

# **SYSTEMS-BASED PRACTICE CONSULTATION Revised January 2020**

## **SYSTEMS-BASED PRACTICE: CONSULTATION OBJECTIVES\***

### **Knowledge**

The resident will demonstrate an adequate knowledge of:

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

### **Skills**

The resident will demonstrate the ability to:

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

### **Attitudes**

The resident will appreciate the importance of the following principles:

- 1) Consider the roles, responsibilities, and different members of the consultee’s system when making recommendations.
- 2) Realize the importance of attitude – the Three A’s of availability, affability, and ability – in a successful consultative relationship.
- 3) Appreciate the importance of being an advocate for the provision of quality care that is safe and effective.

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\* Parentheses refer to systems-based practice competencies in the RRC Program Requirements.<sup>1</sup> See Appendix 1.

## OVERVIEW

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

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

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## IMPORTANCE OF CONSULTATION

Youth with mental illness are in school, juvenile justice, child welfare, primary care, and other systems. The initial point of recognition and intervention for the overwhelming majority of mental health problems is not in mental health settings, but in the community, either by school providers or primary care doctors. Once identified, most youth struggling with mental illness are not seen in traditional mental health settings. The ongoing shortage and uneven distribution of CAPs and other qualified mental health providers requires that a substantial number of CAPs work in consultative and collaborative relationships with systems and other professionals in order to improve access to quality care that is youth-guided and family-driven. It is reassuring to note that treating youth in their natural environments and/or providing treatment in other systems *does* improve access to care, is acceptable, feasible, and effective. In addition, appropriate expert consultation can improve the quality of mental health care. CAPs have unique skills and knowledge that can be combined with the skills and knowledge of professionals in other settings

to provide holistic, high-quality, youth-driven, family-guided care.

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

## DEFINITION OF CONSULTATION

**Consultation** involves two professionals and/or organizations, the **consultant** and the **consultee**.

- The **consultee**, who is an expert in his or her own system, requests that the consultant use his or her expertise to make recommendations about the best method of intervention, in order to benefit the consultee’s patients and/or programs.
- The **consultant** works at the invitation of the consultee. There are two basic types of consultant.
  - A **traditional consultant** provides input to the consultee but carries no administrative authority and no ultimate responsibility for implementation of intervention. Therefore, within a traditional consultative relationship, the consultee retains professional responsibility for the client and is free to follow or not follow the consultant’s recommendations.
  - An **internal consultant**, in contrast, assumes responsibility for youth and families they see, as they function more in the role of an independent contractor. However, while assuming direct responsibility, the internal consultant maintains a collaborative relationship with the consultee.

**Mental Health Consultation/Collaboration** involves a process of interaction between two professionals (pertaining to a mental health issue): the consultant, who is a specialist, and the consultee who invokes the consultant’s help in a current work problem that he believes is within the area of the specialized competency. It can include management of one or more clients or planning of a program for one or more clients.<sup>2</sup>

## TRADITIONAL AND EVOLVING CONCEPTS OF CONSULTATION

There are several proposed models for conceptualizing the roles that CAPs can fill when acting as consultants. No one model completely covers all potential roles that a CAP may play, but an understanding of Caplan’s traditional model can help a trainee begin to distinguish between roles and responsibilities that may occur.<sup>3</sup> The types of traditional consultation involve the following: **case-based, client-centered; case-based, consultee-centered; administrative-based, consultee-centered; and administrative-based, organization-centered**. In this model, one must distinguish whether the focus of the consultation is management of specific cases (case-based) or general organizational issues (administrative-based). The next point of differentiation

involves the role the CAP will play with the patient, provider, consultant, or organization. The definitions below are primarily derived from Caplan,<sup>3</sup> with additional elaboration obtained from two editions of *Child and Adolescent Psychiatry*.<sup>4,5</sup>

