Community Resources—The Role of Other Professionals

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Over a fairly long period of time, many articles have appeared extolling the virtues of multidisciplinary cooperation. If, however, one objectively examines the process of collaboration closely, one does not find an extensive development of this cooperation. Often, the form rather than the substance of collaboration is in evidence. Most of the professionals seem to have heard the music but have not learned the dance. The health professions have more of a city-state configuration than one of a collegial body. Each profession appears to have its boundaries staked out and zealously guarded, and each often seems to be making strenuous efforts to corner the market on prestige and power. Attempts to design and implement programs that could be of immense benefit to patients are frequently hindered by the inability of the various professionals to develop mutual trust. This lack of full commitment to cooperation is often expressed covertly rather than overtly. Since the struggle may be active but unexpressed, it becomes an awkward and troublesome problem. Therapeutic goals can be displaced very easily in team efforts, if intra-organizational conflicts exist.

Societal Forces as Catalysts of Change

The above remarks notwithstanding, there are social changes in the open society that are bringing about forces which may provide a healthy climate for the evolution of more harmonious interprofessional activity. To a considerable extent, the energy and drive of these social forces come from the interaction of rapidly expanding science, technology, mass communication, and our much publicized national affluency. Let us consider the current developments in our society that will assist in propelling the various professions into searching for means to develop greater accord and more fruitful joint undertakings than they have been able to achieve thus far.

The most obvious factor is the large number of persons needing help. The number of persons requiring a special kind of assistance greatly exceeds the number of professional persons qualified to care for them. Thus, the entire number of persons working in the field of mental health is not adequate to cope with the number of persons requiring skilled care. Furthermore, not very many professionals are equipped with the training and personal attributes necessary for working effectively with all social classes and with all forms of emotional problems. To preserve a dog-in-the-manger attitude when this state of affairs exists is tantamount to denying that one is concerned with the well-being of patients. Instead, the situation calls for an intensive and extensive use of all the trained mental health manpower available. To supply the best mixture of professionals for optimal management of each patient's

problems, flexibility of professional roles and mutual support is required. Since population growth is outstripping the production of trained manpower, the best utilization of this scarce resource is very urgent.

A second influence is the closing of the training gap among the various professions. This is taking place at a faster pace than many may recognize, though not nearly as fast as many would have it. A generation ago the psychiatrist's training was vastly different from his colleagues in the other disciplines. Now the availability of federal traineeships and other forms of support has enabled psychologists, social workers, and nurses to secure advanced training. As increasing numbers of these workers are trained at the doctoral level, the difference in competency becomes academic. It seems safe to predict that with the rapid expansion of graduate schools, higher levels of training will become more commonplace in the future.

A third factor is that all the health professions draw from the same large body of basic knowledge about human behavior. It seems pointless to belabor the issue of who has what knowledge. At best, psychiatry and the behavioral sciences are not very precise. No master scientist or group of master scientists has been able to codify these bodies of knowledge in a highly ordered fashion, as has been done in the biophysical sciences. About all that can be said is that Freudian theory is becoming more suspect, and the therapeutic utility of such notions as behavior modification, as adapted from Skinnerian theory and similar theoretical constructs, is beginning to be accepted. The free marketplace of knowledge is equally available to any of the disciplines desiring to draw upon it. Hence, the body of knowledge that is shared by all is constantly increasing in size. The overlapping of abilities in caring for persons in emotional distress is proportionate to the effort each discipline exerts to acquire in depth the knowledge needed for developing expertness.

A fourth consideration is that the high cost of training is emerging as a source of pressure for the full use of professional competence. The cost can be measured in terms of the financial outlay by the individual and by society, as well as by the huge personal investment in prolonged and rigorous training. A costly investment of this size, coupled with the huge demand for patient services, is a catalyst in promoting the full use of the professional talents of all the various disciplines. Professionals grow restless and become alienated from the therapeutic effort if they perceive themselves as undergoing role deprivation. Role deprivation (Bennis et al., 1961) can be defined as either violation of anticipated role expression or failure to meet the expectations of the persons enacting the role. Hence, role deprivation refers to a particular type of conflict resulting from the unmet or violated expectations of the role. When a member of a multidisciplinary team perceives the communicative and decision-making processes as tending to derogate, underuse, or misuse the training and competency he brings to the situation, he is most likely to call attention to this issue by some sort of out-of-field behavior. As he expresses his dissatisfaction in his own particular style, value judgments begin to be placed upon the actions and communicative attempts of others. Energy must be diverted from the clinical ventures to manage the struggles within the group. The irritation of these disruptive events drains off the urge to be innovative and to be supportive of others. It may be the reason why so many stylized, ritualistic, and non-productive interactions become commonplace between the disciplines.

A fifth factor promoting greater collaboration among the health professionals is a better educated public. In one generation, a substantial number of persons in this country have received a college education, and the trend is increasing. When the power of the mass media to keep the public informed is added to this development, the health professionals will find it much harder to justify lack of planning for mutual role facilitation. The assumption of the right of professional prerogative can be taken just so far before the public repudiates this position.

A sixth component that is bringing about new orientations among professionals is the activist theme of the civil rights movement. The civil rights drive is spilling over on all segments of our society. A large portion of the nation's population that has not had adequate health services is now aggressively setting out to insure that it will share in quality service. In addition, there seems to be a spin-off from this social movement that may have a more profound effect on the behavior of professionals. The whole anti-establishment motif is being dramatically demonstrated at many levels of our society apart from the black community. Unless rationality and relevancy are introduced by physicians, nurses, social workers, psychologists, and others in the mental health professions, there is a strong likelihood that establishment-like attitudes will undergo some form of public confrontation. Not only are traditional modes of behavior being questioned outside the professions, but within the professions, the young students are raising burning questions that are not easily answered. Bright, eager students caught up in the excitement of changing value systems will tend to lower the threshold for change by their very presence within each group. The stress of these surging social tides will alter the characteristics of each profession with greater rapidity than at any previous time.

