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**Article:**
Ghag, J., Kellett, S. and Ackroyd, K. (2021) Psychological consultancy in mental health services: A systematic review of service, staff, and patient outcomes. Psychology and Psychotherapy: Theory, Research and Practice, 94 (1). e12264. pp. 141-172. ISSN 1476-0835

https://doi.org/10.1111/papt.12264

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## Abstract

**Objectives.** Psychological consultation in mental health is an organisational intervention aiming to enable mental health care to be delivered in a more efficient manner. This review sought to: (1) clarify what theoretical models underpin consultancy, (2) define how consultancy is implemented, (3) assess the methodological rigour of the evidence base and (4) define the outcomes achieved for services, staff and patients. The review was focal to direct and indirect forms of consultation.

**Method.** PRISMA guidelines were followed. Three databases were searched identifying N=17 studies and these were quality assessed using the QualSyst quality ratings checklist. Studies were grouped by model of consultation and outcome. A thematic analysis then clustered the patient, staff and service outcomes into either discrepant or confirmatory evidence.

**Results.** The most frequently adopted theoretical models underpinning psychological consultation are cognitive-behavioural and cognitive-analytic. Method of consultancy implementation is typically via case formulation meetings. Study quality varied from limited to strong. The main confirmatory and positive outcomes for staff were an increase in understanding and also more positive feelings towards patients and for the service there is reduced need for other interventions.

**Conclusions.** Psychological consultation appears a useful and worthwhile aspect of leadership by psychological therapists. Training in delivering consultancy needs to be well integrated into the core curricula of clinical training programmes. The evidence base is still in its infancy and further well-controlled research is required.

**Practitioner Points**

- Psychological consultation improves staff insight and understanding of patients.
- Psychological consultants need to remain visible and accessible to teams and use a theoretical model to guide consultation.
- Training and supervision in consultation are necessary to support psychological therapists in these roles.

Psychological therapists are increasingly required to offer more than just direct therapeutic work in order to influence outcomes for the ever increasing numbers of patients accessing mental health services (Department of Health, 2007). Clinical-organisational consultation is therefore a key means of providing 'indirect work' (Nolan, 2014) to influence and improve how other mental health professionals deliver care to patients. Onyett (2007) argued that consultation was a key method for delivering psychologically-informed care in an efficient manner. Consultation supports staff particularly in developing their therapeutic skills whilst working with complex clients (Sampson, McCubbin, & Tyrer, 2006). Furthermore, Onyett (2007) stressed the importance of psychological therapists supporting reflective practice through consultation. The reflective space offered by consultation is consistent with the Francis Report (2013) that stated that psychological therapists should enable and facilitate compassionate organisational cultures (Oelofsen, 2014). Given the increasing availability of psychological interventions globally in mental health systems (Singla et al. 2017), then the development of evidenced-based consultation has international relevance (Sperry & Sperry, 2012).

There are many models of consultation, including behavioural consultation (Bergan & Kratchowill, 1990), process consultation (Schein, 1988) and organisational systems consultation (Gutkin & Curtis, 1999). Consultation aims to increase staff confidence, by helping them to be more skilful and competent in their work and so improve the experience of care for patients (Caplan, 1970). As psychological consultation enables greater understanding and insight into patients, it aims to increases the bandwidth of possible helpful interactions and interventions and reduce the frequency of unhelpful/harmful interactions (Evans, Law, Turner, Rogers, & Cohen, 2011). Consultation provides a link between psychological theory and clinical practice

(Johnstone & Dallos, 2013), whereby psychological concepts and associated change methods can then be implemented by other professionals (Onyett, 2007). Consultancy is not to be confused with clinical supervision (Milne & James, 2000; Whitton, Collinson, & Adams, 2013). The supervisor is accountable for the supervisees' practice, whereas the consultant provides guidance/advice, which the consultee (or team, ward or organisation) can then choose whether to implement or not (Alban & Frankel, 2007). Being competent in working psychologically across teams and care systems is now a fundamental aspect of the practitioner psychologist role (HCPC; 2015).

Carradice and Bennett (2012) provided a framework that differentiated the possible levels of consultation (see Table 1). This review is focal to psychological consultation delivered at levels 1b and 2, because this is the form of consultancy work appears the most commonly practiced in services (BPS, 2007). Leadbetter (2004, p 134) however stated *"research into consultative practices is very sparse both in terms of evidence of outcomes, but also in terms of illuminative studies that could further understanding of how consultation is structured and managed."* A previous systemic review (Geach, Moghaddam & De Boos, 2018) of eleven team formulation studies noted three types of implementation; (1) a structured consultation approach, (2) via semi-structured reflective practice meetings and (3) by using an unstructured ad hoc approach. This current review is differentiated by being guided by an existing model (Carradice & Bennett, 2012), identifying more recent studies, focussing on identifying the theoretical underpinning of consultation and producing a far more detailed analysis and synthesis of outcomes across patients, staff and services. The rationale for this review was to (a) provide recognition that consultancy is an established aspect of psychological therapists' roles, (b) provide an up-to-date synthesis of the consultancy outcome evidence that then informs commissioners and policy makers, (c) identify

good research practice and (d) to highlight any potential risks or pitfalls of the consultation approach.

## Methods

### Design and Search Strategy

The systematic review was conducted according to the PRISMA guidelines (Moher, Liberati, Tetzlaff & Altman, 2009). Traditionally, heterogeneity is minimised to ensure reliability of systematic review findings (Lorenc et al., 2016). However, the questions being asked about psychological consultation in the present review were complex. Petticrew et al. (2013) argued that incorporating complex review questions facilitated greater understanding regarding the processes and outcomes of psychological interventions. The present review therefore did not limit studies by design and attempted to synthesise results across quantitative, qualitative and mixed-method consultation outcome studies. Literature searches were conducted using bibliographic databases PsycINFO (for papers between 1806 – May Week 1 2019), Scopus and Web of Science Core Collection (between 1900 – 2019). Google Scholar was also accessed to find any grey literature and unpublished studies. This identified N=9 studies for which the authors were approached and given one month to supply the paper. To identify studies not captured in the electronic searches, ancestry searching from the reference lists of the articles was conducted. No start date parameters were set to ensure all relevant studies were captured. Searches were conducted based on the search string psychol* AND (consult* OR "indirect work" OR "team based formulation" OR "case formulation" OR "case conceptualisation" OR "case consultation" OR “reflective practice”) NOT (sport* OR school OR coach* OR police). The NOT term was used to exclude studies according to eligibility criteria. The keywords were searched for in the title and abstract fields and duplicates removed. The remaining studies were screened in

two stages (a) titles and abstracts were assessed to eliminate clearly irrelevant studies and (b) full-texts were assessed when it was unclear as to whether studies met the eligibility criteria. Results were combined in EndNote Basic.

## Selection of studies

The process of paper selection is presented as a PRISMA diagram in Figure 1. Two authors (JH and SK) were involved in the screening process; GH independently screened the titles and abstracts for relevance and these were cross-checked by SK. If it was not possible to decide on selection from the title and abstract, a full-text screening was performed. Any disagreements between reviewers were resolved through discussion.

### Eligibility Criteria

To be included studies need to (a) have delivered and evaluated psychological consultation, (b) have been delivered at levels 1b and 2 of the Carradice & Bennett (2012) model, (c) had an identifiable hypothesis or research question and (d) been published in English. Studies were excluded when, (a) the focus was on clinical supervision, (b) the consultation was provided to other psychological therapists, (c) concerned sports/educational/coaching/police psychology and (d) when studies were not primary research.

### Data extraction

A bespoke data extraction tool was used to extract equivalent details of methods and results from each consultancy study. GH extracted the information and this was cross-checked by SK. Any disagreements between reviewers were resolved through discussion. The information extracted included: country and clinical setting, design, sample sizes of patients and staff, mode of implementation, theoretical model

employed, level of the consultancy and outcomes measured. The data extraction form also included aspects of data relevant to the risk of bias.

**Data reporting**

The results, including risk of bias, were grouped by theoretical model of consultation and reported via subgroups of different types of outcome (i.e. service, staff and patient). Agreement on rating risk of bias were determined using Cohen's kappa (McHugh, 2012). As the studies were too heterogeneous for a quantitative synthesis, data were first narratively summarised and then an outcome synthesis performed. This synthesis was performed in order to assess whether the outcomes were discrepant (i.e. suggesting inconsistency of outcome and so questionable reliability) or confirmatory (i.e. suggesting consistency of outcome and reliability). Consistency of coding in the outcome synthesis were also analysed via Cohen's kappa (McHugh, 2012).

