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ABSTRACT

The author discusses the responsibilities that professional counselors have for and to paraprofessionals who work in their field. He mentions seven areas of professional responsibility related to the training and use of paraprofessionals: (1) responsibility for the overall planning of training and service programs; (2) responsibility for role definition; (3) training functions of professionals; (4) client acceptance of paraprofessionals; (5) aiding of paraprofessionals in career mobility; (6) consideration of monetary compensation; and (7) legal liability. The author concludes that the main responsibility of professionals in providing humane and effective services is to encourage the creative potential for work of the paraprofessionals. Paraprofessionals need help in training, supervision and standard-setting, as well as enthusiastic and responsible partnership. (Author/WS)

PEER COUNSELING AND PROFESSIONAL RESPONSIBILITY*

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Fr. the titles in the program I judged that my fellow panelists would be describing programs for the delivery of mental health services using professionals in new ways or in new settings, and especially using paraprofessionals. The latter -- the nonprofessionals, peer counselors, subprofessionals, or as Eisdorfer & Golann (REF.) refer to them, the "new professionals" -- are now to be found in free clinics for street people, juvenile detention centers, nursery schools and day care centers, crisis intervention centers, state hospitals, drug rehabilitation programs, poverty agencies, and scores of other settings. (Schwartz, 1971; Gruver, 1971; NIMH, 1971). One would be hard pressed, in fact, to think of many areas of mental health work that aren't being handled somewhere by people with far less than professional credentials. We are truly in the midst of what Francine Sobey (REF.) calls in the title of her book, "The nonprofessional revolution in mental health."

So, rather than giving another example of how to train or utilize the services of paraprofessionals, or analyzing why at this stage in our national life we are at last becoming aware of the health and mental health needs of the underprivileged and neglected segments of our society -- an interesting sort of neo-populism reflected in consumerism à la Ralph Nader, a heightened consciousness among minority and oppressed groups, and a general questioning of established authorities

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and institutions -- instead, I've chosen to discuss some areas of professional responsibility we have for and to the paraprofessionals who work in our field. The explosive increase of paraprofessional personnel, numbering many tens of thousands now, raises tricky issues for those of us with professional investment in mental health. All of us feel, or should feel, a deep sense of responsibility for the standards of our profession and for the public good. We may have some understandable reluctance to turn amateurs, however well-intentioned, loose on the public, however great its need for mental health care. Now there are literally scores of thousands of people with widely diverse levels of training and experience introducing into what used to be our territory a host of new theories and techniques, some of which make us feel pretty uncomfortable. We hope to prevent any debasement of our craft through misuse or falsely optimistic promises, and as professionals we have major responsibility wherever possible to protect the public from quacks. As the presumed experts, we are sometimes asked to evaluate these new mental health workers and their methods; the validity of their claims, their areas of competence, their maturity of judgment in dealing with complex psychosocial problems, their own mental health, what functions and responsibilities they can properly assume.

The picture is very broad and very mixed. I think of the drug drop-in center at my university where paraprofessionals are doing highly effective work on a 24-hour basis with students having drug-related problems and now extending their counseling services to many other sorts of student and non-student problems. I also think of people at the same university who have been through a weekend encounter group experience and have then

declared themselves qualified for T-group leadership. Then there are A.A. members, without any formal training or supervision, going out at night to rescue fallen comrades, counseling families of alcoholics, tackling dreadful situations most of us would cheerfully avoid. And I'm familiar with the tragic case of a well-meaning ex-addict who tries to rehabilitate other addicts and who currently faces criminal charges because one of his clients died, lacking medical attention, from an overdose of heroin. These are all mental health paraprofessionals.

The issues of responsibility for us are vexing indeed. Just where do we as professionals get involved -- in setting standards of work, as sponsors or supervisors of paraprofessionals, as self-appointed policemen, understandably cautious about taking risks but thereby perhaps stifling humane and creative endeavors? Do we ourselves have solidly agreed-upon standards of mental health work? Or are the operative factors for us mainly personal biases, a higher or lower threshold for indignation, a zeal to run other people's lives vs. a laissez faire posture of benign neglect -- everyone does his own thing?

It's a dilemma we can't escape. Our legal status as professionals requires the exercise of responsibility. One definition of a profession is, "The practice of a learned art out of a spirit of public service according to a code of ethics promulgated and enforced by the group." Unless or until the concept "professional" is abandoned, the burden is on us to define and continually redefine what are meant by "mental health" and good mental health practices; to know what's going on in the field, especially along the frontiers; to promulgate and enforce standards which genuinely encourage innovation and the entry of new manpower and

new ideas but which at the same time provide safeguards against exploitation of the public's uninformed demand for services; and, most important, to examine ourselves and our own practices with all the honesty we can muster.

