

PROBLEMS IN ROLE NEGOTIATION AND DECISION-MAKING

IN A PSYCHIATRIC TEAM

by



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PROBLEMS IN ROLE NEGOTIATION AND DECISION-MAKING

IN A PSYCHIATRIC TEAM

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ABSTRACT

The thesis is a study of two psychiatric teams, one adult, the other adolescent, working in an out-patient facility in the same psychiatric hospital. The teams are analyzed with respect to their decision-making ability and the extent to which their functioning is a reflection of the hospital system.

The two research questions posed are directed at team interaction and team-hospital relations. The research questions are:

- (1) How do role negotiations effect team decision-making?
- (2) Is team functioning a reflection of the hospital system?

In regard to question (1), the literature supports the view that the main task of an interdisciplinary team is to make negotiated rather than unilateral decisions. Decisions should reflect the inputs from all members of the team. The psychiatric teams, being interdisciplinary, should negotiate to develop alternatives based on guiding criteria from all disciplines. A team decision involves choosing the best alternative presented in the context of an appropriate therapeutic or administrative goal.

In respect to question (2), it will be argued that, since the teams are sub-systems of the larger hospital system, they are in a dependent relationship to it. As such, they tend to reflect to a large extent its main characteristics, especially, with regard to modes of decision-making. That is, if the hospital makes unilateral decisions, the teams will reflect this tendency.

In the examination of both questions, the sociological perspectives of symbolic interaction and general systems theory are employed as they seem to provide a reasonable framework for analyzing the data.

To gather the data, tape recordings of consecutive team meetings and interviews with members of both teams were made in conjunction with documentary analysis.

The ability to make team decisions involves some understanding of the negotiation process and it appears from the study that members lack such skills. It is also evident that the closed hospital system undermines the climate for negotiations. Consequently, it would not be sufficient to merely develop team decision-making skills without at the same time changing the present closed hospital system to accommodate a more open team system.

Initially, to bring about desired changes on the teams, an in-service training program is required which would not only increase cognitive skills for team decision-making, but would also motivate members to use these skills once they are acquired. To lend some support to the proposed changes on team functioning, the hospital system of which the team is a part should also be changed, given the reciprocal nature of their relationship. A less rigid and authoritarian hospital organizational structure might help to encourage the maturation of a more open team system where members would negotiate to reach team decisions.

Out of this kind of inter-disciplinary decision-making might evolve a non-medical model of therapeutic intervention which assumes that adequate mental health services can be provided by all the mental health professionals including the psychiatrist, all working together as equals.

In making recommendations for change it is helpful if the change agent appreciates that both systems, the team and the hospital must be encouraged to change together since they are in a reciprocal relationship. So, in the implementation of any meaningful innovation he would need the active participation of team members as well as those in the hospital hierarchy. Also, since sudden changes would probably be resisted perhaps at all levels of the organization, the change agent would have to be satisfied with facilitating incremental change or step by step implementation and in this way insure gradual incorporation of the proposed changes into both systems.

Dedication

To Rita, Tom and Julianne who have contributed so much to this study by their persistent encouragement, love and sympathy.

Acknowledgements

I would like to express my thanks to all my co-workers who have helped me in the writing of this thesis. In particular, I wish to extend my appreciation to:

Dr. Chris Nash, whose understanding of systems theory in relation to inter-disciplinary teams developed the perspective for analyzing the functioning of the teams internally and externally.

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Sue Salewski, who with heroic persistence managed to decipher my writings and type them into understandable expressions.

Chapter I

Introduction

The thesis describes and analyzes the functioning of an adult psychiatric team in a community mental health facility. For purposes of comparison a similar adolescent team in the same hospital setting is referred to. Both are assessed in terms of their internal and external interactions. The internal relationships of the team members are examined to see whether they reflect the kind of relationships the team has with the system of which it is a part, i.e., the hospital.

Consequently, there are two parts of the thesis, one which is related to the other:

- (a) The team, how it functions and the interpretation of the process.
- (b) The hospital as the context for team functioning or malfunctioning.

Organization and History of the Hospital

The present study was done at a Northern psychiatric facility which is

now a community mental health facility but was up to the mid 1960's a Tuberculosis Hospital. It was converted to its present status when tuberculosis no longer required hospital treatment. The hospital geographically reflects its isolation also, being situated about eight miles out of town and until recently, accessible only by a rather treacherous and lonely, although picturesque road.

When it was a T.B. Hospital, the isolation of the patients from the community and the community from the patients was seen as a significant and meaningful part of the treatment objectives. The by-laws of the hospital and the organization itself assured top-down control by the medical superintendent who delegated this responsibility to other medical staff. Medical people made all the decisions around patient care, and this traditional role of the doctor has not really changed that much even though the facility has become a community psychiatric hospital staffed by different professional disciplines. In the days before the conversion to its present status, the only other profession that worked with the patient besides the doctor was the nurse. However, she recognized her role, and was recognized by the doctor as a colleague although with somewhat lower status acting only upon his direct authority or the indirect authority of prescribed routines.

Top-down decision-making and submissive subordinates encouraged the hospital to function as a closed system. The traditional complementary role of the nurse-doctor relationship coupled with the by-laws that sanctioned the medical model as the treatment of choice did not make it easy for other professionals, to carve out an appropriate role when the nature of the

hospital changed.*

The professionals remain under the authority of the medical profession as is shown in the organizational chart, even though they share with the medical profession responsibility for patient care. As will be shown, the legitimization of only one discipline for decision-making leads to a particular kind of hierarchical control that encourages passivity in the non-medical professions.

History of the Team

When the first in the recent series of out-patient psychiatric teams was formally organized at the psychiatric hospital in 1975, a psychiatrist was placed in charge. His job was to direct the "paramedicals" in the treatment of cases which he initially diagnosed. At designated times the team consulted together to discuss what progress in therapy was being achieved. The course of therapy and the deployment of professionals were directed towards the removal of symptoms. This approach to therapeutic intervention is described as the "medical model" and is distinct from the holistic or interdisciplinarian approach which considers symptom removal as one rather than the total focus of therapy. This holistic approach is another name for the "team approach" in which inputs from all disciplines (alternatives) are used to make decisions on the course of treatment for all patients.

In contrast to the above definition of team treatment, most of the

* The hospital operates under the Mental Hospitals Act (RSO 1950, C229 and the Community Psychiatric Hospitals Act, 1960-61).

decisions about the treatment of the patient were made by the psychiatrist. There appeared to be little concerted effort on the part the other professionals on the team to change the way decisions were being made.

Meaningful discussion became increasingly infrequent and the team's main function seemed to center around the distribution and acquisition of cases under the continued guidance of the psychiatrist.

Both the adult and adolescent teams studied here are still at the above level of functioning which gives rise to the question of their effectiveness as seen in their ability to make team decisions. Their lack of ability in this area is shown by the present case study.

The Formal Organization

Organizations are, according to Schein (1970, p.443) dynamic in terms of the activities of its members and are defined as "the rational coordination of the activities of a number of people for the achievement of some common explicit purpose or goal, through division of labor and function, and through a hierarchy of authority and responsibility". The author further states that an adequate model of organizations must reflect the dynamic nature of organizational behavior. By definition, organizations have the characteristics of systems that are composed of interrelated components and conduct transactions with a larger environment. A system is a set of interrelated elements which are, according to Buckley (1967) interdependent in that changes in one component may lead to changes in other components. But changes in any system depend on feedback (Katz & Kahn, 1960) and where little exists a system changes with great difficulty if at all. Such a

system is defined as closed (Jones, 1976).

The organization chart of the psychiatric hospital is a good illustration of a closed system. In actuality it is a clinical organization chart and shows the hierarchical control of the medical profession, and how the "allied health professions" such as psychology and social work are actually subverted under the medical profession.

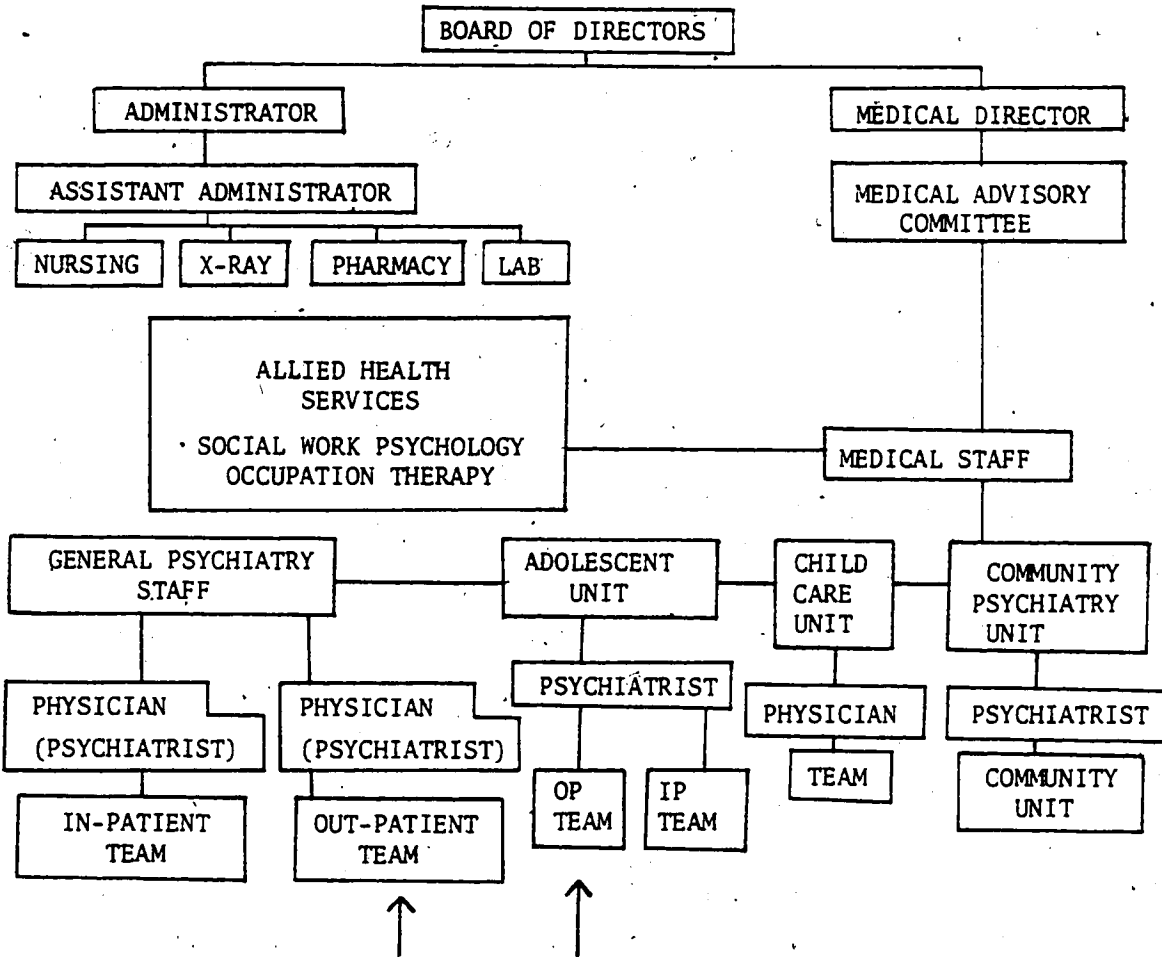
It will be further shown that the dominance as expressed by the provincial as well as the hospital by-laws acts as a barrier to adequate team functioning.

The peer relationship recommended for the development of the team approach would appear to be difficult to sustain when a hierarchical environment is the context in which the team actually functions. Psychiatry, as the chart shows, controls the three services and all the teams within the services, both in-patient and out-patient.

The Influence of the Hospital

The team, as a sub-system of the hospital will tend, as will be shown, to reflect the system of which it is a part. For example if the hospital is a closed system, as reflected in its decision-making, by-laws and organizational structure, it will be detrimental to an open climate on the team. The closed climate of the team tends to undermine the development of open communication which prevents in turn the negotiation of dynamic roles among its members.

THE HOSPITAL ORGANIZATION CHART



(The subject of this study.)

The terms "open" and "closed" with reference to an organization relate to the decision-making process. In a closed organizational system, decisions are made at the top and subordinates are expected to implement the decisions made. They are not consulted in most cases. In an open system policies or decisions are made after consultation with subordinates. The philosophy of an open system is that those who have the responsibility of implementation should have some say also in policy formation. This philosophy promotes an "open climate" which, as will be shown encourages role negotiation. Conversely, a closed system discourages role negotiation and consultation.

Team Membership

As far as professional membership and the number of personnel, both the adult and adolescent teams are similar. But here the similarity ends. The differences are rather striking in terms of both education and experience. None of the social workers in the adolescent team have a degree but all three are graduates of a community college. Of the three members of the psychology department on the adolescent team, only one has a master's degree and the other two have bachelor's degrees.

The clinical director is a qualified psychiatrist but he leaves the running of the team to the coordinator (psychometrist) and only occasionally attends meetings.

There are three occupational therapists who are designated as "child care workers" and they are responsible for contacts with individual as well as conjoint types of therapy, the psychometrists administer tests, and the

psychiatrists administer medication for symptom removal and admit patients to hospital when required.

The adult team has highly qualified personnel with all social workers having their master's degree, a qualified psychiatrist and two medical doctors. There are two psychologists and one psychometrist who continually complains of being "stuck" with all the testing. However, from a legal point of view, this is all the non-doctoral psychology staff can do without continuous supervision.

The role of the coordinator is filled by a nurse, whereas the similar role is occupied by a psychology staff member in the adolescent team. There is also one occupational therapist who takes care of recently discharged patients and an intake worker who is a nurse and who is totally responsible for intake. Intake on the adolescent team is dispersed among all members who tend to use unspecified criteria for admitting to their service. Both teams operate independently from each other.

Assessment of the Patient

A patient coming to the out-patient services can be self-referred or be referred by his doctor, his family or any social agency. Appointments can be made by letter or phone or by the person just dropping in and seeing the receptionist who will make the appointment for him to see the intake worker. If it is an emergency and the intake worker is not available, one of the professional staff will see the patient immediately. However, ordinarily, the intake worker is the first to see the patient and does an assessment to determine his psychiatric status. If, in the intake worker's

opinion, the patient appears to be psychotic or severely disturbed, she will consult with the psychiatrist who may agree that the patient is indeed seriously disturbed and should be admitted to hospital. When this occurs, the in-patient services becomes responsible for him and the out-patient service may never see him again unless of course he is referred back following his discharge from hospital.

If, in the opinion of the intake worker the patient is not psychotic or seriously neurotic, she completes a file on him and gives it to the coordinator who brings it to the team meeting. The completed file contains an assessment of the problem and the kind of therapy recommended, e.g. individual, marital, sex counseling, I.Q. assessment or perhaps occupational therapy. Upon such an assessment, the appropriate discipline volunteers to pick the case up. Sometimes there is disagreement about the assessment, but usually there is not, so, on the basis of the assessment made by the intake worker, the therapy recommended is initiated. This hardly suggests team work but rather unilateral decision-making.

There is an obvious weakness in the way the intake procedure is currently organized because there is only the intake worker, a nurse who makes the assessment on a patient who may be exhibiting psychotic behaviour at one level, but the cause may exist at another. Her own professional perspective may not be encompassing enough to accurately assess the problem and thus precludes appropriate therapeutic intervention at a later state. This is why a team approach at this initial level is necessary.

At one time the intake team did include a social worker and a psycho-

logist, but they resigned when their adequacy was questioned during one of the team meetings. Obviously a better assessment might insure a better therapeutic plan to be developed for the patient that would be to his ultimate benefit.

The adolescent out-patient team is differently organized as far as the intake procedure is concerned. All team members share the intake duties which are rotated daily. Consultation most often occurs outside of team meetings if required and usually the therapist who picks up the case at intake remains the responsible therapist.

The Intake Process

It is the job of the intake worker to decide whether or not the case should be handled at intake, referred to a more appropriate agency, to an individual in the team, to a pair, or to the team itself through the team coordinator.

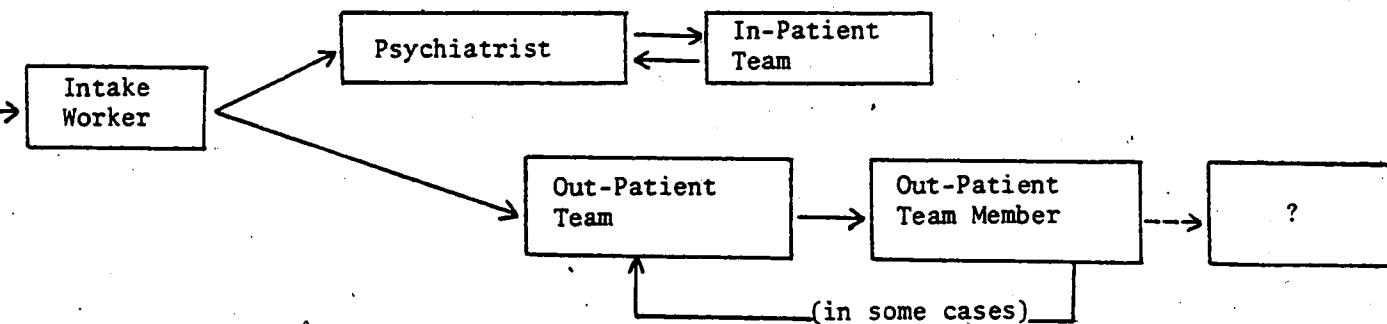
Perhaps the intake worker may decide that patient treatment can be expedited by informal referral such as asking a social worker, a psychologist or psychiatrist to assess the patient and so by-pass team consultation. In this way the team approach could possibly be eventually undermined, so that it becomes, under the superficial appearance of a team, in reality a clearing house for the distribution of cases.

At intake, a patient is assessed and the process at this point can be a crucial phase as it may affect the manner in which later stages of team treatment become implemented.

Sometimes however, when the patient is acutely psychiatrically ill, it is necessary for the intake worker to refer directly to the psychiatrist who then admits him to the hospital.

The diagram below illustrates the "critical path" of a patient from intake to case termination. This is the context in which decisions about treatment are made.

I. Intake II. Case Assignment III. Initial Treatment IV. Extended Treatment



- | | | | |
|---|--|---|---|
| <p><u>Tasks:</u></p> <ul style="list-style-type: none"> i. make a preliminary assessment <ul style="list-style-type: none"> (a) problematic behavior (b) previous history (c) sleeping, eating, other patterns ii. route to psychiatrist or out-patient team. | <p><u>Task:</u></p> <p>Allocate cases to team members.</p> | <p><u>Task:</u></p> <p>Undertake initial treatment.</p> | <p><u>Task:</u></p> <p>Follow-up/assessment in real life contexts.</p> <p>This type of evaluation does not presently occur.</p> |
|---|--|---|---|

Team Organization

An interdisciplinary team ideally is set up to have a full range of psychological, social work, and medical services available in the same unit. Their different expertise theoretically at least can be used to focus on a problem from diverse professional viewpoints. The roles of the team members from a dynamic aspect are mainly psycho-therapeutic which means that the decisions about treatment of patients are not the exclusive right of any one profession.

There are some situations of course where the individual's professional background is better suited than another in providing the required therapy. But every therapy has its limits and each professional on the team should know where his ends and the others' begins. This implies that the definition of roles has to be an ongoing process which allows different members to become involved as the case progresses.

The use of the perspectives and ideas of several therapists of various disciplines for diagnosis and treatment also insures against the errors and lapses that one therapist working alone may make especially in such a complex field as "mental illness".

The Team Approach

If problems coming to an interdisciplinary team could be categorically divided into medical, social, behavioral and vocational and then treated by the related discipline, there would be little need for a dynamic interactive perspective. However, as experience has shown, problems tend to overlap

and symptoms such as depression do not necessarily have their roots in a psychiatric dimension. Such a symptom as depression or certain forms of schizophrenia may not be biologically determined but as Laing (1959) observed, could be the consequence of faulty family communication or as Szasz (1973) stated, might be merely the symptom of problems in living. The symptom may be treated by pills or electric shock, but unless the life style changes, the symptoms could once again reproduce themselves.

Obviously, in such a case, social as well as psychiatric intervention is needed. This kind of overlapping which is a frequent occurrence in cases referred to psychiatric teams illustrates the need for a cooperative, non-linear approach to treatment.

The Problems of an Interdisciplinary Team

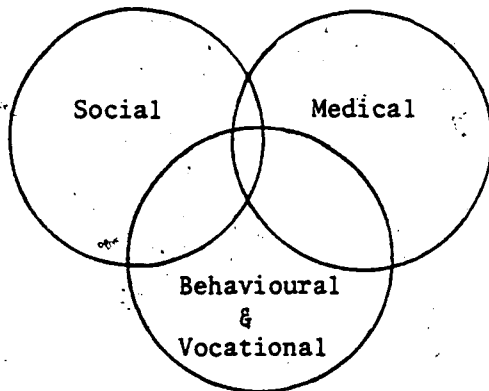
When people on a team work together there is always a certain amount of overlapping because as one phase in therapy is ending, e.g. symptoms are coming under control, another phase is indicated, e.g., family therapy. The point to be stressed here is that a decision has to be made about the degree of involvement of each discipline as one phase ends and the other begins. No static job description gives any clue with regard to how much one should take over and the other withdraw. Such a situation as this in a team can only be resolved through individuals negotiating or discussing with each other their respective definitions of the situation and making decisions. In a team, if it is to function as a team involving different disciplines, negotiation of roles is required so decisions that result are representative of a wide range of feasible alternative treatments.

The tendency of team members to identify with their respective profes-

sional ideologies seems to rigidify their attitudes alienating them from one another. Their working together becomes more a reaction to their own criteria rather than an interaction with the criteria of others.

The diagram below is a graphic illustration of problem areas of concern to the treatment team. These are social, medical, behavioral and vocational. The overlapping of two circles indicates the need for consultation between two disciplines such as social work and psychology, or psychiatry and psychology, etc. This is not strictly team work. However, when all three circles overlap, indicating the problem exists in all areas, then all members need to become involved and effectively interact to react to the problem as a team. Where no overlap exists at all, then the problem belongs exclusively to a particular discipline who may or may not discuss as he wishes.

The Interdisciplinary Team



Rubin and Beckhard (1979 p. 360) state that to function effectively, a team needs not one but many leaders. What this means is that, depending on the problem to be solved, different people should assume responsibility for treatment. But what often happens in interdisciplinary health teams is that members feel that the doctor should make the decisions because he's the most

important member of the team or because he has the legal responsibility for treatment. Continued reliance on the medical model results in an over-emphasis on medical issues versus social issues.

Ideally then, on psychiatric teams, the doctor and the rest of the team should act as peers, realizing that no one possesses all the information needed to solve all the problems or make all the decisions.

The psychiatrist is actually the most powerful team member and often uses his legitimate authority to make decisions for the team. Outward acquiescence by the other team members is often merely a pose because they use their own knowledge base to subvert the psychiatrist's treatment plans and do as they like.* In practice, since there is seldom any check on what happens to the patient, these informal decisions become the actual treatment plan, even though formally there is no recognition that such a plan exists.

The Role of the Author

The role of the author, who is also an employee of the psychiatric hospital, was more that of an observer participant than a participant observer. The typical role of the participant observer is to get close to the ones he is studying so as to understand the meaning of their behavior. To do this he "shares as intimately as possible in the life and activities of those under study", (Denzin, N., 1978 p.184) without of course adopting their perspective, so he adopts appropriate methods to remain as objective

* French discusses these various aspects of power in an article entitled "A Formal Theory of Social Power"; General Systems, Vol. II, 1957.

as possible.

The present researcher already participated in the life of those he is studying and needed to become less of a participant and more of an observer to objectify the data and see it less from the perspective of his employee status. Having been a non-medical professional for a number of years in this setting dominated as it is by medical people tends to color one's perspective differently than a new observer coming in from outside.

An indication of possible bias originates also in the author's dislike of authoritarian institutions such as hospitals in general and this one in particular. Also the author is not favorably disposed towards the privileged power position of the psychiatrist with respect to the other professions even though their elevated position is legitimized both by provincial and hospital by-laws.

This rather prejudiced view presents a challenge to assemble sufficient data to either support or refute my ideas. This made it necessary to search for varying kinds of data such as interviews with all members of the team that represent the different disciplines, actual tape recordings of meetings and a study of relevant as well as available documents so as to objectify the study as much as possible.

The use of participants to help code the data allowed them to interpret it from their own experience so is consistent with the methodology of symbolic interaction and helps to further lessen idiosyncratic explanations and biases.

Theoretical Approach of the Research

The theoretical approach to the data assumed by this thesis is that of symbolic interaction and general systems theory. Using the two theories enables the researcher to appreciate the reciprocal influence of individuals and organizations which is of value especially when considering the ways in which changes could be effected in both.

The particular ways individuals interact creates a particular kind of system, i.e., open or closed (Maxwell Jones, 1976). This in turn influences their subsequent interaction and the result is that the system becomes balanced at a particular level, either dynamic and open, or static and closed. The open system stimulates change, whereas the closed system works to maintain the status quo. If a system is open or closed, it effects its subsystems in a similar manner, i.e., to be open or closed.

A similar situation exists between the team and its members as between the team and the hospital. If the team is dynamic it tends to complement a dynamic system, and if it is static, it would complement a static system.

Focus of the Study

This thesis is a study of the decision-making ability of two interdisciplinary teams in an out-patient psychiatric service. It is suggested that a non-medical model of therapeutic intervention is desirable for their effective functioning. The other possible ways for the teams to function are the medical model which is the way the teams work now and the anti-medical model which de-emphasizes a clinical approach.

The difference between a medical and non-medical model is that the medical model assumes treatment can best be administered by a physician while the non-medical model assumes that mental health services can be provided by the different professionals on the team.

The anti-medical model represents a shift from the professions to administration, (Willer, 1980 p.91). The control of health care services rests in the hands of administrators rather than the health professionals. The control of quality of care will be based on bureaucratic criteria (cost containment) rather than professional criteria (welfare of the patient).

The rationale for advocating a non-medical model especially for an out-patient team is that symptoms develop out of a whole range of problems both in the individual himself and the way he interacts with his environment, and so consequently a variety of skills is needed to treat them. At different phases of therapy different disciplines should be responsible for making decisions about the kind of approach needed which involves negotiation with other team members about appropriate kinds of therapy as new goals develop in the metamorphosis of treatment.

It will also be shown in the study how the hospital structure effects the role negotiations and the decision-making ability of the teams.

The Structure of the Thesis

Chapter 2 describes the literature to establish a conceptual framework from which the two problem areas are described.

Chapter 3 develops the methodology for examining and providing the data

about teams. What they do and how they do it is described in Chapter 4. It provides also the basis for seeing the relationship of teams to hospital organizational and communication network as described in the chapter.

In Chapter 5 the data are analyzed to see what the dimensions of the problem areas are and how adequate the conceptual framework is.

Developing policy implications from the research is the subject of Chapter 6, and Chapter 7 discusses what further research is needed and identifies the questions that have not been answered.

Chapter II

A Review of the Literature

Introduction

This chapter presents a review of the literature on work teams functioning in hospitals and other settings with special reference to team effectiveness, role negotiation and the organizational concept of teams.

The review also addresses itself to explaining the usefulness of General Systems Theory and Symbolic Interaction to understand team functioning both within itself and within the hospital system.

First, the issues of the team concept and team effectiveness are discussed, then, its purpose, that is, what are its tasks relative to the hospital and the team members. Then the concept of role negotiation is explained to suggest a way the work gets done. The theory of symbolic interaction is described with its emphasis on team members' perception of the team and its environment.

Through General Systems Theory the scene will be set for an examination of the influence of the hospital system on team interaction. The systems approach here stresses the interdependence with the internal parts of the hospital system.

The literature provides the theoretical perspective for a case study of the teams themselves and their relationship with their hospital environment.

Since changes are to be recommended some findings on organizational innovation are reviewed.

The Concept of a Team in Psychiatric Treatment

Introduction

To begin to understand how the problems of team functioning arise, it is essential to examine the evolution of team treatment. This helps the reader see how little attention has been given to adequate conceptualization of team functioning. Precisely the kinds of problems identified intuitively by the author have been mentioned in critical appraisals of teams in mental health by others. The study, then, takes place in the context of growing dissatisfaction from psychiatry itself with the level of team effectiveness. Finally, the concept of teams includes the idea that a team is a functional subdivision of the staff of the total hospital. Thus, it is a sub-system of the total system.

The Rationale for Team Treatment

The rationale or purpose behind the formation of an interdisciplinary

psychiatric team to treat mental illness is, to say the least, an intriguing one. If mental illness is in reality an illness a medical person should be directing all members how to function, much as the surgeon does when he directs his surgical team.

However in a psychiatric team treatment of the illness, i.e., removal of the symptom, is only one of the requirements for effective intervention. The causative factors existing in the patient and in his milieu also have to be modified along with or subsequent to treatment of his symptoms. This requires the active intervention of other disciplines besides the medical one. These other disciplines should interact with, rather than react to, the medical discipline with respect to decisions regarding how they should intervene in therapy.

Szasz (1960), a psychiatrist, felt that no one profession should be the dominant figure for deciding about treatment. He considered that people break down and become "mentally ill" because of problems in living which had real societal causes. Psychiatrists were merely attaching psychiatric labels and treating the labels, not the real events with which people were failing to cope adequately. So they were not being effective since their perspectives were too inhibiting.

R.D. Laing (1960), David Cooper (1967), and Aaron Esterson (1959), helped to develop an existential/phenomenological framework that attempted to explain peoples' felt experiences into a preconceived rigid mold such as the psychoanalysts do. They broke with the biological determinism of psychoanalysis, and recognized a social context for mental illness. In The

Divided Self, Laing noted how psychological classification can be a method of not dealing with people's problems and serves to mystify professionals rather than help them with their patients.

In 1962 Laing and Cooper set up an experimental ward in a mental hospital in London with the view of treating patients' problems outside of the usual psychiatric labels. They defined patients as having emotional problems because of inability to communicate and interact meaningfully with other people. Their approach was to have group discussions and sessions where people developed a greater capacity to attach words to their thoughts and feelings. In less than a year, even those patients with severe psychiatric problems who had never left the hospital were able to have ground privileges and some were able to go into town and shop for themselves. Others in the hospital who were not subjected to this experiment remained as they were, locked into their own hallucinations.

In 1970, Dr. Franco Basaglia^{*}, practicing in Italy decided to cast aside psychiatric labels and treat the institutionally mentally ill as human beings. He also used group discussions and initiated patient government much along the lines of Maxwell Jones' (1976) therapeutic community. He wanted to raise their level of consciousness and take more responsibility for making decisions.

He tried to encourage the patients to understand their illness from a personal and social context, i.e., integrating their symptom back into the social roots from which they sprang.

Treating not only the symptoms but the individual in his social and

* Discussed by Francescato & Jones in Radical Psychology (pp. 531-539), cf. Bibliography.

personal contexts is described as the "holistic" approach. The psychiatric team represents one way in which the holistic approach can be put into effect as the team members assess and plan the treatment of the patient from different points of view. The team structure should allow this approach to patient care to become possible through the interactions of the various disciplines of social work, psychology and psychiatry on the psychiatric team.

In Ontario, the interdisciplinary teams in a psychiatric unit function under psychiatric responsibility.* This usually means that the primary focus of such teams is the relief of symptoms and under this mandate the teams would be considered effective if they maintained this focus, i.e., the case would be closed once the symptoms have disappeared.

Nevertheless, all the disciplines of psychiatry, psychology and social work are specially trained to consider other factors being as significant as the removal of symptoms. The goal would be to change the causes which underlie symptom formation, either in the individual or his environment. For example, an individual might be depressed due to failure in an educational program which is unsuited to his low I.Q., or because he cannot concentrate because of family problems.

Clearly in such cases, the use of the medical model of symptom removal is insufficient and requires the work of the different disciplines at different levels of treatment which they must negotiate about.

* Mental Hospitals Act, RSO, 1950, C229, Bill S1, Community Psychiatric Hospitals Act, Department of Health, 1961.

There is no doubt that the psychiatrist is granted full authority and responsibility for the treatment of mental illness, but this would hardly seem to preclude delegation of some of this responsibility to those professions who have recognized expertise in significant areas that affect the patient's adjustment.

The Team as a Means of Multidisciplinary Treatment

Team treatment is defined according to Fry and Miller (1974 pp. 417-431) as "a group of helping or healing professionals practicing as a small work group composed of persons from different disciplines". Professionals acquire their identities through a process of socialization and training which instills a sense of commitment to peers. Their education and socialization does little to prepare them for team participation where relations between professionals depends on their ability to negotiate with each other, as team work implies.

The tendency for the most part is for team members on a psychiatric team to talk together but to work alone but under the direction or apparent direction of a psychiatrist. The Ontario Psychiatric Hospitals as well as most community psychiatric hospitals in Ontario, according to Hanley (1971), have all organized their psychiatric teams under the direction of a psychiatrist who is supposed to take legal responsibility for all the decisions taken by the team.

The psychiatrist may have rigid and static interpretations of his role as well as the role of other members of the team as the following excerpt

from Wolberg (1971) shows. His work is considered a classic in modern psychiatry and is fully endorsed by the American Psychiatric Association.

His thesis is that the background of the psychiatrist and his affiliation with medicine puts him in the best position to direct the psychiatric team. He may as he wishes utilize ancillary workers such as clinical psychologists and psychiatric social workers - while retaining medical responsibility.

• The Concept of Team Functioning

In some psychiatric clinics, the traditional Mental Hygiene Team, consisting of psychiatrist, clinical psychologist and psychiatric case worker, is still considered the preferred therapeutic framework. Changing conditions of practice since World War II have, however, to some extent altered the conception toward that of a preferred model. In this, the professional responsibility of each team member is defined, and there is provided a basis for mutual interaction and the pooling of skills. The team is regarded as a group of specialists or consultants, each playing a specialized role as well as having some sort of therapeutic function. In addition to the three professionals mentioned, other professionals are sometimes employed, according to the specific needs of the clinic and the kinds of cases are being treated. Thus, teachers may be utilized for reading and writing disabilities, speech therapists for stuttering, and rehabilitation workers for special losses of function. The various specialized operations of the conventional team members in a community psychiatric clinic are delineated in Chart IX.

Chart IX is reproduced since it provides a clear indication of the fastidiousness with which roles may be prescribed if one accepts such a delineation.

The traditional aspect of Wolberg's concept of how the team should actually function described here reflects the static rigidity of his description in Chart IX.

CHART IX
FUNCTIONS OF VARIOUS TEAM MEMBERS IN A COMMUNITY PSYCHIATRIC CLINIC

PSYCHIATRIST

1. Establishing a psychiatric diagnosis.
2. Physical examination where needed.
3. Neurologic examination where the psychiatrist is qualified.
3. Administration of narcosis, drug therapy, insulin, and electric convulsive treatments where necessary.
6. Arranging for commitment and hospitalization when necessary.
7. Handling routine physical and neurologic check-ups on patients with physical and psychosomatic problems.
8. Handling of psychiatric emergencies, such as severe depression, suicidal tendencies, excitement, psychotic manifestations, etc.

