Interdisciplinary collaboration in the field of mental health

Report of a conference

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Dr Len Ratoff

The central position of the primary health care team was stressed by Dr Len Ratoff at a three-day conference of *Interdisciplinary Collaboration in the Field of Mental Health* held at the Tavistock Institute of Human Relations on 2 to 4 July 1973. This team, said Dr Ratoff, should contain general practitioners, health visitors, district nurses and social workers working closely with the district psychiatric team.

Dr Ratoff pointed out that by ' peeling off ' the infectious diseases we have now exposed a new ' layer of diseases ' in which psychosocial factors play an important part. Unfortunately the general practitioner's training does not fit him for the range of problems which must be tackled or for the difficult task of working with members of other professions who have special skills which can be brought to bear in tackling these problems.

A recent survey has shown that social workers often feel that " doctors just do not understand the kind of animals we are ". There is an ' adolescent conflict ' between doctors and social workers which derives from differences in age, sex, training, status, pay and self-perception of skills which makes it hard for the two professions to work effectively together. In Ratoff's opinion joint training schemes in which students of the various professions can learn to collaborate at an early stage in their careers may prevent barriers of mutual antagonism from growing up.

Miss June Neill

This view was endorsed from the point of view of the social worker by Miss June Neill, co-author of *Social Work and General Practice.* Miss Neill stressed that interdisciplinary relations are not always pleasant, they can be frustrating, difficult, aggravating and challenging but the pay-off in terms of the quality of service and the increased conviction of competence in one's own skills makes interdisciplinary team work well worth attempting.

Describing her own participation in a general-practice team Miss Neill emphasised the importance of frequent meetings between team members aimed at clarifying roles and improving liaison. The provision of a quiet room in which members can regularly get together to talk about patients and their families often enables effective action to be taken in dealing with long-standing problems, family difficulties in coping with sickness and death and problems in the relationship between children and parents resulting in truancy and the like.

It is high time that leading educators got together, said Miss Neill, to decide how interdisciplinary training can be organised in detail. One must doubt if it is enough to put students together unless there is also some sharing of theory.

Mrs June Clark

The health visitor's view was expressed by Mrs June Clark, author of *Family Visitor.* By working closely with general practitioners the health visitor is often in a position to visit families before ' troubles ', be they sickness or social problems arise. She is virtually the only person engaging in primary prevention of mental ill health on a one-to-one basis. Problems in mother-child relationship, post-natal ' blues ', consequences of unwanted pregnancies, still births and to an increasing extent problems of old age and bereavement are all dealt with by the health visitor who must be prepared to act in the capacity of social worker where the need arises while retaining her own special nursing skills. This makes it imperative for her to maintain the closest liaison with social workers and general practitioners.

In her own survey in Berkshire Mrs Clark found that a quarter of the health visitors she interviewed had never been contacted by a local authority social worker and that those who had referred clients to social service departments had rarely obtained any feed-back about them, apparently because it was not thought appropriate that health visitors should be trusted with confidential information.

Attachment to a general practice tends to improve communication with general practitioners but it is not enough for the health visitor to pick up pencilled notes from the surgery and the general practitioner is no more qualified to ' prescribe ' nursing care than the health visitor is to prescribe drugs. Proper referral and reporting back at regular team meetings are essential but the health visitor also needs regular contact with other health visitors if she is not to become professionally isolated.

Dr D. Bennett

Problems of collaboration within the hospital psychiatric team were discussed by Dr Douglas Bennett, psychiatrist. Conflict often exists not only between professions but even within professions (*vide* Strauss' classification of psychiatrists as ' somato-therapists ', ' psycho-therapists ' and ' socio-therapists '). Nurses tend to see patients as members of a ward group, doctors see them as individuals and ignore interactional effects and social workers see them as parts of a family. We need to recognise these differences and capitalise on them rather than allowing one team member to ride roughshod over the others.