I turn now briefly to seven areas of professional responsibility related to the training and use of paraprofessionals.

First, there is our responsibility for the overall planning of training and service programs. Under this heading come the other six I'll mention next, but here I want only to emphasize the complicating but crucial ingredient of community participation, including that of paraprofessionals and client populations, in the initial stages and throughout the life of the program. The days are long past when experts could be certain they alone knew what was best. We must pay close attention to the community's priorities regarding services needed, allocation of resources, evaluation of personnel, etc., and there are sensitive issues here, including political and ethnic considerations, and real or potential conflicts in values (cf. Vallance, REF.). But as professionals we are obliged to be accountable for the program's success or failure.

Second, our responsibility for role definition -- i.e., the specification of job functions, expectations and limitations for paraprofessionals in the program. The lack of clear role definition and job performance criteria has nearly wrecked some programs because of the paraprofessionals' uncertainty about what was expected of them and what they'd be held accountable for.

And it needs to be added that paraprofessionals can lose their

early enthusiasm if their roles are defined to comprise mainly hack work, the dull routine tasks which the professional staff wants to be relieved of. The use of paraprofessionals cannot be either justified or sustained by appeal only to the argument that they release professionals for "more important duties." It is not just the manpower shortage which recommends the use of non-professionals but their capacity to serve new client populations, their innovations in the delivery of mental health services, and their energizing of existing programs by stimulating, challenging, even teaching us professionals some new things. One of our responsibilities is helping them assume greater responsibilities.

Third is the training function of professionals. All I'll say here is that training, teaching, and supervision are special skills, not necessarily possessed by all the agency's professional staff. As Eisdorfer and Golann (REF.) point out, the training team needs as careful selection as the trainees.

Fourth, client acceptance. By this I mean that it is part of our responsibility to make sure there's a market for the paraprofessionals we train. I could cite examples of programs in which non-professionals, ready and eager to render services, found themselves "underwhelmed" with business. It is obviously important, if newly fledged paraprofessionals are not to be utterly discouraged, to ensure that there are jobs available and a constituency likely to need and want to use their services.

A complication in this regard is the danger of cooptation -- of

selecting, training, and molding the nonprofessional personnel to such a degree or in such ways that they are no longer identified with or acceptable to the very community groups they hoped to serve. Even changes in dress or language can set up barriers. Especially with indigenous community workers, the professionals need to resist the impulse to convert paraprofessionals into junior editions of themselves.

A fifth area of responsibility we have for paraprofessionals is that of career mobility. Some programs which train and use nonprofessional personnel have a self-serving quality in that new recruits are kept on in relatively uninspiring unskilled positions. I believe we are responsible not only, as I mentioned above, for helping nonprofessionals find jobs appropriate to their skills but also for helping them move up to higher levels of education and to positions of greater challenge. Which means that the professionals must be reconciled to seeing some of their best trainees and nonprofessional workers leave, and indeed to facilitate this in order to prevent their jobs from turning into dead ends.

One aspect of career mobility is geographic mobility, and this may come down to some form of certification or licensing. If trained, experienced paraprofessionals are to be able to move from one agency to another across the country, they may need or indeed demand credentials, some form of negotiable currency which qualifies them in settings other than the one they trained in. The issues surrounding certification, licensing, accreditation, examinations, and so on are things we have hardly even begun to face for nonprofessionals in our field. Yet there is a growing body of literature which describes the emergence of new occupational categories in other professions -- new roles and functions

which exist at first without formal status but which gradually gain legitimacy through self-regulation and the establishment of licensing agencies, boards of examiners, and other credential-granting procedures. (cf. Roemer, REF.) In the health fields, of course, this has been the pattern with many groups: dentists and dental hygienists, optometrists, speech therapists, lab technicians, dietitians, and 20 or 30 more.

Basically, what seems to happen is that professional organizations, on the one hand, seek to restrict entry into the field on grounds of upholding high standards of training and demonstrated performance; they tend to stand for conservative practices by insisting on educational credentials, close supervision by senior professionals, and relatively limited functions for the newcomers. On the other hand, especially in fields suffering acute manpower shortages, the priorities swing under the pressure of societal demands in the direction of relaxing standards in order to encourage innovative techniques and the entry of non-traditional, less highly qualified personnel. The courts, state legislatures, funding agencies, and training and service programs, reflecting social needs and responsive to the pressures of professional associations, can act to stimulate or discourage "new careers" by making it easier or harder for paraprofessionals to function in roles heretofore reserved for better trained, fully certified professionals.

Since we professionals sit on the certification and standards boards, direct the agencies, write the grant proposals, and can influence legislative and judicial opinion, the burden is on us to act responsibly in this shifting balance: to protect the public interest but at the same time to encourage the flow of new talent and new ideas into the mental health delivery system.

