Reciprocal Consultation Guide

Domestic Violence & Mental Health Collaboration Project

King County, WA
May 2012

CONSEJO
Counseling & Referral Service

KING COUNTY COALITION AGAINST DOMESTIC VIOLENCE

New Beginnings
Ending domestic violence

Proudly serving the LGBT Communities since 1969
SeattleCounselingService

sound mental health

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Executive Summary

The Domestic Violence and Mental Health Collaboration Project, a recipient of funding from the federal Office on Violence Against Women, identified a need for a system of reciprocal consultation between partner agencies: Consejo Counseling and Referral Service, New Beginnings, Seattle Counseling Service, and Sound Mental Health. The resulting Reciprocal Consultation Initiative is part of an overall effort to create sustainable systems change in order to better meet the needs of survivors of domestic violence with mental health concerns.

Reciprocal Consultation is the process of sharing expertise across disciplines in order to improve service provision. It is available on an individual basis as needed as well as during scheduled meetings where one mental health service provider or domestic violence advocate provides consultation to a group of providers from the other discipline or from a different agency. It is distinct from supervision and is a valuable component of collaboration.

Since the Domestic Violence and Mental Health Collaboration Project is cross-disciplinary, we are not using a standard mental health or domestic violence consultation format, but a hybrid of the two. Respect for our differences, for each other, and for the people we are serving is important to the success of our consultations.

Immediate safety needs should be prioritized during consultation. The cultural identify of both the service recipient and the provider should be considered, but information that would disclose the identity of the service recipient should not be shared without release of information forms signed with both agencies.

Each partner agency has a consultation coordinator who will assist Collaboration Project providers in obtaining consultations and will track the consultations provided using the Requests Form. Providers seeking consultation will complete the Project's Consultation Form and will send the completed form including the recommendations provided to the Project Coordinator, alison@kccadv.org, so she can keep track of lessons learned. She is also available to address any concerns that arise.

We anticipate that our Reciprocal Consultation Initiative will result in increased communication and better understanding between providers, better services for survivors with mental health concerns, and stronger connections between partner organizations.

Introduction

In October of 2007 the Office on Violence Against Women (OVW), U.S. Department of Justice awarded a three-year grant to the City of Seattle Human Services Department's Domestic Violence and Sexual Assault Prevention Division for the Domestic Violence and Mental Health Collaboration Project. The purpose of the grant was to create sustainable systems change for survivors of domestic violence who have mental health concerns.

In October of 2010 the Office on Violence Against Women (OVW), U.S. Department of Justice awarded a two-year continuation grant to the Domestic Violence and Mental Health Collaboration Project to continue and build upon the project's work. The City of Seattle turned over the leadership for the project to the King County Coalition Against Domestic at that time. Currently, the Domestic Violence and Mental Health Collaboration Project is a partnership between the following agencies:

CONSEJO
Counseling & Referral Service

A social service organization that provides behavioral health and domestic violence services to Latinos, many of whom speak Spanish as their primary language.

KING COUNTY COALITION AGAINST DOMESTIC VIOLENCE

A county-wide coalition of domestic violence agencies and allied organizations that works to end domestic violence by facilitating collective action for social change.

New Beginnings
Ending domestic violence

A community-based domestic violence agency that provides a 24-hour help line, advocacy-based counseling services, support groups, emergency shelter, and transitional housing.

Proudly serving the LGBT Communities since 1969
SeattleCounselingService

A community mental health agency for lesbians, gay men, bisexuals, and transgender (LGBT) persons that provides mental health care, addictions treatment, domestic violence/sexual assault advocacy, and HIV/AIDS services.

sound mental health

A large, community mental health agency that provides a full continuum of recovery-oriented mental health and drug/alcohol treatment services including crisis intervention, rehabilitation, support, education, outpatient therapy, and residential programs.