**Quality Ratings**

Each study was scored using the QualSyst quality ratings checklist (Kmet, Lee, & Cook, 2004). QualSyst provides quality assessment criteria to evaluate both quantitative and qualitative primary research papers and this checklist is particularly appropriate for literature reviews across broad-based study designs (Kmet et al., 2004). The quantitative aspect of the checklist contains 14 criteria that equate to 28 total possible points. Each criterion is allocated two points when met, one point when partially met and no points if not met. These are summed together to create a total sum. There is also an option for not applicable (NA) where the total number of NA's multiplied by two, generates a total possible sum. The final summary score is calculated by dividing the total sum by the total possible sum. The qualitative checklist contains 10 criteria that equate to 20 total possible points. Each criterion is allocated two points when met or one point when partially met. The final score is calculated by dividing the total points

achieved by 20. Lee, Packer, Tang, and Girdler (2008) provided a QualSyst score interpretation guide: strong (>0.80), good (0.71-0.79), adequate (0.50-0.70) and limited (<0.50). Three papers were randomly selected (one from each methodology; quantitative, qualitative and mixed methods) and then second-rated by an independent assessor (a trainee clinical psychologist). Inter-rater reliability was at the almost perfect agreement level ($\kappa$ = .82, 94% agreement; McHugh, 2012).

**Data analysis**

The analysis took place in two phases. To address the first three aims of the review, studies were first grouped by the model of consultation used and data related to the mode of consultation were extracted and quality scores reported. To address the fourth aim of the review, results from the original studies were then synthesised by clustering outcomes related to patients, staff and services via a thematic analysis (Braun & Clarke, 2006). The approach taken was inductive (Goddard & Melville, 2004) as this analysis aimed to generate broad conclusions concerning outcome from the consultancy evidence base. Patterns and regularities in outcome were recorded in order to reach conclusions. This involved extracting quantitative results from the quantitative and mixed methods studies (e.g. when significant change on a primary outcome measure had been reported), which then formed the basis of a template for the qualitative studies. Qualitative themes from the qualitative and mixed methods studies were extracted literally (to preserve meaning) and added to the template based on conceptually similar results. Therefore, the themes extracted were the latent themes from the original studies. Through an iterative process of clustering around main themes and subthemes, a table of synthesised results from the studies was generated. Two studies were required to generate a subtheme. This process allowed a combined picture to emerge from the outcomes of the studies. The value of each theme could then be

assessed on the quality of the studies and whether the various findings contradicted or confirmed each other. Where findings were confirmatory, themes were coded whether they broadly agreed and added depth (i.e. "confirmatory: convergent and expansion") or findings broadly agreed and added breadth (i.e. "confirmatory: convergent and complementary"). A trainee clinical psychologist second blind-rated the convergence codes; inter-rater agreement on the convergence codes was $\kappa = .82$ (89% agreement), $p < .05$, suggesting an almost perfect level of agreement.

## Results

The PRISMA is presented in Figure 1 and this illustrates that *N*=17 eligible studies were quality assessed (Kmet et al., 2004). The details of these studies and the associated quality scores are summarised in Table 2. The seventeen studies contained N=383 staff and N=145 patients. In terms of the levels of consultation work, then 15/17 (88.23%) of the studies evaluated indirect consultation at level 2 (Carradice & Bennett, 2012) and two evaluated the direct form of consultation (i.e. where the patient and the staff member are present during the consultation; Kellett et al. 2019; Prior et al. 2003).

Four studies used a purely quantitative design, seven a purely qualitative design and six studies used mixed-methods (i.e. housed within two randomised controlled trials). All studies were conducted in the UK. Staff sample sizes ranged from 5-89 and the patient sample sizes ranged from 1-58. Where qualitative or mixed methods were used, only two studies ascertained the patient perspective on consultation; both of these studies reported a positive patient experience (e.g. feeling that the care quality had improved). Typically, consultation was delivered via team formulation meetings and

this was the case for all the CBT consultation studies. All consultation was delivered by clinical psychologists or psychological therapists. Use of manuals to enable consultation fidelity was rare, with only one study reporting the use of a manual (Kellett et al. 2019).

In terms of study quality, then 58.82% (10/17) of studies met criteria for strong methodological quality. All studies were of at least adequate quality, except for two mixed methods study where the quantitative aspect was of limited quality (Prior et al., 2013) or the qualitative aspect was of limited quality (Stratton & Tan, 2019). Stronger quantitative consultancy studies were characterised by clear objectives, appropriate study design, appropriate participant selection strategy and sample size, blinding procedures and use of appropriate analyses. Stronger qualitative consultation studies were characterised by clear objectives and appropriate study design, with connections to a theoretical framework, clearly described data collection and analyses, use of verification procedures and researcher reflexivity.

**Models of psychological consultation and organisational contexts.**

*Cognitive-behavioural consultancy.* Seven studies used a cognitive-behavioural consultation approach, which formulates the life experiences that create current patterns of thoughts, feelings and behaviour for the patient. All seven studies accessed staff viewpoints (with an average sample size of 19 staff) and the three CBT studies that accessed patient views simultaneously had an average sample size of N = 27 patients. The specific models were Beckian (Berry et al. 2009; Berry et al. 2015; Murphy et al. 2013) with psychiatric rehabilitation staff or the “5 areas” approach with staff supporting intellectual disability patients (Ingham, 2011). Craven-Staines et al. (2010) used their self-devised Roseberry Park model (based on cognitive behavioural principles) with community and inpatient older adult staff. Summers (2006) with

psychiatric rehabilitation staff and Wainwright and Bergin (2010) with inpatient older adult staff, failed to state the use of a specific cognitive behavioural model, but reported using CBT principles. Berry et al. (2009) and Summers (2006) also used CAT/attachment and object relations theory, respectively, alongside CBT approaches.

*Cognitive analytic consultancy.* Three studies used a purely cognitive analytic therapy (CAT) consultation approach and one study was informed by CAT. Cognitive analytic consultancy is a relationally-based approach to consultation which facilitates insight into how patients and teams unhelpfully reciprocate. Each of the three purely CAT studies accessed staff viewpoints (with an average sample size of 12 staff) and two of the three studies accessed patient viewpoints and had an average sample size of N = 39 patients. Kellett et al. (2014) delivered cognitive analytic consultancy by delivering training based on CAT principles, followed by case consultation and CAT-based supervision in an assertive outreach team. Berry et al. (2009) used CAT as part of a mixed approach to their psychological consultation discussed above with psychiatric rehabilitation staff. Kellett et al. (2019) evaluated the use of the Carradice (2013) cognitive analytic consultancy model with community mental health teams across three routine service sites. Stratton & Tan (2019) evaluated team formulation consultancy based on CAT principles on an in-patient unit.

*Consultee-driven consultation.* Two studies used the consultee-centred model of consultation (Caplan, 1970; 1995) where particular attention is given to the consultees working difficulties with any patient. These studies had an average sample of N=27 staff and did not assess patient viewpoints. Dimaro et al. (2014) offered consultation to social workers in a looked-after children's setting. Evans et al. (2011) offered consultation to staff working in a residential care setting for young people.

*Graded sequence of stages of consultation.* One mixed methods study (Prior et al.,

2003) described grading the sequence of stages of consultation to health visitors from initial group consultancy session, to a one-off meeting with the child and their family.

*Undefined model.* Four studies did not specify any theoretical model and had an average staff sample size of N=29 and these studies did not assess any patient viewpoints. Clark and Chuan (2016) delivered consultation to probation officers working with offenders with personality disorder. Douglas and Benson (2015) delivered consultation via a psychosocial forum in a paediatric gastroenterology setting. Whitton et al. (2016) delivered consultation to a secure forensic intellectual difficulties and autism service. Mattan and Isherwood (2009) delivered consultation across different settings (e.g. intellectual difficulties, health psychology and adult mental health).

*Psychoanalytic/attachment/object relations.* Two papers (Berry et al., 2009; Summers, 2006) mentioned using attachment theory and object relations theory, respectively, as a secondary model.

**Content of the consultation**

Psychological consultancy contained a variety of differing methods. Thirteen of the seventeen studies (76.47%) explicitly described developing a case formulation as a part of the consultation process. Formulations were developed in the context of meetings with the MDT (Berry et al., 2015; Craven-Staines et al., 2010; Douglas & Benson, 2015; Kellett et al., 2014; Murphy et al., 2013; Summers, 2006; Wainwright & Bergin, 2010; Whitton et al., 2016; Stratton & Tan, 2019) or without the MDT (Berry et al., 2009). One study used case formulations with individual staff (Dimaro et al., 2014) and one developed case formulations with both staff member and patient present (Kellett et al. 2019). Of the five studies that did not use case formulation, the consultation consisted of general case discussion (Clark & Chuan, 2016; Prior et al., 2003), various (non-specific) approaches (Mattan & Isherwood, 2009) and two studies did not report

how they delivered consultation (Evans et al., 2011; Ingham, 2011). Other methods of psychological consultation included workshops (Ingham, 2011), training (Clark & Chuan, 2016; Kellett et al., 2014; Murphy et al, 2013) and a psychosocial forum (Douglas & Benson, 2015).