CASEWORKER

1. Intake interviewing (clarification of services to prospective patients and determining if services are consonant with the needs of the patient).
2. Preparation of patients for psychotherapy, dealing with resistances to treatment and establishing the proper motivation for treatment.
3. Exclusive handling of, or acting as a consultant for problems in patients relating to finance, health, employment, recreation, housing, exercise, companionship, and special training. Acquainting patients with, and aiding them to utilize most effectively, available community resources.
4. Acting as a casework consultant to other team members where environmental manipulation in their patients is essential in addition to psychotherapy.
5. Acting as a liaison between the patient and his family, employer, teacher, etc. when it is essential to interpret patient's illness to them, to give them reassurance, or to enlist their interest and cooperation.
6. Handling of parents, mate or children of patients who are being treated by team members and who require counseling or psychotherapy as an aid to the treatment of the patient.
7. Handling of children with primary behavior disorders.
8. Organizing and handling administrative details of educational projects of team. Interpreting the work of the clinic to the community; securing cooperation of the community in the work of the clinic. Acting as a liaison between the clinic and community organizations which are implementing community programs related to health, welfare and social security.

PSYCHOLOGIST

1. Diagnostic testing: Intelligence, educational achievement, vocational, projective personality tests.
2. Exclusive handling of, or acting as consultant for:
 - a. Problems of school adjustment, maladjustment and placement.
 - b. Corrective work in educational field; therapy of reading or other educational disabilities.
 - c. Career planning, vocational guidance.
 - d. Rehabilitative work for physical and sensory defects particularly in educational and vocational areas.
 - e. Speech disturbances.
3. Organizing and handling administrative details of research projects of team.

According to him there is no room for negotiations when limits to a particular therapeutic modality are becoming obvious or a different degree of involvement is needed from the different disciplines as seemed to be needed when treatment began. For him, no grey area exists when no one can be quite sure what is needed or if it does exist should be looked at by the team in consultation. The only one who treats the total patient is the psychiatrist.

The rest of the team conduct themselves according to the roles assigned to them by the psychiatrist. The following is an excerpt of his concept of the functioning of a psychiatric team.

"Often in the traditional clinic, the psychiatrist, the psychologist and the social worker have conferences related to the problems of a single parent. The psychiatrist contributes what he feels to be the dynamics of the case, the psychologist brings up an evaluation of the patient from a psychological point of view, including projective testing, and the social worker helps round out the picture with an account of social problems in the environment and in the family structure."

He feels furthermore that the interventions of all team members at all times should be under the supervision of the psychiatrist who is trained in psychotherapy and sees team relationships with the psychiatrist at the top directing how the other team members should function in their pre-defined roles.

"The clinical psychologist is employed on the team to administer diagnostic batteries like intelligence, educational achievement, projective and personality tests....and for research designing and administration". (Wolberg op. cit. p. 372)

As for the function of a social worker he says, "The social worker

(should be concerned with) the patient's social situation, especially the interpersonal relationships within the family. In the event the patient decides to accept treatment, the social worker can utilize this information to help relieve environmental pressures provided the psychiatrist decided that the help of a social worker is required.

Besides defining static roles for the other team members, he warns them of the dangers of trying to do psychotherapy with patients. He sees that not only as usurping the designated role of the psychiatrist but as flirting with the possibility of the other team members (social workers and psychologists) losing their own professional identity, and not being able to continue to do case histories and test patients. He fails to see how role modification might be required because some role overlapping may occur as the patient progresses from one stage of treatment to another. He does not concern himself with team decision-making.

Critical Appraisals of the Team Concept for the Study

Contemporary authors are not too supportive of the team approach and many articulate similar criticism to Wolberg and one author in particular describes the team as "an exercise in buck-passing and subtle forms of sabotage" as members try to avoid involving themselves. No one seems to be clear about how they should function. Part of the problem in knowing how to function on a team according to Rackoff (1976 p.8) stems from the complicated nature of mental illness itself. For the different disciplines mental illness and mental health mean different things which seldom are clarified when teams are discussing their cases according to Beckhard (1969 p.33). For

example, for a psychiatrist depression would indicate the existence of a psychiatric problem; a psychologist would look for problems in behavior or adjustment whereas a social worker might look to interpersonal or interactional difficulties, e.g., shyness as a problem to be resolved. Differences in training influence each profession to be sensitive to different phenomena which result in different treatment modalities.

Another problem says Rachoff is that those who are being asked to function on a team are often confused about which approach is most successful with which patients using which criteria or whose criteria.

Some of this confusion might be cleared up, says Patrick (1976 pp. 32-38), if the roles of each team member were explicitly spelled out. If this were done everyone would be clear about who does what and consequently make possible a systematic application of differential expertise.

Horowitz (1976 p. 61) is skeptical that the psychiatric team could ever express differential expertise because it is too controlled by the psychiatrist who determines the operation of the team, particularly how the other specialists will be utilized. Team objectives are set by him, not so much as a result of a collaborative effort, but as a function of the medical model. Page (1976 p. 19) concurs with this view and cites poor communication among team members as the reason why the team rather than being a truly interdisciplinary venture is controlled by one discipline, psychiatry. So he concludes that the team is really a myth because it fails to facilitate the input of information from all disciplines to bring it together as a team.

The dominance of the psychiatrist encourages dependency and passivity, and consequently the other disciplines leave the thinking and problem-solving to the psychiatrist, according to Rae Grant (1969 p. 4). He feels the psychiatric team is ineffective as a therapeutic modality and thinks it should be scrapped in favor of voluntary consultation between mental health professionals. Teams blunt the effect of individual expertise. "Even a team of strong individuals," he concludes, "who could make major contributions could end up as a weak team because team work tends to undermine the effectiveness of individual expertise".

To help the team to close the chasms that appear to separate the team members, Kingsley Ferguson (1976 p. 6) admonishes them with the message that love conquers all. To those who might find difficulty in living with such a message he offers another one which is "communication is the name of the game".

In other words, the main objective of the team members is to learn to communicate to create a climate where members can share their expertise. "Communication", he concludes, "should be a team objective to keep things rolling until the real thing comes along". (ibid. p. 6) A democratic joining of the different disciplines is facilitated through communication. Failure to communicate will hinder the development of the kind of social and emotional climate that makes it safe to air "fundamental differences as well as honeyed harmonies".

The importance of communication to facilitate the democratic joining of the different disciplines so that all disciplines make a significant contri-

bution to team decisions is also stressed by Anselm Strauss (1964 pp. 111-116). Just because formal authority and responsibility is vested in the psychiatrist, he should not be given the responsibility of thinking problems through and making the decisions for the team. Strauss maintains that the psychiatrist has to come to terms with his team concerning methods of treatment and assignments of tasks. This involves a particular kind of communication which he calls "negotiation".

Negotiations occur when professionals on a team discuss the merits of treatment from their own particular ideological or professional perspective. While doing so they are making claims to "essential" roles, aspiring to new ones, dumping old ones and in some cases even forcing each other to assume indicators of a "field of negotiation" which actually results in a division of labour. This enables each discipline to take responsibility for decision-making and evens out the work of the team, and tasks become delegated to the appropriate discipline. The basis for acquiring a task are "claiming" and "proferring". These will be defined more fully in the methodology section. The alternatives to negotiation include refusals to negotiate or the breaking off of negotiations, appeals to rules or authority, attempts at education or persuasion, and various forms of coercion, real or implied.

Communication is seen by the authors reviewed as being a requirement for effective teamwork, while Strauss sees a particular type of communication, i.e., negotiation of roles, as the form communication should take for effective teamwork. It is hypothesized that role negotiation as a form of communication is a necessary condition for effective teamwork. The question to be looked at now, however, is what is effective teamwork? One answer to

this question is how well it achieves its goals. As Strauss (op. cit. p. 116) states, the one goal all team members have in common is that of getting the work done. But there are as many goals as there are disciplines as already has been pointed out. Failure to negotiate differences produces conflict and where conflict is not resolved by further negotiations personnel either quit the team, leave the organization altogether or become apathetic and refuse to interact with the other members.

What is Team Effectiveness?

There are different ways of looking at effectiveness. Team effectiveness for an interdisciplinary team where different criteria or perspective are needed to perform a successful task would be affected by the team's ability to use different criteria when appropriate to do so for making decisions. Being made aware of each other's criteria allows all the members of the team to take the risk and responsibility for making a decision. The ability to make decisions in this way could be considered as a sign of the team's effectiveness. Brill (1976 p. 33)

According to Bass (1960 p. 63) the ultimate measure of a team's effectiveness is more in its ability to satisfy the needs of its members than its success in performing its tasks. Struder (1971 pp. 132-136) supports Bass's interpretation of effectiveness and says it will continue provided each team member's personal needs are met. He lists these needs as inclusion, control and affection. Each needs to find relationships which include him in a satisfactory way, over which he has some control, and one in which he achieves self-esteem.

Team Effectiveness as Effectiveness at Designated Tasks

According to Bennis (1962 p. 269) the concept of effectiveness is difficult to measure because most present techniques provide only static indicators such as output characteristics, i.e., performance or satisfaction. It is through its use of a "dynamic process of problem-solving" that provide the critical measures of an organization's health. The process is valid for a team assessment as well. The traditional ways that are employed to measure organizational effectiveness do not adequately reflect the true determinants of organizational health and success. The criteria for measuring effectiveness are the processes by which the organization searches for, adapts to and solves its changing goals. The author concludes that the more democratic or open the decision-making process is, the more creative and problem-solving the organization is and so the more effective. Those who are affected by the decisions should participate in making them. This process adds to the organization's flexibility and creativity and allows it to be in a dynamic relationship with its environment which is required for its survival and continued effectiveness.

Brill (op. cit., p. 74) does not consider that the individual satisfaction of team members is a sufficient condition to produce effectiveness, rather it is more how they perform the main task which they are organized to do: to make decisions. Simon (1959) also agrees that efficiency is achieved when the members of an organization (which would also include the team which is part of the organization) are trained to make decisions for themselves, which would lessen the need for the constant exercise of authority or advice.

The team as defined by Brill is "a group of individuals, who possessing

particular expertise, meet to communicate their knowledge to make decisions around a common goal".

In the case of the psychiatric clinical team, the designated task is to make decisions about what therapeutic and further diagnostic procedures would be appropriate for patients being admitted or continuing in care at the in-patient or out-patient facility. So Brill's definition is an appropriate one, with the "common goal" being improvement in patient well-being.

The Team as Decision-Maker

Introduction

In an interdisciplinary team, decision-making is central to the concept of effectiveness and requires that all members become involved in the process. Such a team is effective when most, or all of the members at best, participate actively in reaching a decision. Also, if all do not overtly share in the decision, they feel part of, a responsibility for, and a commitment to the outcome of the process. (Brill 1976, op. cit.)

Procedures for Decision-Making

Schein (1969) in commenting on team decision-making identified appropriate and inappropriate decision-making styles. Decision-making by authority is applicable in emergency situations. Ordinarily it is not conducive to maximum development and usage of the strengths of the team model. Usually when authority is used to make decisions for the team it is because of lack of response and is a warning signal that the team is in

trouble. It indicates withdrawal, non-participation and non-involvement, and perhaps a lack of commitment to decisions that are made in this fashion. The most appropriate kind of decisions are those where decisions are made by consensus in which there is prior understanding on the part of all team members that they will accept and abide by decisions of the group. It implies recognition of unity and wholeness of the team and the fact that members can retain their right to differ and at the same time operate in terms of the totality. It is a measure of the effectiveness of the team when most or all of the members participate actively in reaching decisions and share in the responsibility for and commitment to the outcome of the process.

The model to evaluate the quality of team decision was developed by Dufresne (1976). He used it as a method to help improve the quality of student decision-making through group discussion.

The rationale behind its introduction was that people have to be involved at the beginning of a decision-making process, i.e., problem identification to become aware of the need for a particular action decided upon. The emphasis in this kind of training is to make people realize they have to generate alternatives among themselves based on criteria or reasons and then ultimately implement what the group decides is the right alternative which is defined as a team decision. Members come to recognize the importance of considering the values of others as a guide to choosing the most appropriate from among the various alternatives.

In the model, the author uses a rather complicated procedure for developing alternatives to help in team decision-making. Eight steps are

outlined and although these are not necessarily valid, they are a convenient method to encourage team members to interact. The most important process to enable teams to make decisions are the generating of alternatives based on explicit or implicit criteria. Criteria are the rationale behind the development of alternatives that are needed for a team decision. Decisions made using this approach should increasingly be the consequence of the dynamic interaction of all the group members and be less reflective of the criteria of one.

What the author sees the team as doing is making decisions based on alternatives generated by the team. These alternatives relate to guiding criteria, i.e., a decision to choose a particular alternative as a goal is related to the value of that goal as compared with other possible goals. For example, a decision to buy a Chevrolet rather than a Rolls Royce would be governed by how people rated the criteria of economy over luxury. In therapy a decision to do psychotherapy over pill giving would perhaps depend on how the therapist values symptom removal over the gaining of insight.

In therapy, the different team members have different criteria and would prioritize these according to their different professional ideologies. Therefore it is important that for the optimal treatment, all members discuss how they define the problem and what criteria should be considered when devising a treatment plan that would be for the ultimate benefit of the patient.

When individuals in the team use their own criteria only to make decisions these would be considered to be "low level" or "egocentric" criteria.

When criteria from all members are considered Dufresne called these "high level" criteria. Developing the capacity to consider only high level criteria for team decision-making is recommended for effective teamwork.

He further states that the willingness of members to participate and be open-minded to all ideas presented is a precondition for the generation of higher level criteria. Such free interaction enables the team to decide on an appropriate course of action knowing the reasons for their choice.

The original model of Dufresne for developing team decision-making goes as follows:

- (a) i. Clarifying the problem;
ii. Stating the problem as a question;
- (b) Generating alternative possible solutions;
- (c) Eliminating alternatives which appear to have no connection with the goal;
- (d) Presenting criteria for accepting or rejecting any or all alternatives;
- (e) Ranking criteria according to greater or lesser importance;
- (f) Linking all criteria with each alternative;
- (g) Considering the effect of future developments that would change the value of the alternative selected;
- (h) Making a team decision implementing the alternative.

The basic purpose of the model is to teach members how to interact in order to make decisions as a team.

An example of how the above decision-making framework might be applied

in a psychiatric team is as follows:

a(i) A case is presented of a young woman suffering from a moderate form of post partum depression, i.e., a depression following the birth of a child, in this case, her first. The couple are both professionals and have been married for five years. The child was unplanned and mother views it as an inconvenience because the baby has interrupted her career.

Almost since the beginning of the marriage there has been conflict precipitated at least according to the wife by the husband's drinking. Previous to her pregnancy, the wife had seriously considered separation.

a(ii) The question for the team to consider is what kind of treatment goals might be appropriate in this case?

b, c. The members now present various treatment alternatives based on desirable and feasible criteria. The overriding or most important criteria guiding the choice of alternatives is of course the ultimate welfare of the wife. Within this context various alternatives for intervention are subsequently considered.

d, e. The psychiatrist would be guided by his definition of the situation requiring the removal of symptoms (C1). This would suggest a couple of alternatives such as E.C.T. (A1), prescribing anti-depressants (A2) or perhaps the total removal of the patient from a stressful home environment and admittance to hospital (A3). However since the depression is moderate, he decides to eliminate (A3) and this would then eliminate

automatically (A1) since shock treatment is only possible as an in-patient.

f. He decides on (A2) which would then require out-patient therapy. But the social worker becomes concerned with the stressful environment which appears to be causing the symptoms and considers the desirability of a type of milieu therapy (C2). On this basis he recommends marital counseling (A4) or separation and an individual program of psychotherapy. The psychologist may see the problem as one involving personal maladjustment (C3) which he sees requiring a different or added kind of intervention such as one involving projective testing to ascertain the possible existence of incompatibility of personality (A5).

g. A course of treatment is considered which incorporates what is desirable for the patient now (symptom removal) and what is feasible (out-patient status). The value of the alternative related to the above criterion (anti-depressants to relieve depression) would lessen as symptoms are lessened and other forms of therapy as suggested by the social worker and psychologist become possible.

h. The psychiatrist decides to begin treatment. His implementation is a consequence of team generated criteria and alternatives and as therefore a team decision. Other treatments besides his own will be subsequently applied, which is insured by the discussion.

The next section refers to role negotiations that describes specific ways in which members communicate their own and others' roles.

Role Negotiation

Role negotiation describes the process whereby members develop their respective roles through their own interpretation and discussion of them with other team members rather than having them prescribed unilaterally by others. A role may be preferred by another member but only in the context of possible negotiation.

Strauss, A (1964, pp. 106-128) after studying psychiatric teams in two Chicago hospitals concluded that professionals on a team carve out their own roles through a process of negotiation. The negotiations centered around which tasks should be performed by which team members and how these tasks or concrete roles became operationalized. Strauss used the term "role negotiation" for these processes.

Status or position helps to determine the kind of role an individual plays on the team. A social worker is expected to do a number of tasks which do not require negotiation. These are for example writing files, attending workshops, supervising students or arranging welfare for students. A psychologist as well is expected to perform such duties as giving projective or I.Q. tests, or a psychiatrist is expected to be responsible for prescribing medication for removal of symptoms. These are expected roles and do not require negotiation.

Negotiations here mean that individuals define their own role of intervention on a case or someone else's, with the others' concurrence. Other negotiations occur besides role negotiations but for the sake of clarity and consistency these kinds of negotiations (e.g., diagnoses) are referred

to as discussions.

As we have explained, even though roles are defined by different professional backgrounds, the changing condition of the patient at different levels of treatment require modification of the static definition. The situation in therapy, especially in out-patient therapy, is a dynamic or changing one that invites a dynamic approach which requires statically defined roles to be negotiated. Members, by negotiation as Blumer (1969) would say are able to understand where the other person is coming from or "take on the role of the other". The empathy developed stimulates members to be sensitive to one another's professional ideology thereby helping to make the climate open for continued communication.

The organization of roles emerges, says Strauss (op. cit. pp. 125-128) from the people themselves as they do the work. Tasks, or what people do, form a basis around which they discuss concrete roles or tasks. Tasks are negotiated in different ways as people work together. He described these tasks as they related to member interaction on psychiatric teams in the two Chicago hospitals where he did his research. He categorized the kinds of negotiation as Task Claiming (TC), Task Proferring (TP) or Task Stripping (TS).

The coding system as used by Strauss to identify what kinds of role negotiation are occurring on teams is illustrated by the coding of a team discussion that was taped as part of this present research.

(i) T.P. - Task Proferring: e.g., (psychiatrist to social worker) I would like you to see this case for me. It is a marital. The problem is the wife

is too dependent on her family of origin. Every weekend she leaves her husband and visits her family in Chelmsford.

(ii) T.C. - Task Claiming: e.g., (social worker) I have already been involved with this case and there's no doubt that she needs to get away from him. But the real problem is her lack of education so I sent her to Cambrian College. . .

(iii) T.S. - Task Stripping: e.g., (psychiatrist) I don't think she can handle that kind of major change. You would be better off to deal with her dependency on her parents.

There is another aspect of negotiations which is at a less direct level, the level of metacommunication, or simply statements about the communication which is taking place. For example, what the psychiatrist might be implying when he ended negotiations with the social worker is "I am more competent to judge such matters than you are. After all, I am a psychiatrist and you are only a social worker" or "I think I'm right and you are wrong". The communication seems to be at two levels, content and relational statements about roles. Metacommunication involves relationship statements which are usually implicit.

The interpretation members have of their roles and how they interpret them to each other forms the basis of their negotiation.

The following excerpt from a team meeting illustrates more clearly what is meant by the content and relational aspects of an interaction.

The psychiatrist and the intake worker, a nurse, are discussing problems concerning the proposed intake process of the adult out-patient team. He feels it denies the psychiatrist the right to admit or not admit patients. The intake worker feels the process helps the psychiatrist to make a better decision about the patient's mental status. As will be shown, little empathy or sharing of perspectives results from the interaction.

Psychiatrist: I don't see any reason why the psychiatrist should accept the intake worker's assessment of a case for admission.

The psychiatrist does two things here. The content of the message is his refusal to accept the intake worker's assessment of the case. The meta-communication is the expression of his dominance and right of refusal.

Intake Worker: I don't see where the problem is. There's a full assessment by one or two persons from the intake team which have concluded that admission is necessary so that should be enough to warrant admission.

In supporting her own position that the intake procedure is adequate she also refuses to accept being dominated by the psychiatrist. Both are supporting also their particular ideological positions. The metacommunication is implicit. In understanding its meaning, it should be made explicit to clarify the total meaning of the message.

Psychiatrist: The doctor has the responsibility of the case after the intake worker has seen him. Some doctors won't accept patients for admission that only has the intake worker's assessment.

The psychiatrist refuses to give legitimacy to the intake worker's assess-

ment. He is also reacting negatively to what he seems to be perceiving as an invasion of his territory. He is as it were warning the intake worker to back off. This metacommunication is implicit. M(i)

Intake Worker: If the intake form is completed appropriately I can't see why not. So far I've had no problems with that.

The intake worker is still trying to persuade the psychiatrist to accept the form. In this she is accepting his dominant position on the team.

Psychiatrist: If admission is required the doctors just can't accept the evaluation of the intake worker. That's not enough.

The psychiatrist continues to refuse to grant legitimacy to the intake process. He refuses to negotiate, reinforcing his arbitrary position.

There is little attempt on both sides here to see each other's reality and become empathic to work more meaningfully together or at least understand why they couldn't do so. More empathy might be elicited among team members through explicit metacommunication. This process, as Watzlawick (1967 pp. 51-54) points out, helps to develop awareness of relationships as well as open up negotiations so new roles are created. Static roles defined outside the team by the hospital system would not be any longer the basis for determining interactions within the team.

For example, the utilization of metacommunicational transactions would lessen the tendency to interact according to hierarchical status, which now

allows those who have the most power to make all the important decisions. Those in power might then find it less easy to make unilateral decisions because of the possibility of being confronted on this issue.

The other members must be willing to risk presenting their own insight or criteria and to accept the blame if something goes wrong. The sharing of responsibility is what the team is supposed to be all about and despite the risks of being wrong, a greater payoff would be more effective functioning.

Role Negotiation: A Model for Analysis of Team Process

Role negotiation is a process which is considered as a necessary condition for team effectiveness. As the interactions are a consequence of interpretation of one's own and the others' roles both the communication content and the metacommunication need to be coded. Some of the comments are coded on the basis of content while others are coded on the basis of what is metacommunicated.

Negotiations and Decision-Making

Decision-making is a process of coming to an agreement about what is to be done while role negotiations is a process of coming to an agreement about who does what. But it would seem that before a decision is made, people either have to lay claim to a task or be offered one to become involved initially. Otherwise presenting ways of dealing with a problem become an empty discussion without a commitment to act by any team member. Also, if members do not negotiate their roles, then stereotyped ones become the usual

therapeutic modality and a lack of shared responsibility gradually undermines the dynamic quality of the team. To keep the team in dynamic balance members are required to lay claim to a particular role then discuss ways in which that role is operationalized through choosing alternative ways of dealing with a task which is presented.

Role negotiation becomes linked to the decision-making process implicitly or explicitly through the development of alternatives with their related criteria.

The Hospital System and The Team System

Introduction

The teams do not operate in isolation but are part of the hospital structure so are influenced by it to be open and changing or to be closed and static.

It will later be argued that to bring about changes in the team system similar changes need to be brought about in the hospital system of which the teams are a part to balance both systems. If the sub-system or team is changed without changing the hospital system, the systems become unbalanced. To bring about balance or equilibrium, the larger system will act to resist attempts by the sub-system to bring about change, in other words the larger system acts against moving towards a new dynamic state as will be defined in the discussion of the nature of systems and their functioning.

General systems theory helps to explain how similar systems to the

ones being described here function and change so it seems appropriate at this point to describe this theoretical perspective. It is a useful adjunct to role theory and decision-making theory because it explains the team in a wider context, i.e., its environment.

General Systems Theory

A system is generally understood (Bertalanffy 1962 p.11) as greater than the sum of its parts. It is defined as a set of elements standing in some consistent relationship or interactional stance with one another. No system can be understood once it has been broken down into its component parts as no single element acts independently as each is dependent on the other to function.

Therefore, to explain events in the system, a holistic or multi-causal approach is required rather than a linear approach so that the relationship between the elements can be taken into account. For example, an holistic approach is needed to understand how families function in order to bring about change in their function. An understanding of each individual of the family without understanding how that individual related to the rest of the family members would define the linear approach. The holistic approach would define the elements or family members but would go one step further and define their relationship which describes the family system.

Another important characteristic of systems theory relates to concepts of control referred to as a dynamic steady state which keeps the system in balance. A dynamic steady state, as Steinglass (1979 p. 309) describes it,

suggests an image of elements in constant dynamic interaction while relating meaningfully to each other and which permit adaptation to occur. This kind of "controlled adaptation" is the key to meaningful change. Controlled adaptation also is critical to growth and development in any living system.

Homeostasis which is one aspect of control describes a system in balance. The concept of homeostasis and the corollary notions of positive and negative feedback have been adapted by Jackson (1965) in his theoretical notions of family homeostasis. Jackson proposed that a series of mechanisms can be identified whose primary purpose is the maintenance of an acceptable behavioral balance within the family. The notion is that families tend to establish a behavioral balance or stability and to resist any changes from that predetermined level of stability.

Homeostasis describes the process by which any system regulates itself. The major tool that systems use to accomplish this is the feedback loop. In this process, goals are established for the system, then the performance of the system is regulated against the pre-established goals. The feedback loop in a social organization is, of course, communication. Systems can be characterized as having static equilibrium or dynamic equilibrium. Systems with static equilibrium appear not to change while those with dynamic equilibrium do change.

The two different kinds of equilibrium generate static or dynamic relationships or roles within an organization, according to Cowan (1963 p. 125). Relationships within a system need to be ongoing so that dynamic equilibrium is maintained to stimulate the required changes dictated by a changing and

dynamic world. Otherwise roles remain static and the sharing of expertise between members to develop meaningful goals is not realized. Traditional or uni-causal thinking begins to become the dominant ideology which can be counterproductive especially on a psychiatric team. Decisions on the team then become imposed by the one who is perceived as having the most power.

Power in this context refers to a person or group possessing it in relation to others (Brill op.cit. pp. 96-99) The power structure on a team can exist at two levels - the formal power structure consists of those persons who, by virtue of their designated positions, status, and roles, possess power to control, punish or reward. The informal power holders are those who have power because of their capacity for natural leadership, efferent qualities, knowledge, etc. The structure that evolves around these two power patterns will affect all vital team operations.

Relevant to the theory of systems and its interacting parts is decision theory which analyzes rational choices within organizations based upon the examination of a problem and the generating of different alternatives for problem resolution. An open system contains the feedback process that enables it to interact effectively both internally and externally. (Speer 1970 pp. 264-270)

Just as communication between the parts of a system tie it together internally, so the extent that it engages in interactions with systems outside itself acts as an indicator of that system's viability and openness.

The usual response of an open system to its environment is an elaboration

or change in its structure to a higher and more complex level of functioning. The feedback system works to enable that system to function morphogenically within itself and with systems outside of itself. The system works in a morphostatic way to prevent change from occurring. When the two systems are in balance they can prevent severe and rapid changes from occurring which might be damaging to its equilibrium. Equilibrium in Spear's view, not only describes steady states but also includes change of state as an inherent and necessary aspect of any system for efficient operation (Spear, D. op. cit. pp. 264-270).

Maxwell Jones (1976 p. 17) suggests that sub-systems become isolated from the wider system and become "closed" or cut off due to the absence of sufficient two-way communication. The result is that decision-making power is reserved for the people at the top. The people at the bottom end up with no power and no responsibility. The lower echelons are not asked to participate in decision-making that affects them directly.

The closed system represents a static state of equilibrium where no changes occur and the group is concerned with protecting itself by maintaining the status quo. An open system represents a dynamic state of equilibrium where all participants interact.

A system, says Kilburg (1977 pp. 73-102), is in the eye of the beholder. Human beings are trained to process information so as to discover any degree of "systemness" within it. Organizations or systems must develop this capacity to discover patterns or systems. If not, their ability to survive and develop will be severely threatened. Systems begin with elements and

when two or more elements interact a system is created. The boundaries of a system can be defined merely by labelling all the elements that are considered part of the system. Boundaries can be open or interacting or closed and not interacting. No social or living system is completely closed but can be relatively closed in terms of severely limited interaction.

Systems Theory and Team Dynamics

According to Watzlawick (1967), a social system functions dynamically when individuals within the system interact through sharing information, i.e., when there is a communication and feedback process. Downward communication only is typical of a closed and static system, which maintains the system on a static or unchanging state. Authoritarian organizations such as most hospitals and the army are of such a nature.

The main characteristic of an open or dynamic system is that changes occurring in one part serve as stimuli for changes in other parts. The changes thus produced act back on the initial stimulus bringing about changes in it.

By way of illustration let us take the psychiatrist in Wolberg's model who makes assignments to team members according to his own definition of their roles. Because their roles have already been predetermined they are not expected to negotiate from their own interpretation. So the psychiatrist refers them cases on the basis of predetermined role definitions which may not take into account the others' role perceptions. They may, for example, wish to approach the problem in a different way or perhaps have no wish to become involved at all.

The psychiatrist, by assigning roles helps to maintain the team as a static system, whereas if he encouraged each member to negotiate his own role, he would be helping to promote the team towards a dynamic and open system. In such an open system the psychiatrist could learn to appreciate therapeutic intervention from all points of view, and as well the others would be more appreciative of his theoretical approach. Criteria from all the disciplines might then be seen as useful for developing alternative strategies for patient care from which team decisions could be made.

Systems Theory in Mental Health Organizations

In the average psychiatric team, as Strauss (1964) sees it, the various professions have successfully established claims to expertise to particular problem areas. The common interests of social workers and psychologists especially in milieu therapy has created an ideological bond between them. They have become allies in supporting their claims against the monopoly of the medical profession. Nurses and physicians, despite sharp status difference, have a common medical approach to patients and similar conceptions of medical responsibility.

Alliances are formed as a result of this kind of collegueship on the team so that decisions are more often the outcome of negotiations outside the team. This phenomenon has been noted in transcripts from meetings and is shown in Chapter IV and implies that the team somehow needs to create a common bonding that would transcend professional differences and develop a new sense of purpose. Limited feedback does little to improve the level of

competency in case handling and inhibits different disciplines from effectively working together.

The implementation of a new sense of purpose involves shaking up the organization of treatment by members negotiating new roles based on their emerging expertise rather than on hierarchically defined roles as is the case in many hospital settings.

The developing of new roles through negotiation conceives of the personality as an active system (Gray 1974 p. 97), rather than reactive or robotic. Morphogenesis is recognized as a natural law, that is, disturbances in the balance of the system is dealt with through internal structuring and new growth rather than being suppressed to maintain the status quo. The recognition that the personality is not mechanistic accepts man's capacity to engage in symbolic activities such as the interpretation of reality and interacting with others as a consequence of the interpretation.

Systems theory, says Gray (ibid), postulates that since man's personality is an active and dynamic system it should not be repressed by any system to maintain the status quo. The system should accommodate to man's dynamic nature and that both interact so that the system will achieve new growth. The hospital system with its strict adherence to hierarchical priorities maintains itself at a morphostatic level. The dead bureaucracy of the hospital is in contrast to the natural dynamic system of the individual so that it produces an imbalance detrimental to the adequate functioning of both.

Barriers to Change

The hierarchical and closed system influences the team and their members not to interact dynamically and the same influence isolates the hospital from the surrounding community. The consequence is that change at all levels is minimum, or if it does occur, it is short-lived. The system as it now exists, resists any feedback from anyone except those who are already designated to make policies. The rest are expected to trust that the decisions made are in the best interests of all. Therefore, bringing about changes in such a closed system is obviously a challenging prospect because it requires an interrelated approach. Implementing such an approach is described by Fullan (1975) and is the subject of the next section.

Making Changes in the System

Any contemplated changes, according to organizational development theory requires some planning. As Struder (1971 p. 132) states, planning for change involves the development of strategies to move any social system to a new state. According to Fullan (1975), making changes in an organization is a complex and gradual process which basically involves four dimensions: changes in organizational structure, role behavior, knowledge and understanding, and value internalization. Thus, an innovation is seen to be implemented to the extent that new structural or organizational features are put into practice, that the actual behavior of system members

changes, that system members know and understand the purpose, assumptions and behavioral methods of implementing what they are attempting, and that the members value the innovation as desirable and worthwhile.

How the Analysis Gives Rise to Recommendations

The analysis of the hospital and the team will be used as a basis for proposing changes according to the four dimensions for organizational change as described by Fullan. This process will be referred to as needed in the chapter on recommendations.

(i) Structure: As a starting point, a formal organizational structure has to exist to assess what if any change is needed. In this study it may be found that the hospital is a non-communicating, top-down administrative hierarchy. The teams tend to reflect a similar characteristic. Changes therefore have to be made in the wider system or the hospital structure to bring about the desired changes in the team or sub-system which has a dependent relationship on the former. The hospital needs to move towards a more open system in the formal organization. In any authoritarian system, change will only be achieved with the co-operation of those in authority.

(ii) Role/Behavior: Professionals tend to work from a pre-defined and static definition of their role. This, of course, is appropriate if one is working alone as a professional but is not the best way to work as a member of a team where tasks are supposed to be shared. Tasks are shared when roles are negotiated but cannot be shared where there is a uni-dimensional approach. Negotiation has two connotations here. One is that the idea of negotiation itself constitutes a new role for most professionals. Another

connotation is that negotiation requires the consideration of the other person's criteria while at the same time forming one's own action.

(iii) Knowledge and Understanding: The professionals on the team may have little knowledge of decision-making or the skills required to make them systematically. Knowledge and understanding for this task can be developed not only at the team level, but at all levels to keep all systems open. Part of the problem is that professionals are not taught to be self-reflective. They may be reflective with patients in a group but not as professionals in a group pooling their insights and coming up with a plan of treatment that considers all facets of the patient's functioning. The problem seems to be a lack of appreciation of where everybody else is coming from.

(iv) Values: The changes being contemplated would have to be supported by all team members who would value these changes mainly because it would enhance their skills both professionally and as decision-makers. Some psychiatrists, especially those who believe in the medical model might be expected to resist any change that would perhaps lessen their decision-making power.

