consult with systems that serve youth and families. (1-12)
2) Acquire specific information about the culture of the system and/or a provider requesting consultation. (1-7)
3) Stay attuned to the needs of all members impacted by the consultation. (1-7)
4) Be attuned to systems issues that may impact the ability of a system to meet the needs of youth and families, and take advantage of opportunities to respond to these needs. (1-7)
5) Apply the “nuts and bolts” of a typical consultative relationship. (1-7)
6) Recognize the importance of maintaining safety as the top of the hierarchy of intervention in consultation. (1-7)
7) Identify psychiatric resources (best practices, practice parameters, etc.) that can help to understand general issues about systems to which you consult. (1-7)

Attitudes
The resident will demonstrate the commitment to:
1) Consider the roles, responsibilities, and different members of the consultee’s system when making recommendations. (1-7)
2) Realize the importance of attitude – the Three A’s of availability, affability, and ability – in a successful consultative relationship. (1,4,5,10,11)
3) Appreciate the importance of being an advocate for the provision of quality care that is safe and effective. (2,4,9,10,11,12)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements.¹ See Appendix 1 for complete list of competencies.

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OVERVIEW

This module provides a brief conceptual framework for the process of consultation and lays the groundwork for the remaining modules. Because most youth enter and/or receive care outside the formal mental health system, the need for psychiatrists to understand the general approach to consultation, as well as the administrative and legal aspects, is vital. The goal of this module is to help the trainee begin to develop an appreciation of potential roles of a child and adolescent psychiatrist (CAP) as a consultant working with individuals and/or systems in order to encourage the provision of family-driven, youth-guided care that is safe and effective. The importance of recognizing the values, mandates, and cultures of the systems as well as the members of the systems and child and family should be emphasized.

CAPs have been exposed to inpatient consultation during adult training. Consultations provided to medical services by a resident and attending physician are only one type of consultation-liaison work that can occur. Lessons learned from adult and child consultation-liaison experiences should be elicited. The experiences can be utilized to help reach an understanding of the similarities and differences between traditional inpatient training experiences and the diversity of opportunities outside inpatient medical experiences. Discussion of prior experience, both rewarding and frustrating, can also help the trainees recognize any preconceived notions they may have about the role of consultants in the community. This should allow the trainees to expand their expectations about consultation beyond the traditional CAP-patient-“primary team” relationship to consider potential roles within a program, a system, and/or the larger community.

This module has four main elements: (I) Importance of consultation; (II) Traditional and evolving concepts of consultation; (III) Components of a successful consultative relationship; and (IV) Nuts and bolts of the consultation process.

I. IMPORTANCE OF CONSULTATION

Youth with mental illness are in school, juvenile justice, child welfare, and other systems. The point of recognition and initial intervention for the overwhelming majority of mental health problems is not in mental health settings, but in the community, either by school providers or primary care doctors. Once identified, most youth struggling with mental illness are neither seen by psychiatrists nor seen in traditional mental health settings. The ongoing shortage and maldistribution of CAPs, as well as other qualified mental health providers, requires that a substantial number of CAPs work in consultative and collaborative relationships with systems and other professionals in order to improve access to quality care that is youth-guided and family driven. It is reassuring to note that treating youth in their natural environments and/or providing treatment in other systems does improve access to care, is acceptable, feasible, and effective. In addition, appropriate expert consultation can improve the quality of mental health care. CAPs have unique skills and knowledge that can be combined with the skills and knowledge of professionals in other settings to provide the highest quality youth-driven, family-guided care.

Although a consultant is just a “guest” in the system they serve, a successful consultative relationship can provide many opportunities to be involved with the ongoing improvement of a system. CAPs have unique training that includes: (1) medical evaluation and treatment of
physical and mental health conditions, (2) utilization of non-psychotropic therapeutic modalities, and (3) intensive experiences in multiple levels of care. These experiences make the CAP well-placed to bring their diverse opportunities to many settings, from schools to residential treatment units. A child and adolescent psychiatrist who stays attuned to the needs, responsibilities, strengths and limitations of a system can help to identify recurrent themes in consultation and be an impetus for system change over time. CAPs can and should model the implementation of system of care principles, youth-guided and family-driven care, and principles of patient safety.

II. TRADITIONAL AND EVOLVING CONCEPTS OF CONSULTATION

The outline below highlights some important terms regarding the different types of consultation. Consultation involves two professionals and/or organizations, the consultant and the consultee. The consultee requests that the consultant use his or her expertise in order to make recommendations about the best method of intervention. The consultee is an expert in his or her own system and must balance the needs and culture of the organization and client to ultimately enact the recommendations of the traditional consultant, who carries no ultimate responsibility for implementation of intervention.

