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ABSTRACT

A PATTERN FOR DEVELOPING AND MAINTAINING CONTINUING MENTAL HEALTH CONSULTATION WITH PUBLIC AGENCIES IS PRESENTED. USUAL MODELS OF CONSULTATION ARE PREDICTED ON AN INVITATION TO CONSULT; THEY ARE TIME LIMITED AND PROBLEM SPECIFIC. DESCRIBED HERE IS AN ENTRY PATTERN FOR CONSULTATION THAT IS NOT PREDICTED ON AN INVITATION TO CONSULT, IS CONTINUOUS IN NATURE AND IS NOT NECESSARILY PROBLEM SPECIFIC. THE STEPS TOWARD IMPLEMENTATION ARE: (1) SECURING SANCTIONS TO CONSULT, (2) DEVELOPING ENTRY POINTS, (3) ELICITING PROBLEMS, AND (4) DEVELOPING SOLUTIONS. EXPERIENCES WITH THIS APPROACH ARE DESCRIBED. (AUTHOR)

An "Action-Facilitation" Entry Pattern of Mental Health Consultation*

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ABSTRACT: A pattern for developing and maintaining continuing mental health consultation with public agencies is presented. Usual models of consultation are predicated on an invitation to consult; they are time limited and problem specific. Described here is an entry pattern for consultation that is not predicated on an invitation to consult, is continuous in nature and is not necessarily problem specific. The steps toward implementation are: (1) securing sanctions to consult, (2) developing entry points, (3) eliciting problems, and (4) developing solutions. Experiences with this approach are described.

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The advent of the community mental health center places a new emphasis on the consultative relationship of the mental professional to other helpers in the community. Each center is required (Community Mental Health Centers Act of 1963 [1964]) to develop a consultation and education service. Professional man-hours are being allocated for the new service which is reaching out for opportunities to engage the community. This new situation may require a reappraisal and modification of some of the existing approaches to consultation.

Four major models of consultation have evolved. These are: Caplan's Process Approach, Lippitt's Change-Agent Model, Wolberg's Education Model, and Altrocchi's Group Method. Each is predicated on a direct request to consult. Each also defines consultation as a time-limited approach related to the resolution of a specific or a general problem. Caplan (1963) defines consultation as an interaction between the specialist-consultant and the consultee who requests help regarding a current problem. A basic assumption of this model is that consultation be offered during a period of crisis in such a way that the knowledge and skills of the consultee are supplemented. The consultant has no administrative authority over the consultee and no responsibility for his future actions. He works only to help the consultee clarify the work problem. Lippitt, Watson and Wesley (1958) provide a social psychology and group dynamics approach in which the consultant is a "change-agent" but not a part of the consultee's hierarchical social system. The consultation task is to define a structural or functional change in the consultee system that would correct the presenting problem. In this process,

consultation does not focus on the interpersonal relationship between consultant and consultee but remains strickly problem-oriented. Wolberg (1962) identifies consultation as an education process based on a temporary relationship between the consultant and consultee. Initial identification of the problem is followed by actively enhancing the problem solving skills of the consultee, aiding communication within the system, aid in implementing a plan and handling the resistance to change. Helping attain necessary resources when needed and educating the staff to the mental health aspects of their work is a goal of the consultation. This often involves training supervisory staff to continue ongoing inservice training programs.

Altrocchi's (1965) group consultation is designed as a process to aid professionals in becoming more sensitive to the needs of their clients. It is educational in emphasis and seeks to teach by means of "the group's process." The restriction which Caplan places on the emotional content of the consultation is not present. Altrocchi's chief goal is to help the consultee through the use of participating group involvement to achieve solutions to his problems independently.

Each of the major models reviewed offers features that make them inapplicable to the local situation. Each focuses on a time-limited relationship; each is problem-specific; and, each is predicated on an invitation to consult made by the consultee.

The absence of a request to consult places different requirements on the consultant. It makes it necessary to develop institutional sanctions to obtain points of entry into the consultee social system, and to devise a flexible approach for operating within the framework of the consultee. Experiences involved in this model of approach are outlined below. Before describing those experiences, however, it might be useful to specify the context in which they occurred.