However, the non-medical model is being accepted as the appropriate one for out-patient psychiatric teams.* The acceptance by some members of the psychiatric community of a non-medical model with greater responsibility for decision-making by all team members will enhance the value of the team

* This model has been supported by Lee B. Macht in his discussion of Community Psychiatry pp. 627-664, The Harvard Guide to Modern Psychiatry, Cambridge, 1978, Harvard University Press.

approach to decision-making and add to the likelihood of the permanency of such a change in team functioning once it is implemented. Change in this respect will be seen as less of a threat to the traditional authority of the psychiatrist than as a step towards progress in a more rational approach to the treatment of patients suffering from the problems of "mental illness".

The complexity of mental illness requires, as Szasz suggests, the other professionals on the psychiatric team becoming actively involved in the whole process of consultation and treatment for better patient care.

This would require the locus of the decision-making process to be changed from where it presently resides so that the totality of the patient's reality can become appropriately assessed and, if required, treated by the appropriate professional on the team.

Aspects of Team Functioning

Two areas of team functioning are examined, first the team as an entity within itself, in terms of its processes and outcomes, and secondly within the context of its environment, i.e., the hospital. Within itself, its effectiveness is measured with reference to its ability to make decisions. It is suggested however, that in order to make decisions, it is necessary for team members to negotiate their roles. In an interdisciplinary team, such a process facilitates team decision-making by generating alternatives. Without it, team decisions do not result since team members do not accept role-stereotyping by others.

The second aspect to consider here is the position of the team in re-

lation to the hospital. The team interacts with the hospital and in doing so tends to take on some of its decision-making characteristics. This relationship has implications, especially with respect to proposing systematic change because the team and the hospital are related as a sub-system to a system. This requires that both parts be analyzed for sufficient understanding of how the system operates; take into account the reciprocal aspect of change.

Methodological Guidance

Using the literature as a methodological guide, the research was able to modify and utilize the work of Dufresne et al. to provide an analysis of team decision-making, and of Strauss to examine communication about roles and tasks concurrently with the decision-making process. Both authors are considered as complementing each other relative to describing team processes.

The interview procedure was guided by symbolic interactionist methodology where the researcher tried to understand the other's definition and feelings about a situation. The approach can be likened to an open-ended, non-structured kind of interviewing process which allows the interviewee to express not only his thoughts but his feelings about himself and the reality he is experiencing.

Conceptual Framework

The study of the relevant literature serves as a perspective for viewing the various relationships between the team and its members, the team and the hospital, as well as the hospital's relationship to the community.

Seeing the phenomena as interacting parts of a system that is linked together in a particular way through various forms of communication emphasizes the benefit of looking at reality holistically rather than piecemeal.

The interdependence of the parts of a system and their relationship to each other also gives some indication how changes might be induced. Realizing how the parts of a system are interacting or not interacting can be the first step in understanding the most effective way of inducing change in it. That is, if members are helped to interact differently, a change in part of the system is achieved. Such a change will effect its interactions with the other parts and consequently a gradual change is effected.

The following is a brief description of the conceptual framework which serves as a perspective for studying the team and the hospital.

1. Team Effectiveness: This describes the ability of the team to make decisions. Team decision-making on an interdisciplinary team requires that all disciplines negotiate alternatives from their own criteria for the process for team decisions to occur. Role negotiation permits an interdisciplinary way of diagnosing each case and permits a more flexible approach in the beginning as well as later stages in therapy when a certain degree of overlapping is bound to occur due to changes brought about by the treatment process.
2. Role Negotiation: Role negotiation which involves the discussion of who does what on the team has a context as well as a relational aspect. As

symbolic interaction, the interpretation of the message requires an understanding of what the message means as far as conveying information is concerned, and what the message says about the relationship between the sender and the receiver, e.g., who is in command. For understandable communication, both the context and relational characteristics should be made explicit. This would enable both parties to "more easily", as Mead says, "take on the role of the other". The coding takes both aspects of communication into account.

3. General Systems Theory Overview: This theory which provides the framework for analyzing the team and the hospital conceives of all reality as a hierarchy of related systems and sub-systems. Systems result from the dynamic interaction of their parts, not merely from the sum of their parts. Social systems function as the result of an exchange of information among the parts.

4. Change Theory as Part of General Systems Theory: The amount and type of information that is exchanged between the parts of a system (feedback) accounts for its dynamic equilibrium or static equilibrium. Where there is static equilibrium, changes with the system tend to be resisted. A dynamic equilibrium allows changes to occur. However, with all systems, incremental changes meet with less resistance than sudden changes according to the literature.

Team Relations

The literature review presents the typical psychiatric team as a weak group of individuals under the ideological and organizational power of the psychiatrist. He seems to be the only one who takes the most responsibility in directing the team to carry out pre-defined tasks working from the medical model of linear causality.

To be effective as an interdisciplinary team, a psychiatric team should make decisions about treatment that result from role negotiations. When individuals are presenting alternatives they are also negotiating their roles so the process of negotiating is linked to the process of decision-making.

The decision, if it is a team decision, is the result of the negotiation process. Here is an example of a decision being made without the negotiation process occurring and one where it does.

In the first case, a problem is presented of a woman who is depressed, living in a situation which is quite stressful. The psychiatrist decides to see her and place her on medication to control her depression. He tells the social worker to investigate the family to see where the stress is coming from. The social worker agrees to do so. No negotiation of roles occurs. In the second case, the intake worker reads out the history and asks for comments. All members of the team present alternative forms of treatment, in other words, negotiating their roles. The psychiatrist suggests that symptom reduction is the first priority but that other forms of treatment are appropriate once this form of therapy is completed. In the

latter case, the team is considering future plans for intervention once the symptoms have been reduced. The whole team has been involved in the treatment of the case through all disciplines negotiating their respective roles for intervention.

A refusal to negotiate as exemplified by the various forms of task stripping, amounts to negative negotiation. Positive negotiation in which individuals suggest tasks for themselves or each other is more likely to occur where team members feel some sense of power and are willing to risk communicating their respective alternatives.

The existence of positive role negotiation shows that members are interacting to develop new roles for themselves instead of merely reacting to roles assigned to them. By negotiating each professional does two things: (i) he expresses his interpretation of his own role, and (ii) allows others to relate to him on the basis of his interpretation rather than on a static or predetermined basis.

Role negotiation then, is the beginning process for dynamic interaction and is seen as necessary for adequate interdisciplinary team functioning.

Team-Hospital Relations

This aspect of the study presents the team as a sub-system in a dependent relationship to the hospital system.

The manner in which the team functions is understandable when observed against the background of the particular kind of institution in which it is

embedded. The association helps to throw light on the meaning of the ongoing relations both on the team and in the team's immediate environment.

For example, if the institution is authoritarian, the team itself, because of the dependent nature of its position is influenced to act in authoritarian ways mainly by allowing arbitrary decisions. If top-down decision-making is practiced in the institution, it tends not to be challenged on the team as well. Members act to support the linear model.

However, if the institution is democratic and bottom-up decisions are allowed, little imposition occurs or is tolerated and decision-making reflects the interactional model at all levels. This hierarchical nature of the institution changes to a more dynamic and open entity.

The literature, by describing the contextual nature of the team's functioning, highlights the dependent nature of its existence. It also implies the need for an appreciation of the total organizational environment which needs to be considered when contemplating change. Changes, for example, contemplated for an authoritarian institution, would have to be proposed from the top.

Buckley states that an adequate understanding of the interactions of a team necessitates an understanding of the system of which the team is a part. Speer (op. cit. 1970) observed that just as communication between the parts of a system or team tie it together internally, so the extent that it engages in interaction with systems outside itself acts as an indicator of that system's viability and openness. Jones (op. cit. 1976) says that

insufficient two-way communication closes off the sub-system from the wider system and the result is that the sub-system becomes dependent and powerless. Effective action by the teams only becomes possible when a system is open.

However, states Blumer (op. cit. 1968) systems operate from interactions that relate to the interpretations of each participant in the system. Effective action by the team may then be only possible when the wider system is perceived as open and people become willing to effectively negotiate their roles.

The conclusion to be derived from the literature is that:

The failure to work as a team is partly a reflection of the total hospital system.

The use of the word "partly" is an acceptance of the possibility that no uncausal variable operates to produce team effectiveness or ineffectiveness per se. Sub-systems as the teams which interact with the larger system tend to distort the "mirror image". This means that the team must accept part of the responsibility for the adequacy or inadequacy of its functioning but so must the system itself. This premise justifies initiating change in both systems.

Chapter III

Methodology

Introduction

The data to examine the research questions posed by this case study are contained in the tape recordings of team meetings gathered over a six month period, from documents, and from interviews with members from both teams.

The research questions to be examined are:

- (i) Does role negotiation affect the decision-making aspects of team effectiveness? and
- (ii) How does team functioning reflect the hospital system?

With regard to question (i), effectiveness or ineffectiveness relates to whether or not decision-making is occurring in the teams. The analysis of team meetings is also used with reference to question (ii) where emphasis is on the relationships between the team and the hospital. The interviews

serve to answer the questions related to (i) and (ii). Questions are asked about members' perceptions of the effectiveness of their teams and how they perceive the "climate" as effecting how the team is functioning. These perceptions although subjective in the sense that they are each member's perception of reality can be considered as valid according to what Denzin (1978) describes as "symbolic interactionist" methodology, i.e., as part of a triangulation process to be explained in a later section of the present chapter. The analysis of the formal hospital structure provides information to answer the question posed by question (ii). Information is obtained regarding how the hospital is actually organized which gives use to the kind of system in which the teams function.

Table 3.1 presents a graphic explanation of how the data collected relate to the two questions posed. Data collected from the four sources as outlined provide the means by which answers to the questions are obtained.

Team Interaction

Introduction

The first question is how role negotiation is a requirement for team effectiveness. The data source for question (i) is the tape recordings of the team meetings. The tape recordings are coded to show how effectiveness or ineffectiveness are related to the kind of decision-making and role negotiation occurring on the teams. This is identified as data source (1).

Data source (2) is also used to discuss question (i) as to how team members perceive team effectiveness in accordance with symbolic interaction-

Table 3.1

Methodology Framework

An overview of the research project. How the data collected relate to research questions (i) and (ii).

Description of the Framework and General Questions

Data Source	Question (i) Q: How does R.N. affect team DM?	Question (ii) Q: Is team functioning a reflection of the hospital system?
(1) Tape recordings of team meetings. (two teams)	D.M. Coding of steps shows how team works.	Shows general effectiveness of teams.
(2) Interviews with individuals from team.	How do team members perceive effectiveness and role negotiation.	How do team members perceive the team and hospital system.
(3) Analysis of formal hospital structure.		Information re actual hospital structure. (general systems theory)

ist methodology (Denzin, op. cit. p. 130)

Data Collection: Description of the Sample

The adult and adolescent teams have about 10 members each when there is full attendance. In the tape recordings the attendance of either team never exceeded 8. In the sessions which were not recorded the attendance continued in a similar pattern which suggests that being recorded was neither a positive or negative event for the members.

In the adult team at least two physicians were present, one a psychiatrist and one a medical doctor. Others included three psychology personnel, three social workers, two community health nurses, and one occupational therapist. The nurses and physicians attended all the meetings held twice a week. The psychology personnel were the most frequently absent and the social workers less so. The adolescent team is similarly composed and their meetings not quite as well attended. The psychiatrist in charge of the adolescent team is also the clinical director of the hospital. Their meetings are also held twice a week and he is in attendance at one of these meetings. Absenteeism is more frequent in the sessions where he is present.

Verbatim recordings were made of seven adult and four adolescent team meetings. These were as nearly as possible consecutive meetings, some lasting over an hour and others lasting twenty minutes. Sometimes it was not convenient to record a session because the researcher was taking his turn at intake. This perhaps was a mistake because it prevented a comparison of tapes with and without the researcher's presence which could have removed bias.

The different teams used the same small conference room so meetings had to be differently scheduled. For both teams one day of the week is kept for a business meeting in which team problems and procedures are discussed. Another day in the week is set aside for consultation of cases. Both types of meetings were tape-recorded.

Members were quite willing to be taped although initial reaction brought comments such as, "This one is for posterity", or "Maybe I should watch my language since I'm being monitored". Eventually as each settled into their routines, the first hesitant reaction to being observed lessened and in subsequent meetings, little if any mention of the recording apparatus was made.

Data Analysis: Coding

Both teams were studied for the purpose of assessing their effectiveness in terms of their decision-making ability. The making of decisions depends on discussion by all the team so that the decision reflects the work of interacting or communicating members.

The main categories used to identify the decision-making process on the teams are modifications of the type developed by Dufresne and take into account the input from all the disciplines. Consultation among team members enables problems to be assessed from different perspectives relative to the different disciplines. For example, a problem may be defined as behavioral, requiring psychological evaluation, or, symptomatic indicating psychiatric assessment is needed; or interactional that points to the need of some kind of intervention between the individual and his environment that would help

the individual develop more adequate coping skills, e.g., assertiveness. The different perspectives are proposed as the different members discuss alternative ways to treat the problem presented.

The steps to the decision-making model for a team which is relevant to our purposes and which will be used to code the meaningful interactions of the team meetings are:

1. Statement of the Problem
2. Generating Alternatives
3. Presenting Criteria
4. Making a Team Decision

1. Statement of the Problem

The differential statement of the problem basically classifies it into the three areas of interdisciplinarian expertise, i.e., psychiatric, psychological and social work. When the problem is described as one involving the display of mainly psychiatric symptoms it is classified as symptomatic. Where there is mainly evidence of personality maladjustment (e.g., failure to control impulses) the problem is categorized as behavioral. When an interpersonal problem such as family disorders or marital conflict is described it is defined as interactional. Such classification of problems is convenient for coding purposes and serves to classify the area of difficulty that the patient is seen to have.

The coding for defining the type of problem being presented is now described.

- P(b) - A personality assessment is required because of behavior problems (psychological problem).
- P(s) - The patient is exhibiting obvious psychiatric symptoms such as autism, depression, or withdrawal (psychiatric problem).
- P(i) - Interactional difficulties are being manifested in personal or social relationships (social work problem).

When the different disciplines discuss their views during the meetings, they are coded. Different criteria are being presented from each particular professional perspective or ideology which guides either explicitly or implicitly the choice of a particular alternative for possible action.

Criteria and Alternatives

Criteria are defined as the reason for choosing an alternative or course of action. Any alternative has within it explicitly or implicitly certain aspects of criteria which are coded as such when assessing the nature of the verbal interactions of the team. The types of criteria that seem appropriate as a guide for team goals are:

1. Feasibility:

This relates to the suitability or practicality of a particular course of action. In relation to a therapeutic goal, for example, it would not be very expedient to recommend family therapy for a patient who can't communicate. Also, if no member of the team is trained to do psychoanalysis, it would not be practical to refer a patient to a team member with this purpose.

in mind. (On the other hand, if a team member did have competency in this area, it would be unreasonable to refer the patient outside the team. Such activity could be reasonably interpreted as task stripping at the metacommunicational level since it amounts to a refusal to negotiate roles with team members who actually have the expertise.)

2. Desirability

This kind of criteria depicts what worthwhile advantage one alternative has over another. It usually relates to the levels of aspiration a therapist has for a patient for limited or relatively unlimited coping. If the therapist aspires for merely limited coping, he may simply prescribe pills for symptom removal. If the therapist thinks the patient needs to develop skills for less limited coping, he may not only prescribe pills for symptom removal, but recommend a course of therapy to keep actualize more of the patient's potential.

3. Cost:

This form of criteria which is a limiting factor considers what may have to be endured for something gained. How much difficulty for example would a patient have to suffer in order to gain better health and if the suffering is worth it. The patient may want to take pills to get quick relief from his depression, and not want to involve himself in therapy sessions that would be costly in time and money at least in the short run. Considering the long term benefits may make present suffering acceptable and balance out the cost of longer term therapy. The cost of doing something should also have to be measured against the cost of doing nothing. How more

costly would it be for example for a miner suffering from claustrophobia to stay at work and gradually become incapacitated than to come in for treatment and suffer a short term financial loss. Or perhaps a depressed housewife might save money in the long run by coming into hospital and getting early treatment for her depression while paying a housekeeper to look after her demanding family. Getting away from the stress in time prevents chronic depression from developing while at the same time developing coping skills through psychotherapy may enable her to handle family stresses more successfully.

As previously stated, criteria guide the choice of alternatives. Alternatives are developed as part of role negotiations, that is members develop alternatives when they negotiate their role either in relation to a particular task (task claiming) or in relation to someone else's definition (task preferring).

An alternative is judged better or worse according to what criterial attributes it possesses. For instance, we not only ask whether alternative X is more desirable than alternative Y, but we have to also consider whether it is more feasible and is it efficient in terms of financial, emotional or time costs to client and treatment agency.

As the different team members present alternatives for task intervention from their own professional perspectives, two things happen. They negotiate new roles for themselves and open up their decision-making space. Conversely, when alternatives are chosen from one or two professional perspectives the decision-making space narrows relatively.

It is hypothesized that a team decision has to take into consideration all possible alternatives and consider them in the light of the criteria such as feasibility and desirability. As was explained in the introduction, some alternatives may require role negotiation and some do not. This is evidenced for example when a patient is so chronically or acutely ill that symptom removal precludes consideration of any other alternative. So, no problems exist regarding decision-making when the alternative is that obvious. When the problem is complex and the examination of various alternatives are necessary, then role negotiation may be required. Failure to discuss at this point results in an irrational decision, or perhaps no decision at all. Over a period of time, continued refusal to negotiate or refusal to use specified criteria to reach a decision maintain the team at a static state. This would allow those with power outside the team to dominate its activities, which as will be shown in a later chapter, actually does occur.

In team discussions, when alternatives are presented, they will be coded as A1, A2, A3, etc. in order of presentation.

When criteria are explicit they will be coded as C. Implicit criteria will not be coded as they are contained in the alternatives expressed by team members.

Decisions are coded differently depending on whether they are made by the team, whether they are a result of joint discussion of alternatives or whether they occur unilaterally, that is, from egocentric criteria.

A decision which is made to put into effect one of the many alternatives

generated from all disciplines is a team decision, coded as D(t).

Joint decision results from two members of the team discussing a case and one of them implementing a specific alternative based on the discussion. Coded as D(j).

An individual decision is one in which a specific alternative is implemented by someone unilaterally without considering team generated alternatives and related criteria. Coded as D(i).

Frequently although many alternatives are generated through team discussion no decisions are reached either because the discussion is not specific enough to reach a decision or too much conflict occurs as a result of the discussion, or some other reason. When no decision is reached, it will be coded as ND.

"No decision" does not necessarily mean that cases are left in limbo and no treatment occurs, but only that it is so in the particular context of the formal team meeting.

Informal discussions are often held outside team meetings where assessments are made and alternative forms of treatment are discussed which result in a decision as will be shown in the substantive findings.

The Total Process of Negotiations

In a team such as described by Wolberg's model, roles are static and

predetermined so that no discussion occurs as to how individuals would like to intervene on a case from their own background and perspective. Consequently members are blocked from negotiating new or dynamic (changing) roles for themselves based on their own background and training. As members communicate their interventions, they are possibly negotiating a dynamic role for themselves. This in turn stimulates a dynamic role for others as it encourages them to interact and present their alternatives. Negotiations are part of the total process by which alternatives are presented.

Team decisions are the consequence of all members discussing alternative forms of treatment based on explicit or implicit criteria which guides the choice of alternatives. According to the level of discussion on the team, different types of decisions emerge. As different alternatives are suggested the negotiation of new roles are being defined. Since negotiations are seen as part of the process by which alternatives are presented, it becomes an interactive process which justifies the use of parallel coding to describe the communication of team members as is shown in Chapter IV.

Categories of Negotiations

The categories of negotiations used in this study are derived from the model used from Strauss and are modified to take into account the content as well as the relational aspects of communication.

The interactions which are coded are defined as

1. Task Claiming: The team members perceive the problem as coinciding

with his professional expertise so decides to take on the task. Coded as T.C.

Task claiming where the member won't negotiate a decision, but appeals to tradition or his own authority. Coded as T.C. (aa).

2. Task Proferring: A team member defines a problem or task as belonging to another discipline and on that basis, refers the case. Coded as T.P.

The three sub-categories of Task Proferring are:

- (a) Rejecting the Proferring:

Sometimes a member will reject the proferring made by another because it does not coincide with his own definition of his role. Coded as T.P. (r).

- (b) Task Proferring to Outsiders:

This amounts to implicit task stripping in the team. Someone says that a particular problem could be handled more appropriately by some other team within the organization or a service in the community. This type of negotiation is seen as inhibiting the decision-making process. Coded as T.P. (o).

- (c) Task Proferring, Non-Specific:

No one in particular is defined as an appropriate therapist, either on the team or outside of it. It is usually prefixed by such a remark as, "Someone should do something about this problem". Coded as T.P. (n).

Task Stripping:

Someone on the team remarks that a particular case is not appropriate for a particular discipline and assigns the case to himself, or someone else without seeking any agreement by the team, or asking how other members feel about it. This category describes actual task stripping. It negates the existence of role negotiation and involves getting rid of the task and making no decision. Coded as T.S.

Implied Task Stripping:

No explicit statement is made that someone is not capable of treating a particular case but such tactics as stopping the discussion, or introducing a new case before a decision is made about the previous one are examples. Coded as T.S. (i)

Episodes:

When a problem is presented followed by a discussion it is identified here as an episode. As new episodes are introduced they are numerically identified. Coded as e₁, e₂, e₃, etc.

The material is being coded in two ways, one at the content level (decision-making) and the other at the metacommunicational (role/task negotiations). In some cases the negotiation episodes are quite explicit and therefore shift to the content level, i.e., the discussion focuses quite explicitly on who should do what.

To sum up: the process of decision-making involves the negotiating of alternatives of which role negotiation is part. Team decision-making results when one of the alternatives generated by the team is chosen to make a decision.

Failure to negotiate is exemplified by the various forms of task stripping which prevent alternatives from being considered from which team decision occurs.

The Interview

The format of the interview used was non-standardized to encourage free expression by the respondent. By permitting free expression the inter-

views allowed each respondent to identify and describe his own impressions of the extent to which the team interacted to make decisions, i.e., its effectiveness and what influence the hospital had on the kind of decisions that were being made on the team. The interviews constitute a subjective interpretation of team and hospital functioning and when used in conjunction with other methods (Denzin, op.cit. p.129) e.g., direct observation, helps to increase the validity of the study.

Acceptance by the researcher of another person's accounts or interpretation is increased when the researcher is familiar with the background of the person as well as the environment he is describing. According to Scott and Lyman (1972 p. 404) these characteristics are sufficient to accept accounts "because they seem accurate in the circle where they are employed". In the case of the present researcher, both he and the subjects being familiar with the situation being described, the meanings are understood by both and the researcher knows what to accept as true or not true. Just as familiarity with the respondent's background and the environment he is describing, increases the validity even more, so in this study the interviews with team members are combined with tape recordings of team meetings to increase its validity. The two different criteria used, one subjective and the other objective, gives the study a two dimensional aspect, reality as it is (from the recorded data) and reality as seen by the team members (from the interviews). Using subjective reality for explaining phenomena is described by Denzin (op.cit.p121), as symbolic interactionist theory. According to Denzin, the application of "symbolic interactionist" theory as a guide to research is to apply its theoretical framework to linking subjective data such as obtained through the interviewing of team members with other

observations such as the tape recordings from team meetings. From the symbolic interactionist perspective reality has a negotiated existence which makes interaction an outcome of each individual's perceptions. Consequently, the interviews present each person's perceptions of team effectiveness and the influence of the hospital system.

The use of the symbolic interactionist approach allows the researcher to appreciate how participants perceive what is happening. The researcher can observe role negotiation and decision-making in action in the meetings. The symbolic interactionist perspective is achieved through the interviews with the team members. By talking to them about their feelings and perceptions of the team and the team as a part of the total system, the researcher is able to understand their reality or at least can consider the same reality from their point of view. As different individuals focus on the same reality and interpret it from their perspective, a more objective and valid view of that reality becomes possible.

Team-Hospital Relations

Introduction

The statement that failure to work as a team is partly a reflection of the total hospital system is tested through tape recordings of team meetings, interviews with individual members of both teams and the analysis of the formal hospital structure.

The data sources include (1) the clinical organization chart, memos and by-laws which provides information about the actual hospital structure,

(2) tape recordings of team meetings which shows the general effectiveness or ineffectiveness of teams, (3) interviews designed to assess how team members perceive both the team and the hospital system and how they interact.

The coding of team interaction with reference to decision-making and role negotiation was done with the help of a social worker from the adult out-patient team, and a psychologist from the adolescent team. Discussion with the other professionals was used to heighten the objectivity of the interpretations and strengthen the reliability and validity of the study.

The interviews allow the researcher to understand each member's perception of the hospital structure and how the perception of the structure might be affecting team processes. Their subjective experience of organizational structures (e.g., rules) and the invocation of these experiences in communication tends to affect the interaction. If, for example, individuals see the hospital as authoritarian with decisions imposed through a hierarchical structure, they will not express their own criteria for decision-making feeling that in this particular context such a presentation would not be acceptable.

Summary

The framework for the examination of the teams is a utilization of a multi-methods approach which is a modification of the triangulation process suggested for symbolic interactionist research as described by Denzin.

The general questions proposed by the two parts of the study are related

to specific sources which are subsequently used to supply the data.

The consequence of using such a varied approach for collecting the data will hopefully be an increase in the validity of the study, both internally and externally.

Data Analysis

The tape recordings show whether members are actually negotiating their roles and what kind of decisions are made as a consequence of negotiation or non-negotiation.

The presence or absence of team decisions could indicate a number of things, such as the attitudes of team members as to working or not working as a team, their knowledge or lack of knowledge of decision-making as well as the attitude of the hospital as to how the teams should actually run. If, for example, the authority and responsibility for total patient care is defined in the role of the physician by the hospital, then the hospital system would be seen to support hierarchical control. As a matter of fact hierarchical control is seen by many members to be supported by the San and to be undermining the adequate functioning of the teams as will be shown in a later chapter.

Methodological Decisions and Difficulties

Most of the literature on participant observation seems to be preoccupied with discussing the problems that an outside researcher should take into account before entering and while being on a research site. Advice is

given about how to get in the institution, how not to get ejected, the problem of not taking sides, of "going native", getting the right informants, and so on.

Little is said of the problems on the inside researcher especially the caveat of going native. The present researcher was already "native", more of an observing participant than a participant observer, always in danger of losing the ability of accurately describing the environment as it actually exists. On the positive side, however, the inside researcher does not have to fear as much the possibility of being ejected for a misdemeanor, because he knows how to keep a low profile and fit into the system when it is appropriate to do so.

The outside researcher, being less socialized into the organization is more prone to question some assumptions which tend to be taken for granted by the insider. Thus he is more likely to give equal weight to all informants rather than seek for "proof" of the things he already "knows" to be true. Also being unencumbered by past commitments and entanglements, he would feel less pressure to slant his findings to accommodate particular favorite groups or conversely to criticize groups that have curried his disfavor.

But then, the problem of idiosyncratic interpretation confronts both types of researcher so that both need help in maintaining objectivity. Perceiving the same reality in different ways helps the individual to distance his own biases sufficiently away from it so that he is able to see it for what it is. Using different ways to measure the same phenomena to retain

objectivity involves participant observation which is participating in typical work situations of the subjects one is studying, interviewing to appreciate their interpretations of that reality; then analyzing documents that describe the environment under study.

A multi-methods approach for gathering data helps to correct any possible impressionistic bias that one method alone might have produced and allows the researcher to stand back and appreciate the reality for what it is rather than what he makes of it. As a result the analysis of the data contains more objectivity than would otherwise be possible.

The next chapter presents the results of the data collected through the symbolic interactionist methodology described here.

Chapter IV

Results

In this chapter, we are going to compare the adult and adolescent teams and how they reflect the hospital system. Before proceeding with this study, it seems appropriate now to place the teams in historical perspective. The teams are quite similar in terms of their goals and the disciplines that compose them. They differ only in respect to the ages of the clients which they serve, i.e., anyone over 18 years old is automatically placed in the category of an adult and is served by the adult team. Below that age, the clients are the responsibility of the adolescent team.

The adolescent team developed primarily in response to the needs of the CAS, the guidance departments of the high schools, the juvenile courts and the parents of the adolescents. The need to have a diagnostic and treatment centre for adolescents accelerated in the 1960's by the increasing numbers of teenage children becoming involved with drugs. So in 1966 the

clinical director organized a treatment team to handle specifically adolescent problems beginning with an out-patient program and later augmented by an in-patient program to handle more severe or chronic cases.

The adult teams had been originally organized to meet the needs of the in-patient services and as such had traditional roles to play as assigned to them by the psychiatrist in charge. As more requests for out-patient services developed in the community, the sanatorium decided in 1974 to assign a coordinator (a nurse) to take charge of the team's administrative functioning under the direction of the service head, a psychiatrist. The adult out-patient treatment team accepts referrals from all community agencies and self-referrals for problems relating to personal or social maladjustment. Both teams function basically the same in that theoretically all cases are brought to the team for consultation so that the appropriate disciplines accept the case for treatment.

How effectively the teams interacted to make decisions about problems presented to them and the various factors influencing them is seen in this chapter. Data relating to team interaction is presented first, followed by data pertaining to team-hospital relations. The adult out-patient team is examined first, then the adolescent out-patient team.

Question (i) Team Interaction

(a) The Adult Out-Patient Team

To analyze the team meetings the interactions of the team members are examined to see if role negotiation and decision-making are occurring and

what kind of role negotiation is associated with what kind of decision-making. An excerpt from one of the team meetings (adult team) is presented by way of illustration with the appropriate coding. The team members have been presented with a case by the intake worker and involves a symptomatic problem, P(s). Each interaction is coded as to whether it is a step in decision-making (D.M.) or whether it is a role negotiation (R.N.).

Excerpt (1).

D.M.

R.N.

Intake Worker: I have an intake. It is a case initially seen by (J) (psychologist) some months ago. She was thinking of killing herself so I referred her to (T) (psychiatrist) for possible admission. She was separated from her husband for about a year, but now wants to go back to him because she can't find work. T gave her some pills to hold her over the weekend. When she returned it was felt she might be better treated as an out-patient.

P(i)

TP(t)

Psychiatrist: (J), when you treated her last June, you surmised that her lack of self-esteem, lack of goals and paranoia and constant marital conflict were the contributing factors of her illnesses.

P(b)

Psychologist: Yes, but after I did therapy with her she seemed to come out of her shell.

Psychiatrist: Well, she doesn't do well on pills. She needs some tangible things to lock herself into. I wondered about her relationship with her husband. (psychiatrist proposes another form of therapy which the psychologist had reported as being successful, which amounts to rejecting the criteria and can therefore be considered as task stripping) He comes to visit her the odd time, usually when he can't stand his own cooking. They need marriage counseling. Either work at it or forget it.

A1

TS(i)

A2

	<u>D.M.</u>	<u>R.N.</u>
<u>Psychologist:</u> I feel skeptical about their ability to resolve their marriage in any direction because of all the previous fighting and the way he constantly puts her down. They are continually embroiled in conflict because neither of them seem to be able to come up to the other's standards. (Psychologist rejects criteria for the alternative of marital counseling suggested by the psychiatrist. This amounts to a task or role stripping.)	C	TC TS
<u>Psychiatrist:</u> I'm wondering if her husband could be seen by somebody. Either get involved or screw off. (The psychiatrist proposes another alternative and proffers the task to no one in particular. He is engaging in implicit task stripping.)	A3	TP(n)
<u>Psychologist:</u> Weekly sessions with me were never enough for her. We were always teetering on the point where she was ready to fall apart. In her relations with her husband she would set herself up to be used then be bitter about him taking advantage of her. (The psychologist tries to emphasize the importance of continuing individual therapy with the wife.)	P(i) C	TC TC
<u>Social Worker:</u> How do you develop ego strengths in her so she can control some of what's going on? (The social worker is supportive of the psychologist).	A4 C	TP(t)
<u>Psychologist:</u> I try to get her to work on some of the echoes from the past, feelings towards her parents and feelings towards her husband, separating the real from the historical. (At this point the coordinator intervenes and asks for other cases to be presented. This, as will be shown, interferes with team decision-making.	A5	TC
<u>Coordinator:</u> Let's get back to the other case.		
<u>Psychiatrist:</u> As far as that case is concerned, he's never been involved in any of her admissions, now he's coming in and mixing her up. The nurses on the floor feel this couple needs a male therapist.	C	TP(n)
<u>Other Psychiatrist:</u> I'll see him.	A1	
<u>Psychiatrist:</u> No this case needs more marital therapy. (Continue to reject the original psychologist's criteria.) I think a social worker should see him.	C A2	TP(t)
<u>Social Worker:</u> Maybe I should see him then.	D(j)	

e2

This first excerpt shows how the psychiatrist ignores all the alternatives presented by the psychologist and the social worker and assigns the case on his own interpretation of what is needed. Ignoring the other members' definition of the situation, he imposes his own and assigns a role that is not negotiated and therefore static. The decision that results, not being an effect of negotiations, undermines future negotiations because it shows the futility of them.

Part of the responsibility for allowing the negotiations to stop the way they did belongs to the coordinator by bringing up other cases before a decision was made on the initial case. Suddenly presented with an unresolved case that should have been dealt with earlier, all the members acted almost traditionally in allowing the psychiatrist to make the decision. Failure to deal appropriately with each case that comes up and not letting it go until a decision is made accentuates the problem of the adequacy of the coordinator's leadership once again. It points out, as the psychiatrist commented, her lack of understanding of case dynamics. But unfortunately the criticism never seems to get back to the coordinator who remains "puzzled by the team's unwillingness to express themselves or get them to work any better as team members".

Continuing negotiations may have led to team decision-making but introducing new cases in the middle of the discussion had the effect of stopping negotiations which might have led to a team decision. The result was a unilateral decision by the psychiatrist to have the social worker do marital counseling. This action tends to support the view of one psychiatrist about team decision-making when he said, "The team is a dictatorial

authoritarian arrangement run by the psychiatrist who has all the power and makes all the decisions".

Failure to frankly discuss such important issues such as the above, e.g., through metacommunication, gives support to a sort of conspiracy of silence, coloring the team meetings with a kind of repressiveness which is stated in interviews with the members of both teams.

This is perhaps why some of the members, such as the psychologists and social workers, felt that they could not develop satisfactory roles for themselves on the team. They seemed to feel their effectiveness as professionals could best be expressed out of it in informal discussions with others or within the collegiality of their own departments. This was pointedly expressed by the psychometrist and the social worker of the adult team.

The reason for not working together effectively was given by the psychologist who stated, "The team is too unwieldy a way of working together. Our jobs don't fit right so that it's easier to work alone. So what do I do, I go to my department boss for advice about how to handle a case. I don't have any commitment to the team". This attitude strengthens the departmental ideology and weakens the interactive process of the team.