There was a large variation in the reported frequency and duration of consultation. Studies reported consultancy sessions running twice per week (Craven-Staines et al., 2010), weekly (Berry et al., 2015; Craven-Staines et al., 2010; Douglas & Benson, 2015; Prior et al., 2003; Stratton & Tan, 2019), fortnightly (Summers, 2006), monthly (Clark & Chuan, 2016), or as required (Dimaro et a., 2014; Evans et al., 2011; Mattan & Isherwood, 2009). One workshop ran over two days (Ingham, 2011), and a training session ran over three days (Murphy et al., 2013). Three studies reported no frequency at all (Berry, 2009; Kellett et al., 2014; Wainwright & Bergin, 2010; Whitton et al., 2016). In terms of duration, consultancy sessions ran for 1-hour (Berry et al., 2015; Prior et al., 2003; Wainwright & Bergin, 2010; Stratton & Tan, 2019), 1.5-hours (Craven-Staines et al., 2010), 3-hours (Ingham, 2011), 5-sessions (Kellett et al. 2019) or as required (Dimaro et al., 2014; Evans et al., 2011; Mattan & Isherwood, 2009). Seven studies failed to report the duration of the consultation.

**Outcomes of psychological consultation.**

Studies were clustered by the key outcomes regardless of model (see Table 3). The four overarching themes were (1) *client outcomes* (three subthemes: symptom improvement, reduction in problematic behaviour and improved service engagement), (2) *staff outcomes* (four subthemes: better patient understanding, increase in clinical confidence/competence, improved satisfaction/wellbeing and better feelings towards patients), (3) *consultant factors* and (4) *the wider organisational impact of the consultancy*. In summary, confirmatory findings of the positive impact of

organisational consultancy were found in relation to a reduction in problematic behaviour in patients, better patient understanding in staff, improved feelings towards the patient in staff, consultants being visible/accessible/skilful and consultancy preventing further unnecessary clinical interventions.

***Client outcomes***

*Symptoms.* Of the four studies that measures symptoms, only one reported statistically significant reductions in client symptoms. Two randomised controlled trials produced complementary findings in reporting no statistically significant change in client symptoms. Berry et al. (2015) reported no changes in longer-term client outcomes (e.g. symptoms, functioning, behaviour, on-going risk, changes in medication and relapses) during the 6-months prior to and during consultation. Kellett et al. (2014) reported that no statistical differences in psychological distress between the cognitive analytic consultancy (CAC) or treatment as usual (TAU) arms. One case series that enabled a baseline comparison showed that patients were significantly less fragmented (i.e. reductions to state-shifting on the Personality Structure Questionnaire; *PSQ*, Pollock et al. 2011) following consultation (Kellett et al. 2019).

*Problematic behaviour.* Both of two studies reported expansive findings in relation to reduced problematic behaviour following consultation. Ingham (2011) found post-consultation reductions in the levels of challenging behaviour (e.g. verbal and physical aggression) and reduced risks of a client's placement breaking down. Clark and Chuan (2016) found a significant and useful decrease in mean rates of prison recalls following consultation, and this effect was sustained over two years.

*Engagement with the service.* Three studies reported discrepant findings in relation to clients' engagement with services. Two of the three studies showed improved engagement. Clark and Chuan (2016) reported that failure to attend appointments was

reduced by two-thirds and Kellett et al. (2019) reported low dropout rates as a proxy for engagement. However, Kellett et al. (2014) found no significant differences in overall client engagement when comparing CAC with TAU.

***Staff outcomes***

*Increased understanding of the patient.* Eleven of the seventeen studies (64.07%) reported expansive findings reporting improvements in staff understanding of patients' difficulties following consultation. Three studies used quantitative approaches. Berry et al. (2009) reported staff increased their understanding of patients' problems, felt patients made more effort in coping, felt more optimistic about treatment, and generally felt more positive towards patients. Dimaro et al. (2014) reported that staff most frequently perceived that consultation had facilitated a better situational understanding of their patients. Whitton et al. (2016) reported improved consistency amongst the MDT in understanding patients and their difficulties, staff/patient dynamics, and staff reporting that consultations were insightful about how patients' backgrounds informed their difficulties.

Eight studies reported improvements in staff understanding of clients' difficulties using qualitative methodology. Summers (2006) reported increased understanding through the formulation meetings. Murphy et al. (2013) found consultation generated new ways of thinking which helped staff develop more positive, supportive relationships with clients. Kellett et al. (2014) reported that consultation allowed staff to gain a deeper understanding of patients, thought about patients in a different manner, and no longer felt stuck in unhelpful patterns. Craven-Staines et al. (2010) reported that staff found formulation meetings useful because combining different team member's perspectives helped to highlight 'team blind spots' about certain patients. Evans et al. (2011) reported that staff found linking theoretical

concepts to the histories and backgrounds of patients enabled them to gain a deeper understanding of patients as individuals, rather than just the challenging behaviours they were displaying. Wainwright and Bergin (2010) reported that formulation meetings helped some staff to make sense of patients, allowing them to take a deeper look at their histories. However, other staff continued to see clients as a series of diagnoses. Kellett et al. (2019) illustrated greater staff insight regarding patient relational styles and the manner in which this could elicit unhelpful reciprocation for staff. Stratton & Tan (2019) reported a theme of staff being more aware of patterns, making links and actively using the case formulation in the effort to understand.

*Confidence and competence.* Eight studies reported discrepant findings on staff confidence and competence as a result of psychological consultation, with four of the eight showing positive outcomes. Of the studies which reported positive findings, Berry et al. (2009) found statistically significant post-consultation improvements in staff confidence in their work and Prior et al. (2003) reported a slight increase in perceived competence. Douglas and Benson (2015) reported staff felt consultation helped them to develop further skills in dealing with difficult situations. Evans et al. (2011) reported the consultant supported staff in their decision-making and monitored their progress, which helped staff feel validated and increased their confidence about themselves and their practice. Kellett et al. (2019) reported that staff felt significantly more competent following consultation, compared to baseline.

Of the four studies which reported negative findings, Whitton et al. (2016) found no significant difference in post-consultation staff confidence. Dimaro et al. (2014) found very few staff reported improvements in post-consultation confidence in their skills and ability to manage difficult situations, or make changes to their practice by using different skills/interventions/alternative ways of communicating. Evans et al.'s

(2011) found consultation facilitated some staff ruminating on their lack of confidence in their knowledge and skills. Kellett et al. (2019) reported some negative themes of both staff and patients being challenged by the consultation. Stratton & Tan (2019) reported a theme of the staff feeling under-confident in effectively translating the consultancy into a change in their actions with ongoing patients.

*Satisfaction and wellbeing.* Five studies found discrepant findings in relation to changes in staff satisfaction/wellbeing, with only two of the five studies showing positive outcomes. Berry et al. (2015) did not find statistically significant reductions in staff stress. However, Summers (2006) reported improved staff satisfaction as a result of consultation. Murphy et al. (2013) reported improved job satisfaction; active involvement in consultation, particularly for unqualified staff, often allowed staff to speak up in meetings chaired by higher ranking staff. Prior et al. (2003) reported their participants were satisfied with the consultation process. Kellett et al. (2019) did not show reduced burnout in staff as a result of consultation.

*Feelings towards the patient.* Three studies consistently reported that psychological consultation positively affected and influenced staff feelings towards patients (i.e. particularly improved empathy) generating expansive findings. Whitton et al. (2016) reported improvements in staff empathy towards patients' problems, and no significant improvements in staff negative attitudes towards patients. Wainwright and Bergin (2010) reported empathy and tolerance towards patients was enhanced by staff understanding the patient's problems, feeling they could move forward with the intervention, feeling abler to help the patient, and the patient's story evoking emotion in staff. Stratton & Tan (2019) reported a theme that consultation enabled a space in which staff could reflect on their feelings about a patient.

### *Consultant factors*

*Visibility, accessibility and skilfulness of the consultant.* Each of the four qualitative studies reported positive and complementary findings regarding how the accessibility of the consultant impacted on the success of the consultation. Murphy et al. (2013) reported that pre-consultation, the consultant was viewed as a busy professional, who was difficult to access and was a separate entity to the team. However, once the consultant became more visible, participants were keen to think about how they might use psychological approaches in their practice and wanted more psychological consultation than they were currently receiving.

Douglas and Benson (2015) reported consultation was an efficient means of accessing psychological input and found the ready availability of the consultant extremely helpful. Evans et al. (2011) reported that accessibility and availability of the consultant generated a sense of safety for staff. Staff felt frustrated when the consultant was not available, particularly when they were working to timeframes and needed the consultant's views to inform clinical decisions. Mattan and Isherwood (2009) reported that the availability, flexibility and the accommodation skills of the consultant were important in how staff evaluated the consultancy. One study (Kellett et al. 2019) noted that the competency and skilfulness of the consultant during consultations was an important factor related to successful consultation outcome.

### *Wider organisational impact*

*Consultancy preventing unnecessary interventions.* Each of the three studies reported positive and expansive findings on how consultancy prevented other unnecessary clinical interventions. Prior et al. (2003) demonstrated that none of cases included in the study were escalated to social services or child protection for the duration of the study. Douglas and Benson (2015) reported the prevention of unnecessary investigations,

treatments, or access to other services, ensuring a more cost-effective treatment in the long-term. Kellett et al (2019) noted across two studies and three NHS Trust sites that consultation enabled 35% (22/63) of complex patients to be discharged from services following consultation.