There are several proposed models for conceptualizing the roles that CAPs can serve when acting as consultants. No one model completely covers all potential roles that a CAP may play, but an understanding of Caplan’s traditional model can help a trainee begin to distinguish between roles and responsibilities that may occur. The types of consultation in this model include case-based client-centered, case-based consultee-centered, administrative-based consultee-centered, and administrative-based organization-centered. In this model, one must distinguish whether the focus of the consultation is management of specific cases (case-based) or general organizational issues (administrative-based). The next point of differentiation involves the role the CAP will play with the patient, provider, consultee, or organization. The definitions below are primarily derived from Caplan although descriptions from two editions of Child and Adolescent Psychiatry were also utilized to help flesh out ideas.

1) Consultation
   a) Mental health consultation/collaboration is a “process of interaction between two professionals: the consultant who is a specialist and the consultee who invokes the consultant’s help in a current work problem that he believes is within the area of the specialized competency. It can include management of 1 or more clients of a counselor or planning of a program for 1 or more clients.”
   b) Consultee – retains professional responsibility for client and is free to follow or not follow recommendations of the consultant.
   c) Consultant
      i) Traditional definition - has no administrative authority, not liable for outcomes. This is similar to the traditional consultation-liaison service.
      ii) Internal consultant – independent contractor, assumes responsibility for youth and families they see. This relationship has developed in many mental health settings.

2) Types of consultation
   a) Case-based
      i) Client-centered
(1) The focus of the evaluation and recommendations is on the client and/or provider in order to serve the need of specific client(s).
(2) Example: Medically hospitalized youth appears depressed and the primary team consults the behavioral health team for an evaluation.

ii) **Consultee-centered**
(1) The focus of the evaluation and recommendations is on the skills/knowledge of the consultee as opposed to the client.
(2) Example: Analogous to supervision.

b) **Administrative-based** (i.e. about the organization or administration)
   i) **Consultee-centered**
   (1) The focus of the evaluation and recommendations is on the program and providing recommendations for improvement. The program is analogous to a client in case-based client-centered consultation.
   (2) Example: A child welfare agency asks for help developing a program to address mental health problems in specific youth and family.

ii) **Program-centered**
(1) The focus of the evaluation and recommendations is the professionals, often regarding administrative issues.
(2) Example: A mental health agency may ask a CAP to serve on a committee designed to evaluate systematic changes that need to occur in order to maintain skilled clinicians.

c) **Internal model of consultation** – often called “mental health collaboration”
   i) Consultant shares responsibility for the case.
   ii) Consultee agrees to respect advice of the consultant because of sharing of responsibility and expertise.

3) **Liaison** – more of an ongoing relationship with consultee and/or a treatment relationship with youth/family than traditional consultation models. Examples may include teaching a team how to help a patient with relaxation in times of distress, improving the systemic response of the hospital to a youth with behavioral issues, encouraging the patient’s views to be recognized in the hospital process, and encouraging early identification. The distinction between liaison and consultation duties may often not be clear, especially in the case of an internal consultant.

It is important to note that in these traditional models the role of the CAP is a consultant who does not have responsibility for the case beyond recommendations that are made. The ultimate decision about whether or not to implement recommendations is the role of the consultee provider and/or organization. In an important variation that has arisen in many mental health centers, a CAP can serve as an **internal consultant**. The role of an internal consultant would be better described as “collaborative liaison” because the CAP has responsibility for a subset of care, e.g. medication management, and is embedded in the organization, e.g. a mental health setting.

A CAP must first understand their required role within the organization and define it in the contract and/or formal agreement (see below III,1). An initial contract may be fairly circumscribed in response to a specific client or organizational need. In time, successful consultation relationships may be dynamic, and contracts with the consultee organization may
change as the relationship develops. The trainees should begin to think about their roles as collaborators who can help improve the quality of services by combining their own expertise with the expertise of the consultees in a process of successive continuous quality improvement initiatives along the continuum of case, individual, administrative, and system level.

III. COMPONENTS OF A SUCCESSFUL CONSULTATION RELATIONSHIP

The following is an outline of some elements of a successful consultation relationship. Once a clear contract and/or agreement about the role of a consultant is in place, the availability, affability, and ability (The Three A’s of Consultation) of the consultant are vital in order to maintain the relationship. It has been suggested that these three factors are the most important qualities of a consultant and in the order listed. Psychiatric consultants are often called in to help with difficult situations and their capacity to offer input in a timely fashion and in a manner that is not offsetting to members of the team cannot be underestimated.