Setting

The Community Psychiatry Section of the University of North Carolina Department of Psychiatry is engaged in a research and demonstration project in rural mental health. The project is directed toward the development and testing of models for the delivery of mental health services to rural areas where helping resources, funding and professional manpower availability are limited. The program format involves a full time indigenous lay staff consisting of a coordinator, a service guide and a secretary. In addition, there is a one day per week visiting staff from the university located approximately one hour away. Staff time is allocated to community education and resource development, to support of local help-giving agencies and personnel and to meeting the emergency and after-care needs of the community. Time priorities are allocated in the order listed.

Problem

Early in the 1967-68 academic year, a decision was made to engage in school mental health consultation. This decision was made in the absence of a specific request to consult. With the restriction that the consultation not be single-case centered, the agenda for consultation was an open one.

The general intent was to strengthen the mental health role of the teacher in the classroom and to assist in the development of mental health related services within the context of the school system. Thus, the entire school system was seen as the consultee.

The steps in implementing the program were seen as: (1) securing sanctions to consult, (2) developing entry points into the system, (3) eliciting problems on which to consult, and (4) developing problem solutions. The consultation effort was to be both process- and problem-centered. The role of the consultant was seen as varying according to the demands of the immediate situation.

Sanctions

The development of sanctions was approached at three different organizational levels within the school system. The mental health staff considered it vitally important to develop a general tone of good will before entering into actual consultation. This was approached through meetings held with the superintendents of the city and county school systems. In these meetings it was stated that the mental health program wanted to find ways of being helpful to the school system and of working along side the school personnel in approaching the problems of school mental health. At the same time, the limited resources for direct patient care were stressed. Both county and city superintendents were pleased with the opportunities of having mental health personnel work within their school systems. Each was asked for advice and counsel concerning how best to proceed.

Following the consultation with the superintendents and with their blessings, separate meetings were held with the principals and supervisors

of each school system. These meetings were called by the superintendents. The program format was essentially the same as with the superintendents. The desire to work with them was expressed and underscored; the limitations on direct services except in case of emergencies was stressed; and, advice and counsel concerning how best to proceed was sought. It was decided in those meetings that the point of entry into the schools would be through the principals.

The third approach to the development of sanctions was by way of an open-invitation-teacher-workshop on the emotional problems of children and behavior management in the classroom. The workshop provided an opportunity for setting the stage for further school contact.

The three levels of meetings established a general freedom to consult with the schools around mental health problems. No constraints were imposed by the superintendents. However, there was an implied contract to work with school personnel in approaching mental health problems and to keep school authorities posted on the approaches being taken. In the service of maintaining open communications, the mental health program staff requested the superintendents to appoint one administrative staff member to serve as a general liaison person to the consultation program. This was done.

System Entry

As mentioned above, the primary point of entry into the system was through the principal of the individual school. Through principal contacts the direction and focus of the consultation was to be determined. It was anticipated that some of the contacts would result in problem consultation at either principal or teacher level. It was also anticipated that some

contacts would yield no reported problem. For such cases, a second pattern of entry was developed. Meetings with teacher groups were requested of the principal. The purpose of the meetings was to elicit from the teacher group their perceptions of mental health related problems experienced in the schools. Both patterns of entry were utilized. Problem centered consultation followed a general case of problem approach pattern similar to that outlined by Caplan (1963). The meetings with the groups of teachers required the adoption of an approach to problem elicitation.

The teacher groups were approached through a standard format involving: (1) a statement of interest in finding ways of working together on mental health related problems, (2) acknowledgement that the teacher has expertise in helping children learn which might be meaningfully pooled together with the clinical experience of the mental health professional, (3) a request to have the teachers name the mental health related problems they see in their daily work, (4) a listing of those problems so that all participants could see them, (5) ranking of the problems in terms of group interest, (6) a joint consideration of alternative local solutions to the top ranked problems and, (7) an effort to gain the involvement of the group in moving toward implementation of solutions.