## Discussion

This review has evaluated psychological consultation conducted at levels 1b and 2 of the Carradice and Bennett (2012) framework. A variety of psychological models are used to underpin consultation, with cognitive behavioural and cognitive analytic consultation models being the primary models used and evaluated. CBT easily lends itself to consultation, because of the model having gained considerable traction across many disciplines, so that consultants can helpfully build on extant knowledge in staff (Currid, Nikcevic, & Spada, 2011). Cognitive analytic theory lends itself well to consultation, as it is a relational model and staff often bring relational and alliance ruptures to consultation sessions (Onyett, 2004). The cognitive analytic consultancy approach is also unusual in that it is the only consultation model to have been manualised (Carradice, 2013). It is worrying that some consultation approaches appeared to be delivered in an a-theoretical manner and theoretically-informed consultation should be the norm (Onyett, 2007). Trials are a relative rarity in terms of the methodologies used to evaluate consultancy. Staff outcomes are measured far more frequently then patient or service outcomes. Follow-up was a rarity across studies (regardless of methodology) and so the issue as to whether consultancy can durably change the organisational culture of care remains an unanswered question. Despite consultancy being practiced internationally (Sperry & Sperry, 2012), it is interesting

that the evaluation evidence base is UK-specific. Similarly, systemic approaches to consultation are often practiced (Campbell & Huffington, 2008) and yet have not been evaluated.

Developing, sharing and using case formulations appears the main method used during consultation. Ability in developing and sharing psychological formulations with other disciplines is a core competency for psychological therapists (Division of Clinical Psychology, 2011; Skinner & Toogood, 2010). Psychological formulations are shared during team meetings, reflective practice forums and ward rounds (Rowe & Nevin, 2013). Studies agreed on the importance of visibility and accessibility of the consultant and so findings support the integration of psychological therapists into clinical teams (Onyett, 2007). An increase in staff understanding appears to occur through the shared development of case formulations during consultancy. The dominant theoretical models identified here (cognitive behavioural and cognitive analytic) take differing approaches to consultation. The cognitive-behavioural model more emphasizes how the thoughts, feelings and behaviour of the client can be understood via team formulation (Berry et al. 2015), whereas the cognitive-analytic approach more emphasises toxic reciprocity between staff and patients (Kellett et al. 2019).

The present review triangulated findings from various methodological designs, and so enabled outcomes to be compared and contrasted. This triangulation process minimised the risk of exaggerating the impact of psychological consultation and provided more valid and reliable evaluation of the primary studies (Golafshani, 2003). Psychological consultation appears to mainly typically improve staff understanding of patients and previous research has highlighted that developing such understanding patients is a crucial aspect of caregiving (Finch, 2004). Improved understanding has been shown to positively impact on how staff attend to client issues and so improves

interpersonal processes (Finch, 2004). The relationship between staff and patient has also been shown to be a moderating factor in reducing relapse (Berry et al. 2011) and from a patient perspective, feeling understood facilitates moving towards recovery (e.g. Stallard, Velleman, & Baldwin, 2001). There was no consensus that psychological consultation improves staff confidence and competence. This would be important to improve on in future studies as increasing staff confidence in managing complex clients can ensure the safety of both clients and the staff team (Martin & Daffern, 2006). When staff feel more confident in managing complex clients, they are also more likely to respond in line with therapeutic considerations, rather than out of fear or anger (Thackrey, 1987).

In terms of clinical and organisational implications, compared to other disciplines in MDTs, psychological therapists are typically fewer in number and therefore are often considered a limited resource (Roe, Yanos, & Lysaker, 2006). Therefore, it is important for psychological therapists to integrate into MDTs and offer consistent access to theoretically-informed consultation (Onyett, 2007). However, valid concerns exist about the extent of training required to be able to offer safe and effective consultation (Meyer, Fink, & Carey, 1988). Clinical psychology training courses have been encouraged to place greater emphasis on teaching team consultation methods (BPS, 2007). One study (Kellett et al. 2019) did emphasise that the competency and skilfulness with which the consultation was facilitated was important. Regular supervision of consultation should therefore be an important governance concern within clinical services. It is interesting to note that some studies describe a more shared language of care being facilitated by consultation (e.g. Kellett et al. 2014) and this implies that consultation can positively influence organisational climate and culture.

In terms of current study's limitations, the review was not pre-registered and this is an acknowledged shortcoming. The heterogeneity of the evidence base precluded a quantitative synthesis and the TA synthesis performed of mixed methods or quantitative studies is open to criticism. Concerns exist regarding the Qualsyst scoring tool (Kmet et al., 2004), as this checklist does not assess the psychometric properties of outcome measures used in the primary studies. Eligibility factors could have been more extensive (e.g. ensuring that the consultation was delivered by a psychologist or psychological therapist). Due to the lack of available measures of competency regarding psychological consultation (Kellett et al. 2019), the skilfulness of consultation provided could not be accurately ascertained, despite competency in delivering consultancy being expected (HCPC, 2015).

In terms of future research, more research is needed highlighting when, if and how staff go about implementing the lessons learnt from consultation, and therefore how 'helping conversations' change on the basis of consultation. Taping and analysis of staff interactions pre and post consultation would be therefore invaluable. Similarly, there are no known process-outcome studies of consultation and future research needs to analyse the 'real' conversations that take place during consultation. Identifying moderating and mediating factors of consultation outcome would be useful. It is interesting to note that the majority of qualitative evidence concerned the views of staff, and so the views of patients are under-represented in the evidence base. Therefore, more research needs to be generated about the patient experience of both the direct and indirect forms of consultation on quality of their care. Advances in the consultancy evidence base could be achieved by gathering short and long-term follow-up, consistent use of valid and reliable measures of service, staff and patient outcomes, task-analysis of consultation sessions, simple health economic analysis, routine competency

assessments and random allocation methods. This review highlights that systemic methods of consultation in particular need to develop an evidence base. The recent development of the valid and reliable team formulation quality scale (TFQS; Bucci et al. 2019) will be a valuable addition to the design of such studies, and also the ongoing governance of consultation in routine services. More international research is needed and more consistent use of controlled methodologies.

To conclude, this systematic review has informed commissioners and policy makers concerning the positive evidence for psychological consultation. It would be currently premature to recommend one type of consultation over another, and the field is yet to develop evidence-based consultation practice based on randomised control trial evidence. This review has highlighted that consultation is however a valid use of psychological staff time, but training in (and supervision of) consultation competencies are important factors for services to consider. Formal means of completing consultation would appear more containing to staff than ad hock 'chipping in' (Christofides et al. 2012). Consultants should remain consistently visible and easily accessible to teams. Consultation offers the opportunity for the efficient use of scarce psychological resources and appears to benefit clients and staff in different ways. Clearly, consultation is not a purely supportive intervention and staff can be challenged by the approach and its emphasis on changing interaction patterns with patients. More work needs to be completed to specify the theoretically distinct methods of consultation action. This review can now be built on by completing further high-quality consultancy outcome research.

## References

*denotes studies included in this review

Bergan, J. R., & Kratchowill, T. R. (1990). *Behavioral consultation and therapy*. New York NY: Plenum.

Berry, K., Barrowclough, C., & Haddock, G. (2011). The role of expressed emotion in relationships between psychiatric staff and people with a diagnosis of psychosis: A review of the literature. *Schizophrenia Bulletin*, *37*, 958–972. doi:10.1093/schbul/sbp162

*Berry, K., Barrowclough, C., Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy, 37,* 39-48. doi:10.1017/S1352465808005018

*Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, B. (2015). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology, 55,* 236-252. doi:10.1111/bjc.12082

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative *Research in Psychology, 3,* 77-101. doi:10.1191/1478088706qp063oa

British Psychological Society. (2007). *New ways of working for applied psychologists in health and social care – organising, managing, and leading psychological services*. Leicester: British Psychological Society.

Bucci, S, Hartley, S., Knott, K., Raphael, J., & Berry, K. (2019). The Team Formulation Quality Rating Scale (TFQS): development and evaluation. *Journal of Mental Health,* doi: 10.1080/09638237.2019.1608930

Butler, A., Chapman, J., Forman, E., & Beck, A. (2006). The empirical status of

cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17-31. doi:10.1016/j.cpr.2005.07.003

Campball, D. & Huffington, C. (2008). *Organizations connected: A handbook of systemic consultation.* Karnac Books, London.

Caplan, G. (1970). *The theory and practice of mental health consultation*. New York, NY: Basic Books.

Caplan, G., & Caplan, R. (1999). *Mental health consultation and collaboration.* Long Grove, Il: Waveland Press Inc.

Carradice, A., & Bennett, D. (2012). Beyond the psychotherapists chair: CAT consultancy, ACAT conference presentation, Manchester. In: D. Pickvance (Ed.), *Cognitive analytic supervision: A relational approach*. Oxon: Routledge.

Carradice, A. (2013). 'Five-session CAT' consultancy: Using CAT to guide care planning with people diagnosed with personality disorder within the community mental health teams. *Clinical Psychology and Psychotherapy*, *20,* 359-367. doi: 10.1002/cpp.1812

Christofides, S., Johnstone, L., & Musa, M. (2011). 'Chipping in': Clinical psychologists'' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice, 85,* 424-435. doi:10.1111/j.2044-8341.2011.02041.x

*Clark, S., & Chuan, S. (2016). Evaluation of the Impact Personality Disorder Project – A psychologically-informed consultation, training and mental health collaboration approach to probation offender management. *Criminal Behaviour and Mental Health, 26,* 186-195. doi:10.1002/cbm.1965

Collins, A. (2011). *Exploring psychological process in reflective practice groups in acute inpatient wards*. (unpublished doctoral dissertation). Canterbury Christ

Church University.