- **Case-based** – centered around specific clinical issues related to one or more clients:
  - **Client-centered**
    - The focus of the evaluation and recommendations is on the client and/or provider in order to serve the need of specific client(s).
    - Example: Medically hospitalized youth appears depressed and the primary team consults the behavioral health team for an evaluation and treatment recommendations.
  - **Consultee-centered**
    - The focus of the evaluation and recommendations is on the skills/knowledge of the consultee as opposed to the client.
    - Example: Analogous to supervision.
- **Administrative-based** – centered around the organization or administration:
  - **Consultee-centered**
    - The focus of the evaluation and recommendations is on the program and providing recommendations for improvement. The program is analogous to a client in case-based, client-centered consultation.
    - Example: A child welfare agency asks for help developing a program to address mental health problems in specific youth and family.
  - **Program-centered**
    - The focus of the evaluation and recommendations is the professionals, often regarding administrative issues.
    - Example: A mental health agency may ask a CAP to serve on a committee designed to evaluate systematic changes that need to occur in order to maintain skilled clinicians.
- **Internal model of consultation** – often called “mental health collaboration”:
  - Consultant shares responsibility for the case with the consultee, has responsibility for a subset of care (e.g., medication management), and is embedded in an organization (e.g., a mental health setting).
  - Consultee agrees to respect advice of the consultant because of sharing of responsibility and expertise.

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

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

### **COMPONENTS OF A SUCCESSFUL CONSULTATION RELATIONSHIP**

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

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

It is important to remember that the consultee must balance their own roles, responsibilities, and authority with the needs and expectations of the administration, organization, identified client and family, and overall client population they serve. The consultant is a mental health expert, in this case a child and adolescent psychiatrist, asked to make specific recommendations that the consultee can either choose to implement or not. A consultant must stay attuned to the actual roles and authority of the identified consultee within the organization. If recommendations cannot be implemented by the consultee because of their ability, time, power, or other administrative or organizational factors, then recommendations will not be perceived as helpful. The more the expert consultant understands the nature of the organization, the clientele served, and the role and responsibilities of all members of the organization, the more useful their consultative services will be.

The following is a brief delineation of the components of a successful ongoing consultative relationship. While some of these may appear self-evident, it is important to consider them as part of an organized strategy:

- Ensure that the consultative relationship is documented in writing and signed via a **formal agreement or contract**, with attention to the following:
  - Specific consultative model.
  - Consideration of the logistical issues needed for consultation, including but not limited to time, space, access to records, access to people, location.

- Approval and endorsement of the consultation relationship by the appropriate authority/administrator.
  - Identification of the individuals involved in the consultation, with clarification of their roles and responsibilities. Because in traditional consultation the consultant does not have administrative power or authority, there must be a clear understanding of who has clinical and administrative authority to implement recommendations.
  - Clarity regarding the duration of the relationship – short term or indefinite.
  - Clarity regarding the method for obtaining feedback, sharing information/communication, and periodically reviewing the relationship.
- Pay ongoing attention to “**The Three A’s of Consultation**”:
    - **Availability** – being available, communicating, and giving back advice to the consultee in a timely fashion.
    - **Affability** – being approachable, appreciating members of the team, and managing your own emotional responses to difficult situations cannot be underestimated.
    - **Ability** – i.e., clinical skills with families, communication skills with members of the team, finding and utilizing up-to-date information about the clinical population the system is serving, and advocating for the patient, family, consultee and system, as needed.
- **Communicate clearly** – avoid jargon, and strive to communicate in a manner that can be understood by non-CAPs and/or people outside the mental health community. Communication should be done in a timely manner.
- Be attuned to the **process** of consultation:
    - Was the consult requested or mandated, and by whom?
    - How is the process going?
    - What are the expectations of the team and the consultee regarding the consult, and are those expectations being met?
    - How are you responding to the expectations of the team and consultee?
- Remain attuned to the **concerns, priorities, and roles** of various members of the consultation system, including leadership and supervisors.
- **Respect** and utilize the skills, knowledge, and expertise of the professionals of other disciplines in making your recommendations.
- Develop and maintain relationships that are **non-coercive and non-hierarchical**.
- Develop and maintain relationships that uphold the competence and professional status of the consultee. This may, at times, require the exercise of discretion when providing recommendations and feedback, particularly in writing. Effective consultative relationships require that the consultee feel supported, and not threatened, by the consultant.

- Stay attuned to the **culture of the consulting organization** at all stages in the relationship.
  - Be aware of the needs, responsibilities and language of other disciplines.
  - Be aware of specific practices and jargon in the field.
  - **Be aware of mandates governing the consultee organization.**
    - Example: School Public Law 94-142, also known as the Education for all Handicapped Children Act was passed in 1975 and created special codes for physical or mental disability. It was later renamed the Individuals with Disabilities Education Act (IDEA) and expanded protection for specific youth <6 years old.<sup>6</sup>
    - Specific requirements and accountability influence culture and attitudes, therefore you must be cognizant and sensitive to the cultural norms of the organization in order to have a successful collaboration.
  