Most of the members were agreed on one thing and that was that they have innovative ways of treating patients, but they seldom discuss their emerging roles at team meetings. This leads to a stereotyping of roles and

a general confusion about who is supposed to do what. Admittedly, this double role is seen to undermine team relations. The passivity and the failure of many of the disciplines to become more active in discussing their cases at meetings was seen by two of the social workers and the chief psychologist as quite desirable. They felt it created more options and flexibility which allows members to either remain in their traditional roles or develop new ones, but not necessarily on the team. They concluded that they may not be effective as a team, but that they were as a group of professionals outside the team.

Excerpt (2):

Excerpt number two will show what happens when a group of professionals try to take over the role which has traditionally been the undisputed territory of another profession. In this excerpt the intake worker, the psychologist, and the social worker try some "task stripping" on the psychiatrist. They want the intake worker to be responsible for doing the history on a mental patient for admittance to hospital. The consequence of this attempt is a reciprocal manoeuvre by the psychiatrist who perceives a threat to his traditional role. It is presented to show that the amount of task or role stripping occurring results in the non-occurrence of team decision. The excerpt is from the fifth tape-recorded team meeting and is concerned with intake policies and procedures, and in particular, with a new type of intake form. The form is designed to allow the intake worker to give a psychiatric assessment of a patient for admission to hospital. The psychiatrist would then have to accept the assessment for admission of the patient to hospital if such were the recommendations. This, of course, would undermine the role of the psychiatrist as an admitting agent. The team

tries to make a decision about the pros and cons of adopting such a form, but fails to do so. An individual decision is made by the psychiatrist.

D.M. R.N.

e1 Social Worker: (Passing out forms) This is the work your glorious intake team has done. The idea is for everybody to go through the document and see if there's any problem you can find with it; discuss it here and decide what changes you want to make. Take twenty minutes to read through it and then we can make some comments. The intake policy and procedures are included.

e2 Psychiatrist: There are some doctors who would not accept the request for admission by the intake worker after the initial assessment.

C TS(a)

Social Worker: So the intake people may make any kind of assessment they like, but there's no guaranty that the patient will be admitted.

C TS(aa)

e3 Intake Worker: I can't see the problem. There's a full assessment by one or two persons from the intake team which concludes that admission is necessary, so that should be enough to warrant admission.

C TC

e1 Psychiatrist: The doctor has the responsibility for the case after the intake worker has seen him. Some doctors won't accept everybody for admission that you do an assessment on.

C TC(aa)

Intake Worker: I can't see why not if its completed appropriately.

C TC

Psychiatrist: That may be true, but when policies become "etched in stone", some doctors won't accept that.

C TC(aa)

e4 Psychologist: Well in that case why bother to have an intake assessment and an intake worker?

C

Social Worker: This means that we would have a doctor for a consultant at intake to provide that kind of information.

C TP(t)

Psychiatrist: If admission is indicated, the doctors just can't accept the evaluation of the intake worker. That's not enough.

C TC(aa)

In this excerpt it will be observed that there are a number of instances where the criteria of feasibility and desirability are expressed by all the disciplines. Cost is not seen as a factor. However no specific alternatives about what members want to do are discussed. One criterion leads to another and these alone are too abstract to tie a decision onto. Specific alternatives about what to do are needed so the members can decide whether to do it or not. For instance, instead of the social worker saying, "This means we would have a doctor for a consultant at intake to provide that information" and leaving it at that, he should say, "A doctor seems to be needed at intake for better coverage, so do we want one or not, I'd like to hear other people's views on this".

Also note the number of new episodes introduced that prevent full discussion of the problem. This indicates poor control of the session by the coordinator. As the discussion continues, new episodes are introduced with no attempt to empathize with the psychiatrist's position.

It will be noted here that the appeal to the authority of the discipline in the last transaction is a rejection of the team as a decision-maker and amounts to implicit task stripping. The social worker then asks for some clarification of the role of the intake worker that would be satisfactory to the psychiatrist. It represents an attempt to renegotiate. Criteria are presented but no alternatives suggested so far.

Social Worker: What then is the role of the intake worker? Why go through this intake assessment? There's a tremendous amount of information, so what's the use of the doctors doing the same kind of thing?

D.M. R.N.

C TC

Here the social worker is questioning the logic of the psychiatrist's position. The problem here appears to be the psychiatrist's unstated resentment regarding the task stripping by the intake team of what he considers to be his traditional role and follows with:

e1

Psychiatrist: The only bone of contention is the idea that it is irrevocable that the doctor will accept cases for admission on the advice of the intake worker.

D.M. R.N.

C TC(aa)

Then the social worker supports the psychiatrist's appeal to authority and undermine the team's right to negotiate new roles for its members.

e5

Social Worker: If I looked at a document which said "The social worker shall", and didn't feel it was a social work task, I would have some reservations about accepting it. So I understand T's (the psychiatrist) feelings. (It is coded as TC(aa) because it supports the psychiatrist's rejection of the team and C1 because the statement reiterates psychiatric criteria.)

D.M. R.N.

C TC(aa)

The psychologist then decides to attack principally the psychiatrist for not accepting the intake team's newly defined role and for his refusal to give it legitimacy.

e6

Psychologist: Then what you are saying is, "Thank you very much for making the assessment, but I'll do my own". If I were coming through here as a patient and sat down for an hour and a half and provided a lot of detailed information to somebody, then had to say it all over again to

D.M. R.N.

C

somebody else, I would say, "Hey, don't you guys talk to one another? Don't you have some communication about this information I have given? Why do I have to give it a second time?" All we wanted was for the doctor and the intake worker to have some say over the case. (However, the psychiatrist rejects the argument presented by the psychologist and presents his own criteria so the role stripping continues.)

A1

D.M.

R.N.

e1 Psychiatrist: If there are no beds, then the doctor has to decide what other options are open. (Here the medical doctor comes to the support of the psychiatrist and by implication rejects the proposed role of the intake worker.)

M.D.: The doctor has to see the patient to make the admission legal and he has to draw his own conclusions which means he has to interview him on his own, even though he has already been seen by the intake worker. I have to repeat certain things to assess the patient's mental status.

C

Psychiatrist: Maybe we should delay any decision about this until I take these proposals to the medical advisory committee.

A2

TP(aa)

The psychiatrist restates his criteria and is task preferring outside the team and by implication is task stripping the team. Removing the task from the team results in no decision being made. The team members acquiesce to the psychiatrist's proposal, thereby contributing to his power and consequently to the team's ineffectiveness. The "pulling of rank" by the psychiatrist is also indicated by the actual and implied forms of task stripping. The power of the psychiatrist to delay a decision places him above the team and appears to support what the psychometrist stated, that the only way open communication and team decision could occur was if all the members had equal power instead of just the psychiatrist. However, when asked about relative power on the team, the psychiatrist felt he had no more power than social workers or psychologists. But as one of the nurses said,

"One thing about power is that when you have it, you don't notice it, but you do notice it when you don't have it". It is also noteworthy here that the team members attempted to strip the doctor of his traditional admitting role and he retaliated by stripping the intake worker's claim to the admitting role.

In excerpt number two it would appear that occurrence of task preferring is neutralized by the equal occurrence of task stripping, although the task stripping is more implied than actual because it is in the form of task preferring outside the team. Also the lack of specificity regarding alternatives seems to prevent task claiming or task preferring and the lack of team negotiations results in an individual decision being made. It would also appear from these interactions that there is mutual dependency between the process of negotiation and the process of decision-making because where alternatives are vague, negotiations stop. An example of this is shown in the following excerpt.

Excerpt (3) *

Psychiatrist: It seems to me we are being asked to play too many roles. The way we are set up is too inflexible. We end up by breaking the rules of our own system.

D.M.

R.N.

C

Psychologist: That's because we are usually under pressure and have to improvise.

C

* This excerpt is an example of metacommunication because the psychiatrist is talking about relationships within the team. Making this explicit could perhaps have encouraged more expression of feeling around the problems expressed earlier around relationships between team members.

	<u>D.M.</u>	<u>R.N.</u>
<u>Psychiatrist:</u> We should have a policy everybody knows about, otherwise the patient ends up by determining our policy for us.	C	
<u>Social Worker:</u> Policies are by-passed by (hall pick-ups)* and people seem to forget about policies when crisis intervention is needed. We need a consistent policy so that something like that doesn't happen.	C	
<u>Intake Worker:</u> There's no hall pick-ups except what happened last week when the back-up people were absent. (social work and psychology)	C	
<u>Social Worker:</u> Crises are not covered by intake policy.	C	
<u>Intake Worker:</u> I can't do anything about crises anyway except for those being admitted and that's because the doctors have agreed to pick them up if I feel that is necessary. Other emergencies I just clear them till someone else comes along to deal with the problem more in depth.	C	TP(o)
<u>Social Worker:</u> But that's the whole purpose of back-up, to deal more appropriately with the emergency. Then they deal with the case, then later bring it up to the regular meeting.	C	
<u>Social Worker:</u> Maybe the wrong people are on the intake team. Others might have the time to give to do the job properly.	C	TP(n) TS
<u>Intake Worker:</u> Let's give it another week and see what happens.	D(i)	

Sometimes alternatives don't have to be vague to be ignored. An example of the ignoring of concrete proposals made by the social worker to the psychiatrist is illustrated above. Here the social worker is outlining what she considers to be a worthwhile treatment plan for one of her patients. The psychiatrist who had initially referred the patient to

* These are unplanned discussions or referrals occurring between team members outside the team meetings.

the social worker disagrees with her assessment and tells her what to do. He outlines a plan of therapy that the social worker outwardly accepts.

Later in a discussion outside the team she told the researcher how angry she had been at the psychiatrist for rejecting her treatment plan and "imposing" his own. But she felt too intimidated to openly disagree with him. Privately she decided to handle the case her own way and reject his plan. In this she was being assertive of her professional criteria, but at a team level she was being unassertive and allowing the psychiatrist to dominate her in decision-making.* As a team member, therefore, it would appear that she was non-effective as she failed to negotiate the kind of role she wanted and have her criteria for therapy accepted.

In a later section of this chapter, tables are presented to compare the decision-making capabilities of both teams and how these relate to their dynamic qualities as seen in the negotiation process.

The attitude of the members of the adult team are now examined to assess how they feel about the team, whether they really want to work in it and how this might contribute to the way the team is seen to be presently functioning.

The psychometrist had been working here for about a year. He was quite anxious to talk about his problems related to working on the adult out-patient team. He was a French Canadian but did not feel that he was discriminated against because of his nationality but that he was being isolated because he was with the psychology department whose head was dis-

* cf p.43 which refers to the metacommunication at an implicit level.

liked by most of the team members. In other words, he was being scapegoated and he didn't feel it was fair. He used to openly discuss his cases at the meetings but he "got the message" that nobody else was interested, so he gradually withdrew, first verbally and second geographically.

On the team he described what he felt as a repressive and depressive atmosphere which

"made me afraid to say anything because I felt I might be laughed at or mocked. The other people just seemed to be happy sitting around and taking pot shots at each other. I was sure as hell glad when the goddam meetings were over. It is not a very constructive atmosphere and you just feel like protecting yourself and as far as I'm concerned, silence was the only protection I could think of. But I'm glad I have the department of psychology to protect me from the team. I can do my own work there and nobody bugs me."

The occupational therapist seldom involves herself in any ongoing discussion unless a question is directed straight at her. Otherwise she sits in the corner knitting a sweater or a scarf for herself and seemingly unaware of the team environment. When asked if she would take a patient into her group or requested to make an assessment of a patient already there she replies, then resumes her task. This is a pose however because as she discussed her observations it appeared she was fairly acutely aware of the environment around her and perhaps projected a bit of herself into the other members when she said,

"The team members are reticent about involving themselves because they are used to working alone and like it that way. We used to run to the psychiatrist for everything but now we are a lot surer of ourselves and only do so for really serious things like when the patient gets depressed or can't work in our program. The team is just useful for picking up referrals from the other people and that's all I use it for."

The team coordinator feels caught in a bind because although she has been given the responsibility of organizing and running the team meetings, she feels she has no authority. This results in people doing as they please and she has no control over them. She has adapted a laissez-faire attitude and for the most part has abandoned any leadership role. She realizes that at the formal team meetings,

"cases are not fully discussed because for some reason or other people are unwilling to express themselves. But this in turn inhibits me from using any of my professional competence. We seem to be all turned off on each other. I wish I knew how to make the team work better than it is, but I don't know how."

I then asked her how she would feel about an in-service training program that would show the members how to communicate better, to which she replied,

"God, anything is better than what we got now. We should either shit or get off the pot."

The lack of communication was seen by the social worker as inhibiting the development of a more formally recognized dynamic role by the social worker on the team.

"If we don't speak up and define our own roles, they will be defined for us and we'll continue to be looked on by everyone else as just flunkies around this place."

She admitted however that in certain cases that the social worker had to submit to the authority of the psychiatrist when it actually came to a "show-down" since he has the legal responsibility for all the patients that

come to the hospital. But this kind of legalistic authority, she admitted,

"makes it too easy for us to do the minimum amount of work and end up as a group with little or no spontaneity. People present ideas and are greeted by silence. No one wants to comment or develop them. Or when by some miracle we actually try new things, they fizzle out and we go back to our old slump."

The chief psychologist commented that the team was only beneficial as a way of picking up cases. He realized that many people thought he was using his authority as chief psychologist to control what went on in the team, and that consequently he tended to inhibit communication. He also has an "in" with the administrator of the hospital so is recognized as having informal as well as formal power. Next to the psychiatrist he is recognized as the next powerful person on the team. But he stated that most of the work is done outside the team and so when the team meets formally,

"we have nothing to say to each other." He continued,

"But if people don't like the way I do things or think I'm controlling, I wish they'd say something to my face and perhaps I could make some changes. Otherwise as far as I'm concerned I like the way things are going, but as I say, I am open to any suggestions."

When the researcher discussed the possibility of initiating an in-service training program to help the team communicate better to make decisions as a team instead of outside of it he stated that he was satisfied with the team just being a group, "the way it is now".

The social worker and the psychologist agreed to a discussion on the subject of being a team during a coffee break after one of the meetings during which the usual passing out of cases to volunteers occurred. They

felt that the group working in the adult out-patient service is not a team and never has been, even though it was originally organized to be a team in the sense of having

"a co-operative cross-sectional way of looking at the problems presented. We tend to see cases as discrete rather than integrated categories which consequently doesn't allow members to click into what each other is doing. There is in the team right now a high level of competitiveness which prevents a lot of co-operation."

The psychiatrist perceives the team members as having innovative ways of treating patients, but these emerging roles do not seem to be recognized at team meetings. Perhaps this is because no one talks about what they are doing or what they plan to do.

The problem, according to the psychiatrist, stems from the co-ordinator's failure to develop team communication.

"I don't think the co-ordinator facilitates enough discussion to get the members to work together, and that's mainly due to her lack of training in team leadership. As a start, however, she should encourage people to present difficult problems for the team to consider. A serious case discussion with everybody throwing in their ideas is a good way to start. We should learn how to talk to each other about cases. There is a need for leadership with sufficient authority and vision to develop goals so that members know what to work towards."

It is seen from the above that there is a general feeling of problems in the area of negotiations with the realization that changes are needed if the team is going to work as a team where all members learn how to develop roles within rather than without the team.

The next section presents the results obtained from interviews and selected tape recordings from the adolescent team.

(b) The Adolescent Out-Patient Team

In this section, the adolescent out-patient team is analyzed to compare it with the adult out-patient team with respect to role negotiation and decision-making. A comparison of this nature is advantageous particularly when considering what changes are required for greater team effectiveness, e.g., more team decisions. To elaborate further, if only the adult team proved to be ineffective, then obviously certain factors in that team prevent it from an effective performance. However, if both teams are seen as deficient, and in similar ways, then both teams and possibly the system in which the teams operate require change. In terms of systems theory such a conclusion would appear to be a reasonable one.

As to the assessment of the functioning of the adolescent team relative to how it negotiates roles and makes decisions, a similar format is used for coding and extrapolating relevant excerpts of tape-recorded team meetings.

It will be shown that where roles are negotiated, a team decision results as defined. Conversely, when members do not negotiate, team decisions are not made. At the end of each excerpt, interviews with team members that relate to the issues discussed at the team meetings will be referred to as in previous excerpts.

The first excerpt shows how, in a series of case presentations, the

team leader prevented the occurrence of negotiations so that in all cases, except one, no decision was reached. In the one situation where a decision was reached, the leader or coordinator made it. To illustrate how this is occurring, an excerpt from a transcript of one of the adolescent meetings is presented.*

The coordinator of the team is presenting his assessment of the problem to the team. The team is numerically similar to the adult out-patient team. At this meeting, however, there are no psychiatrists or medical doctors in attendance. The clinical director, a psychiatrist, expects to be informed on important developments such as needs for admission by the team coordinator when he cannot be present at the meetings which is about every other week. The coding used to describe the decision-making and role negotiation processes is similar to that used to assess the interactions of the adult out-patient team.

D.M. R.N.

e1 Coordinator: This kid was referred by probation and mom. He stole two cars which got him into court and after that he stole two more cars. This did not endear him to either the court officials or his parents. I had the kid tested by (W) (the psychometrist) yesterday.

P(i)

D(i)

TP(t)

Task proferring occurred outside the team meeting indicating the truth of what one of the adolescent team members stated about much of the work being done outside of the regularly scheduled team meetings. Note that here no request for discussion or consultation is made by the coordinator. He has

* The transcript of all the meeting is contained in Appendix A.

already made his decision about what to do with the case, i.e., send him for psychological testing.

The next transaction shows a good assessment of the problem, but again, a lack of negotiation and individual decision-making.

	<u>D.M.</u>	<u>R.N.</u>
e2		
<u>Coordinator:</u> I got two more. One referred by the father. He's 14. He and two cousins ripped off \$150.00 from the (R) Club. He had to pay back the money to the members. He also robbed his own house. I told him his father is more patient with him than he should be. He and his sister fight like cats and dogs. I set him up for psychological testing.	P(b) P(i) D(i)	TC

As in the above, the task proferring took place outside the team and the coordinator does not ask for any comments nor are any given, so in effect "nips" any attempt at negotiation in the bud. He continues:

e3		
The next boy, age 14, was at high school but was turfed out because he was a "pain in the ass". He was very abusive at school to teachers and the kids. He's now back at (SS) School (for emotionally disturbed children, located on the grounds of the hospital). I'm working with him.	P(b) D(i)	TC

The next two cases are presented by two social workers. It is interesting to note that, like the coordinator, they make similar types of decisions and do not open the cases for discussion, so that no negotiation occurs, and once again individual decisions are made.

D.M. R.N.

e4 Social Worker: I have a case referred by CAS. The boy is 14 and refuses to go to school. He hates his home and they hate him. If he's in high school, I'll see him, if not, I'll refer him over to the children's services.

P(b) TC
C

D(i)

The next case is presented after the above by another social worker with a rapid-fire delivery, and as the above, no one challenges the decision which is made.

e5 Social Worker: I have a case of an 18 year old girl who is a CAS-ward. She has been with her present foster home for 11 years and has tried to commit suicide. The family has just had a new baby and she feels rejected and wants to move out. The family got an extension of wardship to help her. I'll have to find out if the family really wants her. They say she is like a daughter, yet I really feel they are keeping her for the money. I want to see the foster parents to see how they really feel about her.

P(s) TC

P(i)

D(i)

There are two problems presented here, one symptomatic which implies psychiatric intervention might be required. There is no mention by anyone that the case should be referred to the clinical director at least to evaluate whether suicidal tendencies are still present. The decision to see the family seems appropriate as there appears to be an interactional problem. As in the other cases there are no criteria or reasons given why certain actions to be taken are more appropriate than others.

The next case involves task preferring with a specific alternative, but the preferred task is denied and another specific alternative is proposed in its place, but no decision as to what to do with the case is arrived at.

It probably would be brought up in another meeting for some resolution, but in this meeting the case dies on the agenda. It appears that although the recommendation for therapy is quite specific, no one wants to act on it.

D.M. R.N.

e7

Social Worker: This case I have involves a behavior change. Before his treatment as an in-patient started, he was perfect in school. Nobody had any trouble with him. He was placid, non-threatening, not aggressive, none of that stuff. Now all of a sudden he blossoms into aggressive arrogance. Anyway, (W) (psychologist), I'd like you to do some testing. This aggressiveness might be a defense against his poor self-image and feelings of failure in his interpersonal relationships. Now he seems to be getting mileage out of his behavior. He can control people by making them afraid of him.

P(b)

P(i) TC

Psychologist: He doesn't sound like he needs to be tested. You've already answered why he behaves the way he does. He's getting mileage out of it.

A
C

Social Worker: Yeah, but he's escalating to the point where he's really acting out.

P(b)

Psychologist: I don't think it's any use to categorize people by testing them. We should use more obvious treatment and get to the kid's feelings about himself and get him to understand how to express them more appropriately.

TS
C
A
ND

The remark by the psychologist at the end of the discussion is one of the clearest example of task stripping presented. Also the number of different episodes so rapidly introduced give the meeting a "chopped up" and discontinuous character. This meeting is typical of the rest of the meetings observed.

The general lack of discussion about the various possibilities of team

treatment seems to indicate a fragmented team approach and denies the opportunity for members to develop skills in role negotiation to effect team decisions.

In later interviews with team members it was admitted that what actually happens on the team is not how cases are really handled, but that much of the discussion around alternative forms of treatment occurs informally, outside the meetings. The formal meetings are merely a way to "keep track of cases" rather than decide on what should be done about them.

The next two excerpts are an example of what happens to the negotiation process when the psychiatrist is at the adolescent team meeting. In the first case, the dialogue tends to be frivolous to the extent that coding becomes impossible. What seems to be happening is a consequence of the generally negative feelings of some of the team members, especially the coordinator, to the psychiatrist as will be shown in the interviews which will follow the presentation of the team discussions. It will also be noted that the psychiatrist seems to play the game of "one upmanship", or how to put the other person down. This makes him, in the eyes of many of the members, a formidable adversary, but they have their ways of coping with him.

D.M. . R.N.

Psychometrist: I got this referral from a school guidance counselor because this kid is always getting into fights. I saw the kid for testing and the coordinator saw his dad for an interview. The kid definitely does have peer problems because he doesn't feel accepted by his peers. A lot of the problem

P(b) TC

D.M.

R.N.

is that he's an odd looking duck. I don't know how to really describe him, but take it at that.

Psychiatrist: It's written down for posterity.

Psychometrist: Yes, for posterity. The kid's interests are not typical teenage interests. He reads about quantum physics and relativity.

P(i)

Psychiatrist: What do you know about quantum physics?

TS(i)

Psychometrist: I've read some.

Psychiatrist: They have a laser now so they can penetrate the earth even to China. You can even read messages that way.

Coordinator: All we'd have to do is learn Chinese.

TS(i)

Psychometrist: It would be a great way to order Chinese food. (Getting serious) But what to do with this kid is another thing.

Psychiatrist: He's an oddball, is that your diagnosis?

TP

Psychometrist: Sure. What do you do with an oddball? He's like his dad who has had similar kinds of experiences when he was growing up.

Coordinator: Yeah, his dad felt like he was always the odd man out and the scapegoat for the rest of the kids. He'll be coming back some time in the latter part of the month, so maybe we can decide on treatment.

D(i)

(The decision here is to wait for more information.)

The manner in which the team interacted seemed to indicate more of an effort to contain the psychiatrist than to seriously discuss who should be responsible for treatment, or for that matter, what kind of treatment would be most advisable. The amount of explicit and implicit task stripping

stops team members from negotiating. This deficiency in turn has resulted in the non-occurrence of a team decision.

The next case involves the consideration of psychiatric criteria at the expense of other criteria, which might be more appropriately considered given the fact that the main problem is one involving a young girl's difficulty with her family. The difference with which psychiatric criteria are accepted and the other types rejected would appear to indicate the degree of influence of the psychiatrist. His influence is similar to the coordinator, but it seems more due to the team's fear rather than its adulation.

D.M.

R.N.

Psychometrist: I have a 14 year old girl, a grade 9 student at high school. The father has been an elementary school teacher who had a nervous breakdown last year and he was diagnosed as a manic depressive. He tried to teach again last fall, but only lasted a month or two. He's staying at home now and decided he's got enough sick time to stay home for a year and try to recover. His medication is a 40 ounce and there's been a lot of antagonism between him and his daughter. The mother doesn't directly criticize his alcoholism but uses the daughter's antipathy to the father's drinking to get her point across.

TC

P(i)

Psychiatrist: Is father high?

TC

Psychometrist: He gets low. He was quite angry in session last week. He maintained he's not an alcoholic or even a heavy drinker, but that he just drinks occasionally. When he's drinking he takes over a child's role, becomes authoritarian. The child does well at school but is unhappy in the home.

P(b)

D.M.

R.N.

Psychiatrist: Well, what sort of behavior did she engage in?

Psychometrist: She ran away from home when dad was drunk. He told her to get the fuck out of the house. So she got out but returned the next day.

P(b)

Psychiatrist: This is touchy.

Psychometrist: Yeah, it's bad because this guy isn't your typical alcoholic. He's got some skills, some education. I think the breakdown seriously....

Psychiatrist: Those are not uncommon with the manic depressive picture, and I think the number of alcoholics we see are often manic depressives. That's why I asked if he was high because most often what happens with the manic is that they are in the manic phase and they drink... I had one guy and he's now retired and this is exactly what happened. He'd get high and he'd drink, then he'd cause a disaster and go in the depths of depression and he'd ruminate and so on. This guy isn't on Lithium is he?

TC

TP(t)

Psychometrist: No, I didn't find out what medications he's on, but I'll explore that the next time he comes in. (Being deferential of the doctor's criteria.)

A1

Psychiatrist: Okay. Maybe you should talk to his family doctor about the father's state because I think this kid might buckle under the pressure of the home environment.

A2

D(j)

Psychometrist: Okay.

In comparing the adolescent team with and without the psychiatrist, there seems to be a common pattern. The psychiatrist does dominate the team generally but he did consider some of the alternatives presented by the psychometrist when he indicated he was concerned about the child buckling under the pressure of the father's alcoholism. He was able to facilitate a joint decision which appears to be a more common occurrence than when the co-

ordinator himself was responsible for the leadership of the team.

Team members, for the most part, said that they can accept the way the coordinator makes decisions for the team, but they couldn't accept that from the psychiatrist. "It's the way he does it", said one of the child care workers. "He never tries to make himself look good by putting you down like the psychiatrist does". "He's okay", said one newly graduated MSW referring to the coordinator, "but his meetings are so disorganized you can't get anybody to listen to what you have to say. Everything seems to have been decided beforehand". One of the psychologists on the team agreed that team meetings were pretty cut and dried affairs because "cases that need discussion are discussed in the halls or in the coffee room. By the time it gets to the team meeting, everything's been decided". "Except in the case of the psychiatrist, meetings are held to formally record decisions that have, for the most part, been already made. It would seem from this that the psychiatrist is resented because he neither formally nor informally negotiates with team members before making a decision.

All those interviewed felt that making decisions on the team is not possible because of the inability to negotiate their roles. Three of the team members however agreed that if they knew how to make decisions as a team they would find the negotiation process easier. It would seem that such knowledge would help to eliminate the "fear" of the psychiatrist and other possible retaliatory effects.

The coordinator of the adolescent team blamed the psychiatrist

for preventing team interaction by making all the decisions and even "ordering them around like servants".

This hardly made the team much of a forum for discussion and decision-making but merely locked people into their roles as perceived by the leader's own interpretation of what their roles should be. It was also a training ground to get them to do what they are told. As to the members themselves, he felt they were too intimidated to negotiate roles from their own perspectives for fear that they might "get shot down in flames". However, when the psychiatrist was absent from the meetings, they did not improve negotiations despite members' feelings to the contrary:

As long as the coordinator was at the meetings the rest of the members felt at least somewhat safe because he would defend them against attacks from the psychiatrist. They, however, pay the price for their dependency on him in these "dangerous" situations because they expect him to make other difficult decisions and solve problems. They seldom listen to each other or discuss much with each other and problems tend to be resolved without any exchange of insight between members. For example in one meeting decisions were made (individual) without any criteria or more than one alternative being generated. They did not protest the coordinator's authoritarian ways because they felt he was working in their best interest. He felt, however, that the team was getting nowhere as a team and during the process of the research which involved training for team decision-making, he felt a program of this nature should be established so the team would know "where the hell they were going" and that decisions would be more systematic. He felt if they could get some training in decision-making techni-

ques he wouldn't always be protecting them and "spoonfeeding" them or at least feel that he had to do it.

As was shown, serious discussion of cases are accomplished informally, outside of team meetings, where most are agreed that the bulk of the work gets done. Informal consultation brings with it an exchange of perspectives or criteria that lessens the probability of a unicausal approach in all cases. But where decision-making is done informally this way, there is no way of knowing whether they ever do adequate decision-making. The only way it could perhaps be achieved would be to take all informal consultation back to the regular team meetings to be considered there. This might at the same time improve the team's negotiating ability out of which could be produced team decisions.

The climate for role negotiation might be improved if the team generally were more appreciative of the value of informal consultation outside the regular meetings. The team's rejection of the value of informal consultation is reflected in the coordinator's criticism of team members who were consulting about cases "outside the team meetings". Informal consultation can be eventually beneficial especially if members are encouraged to bring consultations back for team consideration so that members can share their insights and develop criteria for making team decisions. Instead of being criticized for their behavior members should be praised and made to feel they are making a contribution to the team.

This kind of positive recognition would help them feel more positive towards the team and more inclined to share their insights instead of inhi-

biting them. The sharing of informal consultations in this way might help to reduce the team-department dichotomy that helps to maintain the present alliances and the present power structure. Its weakness is that it undermines formal team functioning.

(i) Team Interaction

It would appear from the data that the decision-making style of both teams tends to be authoritarian. The lack of understanding of the techniques for helping members become effective decision-makers was cited by the coordinator of the adolescent team as the reason why unilateral kinds of decisions were allowed to be made. Like the adult coordinator, he did not know how to make the team work any better. Both, however, did indicate how they would like information to help the team function by getting members to take more responsibility for decision-making.

In order to graphically illustrate what is occurring on both teams and to assess their effectiveness in dealing with the problems brought to them, figures are presented under the following headings: Problems; Criteria; Alternatives; and Decisions. These figures were gathered through coding the raw data, numbering and subsuming them under the appropriate descriptive headings. Sometimes, as is often found in any meeting, the verbal interactions did not easily lend themselves for coding, so were not categorized.

Decision-Making: Adult Team

The data derived from the adult team meetings are presented in figure

Figure 4:1

DECISION-MAKING PROCESS
ADULT TEAM

<u>PROBLEMS</u>		<u>CRITERIA</u>	<u>ALTERNATIVES</u>	<u>DECISIONS</u>	
Behavioral	16			Individual	7
Interactional	14			Joint	1
Symptoms	3			Team	0
				No Decision	25
TOTAL	<u>33</u>	<u>112</u>	<u>36</u>		<u>33</u>

ROLE NEGOTIATION PROCESS
ADULT TEAM

	<u>Task Claiming</u>		<u>Task Proferring</u>		<u>Task Stripping</u>
TC	11	(t)	33	(a)	5
TC(aa)	10	(o)	21	(i)	3
		(n)	13		
TOTAL	<u>21</u>		<u>67</u>		<u>8</u>

4:1, and for the adolescent team meetings, in figure 4:2.

In the adult team, 8 decisions were made out of a possible 33 (32%). None of these were team decisions. On 25 occasions, no decisions at all were made (75%). 112 criteria were presented but alternatives were developed or generated 36 times (32%). This means that 3 times as many criteria were discussed as alternatives which suggests the rather abstract nature of the discussions at the formal level. It also suggests a failure to come to grips with problems presented.

Role Negotiation

Various forms of task stripping (explicit and implicit) occurred on the adult team which appear to have acted as a barrier to continued negotiations that may have resulted in more decisions being made. The frequency of task stripping occurred in 52 out of the 97 negotiation episodes or 55% of the time. If task stripping can be considered as one aspect of negative feedback, then from a systems point of view, such a process would help to bring about a static state, reducing the dynamic quality of team interaction and inhibit the occurrence of team decision-making.

The static quality is shown by the way problems are first presented and defined. For example, in table 4:1, most of the problems initially presented were of the behavioral or interactional variety (66% of cases). This implied social work or psychological intervention. Yet 60% of the time the psychiatrist defined these in terms of his own criteria, rejecting criteria from other team members.

Decision-Making: Adolescent Team

In the adolescent team, 14 decisions are made out of a possible 32 since there are 32 problems to be decided upon (43.7%). On 18 occasions (56%) no decisions were made. Ten of the decisions (33%) are individual, without any discussion. The four remaining decisions result from joint decision-making. In terms of the team's decision-making ability it is rather similar to the adult team, not effective, but does make decisions 25% more often than does the adult team.

Criteria is used to guide the choice of alternatives only 48% of the time which suggests the existence of a "hit or miss" approach to therapy. This further suggests that even though the adolescent team makes more decisions than the adult team, they are not necessarily rational.

Role Negotiations

The negotiation process occurs much less frequently on the adolescent team than on the adult team. For example, the problems presented to both teams are almost equal, 32 for the adolescent and 33 for the adult. Yet negotiations occurred four times more frequently on the adult team than the adolescent team. Obviously decisions were made without negotiations or negotiations were already made outside the formal team meetings. This points out the need for "formalizing" an already existing informal process.

Education for Teamwork

As Brill (1976) states, there is danger for teamwork to generate into

Figure 4:2

DECISION-MAKING PROCESS
ADOLESCENT TEAM

<u>PROBLEMS</u>		<u>CRITERIA</u>		<u>ALTERNATIVES</u>		<u>DECISIONS</u>	
Behavioral	19					Individual	10
Interactional	10					Joint	4
Symptoms	3					Team	0
						No Decision	18
TOTAL	<u>32</u>		<u>12</u>		<u>25</u>		<u>32</u>

ROLE NEGOTIATION PROCESS
ADOLESCENT TEAM

	<u>Task Claiming</u>		<u>Task Proferring</u>		<u>Task Stripping</u>	
	TC	5	(t)	8	(a)	1
	TC(aa)	1	(o)	3	(i)	0
			(n)	0		
TOTAL		<u>6</u>		<u>11</u>		<u>1</u>

a form of parallel activity when team members work merely contiguously together but not actually interacting reciprocally by negotiating or openly discussing their perception of a particular situation, case or problem being presented. Such a failure to interact with one another results in a team never really "jelling". This justifies the comment of one member of the team who states, "We are not really a team, just a group of people who happen to be working together". It justified it because the team never really interacted meaningfully through an appropriate role negotiation process that would cause them to interact reciprocally rather than in parallel fashion so that the roles did not really complement each other.