Sixth, there is the touchy matter of compensation -- i.e., money. If we were to be perfectly frank about it, one of the attractions of paraprofessionals (better yet, volunteers) is that they come cheap. They provide services which would otherwise cost more than our society is willing to spend. But I'm not sure we can continue to take this situation for granted. In some of the programs described by Sobey (REF.), the paraprofessionals rose up to challenge the hierarchy; they joined unions and demanded pay rates comparable to those of the professional staff. In other programs nonprofessionals have demanded or actually seized power, claiming rights to decision-making responsibility and charging the Establishment with the exploitation.

Now, where they can show evidence of equal (and equally good) work, and where they have the backing of political forces within the community, the nonprofessionals' challenge to the professionals is no empty threat. It begins, in effect, to call into question the very distinction between professional and nonprofessional. It asks, among other things: Are those credentials now in your hands really valid? Were all those years of higher education really necessary? Which of us is in fact better able to serve the new client populations -- the addicts, the elderly, the urban ghetto minority groups, the street people? As paraprofessionals emerge as a major force within the mental health field, as they take on more and more important functions in all sorts of settings, and as they prove better able to relate to certain client groups than we can and are able to exercise more relevant leadership in community action programs, it will not be too surprising if they ask for appropriate recognition and

compensation. What will our stance be: opposition or collaboration? These are coming issues, some perhaps already here, which demand of us the highest standards of professional behavior, "in a spirit of public service."

Finally, we come to a different kind of professional responsibility: legal liability. There would be plenty to say in this connection if we were discussing most branches of medicine: malpractice, negligence, legal precedents, and myriad other complexities of medical law. But I've come across practically nothing about legal liability in the literature I've seen on the training and use of paraprofessionals in the field of mental health. Perhaps the reason for this neglect is that the population receiving the services of paraprofessionals is unlikely to sue. They are overwhelmingly the poor, the people of low educational levels, chronic hospital patients, delinquents, addicts, the disadvantaged elderly, the retarded, and the like. And even if they did sue, the courts would be unlikely to award damages. These groups are getting little in the way of high quality professional services; paraprofessionals are doing jobs that for the most part would otherwise simply be left undone. The need for mental health programs, especially for paraprofessional personnel working for the public good at low salaries, is too great and too well recognized to be put in jeopardy by the financial hazards of liability actions.

But several attorneys with whom I discussed this paper advised me that recent trends may have changed the picture somewhat. One factor is the end of the doctrine of eleemosynary or charitable immunity. This is the hundred year old rule of law which protected hospitals, schools, and

other institutions for the public benefit from injury suits, or torts. This has now been abandoned in almost all states. Even though eleemosynary immunity applied only to institutions, not to individuals working in them, it tended to deter litigation because most individuals didn't have enough money to be worth suing. Now, under the "shotgun principle" (sue everyone in sight) or the "deep pocket principle" (sue whoever has the most money), and without the charitable immunity deterent, legal suits are more worthwhile and therefore more common, especially since both individuals and institutions are well covered by insurance.

Another factor that's changed is the availability of legal services to the poor. Just as in the past they have lacked medical and mental health care, they have typically had little access to lawyers and to the whole legal process. But now there are lawyers taking tort cases for indigent clients, financed by legal aid societies and poverty programs or through contingency fees (the lawyer takes 1/3 or 1/2 the settlement if he wins the case; the clients pay no fee if he loses). And some community action programs, including those under the broad heading of mental health, are aimed precisely at informing disadvantaged groups of their rights and at awakening a sense of self-confidence in demanding them -- rights formerly available only to the affluent. People are no longer so likely to be accepting of second-rate care.

But these developments are still in the category of small beginnings. In spite of my attorney friends' admonition, "We are a litigating society, so watch out," the disadvantaged, neglected members of our country remain so for the most part -- medically, educationally, psychiatrically, and legally. Furthermore, there is no reason to believe that the services

provided by paraprofessionals are second-rate. On the contrary, as the literature makes clear. In any case, it ought not to be the fear of legal suits which keeps us honest. I believe that our professional standards and the guidelines for professional responsibility I've suggested here if taken seriously are all the protection we need.

I conclude by urging that our main responsibility as professionals continues as always to be that of providing the most humane and effective mental health services to as broad a range of client groups as possible, seeking new ways to involve paraprofessionals, not just to relieve the manpower shortage -- to hold the line until the real doctors come -- but to encourage their creative potential for work in areas where our own record of success has been less than outstanding. Their goals are ours, and perhaps beyond ours. Paraprofessionals need not only our help in training, supervision and standards-setting, but our enthusiastic and responsible partnership.

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