A seventh aspect of professional unification is the necessity for close

collaboration of many types of trained personnel for successful handling of the rehabilitative phase of illness. The fine articulation of the efforts of different health workers may be called for to restore patients to the level of productive living deemed essential for self-maintenance. The interdependency between all the professions involved is of a very high order. Each must be quite sensitive to what the others can do to contribute to the health goals of the patient.

Finally, another emerging reason for a thoughtful reassessment of how various disciplines can participate jointly in this socially desirable undertaking is the growing concern for a program of illness prevention and health maintenance. The abstract quality and the ill-defined dimensions of this endeavor call for every innovative ability that can be mustered from all the professions. Although the concept is not new, it is amorphous and will continue to be until a concrete plan of action can be spelled out by all those who have the competence to be useful in this uncertain enterprise.

Health Manpower as a Scarce Resource

If the above represents a description of the general characteristics of contemporary conditions, what can be done to give society a health service that is possible? Mental health manpower should be viewed as a scarce resource. Its strength differs from one community to another in both quality and quantity. It represents the total capability of respective communities to mount a program of prevention, care, and rehabilitation. Any program that fails to utilize fully this total resource is indicative of professional whim, interdisciplinary power struggles, or poor planning. A careful assessment of each community will assist in designing a way of bringing the total manpower to bear upon a program of community psychiatry.

Shared Power Encourages Cooperation

A major difficulty is assembling models of collaboration that are on target. In constructing forms of action best suited to the professional groups involved, it is easy to become caught up in preplexing issues since so much is of an abstract nature. It is a truism that persons view the world of work through the selective perceptions brought about by the kind of training they have undergone. Since all have been socialized into the role of their own discipline by a process that tends to develop strong professional biases, they have a predisposition to see the problem and their respective roles in it with decided differences. Subtle distinctions in the definition of the situation and the programs of care are almost certain to occur. One study (Chance and Arnold, 1960) found that the length of occupational experience, membership in a clinical discipline, and formal training in a given theory produced major differences in the assessment of patients' problems. When these biases are understood, it becomes easier to work through the communication barriers and to lay the foundation for developing shared meanings.

The primary basis for the construction of models of care should be the demand systems of patients. Models based on one or another of the professions tend to reflect the caprices and vagaries of each professional type. The chief criterion must be what is effective for patients.

Shared-power models appear to offer the best possibility for success. These models tend to generate maximum commitment and professional excitement, because they permit a high degree of self-expression and the innovative use of professional skills. Professionals usually are more stimulated to work at maximal output levels when they experience the rewards of progress and are enabled to contribute effectively to the attainment of program goals.

In conceptualizing the alternate plans of action, it often is easier to plan for the use of knowledge by a discipline than to try to define that discipline. It is far more important to have a discipline translate knowledge into precise action than to have it spell out carefully and methodically the parameters of a profession. Furthermore, each discipline has a different means of entrée to patients and to the community. Since care is so multidimensional, the use of role expression can become an innovative means of helping apply knowledge and competence where it will do the most good. The application of planned role expression reduces the randomness of activity and promotes better articulation of professional competencies.

Essentials of a Participatory Model

There probably is no one model that is a paragon. There probably is a wider range of competencies within each profession than between professions. This being the case, there will have to be variations on the theme of interdependence. Each workable model will have fine differences, but some general principles will be part of all. Shared interpretations of goals and means; a system where mutual expectations can be fulfilled through a process of complementation; facilitation of each other's roles; self-direction without anarchy; and a sense of professional destiny and self-fulfillment are attributes that seem crucial to the successful mobilization of interdisciplinary resources.

Each of the disciplines brings qualities to the situation that, if properly meshed, can have a cumulative effect upon care, rather than the plateauing one which is likely to be produced if these various potentials are linked in a faulty manner.

Errors of omission in the care process are likely to occur in a loosely constructed system. In addition, opportunities for the refinement of care may go unnoticed. Professional energy is rapidly dissipated. If there are less than sincere attempts made to remedy the waste of professional skill, the attitudes toward collaboration will become increasingly apathetic.

To give encouragement and imagery to the process of professional collaboration, a forum for planning and evaluation must be established. Each discipline should be responsible for selecting gifted and insightful representatives to the committees or councils designated for this purpose. These committees should exist at agency, community, district, and state levels, so that the data from the efforts under way could be analyzed and recommendations for improvement could have legitimate channels for expression. In addition, in-service edducation programs embracing all the disciplines could be planned. When persons learn and study together, their appreciation of each other can be strengthened. When they know they share similar knowledge, they are more prone to use denotative statements with each other instead of the connotative statements employed when there is a lack of shared meanings. When the message system is uncluttered, planning and implementation proceed at an accelerated pace, because ambiguity is kept at a level of tolerance.

In this short paper an attempt has been made to sketch briefly some of the social forces affecting collaboration. A model of shared power has been suggested as a means of most effectively mobilizing the professional mental health manpower and of stimulating the growth of expertness. It is only one alternative among many. The behavioral scientists constantly are studying the best ways to harness human effort for the social good. The application of their findings to the problem of interdisciplinary collaboration may be a valuable means of improving patient care.

References

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