However, it seems that the major barrier in preparing workers for interdisciplinary teamwork has been a lack of unifying concepts and principles that serve to tie the totality of knowledge in a way that can be used. Systems theory is at least partially helpful in resolving this problem, because it facilitates the teaching members how to combine in a meaningful whole and yet retain their individual and professional integrity.

The teams researched are not ideal models because they do not develop specific alternatives on which team decisions can be made. For a team to balance at a desired level of effectiveness, it would need to become as process or relational oriented as it is task oriented. Working together would be seen as important as getting the work done.

Question (ii)

Team-Hospital Relations

The Team as a Reflection of the Hospital System

The question of the extent to which the team reflects the hospital system brings up the second area of investigation which is that team functioning is partly a reflection of the total hospital system. The failure to work as a team is the result of a failure to successfully negotiate roles at team meetings so that team-type decisions can be made.

It is suggested that the hospital undermines the effectiveness of the teams by supporting a closed type of system thereby making it difficult for members to negotiate in order to make team decisions.

It accomplishes this by:

- (1) Supporting the dominance of the medical profession over the rest of the team members.
- (2) Legitimizing the medical model as a guide for decision-making.
- (3) Influencing members to act on pre-defined roles rather than negotiated ones.
- (4) Maintaining conflict between teams and departments which is detrimental to team functioning.
- (5) Relegating the team to an administrative rather than a clinical entity.

The data to examine the above statements about the hospital's influence on the functions of the team will be obtained from the team meetings, the hospital's organization chart, a memo addressed to one of the teams, by-laws of the hospital and interviews with all the representative disciplines on both teams.

1. With regard to point one, the organizational chart, the "allied health professionals" or the non-medical professionals are subordinated to the medical profession. The Medical Advisory Council speaks for all groups in the hospital and is itself subordinate to the medical director. This legitimizes hierarchical control by the medical profession placing it in the dominant position. Of course, since the psychiatric clinic is a hospital, it is quite proper to legitimize authority in the hands of the medical personnel and this is supported by the Mental Hospitals Act (R.S.O. 1950, C229). But as Strauss (1978 p. 110) states, even though formal responsibility and authority rests with the medical person, it does not preclude in practice them coming to terms with their respective teams by negotiating with its members concerning methods of treatment and assignment of tasks.

However, the hospital by-laws give no recognition of any development of a negotiated order in the hospital. They have the responsibility of directing those who are non-medical under the section that states, "Each member of the medical staff shall give such instruction as required of him for the teaching of other members of the staff, nursing staff and professional services staff". The implication here seems to be that the process of

enlightenment should only go one way, from the doctors to the rest of the staff, but not the reverse, which tends to discourage interaction, at least in a formal sense.

An example of both the exercise in dominance of the medical profession via the clinical director and the appeal to that dominance by the adult coordinator is exemplified by the excerpt from a letter shown in Appendix B.

The clinical director was asked to intervene in a problem regarding team members who resented being deployed in emergencies without their consent. The problem had not been successfully resolved. Rather than go to the head of the service, the coordinator by-passed him to go to the clinical director. Below is an excerpt from the letter.

To all members of the Adult Team:

"The days of democracy within the adult service are over as of February 8, 1977.

As a group of "professionals" there are expectations placed upon us when we obtain employment at an agency. It is our duty to fulfil these expectations to the best of our ability if we agree to work at the agency. If any of us feel we are not dependent enough to carry out these responsibilities, then we better reassess our commitment to the agency."

After this somewhat aggressive introduction the director lines up the assigned roles for team members with no offer to negotiate. After these are "explained", the letter signs off with the following admonishment:

"If anyone does not wish to adhere to these rules, it might be best for them to reconsider their appropriateness in the adult service".

A copy of the letter was sent by courier to each member's office where it was presumably read, but never commented on at least in any subsequent formal team meeting.

By involving the clinical director in the team's problems in this way, she not only recognized the clinical director's power over the team but also recognized her own powerless situation, i.e., her failure to bring about a desirable change. The letter represents, as Strauss would say, "an appeal to authority as alternative to negotiation". In other words, she could not share her concerns with the team and enlist their cooperation, but instead turned to an authority figure for help. Such sharing could have provided a reasonable opportunity for some discussion or negotiation between the coordinator and the team.

Feelings of resentment about the tone of the letter were expressed informally among team members, but were never expressed in the team meetings. Another example of the repressive environment of the team members referred to in the interviews. Failure to discuss this rather emotional issue helped to reinforce the team as a closed system making it even more reflective of the hospital itself.

From the above sources of information, it would appear that the ability to negotiate roles is limited by the closed and authoritative hospital system. Each person in the system is also closed as indicated by his static

role so that team decisions are more the consequence of hierarchical influences than the result of negotiation occurring on the team.

Another indication of medical domination is that the services and the committees are all headed by medical people, thereby encouraging the priority of one discipline over the rest. As one social worker remarked, "It's pretty hard not to recognize around here that all the medical people are at the top and that the rest of us, social workers, psychologists and nurses, are at the bottom".

2. The medical model is used for decision-making. What this means is that a linear rather than a dynamic interactive process is used to make decisions. The process coincides with the symptom removal type of ideology that characterizes the thinking of the hospital which is reflected in team decisions. How this happens is explored by the interviews but its occurrence is shown in the type of decisions made by the adult and adolescent teams.

It is interesting also to note that the many complaints directed against the institution and the doctors concerning their authoritarian decision-making habits are practiced by the very people who are loudest in their condemnation, for example, the coordinator of the adolescent unit. This fault is forgiven by the team members more easily than when practiced by the psychiatrist because it's one of their own "standing up to the establishment" as one of the psychometrists from the adolescent team remarked. What they fail to see, however, is that the practice of by-passing the team undermines the development of a team decision-making process which

could become a treatment modality for all disciplines as they work together. By using the medical model for decision-making they keep the team from developing into a system of interactive members who keep the team dynamic through continually negotiating their roles. Using the medical model keeps the system closed and keeps them apart and isolated from one another. Thus, as the psychiatrist from the adult out-patient's team says, "We play into the hands of the administration who are very much at the game of divide and conquer". Their consequent isolation from each other prevents them from uniting so as to develop into a system to effectively counter the administrative system which is completely united.

3. Members are expected to act according to a pre-defined role rather than one which they negotiate for themselves. The pre-defined role is supported by the hierarchical system.

The psychiatrist of the adolescent team felt that social workers especially had to be "pushed into action" because if left to themselves they would remain immobile since their own professional training lent itself to passivity, waiting to be supervised. He also felt that the main function of a psychiatric facility was to treat psychiatric illness which was the prerogative of the psychiatrist whose responsibility is to direct treatment. It would appear that the other professionals tend to feed into his perceptions by being hesitant at the meetings in presenting their criteria or making attempts while he is present to challenge some of his decisions. They in effect perpetuate his domination of the team.

According to the adolescent coordinator his hierarchical hospital

system allows superiors to define roles of subordinates and so supports status inequality. This is in direct contrast to what the team represents, which is equality of status. The team leader or the coordinators should try to negate the hierarchical system's attempts to define their roles and make decisions for the team.

The psychologist commented that though the negotiation of roles by team discussions would be highly desirable, given our set up it was impossible. This was because of what he saw as the hierarchical recognized power of the system being repeated in the structure of the team,

"And it isn't only the psychiatrist, but others, who have the power also such as the chief psychologist and the coordinator".

He agreed with the adolescent coordinator that the only way to curb the tendencies of the team to work from pre-defined or hierarchically-defined roles would be for all members to have equal power, which could come from equal skill at decision-making and from the understanding of role negotiation.

The recognition that each therapist speaks with authority at a certain level of treatment is not recognized by the psychiatrist when he rejects the idea of the social worker not wanting to do marital counseling and suggests education as a desirable goal for her client rather than psychotherapy. There is a tendency for not only the psychiatrist, but other people who like using the medical model, to ignore feedback from other team members and apply their own criteria for treatment especially informally as the

analysis of the adolescent meetings has uncovered.

Concerning the use of hierarchical powers to define team members' roles, a former coordinator of the adult team criticized the clinical director's attitude which influences the teams to function as they do. When he was coordinator every decision he made on the team had to be checked by the clinical director to make sure the team was "functioning according to the plan". It is noteworthy that only the behavior of the coordinator was subject to scrutiny, rather than the whole team itself with obvious implications regarding hierarchical control of role functioning.

The attitude of the psychiatrist to the functioning of the team is perceived by most of the adolescent team as stereotyped and traditional. As one of the Social Workers stated,

"His perception of team interaction is to make the decisions and tell the "paramedics" on the team what to do. Even though we tell him we would like to develop our own way of dealing with cases, he never gets the message".

Attesting to the repressive climate on the adolescent team when the clinical director is present, compared to the open climate when he is absent, gives some indication of how negotiation is undermined by hierarchical influence. As one of the social workers commented,

"I find emotionally there's a hell of a big difference. You can tell people to fuck off here with more comfort than you can when he's around. We don't trust him so we are careful".

The problem of trust permeates also the relationships between the members

of the adult team and has led to problems in communication at the formal meetings. This attitude was summed up by the chief psychologist who said,

"I spend much of my time around here just protecting my own ass".

The trouble with the team-hospital relations, according to the social worker, is that the hospital, besides being organized on service lines, is also organized on departmental ones. The result is that everyone has marginal commitment to both groups and a kind of "double loyalty". It provides a good way of avoiding responsibility and encourages an ambivalent attitude so that the discipline can't develop any clear-cut goals.

From another aspect however, this dichotomy does not necessarily have to be detrimental. A strong department should develop strong professionals able to participate in teams as well as positively contribute to hospital functioning.

4. There appears to be a contradiction in the way the hospital system is set up with its hierarchical power divisions on one side and the division of labor on the other. The division of labor corresponds to the hierarchical structure which reinforces tight organizational control and limits the opportunity for democratic decision-making which depends on feedback. The result of all this according to the adolescent coordinator is that the team leader is always in the position of trying to equalize power to help people to do more than take orders and accept the authority that reflects more power than it does knowledge.

People from the various departments are assigned to different teams usually upon their own request. As was pointed out the members have no administrative status in the team, that is, except the psychiatrist who is officially the head of the service and the team. The coordinator is more of a "traffic cop" or manager. She has no ultimate authority. In a disagreement between the coordinator and the team member, the member can always appeal to the department head who the coordinator says can "land on her" any time they want. Treatment has to be organized through the services according to the organization chart but there is nothing that says how closely the members of the team have to work together as a team. Cases may be handed out to team members but they can consult through their disciplines, or other disciplines or work alone.

This kind of freedom might be seen as acceptable to many people on the team but the very fragmentation reinforces the team as a non-communicating system. Its parts, or people that make it up, do not interact to make the system dynamic. Another consequence of its lack of dynamism, is that it becomes reactive so follows the directions imposed from outside of it. It cannot interact to change what is imposed so becomes balanced at what Speer or Buckley would describe as "a morphostatic" or "unchanging level", much like the hospital of which it is a part.

When an attempt was made to change a particular aspect of the hospital system little sympathy was manifested by the clinical director or the administrator. They reacted swiftly to sustain the authoritarian balance of the system.

An example of this is contained in the following account.

Some time ago, a psychologist, now no longer an employee of the hospital, attempted to establish a professional advisory council to replace the medical advisory council. The reason behind this was doctors were making decisions about patients who were receiving types of therapy from other professionals such as social workers, psychologists, and occupational therapists which they knew nothing about. The professional advisory council would serve as a forum where all who were treating patients could decide on appropriate programs for them.

When the psychiatrist found out what the psychologist was proposing, he confronted her with the threat that he'd "wrap her on the knuckles" if she continued to push for a professional advisory council. The administrator was a little more subtle when she suggested to the psychologist that "If certain people are not happy with the way things are being done around here they are always free to find a job more suitable to themselves elsewhere." Finding no support for her efforts from her professional colleagues, she decided to let the issue drop.

The passivity of most of the staff combined with the hierarchy allows the system to remain static, and the teams tend to reflect this characteristic. But of course this is in the formal sense because informally there is an open, dynamic system operating as it were "outside" the organization, but unable to change the function of the formal organization. Team members, identified with their own discipline and communicating outside the team helped to keep the teams in a static state.

So rather than fight for their own professional identity, they fight among themselves in endless arguments over procedures. In one meeting, for

example, there seemed to be far more concern with procedures for transferring a case from the child care department to the adult department than with criteria about whether the identified patient should be treated or whether the whole family should be assessed for possible treatment. (Individual vs. holistic approach)

According to the former adult team coordinator, attention to each other's deficiencies in being "proper team members" prevents looking at the total system and trying to bring about changes in it. The system is seen as too remote and mysterious or even too foreboding to openly criticize, so team members attack each other which, of course, is perceived to suit the purpose of administration who are seen by the professionals as likened to "divide and conquer".

According to the psychiatrist, the administration looks on the teams with distrust because they feel the teams are trying to usurp power away from it. To keep the team members in line the administration is keeping control of the departments and the clinical director controls the teams through the medical advisory committee and the psychiatrist.

Others in the adolescent team felt that organizational change in the administrative hierarchy was not feasible, but some changes could be made in the teams themselves to limit interference from the administration. A kind of change could be brought about by semi-autonomous status which would lessen the authoritarian control the team is subjected to according to one member. The team members could develop policies and procedures that they would be responsible for maintaining and this would limit hospital interfer-

ence. Complete autonomy would not be possible, of course, because of the fact that the team is part of the hospital, so the hospital could set general guidelines. Better communication might result due to a more equalized status between the two.

The problem of communication between powerless team members and an all powerful administration is seen by another adolescent team member to be detrimental to the establishment of an appropriate communication-feedback network between the team and the administration.

5. The team seems to be more of an administrative entity than a clinical one. The members feel that the teams function for the purpose of referring cases to appropriate personnel, than to develop an effective therapeutic facility. As the recorded team meetings show, there is rarely case consultation that goes to any great depth, especially as to how certain kinds of therapy would be more beneficial than other types. Mostly the discussions revolve around case management. Many blame the repressive climate or the fact that the coordinators either cannot be bothered or don't have the proper training to facilitate enough discussion on case dynamics. Such training presumably would encourage people to present difficult problems for the team to consider according to the view of the psychiatrist.

According to a former coordinator of the adult out-patient team, the teams were never meant to be more than an administrative entity cloaked in the guise of a clinical team.

"When I was hired, I was led to believe that I would have control over the team, to develop it as I saw fit, but as I found out there

were too many constraints. I wanted to get knowledgeable personnel and develop the team but all my time was spent on administrative matters than on clinical problems. So I quit in disgust when I realized that all the hospital wanted me for was to be an imprimatur to the team as its medical legitimizer".

• The adolescent coordinator and the team members agree that the team is used more as a forum to process cases rather than to consult on them. They do not feel that there is enough time to consult on every case which they consider to be more efficiently done on an ad hoc informal basis. To them the team meetings are to record rather than make decisions which is basically an administrative function.

The adult coordinator felt that she would like to make the adult team function in more of a consultive capacity but did not know how to get it to work in any other way than a screening procedure for cases. She felt, also, that her mandate as coordinator did not give her enough power to get members to contribute any more than they were doing. Until the administration defined her role as a clinical coordinator more clearly, the team would remain an administrative entity until it was defined differently by the clinical director. It is interesting to note that the coordinator of the adolescent team did not complain of the constraints to his role as resulting from the failure of the administration to give him more power to control the team.

It is significant to note the different attitudes of the coordinators of both teams in regard to the power they had to lead the teams. The adult team coordinator blamed her failure to make the team more effective on the administration who did not give her enough power to control the team and

"make it work". The coordinator of the adolescent team, on the other hand, took power without being given it, so in fact he ran the team as he liked, limiting to some extent the power of the psychiatrist. His approach was to directly confront the clinical director about control of the team by insisting that he not tell members what to do, but let the team develop its own way of handling cases and working together. However, he did not do this, but instead, made the decisions for the team.

Summary

From an assessment of the interviews it can be concluded that members of both teams see the hospital as a secretive closed system where those in authority rigidly hang onto their power. The various services and committees are perceived by members of both teams to be dominated by the medical professionals and which serve to further insure top-down control by the administration. The medical profession sees the teams as functioning less in terms of an interdisciplinary model and more for the purpose of carrying out functions determined by the medical one.

Chapter V

Analysis

The main factors affecting team performance and hospital-team relations are examined in this chapter. These factors or characteristics of the functionings of intra and inter-relationships are the ones which will be considered when the recommendations for change are made in the chapter to follow.

Team Interaction

As the previous definition stated, role negotiation is a necessary condition for team effectiveness which is found in the team's ability to make decisions.

As Strauss (op. cit. p. 106) states, active and growing working relationships require constant negotiations over such things as new tasks and new functions as perceived by the role incumbents as well as how such changes, should they occur, relate to presently constituted jurisdictional terrain.

Obviously the teams did not exhibit "growing relationships" and discussions seemed to complicate rather than resolve problems, which ended up by being resolved outside of team meetings.

The teams appear to function according to the medical model in most cases, which corresponds to their original purpose which at the time of their formation was perhaps appropriate. At that time (1965) the non-medical model was implicit since the team was an interdisciplinary one, nevertheless they could be considered effective since they were carrying out their mandate, and still are. But now, out-patient mental health teams are defined as interdisciplinary (Macht, 1979, op. cit.) which require decision-making by all the team, rather than direction from the psychiatrist. Considered from present team decision-making models, the psychiatric teams which have been studied are not effective as no team decisions were made.

Negotiations have occurred, but no team decisions resulted mainly because the alternatives for therapy that were suggested were seldom supported by the other team members or were often dismissed by the team leaders. In the adult team, discussions were more frequently around criteria giving the discussions more of a philosophical than a practical atmosphere. In the adolescent team, the opposite was true.

In both teams, the lack of understanding of how to negotiate and make decisions maintains them at a static, undynamic level. This results in control of decisions by those who already have the authority in the hospital hierarchy. In some instances where alternatives were supported by other team members and were specific enough for decision-making, the psychiatrist

would pull rank and make his own decision using his own criteria of desirability rather than that of the other team members or at least in combination with them. When members balked about the unilateral decision he ignored them and said he would let the medical advisory committee make the decision for the team.

As was shown, serious discussion of cases were usually accomplished informally, outside of team meetings, where most agreed meaningful discussions took place. Informal consultation brings with it an exchange of perspectives free from the constraints that the members feel they experience in the formal team meetings. But since it appears that most consultations of the informal sort occur within disciplines, their own professional criteria is a greater consideration for intervention than a cross-disciplinary exchange that is at least theoretically possible in a formal team meeting. To members of both teams, the climate of formal team meetings does not lend itself to free and open discussion because it is regarded as repressive.

The climate is not conducive to negotiations because as was indicated, the team leaders tend to use both explicit and implicit task stripping to control the decisions. Part of the responsibility for allowing negotiations to stall or the team leaders such as the psychiatrists to take over the way they do falls to all members of the team who cannot or will not confront them on this issue. Their passivity merely encourages those in authority to continue to control through unilateral decision-making.

The fact that specific alternatives are not developed, or if developed, are ignored, is probably due to poor leadership training so the coordinators

are confused as to whether they are to be facilitators of negotiation or merely masters of ceremony, and sometimes not even that. Because of inadequate training they fail to facilitate meaningful discussion around team or case dynamics so that consequently members never come to grips with meaningful issues or make decisions that result from the consideration of concrete alternatives proposed by representatives from all disciplines.

Failure to discuss important issues tends to give support to a subtle type of conspiracy that seems to color team meetings with a quality of repressiveness that dares rather than invites people to talk. This is perhaps why some, such as the psychologists and social workers, felt they could not develop satisfactory roles for themselves on the team. They seemed to feel their effectiveness as professionals could best be expressed out of it, in informal discussions with others or within the collegiality of their own departments.

Alienation of Team Members

Most professionals on the team are seen at some time to be engaged in a type of task stripping, but the psychiatrist, having a higher status than the rest of the members of the team, appears to be more effective at it than the rest. His use of this technique however makes for a repressive climate on the team where members seem afraid to communicate, heightens their feelings of alienation from the team and interferes with the decision-making process.

So it would appear that role negotiation is a necessary process for the teams to accomplish the task of collective decision-making. The negotia-

tion process requires the presentation of specific alternatives reflecting explicit or implicit criteria from all disciplines for the achievement of team decisions in an interdisciplinarian team.

Team-Hospital Relations

The empirical findings related to team-hospital relations suggest that the functioning of the team is a reflection of the hospital system, that is, authoritarian, closed and the antithesis of what would be required for promoting dynamic member interaction.

Team members in particular see the hospital administration as monolithic, unwilling to open up, allow meaningful feedback, or in any way lessening the power which it now has, especially as it relates to co-operative decision-making.

Not sharing communication with the parts that compose it, it is seen as promoting policies which isolate its sub-systems in the service of its underlying intention of "divide and conquer".

Changing Team Functioning

It will be difficult to bring about changes in the teams themselves because of the attitude of the dominant profession with regard to how teams should function. The attitude is reflected in the remarks of one of the psychiatrists with regard to the training of team members. It will be noticed how closely his ideas reflect those of Wolberg in terms of the static roles of team members. He contends that proper training for the team should

occur through the services, not the departments. It would be up to the services to define the respective roles of the team members so they could function properly. Since psychiatry is in charge of the teams they would of course be responsible for the assigning of the appropriate roles. Role complementarity would not develop from discussion but through a prescribed, traditional definition. The definition would correspond not necessarily to the ideology of the department per se, but more to the interpretation of the department's ideology by the psychiatrist. The implication of this procedure is the gradual erosion of a truly interdisciplinarian function of the team to that of an undisciplined one of the medical model of psychiatric intervention.

The attitude reflects a lack of understanding by psychiatry and the hospital system itself about the desirable function of an interdisciplinary team of mental health professionals. It also has some negative implications for the training of role negotiation on teams and the whole nature of dynamic teams within the hospital.

The Leadership Problem

The reaction of the adolescent team members is mainly to become dependent on the dominant personality of their coordinator to make decisions or at least so it would appear from the team meetings. His failure to insist on proper procedure, he states, is due mainly to lack of knowledge in how to help teams make a decision. This was also the complaint of the adult coordinator. She sees herself less as a team leader and more of a team manager. The leadership role she leaves up to the psychiatrist who, himself, appears to be hesitant about the role. He feels that if the adult coordinator

were better trained, she could legitimately lead the team.

So it seems that the dominance of the psychiatrist exists partly because of the perception of most of the team members and their failure to metacommunicate so as to openly discuss relationship issues which might be helpful to initiate some change in the way people are perceiving medical dominance. In other words, there seems to be a reciprocal relationship between their perception of medical dominance and their passivity on the teams which allows their definition of the situation to be static and consequently their roles to remain static. This reaction coincides with Stebbins (1972 p. 337) description of the reciprocal effect of the definition of the situation and consequent behavior. Thus, for example, when individuals define a situation a certain way they have expectations of how others will react and their roles are then determined by these expectations.

It is important to understand how the members perceive the hospital system and how their perceptions influence, to some extent, how the system continues to function so as to maintain its unchanging structure, and how the staff members by the way they think and act contribute to its unchangeableness, that is they seem to be contributing to the status quo by doing little to challenge it. An example of an active contribution to the status quo was the behavior of the adult coordinator.

By involving the clinical director in policy decisions for the team she reinforced his authoritarian control while at the same time emphasized her own powerless situation. The letter represents as Strauss would say,

"an appeal to authority as an alternative to negotiations". In other words, she could not share her concerns with the team and try to get them to help her with them, so as a result, turned to "Dad" for help. At no subsequent meeting was the letter ever discussed. Such a discussion could have provided an excellent opportunity for feedback between the coordinator and the rest of the team, and perhaps, even with the clinical director being present. Many feelings about the letter had been expressed informally between members, but never brought back for a formal discussion. However, a team meeting to discuss the contents of the letter with or without the clinical director might have provided an opportunity for members to air the views in public. Failure to openly discuss this sensitive issue reinforced the team as a closed system. The request to have the clinical director solve the team's problem amounts to an acceptance of the domination of the hospital even in the internal affairs of the team.

The confusion in regard to who has the authority that so frequently occurs on the two teams is a result of the administration's failure to outline the coordinator's role so that no overlapping occurs. The problems with the adolescent team and the hospital, as with the adult team and the hospital, is failure to delegate responsibility to the coordinators. The consequence of this is that neither one has a clear concept of his expected role.

The result of this failure is that the psychiatrists maintain their ultimate power over the teams legitimized by both the organization chart and the by-laws. They can at all times be legitimately appealed to in an open confrontation about who has the real authority.

This authority although legitimized is being by-passed because of the amount of informal negotiations and decision-making already occurring.

The hospital, as it was shown, legitimizes the dominance of the medical profession, although it appears from analyzing the decision and negotiating processes of both teams, there are differences in the degree of domination. For instance, the dominance of the medical profession is more prominent in the adult team where clearly the psychiatrist tends to reject criteria from other team members and impose his own. However, the feelings of the members against his domination are not as extreme as they are towards another psychiatrist, who is resented despite his tendency to encourage criteria and decision-making from other team members. The reaction of the adult team members to the dominance of the psychiatrist is mainly one of passivity and denial of the team as an acceptable treatment modality and a stated preference for "doing their own thing". By doing their own thing, the team becomes fragmented and is reinforced as a non-communicating system because its parts, or the people that compose it, do not interact to make the system dynamic. Consequently, it becomes reactive and follows the directions imposed from outside criteria. It cannot interact to change what is imposed so becomes balanced at what Speer or Buckley would describe as "a morphostatic" or "unchanging level", much like the hospital of which it is a part. The passivity of the team members allows those in authority positions to define "appropriate" roles for the team members in ways they would consider to be effective intervention.

Those in authority are the medical practioners who are able to control

the team by their administrative power, and as a result of the teams' own fragmented state.

Summary

1. Teams operate from a clinical model that is now obsolete but is supported by the authoritarian nature of the hospital. The negotiation of roles and the making of team decisions, though desirable for effective team functioning, is not possible, given the closed system in which the team operates.
2. The hospital's organization chart and by-laws have created a differential power structure in the sense of localizing the decision-making in a particular discipline. The incentive to negotiate roles is dampened by this arrangement because it fails to shift the power of decision-making away from established authority.
3. Most team members tend to make decisions based on their own criteria rather than criteria developed by the team. This behavior coincides with the medical model and so tends to discourage negotiations. As negotiations are hindered, hierarchical control of the team is strengthened. The decision-making style of the team is a copy of the hospital organizational model with its top-down decision-making.
4. The hierarchical power structure hinders open communication or negotiation. The power that an individual has outside the team (department head, psychiatrist, coordinator) is the status he retains in the team where it is seen to control decisions. This power increases the feeling

of powerlessness and alienation among the other team members who do not have the knowledge to develop power themselves, i.e., how to make decisions.

5. The main use of the team is that of an administrative entity, as a clearing house for cases, rather than as a forum for serious consultation. On the team, members will not negotiate roles, have little empathy for one another, and as yet have not learned to make decisions. The hospital tends to support the team as an administrative rather than as a clinical entity. Members therefore function as individual professionals who negotiate with their departmental colleagues who they tend to trust and stay clear of the team whose function they do not trust because they cannot define it nor understand how to function within it.

The substantive findings suggest that the team and the hospital are mutually alienating influences and the members' failure to develop dynamic interaction leads to its domination by constituted authority. This allows decisions to be imposed rather than be generated by the process of negotiation. Members feel isolated, alienated, and powerless to change either the team or the hospital system so tend to remain passive or work outside the team. The team itself operates from unidimensional, rather than interdisciplinary, ideology and this way of operating is functional within the hospital system.

It is concluded that team functioning is partly a reflection of the hospital system is supported.

A change in team functioning is required to make it effective, and a change in hospital functioning to encourage team effectiveness is also necessary because the team is also a sub-system of the hospital.

In the next chapter recommendations for change in both structures are outlined.

Chapter VI

Recommendations

This chapter attempts to bridge the gap between knowledge of the problem and making recommendations which according to Lazarsfeld and Reitz (1976) is not an easy thing to do. According to them, no plan of action derives directly from confirmed information alone. Other elements have to be considered before recommendations can be drawn up. For the findings to point to a solution, an "invention" is needed, i.e., a specific course of action designed to change the situation. The analysis has to be "boiled down" to a choice between a few possible courses of action, then see how the alternatives compare as to ease of implementation and relative promise (feasibility and desirability).

In another important question concerning the speed of implementation, the authors suggest "incremental change", that is, changes should be made in steps to avoid the shock of sudden change with the possible consequence of the "digging in of heels" which often results in the proposed innovations

having to be abandoned. Corrections could then be made before proceeding with the next step in consultation with the policy makers who have the ultimate responsibility for implementation.

The active participation of the administration at the early stages of research makes the implementation of an innovation more likely than if they were excluded. This concept of active participation by the users corresponds to Fullan's (1975) strategy. He suggests that if all users actively participate at all levels of implementation, their capacity to implement would increase.

But he warns that conflict is always present in the implementation process even when there is initial general agreement that certain changes are desirable. This is mainly because the whole process is a complex and difficult one. It is helpful, he advises, if people did not prematurely attribute the problems encountered to bad motives or basic resistance to change, but rather to become appreciative of the fact that change is, after all, for many people an unwanted and even frightening prospect.

After describing the various process of implementation which includes such things as feedback, in-service training and periodic evaluation, etc., he concludes that successful implementation has taken place when there are changes in these four dimensions.

1. New structural or organizational features are put into practice.
2. The actual behavior of systems members change.

3. System members know and understand the purpose, assumptions and behavioral methods of implementing the innovation.
4. System members value the innovations as desirable and worthwhile.

Recommendations for system change in the teams and the hospital involves making change in the following four dimensions as described by Fullan.

1. Structure:

These would involve changes being made first administratively by rewriting the by-laws to give all disciplines the right to head, from time to time, services as well as committees. Also, more than just medical people could have direct access to the board by having a professional advisory committee to which both medical and non-medical people could belong. Secondly, internal changes would involve developing the negotiating and decision-making skills of the team to help them function more dynamically or effectively.

2. Role/Behavior:

Changes in roles or behavior would not be required if the professionals worked alone or in isolation. But that is not the case because they work on teams at the San, so expertise has to be shared for decision-making. There is a need to understand also the importance of having a particular perspective or ideology that can be linked or used on a comparison with other ideologies on a team to help decide on how to best help a patient. A clear notion of professional role and an opportunity to express this role in relation to others allows a team to interact so that it reflects the total insights from all its members. It becomes, therefore, a dynamic system that is interactive, not reactive.

To be interactive requires that the team members become knowledgeable in the techniques that will enable them to share their discrete areas of expertise. If they lack the skills in doing this so as to act as a team, effective interaction cannot occur. Knowledge and understanding is then an important ingredient for acquiring the skill to act together as well, of course, as the desire to do so.

3. Knowledge and Understanding:

To make decisions as a team, members have to learn the process of role negotiation. This method of making decisions can occur not only on the team, but at all levels of the system.

Making decisions as a team is a difficult and pain-staking procedure and it may need to be developed by an expert. Also it must be learned well and understood by all as well as practiced consistently to be perfected.

In an organization like the sanatorium, which like most hospitals is run as an authoritarian system with top-down decision-making, there will be a resistance to change. But if the team members know how to function more effectively as professionals through the use of team decision, their commitment to the process would make them value it enough to want to maintain it despite opposition from the system.

This brings us into the consideration of the next point which is Value.

4. Value:

If an innovation works for the benefit of those who implement it, it is valued. More effective performance at all levels as the result of implementing the proposed innovations would presumably influence all the employees to value it and work towards its continuance. A more effective team would also be beneficial to the patients' welfare because it implies a better consultation model for effecting better treatment for them at all levels of their functioning.

To safeguard the implementation of the innovations, a step by step procedure with consultation with all users at each step is advised. This process of "incremental change" is a good way to safeguard the innovation since it tends to reduce resistance to change which often happens if changes are too sudden or massive.

1. Structure

The most significant change to be implemented in the system would be a change in the structure and function of the teams themselves. The model to emulate for an acceptable interdisciplinary team is the one which embodies a non-medical approach, and is considered to be the most effective for adequate team work. Incorporating this model and then training team members on both teams to negotiate their roles and make decisions would

appear to be the first priority for initiating a change in the sub-system. A more effective and a more dynamic process for interacting among the members could perhaps influence changes to occur in other parts of the system as well.

Traditional teamwork would, no doubt, have a psychologist working with a social worker and perhaps collaborating on family therapy, but each would work from his own perspective while working together. These are sets of prescribed situations whereas in situations that are negotiated there has to be some relaxation regarding either procedure or discipline norms. Negotiation gives insight to new ways of working together which a stereotyped role definition cannot fully take into account. The negotiated role allows the team members to interact together to solve problems. Decisions as a team are evolved through a negotiation process which occurs when criteria and alternatives are discussed.

A change is also needed in the intake process so that instead of one intake worker there would be a team of specialists so that assessments would be more accurate.

The statement of the problem would then contain enough information to prescribe appropriate subsequent action. It is the first step in decision-making and would promote a realistic presentation of alternatives. This would mean that a social worker, psychiatrist, psychologist and nurse be part of the team. The consequence of this would be that when a case is brought to the intake team or if the patient is hospitalized his problem would be assessed more holistically and treatment would consequently be more effective.

Team members, as the data shows, understand their roles in terms of their own disciplines. That is, they are able to apply their particular professional ideology for therapeutic intervention. But they do not communicate their ideology or criteria sufficiently on the team to allow team decisions to occur. Failure to debate about criteria usually results in no decisions, or individual decisions, being made. The situation on the team is that although individuals may know their roles vis-a-vis their discipline, they do not know them vis-a-vis the teams.

Since they appear to do effective therapy because they know how to use the criteria relative to their discipline, they could presumably make effective decisions as team members once this criteria became shared or negotiated at team meetings. It would appear then that at the present time there is a need for the team to understand how to make decisions so as to function as a team.

The team functions in a hospital setting, where medical concerns take priority, are reflected by the existence of a medical advisory committee that advises the board on appropriate policies. The appropriate policies are medical priorities that reflect medical concerns. To make such a committee reflect the priorities of all the members of the team, all disciplines could be members of it and its name changed to account for all the disciplines, from "Medical Advisory Committee" to "Professional Advisory Committee".

By all the disciplines being represented, they would be legitimized in the hospital system. They would act and feel more like decision-makers

and provide important feedback for the design of policies that would be for the interest of all groups, not just one.

There needs also to be some way for the board to accommodate membership from specific agencies in the community which could feed back information to bring about changes in their respective relationships. This would allow the agencies more say into the policy-making decisions of the board.

2. Role/Behavior

Unilateral decision-making that obviates team generated criteria kills the dynamic process that produces team decisions. Team decisions should be accepted by all as the only legitimate basis for decisions and on that premise adequate functioning could be developed.

If more knowledge of the processes of role negotiation and decision-making existed in the team, it would help the members act together to produce team decisions. In this way individuals would feel a sense of commitment to the team, making it possible to play reciprocal roles and develop the skills necessary to establish an effective non-medical model that is required for an out-patient psychiatric team.