As part of a comprehensive planning process, the DV/MH Collaboration Project conducted a needs and strengths assessment that revealed that we could benefit from better communication and more collaboration with each other. The assessment informed our strategic planning process and we collectively agreed to implement four initiatives during our initial grant period (2007-2010). They were:

1. Create welcoming environments
2. Enhance knowledge of domestic violence, mental health and related issues among staff of partner agencies on an ongoing basis
3. Strengthen issue identification and response among partner agencies
4. Increase collaboration and communication among partner agencies

The continuation grant we received from OVW enabled us to build upon the work of our first four initiatives with four additional initiatives (2010-2012). They are:

1. **Training and technical assistance** – share tools we have developed and lessons we have learned during our initial grant period with other mental health and domestic violence agencies in King County
2. Integrate **trauma-informed practices** into each of the collaborating partners' service delivery models
3. Pilot **cross-disciplinary support groups** for domestic violence survivors with mental health concerns at our partner agencies
4. Offer regular **reciprocal consultation** across partner agencies and disciplines

This guide has been designed to prepare partner agencies to participate in the Reciprocal Consultation Initiative. Reciprocal Consultation is the process of sharing expertise across disciplines in order to improve service provision. It enables providers to learn from each other in order to better address the needs of the people they are serving rather than merely referring them elsewhere. Reciprocal consultation may take place between providers from the same organization or from different organizations.

Reciprocal consultations may take place on an as needed basis. Any service provider from a Collaboration Project partner agency may contact the consultation coordinator at the partner agency from whom they wish to receive consultation. See page 13 for the contact information for the consultation coordinators and for a list of available consultation topics.

Reciprocal consultations will also take place on a regularly scheduled basis. These consultations will be scheduled by the Project Coordinator in conjunction with each of the participating agencies and will involve a mental health service provider from one agency or program offering consultation to a group of domestic violence advocates from another agency or program on multiple cases at once and vice versa. For example, Sound Mental Health will send a clinician to provide consultation to a group of advocates at Consejo in order to address multiple cases involving domestic violence and mental health concerns during one meeting.

Since this initiative is cross-disciplinary, we are not using a standard mental health or domestic violence consultation format. Instead we are utilizing a process that can meet the needs of both disciplines. The success of our reciprocal consultation depends on all participants having a shared understanding of the purpose of and the process for this. Please carefully read this guide and direct any questions or concerns to the Project Coordinator, Alison Iser, at alison@kccadv.org or at 206.568.5454.

Goals of Reciprocal Consultation

- ❒ To increase knowledge of the intersection of domestic violence and mental health concerns
- ❒ To increase comfort with serving survivors with mental health concerns
- ❒ To increase understanding of how to link people to services
- ❒ To decrease tension and to clear up misconceptions between the domestic violence and mental health fields
- ❒ To broaden thinking to a cross-system perspective
- ❒ To increase understanding of cultural issues
- ❒ To increase ability to give and receive constructive feedback
- ❒ To increase awareness of one's own thoughts, feelings, beliefs, and triggers and how they influence one's work
- ❒ To identify training needs

Anticipated Results of Reciprocal Consultation

1. Increased communication and better understanding between providers
2. Increased understanding of and better services for survivors with mental health concerns
3. Stronger connections between partner organizations
4. Service recipients being connected more quickly and consistently to appropriate services

Consider Seeking Consultation When…

- Strategies to assist a survivor with mental health concerns have not been as effective as you would like and additional perspectives would be helpful.
- The survivor's situation is complex and involves multiple factors, such as cultural influences, immigration, legal issues, parenting, etc.
- The survivor is from a marginalized or minority community that differs from your own cultural identity[1].
- It would be helpful to have additional resources or when resources are limited for the survivor (e.g., the survivor is undocumented.)
- The issue or challenge you are addressing is commonly encountered by participants or providers and it would be useful to get a fresh perspective on it.
- You find yourself reacting strongly to the survivor's behavior or choices.
- You are encountering systems-level challenges or barriers.

[1] Cultural Identity is unique to each individual and is made up of many cultural factors including: age, class, disability, economic status, education, ethnicity, gender expression, geographic location, immigration status, language, national origin, neighborhood, politics, profession, race, religion, sexual identity, and spirituality.

Differences between Consultation, Supervision, and Collaboration

Consultation, the focus of this guide, is not the same as supervision or collaboration. It is a process by which a service provider seeks guidance regarding how to best provide services. This guidance might be provided by a co-worker, a supervisor, or a colleague from another agency.

Providing and using feedback in consultation is typically voluntary and free from obligation, supervisory responsibility, and liability. An exception to this might be consultation from an agency's in house psychiatrist.