Initially, the principal or the teacher or groups of teachers were seen as the primary clients. However, as the problem consultation and the problem elicitation program moved through several schools, it became obvious that the power to act did not reside in the teacher groups toward which the initial consultation efforts were directed. It became obvious that the school system had very good communications downward from the administrative

level to the teacher but very poor communications in the opposite direction. The teachers felt they had little mobility in the system. Therefore, the consultant assumed an information carrying role. Liaison contacts at all levels of the administrative hierarchy were developed. Through these lisison contacts, it then became possible to pickup, define or sense problems at one level or division of the system and to carry those problems and concerns to the other parts of systems, always in an effort to mobilize movement toward solution implementation. The right of the existing structure to move toward implementation through its own avenues was recognized and respected. The problemsand concerns which were focused on were defined from within the systems. At all times, the responsibility for decisions to act were viewed as residing within the structure of the system. Of course, the approach involves an active seeking out of the appropriate individuals in a position to make the necessary decision to act. At one point, we jokingly called our model of consultation by the names "bumblebee" and "pollination" because of the problem-carrying role which was adopted.

This action-facilitation model has, we feel, been a relatively successful one for developing and maintaining continuous system consultation. The approach has stimulated a variety of programmatic efforts during the year since its conception. For example, four separate inservice training endeavors have been launched. The first involved a short-term series of meetings with the first grade teachers in a single school. The focus of those meetings was initially classroom problem centered but ended in a brief workshop on techniques for developing a helping relationship with parents. A second inservice training effort involving a single school has involved

the selection of a child representing a general problem to the school, the evaluation of the child, the development with the teacher and the counselor of a treatment approach to be carried out by them, and evaluation of a general meeting with the teacher to report. This effort is now in its second cycle. The third and fourth inservice training approaches have been in the form of system-wide workshops on "Mental Health in the Classroom." These workshops have been developed in concert with the North Carolina Department of Mental Health and have been offered for certification renewal credit. One of these workshops involved a focus on behavior modification applications in the classroom. Each teacher developed a behavior modification plan for a particular behavior problem. Some plans have been implemented. The inservice training efforts have reached approximately 125 teachers and have been directed toward strengthening their mental health roles.

Central to the consultation approach has been the eliciting of problems from the teachers and developing with them possible solutions. Those problems and the possible solutions have actively been explored by the mental health consultant and have been carried back into the school system at various levels in order to secure some movement toward implementation. One such effort in an elementary school centered around children's reactions to failure and the need for successes. The discussion focused on a need for speech and hearing programs—there were none available. Several implementation approaches were developed by the teacher group. These were tested for feasibility through the administrative structure of the school system and through contacts with various university departments. The suggested approaches were found to be unworkable. Even so, the problem and the need

was carried back into the system repeatedly over a period of several months until the ESEA coordinator indicated that he could obtain funding if the consultants could find some help. With the license gained from the contact, the consultants contacted the speech and hearing program at the local university, found interest and set up a meeting between the interested parties. This meeting resulted in the system having, this year, a speech supervisor and three graduate students in speech pathology on a one day per week basis. Recruitment is currently under way for full time speech personnel. Similar meetings have resulted in focusing interest on the trainable retardates (an interest group is exploring the possibility of developing a sheltered workshop), on the retardate drop-out from school (efforts have been initiated to develop a vocational rehabilitation co-operative program for the system), and on the potential drop-out (a group is exploring the feasibility for applying for Title III project funds for developing a junior high vocational education program). Currently ongoing are a pilot "Olders Teach Youngsters" project in two schools and an active behavior modification consultation program with fifteen head start classes.

Thus far, efforts to gain sanctions for citizen volunteer involvement in remedial education, in after-school recreation and in teach assistance programs have been unsuccessful. These potential projects have not been dropped, however, because citizen interest has remained high.

The description thus far sounds as if the entire focus has been on developing projects and programs. This, indeed, is not the case. A wide variety of case consultations around specific child and family problems have been entered into with plans being worked out with teacher and/or

principals for approach. In addition, a bi-monthly continuous problem conference has been set up by the consultant to meet with specialized helping personnel of the school system. This problem conference includes the curriculum supervisors, the guidance counselors, the school social worker, the school nurses and some of the non-teaching principals. This conference is directed toward problems at both the individual child, the individual teacher and program levels. This continuous case conference may provide a base for developing an active pupil personnel services division with the school system.

In summary, the focus of the consultative effort has been on the development of programs having preventive mental health implications as well as on specific individual level problems. The efforts have been continuous rather than short term. They have been by mental health program initiation rather than by consultee initiation. They have involved the eliciting of problems as well as the working on problems presented. And they have involved a very active participation in the consultee system. However, the consultant has not assumed an <u>administrative</u> role within the system. He has, rather, been an interested helper.

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