The present lack of understanding of how to make decisions allows the most powerful team member to dominate the process, encouraged in his role by the present hospital system. Education for decision-making needs to become a priority in an in-service education program funded by the hospital.

The departments such as psychology and social work, which already serve as a base for professional identity and support could also be utilized to help people become better contributors to the team. Social workers, for example, could learn to negotiate their role by presenting alternatives such as family therapy or marital counseling guided by appropriate criteria,

The department heads should assume the responsibility to train people in team skills as part of their overall responsibility of orienting new people into team roles that reflect the ideology of the discipline to be used as criteria to present for team decision-making.

3. Knowledge and Understanding

Each professional learns how to diagnose and treat from his particular educational experiences, from colleagues with whom he works, from books and professional journals. All these various learning experiences form each ones criteria for diagnosing and treating people. When an individual is alone, working in private practice, he can justifiably make decisions using his own criteria. However, working on a team with other professionals with different kinds of criteria or ideologies requires some sharing as a way of arriving at team decisions. The knowledge and understanding of role negotiation and decision-making is a vital tool to promote the kind of interaction needed so that ideologies become shared and team decisions are reached so that the patient gets the full benefit of total team therapy.

The very method of decision-making could become part of the whole step-wise procedure for teaching role negotiation, i.e., interacting on the criteria

from which tasks are evolved, so achieving two things at once. Starting both processes off is stating the problem or question clearly. If a problem is clearly stated then each one knows what kind of data is required, and what discipline works from the kind of criteria that would bring about the desired outcome, so then the case is referred to that particular discipline. If a problem is not well stated at the beginning of a discussion then no one is clear about their subsequent or related roles.

Implicit communication has to be made explicit to clear the decision-making space so people could see clearly what criteria are being considered and how do the alternatives relate to it. The freedom to negotiate is increased when each really understands what the other means by a certain action or word, or if not that he asks what it means. Explicitness marks the first step towards role negotiation because then everyone knows what each other means. Then the decision-making becomes a strategy or procedure within the larger procedure of role negotiations because once they become explicit about their criteria, it becomes clear then they are within themselves clear statements of role, e.g., "I think this is a psychiatric problem and should be dealt with by using psychiatric criteria".

4. Values

The hospital, the board and the teams need to value the innovations as suggested in order to work for their implementation as well as their continuance. The hospital itself, even though it initially supported the research which is being reported in this study, may not wish to implement some of the recommendations. This might involve too much change in the status quo which

for some could be considered as an unfavourable outcome and so cause a possible "digging in of heels". This is understandable from the point of view that they may not have seen the hospital organization as causing any problems for anyone or that it was in any crisis. So they would not be too excited about implementing any changes, especially if they resulted in a loss of power.

A change for example that the medical advisory committee be replaced by a professional advisory committee would no doubt be met with some resistance by the medical profession who would see nothing gained by conceding some of their decision-making power.

Most psychiatric hospitals presently have professional advisory committees to which all the professionals belong. It was one of these committees at Lakeshore Psychiatric Hospital in Etobicoke that installed a psychologist to run the out-patient psychiatric service in 1976.

The medical advisory council as it presently exists at the san may not be overly enthusiastic in giving a non-medical person the job of heading a service, but it is likely that a professional advisory committee, with its greater number of non-medical would enthusiastically vote for such a change. Most of the staff, including some doctors, consider the medical advisory council redundant and anachronistic as it now stands, so perhaps such a proposed change as the implementation of such a committee is not too remote a possibility.

As for board membership on some of the committees, that is a moot point.

because the board of directors, being a voluntary body, may theoretically see the values of the innovation but may not be too enthralled by having to sit through committee meetings to hammer out policies which would be required as part of their role as committee members.

As far as members from key agencies in the community serving in relevant committees for mutual input, this would seem a valued innovation for them. Many of the social workers that have accused the San of being "ivory towered" in many of their recommendations would have a chance to pull it out of the ivory tower and shed its "country club" attitude. Both could then work together more realistically and be partners in therapy.

Program Approval

In the present authoritarian climate it would be best to get the program approved by the board and the clinical director. However, their approval would not be enough. The authorities may well agree to establish a training program for team decision-making, but unless the members themselves support it, it might well atrophy. Outwardly, or perhaps in the beginning phase, they may start to comply but eventually, because they were not involved in the discussions from the beginning about whether they themselves really want it, they might feel no real commitment to implementing it.

To start the process of role negotiation informal sessions could be arranged so that team members explain their own diagnostic and treatment procedures in a study group to meet every two weeks or so at somebody's home,

away from the hospital environment. There could be as many meetings as there are members. At these meetings each one could describe his role as he sees it on the team such as what each does, why he does it, and what each hopes to achieve in the treatment of a patient. This would begin to de-mystify what each one does and is the first step in negotiating roles as it opens up communication between members about the existence of complementing patterns that make it possible for members to interact with each other. A different kind of negotiation to the one explained by Wolberg is required. Instead of roles being assigned by one person, they are established from each member's perspective of what they should be, so the interaction establishes the role which is slightly different rather than stereotyped for each case.

Once the ice is broken through these informal discussions, a formal program of in-service training could be established for each team by the head of each department. This would be continued for each new professional coming on the team. It is assumed that members would value the team and want to continue the innovation as they felt they were being more effective as team members than they are as members of a team in name only. The team also has to be convinced that the proposal to change how they function is reasonable and would actually work. Their present attitude enunciated by some of the members that they do not really want to be a team and that they are happy to leave it the way it is, could really mean that they would really like it to change so they could feel more effective in it but they do not know how to do it.

The problem of how to become a team requires more than a good feeling

for one another or an open climate to stimulate dynamic interaction. It also requires a knowledge of the process of decision-making so that negotiations could centre around the development of alternatives that eventually lead to a decision to which all members have contributed their insights. This fact was referred to by Nash (1979) who stated that training in decision-making skills would teach members how to interact. According to this author, knowing how to negotiate roles is not necessarily a guaranty that team decisions will automatically occur. However, knowing and using the processes for team decision-making stimulates roles negotiations and both processes reciprocally complement each other to create an open and dynamic team system.

In summary, the change agent, by working first of all to change the structure and function of the teams to make them more effective, could influence changes in the larger systems of which the team is a part. This is a recognition of the fact that the teams and the hospital are interacting parts, as has been shown, so that a change in one has to be accommodated by changes in the others according to systems theory.

It has also been suggested that negotiating with members of administration to effect changes in the by-laws which would allow non-medical people to have equal authority with the medical people, especially in the out-patient services to promote equal or collegial relationship among all staff members. This might also help to promote non-medical headships on services or committees so that dominance of any one profession does not occur.

Finally, incremental change is suggested here not only as a way of

reducing resistance, but to allow for the consideration of problems that may come up during the process of implementation.

For convenience, a summary of recommendations is presented in terms of a proposal for in-service education. The following outline is presented to the administration of the hospital in point form for ease in reading. These are points that are negotiated, not hard and fast rules and as such could form a basis for discussion for possible implementation.

Promoting Team Effectiveness: A Program Proposal Through In-Service Education

Problem A: Proceedings: Observed symptom: Incoherent discussion with jumping back and forth from one issue to another; absence of decisions regarding issues or cases under discussion; unilateral decisions about proposed actions by non-group members and lack of case discussion with such people resulting in ineffectiveness; lack of continuity of case discussion with no review procedures; lack of attempt to gain participation of members in discussion or in decisions.

- Solution:
- (1) Training of present coordinator in chairing and organizing meetings, incorporating proposals from team members (including the researcher) about what problems are and what solutions might be (A) by insider, (B) by outside "expert".
 - (2) Finding and training another team member willing to develop leadership skills and to undertake chairing and organizing meetings; (a) by insider or (B) by outside "expert".
 - (3) Training all team members for chairing and organizing meetings (A) and (B).

Some Criteria for Deciding Among Alternatives:

- (1) Alternative must lead to group acceptance of its own implementation.
- (2) If an individual is involved he or she must be enthusiastic about the proposal to insure active participation.
- (3) Availability of training time.
- (4) Cost of obtaining outside expertise if needed.
- (5) Incorporation of strategies for monitoring of procedures.

Additional Data About Strategies: More effective meeting should require:

- (1) Preparation of agenda and modification of agenda by chairman.

- (2) Some form of recording of procedures to prevent topic jumping, non-decisions and failure to review are obvious to the recorder and communicated by that person to the group.
- (3) Automatic review of cases with progress reports in meetings.
- (4) Attendance at parts of meetings by non-group members when procedures or cases require informed cooperation of such individuals.

Other Data:

- (1) Training time: one day of trainee and trainer. Monitoring later.
- (2) Training involves developing procedures.
- (3) Team time: two hours and feedback.

Proposal: That the team(s) undertake a problem-solving session after reading manuscript of their own meeting with the information presented above as guidance towards objectives. Training based on decision of team.

Problem B: Team ineffectiveness as decision-making about procedures and about cases.

Observed Symptoms: Failure to make decisions, failure to consider all proposed alternatives, non-statement of criteria for decisions, non-assessment of alternatives against criteria, non-consideration of future events.

Proposed Alternative

Solutions:

- (1) Training of current team in decision-making procedures.
 - by outsider
 - by insider
- (2) Training of department heads and administration in decision-making.
- (3) (1) and (2).

Some Criteria for Deciding Among Alternatives:

- (1) Alternative must involve group acceptance to current actual use.

- (2) Decision-making skills as well as knowledge and understanding will be needed.
- (3) Availability of training time.
- (4) Cost of outside help.
- (5) Consonance with team perception of what purpose of meetings and teams are or should be.
- (6) Administrative support must be gained.
- (7) Continuation strategies.

Additional Data:

- (1) Effective D.M. strategies have already been described.
- (2) Effective training procedures have been described.
- (3) Time needed for training: one full day and three follow-up sessions of half day (with monitoring of researcher).
- (4) Outside "experts" resident within 100 miles.

Proposal: That the team undertake, with the support of the hospital, a training program to help team members make more effective decisions about cases. The use of experts to train the team would be required initially and the follow-up session monitored by the researcher. The prescribed method of Dufresne involving a step by step procedure is the model to be used for training team members for decision-making.

Problem C: Lack of communication among various disciplines on the team about role and competencies.

Observed Symptoms: Failure to discuss interdisciplinary role effectiveness, failure to make explicit feelings about role expectancies of others and self, acceptance of authoritarian decision-making.

Probable Alternatives

Solutions:

- (1) Formal training sessions for group in conceptualizing role negotiation.
- (2) Informal education sessions enabling each team member his approach(es) to diagnosis and treatment, perhaps conducted in a social milieu.

- (3) (1) and (2).
- (4) Derivation of continued self-monitoring procedures.

Some Criteria for Deciding Among Alternatives:

- (1) Alternative must lead to role negotiation, adequate coverage to lead to rational decision-making using explicit criteria.
- (2) Internalization of procedures through establishment of continuing communication must occur.
- (3) Group acceptance of alternative needed.
- (4) Availability of training time.
- (5) Cost of outside assistance.
- (6) Group must be able to modify to its own needs the input from outside experts through internal support system.

Additional Data:

- (1) Lack of negotiating climate on team, tends to be repressed.
- (2) Members accept assigned roles.
- (3) Attempts to reinterpret to other the assigned role are ignored.
- (4) Lack of empathy results in the continuance of discrete rather than complementary role.

Proposal:

- (1) Informal sessions needed to "break the ice" and get members talking to each other.
- (2) Explain their own role to others in the informal session for their own and other's classification.
- (3) Informal sessions continue until all team members defined roles.
- (4) Inside or outside trainee is needed to lead the group and encourage the continuance of negotiation.
- (5) Team itself should define the problem and propose the solutions.

Other recommendations included board members taking a more active role by also participating on the committees so they would know the meaning of the policies they were making and their effect on the people who had to live with such policies.

I thought I would hear some sort of reaction to my recommendations but nothing came of it, so I decided to discuss my findings with the administrator to get her feelings. She said she agreed with some of the proposals, but "she'd have to think about what to do about them". Her main feeling was quite defensive in that she did not consider that there really was much wrong with the way the hospital was functioning, "especially now because there are some real smart people coming onto the board". Also she felt that the hospital's relation with the community were "never better".

But she did admit she felt lonely in her job and somewhat isolated from the professional staff especially and would like to make arrangements with the psychiatrist of the out-patient team to permit her to sit in at one of the team meetings to familiarize herself as to how people did their job and the problems they were having. She then asked me if I could arrange it so she could sit in which I agreed to do. As I left, she said it was good to talk about problems openly and she hoped that it might occur more often, and that she was looking forward to meeting with the team "to get to know my staff better".

I left with the feeling that what I had experienced with the administrator was an open type of communication which if nothing else helped to lessen a mutual sense of isolation and what could be the beginning of change.

When the study was completed I decided to present my findings to the administrator, the psychiatrist, and the chairman of the board of directors of the psychiatric hospital as shown in Appendix D.

I outlined in general the problems of the hospital and the teams and how the problems might be resolved if certain recommendations were implemented. Specifically, I pointed out how there would need to be greater opportunity for more open communication between the hierarchy and staff. (See Appendix D) Internally, equality between the professions could be obtained by creating a professional advisory committee to replace the medical advisory committee and that all professionals should have equal opportunity to occupy the headships of services as well as the major hospital committees. The letter also recommended that personnel from the social and health agencies from the community who most frequently used the hospital's facilities should be invited to participate on the committees to link the hospital more meaningfully to the community and lessen its isolation.

Chapter VII

Summary and Conclusion

The thesis studied and compared two out-patient teams - one adult, the other adolescent within the context of a community psychiatric hospital.

To summarize the study a short review of the chapters is presented followed by a conclusion which emphasizes the main points.

In Chapter I, the introduction, a description of the study is given which describes the teams and the hospital as associated systems so that the functioning of one, the team, may be accounted for by the larger system, the hospital. A system may be open or closed, the former resulting in growth and the latter resulting in stagnation. With this underlying concept to furnish a perspective for understanding the interaction of the team within the hospital context, the psychiatric hospital is described. The hospital appears to function as a closed system characterized by top-down decisions which tends to hinder communication and feedback especially at the team level.

Chapter II presents a review of the literature on work teams functioning in hospitals and other settings with special reference to team effectiveness, role negotiation and the organizational concept of teams. The review also suggests the usefulness of general systems theory and symbolic interaction as a way of understanding team functioning within the hospital system. Effective teamwork was considered to be realized when team members negotiate their roles allowing team decisions to be made.

Symbolic interaction which deals with each individual's perception of reality is seen as the basis for understanding team and organizational behavior. From the symbolic interactionist perspective, all reality has a negotiated existence which makes interaction an outcome of each individual's perceptions. As perceptions change behavior changes which is important in considering techniques for change. The way individuals interact in a group eventually evolves into a system held together by the kinds of overtures people make towards each other. As individuals act within their roles a system of interaction develops.

Systems operate from interactions that relate to the interpretations of each participant in the system. Systems vary as interactions vary which in turn depends on the way each defines a particular reality that confronts him.

Teams have to be understood beyond the roles of each member to the kind of environment in which they function. The environment in which the team functions is a closed system where the upper administrative levels maintain the status quo by reserving significant decisions to itself.

In Chapter III the methodology is described and the data collected relates to the two questions which are to be examined. The data source for question (i) to determine team effectiveness or ineffectiveness was obtained from tape recordings of team meetings and interviews. Interviews and the analysis of the hospital structure provide answers to question (ii). Coding was used as a convenient method to identify types of role negotiation and steps and procedures in the making of team decisions. Interviews were open-ended to allow each individual to express freely his own feelings about the team and the hospital.

Problems of research, especially those of the inside researcher are outlined and the difficulties around maintaining objectivity are discussed. Idiosyncratic or subjective interpretation is lessened by the use of triangulation. Different data gathering techniques enable phenomena to be assessed from different perspectives thereby increasing its validity.

Chapter IV shows the results of the study in respect to questions (i) and (ii). The teams cannot negotiate roles to make team decisions. They tend to operate from the medical model which is supported by the hospital system.

The interviews indicate that lack of team decision-making stemmed from inability to share perspectives, or in other words, negotiate roles which prevented team decisions from occurring.

In Chapter V the substantive findings are analyzed in respect to team interaction and team-hospital relations. Through the analysis of the reports

from team meetings and interviews it was shown that a further study is needed to ascertain whether or not team decisions can be made using the coding and literature as a guide. It was noted that both teams lacked the knowledge of decision-making procedures.

In respect to team-hospital relations, it was found that the malfunctioning of the team is a reflection of the hospital system. The inadequacy of the team was associated with the closed hospital system which undermines negotiations and so prevents the occurrence of team decisions. The hierarchical closed system negates the development of an egalitarian climate needed for team effectiveness.

Chapter VI described needed changes in the teams and in the hospital structure so that both could function more adequately. The teams are not effective because they lack decision-making skills, and role negotiation is not an accepted team activity. With training in decision-making they could make better decisions that would involve the negotiation of roles within the formal team meetings.

For improved hospital functioning, rotating headships for services and committees were recommended. Each discipline would have the chance to lead these bodies so that each ideology would be equally respected for its use as a therapeutic modality, and the medical model would no longer be seen as the dominant specialty. In this way, power could be more democratically distributed with an opening up of channels of communication.

The replacing of the medical advisory council with the professional advisory council would be another way of recognizing the legitimate contri-

butions of all professional staff. Bringing board members onto the committees as well as encouraging other agencies to participate as hospital board members, would have the effect of bringing the hospital closer to the community it serves and make it less a psychiatric fortress and more like a community hospital.

Conclusion

From the study it is concluded that for effective team functioning members should know how, and become willing, to negotiate their roles to make team decisions.

However, the teams' effectiveness is a reflection of the effectiveness of the hospital hierarchy which makes unilateral decisions after secret or informal discussions. It acts as a closed system, discouraging feedback from subordinates.

Consequently the teams become ineffective as decision makers, allowing those who already have the designated power to make the decisions, which in turn heightens their feelings of powerlessness and reinforces their alienation.

From a methodological viewpoint, the thesis presents a way of studying phenomena through the methodology of participant observation and from the perspective of an inside researcher whose struggles to remain objective were aided by adherence to the triangulation process. Tape recordings proved especially helpful in the gathering of data from team meetings and interviews

where distortions could most easily take place, especially as the researcher is also an employee.

However, the dearth of documents and memos which could have given a more accurate perspective of the hospital itself and the unwillingness of the administrative staff to be helpful, allowed the perceptions of subordinates to be given more weight than may otherwise have been the case. This could have resulted in a weakness in the accuracy of the assessment of the hospital organization and some of the changes being advocated. To some extent the interviews compensate for the above weakness to give some depth to the study for what it lacks in breadth or scope.

The rationale for advocating changes in the hospital as well as the teams is to achieve dynamic balance in both, so that the wider system supports the sub-systems and vice versa. A closed hospital system and an open team system is unbalanced.

Since equilibrium has to be established for any system to keep functioning, the hospital since it is the larger system, will act to establish a balance between itself and its sub-system (the team). The result will be that the team's attempts to change to an open system will not be successful. Then all will remain the same despite attempts to make changes.

The policy changes in the team and in the organization have to occur simultaneously so that a similar balance will be achieved by both and the changes will have some chance of permanency.

One of the important results of such a change besides a better functioning of both systems is better care for the clients that come to the hospital for help. Professionals who are encouraged to find their own answers are more likely to encourage their clients to try to do the same.

Limitations of the Study

It must be cautioned that this research presents merely one aspect of team effectiveness which is the ability to make decisions as a team.

The teams in the study were examined for only this characteristic which has nothing to do with their effectiveness, as for example, a therapeutic device, a cohesive body, or as a unit of professional expertise, or even as an example of bureaucratic efficiency. It may be all of these, and so perhaps it is illogical to call for changes when these other important variables are not taken into account to see whether the team is basically doing its job because patients may be, after all, getting better.

Some, as it was shown, do not feel the team is an appropriate place to talk about patient care because of the problem of confidentiality. It may be a good place to talk about alternative types of therapy, or maybe planning for a social get together. Others feel more comfortable in having informal ad hoc discussions when they want another opinion.

Most agree however, that the team should be more systematized to work together and that better communication might be a good way to start.

Application of the Study

The thesis presents a systematic method of assessing the effectiveness of a multi-disciplinary team of professional workers in a psychiatric setting. It also illustrates the influence of the hospital system on the function of the team.

Although the study was limited to two teams in the out-patient department, it would appear that the findings could have wider applicability for other teams in similar settings or even in different settings. Team decision-making is an effective tool in cases where problems are multi-causal and require the focusing of different perspectives for effective therapeutic intervention.

Team decision-making is needed so that multi-causal or a systems approach to therapeutic intervention could be achieved. As was shown, knowledge of the need for consultation is not sufficient to have consultation take place. The question then arises as to whether individuals will bother to contribute their insights at a team meeting even if they know it is necessary to make them and their team effective.

The answer to that could perhaps be obtained in a follow-up study by designing an experiment to see if people in a team use the decision-making techniques they have been taught. It might be that this kind of team with interdisciplinary people in it actually neutralizes the collective skills of its members as some people think it does, so that the psychiatric team represents a reverse application of systems theory to the extent that the whole becomes less instead of greater than the sum of its parts.

Consequently, no hard conclusions are to be gleaned about appropriate team functioning from the foregoing study, since the thesis merely represents an exploratory approach to the problem. The study is quite limited, since evidence itself pertained to particular variables (role negotiation and decision-making) to the exclusion of others.

However, as limited as it is, it has arrived at some reasonable conclusions in particular areas in the sense that part of the totality of problems have been examined.

Therefore, the state of knowledge in the area covered by the subject is tentative until more evidence becomes available to develop perhaps a more adequate theory to account for how teams actually do function.

What the thesis also does is point to the need for another study using the elaborated framework described here to investigate the effects of team functioning related to:

- (a) Training in decision-making per se.
- (b) Training in role negotiation per se.
- (c) Training in both decision-making and role negotiation showing linkage between the two in terms of:

Improved patient treatment outcomes.

Improved patient feelings about treatment and treatment facilities.

Improved morale among staff, etc.

Such a study could be funded by the Canadian Mental Health Association or by other Federal or Provincial Health Ministries since the cost of team meetings at present is high and wasteful of resources. Yet teams are necessary in the context of a lack of psychiatrists especially in the remote communities of the north.

Appendix A

Transcript of Adult & Adolescent
Out-Patient Team Meetings

Co-ordinator	- Co.	Psychologist	- Psyl.
Intake Worker	- I.W.	Medical Doctor	- M.D.
Social Worker	- S.W.	Occupational Therapist	- O.T.
Psychiatrist	- Psych.	Child Care Worker	- CCW.
Clinical Director	- C.D.		

TEXT

D.M.

R.N.

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Co. Let's discuss the intake team in regard to transfer forms (from in-patient's), backup, emergencies, coverage for (R) (intake worker), that if the case belongs to somebody in therapy whose going to handle it when they have to be admitted.

P(b)

I.W. We did have a few discussions at our intake team meetings about this with (J) (psychology) and (C) (social work). But we need a procedure for appointments where patients come between appointments that are possibly for admission. What we felt should happen to that person is that whoever is treating him should take time out to fill in the intake form saying what's going on, then present it to the intake worker.

P(b)

TP(t)

A1

Co. Doesn't the intake worker see the patient first?

C

I.W. See what's happening now and make a report

A2

Psych. Does the report have to be on an intake form or on a progress note?

C

I.W. The form is easy to use. Just fill it out, it's easier than making a progress report. It all has to go back to the intake worker anyway.

C

TP(t)

Psych. Why go back to the intake worker when the case is already being handled by the intake team?

P(b)

TP(t)

Co. You said you wanted it that way for consistency. You only wanted to deal with the intake worker coming to you for admission.

C

I.W. You wanted to handle it as a straight-forward emergency.

C

TEXT

D.M.

R.N.

Psych. I don't like to make rules.

I.W. That's the way it should be.

Co. It's better organized this way.

Psych. It's O.K. with me, but does everybody agree to this? We should have a case conference about it. It's a good way to keep track of referral cases, but is it appropriate for cases already in therapy? Perhaps I should consult with the therapist, not the intake worker.

C
C
D(j)
A

I.W. But where the patient appears suddenly and his therapist is away, we need some kind of format for dealing with him. This is only for cases to be admitted to hospital, not for others.

C
P(b)

Co. That covers the people that have to be admitted. What about the others who drop in and are being worked with?

P(c)

I.W. Okay, for instance when the regular therapist is on holidays or not here and his patient wants to be seen. What does he do? That is the problem of the treatment team.

P(b)

Psych. If someone is going on holidays, they should arrange to transfer their cases to somebody accompanied by a brief not about what they should expect.

C TP(o)

S.W. That could be arranged informally.

C TP(n)

I.W. These patients have already been discussed at treatment team meetings and the treatment team should be aware of what's going on with them. This is the treatment team's problem. If there is no provision, they'll just be picked up again at intake.

C

Psych. Everybody is carrying a caseload. They should know how many active cases they have. When they are away, have somebody look after the active caseload for them. The others are inactive and so should be handled at intake when they come in for treatment. If they need medication or a repeat of medication, they can be probably seen by the nurse.

C TP(n)

Co. Then we go back to the old routine where the nurse sees everybody.

C TP(t)

TEXT

D.M.

R.N.

Psyol. Or maybe it should go to the coordinator

C

Psych. Yeah, it's up to you to coordinate.

C

S.W. I think we're making too much fuss about this. It doesn't happen that often.

C

I.W. It happens often enough. I saw two last week that were (J) 's patients. I'm not saying it was dumping, but he saw her late last night, then told her to go to intake the next day. The other one was legitimate because the psychologist sent him over for admission but the guy didn't want to be admitted. I never received a note from either one of the therapists. If it happens enough, I think there should be a set of procedures.

P(b)

TC(da)

S.W. Isn't this something that should be discussed on the treatment team rather than have it discussed at a general team meeting like this?

P(b)

TP(aa)

I.W. Both treatment and intake teams should be responsible for developing some procedure. As it is now, people are just sent over to be admitted or to be interviewed and we don't have any history on them.

C

TP(t)

S.W. The coordinator should sort it out.

C

Co. I don't see it as my problem.

A1

I.W. Nevertheless some procedure should be developed.

C

Co. Everybody here is on the treatment team, let them come up with some procedure.

A2

S.W. Moving right along!

Psych. I thought the purpose of backup on the intake team was to handle emergency problems. The intake worker has the backup of (C) and (J) to look into emergency cases like that.

C

TP(t)

Co. In these cases, the backup is not there.

Psyol. The backup is only used when full assessment is required such as in cases where psychiatric disorders are severe or complicated.

C

TP(t)

<u>TEXT</u>	<u>D.M.</u>	<u>R.N.</u>
<u>Co.</u> Another question that the treatment team has is: What are you using to go from out-patient service to the wards, transfer forms or history?	P(b)	
<u>I.W.</u> Sending transfer forms plus a history, but I present it first verbally and full assessment is recorded within 24 hours of admittance.	C	TP(n)
<u>Psych.</u> As long as nurses on the floor have adequate information to start a treatment plan is the main consideration.	C	
<u>M.D.</u> In my mind the professional responsibility is still a big one. I think of the legal implications. I'm the one who admits the patient. If the lawyer says, "Why did you admit the patient" and I don't have very good grounds since I'm just a medical doctor and not a psychiatrist. I can't say to him "The nurse interviewed this patient and on her statement I admitted him". Is that legally correct? Maybe I'm afraid of things that don't exist, but I'm still the one that is being nailed eventually.	C	TS(i)
<u>Psychol.</u> This is a crucial issue because it initially involves an assessment of the patient's status by the intake team. Either intake assessment is a proper one or it isn't. If it isn't, let's go back and look at it and change it. But the intake process has already been agreed on and approved by the Medical Advisory Committee, the hospital and the team itself. It is a procedure that is established and working and so at that point the person the lawyer should talk to is the psychiatrist who is the head of this unit.	C	
<u>Co.</u> Now the problem is backup for intake.	C	TP(o)
<u>I.W.</u> Yeah, well we felt all team members should be backup for the intake worker. We don't know yet how it should be done, maybe on a daily rotation basis. (J) and (C) still have to be available; that's a different ball game.	C	TP(t)
<u>Psychol.</u> If (C) and I were the only one's providing backup - the intake team would be self-sufficient which wouldn't be a good idea. All the team should share is the intake process.	C	
<u>Psych.</u> I agree, then everyone would get to know what's involved in the intake procedure.	C	TP(n)

MEETING II

TEXT

D.M.

R.N.

Psyol. I have to transfer. (R) saw somebody and asked me to have a look at it as well. My observations weren't that much different from yours. I saw him as needing to acquire some interpersonal skills. I spoke to him about group therapy. I don't see him as having substantial psychiatric problems. He wanted to know more about what happens in group because he hadn't the foggiest idea of what a group process was all about.

P(i)

TP(t)

I.W. When did you see him?

Psyol. Yesterday...go on...

I.W. Well, it just doesn't seem like the proper procedure.

C

Psyol. Well, what is the appropriate procedure?

I.W. You and I should have met together to write up the assessment before this meeting. You by-passed me.

C

Co. If we are going to set down procedures we're going to have to follow them.

C

Psyol. Mia Culpa, I am guilty of violating the proper procedures.

S.W. Is that a venial or a mortal sin?

Psyol. Does this mean I'm kicked off the intake team?

Co. Nothing that easy. For penance you should be intake worker for the month.

I.W. Now you're talking! I'd like that.

Psych. I've got a case for you (J), a real monster.

TP(t)

Psyol. What did I do to deserve this?

Psych. There has been a lot of psychometrics done by (J) while she was here and maybe something more could be done in this area.

P(b)

TP(t)

TEXT

D.M.

R.N.

Psyol. I think there's a lot to be done now other than psychometrics. Both husband and wife need a kind of support system. They should be seen on a regular basis to develop insight.

P(b) —

Psych. What we need for a woman like that is a group experience to build up her ego. I've got the two of them now and I don't know what to do with them. The husband makes the wife's sickness a sort of hobby.

A1

TP(n)

Psyol. With these two I think its important to limit them to the services that are available. Right now they crash in whenever her husband thinks there is an emergency. All we do now is patch them up and send them home. I think she's just "schizy" and her husband doesn't know how to help her.

C

TC

Psych. Her husband is in the civic government where they all get flat heads from stepping on each other to get to the top.

Psych. (unit head) How about meeting the situation head on. Tell him he's having all his needs met by her being like that and that he really doesn't want to change...and this is what she wants too.

C

TP(t)

Psych. Maybe we should just concentrate on treating her for now.

C

Psyol. But he's got very strong dependency needs. He'd come back forever. Anyway, she's got no motivation for treatment, the motivation is entirely his.

C

TC

Psych. He wants me to agree with him that she's the crazy one.

A2

TC

Psyol. We don't know what to do with them. We're still stuck where we were a year ago.

C

Co. Why don't you just get rid of them.

A3

TS(a)

Psyol. You may be right.

C

S.W. This is more of a relational type of issue than an individual one. I think both of them are screwed up when you look at it interpersonally. The guy is really well grounded into his role and he has grounded her into her role and she's accepted it. No matter how much we build her up here, he works on her the rest of the time to fit into the role he wants her to take up.

P(i)

MEETING III

TEXT

D.M.

R.N.

I.W. I have an intake. It is a case initially seen by (J) some months ago. She was thinking of killing herself so I referred her to Tom for possible admission. She was separated from her husband for about a year but now wants to get back with him but the mother-in-law tries to stop this. Part of the reason she wants to go back is because she can't find work even though she is a trained secretary. She didn't want admission when I talked to her. I gave her some pills to hold her over the weekend. When she returned he felt she didn't need admission to hospital and might be better treated as an out-patient.

P(s)

TP(t)

Psych. (J) when you treated her last June, you surmised that her lack of self-esteem, lack of goals and paranoia as well as constant marital conflict were the contributing factors to her illness.

P(i)

Psyol. Yes, but after I did therapy with her she seemed to come out of her shell.

C

Psych. Well, she doesn't do well on pills. She needs some tangible things to lock herself into. I wondered about her relationship with her husband. He has an empty house with no furniture and she has an apartment full of furniture. He comes to visit her the odd time, usually when he can't stand his own cooking. They need some resolution to the marriage, either work at it or forget it.

C

A1

Psyol. I feel skeptical about their ability to resolve their marriage in any direction because of all the previous fighting and the way he consistently puts her down. Of course she does the same thing with him. They are continually embroiled in conflict because neither of them seem to be able to come up to the other's standards. They continue to feel they are a failure in the other's eyes.

C

Psych. I'm wondering if her husband could be seen alone by somebody. Either get involved or screw off.

A2

TS

Psyol. Weekly sessions with me were never enough for her. We were always teetering on the point where she was ready to fall apart. In her relations with her husband and with other men, she would set herself up to be used, then be bitter about them taking advantage of her.

C

TEXT

D.M.

R.N.

Psych. Also, she can't stand her husband because of the way he treats their child. He teases, ridicules and is sadistic with him. She can't stand up to him when he does this.

P(i)

S.W. How do you develop ego strengths in her so she can control some of what's going on.

C

Psyol. I try to get her to work on some of the echoes from the past, feelings towards her parents and the feelings toward her husband, separating the real from the historical.

A3

TC

Co. Are there any other cases to be brought up?

Psych. I've got a problem about the way that children's section relates to us. They plunk kids into the hospital without telling me, and then I'm supposed to look after them. They still find a way circumventing our intake. I saw the kid on the floor, he was like a zombie, semi-autistic, can't form a relationship with the other kids. He was taken from the parents because the CAS from advice given by our social workers saying the child was being abused. Then the social workers gave shit to the parents, the case blew up and the mother came complaining to me. She had been a patient of mine previous to this so-called child abuse situation. Everybody seems to be working at cross-purposes. We need some kind of a unified approach so that something like this doesn't happen again. If they are going to handle cases like this, they need to utilize a team approach, not just cut off bits and pieces and work at them.

P(b)

Psyol. Why aren't the child care services using their own child psychiatrist to refer these kinds of cases to instead of you?

C

Psych. I wish I knew what the hell she was there for.

C

Co. They probably figure that she doesn't want to get involved.

C

Psych. Maybe in that case they should send cases like this out of town to be assessed.

A4

TS(i)

S.W. It sounds as if the child care services should adopt some kind of intervention policy instead of handling their cases on an "ad hoc" basis.

C

TEXT

D.M.

R.N.

Psych. If they can't get a proper assessment of a child, maybe we should try to get them done at the university.

A5

TP(o)

S.W. But I think that's their responsibility. Why isn't it sufficient to tell them how we want cases referred to us.

C

TP(o)

Co. They already know, but by-pass the procedure anyway.