It is important to remember that the consultees must balance their own roles, responsibilities, and authority with the needs and expectations of the administration, organization, identified client and family, and overall client population they serve. The consultant is a mental health expert, in this case a child and adolescent psychiatrist, asked to make specific recommendations that the consultee can accept or reject. A consultant must stay attuned to the role of the competing forces within the organization, as well as the actual roles and authority of the identified consultee. Imagine the consultee as a tightrope walker with a balance bar that has clients, administrators, and regulators, among others on either end of the bar. The tightrope walker is an expert in walking the high wire, but brings a consultant in because the consultant has specific expertise they hope can help. If recommendations cannot be implemented by the tightrope walker because of their ability, time, power, or because it puts someone else at risk of falling, then recommendations will not be perceived as helpful. The more the expert consultant understands the nature of the organization, the clientele served, and the role and responsibilities of all members of the organization, the more useful their consultative services will be.

The following is a brief outline of some components that can contribute to a successful ongoing consultative relationship. Hopefully, many of these are self-evident.

1) Clear expectations about the consultative model (see above) in a formal agreement or contract.
   a) Consultative model (see above).
   b) Consideration of the basic elements needed for consultation - time, space, access to records, access to people, location.
   c) Assure that the consultation relationship is approved and endorsed by the appropriate authority/administrator.
   d) Identify the people involved in the consultation and their roles and responsibilities. Because in traditional consultation the consultant does not have administrative power or authority, there must be a clear understanding of who does have the clinical and administrative authority to implement recommendations.
   e) Define the length of relationship – short term or indefinite.
   f) Clarify the method for:
i. obtaining feedback and/or,
ii. periodically reviewing the relationship.

2) Ongoing attention to “The Three A’s of Consultation”
   a) Availability – being available, communicating, and giving back advice to the consultee in a timely fashion.
   b) Affability – the importance of being approachable, appreciating members of the team, and managing your own emotional responses to difficult situations cannot be underestimated.
   c) Ability – i.e. clinical skills with families, communication skills with members of the team, finding and utilizing up-to-date information about the clinical population the system is serving and advocating for the patient, family, consultee and system as needed.

3) Communicate clearly – avoid jargon, and strive to communicate in a manner that can be understood by non-CAPs and/or people outside the mental health community.

4) Be attuned to the process of consultation – how is it going, how are people responding, how are you responding?
   a) Was the consult requested or mandated?
   b) How is the process going?
   c) What are the expectations of the team re the consult, and how is it going?
   d) How are you responding to the expectations of the team?

5) Stay attuned to the concerns, priorities, and roles of various members of the consultation system.
   a) Leadership
   b) Supervisors

6) Respect and utilize the skills, knowledge, and expertise of the professionals of other disciplines in making your recommendations.

7) Develop relationships that are non-coercive and non-hierarchical.

8) Stay attuned to the culture of the consulting organization at all stages in the relationship.
   a) Be aware of the needs, responsibilities and language of other disciplines.
   b) Be aware of specific practices and jargon in the field.
   c) Be aware of mandates governing the consultee organization.
      i. Example: School Public Law 94-142, also known as the Education for all Handicapped Children Act was passed in 1975 and created special codes for physical or mental disability. It was later renamed the Individuals with Disabilities Education Act (IDEA) expanded protection for specific youth <6 years old.
      ii. Specific requirements and accountability influence culture and attitudes, therefore you must be cognizant and sensitive to the cultural norms of the organization in order to have a successful collaboration.

9) Enhance your knowledge about the population served.
   a) Know the characteristics of population served.
   b) Know the evidence-based treatments and interventions that may be helpful for the population.

IV. NUTS AND BOLTS OF THE CONSULTATION PROCESS

This is a basic list that can be utilized in almost any specific consultation experience. Although
some components of this list may not be elucidated in the order they occur, in general an effort should be made to move through the list in order when approaching a specific consultative question - whether in the context of a preexisting relationship or in the context of a new relationship.

**PRIMARY STEPS**

1) Seek information about the consult and the consultee.
   
a) *What is the consultative relationship?*
   
b) Who identified a need for a consultation - person requesting, or someone else (i.e. mandated consultation—administration, regulatory agency)?
   
c) *Who is the actual consultee?*
   
d) Example: a nurse on a ward is concerned because a youth is requesting a lot of pain medication; the medical doctors were not concerned but consulted psychiatry because the nurse asked for it.