Dr Bennett pointed out that the traditional hierarchical system of medical care often results in fragmentation of tasks and loss of an overall view of the situation. It is not enough to apply a ' medical model ', a ' social work model ' or a ' nursing model ' to the unit of care, rather we need a model of management which allows different ideologies and commitments to operate in a single field.

Dr Bennett favoured Strauss' ' arena model ' which provides a sphere of co-operation, conflict and negotiation between the work team whose essential commitment is not to themselves or their own particular discipline but to the work of the team as a whole. Space and time must be allowed for communication between team members who must learn to tolerate the stress of continually redefining and adjusting their tasks, informing and advising rather than giving or taking ' orders '. In such a setting staff must be prepared to discuss their own needs rather than focusing exclusively on the patient's needs. Paradoxically this seems to make it less likely that the patient will be made into a scapegoat or that stop-gap resources such as the indiscriminate prescription of drugs or electroconvulsive therapy will be used to exert control. Once the team come to respect each other's potentialities they are somehow freer to respect the creative potentialities of their patients.

Dr B. Snowden

The final speaker at the Conference, Dr Brian Snowden, had been appointed as community psychiatrist jointly by the Health and Social Service Departments of the City of Westminster. Coming in at the inception of the social service departments Dr Snowden emphasised the difficulties which arise whenever major changes in the organisation of a profession are made. Aware of the tensions between psychiatrists and social workers Dr Snowden had acted by placing himself at the disposal of the social workers at certain times and had been permitted to attend team meetings. In this setting he was not only consulted about work problems with clients but was able to help support staff through the crises of change without himself taking on the role of staff psychiatrist.

A seminar had been started at which staff of the social service and health departments met to discuss cases, and Dr Snowden regarded it as important that social workers and medical officers should confront the problem of working together and resolving the conflicts which existed betweem them, e.g. by making joint case presentations.

He also advocated the entry of hospital-based staff into the community and community-based staff into hospitals. Psychiatrists should visit homes, general practitioners' surgeries and maternity and child welfare clinics, and the primary care team should visit their patients in hospital and share in meetings with the hospital team.

Absence of general practitioners

The conference was attended by a mixed disciplinary group of health care workers, only general

practitioners were conspicuous by their absence (which attracted comment). Between lectures the membership had been divided into six small groups without a leader and had been left to work out their own means of interdisciplinary collaboration. One group had appointed a social work lecturer as leader but had restricted his role to stopping and starting the discussions. Others had resisted all attempts at formal leadership although the representatives of the discipline under discussion often found themselves the centre of attention. Despite some difficulties in keeping to time boundaries the groups seemed to work effectively together and felt that the experiment had been worth while.

It is obviously not possible to provide here a summary of the discussions which took place in each group but a few points of interest will be noted. The absence from the conference of the key members of the primary health team, the general practitioners, was interpreted as a defensive avoidance of confrontation. It was suggested that the general practitioner, having, like all doctors, been trained in the model of the ' great consultant ' likes to view himself as important, powerful, controlling, clear-thinking and endowed with the knowledge to cope with all his patients' problems. Yet he is only too aware of his failure to live up to this idealised image. Naturally enough he avoids confrontation with these unpleasant realities. In the primary health team the general practitioner may reveal himself as insecure, apologetic, pessimistic and feeling that he has not been trained for the job he must perform. This is not only painful for him, it is equally painful for the health visitors and social workers who have grown used to thinking of the doctor as omniscient and who have not, in the past, expected to work without being told what to do.

This extreme view was, of course, challenged and it was suggested that members of the conference were attempting to make a scapegoat of the poor general practitioner, thereby reducing our own feelings of inadequacy. It was pointed out that it is patients who need to believe in the infallibility of their doctors and since we are all patients the conflict is an internal one.

Doctors are, of course, accountable at law for the consequences of their actions and this too makes many of them wary of trusting others with the care of ' their ' patients. Only when a team had been working together for some time is it likely that it will develop the commitment and acceptance of responsibility which allows mutual trust to grow up.