Supervision is a process for providing clinical or advocacy support and guidance, clarifying agency protocol and expectations, and discussing strengths and challenges related to employment and employment performance. Supervision typically takes place between an employee and his/her direct supervisor.

Supervision implies an obligation for the supervisee to follow the suggestions provided and a measure of responsibility on the supervisor's part for the outcome. Supervision is outside the scope of the Reciprocal Consultation Initiative.

Collaboration is a working partnership between organizations for the purpose of accomplishing common goals. Partners all have a stake in the success of the collaboration and have a high level of interactivity. The partnership includes the sharing of information, resources and effort, as well as sharing the benefits of success.

Consultation may be a component of collaboration since collaboration ideally includes mutual sharing of expertise. However, consultation by itself does not equal collaboration. To achieve collaboration further steps need to be taken.

The DV/MH Collaboration Project strongly encourages both consultation and collaboration.

Tips for Cross-Disciplinary Consultation

Cross-disciplinary consultation will be most successful if we approach it with respect for our differences and for the expertise that each person brings to the process. While we have much in common, the domestic violence and mental health fields have different origins, different approaches to service provision, and sometimes have different philosophical perspectives.

For example, boundaries are more likely to be a focus of consultations between case managers (providers who assist individuals with serious chronic mental health disorders to get their basic needs met) while domestic violence advocates are more likely to discuss social justice and clinicians are more likely to discuss transference and counter-transference[2]. In a cross-disciplinary consultation issues of relationship dynamics, social justice, etc. do not need to be ignored, but can be explored within the framework of how the intersection of domestic violence and mental health concerns impacts service provision and how it impacts the service provider. The goal of reciprocal consultation is not to become more similar, but to broaden our understanding and to improve our services.

It does help to understand the role of the person receiving consultation. If you are not sure, ask the person to tell you. For example, suggesting that an advocate explore family of origin issues with a service recipient would not be helpful because that is outside the scope of advocacy. Similarly, suggesting that a therapist accompany a service recipient to a court hearing is not realistic given the constraints of a therapist's schedule and the funding structure for community mental health agencies.

[2] Transference and counter-transference are concepts that were initially defined by psychoanalysts and that are now used by many therapists from a variety of theoretical orientations. Transference refers to a client's unconscious projections of feelings about significant people in their life onto the therapist. For example, a client may unconsciously see the therapist as a mother figure and respond to her with the love or anger she feels for her mother. Counter-transference refers to a therapist seeing themselves in a client, over identifying with a client, or trying to get their needs met through their work with a client. For example, a therapist might develop romantic feelings for a client or feel like he needs to rescue the client from his troubles.

Ideally, transference can be a helpful process that enables a client to develop insight and work through challenges in therapy. While counter-transference can interfere with objectivity; if approached constructively, it can enable insight into the needs of the client.

Relationship building between service providers and between agencies is also an important consideration during consultations. Consider how the questions posed and the recommendations provided can strengthen those ties. Show appreciation for the other person's participation. Demonstrate respect for the service recipient. Trust that your partner in consultation shares your goals for providing good services. If your partner expresses ideas that are concerning to you, uses language that you feel is inappropriate, or appears ignorant, consider this an opportunity to provide a new perspective rather than an invitation for confrontation. If your concerns are not resolved during the consultation, you are encouraged to contact your agency's liaison or the Project Coordinator, Alison Iser, for assistance in resolving the situation.

Tips for Obtaining Quality Consultation

- Be clear about what you need from the consultation. Prioritize your questions.
- Limit the information you share to what is necessary. Avoid sharing information merely because it is interesting, novel, or surprising.
- Briefly mention some of the strategies that you have already tried.
- Do not rely on the consultant to provide you with all the answers. Ask the consultant to assist you in arriving at solutions yourself when possible.
- While it may be tempting to explain why you have or have not taken a particular approach, try to focus on the consultant's recommendations, not on responding.
- Ask for clarification if language or terminology is used that is not familiar to you.
- Let the consultant know if you have concerns about their recommendations or if you do not feel they are feasible. Clarification or additional suggestions may help.
- Repeat back the key recommendations to ensure that you heard them correctly and summarize any follow up steps.
- If you are not sure if the suggestions provided are a good fit with your agency's philosophy, policies, and procedures, check with your supervisor prior to implementing them.