C

TP(o)

I.W. Why don't we get together with them to discuss the appropriate ways to handling cases when they involve us on the adult team?

A6

TP(o)

Psyol. When it involves adults, where does the child service stop and where do we begin? This overlapping always occurs when the parents have to be brought in.

C

TP(o)

Psych. If all intake went through (R), they could be brought up and dealt with at regular case conferences here so that proper intervention could take place.

A7

ND

Co. I have another transfer I'd like to talk about. She's an in-patient and her child is also getting treatment in the Child Care Service, a 12 year old mental defective. A social worker from Child Care has been working with the mother and child. She got the mother to agree to permanently separate from her husband and take the two girls with her. Last week when the social worker saw her, she decided she now wanted to go back to her husband. The social worker doesn't want to get hung up on a marital case, so would like someone from here to pick it up.

P(b)

TP(n)

Psych. Doesn't the social worker in Child Care have adequate training to handle this case? The idea was to help this patient work through her decision to finally separate from the son-of-a-bitch whose never involved himself in any of her hospitalizations, never communicated with anybody, and treats her like shit. She got all the support of the family to separate and everything was rosy, but as soon as she gets involved with her kid back here, her husband makes a complete reverse, and starts communicating and working like hell to do everything to get her back. It's back now where she's just a quivering hulk in a hospital again. It needs somebody whose not aware of the situation to come in fresh and neutral and deal with these people and see what the hell they want.

P(i)

TP(o)

C

TP(o)

TEXT

D.M.

R.N.

Psych. In her case there appears to be quite a bit of disordered thinking.

P(s)

Psych. We have to accept the fact that she just regresses, but when she made the decision, she had good reasons. She'd been putting up a bluff to her family that her marriage was fine, that everything was great; it was her that was at fault. She was just unable to look after her children, her husband was a great worker, but in reality he was a shit.

P(i)

S.W. Maybe she needs to be a doormat.

Psych. I don't think so because she's desperately unhappy.

S.W. But there seems to be ambivalence here.

Psych. I don't think it's so much ambivalence as it is indecision.

Psych. The husband would never come in, never see a social worker or anybody that was involved with treatment of her.

Psyol. At what point does a case that has been treated in the child service become an adult case? The focus at their end is dealing with the parents in relation to the child, not in relation to each other. This is not an easy issue. I got another example of that kind of thing. It didn't go through adult intake in the usual process. I'm not sure how intake could solve the problem about these situations. The situation I'm referring to is where one of the couple's children are also being treated in child care and the couple not only want the child treated but their marital problems treated as well. So the worker brought the case to me and asked me to be her co-therapist. She, however, was not able to follow through on the case so I needed someone else from my department to help me with it. Now, two people from the adult service are working with the case, but we haven't opened up an adult chart on them, which would be the appropriate thing to do. At first the kid was the identified patient, but then as the couple's relationship got better, he got better. The issue now is, what is happening to their marriage? I bring this case up as an example of the kind of thing that is happening that we as a team need to talk about. I don't think they should be going through intake, but we should be working out procedures about when to transfer from child service.

TP(n)

P(i)

P(i)

TP(o)

P(i)

TP(o)

TEXT

D.M.

R.N.

Psych. Somebody needs to work with him and somebody needs to work with her, then get them together afterward.

C

TP(n)

Co. Let's get back to the other case.

A8

Psych. As far as this case is concerned, he's never been involved in any of her admissions; now he's coming in and mixing her all up. The nurses on the floor feel this couple needs a male therapist.

A9

Psych. I'll see him.

A10

TC

Psych. No, this case needs more marital therapy than psychiatric involvement. I think a social worker should see him.

A11

S.W. Maybe I should see him then.

D(j)

Psych. Yes, now I would like to bring up a problem that concerns patient information from the in-patient service when they transfer a case to us in out-patients.

TP(o)

P(b)

Co. The nurse from the in-patients is meeting with us tomorrow regarding the use of new transfer forms.

I.W. I hope the meeting clears some of our problems up.

C

Psyl. I thought we already finished developing the transfer forms.

C

Co. We are finished until we get everything typed up.

Psyl. But there hasn't been any since.

Co. No, we'll call a meeting with the treatment team to discuss these new forms when they're finished being typed up.

TC(aa)

D(i)

MEETING IV

<u>TEXT</u>	<u>D.M.</u>	<u>R.N.</u>
<u>I.W.</u> I have 3 university students that need therapy. (B) said she would see two of them. (T) has seen one and has requested an MMPI.	P(b)	TP(t)
<u>Co.</u> When are you going to present them?		
<u>I.W.</u> Well, if (B) (S.W.) wants two of them and (T) wants to hang on to one of them till he gets the results of the MMPI, we'll just have to handle it like that.	A1	TP(t)
<u>S.W.</u> I'm a little confused. I thought we developed an intake procedure to avoid case distribution in the halls.	C	
<u>I.W.</u> Well, we aren't going to be here Thursday and people that have done some kind of assessment of these cases...	C	
<u>S.W.</u> That's the point. People have done some assessment. I was under the impression that all intakes would go through you, and they wouldn't be touched until they came into a meeting and were decided upon.	C	TP(t)
<u>I.W.</u> Okay, because the people that came in I needed to talk to somebody about them because they were difficult, complicated cases and the two consulting people were away. (B) was the only person around.	C	
<u>S.W.</u> At that point (B) has filled in for somebody else's position as backup, but that still doesn't get past the point that it was a consult and I was under the impression that they were brought into the meeting and presented and people decided who wanted them.	C	TP(t)
<u>Psych.</u> I think they were acute crises that had to be handled and they all came in at one time. Something had to be done right away. They should have been handled by a university counselling service.	C	TP(o)

TEXT

D.M.

R.N.

(B) and I thought of arranging a meeting with the university's social work department and getting some of this straightened out. The medical doctor there precipitated the crisis and we have to handle it. Anybody with half a brain would have sat down with these people and dealt with it there and then.

A1

TP(o)

S.W. I'm still worried about what happened at intake.

C

I.W. We can't discuss these cases now; they have already been taken care of. It would be unfair to (B) to give these cases to anybody else on the team.

A2

S.W. We need a consistent policy so something like this doesn't happen again. This is exactly opposite to what we are trying to do.

C

I.W. We'll have to look at our procedure again because it doesn't cover emergencies like we just had.

A3

Psych. I think the patients are defining what kind of contact we have with them. Some of them can be handled on an intake basis, but when we function as a crisis clinic we need to use something extra.

C

TP(t)

S.W. That's why there's the social work and psychology backup. Nothing is that important that can't be handled by the backup and then be brought to the next meeting and discussed. But that is bypassed by the hall pickups that we are trying to avoid.

C

TP(t)

I.W. There's no hall pickups except these two which happened when the two backup people were absent.

C

S.W. Emergencies or crises are not covered by intake policy.

C

I.W. We'll give it one more chance this week and see how the backup works. If it doesn't we should scrap it. The intake as it is, is tying my hands for getting rid of anybody who I think is a crisis thing. If I'm to follow the procedures, I can't do anything about crisis except the one's for admission and that's because the doctors have agreed to pick them up and admit them if I feel that is necessary.

A4

TP(t)

<u>TEXT</u>	<u>D.M.</u>	<u>R.N.</u>
<u>S.W.</u> Why do you have to rush in, why not have a waiting list? The (G) Hospital is supposed to handle emergencies.	A5	
<u>I.W.</u> But some of the people require help from us and we can't just send them away.	C	
<u>Psych.</u> Sometimes when we handle emergencies, it's just enough to clear them till someone else comes along to deal with the problem more in depth.	C	
<u>S.W.</u> But that's the whole purpose of backup, to deal more appropriately with the emergency. Then they would deal with the case, then later bring it up at the regular meeting.	C	TP(o)
<u>I.W.</u> But they have the option of taking up the case at intake.	C	TP(t)
<u>S.W.</u> Do they have the option to pick it up at the moment they deal with it?		
<u>I.W.</u> No, no, at the treatment, at the discussion.	A6	
<u>Psych.</u> It seems to me we are being asked to play too many roles. The way we have things set up is too inflexible. We end up by breaking the rules of our own system.	C	
<u>I.W.</u> That's true, at least it's been true of the last week.		
<u>Psych.</u> We are usually under pressure and often short-handed, so in cases like that you've got to learn how to improvise.	C	
<u>S.W.</u> Where the hook up here is, not so much the when and how of intervention, but the flexibility. When one member is absent the whole system dies. So we sit here and say, let's wait for another week until these people are here so we can present a case. It's crazy. The bind is, if we are going to have some policy where cases are presented and people pick them up, we stay with that. Otherwise, we say that any crisis that is handled by backups or anybody else at the time has the option of picking it up or not. If not, it comes here to the general meeting.	P(b)	TP(t)
<u>Psych.</u> We should have a policy people know about instead of people jumping in and taking over.	C	

<u>TEXT</u>	<u>D.M.</u>	<u>R.N.</u>
<u>Psyol.</u> Along the line, personal needs and service needs have to meet. If you're talking about developing policy, personal needs have to become secondary to policy needs.	C	TP(o)
<u>S.W.</u> What I see as the problem is, we make a rule and break it. We can't seem to maintain any consistency.	C	
<u>Psych.</u> Patients define treatment needs. In extreme cases we need to improvise a little bit.	C	
<u>Psyol.</u> We're looking at 2 different kinds of cases, crisis intervention and regular types of cases. What we're talking about now is that crisis cases will be seen and "band-aid" applied. What about the circumstances where particular crisis cases are perceived to need some continued crisis intervention. What we're saying is that nobody attaches themselves to a case unless it goes into a treatment meeting at which point it is disposed of. I guess for these kinds of cases it is a problem if the meeting is only once a week because for some types of cases their own urgency is really unjustified, whereas with some others the urgency is justified especially if they're on a heavy dose of medication, so somebody should check on them if they are undergoing a crisis, but now we don't have a way of doing that.	P(b) C	
<u>S.W.</u> The intake team has the option of continuing with the crisis intervention.	C	TP(t)
<u>I.W.</u> Or the option of saying whether they are crisis or not.	C	
<u>Psych.</u> I think the intake consultants should have the right to allocate cases.	C	TP(t)
<u>S.W.</u> But the allocation of cases should be (M)'s job.	C	TP(t)
<u>Psych.</u> No, it should be the job of the whole intake team when they meet.	C	TP(t)
<u>Psyol.</u> We don't get much of a chance to meet, there are so many other commitments.	C	
<u>S.W.</u> Maybe the wrong people are on the intake team. Others might have the time to give it to do the job properly.	C	TP(n)

TEXT

D.M.

R.N.

I.W. Let's give it another week and see what happens.

A8

S.W. You should be looking at other staff members to fill the positions.

C

TP(n)

I.W. They should clear their books of appointments and work at it as if it was really a priority with them. I'll have to see what the present members will do and assess their performance next week.

D(i)

MEETING V

TEXT

D.M.

R.N.

S.W. (passing out forms) This is the work your glorious intake team has done. The idea is for everybody to go through the document and see if there's any problems you can find with it, discuss it here and decide what changes you want to make. Take 20 minutes to read through it and then we can make some comments. The intake policy and procedures are included.

TP(t)

Psych. There are some doctors who would not accept 4E of the intake procedure that says doctors will accept the request for admission by the intake worker after the initial assessment. Some might decide to throw the goddam thing out. Instead you should have inserted "may accept".

C

TS(a)

S.W. So what we are essentially saying is that the intake people may make any kind of assessment they like, but there's no guarantee that the patient will be admitted.

C

Psych. There may be other mitigating factors such as the patient's physical condition which would make him a better candidate for the (G) Hospital.

C

TC(aa)

I.W. I don't see there's a problem with the way it's done and this is the third time it's come by here and it's been accepted. There's a full assessment by one or two persons from the intake team which have concluded that admission is necessary so that should be enough to warrant admission. Now you're saying (T) that it's not enough any more. It's still the doctor's decision regardless.

C

TC

Psych. He has the responsibility for the case after the intake worker has seen him. Some doctors won't accept everybody for admission that you do an assessment on.

C

TC(aa)

I.W. If it's completed appropriately I can't see why not. So far I've had no problems with that.

C

TC

Psych. That may be true, but when policies become "etched in stone", some doctors won't accept that.

C

TC(aa)

Psych. Well in that case why bother to have an intake assessment and an intake worker?

C

TEXT

D.M.

R.N.

S.W. This means that we would have a doctor for a consultant at intake to provide that kind of information.

C

TP(t)

Psych. If admission is indicated the doctors just can't accept the evaluation of the intake worker. That's not enough.

C

TC(aa)

S.W. What then is the role of the intake worker? Why go through this intake assessment? There's a tremendous amount of information, so what's the use of the doctors doing the same kind of thing?

C

S.W. The doctors seem to be asking for a pre-screening process to weed out a lot of the crap and then get to the nitty-gritty.

C

TP(t)

Psych. The only bone of contention is the idea that it is irrevocable that the doctor will accept cases for admission on the advice of the intake worker.

C

TC(aa)

S.W. If I looked at a document which said, "The social worker will...", and I didn't feel it was a social work task, I would have some reservations about accepting it. So I understand (T)'s feelings about the "will" as it relates to the doctors.

C

TC(aa)

Psychol. If we are setting up intake procedures in a sequential, logical way, then by the insertion of "may" instead of "will", the implication is that the whole thing is "thank you very much for making the assessment but I'll do my own". This means that intake doesn't require the elaborate procedures we set up. If I were coming through here as a patient and sat down for an hour and a half and provided a lot of detailed information to somebody, then had to say it all over again to somebody else, I would say, "Hey, don't you guys talk to one another, don't you have some communication about this information I have given? Why do I have to give it a second time?" The spirit of the proposals was to help the doctors in the process of admission, not to dictate to them how they should admit a patient. It is not legally binding. It is not intended here that the intake worker and the doctor should have some kind of confrontation. If this is the case, then we should reverse that aspect of the procedure to prevent that happening. We want both the doctor and the intake worker to have some say over the case.

C

Psych. If there are no beds, then the doctor has to decide what other options are open.

C

TS

TEXT

D.M.

R.N.

Psycol. Let's leave it at "will" and add another phrase which says that in case the doctor has questions about the appropriateness of the recommendations, he has a right to draw his own conclusions.

C

TP

Psych. You see, the doctor has a right to refuse to see the patient, just as the patient has a right to admission. The patient has a choice and the doctor has a choice.

C

TS

M.D. But the doctor has to see the patient in order to make it legal and he has to draw his own conclusions which means he has to interview him on his own, even though he has already been seen by the intake worker.

C

TC(aa)

Psycol. I thought the reason why we developed the intake procedures was because of the need for an intake service. Now we're talking about a screening service, and the two are different.

M.D. I have to repeat certain things to assess the patient's mental status.

C

TC(aa)

Psych. Maybe we should delay any decision about this until I take the proposals to the M.A.C.

D(i)

MEETING VI

TEXT

D.M.

R.N.

I.W. I have a case referred to me by the CAS. They are a French Canadian family and some marital counselling has been done at the service Famille. They has some problems in understanding English. We don't have a French marital counsellor here, but I wonder if you, (M) would take the case for an assessment.

P(i)

TP(t)

Psyol. What was the dig that we don't have a French marital counsellor.

C

I.W. That's my mistake (M). I don't know how much marital counselling you want to become involved in.

C

S.W. Maybe all they want is an assessment.

A1

TP(n)

I.W. No, it says on the referral that they are wanting marital counselling with a French speaking worker.

ND

I.W. I have another case involving a very complicated history which I won't go into, but it needs to be picked up because of a crisis situation. It involves a divorced lady with a 9 year old child. The crisis occurred when she went home for the weekend and found out her mother is having an affair with a 23 year old man. When she came back her own boyfriend rejected her and now she doesn't know who to turn to. She is a suicidal person and she tried suicide when she was under stress before and I'm afraid she might try it again, so she needs some kind of support. Previously she utilized all the resources in the community but nothing yet seems to have touched her.

P(i)

TP(n)

Psych. It looks as if she's just floundering around from one failure to another.

ND

Co. Does anybody want to take the French speaking case?

TP

Psych. What are the French Canadian resources in the community?

TP(o)

Co. I think they're listed in the phone book.

S.W. People at the university have something to do with the French Canadian counselling services, I think it's social work.

TP(o)

TEXT

D.M.

R.N.

Psych. These people should be made aware that these resources exist.

S.W. This makes more sense than handing the case to (M).

ND

TS

Co. What about the other cases?

I.W. There's only one other.

Co. Will you take that (S)?

TP

Psycl. O.K.

D(i)

Co. Now I'd like you to take a look at these transfer forms the nurses have developed to see what you think about them. They want a brief history and a reason for hospitalization as one of the headings.

P(i)

TP(t)

O.T. There is nothing here describing the presenting problem. Also it's important to state what the therapist has done up to now.

M.D. There should be a reason stated for the transfer.

C

I.W. I think if its an ongoing case you'd have to know what the therapist has been doing and what kinds of treatment the patients have been receiving.

C

TP(n)

Psycl. I agree, there should be some reasons given as to why hospitalization is necessary.

C

Psych. The history could be stated in a point system instead of the referring person writing a dissertation. We don't need long histories. You should be able to put it down on one page. The recording should be goal oriented, such as problems, assessment, and goals of therapy. There should be some continuity from out-patients to in-patients and back again.

C

Co. Would that meet your needs at intake, (R)?

TP(t)

Psych. It's helping people to organize their thinking as to where they are going with the patient. Is it symptom relief, or family relief or diagnostic assessment or treatment? Some of the people we're bringing in are just for the purpose of clarifying what's really the matter with them.

C

M.D. Why not just a brief history and reason for transfer and summary of treatment. That should be sufficient.

Al

TEXT

D.M.

R.N.

Co. What the nurses had in mind was, are you planning to take the case back, that is, are you going to continue the marital counselling or whatever you have been doing, or that you are referring and don't want them back.

C

TP(t)

Psych. Should we have a check-off?

I.W. We need background information, something about the ongoing treatment so date, whatever kind of things are pertinent to the admission and probably reasons for hospitalization and discharge planning. That's fine from therapist to therapist. They can say if they are going to take the patient back. But if I'm just admitting somebody that's brand new and severely depressed, they can't expect me to predict whose going to pick them up.

C

Co. What happens sometimes is that when one of us is working with someone, and they are referred to someone else after their hospitalization, by the nurses or someone else, then the first therapist is left sitting there wondering, "What did I do wrong?", or "What happened?" So they felt these kind of referral forms might prevent this from happening.

C

S.W. Whose going to fill out these, everyone?

Co. Anyone that's working on crisis cases that need admission to the in-patient service.

C

TP(n)

I.W. Should we just have a brief history then and just add the background information and the ongoing treatment to date?

O.T. Doesn't background mean the same as brief history?

Psych. It can or it can't. Brief history could mean how many kids in the family and other identifying data.

C

Co. Brief history includes background information and ongoing treatment.

I.W. Well, the nurses weren't happy with what's been sent over previously. They were asking for better kind of information, something they could work with.

C

TP(n)

TEXT

D.M.

R.N.

O.T. There should be more space for a brief history. C

I.W. This whole procedure needs to be discussed a little further. These things should contain what the intake team feels is important when it's a transfer from service, not just from out-patient to in-patient, or from in to out. It has to satisfy everybody. C

Psyc. Can that transfer form be used to transfer cases from child service to adult service?

Co. We need to have it serve all purposes.

ND

MEETING VII

TEXT

D.M.

R.N.

Psyol. I have a case of a battered husband who got hit with a frying pan by his wife after she tied him in bed when he came home drunk. Before this she had been beaten by him for years.

P(i)

S.W. Is this the first time she retaliated?

Psyol. That's the only time she ever did; the day they were supposed to see me they didn't show up. She was admitted to the psychiatric unit at the S-G Hospital and he to the Intensive Care Unit of the same hospital. She had taken an overdose after she beat him up.

Co. She decided she was going to do it once and make a good job of it.

S.W. Imagine somebody coming at you like that with a frying pan...

Co. Waking up to that.

Psyol. I guess the thing that bothered me most about that case was the fact that it was our case - it belonged to the psychiatric hospital; we had been working with this couple for some time and one thing you got to admit, we lost it to the (G), brand new therapist, brand new psychiatrist, everything all changed, then after all that, a couple of months of marital counseling they want to keep the case.

Co. O.K., now we have a number of intakes. I'll just read them over and people can decide who they would like to pick up.

(case presentations and pickups)

Psych. I have another case, a 360 lb. woman who is depressed but also has death wishes against her common-law husband. I would like to see her come into hospital. However, she has a 6 year old child she is worried about. She doesn't want to leave it and her husband feels her place is at home taking care of her responsibilities. He doesn't like the idea of her hospitalization.

P(i)

Psych. Maybe if she didn't have the child to worry about, she'd come into hospital and get straightened out herself...by the way, where is our intake team?

A1

TEXT

D.M.

R.N.

Co. They are at the crisis intervention seminar being held at (L).

Psych. Maybe we should leave this case till they come back.

A2

Co. Then we'd have a crisis on our intake team ...I have a transfer from in-patients.

ND

Psycol. Before we get into that I would like to ask someone else to pick up a case which I don't feel I can deal with effectively. You see, I have known this couple for twenty years, first through the wife being a classmate of my wife during her high school days. I met him in Toronto when I lived there. He's the kind of guy that tries to hold onto a relationship by being nice and she doesn't respect anybody who is nice and easy. So now she's hooked up with a guy in his early twenties who is a sociology student. He wants her but doesn't want her 3 kids whose ages are 15, 7 and 3. She's learning to "disco" with him and in a way, reliving her adolescence. They've had previous counselling of a very inappropriate nature. She was seeing a psychiatrist in Toronto for quite some time. She got the fellow all wrapped up so that he lost his objectivity and saw everything her way.

TP(n)

P(i)

Psych. Is she hypomanic?

Psycol. I see her as more hysterical than hypomanic. I saw them on an individual basis which seemed to help them, but when they asked for marital counselling, I told them I wasn't prepared to see them. She has pretty well made up her mind that she is going to break the relationship. In some respects though, she can't figure out how she's going to do it, like what about the kids and financial security. She's giving her husband the message that if he behaves himself, she might go back to him, so he's being super nice, just the opposite to what he needs to be. My advice to him was to be more "macho", a style which she ultimately wants but tends to resist. If he tries to assert himself she undermines him and slaps him into place.

P(s)

Psych. You mean to say, if she's a hysteric she has psycho-pelvic disorders.

Psycol. The original definition of "wandering womb", yes, I think that's the case, pretty well classic.

TEXT

D.M.

R.N.

S.W. Is that a new psychiatric definition?

Psychol. No, that one has always been around as far as I know.

Psych. I still relate to it anatomically.

ND

Co. Okay, now for the transfers. It's (T)'s patient. He's 52, a chronic schiz. He needs modicate injections and follow-up in O.T.

P(s)

TP(t)

Psych. I wasn't sure how well he'd function outside and I was interested in his symptomatomatollogy, so I'll see him as well. He's kind of a changeable guy.

D(i)

Co. Are there any other transfers from other sections you want to talk about?

S.W. I have one you referred to me some time ago, (T). She's extremely self-conscious, shy, and afraid to go back to her job. She is also involved in an extra marital affair which she refuses to give up.

P(n)

Psych. Can we talk about this at our in-patient conference or do you have time?

S.W. No, but I can continue to see her on an out-patient basis. It took her husband two years to realize that she was having an affair with the next door neighbour. All he could say when he found out was "Don't go over there alone".

D(i)

TC(aa)

Psych. What a creep.

S.W. An affair of the heart, but now she's wondering what she really wants to do, what is important to her in life from now on.

MEETING OF ADOLESCENT TEAM

(without Psychiatrist)

TEXT

D.M.

R.N.

Co. This kid was referred by probation and mom. He stole two cars which got him into court and after that he stole two more cars. This did not endear him to either the court officials or his parents. I had the kid tested by (W) yesterday (the psychometrist), the "Hand Test" mainly for court purposes. Kid seems all right, mainly seeking some excitement and status and attention and I get the suspicion that he got more status through the court and probation. The mother runs a confectionary and the dad runs a (GH) bus. Father isn't too well, has some back problems, in and out of the hospital.

P(b)

P(i)

Co. I got two more. One referred by the father. He's 14. He and two cousins ripped off \$150.00 from the (R) Club. Had to pay back the money to the members. He also robbed his own house. Father travels for some mining company, spent the money at "(LJ's)" at the Shopping Centre. I told him the father is more patient with him than he should be. He and sister fight like cats and dogs. I set him up for psych testing. The next, a boy age 14. Was at high school but was turfed out because he was a "pain in the ass". Very abusive at school to teachers and kids. Now he's back at (SS) School. I'm working with him again. His last contact with me before this was last summer. I suggested they contact CAS or the Regional Police. They gave him shit and since then he has been O.K. until he started raising more hell. He requested to speak to him so I'll be seeing him today. Another case from North Bay. He's 18 and referred by Dr. (RG). School and related problems and also physical difficulties. They want an assessment from us.

P(b)

D(i)

D(i)

S.W. Am I writing all this down, all I have is "Lots of physical difficulties".

Co. Never mind writing it all down. Just say physical and school related problems. Keep it short.

Co. Well, there's the other case you were supposed to undertake with (J) 3 or 4 weeks ago, do you remember?

Psyol. Yeah, he ended up in the detention home.

Co. So that ends it?

Psyol. Yeah.

<u>TEXT</u>	<u>D.M.</u>	<u>R.N.</u>
<u>Co.</u> Well, here's another one. A boy, age 15 referred by the family doctor. Presently he's in North Bay. Lot of criminal crap. He wants an assessment on the kid for court purposes. So I said we would set up an appointment for him next week. I prefer not to see him if someone else wants to.	P(b)	TP(t)
<u>S.W.</u> What kind of recommendations do you want for the court?		
<u>Co.</u> I get the impression that the detention home would keep the kid but they want some assessment to know how to deal with him while he's staying there, i.e., where to set the limits for him. All we can do is make recommendations on what kind of place would be appropriate. It doesn't matter, if you don't want it, I'll take it.	A1	
<u>S.W.</u> I'll take it, but it's hard to do those things when they live in (N).	D(j)	
<u>Co.</u> Well the other alternative is to see the kid once and set up for an admission and just put him on the waiting list.	A2	
<u>S.W.</u> But when's the court day?		
<u>Co.</u> It's today, but I'll tell the juvenile court judge. I'll be working on it and that will be fine.	A3	
<u>Co.</u> There's one more here. This one's from the CAS. It's dated December the one hundred and eleventh.	P(i)	
(derisive laughter from team)		
<u>S.W.</u> And the CAS was telling me the other day that our secretaries can't type worth a dam.		
<u>Co.</u> Their's can't type worth a hoot. Anyway, it's a delinquent girl age 15.	P(b)	
<u>S.W.</u> What's the deal with her?		
<u>S.W.</u> The deal is, she's in Special Ed. program at high school. She's got charges of theft - stole a wallet. (J) said she'd pick it up. That's it for me.	D(i)	
<u>S.W.</u> I have a case referred by the CAS. The boy is 14 and refusing to go to school. He hates his home and they hate him. If he's in high school I'll see him, but if not, I'll refer it over to the children's services.	P(b) D(i)	

TEXT

D.M.

R.N.

S.W. I have a case of an 18 year old girl who is a CAS ward. She has been with her present foster home for 11 years and tried to commit suicide. Referred to us by the psychiatrist from adult O.P., difficulty in home with the family who just had a new baby. She feels rejected and wants to move out. The family got an extension on wardship to keep her. She's a bit slow, is in grade 11 at high school. Had been in occupational and switched over. I'll have to find out if the family really want her. They say she is like a daughter, yet I really feel they are only keeping her for the money. I want to see the foster parents to see how they really feel about her.

P(b)

P(i)

D(i)

S.W. I have another case referred by the juvenile court judge. Actually I think there was some confusion in getting this case because when one of the workers found it was from (R) he was afraid to open it so it's a bit late in being processed. Anyway the kid is having difficulties at school and was also charged with possession of marijuana. The police searched the house until they found one cigarette and the kid was so upset he stole a truck and ended up in detention.

P(b)

S.W. Did he have previous involvement with the police?

P(b)

S.W. No.

S.W. Why would they be so anxious to get him then?

Co. Because it suits them.

S.W. Why the hell did they send him here?

S.W. For an assessment.

A1

Co. What a society this is. The whole thing doesn't make sense. Setting the kid up so that he gets into trouble then asking us for an assessment. All we do is assess cases for these clowns.

ND

Psyol. It's time to present new cases from intake. The mother dragged this 18 year old girl in and a large part of it is the mother's problem. The father is an alcoholic and the children are disturbed by his behaviour. There's a large family with mother sitting in the middle, feeling pressure from all sides and trying to keep the peace. The girl wants to leave home and the parents don't understand why she wants to leave home. So we discussed the girl's needs

P(i)

TEXT

D.M.

R.N.

to try it on her own. The girl doesn't want to come here anymore. The parents want to come. The girl is now looking for a job.

S.W. Some chance.

ND

Psyol. I have another case, a girl 17 at the receiving home. She asked to be taken in. Had been a former CAS ward and wants to come back because she has not been able to make it out in the world. No ability to cope. She's never been seen here before.

P(b)

S.W. Who referred this girl?

Psyol. She referred herself. When we're finished making our assessment she will remain in CAS care. That's the end of the intake.

D(i)

TC

Co. Well, I have an old case. (K) got a call from (P) Mental Health Centre. They were having a meeting yesterday, a disposition meeting, and this guy's name was the topic of conversation, so what I've done is put the kid on the waiting list for 3rd floor to do our own assessment, then whip him over to adult. We had him as a patient last fall.

P(b)

O.T. Actually how old is he?

Co. 19, 20 in May. At (P) they don't know their ass from a hole in the wall in terms of placement, so they're trying to dump him on us.

S.W. Wasn't the clinical director involved before this?

Co. Yeah, but he didn't do piss all with it. He was supposed to send a letter down to (P) with recommendations for treatment.

S.W. But then didn't he say it should be picked up by the adult team?

Co. He said it but didn't do anything about it; that was back in November. The kid got picked up and was sent to (P) and now they want to ship him back to us. When he comes in I'd like to have the team working on the thing so we can get it done quickly and pass it on to adult. That's it for the cases.

D(j)

MEETING II

TEXT

D.M.

R.N.

CCW. (H) and I are sitting on this committee called "Professional Development and Community Education" with (A) and (J) and (B). We are trying to identify such things as the need for professional development internally for staff and for agencies in the community. It's all very confusing but the main problem which they have identified is the requests for community education from the various services are cutting into clinical work. We have had four meetings about it and it's very confusing and I can't see too much more except that H and I think that we have to get feedback from individuals in this place, and we also need a lot of information from the agencies that we are serving.

P(b)

O.T. We should get people from the high schools down here and give them a good presentation on topics they'd like to know about, and what we do.

C

S.W. The whole question of community education came up at a community psych unit meeting and got left there. It was only when Comsoc (Community & Social Services, which now funds the child and adolescent services) said "you got to do community education" was the committee on education formed here, as much as (A) says this was initiated by the (S), so we are really only responding to pressure from Comsoc. In a way it's neat because we are looking at everything from a holistic approach, e.g. if we are going to use community education, what are the repercussions for staff training, what are the means for funding and clinical services and so on. In another way it is so massive you can't get a handle on it.

C

CCW. I agree it's neat, but it's so overwhelming when you look at it, it becomes unreal. But there is potential for a different kind of role for this place to provide for the community locally and for the region at large in terms of clinical service and community education. There's a potential for it, maybe not a great one but it's there. You change one small aspect like this and other things begin to happen. One thing that should happen is that we should look more critically at our relationships with other agencies in the community. We have an image now of what we do and they have an image of what we do and I don't think the two jive very well.

C

TEXT

D.M.

R.N.

S.W. How about if we set another meeting time to present what different kinds of things we are doing and just do a brainstorming kind of thing of how we'd like to do community education with the team and what that means and get some feedback from the members.

C

CCW. But there is a major conflict here. Some were saying, let's keep this thing quiet. I said "bull shit" to that because we need to have total involvement to deal with all the issues, so we have to spread out and go deeper and wider, but they say just do a small little thing, and be very quiet about it, so that remained unresolved and no decisions were made, other than it was left, so I would like to open it up at this team level for more input.

C

TP(t)

S.W. Why some want to keep it quiet is because the educational committee has no power, no authority. All it can do is come up with recommendations to administration and they can chuck them if they want, which wouldn't be much different from what they usually do.

C

TC(da)

CCW. But the idea is to raise issues regarding staff and community education development that eventually would be brought to the board level and make some significant changes in the function of this place. One of the things here of course, are people here actually interested in doing community education and what does that mean.

C

TC(da)

Co. Well as long as there's some bucks in it, people are interested. To hell with that amateurism stuff.

C

CCW. I think our team already does a fair amount of community education.

C

S.W. Do you want to set up another meeting to discuss this further?

O.T. Maybe next Friday!

A1

Co. Let's see how it is.

TP

O.T. What about a commitment to stay after the meeting to discuss it?

Why not give a brief outline of what we've done so far at the next meeting? We can't do it justice until we clarify for everyone what we are doing or supposed to be doing.

A2

TEXT

D.M.

R.N.

Co. There's weird ideas around this place about what constitutes education. What is seen as educating others? I've gotten more out of preparing material for others than out of workshops or conventions I've attended.

C

CCW. One of the encouraging things is rather than just reacting to requests from the community they want to move towards more of a planned model of providing that type of education. How far that goes we haven't finished it. If it means an actual unit in itself or department in itself that we provide community education programs and plan that out and control that out with other agencies, it could be one option. There could be twenty million other options in terms of people being able to move freely from clinical positions to educative positions if people are interested. That is the exciting part about it.

C

ND

S.W. This case I have his behaviour changed. Before his treatment as an in-patient started he was perfect in school. Nobody had any trouble with him, placid, not threatening, not aggressive, none of that stuff. Now all of a sudden he blossoms into aggressive arrogance. Anyway, (W) I'd like you to do some testing. This aggressiveness might be a defence against his poor self-image and feelings of failure in his interpersonal relationships. Now, he seems to be getting mileage out of his behaviour. He can control people by making them afraid of him, and people are really intimidated of him.

P(b)

A3

TP(t)

Psyol. It doesn't sound like he needs to be tested. You've already answered why he behaves the way he does. He's getting mileage out of it.

T(d)

S.W. Yeah, but he's escalating to the point where he's really acting out.

P(i)

O.T. It sounds like something the others are feeding into.

Psyol. I don't think it's any use to categorize people by testing them. We should use more obvious treatment and get to the kid's feelings about himself and get him to understand how to express them more appropriately.

C

ND

MEETING III

TEXT

D.M.

R.N.

C.D. All right.