2) Clarify the need/question of the consultee.
   
a) Utilize *direct questioning* in order to help clarify the consultee’s question and better understand the focus of the consultation.
   
b) Why is consultation on this issue occurring at this time?
   
c) Will the consultation be *case or administrative-centered?*

3) *Clarify expectations*, i.e. existing relationship or new relationship?
   
a) If any **bottom-line issues** are evident have a frank discussion with the consultee about them.
   
i. Bottom-line issues are any concerns that can potentially (a) impact the safety of the patient or family, (b) result in legal or ethical concerns, and/or (c) impact the viability of the consultation relationship.
   
ii. Bottom line issues **cannot** be ignored in the consultation, and must be addressed above and beyond other interventions or concerns.
   
b) Is this request within the bounds of the current consultative relationship with the consultee?

**SECONDARY STEPS**

4) *Collect information.*
   
a) What to *clarify* for yourself (with consultee, as well, if possible).
   
   a) What are potential bottom-line issues (e.g. ethical, legal, safety, consultation structure)?
   
   b) Is there evidence of **theme interference** (when preconceived stereotypes or unresolved issues interfere with interventions at any level)?
      
      (1) Example: the belief that all children requesting pain medications are addicted.
      
      (2) How to elicit theme interference:
         
         (a) When responding to a request for a consult don’t ask only about clinical facts, but of the team’s interpretation of the facts and specific concerns.
         
         (b) Use frequent questioning to widen the consultee’s thoughts about the case.
         
         (c) If theme interference is recognized, use non-psychiatric jargon in order to encourage the team to recognize other possibilities, the role of their own concerns with the patient, or to realize that the negative outcome, as they predict, is not inevitable.
c) Identify potential **covert and overt agendas**.
   
   (1) **Covert Agenda** – When, in addition to the stated reason for the consult, there is another reason that may actually be more important to the team, but unvoiced for a variety of reasons ranging from lack of self-awareness to deception.

   (2) **Overt Agenda** – Teams consult psychiatry every time that there is an overdose attempt because this is the process needed to get an admission to the psychiatric floor.

d) Consider conflicts of interest – competing services or competing sources of recommendations.

e) Be aware of the potential for your own distortions to interfere with the process.

b) **Communicate** with members of the team.

   i) **Think widely** about all pertinent members of the team/system.

   ii) Obtain **youth and family information and opinions** (if client-based case-centered consultation).

      (1) *Be clear about your role* in the consultative process.

      (2) *Be clear about the limits of confidentiality* in the setting.

      (3) *Address bottom-line issues*.

      (4) Perform appropriate clinical interview with youth and family.

         (a) Obtain youth and family experiences regarding interaction with staff/team and need for consultation.

         (b) Pay particular attention to any issues of culture/ethnicity that may be contributing to the reason for the consultation.

5) *Feedback of information and recommendations to consultee.*

   a) **Hierarchy of interventions** (Notice this is also a hierarchy that begins with bottom-line issues, i.e. consideration of interventions should actually occur in this order, with bottom-line issues occurring first.)

      i) Assure safety.

      ii) Obtain information.

      iii) Ethical (may be mandated by state law).

      iv) Consultation viability (i.e., is consultation consistent with the contract?).

      v) System boundary issues (covert agenda, theme interference, etc.).

      vi) Family boundary issues (routine clinical considerations).

      vii) Family-staff boundary issues.

   b) Timeliness and clarity are vital.

   c) Consider the roles, responsibilities, and limitations of the consultee when making recommendations.

6) *Assess the impact of intervention, get feedback.*
**APPENDIX 1**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.

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REFERENCES

6. Individuals with Disabilities Education Act, 20 USC §1400 et seq.

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Consultation – Discussion Vignette I – Trainee Version

A local youth detention center is creating a dual diagnosis treatment “cottage” within its facility. This cottage will be specifically dedicated to treating youth with a history of substance abuse and comorbid psychiatric disorders. It will be the first cottage in the facility for youth with mental health problems and the youth in this cottage will be the only youth in the entire facility with access to a child and adolescent psychiatrist for evaluation and treatment. Up to this point, youth who were admitted to the facility would be continued on their psychopharmacologic regimen by the primary care doctor who is on site Monday thru Friday. There are nurses available 24 hours a day to administer medications and report back to the primary care doctor. It was felt that this process was not adequately meeting the needs of many clients. The nurses will continue to be available to give medication, but only standing orders. They can also do limited monitoring and facilitate blood draws, as well as interact with the on-site primary care doctor. You are approached to be a consultant for this institution.

1) What could you do prior to setting up a formal meeting in order to help facilitate the process?

