Patterns of Cooperation of Child Psychiatry with Other Departments in Hospitals

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ABSTRACT: Four patterns of child psychiatrist cooperation which have implications for prevention are described: Autonomous Psychiatric Unit; Consultation; Collaboration; and Executive Partnership. These represent a gradient of increasing participation of psychiatrists inside the other department in the treatment of patients, in case responsibility, and in administrative authority over the service system.

Our focus in the present paper is on the range of alternative operations of child psychiatrists and their mental health specialist colleagues with a preventive orientation inside the boundaries of nonpsychiatric units in a general hospital in regard to patients who continue to be treated for bodily illnesses by our medical colleagues. There are four main possible patterns of psychiatric service: (1) Autonomous Psychiatric Unit, (2) Psychiatric Consultation Service, (3) Collaborative Service between Psychiatrists and Medical Colleagues, (4) Jointly Administered Psychosomatic Service (Executive Partnership).

Autonomous Psychiatric Unit

This is a circumscribed bounded unit which is separated from the other departments. The psychiatrists restrict their professional responsibility and accountability to their own patients whom they have accepted following referral from other departments of the hospital or from outside the hospital. They are not responsible for the medical care of patients of other departments, nor may they intervene in their administrative affairs. Communication with other units, apart from the development of social relationships with colleagues and participation in the general political life of the hospital is restricted to maintaining channels for the transfer of patients via the referral

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Consultation

The psychiatrist offers his specialist services to help colleagues in other departments improve their care of their patients without the need for referring the latter to the psychiatric department.

In this type of service the psychiatrist accepts no responsibility for the continuing care of his colleagues’ patients nor for the clinical outcome of such treatment. The relationship between consultant and consultees is non-hierarchical, meaning that the consultant has no power to force the consultees to change their ideas or practices. He can only influence them if what he says makes sense to them. The consultees are therefore free to accept or reject part or all of the psychiatrist’s clarifications and recommendations. The psychiatrist also has no authority to modify his colleagues’ service system.

But in all consultation the psychiatrist must study the language and the methods of working of his consultee colleagues, because in addition to expert understanding of the mental health dimensions of the disturbance in the client and his family, the consultant must communicate his findings in language that is understandable to them and must tailor his recommendations to the capacities and constraints of consultees, who are the sole agents in benefiting the patient.

To optimise clarity of exposition we restrict ourselves in this paper to Case Consultation. For a discussion of Administrative Consultation see Caplan (1970). There are two types of Case Consultation:

Client-centered Case Consultation. The primary task is to investigate the patient, to diagnose his condition and to recommend improved ways for the consultees to treat him on their own or by referral to the psychiatrist. The consulting psychiatrist usually investigates the patient inside the setting of the consultee unit, but his involvement with the consultee service system is minimal.

Consultee-centered Case Consultation. The primary task is to add to the sensitivity, knowledge, skills and professional objectivity of the consultee colleagues by involving them in discussions about their patient, so that they may freely choose how to improve their professional functioning and therefore how to benefit this patient and others like him. The psychiatrist may receive his information about the case entirely from his consultees and may not need to investigate the patient directly. But in all cases the consultant must penetrate the system and to reporting on the operations of the psychiatric department.