THE ROLE OF A CONSULTANT PSYCHIATRIST IN A RESIDENTIAL CARING ESTABLISHMENT*

(A personal view)

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In this paper I have outlined a model for the role of a Consultant Psychiatrist who is appointed for the purpose of providing 'staff support' in a Residential Caring Establishment. Some of the issues that arise are stated and discussed. The use of the model I propose leads to some recurrent, identifiable psychosocial phenomena which warrant further study and discussion.

Psychiatrists are appointed to assist with the work of Residential Caring Establishments for two main reasons. In the past, the primary reason has commonly been because the psychiatrist has special knowledge and experience in relation to the clientèle; his appointment is then a clinical one, and he would expect to have executive authority to match his clinical responsibility. This would largely apply in connection with 'treatment' and 'treatment plans'. The second main reason is to provide 'staff support'. It is to this function that my paper is addressed, since it seems to be becoming more common for psychiatrists to be appointed by an Area Health Authority to assist Social Services in this respect. The idea seems to be that with the increasing professionalism of social workers it is appropriate for much of the clinical responsibility and authority previously carried by doctors to lie within the social work hierarchy.

I think many doctors are concerned—even angry—at the diminished authority with which they are invested. Some have espoused the fashionable idea of the 'interdisciplinary team', while others question the extent to which this concept can lead to the dispersal of responsibility to the point where its location can no longer be identified. Anyone familiar with the use of the 'case conference' as a decision-making occasion will be aware of the way in which such a procedure may be used to evade or inappropriately delay decisions. Even case conferences can be wrong. In a Residential Care situation involving residential social work staff, field work staff, a psychiatrist, perhaps a paediatrician, maybe a teacher, the police . . ., a wrong decision reached and recorded can take far too long to alter, if only because of the difficulty in getting all those people together again.

I want to discuss an alternative model for the position of a psychiatrist in all this. I contend that the proper position is that of a Consultant in the true sense of the word, namely a doctor with particular expertise and experience who is available to the Social Work staff for consultation about their work. Being consulted by the staff is the central platform of the psychiatrist's work. The outcome of a consultation will seldom be advice, except perhaps to indicate which people need to work something out between themselves, and what it is that needs sorting out. In ideal circumstances, even this will not be necessary, since the clarification arising from consultation will enable people to see for themselves what is important in a particular situation. Experience teaches that what will frequently be important is unresolved tension between members of staff.[1] It has to be very clear, though, that the psychiatrist is not functioning as a therapist of any kind for the staff. His primary concern is for the clientèle. Whether or not he can usefully serve as a 'psychiatric referral agency' for staff if asked to do so remains, for me, a vexed question.

In order to be effective as a Consultant, the psychiatrist requires certain things beyond his own expertise and knowledge. He requires access to multiple sources of information. In my experience, the Head of an establishment has to exercise some authority to persuade his staff to provide the psychiatrist with necessary information. The model I have worked with is that of the Head establishing an atmosphere in which no one is entitled to assume that the psychiatrist has been told what is going on; in this way staff are placed under some obligation to tell the psychiatrist about emotionally significant events that have taken place. A frequent source of significant information for the psychiatrist lies in what he does not get told about by the 'proper' person at the 'proper' time.

Perhaps an example will clarify this. I arrived at a Home, and the atmosphere was thick with tension but *no one would tell me what it was about.* All insisted that it was something that only the Principal could tell me. It turned out that the Principal had simply decided to move several staff around within the

* In referring to Residential Caring Establishments, I am talking about a wide range of places: Children's Homes, Assessment Centres, Adolescent Residential Homes, Mental Health 'halfway houses', and homes for the disabled and elderly.

Unit. The detailed dynamics are too complex to record here, but my simple observation was sufficient to alert me to the intensity (and irrationality) of current conflicts pertaining to authority issues within the Home.

The maintenance of the position of having access to multiple sources of information depends on two things. Firstly, the psychiatrist must not have executive authority or responsibility; secondly, and by direct implication from the previous point, he must not act as a channel of communication. His job is to promote appropriate communication between staff—not to do it for them.

This brings us to the important question of confidentiality. It is obvious enough that people will confide more if they are assured of confidentiality. If staff wish the psychiatrist to keep something confidential, he should do so. Usually, he would do so anyway on personal matters.

I am assuming that access for staff to such a Consultant is desirable, and that senior people in their own management hierarchy cannot provide the same facility. I contend that there are certain kinds of information which, if received by someone in a position of authority, must be passed on to a higher authority despite previous promises of confidentiality which may inadvisably have been made. The obvious example is that of someone confiding an improper sexual relationship with a client. Only in a strictly confidential relationship is it likely that such a confidence will be given, and an opportunity thus become available to help the staff member to seriously explore and think about the implications of such behaviour for himself and his client.

The permitting of a fully confidential facility for staff in relation to the psychiatrist requires a considerable degree of trust on the part of senior management. It takes time and work on the part of the psychiatrist and individual senior managers to establish this trust. For example, one would imagine that most senior managers would need to satisfy themselves that the psychiatrist will not encourage improper behaviour by staff; it is also necessary for the psychiatrist to find out what is considered improper by particular managers; in contentious ethical areas it is not possible for him to deduce this from his own ethical principles.