*Craven-Staines, S., Dexter-Smith, S., & Li, K. (2010). Integrating psychological formulations into older people's services – three years on (part 3): Staff perceptions of formulation meetings. *PSIGE Newsletter, 112,* 16-22.

Currid, T., Nikcevic, A., & Spada, M. (2011). Cognitive behavioural therapy and its relevance to nursing. *British Journal of Nursing, 20,* 1443-1447. doi:10.12968/bjon.2011.20.22.1443

Department of Health (2007). *The creating capable teams approach*. London: Department of Health.

*Dimaro, L., Moghaddam, N., & Kyte, Z. (2014). An evaluation of psychological consultation to social workers. *Adoption and Fostering, 38,* 223-237. doi:10.1177/0308575914543232

Division of Clinical Psychology (2010). *Clinical Psychology: The core purpose and philosophy of the profession.* Leicester: British Psychological Society.

Division of Clinical Psychology (2011). *Good practice guidelines on the use of psychological formulation.* Leicester: British Psychological Society.

*Douglas, J., & Benson, S. (2015). Psychological consultation in a paediatric setting: A qualitative analysis of staff experiences of a psychosocial forum. *Clinical Child Psychology and Psychiatry, 20,* 472-485. doi:10.1177/1359104514527768

*Evans, K., Law, H., Turner, R., Rogers, A., & Cohen, K. (2011). A pilot study evaluating care staffs' perception of their experience of psychological consultation within a mental health setting. *Child Care in Practice, 17,* 205-19. doi:10.1080/13575279.2010.541423

Finch, L. (2004). Understanding patients' lived experiences: The interrelationship of rhetoric and hermeneutics. *Nursing Philosophy, 5*, 251-257. doi:10.1111/j.1466-769X.2004.00181.x

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry. Executive summary*. London: The Stationary Office.

Geach, N., Moghaddam, N.G., & De Boos, D. (2018). A systematic review of team formulation in clinical psychology practice: Definition, implementation and outcomes. *Psychology and Psychotherapy; Theory, Research and Practice, 91,* 186-215.

Goddard, W. & Melville, S. (2004). *Research Methodology: An Introduction.* 2nd edition, Blackwell Publishing

Golafshani, N. (2003). Understanding reliability & validity in qualitative research. *The Qualitative Report*, *8*, 597-606.

Gutkin, T. B., & Curtis, M. J. (1999). School-based consultation: Theory and practice: The art and science of indirect service delivery. In T. B. Gutkin, & C. R. Reynolds (Eds.), *The handbook of school psychology* (3rd ed.). New York, NY: Wiley.Higgins, J., & Green, S. (Eds.). (2011).

Cochrane Handbook for Systematic Reviews of Interventions. Version 5.1.0 [updated March 2011]. The Cochrane Collaboration.

Health and Care Professions Council (2015). *Standards of proficiency – practitioner psychologists.* London, UK; Author.

*Ingham, B. (2011). Collaborative psychosocial case formulation development workshops: A case study with direct care staff. *Advances in Mental Health and Intellectual Disabilities, 5,* 9-15. doi:10.5042/amhid.2011.0107

Johnstone, L., & Dallos, R. (Eds.) (2013). *Formulation in psychology and psychotherapy.* Hove: Routledge.

Kalliath, T., & Morris, R. (2002). Job satisfaction among nurses: A predictor of burnout levels. *Journal of Nursing Administration, 32,* 648–651. doi:10.1097/00005110-200212000-00010

*Kellett, S., Wilbram, M., Davis, C., Hardy, G. (2014). Team consultancy using cognitive analytic therapy: A controlled study in assertive outreach. *Journal of Psychiatric and Mental Health Nursing, 21,* 687-697. doi:10:1111/jpm.12123

*Kellett, S., Ghag, J., Ackroyd, K., Freshwater, K., Finch, J., Freear, A., Hartley, J., & Simmonds-Buckley, M. (2019). Delivering cognitive analytic consultancy to community mental health teams: Initial practice-based evidence from a multi-site evaluation. *Psychology and Psychotherapy: Theory, Research and Practice.*

Kmet, L., Lee, R., & Cook, L. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields. *Alberta Heritage Foundation for Medical Research.*

Lee, L., Packer, T., Tang, S., & Girdler, S. (2008). Self-management education programs for age-related macular degeneration: A systematic review. *Australasian Journal of Ageing, 27,* 170–176. doi:10.1111/j.1741-6612.2008.00298.x

Lorenc, T., Felix, L., Petticrew, M., Melendez-Torres, G., Thomas, J., Thomas, S., … Richardson, M. (2016). Meta-analysis, complexity, and heterogeneity: a qualitative interview study of researchers' methodological values and practices. *Systematic Reviews, 5,* 192. doi:10.1186/s13643-016-0366-6

Martin, T., & Daffern, M. (2006). Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric

setting. *Journal of Psychiatric and Mental Health Nursing, 13*, 90–99. doi:10.1111/j.1365-2850.2006.00920.x

*Mattan, R., & Isherwood, T. (2009). A grounded theory investigation of consultees' perception and experience of psychological consultation. *Mental Health and Learning Disability Research and Practice, 6,* 169-183. doi:10.5920/mhldrp.2009.62169

McHugh, M. (2012). Interrater reliability: The kappa statistic. *Biochemia Medica, 22,* 276-282.

Meyer, J., Fink, C., & Carey, P. (1988). Medical views of psychological consultation. *Professional Psychology: Research and Practice, 19,* 356-358. doi:10.1037/0735-7028.19.3.356

Milne, D., & James, I. (2000). A systematic review of effective cognitive-behavioural supervision. *British Journal of Clinical Psychology, 39,* 111-127. doi:10.1348/014466500163149

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. *PLoS Med 6(7):* e1000097. doi: org/10.1371/journal.pmed.1000097

*Murphy, S., Osbourne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging and Mental Health, 17,* 441-448. doi:10.1080/13607863.2013.765829

Onyett, S. (2007). *Working psychologically in teams: New ways of working for applied psychologists in health and social care*. Leicester: British Psychological Society.

Pearson, A., White, H., Bath-Hextall, F., Salmond, S., Apostolo, J., & Kirkpatrick, P. (2015). A mixed-methods approach to systematic reviews. *International Journal*

*of Evidence Based Healthcare. 13,* 121-131. doi:10.10.1097/XEB.0000000000000052.

Peterson, U., Bergstrom, G., Samuelsson, M., Asberg, M., & Nygren, A. (2008). Reflecting peer-support groups in the prevention of stress and burnout: Randomized controlled trial. *Journal of Advanced Nursing, 63*, 506-516. doi:10.1111/j.1365-2648.2008.04743.x

Petticrew, M., Anderson, L., Elder, R., Grimshaw, J., Hopkins, D., Hahn, R., … Welch, V. (2013). Complex interventions and their implications for systematic reviews: A pragmatic approach. *Journal of Clinical Epidemiology, 66,* 1209–14. doi:10.1016/j.ijnurstu.2015.01.004

*Prior, H., Stirling, H., Shepherd, K., & Stirrat, J. (2003). Advantages of a staged consultation supervisory model for health visitors, from child clinical psychology. *Clinical Psychology, 26*, 32-34.

Roberts, V. (1998). Psychotic processes and community care. In A. Foster & V. Roberts (Eds.), *Managing mental health in the community: Chaos and containment.* London: Routledge.

Roe, D., Yanos, P., & Lysaker, P. (2006). Overcoming barriers to increase the contribution of clinical psychologists to work with persons with severe mental illness. *Clinical Psychology*, *13,* 376–383. doi:10.1111/j.1468-2850.2006.00051.x

Rowe, G., & Nevin, H. (2013). Bringing ‘patient voice’ into psychological formulations of in-patients with intellectual disabilities, autism spectrum disorder and severe challenging behaviours: Report of a service improvement pilot. *British Journal of Learning Disabilities, 42,* 177-184. doi:10.1111/bld.12026

Sampson, M., McCubbin, R., & Tyrer, P. (Eds.). (2006). *Personality Disorder and*

*Community Mental Health Teams: A Practitioners Guide*. Chichester: John Wiley and Sons Ltd.

Schein, E. H. (1988). *Process consultation* (volume 1, 2nd ed.). Reading, MA: Addison-Wesley.

Shattell, M., McAllister, S., Hogan, B., & Thomas, S. (2006). "She took the time to make sure she understood": Mental health patients' experience of being understood. *Archives of Psychiatric Nursing, 20,* 234-241. doi:10.1016/j.apnu.2006.02.002

Singla, D.R., Kohrt, B.A. Murray, L.K., Anand, A., Chorpita, B.F. & Patel, V. (2017). Psychological treatments for the world: lessons from low- and middle-income countries. *Annual Review of Clinical Psychology, 13,* 149-181. doi: 10.1146/annurev-clinpsy-032816-045217

Skinner, P., & Toogood, R. (2010). *Clinical psychology leadership development framework.* Leicester: British Psychological Society.