- **Enhance your knowledge of the population served.**
  - Know the characteristics of population served.
  - Know the evidence-based treatments and interventions that may be helpful for the population.

## **NUTS AND BOLTS OF THE CONSULTATION PROCESS**

This is a basic list that can be utilized in almost any specific consultation experience, whether a new or continuing consultative relationship. Although some components of this list may not always unfold in a strictly linear manner, in general an effort should be made to move through the list in order when approaching a specific consultative question:

### **Primary Steps**

- Seek information about the consult and the consultee.
  - *What is the type of consultative relationship?*
    - Who identified a need for a consultation – person requesting or someone else (i.e., mandated consultation – administration, regulatory agency)?
  - *Who is the actual consultee?*
    - Example: a nurse on a ward is concerned because a youth is requesting a lot of pain medication; the medical doctors were not concerned but consulted psychiatry because the nurse asked for it.
  
- Clarify the need/question of the consultee, so that you can be confident that you understand what is being asked of you.
  
- Utilize *direct questioning* in order to help clarify the consultee's question and better understand the focus of the consultation.
  - Why is consultation on this issue occurring at this time?
  - Will the consultation be *case or administrative-centered*?
  
- *Clarify expectations*, i.e., existing relationship or new relationship?
  - If any **bottom-line issues** are evident, or if it is unclear if there are any bottom-

- line issues present, have a frank discussion with the consultee about them.
  - Bottom-line issues are any concerns that can potentially impact the safety of the patient or family, result in legal or ethical concerns, and/or impact the viability of the consultation relationship.
  - Bottom line issues *cannot* be ignored in the consultation, and must be addressed above and beyond other interventions or concerns.
- Is this request within the bounds of the current consultative relationship with the consultee?

## Secondary Steps

- *Collect information.*
  - What to *clarify* for yourself (with consultee, as well, if possible).
  - What are potential bottom-line issues (e.g., ethical, legal, safety, consultation structure)?
  - Is there evidence of **theme interference** (when preconceived stereotypes or unresolved issues interfere with interventions at any level)?
    - Example: the belief that all children requesting pain medications are addicted.
    - How to elicit theme interference:
      - When responding to a request for a consult don't ask only about clinical facts, but of the team's interpretation of the facts and specific concerns.
      - Use frequent questioning to widen the consultee's thoughts about the case.
    - If theme interference is recognized, use non-psychiatric jargon in order to encourage the team to recognize other possibilities, the role of their own concerns with the patient, or to realize that the negative outcome, as they predict, is not inevitable.
  - Identify potential **covert and overt agendas**.
    - **Covert Agenda** – When, in addition to the stated reason for the consult, there is another reason that may actually be more important to the team, but unvoiced for a variety of reasons ranging from lack of self-awareness to deception.
    - **Overt Agenda** – Teams consult psychiatry every time that there is an overdose attempt because this is the process needed to get an admission to the psychiatric floor in their state.
  - Consider conflicts of interest – competing services or competing sources of recommendations.
  - Be aware of the potential for your own distortions to interfere with the process.
- *Communicate* with members of the team.
  - **Think widely** about all pertinent members of the team/system.
  - Obtain **youth and family information and opinions** (if client-based case-centered consultation).
    - *Be clear about your role* in the consultative process.
    - *Be clear about the limits of confidentiality* in the setting.

- *Address bottom-line issues.*
  - Perform appropriate clinical interviews with youth and family.
    - Obtain youth and family experiences regarding interaction with staff/team and need for consultation.
    - Pay particular attention to any issues of culture/ethnicity that may be contributing to the reason for the consultation.
- **Provide *feedback* of information and recommendations** to the consultee.
  - **Hierarchy of interventions** (Note this is also a hierarchy that begins with bottom-line issues, i.e., consideration of interventions should actually occur in this order, with bottom-line issues occurring first.)
    - Assure safety.
    - Obtain information.
    - Ethical (may be mandated by state law).
    - Consultation viability (i.e., is consultation consistent with the contract?).
    - System boundary issues (covert agenda, theme interference, etc.).
    - Family boundary issues (routine clinical considerations).
    - Family-staff boundary issues.
  - Timeliness and clarity are vital.
  - Consider the roles, responsibilities, and limitations of the consultee when making recommendations.
  - Relate “chief complaints of the concerned parties (staff, parents, child, etc.) to each other.
- **Assess *the impact* of intervention, and get additional feedback that can be used to improve the overall experience and process.**

## **MEDICAL-LEGAL ISSUES IN CONSULTATION<sup>7</sup>**

Malpractice and liability concerns regarding consultative activities can serve as a barrier to the development and maintenance of collaborative relationships between physicians, an important tradition within the medical field. The level of liability depends on the type of consultation. In general, the further away the consultation from a formal patient-physician relationship, the lesser the risk of litigation.