Tips for Providing Quality Consultation

- If you do not have the necessary expertise to provide consultation, offer to assist with finding a consultant who can help.
- Check in with the person seeking consultation to make sure that you understand what they need and to assist them in prioritizing their questions, if needed.
- Ask about their experience or comfort level with the issue for which they are seeking consultation and briefly describe your experience with the issue.
- Ask what strategies they have already tried.
- Focus on what the person is requesting, not on how you are going to respond. If needed, ask for some time to formulate recommendations.
- Assist the person seeking consultation in finding their own solutions.
- Acknowledge the service provider's strengths prior to offering constructive feedback or a new approach.
- When offering feedback, be cognizant of the inner resources of the service recipient (i.e., what they can and cannot accomplish at that point in time.) For example, a survivor might not be ready to explore their trauma history prior to strengthening their coping skills and their support network.
- If you feel that the person seeking consultation needs support around boundaries or counter-transference, refer them to their supervisor for that assistance.
- Ask if the person seeking consultation received what they needed.
- Suggest additional resources (e.g., articles, websites, etc.) that may be helpful.
- Instill hope. This is an important part of service provision and it is also a valuable component of consultation.

Key Questions

Are there any immediate safety needs that need to be addressed and prioritized?

Risks from a current or former abusive partner?

Intentional self-harm?

Suicidality?

Threat of deportation?

Other immediate safety needs?

What does the service recipient want from the agency or agencies providing services?

How does the service recipient's cultural identity affect their options, resources, and barriers?

How do the service provider's beliefs about the service recipient's cultural identity affect the services provided?

How might a particular approach or resource impact the service recipient's safety, support system, healing, recovery, and self-determination?

Following the consultation, do the provider and the provider agency have the sufficient expertise and resources to provide quality services to the service recipient? If not, what gap still exists and what can be done to address this gap?

What resources are available for learning more about the issues discussed?

Available Consultants

The consultation coordinator can connect you with the appropriate consultant.

Agency	Coordinator	Contact Info
Consejo	[redacted]	
New Beginnings	[redacted]	
Seattle Counseling	[redacted]	
Sound Mental Health	[redacted]	

Domestic Violence Topics	Organizations that can provide consultation
Chemical Dependency	New Beginnings
Children and Youth	New Beginnings
Domestic Violence	Consejo and New Beginnings
Immigration	Consejo
Same Sex Domestic Violence	Seattle Counseling Service
Shelter	New Beginnings
Transitional Housing	Consejo and New Beginnings

Mental Health Topics	Organizations that can provide consultation
Chemical Dependency	Consejo and Seattle Counseling Service
Children and Youth	Consejo and Sound Mental Health
Chronic Mental Illness	Sound Mental Health
Coming Out	Seattle Counseling Service
Deaf Services	Sound Mental Health
Developmental Disabilities	Sound Mental Health
Diagnostic Treatments	Sound Mental Health
Dual Diagnosis – CD/MH	Sound Mental Health
Families	Sound Mental Health
HIV/AIDS	Consejo and Seattle Counseling Service
Latino Services	Consejo
LGBT Youth / Dating Violence	Seattle Counseling Service
Mental Health	Consejo, Seattle Counseling and Sound Mental Health
Offender Treatment	Sound Mental Health
Older Adult Services	Consejo and Sound Mental Health
Sexual Assault	Consejo and Seattle Counseling Service
Sexual Minorities	Seattle Counseling Service
Transgender Services	Seattle Counseling Service
Trauma Informed Care	Sound Mental Health

Guidelines for Participants

Feedback

When offering feedback, please do so from a strengths-based perspective (for both the service recipient and the service provider.) The purpose of the consultation process is not to develop a plan for the service recipient, but to develop the provider's skills and knowledge. Out of respect for service recipients, speak as if they were present.

Language

Try not to use lingo or acronyms that are specific to your field. If it is necessary to use them, be sure to define them.