Sperry, L. & Sperry, J.J. (2012). *Case conceptualisation: Mastering this competency with skills and ease.* New York, NY; Routledge.

Stallard, P., Velleman, R., & Baldwin, S. (2001). Recovery from post-traumatic stress disorder in children following road traffic accidents: The role of talking and feeling understood. *Community and Applied Social Psychology, 11*, 37-41. doi:10.1002/casp.610

*Stratton R., & Tan, R. (2019). Cognitive analytic team formulation: learning and challenges for multidisciplinary staff. *Mental Health Review Journal*, doi: org/10.1108/MHRJ-01-2019-0001

*Summers, A. (2006). Psychological formulation in psychiatric care: Staff views on their impact. *Psychiatric Bulletin, 30*, 341-343. doi:10.1192/pb.30.9.341

Thackrey, M. (1987). Clinician confidence in coping with patient aggression: Assessment and enhancement. *Professional Psychology: Research and Practice, 18*, 57–60. doi:10.1037/0735-7028.18.1.57

Thompson, A., Donnison, J., Warnock-Parkes, E., Turpin, G., Turner, J., & Kerr, I. (2008). Multidisciplinary community mental health staff's experiences of a 'skills level' training course in cognitive analytic therapy. *International Journal of Mental Health Nursing, 17,* 131-137. doi:10.1111/j.1447-0349.2008.00521.x

*Wainwright, N., & Bergin, L. (2010). Introducing psychological formulation in an acute older people's inpatient mental health ward: A service evaluation of staff views. *PSIGE Newsletter, 112,* 38-45.

Whitton, C., Collinson, R., & Adams, T. (2013). Psychological supervision and consultation for nurses in a learning disability forensic service. *Journal of Intellectual Disabilities and Offending Behaviour, 4,* 90-99. doi:10.1108/JIDOB-11-2012-0003

*Whitton, C., Small, M., Lyon, H., Barke, L., & Akiboh, M. (2016). The impact of case formulation meetings for teams. *Advances in Mental Health and Intellectual Disabilities, 10*, 145-157. doi:10.1108/AMHID-09-2015-0044

Yang, L., Chang, K., & Chung, K. (2013). Methodology rigor in clinical research. *Plastic and Reconstructive Surgery, 129,* 979-988. doi:10.1097/PRS.0b013e31824eccb7

*Figure 1.* PRISMA flow diagram of the study selection strategy

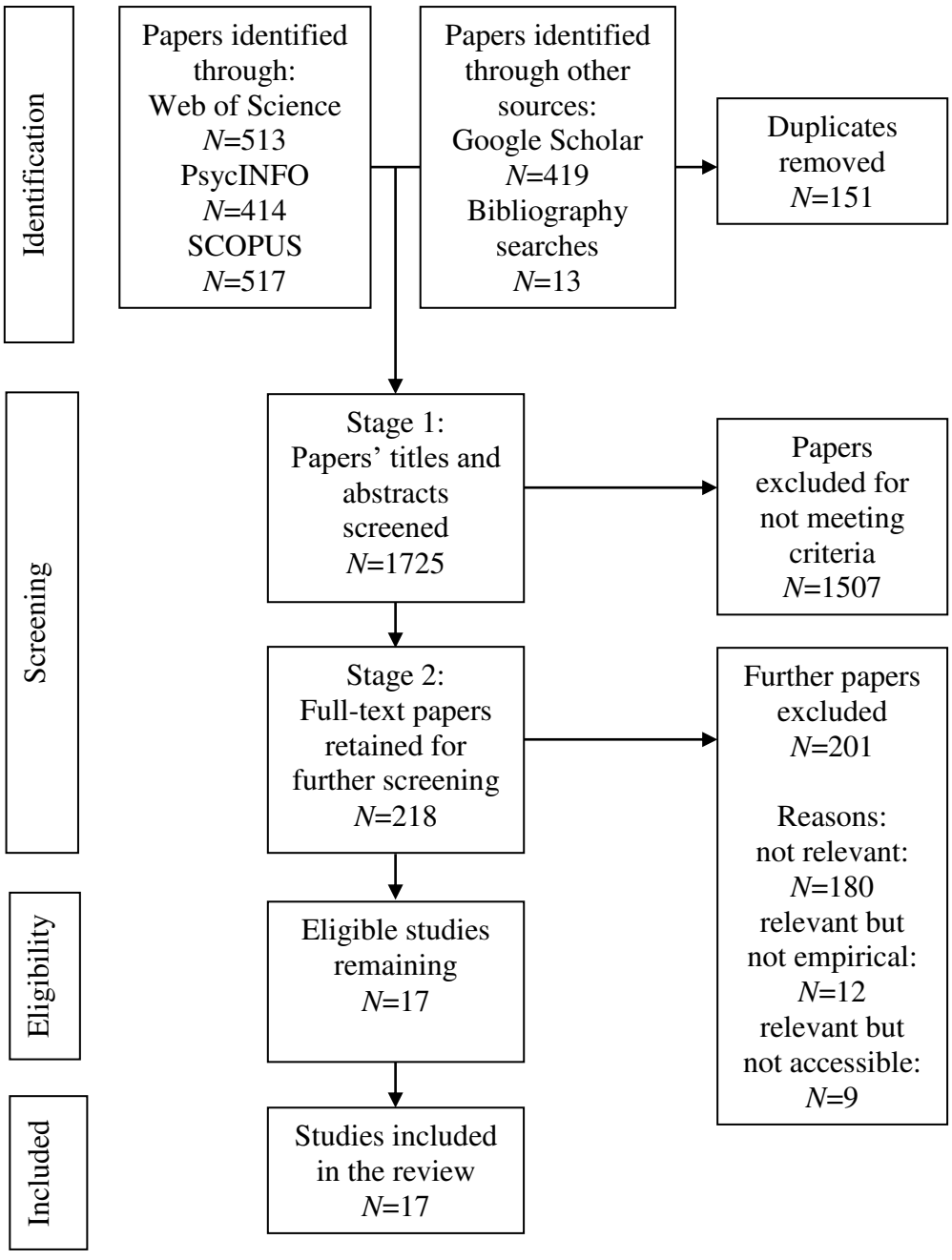

Table 1: *description of the levels of consultation*

| **Levels of work** | **Nature of consultation work** | **Potential organisational impact of consultation** |
|---|---|---|
| 1a: Direct work | The psychological therapist offers direct therapy to the client and gives feedback to the team working with the client in the form of a formulation (with client permission). *This is not considered consultation.* | Can be a time intensive approach, but often required for management of complex cases (Wellbeing Information, 2017). |
| 1b*: Direct work | The psychological therapist offers joint time-limited direct work with the client and a member of their team, to provide a formulation and/or a care plan that the client and member of staff (or team) can implement. The psychological therapist is functioning at a consultative level and modelling psychologically-informed approaches to other professionals. *This is considered consultation.* | Due to the focal and time-limited nature of this level of work, it can influence a high number of clients and staff in the system and is an efficient use of therapists' time. |
| 2*: Indirect work | The psychological therapist offers indirect work using psychological theory to staff member/s to advise and support their work, without the client being directly involved. *This is considered consultation.* | These consultations (e.g. via reflective practice meetings) can potentially influence the approach of a higher number of staff (Caplan & Caplan, 1999) and change the organisational culture of care. |
| 3: Indirect work | The psychological therapist works at an organisational level, perhaps consulting on service design or interventions to change the working practices and culture of a service. *This is considered consultation.* | Has a broad and secondary benefit of improving care for clients through macro system change (Onyett, 2007) |

Note. *=Levels of consultancy considered in the present review

Table 2. *List of included studies, setting, model of psychological consultation and quality rating*

| Author(s) | Design | Sample size | Setting | Mode of consultancy | Psychological model | Level(s) of work | QualSyst summary score |
|---|---|---|---|---|---|---|---|
| ***Cognitive/Cognitive-behavioural*** | | | | | | | |
| *Berry, Barrowclough, & Wearden (2009) | Quantitative: Pre and post outcome measures | *N*=7 (client) *N*=30 (staff) | Psychiatric rehabilitation unit | Team-based (nurses and support workers) formulation meetings on ward at handover time | Used a mixed theoretical model approach of Becks (1976) cognitive model, CAT and attachment theory | Level 2 | .95 (strong) |
| Berry, Haddock, Kellett, Roberts, Drake, & Barrowclough (2015) | Quantitative: Randomised single-blind cluster, comparing TAU with intervention | *N*=36 (client) *N*=74 (staff) | Long stay psychiatric ward | MDT-based formulation meetings on ward. 24 one-hour sessions over 6 months | Beck's (1976) cognitive model | Level 2 | .96 (strong) |
| Craven-Staines, Dexter-Smith & Li (2010) | Qualitative: thematic analysis | *N*=20 (staff) | Older adult inpatient and community | MDT-based formulation meetings over 2 services on ward/team office, either weekly or twice weekly, both for 1 and half hours each. | Roseberry Park Model/ CBT model | Level 2 | .85 (strong) |
| Ingham (2011) | Quantitative: case study Pre and post staff outcome measures | *N*=1 (client) *N*=7 (staff) | Intellectual difficulties service | Team-based (care staff) formulation via two 3-hour workshops | Workshops used a 5-problem area's framework (Dudley & Kuyken, 2006) to develop a psychosocial case formulation | Level 2 | .94 (strong) |
| *Summers (2006) | Qualitative: grounded theory | *N*=25 (staff) | High dependency rehabilitation | MDT-based formulation meetings on ward, fortnightly | Developed either CBT or object relations formulations | Level 2 | .8 (strong) |