S.W. This boy is 15 3/4 and was kicked out of school. Last year he was removed from the home for the same problem, not going to school and put in a foster home. Did all right there and is back home this year. He's a middle child of a family of 5.

P(b)

C.D. Hang on a minute. You mean he was suspended from school for truancy?

S.W. Right.

C.D. Well that makes some sense.

S.W. His parents were both divorced and then came together. A combination of step-brothers and step-sisters. The concern of the attendance counsellor because of the repetition of truancy caused her to approach me to find out what we could do to help. I haven't gotten very far with him at all. I've seen the parents and gotten further ahead with them than with him.

D(i)

C.D. It sounds like a tough one eh? I guess we'll have to wait and see. And...

S.W. We had an emergency Friday afternoon. This mother was very well known to me and her daughter spent 3 days crying and mother was very concerned. She's the only child left at home. Mother is in her 60's, she spent a good Christmas at her older sister's house and after Christmas when she went back with her mother she felt she was going back to an old age home.

P(i)

C.D. How many brothers and sisters does she have?

S.W. I'm not exactly sure. Her mother said all her children have gone through this sad phase and eventually all have snapped out of it. I'm going to see the girl again. She goes to (N-D) College and is a very good student in grade 12. The other thing that may have precipitated this is that her mother now has a boyfriend and they might get married so the girl wonders where she'll fit in.

D(i)

C.D. Is the boyfriend 60 as well?

S.W. Yeah, they make a cute couple.

TEXT

D.M.

R.N.

C.D. Any other cases?

Psyol. Yeah, I think so.

C.D. True to form, (P).

Psyol. Oh yeah, it's from a guidance counsellor. I saw a kid some time ago for one deal assessment. The presenting problem is pretty simple. The kid gets into fights, the circumstances are not too clear as to what sets the fights off. But he's gotten into a couple of fights at the high school level. He's gotten into them at the elementary school level too. I saw the kid for testing and (J) saw the dad for a while there for an interview. The kid definitely does have peer problems, a lot of it because of rejection or not feeling accepted by his peers associated with a lot of anger. A lot of feeling sorry for himself. He has an affective base that can easily be triggered by something going wrong. A lot of it might be of an odd looking duck in his facial appearance. I don't know how to really describe him, but take it at that.

P(b)

P(i)

C.D. It's written down for posterity.

Psyol. Yes, for posterity. The kid's interests are not typical teenage interests. He reads about quantum physics and relativity.

C.D. What do you know about quantum physics?

Psyol. I've read some.

C.D. They have a laser now that you can penetrate right through the earth, even to China. You can send messages this way.

Co. All we'd have to do is learn Chinese.

Psyol. It would be a great way to order Chinese food. But what to do with this kid is another thing; like I was thinking, O.K. first of all...

C.D. He's an odd ball. Is that your diagnosis?

Psyol. Sure. What do you do with an odd ball? He's like his dad who had similar kinds of experiences when he was growing up.

TEXT

D.M.

R.N.

Co. Yeah, his dad felt like he was always the odd man out and the scapegoat for the rest of the kids and recognizes that his son is the same way. He gets all the negative attention. We should have more contact with the dad and the mom and the kid and possibly even the brothers. He'll be coming back some time in the latter part of the month so maybe we can decide on treatment.

A4

TP(n)

C.D. Yeah, because if he keeps going the way he is now you might have him in on the floor.

ND

S.W. This is an 18 year old girl. Her mother sort of dragged her in one day, doesn't go to school, and no job. The mother seems to have the biggest problem. The girl wants to leave home, and mother was hoping I'd convince the girl to stay. The father is described as alcoholic, verbally abusive to the children. This makes the patient very angry and is the main reason why she wants to leave home. The mother hoped by coming here, I'd have some magic formula to help her deal with the father. Of course, I don't. Mother tends to take everyone's problems onto her shoulders. She has brothers and sisters; her husband has several brothers and sisters and the mother is the "strong one". But mother has no one to talk to, so this is in reality her problem that the daughter seems to be expressing. I'm trying to get mother to let everyone alone and let them live their own lives and also let her daughter go and make her own mistakes. The daughter doesn't want to come back here. As far as she is concerned her problem will be solved as soon as she leaves home.

P(i)

C.D. O.K. Fine. Any other new cases?

Psyl. I have a 14 year old girl, a grade 9 student at M-C. The father had been an elementary school teacher who had a nervous breakdown last year, diagnosed as a manic depressive. He tried to teach again last fall but only lasted a month or two and he's staying home now and decided he's got enough sick time to stay at home for the year and try to recover. His medication is a 40 ounce and there's been a lot of antagonism between he and his daughter. The mother doesn't directly criticize his alcoholism but she uses the daughter's antipathy to the father's drinking to get her point across.

P(s)

C.D. Is father high?

TEXT

D.M.

R.N.

Psyol. He gets low. He was quite angry in the session last week. He maintained he's not an alcoholic or not even a heavy drinker, but that he just drinks occasionally. Mother and daughter say to his face that he is an alcoholic and he sloughs it off by saying that they're entitled to their opinion and I'm entitled to mine. When he is drinking he takes over a child role. He tries to exert his authority when he's drunk but goes overboard and gets very angry. She does very well in school and has no problems. The focus is on dad's alcoholism. He is starting to move a bit and said possibly his drinking is not helping the situation. So we'll meet again and see what happens.

C.D. Well, what sort of behaviour did she engage in?

Psyol. She ran away from home when dad was drunk. He told her to get the fuck out of there. So the girl got the fuck out, but returned the next day. But the parents are now saying she's going to run away and wanted some reassurance from us that she wouldn't.

P(i)

C.D. Another run might be the responsible thing anyway.

Psyol. Yeah.

C.D. This is touchy.

Psyol. Yeah, it's bad because this guy isn't your typical alcoholic. He's got some skills, got education. I think the breakdown seriously...

C.D. Those are not uncommon with the manic depressive picture, and I think that the number of alcoholics we see are often manic depressives. That's why I asked if he was high, because most often what happens with the manic is that they are in the manic phase and they drink...I had one guy and he's now retired and this is exactly what happened. He'd get high and he'd drink, then he'd cause a disaster and go in the depths of depression and he'd ruminate and so on, tremendous depth, then he wouldn't drink at all. Whenever he got high he'd drink. This guy isn't on Lithuim or anything, is he?

P(s)

Psyol. No. I didn't find out what medication he's on, but I'll explore that the next time he comes in.

TEXT

D.M.

R.N.

C.D. O.K. Maybe you should talk to Dr. M. expressing your concern (the patient's doctor) about the father's state because I think this kid might buckle under the pressure of the home environment.

A1

TP(t)

Psyol. Yeah.

C.D. Make him aware of what's going on as far as the kid's concerned and that might modify his approach to the case.

D(i)

Psyol. O.K.

C.D. What about cases on the floor (in-patients)?

S.W. This case. I talked to the people at the detention home towards the end of his 30 days stay there and he totally lost control in a couple of situations. The situations are somewhat typical of the ones that have been described in which the kid is not really exonerate...he's always out of control. Part of the dynamics of that is what (W) picked up on the T.A.T. which confirmed our original ideas about him.

P(b)

TC

Psyol. What seems to operate in the kid is (1) you've got the low ego. He constantly sees himself as a failure in the group. A guy that screws up everything. (2) The anger is almost independent. It fits in with the low ego impression in that what will happen is that someone will discover him doing something wrong and his first reaction is "What an asshole I am. I totally botched it up", and he's mad at himself, but then sees the other person that has caught him. He's not really angry at that person, but if it's a weak person he can inflate his own good feelings by beating up that person. He fights people that can't fight back. But later he feels bad that he picked on somebody weak. What he needs is ego building satisfactions to make him feel good so he'll feel less angry with himself.

P(i)

C.D. O.K. I think you got a handle on it then, what do you want to recommend to the court? Suppose they find him guilty in this latest assault, what are you going to do then? What are you going to recommend?

S.W. I don't know. The family bothers me most. I would like to see them.

A1

TC

TEXT

D.M.

R.N.

Psyol. The day program wouldn't be so bad for this kid. If he can feel good...

Co. There's a good detention home in Orillia, he wouldn't be able to bust out of there. We got nothing to lose.

A2

C.D. That might be the thing.

Co. It's pretty rough but if he can get through there, there's a hell of a lot of self-satisfaction.

S.W. I doubt he could make it through there.

Psyol. It's a good place to start to do some re-thinking about himself.

A3

C.D. O.K. Let's get the verdict and tell them we need two weeks adjournment, then we'll give them our recommendations.

D(j)

C.D. Next case.

S.W. Miss M. 16 year old girl, very promiscuous. She uses this to gain attention.

P(b)

C.D. What she needs probably is to learn some skills, interpersonal skills so she can get what she wants in a more successful way. Both her and her friend were after me yesterday wanting some attention and were quite angry when I didn't give them any. One was more successful than the other as she took after me in hot pursuit as I went down the hall and finally cornered me. But she didn't give me shit like she should have. It would have been more appropriate for her to do so. (P), I think you should do more testing in this case to find out about her personality.

A1

TP(t)

ND

C.D. Next case.

Psyol. The lad is asking to go home. He's 17 and sort of adolescent and adult. He hasn't been at school for 2 years and he doesn't fit into any of our adolescent programs here and maybe should go home to (T) and let the people there look after him. The problems that brought him here aren't really adolescent concerns. He readily fits into the adult classification. Also, the medication given to alleviate his psychosis have not made sufficient inroads. The prospects for discharge are not too good. There is no place for him to go except home but the possibility of him going there is nil. But there may be a way out of it I think. If he could be dealt with as an adult or get him discharged to another hospital.

P(s)

TP(o)

A1

TP(o)

TEXT

D.M.

R.N.

C.D. Why not send him home for a few days and see how it works out.

A2

TP(t)

Psyol. I agree. But he doesn't do well at home without supervision. We could get supervision through one of the social workers at (S.M.)'s Hospital in (T). He could come here first for consultation so he would be able to help more effectively once the patient gets home. We could act as a backup.

A2

C.D. Well, we're supposed to anyway. His psychiatrist said he belonged in (NB), not in an adolescent program. He's a pretty sharp psychiatrist, so I think he'll go along with what you suggest. You do that and if you have any trouble let me know when I get back. I'll get in touch with B , and talk to him myself. So see what you can do.

A3

Psyol. What I'd like to do is have a social worker come down here from (T) and be responsible for that lad.

A4

TP(o)

C.D. O.K., but I think we should temporize. Next case.

D(j)

TS(a)

Co. That's it.

MEETING IV

(with Psychiatrist)

TEXT

D.M.

R.N.

Co. Last week this patient said she was going to make and sell me a planter. She didn't ask if I wanted it or not. So I said, "You make it, I'll take a look at it and decide if I want it or not". She kind of pouted but said it was O.K. with her. So yesterday she said, "I finished it, and will sell it to you for \$6.00", but I said, "No, \$5.00", she said "No, \$6.00", so I said, "Well, forget it". Whereupon she got pissed off with me. So she then accosted me and nearly beat the shit out of me on the elevator and said, "It's pretty hard to do business with you".

P(b)

O.T. But later she said she'd compromise which I said was very good. Anyway, she's showing an interest in involvement.

A1

TC

S.W. This case I had to take down for a court appearance for wardship. A 15 year old girl sent to us from (NB) for assessment. She came with me to the court, wearing sneakers, her clothes were grubby; no socks and complained to the judge about what was wrong with her treatment out here and that no one was doing their job properly. She made a ridiculous fool of herself. She had a captive audience and went melodramatic.

P(b)

Psyol. She very effectively swept with a twirl of her body out of the courtroom.

O.T. I've seen her sweep down the hall in her low cut nightie and her housecoat just to get people to notice her.

S.W. Her presence is just unbelievable and laughable.

Co. She's very neurotic this kid, her behaviour is a fine line between funny and stupid. But I think we need to be careful about giving too much positive feedback about her behaviour being humorous, or cute because we can wield arbitrary power over her ourselves. She doesn't know how to be assertive in a positive way. Otherwise she just loses control and makes a fool of herself. She may be right but she doesn't know how to put it across. She should be taught how. Dramatizing the way she feels, as though she were on a stage, is not the way to express herself if she wants to be believable.

P(i)

TEXT

D.M.

R.N.

C.D. I agree with that.

S.W. Yes, there is a way to do it and a way not to do it.

Co. But the staff shouldn't laugh at her when she isn't doing it right, that just reinforces her ludicrous behaviour.

S.W. But we don't do it openly, we just laugh among ourselves.

Co. A person has to be told what is doing on before he puts himself through these circumstances where the outcome is a high probability of failure or to develop one's capacities to cope.

C

ND

S.W. I have another case. He's 16 years old and has outbursts he can't control. After the event he can rationalize what's happened and why he acted the way he did, but he doesn't know how to control himself once he's in them.

P(b)

CCW. Well, the times these have been happening before, we get the details out of him in terms of understanding what is happening is because of certain events, such as his girlfriend not visiting or his parents not visiting.

S.W. It's hard to tell which end of the...maybe our efforts to help him control himself are not working is because of another factor we are not aware of. I don't feel very clear about it. The kid can understand so well other people's problems but not his own.

C

O.T. He told me it was his girlfriend that gets him upset and causes him to act out this way. When she doesn't come in he thinks she's dead and can't think of anything else.

Nurse Do you think he's convinced of that or is he just looking for a reason to act out?

S.W. Is there any way of getting her out here?

A1

Nurse I don't see how that would help. His family should be seen as to what they think is the problem and how they might help to deal with it. They should be more involved than they are.

A2

TEXT

D.M.

R.N.

Psyol. I think perhaps the family has a lot more to do with the way he feels than he'll admit anyway. Could we keep this in abeyance till we get more information.

P(i)

S.W. Why don't you see the kid and see what he thinks about talking to hfs family?

A2

Psyol. I would like the team to review a case for me. I have been seeing this kid for a week. He hasn't shown any signs of depression, he hasn't made any comments about suicide, even jokingly.

P(s)

TP(t)

S.W. He talked about killing himself to me, but it was jokingly. But he didn't elaborate on it.

Psyol. But over the weekend his mood was good. He's one of those kids whose very hard to read. But I don't think he wants to kill himself, he just wants attention.

Nurse I don't think you should take this lightly. He might do it. Don't forget you are responsible if he does it. We even keep spoons away from kids like that.

Co. Don't tell me he's going to spoon himself to death.

Nurse That isn't funny.

S.W. Well, we should take some suicide precautions maybe get him under close observations. How do others feel about it? I don't think he's serious.

A3

Nurse I told him he was not being reasonable, and I would like to tell the team that he needs to have someone do some psychotherapy with him.

A4

TP(o)

S.W. Let's tell him that the suicidal precautions will be taken off and he'll be given back his clothes if he quits threatening suicide. Also someone could take him out of hospital for some recreational activity.

A5

TP(t)

D(i)

Appendix B

February 9, 1977

To all Members of the Out-Patient Team:

The days of democracy within the Adult Service are over as of February 9, 1977.

As a group of "professionals" there are expectations placed upon us when we obtain employment at an agency. It is our duty to fulfill these expectations to the best of our ability if we agree to work at the agency. If any of us feel we are not dependable enough to carry out these responsibilities then we had better reassess our commitment to the agency. In future, to be a part of the Adult Out-Patient Service it will be expected that:

- (a) You participate in meetings that are called and that your participation is of a constructive nature to help your co-workers.
- (b) All cases in your case load will be accounted for in the appropriate manner - this manner will be open for discussion but the final decision will remain with the co-ordinator.
- (c) Log sheets will be filled out on a monthly basis and given to the co-ordinator by the end of the first week of each month.
- (d) Each department will take call by rotation. A schedule to be given to the co-ordinator, by Friday the week before. You will be available 9-12 and 1-5 for all calls - emergency or otherwise. If changes are to be made in the schedule, the co-ordinator must be informed prior to it happening.
- (e) If a case is booked with another therapist the information is to be attached to the book. If this is not available you will be expected to see the case yourself.
- (f) All intakes are to present within one week of initial contact.

If anyone does not wish to adhere to these rules it might be best for them to reconsider their appropriateness in the Adult Service.

signed
Team Co-ordinator

co-signed
Director of Psychiatry

*Letters passed out to the team members privately but never discussed openly at any subsequent meeting.

Appendix C

Interviews

The series of interviews in section (i) deals with members' attitudes concerning the effectiveness of the team. In section (ii) interviews relate to team members' perceptions of the influence of the hospital on team effectiveness.

A. Team Effectiveness (Adult O/P Team)

The psychometrist feels the team is incapable of negotiating roles because certain members of the team, especially the psychologist and the two psychiatrists have too much power and the rest of the team members have too little.

"The team is a dictatorial authoritarian arrangement that represses the feelings of the individuals who don't have the power". He felt that the only way open communication could occur would be if all members have equal power, but this was not the case.

He continued to criticize the team in terms of its lack of complementarity and as a poor consultation process.

"None of our jobs fit into each other, we just all do our own thing, and that's as far as it goes. As far as consultation, it's just between me and my boss, which is of course a departmental rather than a team transaction."

The passivity of the team members and their failure to work

effectively together is remarked by the occupational therapist, but she sees the team climate changing.

"They are a little reticent about involving themselves. They just sit around and wait for referrals. Maybe it's their background. They are used to working individually so it's hard for them to change."

However, the team members don't depend on the psychiatrist to tell them what to do with a patient as much as they used to. The psychiatrist is more used now as a last resort and we are becoming more independent and making progress on our own.

Defining Positions

According to the psychiatrist and the co-ordinator of the adult out-patient service, positions should not be defined through departments but through the service so people would know how to play their appropriate roles as team members. Before they get someone for the team the department heads should talk over their suitability with other members to see if they could fit in.

"Qualifications", said the psychiatrist, "should not only satisfy the departments, but they should also satisfy the members of the team in terms of how well they can function as a member." Communication is a problem on the team which does not permit cases to be fully discussed according to the co-ordinator.

"In the formal team meetings cases are not fully discussed because

for some reason people are unwilling to express themselves." This repressive climate is detrimental to her functioning and she sees it as retarding the others..

"As for the team itself, it doesn't allow me to utilize any of my professional competence nor do I see any of the others working at their potential, but I don't know how to make it function any different."

But she doesn't see the cause for the kind of dysfunction she describes as being on the team itself who are, according to her, "basically frustrated and turned off on each other". The cause of the whole problem is in the organization and more specifically the unit director (the psychiatrist) who basically controls the team and the departments to whom all members are accountable.

The need for strong team leadership was expressed by the child psychologist as the means to developing a more effective team.

"There is a need for leadership with sufficient authority and vision to place limitations and develop goals so that members know what to work towards. Also, decisions should occur through group discussions rather than individuals doing their own thing. Optimally then, changes would occur through team meetings wherein the need for change is justified and that the change is in the interests of the better functioning of the team."

The unit director also criticized the co-ordinator for her failure

to develop team communication.

"I don't think the leader facilitates enough discussion of case dynamics but then she lacks the training. However, she should encourage people to present difficult problems for the team to consider." The general feeling about being a team and negotiating roles is summed up by the following excerpts from a psychologist and social worker.

"The group working in the adult out-patient service is not a team and never has been. A team is one which makes use of differential staff and homogeneity of clinical roles which would need to be discussed to develop a team. Also I think a lot of the interaction in meetings indicate that we are not a team in the sense of having a co-operative cross-sectional way of looking at the problems presented. I see them as discrete rather than integrated categories. This doesn't allow members to click into what each other is doing. There could be better co-operation based on the willingness of people to share their professional identity, but there seems to be a high level of competitiveness which prevents a lot of co-operation."

According to the psychologist, the team members do have innovative ways of treating patients, but these emerging roles are not recognized at team meetings. The consequence of this is the stereotyping of roles but he felt most of the team members were happy with this approach because it was meeting the needs of the individual therapists. He asked the flexibility of the team "which allows me the option of remaining in my traditional role or develop a new one if I want to. We may not be

effective as a team, but we are as a group. A team as such requires interdependency and a group only requires complementarity, in other words, we can do effective work without everybody being here."

Adolescent Co-ordinator

The adolescent co-ordinator felt that the hospital, since it is organized as a hierarchical system with divisions of power supports status inequality while the team system with its division of labour supports equality of status. Therefore, he feels it is the responsibility of the team leader to equalize roles to negate attempts by those with power to define other roles or make decisions outside the team.

He suggested that a psychiatrist may be using his hierarchical power to cut people down so many times that they don't like to communicate while he's on the team. "His perception of team interaction is to make the decisions and tell the paramedics on the team what to do. At first they would take it and do his bidding but when I became co-ordinator I stopped all that nonsense. I let him know it was not his case and they had to develop their own way of dealing with it. He never gets the message, so we have to repeat the message for him at every meeting where he's in attendance. He can't deal with people and the only thing to do is to get him out of here, and I told that to the rest of the people in administration and they agreed that I was right. He doesn't seem to have any empathy for others which I feel is an important quality to have when you're on a team."

The psychologist agreed that the climate at team meetings was much better when the psychiatrist was not around. "I find emotionally there's a hell of a difference. You can tell people to fuck off here with more comfort than you can when he's around. But even though he may inhibit free expression of feeling he can no longer push us into a role we don't want. But we don't trust him so we are careful what we say."

No longer being pushed into roles is due at least according to the social worker is the result of the co-ordinator's strong leadership. "We used to take a lot of shit from him but now we're stronger because of the way our co-ordinator stands up to him. Now if I believe in the way I'm doing a case, I don't let him dictate what I should be doing, but I wish he'd just stay to hell away from our meetings and let us get on with our work."

Trust for each other is increasing as their communication increases. One of the child care workers expressed it this way. "We are stronger now and are beginning to depend more on our own abilities to be able to do an adequate job. So the trust carries over in the way we relate to each other. The more we trust the more we can communicate, then the more successfully we can work as a team.

At the present time, between administration and the teams, "there's a mutual distrust, looking at each other through a vacuum, and wondering whose going to make the first move to jump into that vacuum. If the team does that, it can take some of the power away from administration.

Generally team members see the hospital as a secretive and closed system with those in authority hanging onto their power. Although there are committees set up to advise on various problems, there is no indication that anything they advise is ever implemented. As the chief psychologist said:

"No one really understands how the administration functions as there are no charts available to describe it. Only the clinical organizational chart is available. I wonder if everyone tried to draw an administrative organizational chart, if we'd get as many diagrams as people."

It was suggested by the psychiatrist that people on the team should try to get on the various committees to have decision-making power but a chief psychologist said that he had experience with various committees as did some of the social workers on the team. However, that did not give them any formal or decision-making authority. They were just recommending bodies. He described the situation as secretive with the administration keeping its authority to itself. Decisions are informally made, as he stated.

"I don't know of any committee in this place that has any formal authority. Also they don't have any lines of communication to anybody. All committees are recommending bodies. I'm not sure who they recommend to but they recommend. So any recommendations to administration go to a body that is not involved in carrying through the recommendations. Most of the important decisions are made behind closed doors."

A psychiatrist who had been in the out-patient team felt there were too many constraints to performing his job as a team leader adequately. The constraint came from the constant interference of the psychiatrist.

"When I was hired I was led to believe that I would have control over the team, but everything I tried to do was controlled by the psychiatrist, because it was seen as a threat to his authority. I was the "fall guy" for anything and everything that went on without any power to change it and without any authority to lead. I became somebody only to give an imprimatur to the group as a medical legitimizer."

The administration is seen as not wanting to grant power outside the departmental organizational structure.

He felt that a change could be brought about if the psychiatrist could somehow be prevented from controlling in every detail what is going on.

The concentration of the power at the top was seen by one of the social workers on the adult team as undermining the relations of the team members and subsequently the effectiveness of the team. The team cannot be improved unless the system which undermines it, is changed.

"The overall system needs to be changed so that the team can be changed. Otherwise I think conditions will pretty well remain the same. Big brother up there is slapping us down, and we slap each other down instead of slapping back. As it is now, too many individuals are

sacrificed to the system. We are not an effective team, but the last rung in a hierarchical pecking order."

The existence of a hierarchical pecking order is accepted as a fact by all the team. The "slapping each other down" phenomena occurs regularly. Psychiatrists are the scapegoats for the team problem, and they are attacked by the team members instead of the administration.

One psychologist remarked, "I see the pecking order as an established fact. Sometime back I ran across an organization chart which listed all the medical staff as directors of something. The medical people have all the power here."

To this the psychiatrist remarked, "I don't have the feeling that I have any more power on the team than social work or psychology."

But the social worker agreed with the psychologist that the problem was the psychiatrist who had too much power.

"In everyday life at the psychiatric hospital you find all the committees headed by medical people. You seldom find social work or psychology heading anything. It's pretty hard from this not to recognize that medical people are at the top."

Along with the picking out of scapegoats, a distrust of each other has resulted in problems in communication at the formal meetings. One of the social workers felt too intimidated to confront the psychiatrist

on an issue so she represses it until after the meeting through an informal discussion with an individual she feels she can trust.

The general feeling of distrust was described by the unit director, a psychiatrist was due to the fact that team members had no respect for maintaining confidentiality. "Around this place there are squealers, you make a decision and somebody squeals on you. When you say something in this room you don't really know who is listening and what they are going to do with it. You say something here and then go over to the hospital and somebody there says something pertaining to what you said and you wonder how the hell it got over there."

The psychologist was supportive to the fact that there was a lack of trust detrimental to open communication and said that certain people had an "in" and others did not, then added, "There's so much unpredictability about what's going to happen, you don't know where you're going to be hit from, so you soon learn to cover your ass and just keep your mouth shut."

Lack of trust of those in power was a shared feeling of the team members and indicated their feelings of vulnerability and powerlessness to change their status vis a vis administration. This was summed up by the head of the out-patient service in this way:

"The medical and administrative director have the full support of the board, a carte blanche to act the way they wish and run the "san" on the basis of their own judgment. The administrator especially has unlimited powers and it's good that she's at least some of the time, a

"benevolent matriarch, as long as you are quiet and conforming, you will always have a secure job here."

As for changing the team's function, to improve relations among the members, it would not be possible unless the whole system changed. The social worker defined the situation this way:

"The former team leader felt that it was not necessary to change the whole system to open up communication, but to give the team a more autonomous status. This could be brought about by "preventing the medical director from controlling what is going on in the team". He could lay down general guidelines by leave the implementation of these guidelines to the members themselves."

Others on the team blamed the lack of clean policies as the reason why the hospital was able to take over so much control. The occupational therapist felt that "Once we had written policies that everybody agreed to, the co-ordinator could bring them over to the administrator. Then they could be brought back to us and we would know what they think and how supportive they really are of us."

Policies that were supported by the administration and the team members would end the distrust and communication problems on the team and make it more effective, according to one of the nurses who stated, "It's difficult to get started when the membership doesn't know what it wants. Now everybody is working at cross purposes and so nobody makes a decision. The group doesn't say what it wants so we keep running around in circles."

Looking for scapegoats and distrusting each other keeps the team "in circles" and avoids the larger issue of a dysfunctional system that may need changing before team communication can improve.

Appendix D

Chairman, Board of Directors

Dear Sir:

Enclosed please find a synopsis of the doctoral thesis which I completed recently for the Ontario Institute for Studies in Education, University of Toronto. The research, while being of interest to those in the clinical area, might also be of interest to the board of directors as well as to the hospital administrator and the clinical director.

In sending this report, I would like to use the opportunity of extending my appreciation to the board, the administrator and the clinical director for your encouragement and support that enabled me to complete the study.

Sincerely,

Charles L. Dixon, M.Ed.
Out-Patient Department

CLD:11

cc: Administrator
Psychiatrist

SYNOPSIS OF RESEARCH REPORT

"Decision-making in a Psychiatric Team"

The research evaluates the effectiveness of two psychiatric teams, adult and adolescent in and out-patient facility of a community psychiatric hospital, namely the Sudbury Algoma Sanatorium.

Team effectiveness is defined here as members' ability to negotiate their respective roles and make decisions as a team rather than have decisions imposed.

To gather the data, organizational charts, documents and the taped recordings from interviews and team meetings were used. The results showed that the teams are not as effective as they could be because they do not make decisions as a team. Decisions tend to be made on the basis of unstated criteria which are unacceptable to many team members and selection is made from among very few alternatives.

The team was found to be a reflection of the hospital system which is controlled by hierarchical power which results in top-down decision-making.

Authoritarian decision-making which is characteristic of both teams is supported by the hospital system in which both teams operate.

To make both systems more effective, the following recommendations are made:

- (1) Initiate in-service training programs to teach team members the processes of role negotiation and team decision-making. Without this, the time spent in "team" meetings is wasted, since better patient care cannot result.
- (2) Make the department heads responsible for training new staff members to take their appropriate roles on the team. This would also create stronger professional identity so that teams would be truly interdisciplinary. Clarity of professional roles enables role negotiation to occur.
- (3) Board members should be invited to sit in the major committees to help them make more realistic policies in support of better utilization of all professions and in the goal of better treatment.
- (4) There should be rotating headships for all the services and all the committees. This would mean that different disciplines would have a chance to influence therapy and other administrative procedures.
- (5) A professional advisory council should be created to replace the medical advisory council so that decisions would reflect the ideologies and expertise of all the professional staff at all times.
- (6) The agencies in town that repeatedly use the services of the hospital, should be represented on the major committees. This would help to bring the sanatorium closer to the community.

With the gradual implementation of the above proposed changes, the total system including the teams would become more effective.

The consequence should be a more co-operative spirit, with all members sharing their expertise to increase their professional competence to benefit ultimately those for whom the hospital exists, the patient.

Appendix E

At the end of the observation period an arrangement was made to meet with both teams separately to discuss their perceptions of:

- (1) Team Effectiveness
- (2) The Influence of the Hospital System

ADULT OUT-PATIENT TEAM

Team Effectiveness

TEXT

S.W. I think most of us agree that we are not a team but a group of people just working together. Nevertheless, we are still effective as individual therapists and we are flexible on the team to take on new roles if we want to. If we don't, then that's our business.

S.W. Also, some of us work as a team informally and team meetings are not a very good criterion of how we work together.

Psyol. I guess we just accepted the definition of ourselves which is we are not a team but a group. If people want to be involved as a team it's up to them.

S.W. I like the idea of staying the way we are just being a group and I think most of the others feel the same way.

Psyol. At least we have consistency and the present system is satisfactory to us, and since we don't want to be a team anyway even though we are classified as such, no changes appear to be necessary.

I.W. Well, I've said that long ago, so it's nothing new. Our only problem as a team is people's unwillingness to pick up cases. Nobody seems to want to do any work.

S.W. This group has no spontaneity. People present new ideas and are greeted by silence. No one wants to comment or develop them. Or when we actually try new things, they fizzle out and we go back to our old slump.

I.W. That's like the "load sheets". Every month that are about to be closed are supposed to be presented for discussion. The load sheets are there, but no one discusses them.

Psyol. It takes up too much time and we got other things to do.

S.W. This team is like a pathological family. We always make resolves to do better, but nothing ever happens. Maybe if we did discuss cases more thoroughly, we could all become involved at a more therapeutic level. Since we don't discuss nobody does anything, so our roles never change. But now we are a group, I'm out of my delusion.

The Influence of the Hospital System

TEXT

S.W. Part of the problem is that we don't know who has the power and what to expect from the hospital system. Is the power in the informal system or the formal system. It seems that most of the important decisions are made behind closed doors.

Psyol. We have an organizational chart which tells everybody how they should operate but nobody pays much attention to it unless it suits them.

Psych. There's so much unpredictability about what's going to happen, you don't know where you're going to be hit from and you soon learn to cover your ass.

Psyol. It makes it hard to say anything, there's no confidentiality, ever here on the team.

Psyol. That's odd that in a hospital where we are all supposed to respect confidentiality that we don't have it for each other. I think the dilemma is the information is used in other contexts for purposes for where it was not intended.

S.W. And there's no way you get to explain your position either. Nobody asks you. They just go with the informal sources they have. You never really get to state your case. Anybody can state whatever case they want as long as they're in power and you're out of it.

O.T. I don't like the idea that we are always put into the position of having to justify our existence to the administration.

S.W. It is us that feels that way, or are they making us feel that way?

Psyol. They don't recognize us because we don't recognize ourselves. We all work outside the team and when we meet formally we have nothing to say to each other.

Psyol. But there are more benefits here working informally than working formally. The team is a mirror image of the hospital, things get done but no one knows how.

Psych. They don't get done by the doctors. We spill our guts at the MAC meetings but nothing gets done. We are like everybody else. All we do is make recommendations and decisions are made behind closed doors.

Psyol. All the committees are the same. They just recommend but don't decide on anything.

Psyol. All the committees are headed and staffed by medical people. You seldom find a psychologist or social worker on them.

TEXT

Psych. I don't have the feeling that I have any more power than does social work or psychology.

Psyol. There's a definite pecking order in this hospital with psychiatry at the top. Sometime back I ran across an organizational chart which listed all the medical staff and everyone of them was listed as the director of something. The medical people may not like seeing themselves as having all the power but that's the way it is.

ADOLESCENT OUT-PATIENT TEAM

Problems in Working as a Team

TEXT

Co. We don't have many problems at least that matter too much. Members tend to be supportive rather than critical of each other.

Psyol. That's because we are task rather than department oriented. Also, we don't play one role all the time, we diversify. For example, I don't see cases just as walking I.Q.'s. In other words, I never think how I should intervene as a psychologist, more as a therapist.

Co. And that's the general attitude of all members, we like to negotiate. No one is rewarded for holding anything back, and no one is on an ego kick to exert power over the others, with the exception of course, of the medical director.

S.W. Lot's of time it isn't all that good around here, sometimes I feel cut off.

O.T. I don't think you get cut off.

CCW. I agree with (K), because sometimes I feel cut off too. Like last week. There's situational things sometimes, it was the first group meeting I have in three weeks. Things I wanted to discuss at the end of the meeting but everyone seemed so tired of being confined in a small room that I just let it go. I'd like to see how intake gets done. There's a lot of wasted discussion around just getting things recorded in books. The recording should be cut down.

S.W. I don't think so.

Co. I feel the depth of discussion here in some cases tends to be superficial. However, we do discuss cases in depth informally. So I guess every case eventually gets discussed in depth because they are all brought back to the meeting.

O.T. We should make it a formal rule that everything that doesn't get discussed in a meeting is held over to the next meeting.

TEXT

S.W. I get the feeling people are not interested in what I have to say about community work. That gets me angry.

O.T. I don't see how you can say that. I meet with you a lot outside the meetings to work on community projects.

Attitude to Hospital Influence

Obs. What about the difference in meetings with and without the clinical director.

Psyl. I think the consensus is there's a hell of a difference.

Co. Yeah, that's right. You can tell people here to fuck off here with more comfort than you can when he's here. He inhibits free expression of feeling. The rest of the members respect and trust one another, but nobody respects or trusts him. We don't hassle each other for mistakes we make on cases so we talk about it. We don't trust him so we are careful what we say.

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