Dr A. Brook

Sickness evokes care and the patient will probably always come first as the focus of care. The conference chairman, Dr Alexis Brook, pointed out that, according to the Oxford Dictionary, the word ' patient ' was first recorded as being used in 1374 for " one who suffers ". But illness often produces suffering in members of the family who are not identified as ' sick '. Is it possible that the 600th anniversary of the ' patient ' might coincide with an extension of our frame of reference to include the ' family '? We should get away from the doctor-patient unit to look at other systems of care and the family health care team could be viewed as one kind of system.

Supporting health care teams

There was much discussion of the support which health care teams require. Professionals tend to seek support from members of their own disciplines and it is important to ensure that in our enthusiasm to care for our patients we do not forget to care for our staff. This is especially the case when they are having to cope with intractable problems, the supposedly ' hopeless ' case, be he dying or crippled, and families whose needs are beyond the resources of any single caregiver. The support of peers is as important as the support of seniors and friendship links with supportive persons should be fostered.

Because the roles of supporter and co-ordinator usually take second place to direct service to patients or clients and because these roles require special skills of their own there is a place for those with an understanding of human relations to provide consultation to the ' front-line ' workers who provide the greater part of the care of the distressed and the mentally sick. Faced with the ratio of one consultant psychiatrist to 60,000 persons in the population it is evident that psychiatrists could never treat more than a small proportion of the mentally ill and opinion was divided whether they would or would not do better to forego treatment altogether and devote their time to the provision of consultant services.

At the other end of the scale are the families themselves and a plea was made for providing support for those members of the family who bear the brunt of the community care of the mentally ill. It is only the full support of the family that will enable an ' open door ' policy to work and we cannot expect the family to support the patient if we do not support the family. This means that communication within the primary care team is not enough. Feed-back and feed-forward to and from the family form the basis for evaluation of our work and for monitoring its progress.

Several participants emphasised the value of collective help, both from self-help groups within the community and from voluntary bodies. A little professional help given at the right time could enable a great deal of support to be mobilised and minimise the risks to self-esteem and public identity which so often arise when help is offered only to those who accept the label of ' sick ' or ' weak '.

Collaboration in planning

Members of the caregiving professions are often expected to cope with the casualties of the man-made environment without collaborating with the planners of that environment to improve it. It was felt by some that here was another field for cross-disciplinary collaboration which had hardly been considered and that the current balance of support for curative as opposed to preventive action was short-sighted.

The problems of collaboration between hospital-based services and community-based services are bound up with the division between specialist and generic services. How much specialisation is a question that has never been satisfactorily resolved and opinions were divided concerning the place of such interstitial figures as the ' community psychiatric nurse ' (a nurse attached to the hospital service and working with psychiatric patients in the community) and the ' community terminal care nurse ' (a nurse attached to a terminal care unit and providing services to families of patients dying at home and the district nurses who care for them). Like the community psychiatrist these nurses are likely to be seen as ' peripheral ' by both hospital-based and community-based colleagues but it is clear that their interstitial position also provides them with their greatest asset, the ability to cross boundaries and to work closely with specialists and generalists.

Since support is particularly necessary at times of change the coming reorganisation of the National Health Service is an occasion for anticipatory guidance. The experience of social service reorganisation did not leave the conference members with much confidence that such guidance would be provided by the Department of Health and Social Security and it is clearly important for staff at all levels to begin to talk through and work at the problems that are likely to emerge.

In drawing to a close a fruitful conference Dr Brook concluded that there are no simple answers to the problems of collaboration between disciplines. The essential skill which we must all seek is the ability to tolerate uncertainty, to live with the tensions of trusting the unknown until we have learnt to know and respect each other's peculiar abilities. It seemed to him that although the conference members were not blind to the very great difficulties in achieving effective collaboration we were none of us inclined to despair of achieving it.

READING LIST

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