2) What are some of the things you would like to know when you meet formally and how would you get this information?

You have your initial meetings and realize that the administration is quite committed to having
an internal child and adolescent psychiatry consultant, and will expect the psychiatrist to perform psychiatric evaluations, ongoing medication management, consultation with staff, as well as collaboration with families and system partners. When speaking with the frontline staff you recognize a wide variability in training and interest in mental health interventions. The social work and therapy staff has just been hired from other settings within the state system and is quite excited to make an impact for these youth. Although some frontline staff is interested in mental health training, many have never had any specific training about working with youth who have mental illnesses. You are interested in fulfilling the role of an internal consultant, and your contact mentions that the state is also requesting ongoing training of the frontline staff as a component of this program.

3) What should you do in order to formalize the relationship?

4) Review the definition of consultation relationships. Name the types of consultation that you will be providing.
Consultation – Discussion Vignette II – Trainee Version

A local pediatric office that is an outpatient site for pediatric residents is concerned about the training being provided regarding the identification and management of psychosocial issues and mental health problems in children. The attending physicians admit that they are not as comfortable as they wish they could be with psychosocial problems and approach you to provide consultation to the clinic in order to help educate the residents. You would not be a member of the medical staff for this hospital or outpatient setting, but you would sign a confidentiality agreement as a consultant to the medical staff. This is a similar agreement that representatives of surgical equipment companies sign when they come in and teach surgeons how to use their new equipment. They are quite excited to get started.

1) How can you approach this opportunity?

You clarify that you will be providing consultation to the attending physicians and residents on cases with psychosocial issues and mental health needs that are seen in the clinic. You will not have responsibility for the cases. You will not be alone with patients. You will primarily be performing “decision support,” and will enter patient rooms with the team to help clarify information and assure that adequate plans are conveyed.

In order to understand the culture, you spend two weeks in the clinic observing the interactions. This is a typical busy academic clinic with medical students and residents coming in and staffing with one of the eight attending physicians. The trainee reports the information he or she has obtained to the attending, who then asks additional questions, clarifies the possible formulations of the problem, and identifies information that still needs to be obtained. Advanced residents go back in alone; earlier stage residents go back in with the attending who will have a varying level of interaction with the patient depending on their confidence in the information obtained and the urgency of the situation.
Consultation – Discussion Vignette III – Trainee Version

You have been consulting weekly to a day treatment center for over one year, providing individual case consultations and in-service training for social workers, teachers, and aides. You are not contracted to provide direct-care to patients, but instead support and feedback about treatment options based on the information provided to you by the social workers. The head social worker, who is your usual consultee and point of contact for individual consultations, asks you to observe a child in one of the classrooms. This child has recently been a management problem for one of the teachers. The social worker informs you that the child is aggressive and openly disobedient to the teacher, and that the teacher fears some acting out is imminent.

1) What is the preexisting consultation relationship? Is there more information you would like to know to clarify what the preexisting consultation relationship is?

2) What are your primary steps?

3) What are your secondary steps?

4) What are the bottom-line issues in this scenario and what are the implications of bottom line issues?

At the next in-service you talk about management techniques of aggressive students. Although the teachers and social workers are pleased to receive more training, they express frustration that many youth are increasingly aggressive as they are discharged from brief stays in the hospital, and that safety concerns could be more adequately addressed while the youth are in their care. They ask you to join a task-force that is being convened in order to address issues related to safety with a specific goal of evaluating student-staff ratios.

5) What type of relationship would this be?
Consultation – Discussion Vignette IV – Trainee Version

You are a child psychiatric consultant to a therapeutic abortion clinic in a general hospital. Your role is to provide psychiatric evaluations and consultation to the abortion clinic staff for all patients who apply for a therapeutic abortion under the age of 18 years.

1) What is the preexisting consultation relationship?

Jaral is a 16 year old black female who presents for a therapeutic abortion at 8 weeks gestation. She tells you that her parents are unaware of her pregnancy. She told her boyfriend, by whom she is pregnant, and his response was to say that he would have nothing to do with her or the baby if she kept it. The patient expresses ambivalence about her own feelings regarding abortion, but is fearful that she would be rejected by her mother as well if her mother discovered that she was pregnant. She feels this way because she alleges that as a 13 year old she was sexually abused by her mother’s boyfriend at the time, who fondled her, but when she told her mother about this her mother became angry and told her that she was making it up because she did not like her mother’s boyfriend. She has felt somewhat distant from her mother emotionally ever since. The patient also states that she has begun to skip school this year and that she has been drinking alcohol on occasional weekends with friends.

2) What are your first steps now?

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