Table 2. (continued)

*List of included studies, setting, model of psychological consultation and quality rating*

| Author(s) | Design | Sample size | Setting | Mode of consultancy | Explicitly named model | Level(s) of work | QualSyst summary score |
|---|---|---|---|---|---|---|---|
| ***Cognitive/Cognitive-behavioural (continued)*** | | | | | | | |
| Murphy, Osbourne, & Smith (2013) | Qualitative (exploratory): thematic analysis | *N*=10 (staff) | Mental health and dementia care wards | MDT training package (3-day) including formulation plus weekly formulation consultation sessions | Dexter-Smith (2007) | Level 2 | .75 (good) |
| Wainwright & Bergin (2010) | Qualitative (service evaluation): pre and post interviews using content analysis | *N*=5 (staff) x2 interviews each | Acute older adult inpatient mental health ward | MDT formulation meetings (max 3 sessions per client) lasting 1 hour | CBT | Level 2 | .75 (good) |
| ***Cognitive Analytic Therapy/consultancy*** | | | | | | | |
| Kellett, Wilbram, Davis, & Hardy (2014) | Mixed methods: RCT + 3-month follow-up | *N*=10 (clients in CAC)<br>*N*=10 (clients in TAU)<br>*N*=7 (staff pre)<br>*N*=8 (staff post) | Assertive outreach team | Working with individual staff + MDT + 2 day training inc. reformulation + 3-month consultation | Cognitive analytic consultancy | Level 1b and 2 | .8 (strong; qual)<br>.95 (strong; quant) |

Table 2. (continued)

*List of included studies, setting, model of psychological consultation and quality rating*

| Author(s) | Design | Sample size | Setting | Mode of consultancy | Explicitly named model | Level(s) of work | QualSyst summary score |
|---|---|---|---|---|---|---|---|
| ***Cognitive Analytic Therapy/consultancy (continued)*** | | | | | | | |
| Kellett, Ghag, Ackroyd, Freshwater, Finch, Freer, Hartley & Simmonds-Buckley (2019) | Mixed methods: pre and post service evaluation and qualitative interviews<br>Mixed methods: case series | *N*=58 (client)<br>*N*=5 (client)<br>*N*=5 (staff) | Community mental health teams across three sites | 5-session cognitive analytic consultancy | Cognitive analytic consultancy (manualised) | Level 2 | .8 (strong; qual)<br>.95 (strong; quant) |
| Stratton & Tan (2019)<br><br>Also see Berry et al. (2009) | Mixed methods: service evaluation | *N*=16 staff (quant)<br>*N*=6 staff (qual) | Tier 4 inpatient female personality disorder unit | Team formulation sessions | Cognitive analytic consultancy | Level 2 | .33 (limited quant)<br>.50 (adequate qual) |
| *Consultee-driven consultancy* | | | | | | | |
| Dimaro, Moghaddam, & Kyte (2014) | Mixed methods: questionnaires and focus groups | *N*=48 (staff questionnaire)<br>*N*=9 (staff focus group) | Social Care: looked after children | As required, individual consultee-driven assessments, formulations and interventions | Consultee-centred model of consultation developed by Caplan (1970) and outlined by Golding (2004) | Level 2 | .75 (good; qual)<br>.59 (adequate; quant) |
| Evans, Law, Turner, Rogers, & Cohen (2011) | Qualitative: thematic analysis | *N*=6 (staff) | Specialist residential care for young people | As required, individual and group consultation | Consultee-centred model of consultation developed by Caplan (1995) | Level 2 | .75 (good) |

Table 2. (continued)

*List of included studies, setting, model of psychological consultation and quality rating*

| Author(s) | Design | Sample size | Setting | Mode of consultancy | Explicitly named model | Level(s) of work | QualSyst summary score |
|---|---|---|---|---|---|---|---|
| *Graded sequence of stages of consultation* | | | | | | | |
| Prior, Stirling, Shepherd, & Stirrat (2003) | Mixed methods: frequency comparisons and qualitative feedback | *N*=6 (staff) discussing *N*=18 (clients) | Child services with health visitors | Case discussion weekly, 1-hour groups over 6 months | Own model | Level 1b and 2 | .5 (adequate; qual)<br>.33 (limited; quant) |
| ***Undefined model*** | | | | | | | |
| Clark & Chuan (2016) | Quantitative: recall rates measured, descriptive findings presented only | *N*=10 (staff) | Probation officers working with personality disorder | Case discussion and training based on knowledge & understanding framework, monthly | Not specified | Level 2 | .82 (strong) |
| Douglas & Benson (2015) | Qualitative: thematic analysis | *N*=6 (staff) | Paediatric gastroenterology | MDT psychosocial forums, weekly | Not specified | Level 2 | 1 (strong) |
| Mattan & Isherwood (2009) | Qualitative: grounded theory | *N*= 11 (staff) | Various: LD, health psychology, adult mental health | Various approaches depending on psychological therapist | Not specified | Level 2 | .75 (good) |
| Whitton, Small, Lyon, Barke, & Akiboh (2016) | Mixed methods within group, self-report pre and post questionnaires | *N*=89 (staff) | Secure forensic learning disability and Autism service | Regular MDT-based formulation meetings | Not specified | Level 2 | .65 (adequate; qual)<br>.85 (strong; quant) |

Table 2. (continued)

*List of included studies, setting, model of psychological consultation and quality rating*

| Author(s) | Design | Sample size | Setting | Mode of consultancy | Explicitly named model | Level(s) of work | QualSyst summary score |
|---|---|---|---|---|---|---|---|
| ***Psychoanalytic/ attachment theory/Object relations*** | | | | | | | |
| Also see Berry et al. (2009)<br>Also see Summers (2006) | | | | | | | |

*Note.* * = study discussed more than once. MDT = multidisciplinary team. LD = learning disability

Table 3. *Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| *Client outcomes* | | | | |
| SYMPTOMS | 1. Berry et al. (2015) (STRONG) | 1. Clients completed the Positive and Negative Syndrome Scale; Global Assessment of Functioning Scale; Severe Behaviour schedule. | 1. QUANT: No statistically significant differences in patient functioning | Discrepant |
| | 2. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT) | 2. Clients completed Clinical Outcomes in Routine Evaluation Outcome Measure; Work and Social Adjustment Scale | 2. QUANT: No statistically significant differences in psychological distress, disability or overall engagement in cognitive analytic consultancy patients compared to treatment as usual patients | |
| | 3. Kellett et al. (2019) (STRONG – QUAL, STRONG – QUANT) | 3. Clients completed the Clinical Outcomes in Routine Evaluation, Work and Social Adjustment Scale, Service Engagement and Working Alliance Inventory in the service evaluation.<br>In the case series clients completed the Clinical Outcomes in Routine Evaluation, Personality Structure Questionnaire and Working Alliance Inventory. | 3. QUANT: significant reduction in patient distress in 2/3 service evaluation sites.<br>Significant reduction in fragmentation in patients in the case series. | |

Table 3. (continued)

*Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| *Client outcomes (continued)* | | | | |
| PROBLEMATIC BEHAVIOUR | 1. Ingham (2011) (STRONG) | 1. Staff idiosyncratic behavioural measure; specifically designed carer questionnaire measuring severity of challenging behaviour and impact of behaviour on self and others | 1. QUANT: Reduction in challenging behaviour (e.g. physical aggression, shrieking, verbal aggression) post-workshops. Staff perceptions of behaviour fell post-workshops and impact on self and others fell post-workshop | Confirmatory: convergent and expansion |
| | 2. Clark & Chuan (2016) (STRONG) | 2. Recall to prison data and case management recording system | 2. QUANT: Significant decrease in the mean rate of prison recalls following introduction of the intervention, and this effect was sustained over two years | |
| SERVICE ENGAGEMENT | 1. Clark & Chuan (2016) (STRONG) | 1. Recall to prison data and case management recording system | 1. QUANT: Significantly reduced non-compliance with supervision | Discrepant |
| | 2. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT) | 2. Staff completed Service Engagement Scale | 2. QUANT: No significant improvements in overall engagement with assertive outreach team in cognitive analytic consultancy or treatment as usual patients | |
| | 3. Kellett et al. (2019) (ADEQUATE – QUANT) | 3. Dropout rates | 3. 28.40% dropout rate in service evaluation sites and zero dropout rate in case series. | |

Table 3. (continued)

*Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| *Staff outcomes* | | | | |
| BETTER UNDERSTANDING OF THE PATIENT | 1. Berry et al. (2009) (STRONG) | 1. Staff completed Brief Illness Perception Questionnaire; Illness Perception Questionnaire for Schizophrenia | 1. QUANT: Significant improvements in staff perceptions of service users' problems on all dimensions assessed (more helpful attitudes towards working with patients' post-intervention; staff rated patients as putting in more effort in coping, felt more positive about clients and more optimistic about patients' treatment outcomes). | Confirmatory: convergent and complementary |
| | 2. Dimaro et al. (2014) (GOOD-QUAL, ADEQUATE-QUANT) | 2. Staff questionnaire using attachment-trauma perspective of consultation | 2. QUANT: Majority of respondents reported 'increased understanding of the child and/or problems', and 'provided consultee with new ideas, a better way to consider a situation or a theoretical understanding' | |
| | 3. Evans et al. (2011) (GOOD) | 3. Qualitative staff interviews | 3. QUAL: Main theme of 'seeing the value of consultation' with subtheme of 'putting the dots together – making sense' | |
| | 4. Kellett et al. (2014) (STRONG – QUAL, STRONG - QUANT) | 4. Qualitative staff interviews | 4. QUAL: Main theme of 'increased awareness'. Main theme of 'changes made to the clinical approach' with subtheme 'increased awareness of patient's perspective' | |
| | 5. Murphy et al. (2013) (GOOD) | 5. Qualitative staff interviews | 5. QUAL: Theme 'mechanisms of benefit': staff reported formulation helped knowledge and understanding of the patient | |
| | 6. Summers (2006) (STRONG) | 6. Qualitative staff interview | 6. QUAL: Theme "it makes you understand the reasons why people are like they are" | |
| | 7. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT) | 7. Self-designed staff questionnaire including an open question | 7. QUANT: Significant improvements in understanding the patient's psychological issues post-consultation and why that patient presents with their current problems | |
| | 8. Craven-Staines et al. (2010) (STRONG) | 8. Qualitative staff interview | 8. QUAL: Theme 'increased understanding of the patient' | |
| | 9. Wainwright & Bergin (2010) (GOOD) | 9. Qualitative staff interview | 9. QUAL: how staff understand service users: Theme 'by making sense', 'in terms of non-linked descriptive information'. | |

Table 3. (continued)

*Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| BETTER UNDERSTANDING OF THE PATIENT (continued) | 10. Kellett et al. (2019) (STRONG – QUAL) | 10. Qualitative staff interview using the Change Interview | 10. QUAL: themes of improved understanding of the patient, better self-awareness and use of CAT model | Confirmatory: convergent and complementary |
| | 11. Stratton & Tan (2019) (ADEQUATE – QUAL) | 11. Qualitative staff interviews | 11. QUAL: theme of noticing patterns, making links and using the CAT map | |
| CLINICAL CONFIDENCE & COMPETENCE | 1. Berry et al. (2009) (STRONG) | 1. Staff completed Brief Illness Perception Questionnaire; Illness Perception Questionnaire for Schizophrenia | 1. QUANT: Statistically significant improvements in staff confidence in working with their patient | Discrepant |
| | 2. Dimaro et al. (2014) (GOOD – QUAL, ADEQUATE- QUANT) | 2. Staff questionnaire using attachment-trauma perspective of consultation | 2. QUANT: No improvements in 'increased confidence in consultee's existing skills and/or ability to manage the situation' or 'changes to direct practice by using different skills/interventions or different ways of communicating'. | |
| | 3. Douglas & Benson (2015) (STRONG) | 3. Qualitative staff interviews | 3. QUAL: Main theme of 'influence on clinical work' with subtheme of 'building confidence with difficult situations' | |
| | 4. Evans et al. (2011) (GOOD) | 4. Qualitative staff interviews | 4. QUAL: Main theme of 'initiating consultation' with subtheme of 'doubts about what you know and how you perform' post-consultation. Main theme of 'seeing the value of consultation' with subtheme of 'I am doing alright - self-validation' | |

Table 3. (continued)

*Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| CLINICAL CONFIDENCE & COMPETENCE (continued) | 5. Prior et al. (2003) (ADEQUATE –QUAL, LIMITED-QUANT) | 5. Health Visitor Questionnaire, Knowledge of Behavioural Principles as Applied to Children questionnaire | 5. QUANT: Frequency comparisons reported a slight increase perceived competence. Frequency comparisons reported showed slight upward trend in most pre and post scores on the Knowledge of Behavioural Principles questionnaire | Discrepant |
| | 6. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT) | 6. Self-designed staff questionnaires | 6. QUANT: No significant difference in staff confidence post-consultation. | |
| | 7. Kellett et al. (2019) (STRONG – QUANT) | 7. Perceived Competence Scale | 7. QUANT: significant baseline to follow-up increase in competency | |
| | 8. Stratton & Tan (2019) (ADEQUATE – QUAL) | 8. Qualitative staff interviews | 8. QUAL: theme of not feeling confident enough to utilise consultancy effectively with ongoing patients | |

Table 3. (continued)

*Synthesis of qualitative and quantitative results for the outcomes achieved by consultancy*

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| SATISFACTION & WELLBEING | 1. Berry et al. (2015) (STRONG) | 1. Staff completed General Health Questionnaire; Maslach Burnout Questionnaire | 1. QUANT: No statistically significant improvements in general health or emotional exhaustion and personal accomplishment subscales of MBI. However, statistically significant improvements in depersonalisation post-intervention | Discrepant |
| | 2. Murphy et al. (2013) (GOOD) | 2. Qualitative staff interviews | 2. QUAL: Theme 'the impact of psychology on feelings invoked by the workplace' | |
| | 3. Summers (2006) (STRONG) | 3. Qualitative staff interviews | 3. QUAL: Theme 'dimensions of benefit': staff reported formulation helped improve their satisfaction | |
| | 4. Prior et al. (2003) (ADEQUATE –QUAL, LIMITED-QUANT) | 4. Session Evaluation Form | 4. QUANT: Frequency scores indicated increasing satisfaction over the consultation period. | |
| FEELINGS TOWARDS THE PATIENT | 1. Whitton et al. (2016) (ADEQUATE-QUAL, STRONG-QUANT) | 1. Self-designed staff questionnaires | 1. QUANT: Statistically significant improvements in staff empathy towards the client and their problems, post-consultation. Frequency outcomes: most staff did not think that the formulation meetings made excuses for the client's behaviour. No significant differences in staff negative attitudes and feelings towards the patient, post-consultation. | Confirmatory: convergent and expansion |
| | 2. Wainwright & Bergin (2010) (GOOD) | 2. Qualitative staff interviews | 2. QUAL: staff relationships with service users: themes 'factors that help empathy and tolerance' 'factors that damage empathy and tolerance' | |
| | 3. Stratton & Tan (2019) | 3. Qualitative staff interviews | 3. QUAL: theme of pausing to think and feel regarding relationships with patients | |

Table 3. (continued)

| Theme | Author/s (quality rating) | Measure/s | Results | Merged findings code* |
|---|---|---|---|---|
| *Consultant factors* | | | | |
| IMPORTANCE OF VISIBILITY, ACCESSIBILITY AND SKILFULNESS | 1. Douglas & Benson (2015) (STRONG) | 1. Qualitative staff interviews | 1. QUAL: Main theme 'influence on clinical work' with subthemes of 'using psychological expertise', and 'having a psychologist to treat psychological problems' | Confirmatory: convergent and complementary |
| | 2. Evans et al. (2011) (GOOD) | 2. Qualitative staff interviews | 2. QUAL: Main theme 'building the consultative relationship' with the subtheme of 'availability and responsiveness of the consultant' important to create sense of safety | |
| | 3. Mattan & Isherwood (2009) (GOOD) | 3. Qualitative staff interviews | 3. QUAL: Main theme 'interpersonal dynamics' with subtheme of 'availability of consultant' | |
| | 4. Murphy et al. (2013) (GOOD) | 4. Qualitative staff interviews | 4. QUAL: Theme "It's here now. You can touch it now: The importance of visibility and accessibility" | |
| | 5. Kellett et al. (2019) (GOOD) | 5. Qualitative interviews | 5. QUAL: skilfulness of the consultant related to outcome of the consultancy | |
| *Wider organisational impact* | | | | |
| PREVENTS OTHER UNNECESARY INTERVENTION | 1. Douglas & Benson (2015) (STRONG) | 1. Qualitative staff interviews | 1. QUAL: Main theme 'influence on clinical work' with subtheme of 'prevents unnecessary medical interventions' | Confirmatory: convergent and expansion |
| | 2. Prior et al. (2003) (ADEQUATE- QUAL, LIMITED-QUANT) | 2. Referral figures | 2. QUANT: Consultation was never escalated beyond Stage 1 for all cases. None of the cases were referred to social services. No child protection issues arose during the study period. Reduced referrals to psychology department following consultation intervention. GP practises making fewer referrals and now only referring complex cases | |
| | 3. Kellett et al. (2019) (LIMITED – QUANT) | 3. Need for further intervention rates | 3. QUANT: 35% of complex patients discharged from service following consultation | |

*Note. *Merged findings codes: "Discrepant" = findings are contradictory; "confirmatory: convergent and expansion" = findings broadly agree and add depth; "confirmatory: convergent and complementary" = findings broadly agree and add breadth*