Identifying Information

Unless the service recipient has signed release of information forms from both agencies specifying that staff from the two agencies may discuss them, **do not disclose identifying information**. What constitutes identifying information may vary depending on circumstances. For example, if an incident has been in the news or if the service recipient is from a minority community, then specific details about their situation may be identifying even if their name is withheld. For information about confidentiality similarities and differences between the domestic violence and mental health fields, see the comparison chart on page 18.

Documentation

Each person seeking consultation will complete a DV/MH Collaboration Project Consultation Form and will give a copy to the person providing consultation (in person, over the phone, or via email.) The person providing consultation will shred their copy and will delete any electronic versions following the completion of the consult, but may retain the portion that describes the recommendations and follow up. Organizations are welcome to document information regarding their own service recipients, but may not document information regarding the service recipients of other organizations. The person seeking consultation will send a copy of the consultation form including the recommendations provided to the Project Coordinator Alison Iser at alison@kccadv.org.

The Consultation Coordinator for each partner agency will fill out a Consultation Requests Form and email it to the Project Coordinator following the end of each month. She will use the forms to compile the annual lessons learned report and to keep track of the number of consultations conducted.

DV/MH Collaboration Project Consultation Form

This form is not intended to replace agency-specific paperwork, but is instead meant to prepare both the person seeking and the person providing consultation for the process of cross-disciplinary consultation. The person seeking the consult needs to send the completed form with recommendations included to alison@kccadv.org.

Date of Consultation: _____

Client Name / Number*: _____

Person Requesting Consultation

Name _____

Title _____

Organization _____

Person Providing Consultation

Name _____

Title _____

Organization _____

Describe the main issue you would like addressed:

_____

_____

_____

Describe the service recipient's relevant history and current needs:

_____

_____

_____

_____

_____

_____

Why are you seeking consultation?

_____

_____

_____

……✂……✂…….

Consultation recommendations:

_____

_____

_____

Follow up, if any:

_____

_____

Do not include any identifying information about the service recipient on this form unless the service recipient has signed a release of information form with **both providers. A pseudonym may be used to facilitate ease of communication.*

DV/MH Collaboration Project Consultation Requests Form

Each Consultation Coordinator will complete this form and email it following the end of each month to alison@kccadv.org.

Agency:			**Month:**		**Year:**	
Date of Request	**Person Seeking Consultation**	**Agency**	**Phone Number**	**Email Address**	**Topic**	**Person Providing Consultation**

Confidentiality and Privilege - Differences and Similarities for Community-Based Domestic Violence and Mental Health Providers

Please note that this information is not intended to constitute legal advice. It is for informational purposes only.

Area	Community-Based DV Service Providers	Community-Based MH Service Providers
Background	Both fields are concerned about the best interest of the service recipient. Both fields educate service recipients about how information is used and about their rights.	
	Honoring service recipients' confidentiality is seen as critical to reinforcing autonomy and self-determination. Survivors should ideally determine how their own info is shared. Confidentiality & safety are highly related. Abusers often seek out info about their partners in hopes of using it to further their control.	The service recipient's role in making decisions about sharing info is emphasized. Funders require info (e.g., diagnosis and treatment plan) from providers. Liability concerns influence documentation practices.
Documenta-tion Practices	There is a strong contrast in documentation practices.	
	The emphasis is on documenting as little as possible in order to protect the service recipient.	The emphasis is on documenting thoroughly in order to provide an accurate clinical picture, to meet the expectations of funders/gov't, and to protect the organization from liability.
Consultation	The use of external consultation and the specificity of info shared during consultation differ significantly.	
	External consultation is not routinely sought, but if sought, would not include identifying information. Info might be altered or made quite general in order to safeguard the identity of the service recipient.	Consultation is required for "special populations" and is routinely sought regarding best practices, risk to self and others, coordination of care and medication. Providing detailed information is considered the best way to obtain useful advice. In some cases, service recipient names may be shared.

<table>
<tr><td rowspan="2">Limits to Confidentiality</td><td colspan="2">Differences:
It is permissible for MH providers to share info without ROI's with other professionals.
It is not acceptable for DV advocates to do so.
MH providers are required to report communicable diseases that pose a public health risk.
DV providers are not.