If a CAP is **educating other professionals**, with no specific names of patients or specific cases discussed, the CAP is at minimal liability risk. “**Curbside**” consultations, in which the CAP has not formally evaluated the patient, have been generally considered to be protected from litigation as no formal physician-patient relationship has been established. It is extremely rare for an informally consulted physician to be the subject of a malpractice suit. Nevertheless, the following strategies may help to further minimize liability:

- 1) Avoid using prescriptive language in communications. For example, CAPs should *inform* the collaborating professionals regarding best practices for assessment and management of various presenting problems. CAPs should *suggest* or *recommend* that the collaborating professional *consider* follow-up plans and interventions.
- 2) Consider maintaining a log to record basic information about the consultation encounter including identifying information of the collaborating professional and

- clinical information (but not identifying information about the patient), a brief description of consultation question, and recommendation made. Such a log would be useful in the unlikely event of a subpoena.
- 3) Unless necessary for clinical purposes, identifying information about the patient should not be shared.

In some cases collaborating professionals and CAPs may develop more **formal consultative relationships** wherein the CAP consults on an ongoing basis with another physician. Specific patients may be discussed in more detail, but the CAP does not see the patient for evaluation. The collaborating professional is responsible for making independent medical judgments, implementing treatment, and communicating with the patient and family. In such an ongoing consultative arrangement, both parties should document the consultation. It is considered a legitimate professional service that can be billed and paid for by some health plans. The CAP is responsible for the professional advice provided to the collaborating professional even though he/she has not established a physician-patient relationship with the patient.

In the most **comprehensive** of consultations, CAPs may **personally evaluate a specific patient** referred by a collaborating professional and render recommendations to the family and to the referring provider. These consultations have the same legal risk as any other situation in which CAPs provide direct patient care. As is customary, CAPs should obtain voluntary and knowledgeable informed consent from the patient and/or guardian before assessment or treatment. A written release authorizing communication between professionals and specifying the nature of clinical data to be shared mitigates confidentiality and privacy concerns. Clinically relevant material should be documented. Because this is a customary service, standard professional liability policies should provide coverage and assure protection if there is an allegation that the CAP or referring provider has violated the standard of care, with resulting harm.

## **CONCLUSION**

Child and adolescent psychiatrists are often involved in collaborative and consultative relationships with other professionals throughout systems of care, particularly due to their relative shortage in number and uneven distribution in the workforce. There are multiple types of consultation models and consultant roles, which vary in the amount of responsibility that the CAP takes in implementation of recommended interventions. The roles and responsibilities of the consultee and the consultant depend on the needs and expectations of the administration, organization, identified client and family, and overall client population served. In order to promote effective, high quality consultative relationships, CAPs should work to ensure that the following occur: determination of the type of consultation model needed to achieve agreed upon goals of the relationship; delineation of roles and expectations; maintenance of mutual respect between the consultant and the consultee and team; and ongoing timely communication, feedback, and assessment of the overall process.

## APPENDIX 1\*

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

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

\* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

[https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405\\_ChildAdolescentPsychiatry\\_2019\\_TCC.pdf?ver=2019-03-28-161025-277](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277). July 1, 2019.

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*Acknowledgements: We would like to thank Peter Jensen, M.D. for allowing us to draw upon teaching material that he has utilized for formal and informal consultation trainings.*



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

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

4) Review the definition of consultation relationships. Name the types of consultation that you will be providing.

## Consultation – Discussion Vignette II – Trainee Version

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

1) What factors should you consider in order to proceed with this opportunity?

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

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

### **Consultation – Discussion Vignette III – Trainee Version**

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

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

2) What are your **primary steps**?

3) What are your **secondary steps**?

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

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

5) What type of relationship would this be?

## Consultation – Discussion Vignette IV – Trainee Version

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

1) What is the preexisting consultation relationship?

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

2) What are your first steps now?