There is an aspect of staff support which requires mention here. This is the simple provision of appropriate praise and encouragement. Within the context of my model, this is primarily a function of good management; the psychiatrist needs to avoid the danger of indulging in too much of it himself.

I have said nothing so far about the clientèle. It is helpful if the psychiatrist has some direct contact with them, and staff generally expect this. However, there are serious dangers to consider:

The psychiatrist is not a personal psychiatrist to any client. Staff sometimes want to make him so in order to evade issues which are really primarily staff problems. Further, the danger (perhaps particularly for a child) of 'having a psychiatrist' tends to be under-rated. It provides the client with a possible 'identity'—let's call it the identity 'Mentally Ill'. This is not only a stigma, but can be a powerful weapon in the hands of the client, his family and even the staff. It can be used to manipulate us at serious cost to the client in terms of emotionally disconnected relationships. We have to be sure that the psychiatrist has positive help to offer of sufficient magnitude to outweigh these dangers.

In a Residential Care situation, I think the psychiatrist can sometimes do very useful limited direct clinical work with the *relatives* of a client.

It will have become apparent that the foundation of the psychiatrist's work is, in the broadest sense, educational. He can also be used more specifically to take part in such in-service training as may be taking place.

Working with this model for some seven years, I have found that certain themes recur over and again in relation to me. The most striking is the frequency with which staff at most levels will employ any and every device that they can to allow themselves to attribute inappropriate authority to me. This happens despite the fact that they frequently also complain of already having too many managers around! There are obvious reasons for this, such as the anxiety to 'place' me in a clearly defined, identifiable and controllable position; also the wish to use me to undermine the authority of the proper authorities. However, these motives do not seem sufficient to account for the nature and quality of the phenomenon. I contend that it warrants considerable further study.

Another regular theme is the expectation that I will wish to participate with staff in meetings with no one in charge, and with no specific objective. Generally, there is conflict among staff, often seriously polarized, concerning the value of this occupation; the remarkable thing is that they all incorrectly and persistently attribute the origin of the idea to me. In fact I am quite clear that it is wholly inappropriate for a psychiatrist to attempt to conduct any kind of 'therapeutic group' with a group of staff who are working and living together.

These are just two examples. What I do think happens is that a good deal of emotional heat gets ventilated in relation to me around these essentially

irrational issues, and this serves the purpose of protecting the clientèle from being the focus around which staff problems are played out.

It seems right to me that the psychiatrist's role in this kind of situation should be largely defined in terms of what he does not do. In principle, if there isn't any trouble, he should not have a job! Psychiatrists of experience are extremely expensive personnel, and it is surely vitally important that they do not become engaged in carrying out duties that can be managed perfectly well by less experienced, less highly trained and less expensive personnel. I sometimes think of my work as being like that of being a pretty tough football in a football match; for those who wish to observe and to know what is going on, there is much to be learned by watching the particular direction in which I am being kicked at any particular time!

Reference

1. STANTON AND SCHWARZ (1954). *The Mental Hospital.*

A COMPARISON OF PSYCHIATRIC EXAMINATIONS IN THE UNITED STATES AND CANADA

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Some years ago, I wrote an article about psychiatric residency training in the United States.[1] As my own experiences on making enquiries in England had been that very few people knew what went on or was available in the US. I felt that it might help those who were contemplating taking some or all of their postgraduate training there. Also, that it might be helpful to those wanting to make some comparisons between the training they were receiving in England and that available in the US.

In both Canada and the United States, certification examinations are taken at the *end* of training, unlike the M.R.C.P. for example which is almost an admission requirement to *commence* specialty training. Indeed, eligibility for the oral part of the American Board exam requires *two years* of work *after completion of training*.

At the present time there is a significant difference between Canada and the United States. In Canada, the F.R.C.P.(C) or certification examination pass is virtually a necessity to practise as a psychiatrist, indeed it is a legal requirement in some provinces. In the major cities of Canada therefore, with the exception of a few psychotherapists or psychoanalysts, any practitioner of repute in private or university practice would have certification.

By contrast, in the United States, Board Certification, the DABPN, is not a necessity at the present time. Anyone can call himself or herself a psychiatrist and open an office as such. In the psychiatric community, until recently, completion of an approved residency training at a centre with a good reputation was sufficient for initial acceptance, even a university faculty (part-time) appointment, and Board certification was a sort of luxury, often associated with those who aspired towards full-time academic careers.

In recent years, this situation has changed in the United States. There is a widespread feeling that the country is moving towards some form of universal health insurance, and already medical insurance coverage of a variety of forms is spreading. With such increases, whether governmental or non-governmental insurances, come increased requirements for accreditation and accountability. In practical terms this means that payments are being made, or are going to be made, only to legitimately designated practitioners, and different payments will be made according to different levels of practitioner as measured in *objective* terms.

Consequently, in recent years there has been an enormous increase in the numbers of doctors taking the specialty board examinations, and this is particularly true of psychiatry.

Nevertheless, the difference still remains, that is that the Canadian *has* to take (and pass) the boards; the American is still taking them out of choice, not necessity.

A major consequence of this difference is[2] that there is much greater pressure on the Canadian examination candidates. Study groups are set up 1½ years or more before the examinations; candidates take mock examinations, practise orals, write essays, for months before, and their training programmes are very much examination oriented.

By contrast, the American candidates for the most part have spent perhaps a few months in a general