Similarities:
Both fields inform service recipients about their confidentiality policies and the limits to confidentiality.
Both fields report child abuse, vulnerable adult abuse, and danger to self or others.
Both fields typically share only the information necessary when making mandatory reports.
Sharing info inappropriately violates state and federal laws and could have financial consequences for both fields.</td></tr>
<tr><td>Info would only be shared internally on a "need to know" basis, for mandated reporting, or in response to a court order (although court orders would typically be fought via legal means.)

Service recipients are often encouraged to make child abuse reports themselves with the assistance of their advocate.</td><td>Limited info is shared without a Release Of Information form for the following reasons:
1. For payment
2. To assess operational quality (audits)
3. For mandated reporting
4. Consulting with another MH professional (some orgs may require ROI for this)
5. Health & welfare (e.g., if client is in ER)
6. To a coroner or medical examiner for investigation of homicide or suicide
7. If the service recipient is involuntarily detained for treatment, then urgent clinical info can be shared, next of kin may be notified.
8. After death, permission to access records goes to next of kin or a legal representative. MH providers limit access as much as possible, but records can be obtained with a court order.</td></tr>
</table>

Info Shared with Authorization	While both fields typically seek to limit the info that is shared with a ROI, the differences in documentation practice mean that MH providers have much more info that they may potentially share.	
	Info shared is typically very narrowly defined and pertinent to a particular situation. Even with a broad ROI, info shared would be limited.	Info shared is typically narrowly defined. Even with a broad ROI, info shared would typically be less than the whole file. Professional standard is "minimum necessary."
Release of Information (ROI) Forms	Both fields have the following minimum standards for ROI's: Who info is being released to, what info is being released, when it expires, and option to revoke at any time. The ROI must be voluntary and written (not verbal.) If no end date is given, it is valid for 90 days.	
	Advocates explain the importance of being clear about what info can be shared and the potential risks of sharing info. Advocates sometimes give service recipients the option of signing a release to share info, if they are murdered.	MH providers are medical providers and adhere to HIPAA regulations. However, Washington State laws regarding ROI's for Mental Health & Chemical Dependency service providers are stricter than the federal HIPAA standards. Many MH agencies have policies that are even stricter than state law requires.
Accepting ROI's from Other Agencies	There is a strong contrast in ROI acceptance practices.	
	Typically, service recipients must sign DV program's ROI even if ROI is received from another provider. This is to ensure that service recipient received info about the risks and benefits of sharing info.	Will accept ROI from another agency if it meets the requirements of WA State law & HIPAA and appears to be valid.

<table>
<tr><td rowspan="2">Records Access</td><td colspan="2">MH funders (including the government) have access to service recipient records while DV funders do not. Neither field encourages service recipient review of records.</td></tr>
<tr><td>People with access to a service recipient's record:
Staff on a "need to know" basis
Service Recipient (in the presence of a staff person)
DV funders may have access to random individual records, and generally have access to aggregate data.</td><td>People with access to a service recipient's record (varies depending on funding source for their services):
Staff on a "need to know basis"
Service Recipient (parts of the record may be marked out, if the therapist deems that the info is harmful to the service recipient)
The County MH Division for people they fund
Insurance Companies
Crisis Team has access to service recipient's Crisis Plan</td></tr>
<tr><td rowspan="2">Privilege</td><td colspan="2">Both fields have privilege. Privilege includes info that is confidential, but not all confidential info is privileged. Privilege protects DV Advocates and MH Professionals from having to testify about conversations with service recipients and helps protect their records. In order for communication to be privileged, it must occur between the provider and the service recipient only, with no one else present.
There is an exception for interpreters who are present solely to facilitate communication.
Because privilege is relatively new for both fields, the application of privilege is not yet well defined.</td></tr>
<tr><td>Privilege for DV Advocates in WA State began in June 2006.</td><td>Privilege for MH Professionals in WA State began in October 2009.</td></tr>
<tr><td rowspan="2">Situations that Invalidate Privilege</td><td colspan="2">For both fields, the service recipient can choose to waive privilege.</td></tr>
<tr><td>Service recipient waives privilege
Others are present for the communication (e.g., happens during support group or while friends or family are present)
Mandatory reporting
The info is shared later with another party</td><td>Written ROI
Service recipient waives privilege by suing the provider
A subpoena from the Secretary of Health in response to a complaint about the provider
Mandatory reporting</td></tr>
</table>