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TEAM DEVELOPMENT AS PLANNED CHANGE: AN INTERVENTION WITH AN INTERDISCIPLINARY TEAM IN A GERIATRIC PSYCHIATRY PROGRAM

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by

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BY

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ABSTRACT

The following social work practicum was undertaken to plan, implement and evaluate an interdisciplinary team development intervention in a Geriatric Psychiatry setting. The intervention was developed to address the interaction between the task and socioemotional activities of the team, within the context of program and organizational goals.

The writer's rationale for this intervention and the approach taken is based on a theoretical framework drawing on literature selected from team and team development theory, Geriatric Psychiatry, organization theory, adult education theory and group theory.

The team development program is based on the premise that task accomplishment will be facilitated by cohesive and effective team functioning, and that teams need to develop certain skills and attitudes in order to work together effectively. The need for a catalyst, or change agent, in this process is substantiated.

This report outlines a framework for team development, and describes the intervention which was implemented in ten two-hour sessions with team members of the newly-formed Department of Geriatric Psychiatry at Deer Lodge Centre.

The objectives of the practicum were twofold:

(1) To facilitate improvement in the team's ability to work together, within the context of having to provide service to clients; and

(2) To help team members deal with ambiguity, change, conflict and complexity inherent in the work situation, in a way which would promote progress for both the team and service delivery.

An evaluation (formative and summative) utilizing a range of measures provides both subjective and objective data on which is based an assessment of the impact of the intervention in relation to the stated objectives.

As assessed by the team members and the writer in process evaluation, the impact of the intervention was positive in terms of the stated objectives. In addition, the writer's objectives for learning and skill development in relation to planning and implementing a team development intervention were met. Evaluation was also helpful in identifying ways in which such an intervention could be strengthened and applied to other settings.

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INTRODUCTION

1. FOCUS OF STUDY AND RATIONALE FOR INTERVENTION

The focus of this practicum is the interdisciplinary team approach to service delivery in a Geriatric Psychiatry program. The intervention involved the planning, implementation and evaluation of an interdisciplinary team development program based on a model for planned change.

The practicum was completed in Deer Lodge Centre with the newly-formed Department of Geriatric Psychiatry, which consists of two programs -- the Day Care for the Cognitively Impaired, and the Geriatric Psychiatry Program. Over a period of five months, preparatory meetings and a series of ten two-hour team development sessions were held, involving five team members initially and incorporating three new members as they joined the team.

The rationale for the undertaking of the team development intervention in this practicum was based on a theoretical framework drawing on literature selected from the following:

(1) team and team development theory;

(2) Geriatric Psychiatry theory and research;

(3) organization theory;

(4) adult education theory, and

(5) group theory.

In brief, the interdisciplinary team has been viewed as the most effective approach to assessing the needs of the elderly with mental health problems, and effecting positive change through the use of various treatment modalities (Thomae, 1980; Busse and Pfeiffer, 1977; Gatz et al, 1980) . To accomplish this task, it is vital that the team members work together in a cooperative and collaborative manner.

Despite the popular usage of interdisciplinary teams in the health care setting, health care professionals do not routinely receive training on how to function effectively within a team. Due to the interaction of numerous internal and external factors intrinsic to interdisciplinary team functioning, and the lack of training for teamwork, it can happen that the individual and collective skills of all team members are not fully recognized or utilized.

Further to the above, the literature suggests that if difficulties are being experienced within the team there may be a detrimental impact on service delivery. Conversely, if a team learns to communicate, manage, support, grow and problem-solve, there are indications that there will be a positive impact on service delivery (Fry, Lech and Rubin,

1974).

This practicum was based on the premise that improved utilization of the interdisciplinary team approach would promote greater cohesion and collaboration among team members, and lead to improved service delivery.

The need for some kind of intervention is consistent with the theories of Schon (1983), Brill (1976), and Pankowski et al (1973), among others, who indicate that despite concerns or conflicts within a team there is still a strong motivation to maintain the status quo and resist change. Thus, team development requires a catalyst, someone who is willing to intervene in the status quo and promote change, and also has an idea of how to accomplish this change effectively.

The method for the intervention was based on the premise that an action-oriented, interactive process utilizing concepts from group, organization and adult education theory would best meet the needs of the interdisciplinary team. The intervention was planned and implemented within the context of the needs of each team member, the team as a whole, service delivery, and the external environment of the team including the organization and the community.

2. OBJECTIVES

There were two sets of objectives for this practicum, the first related to the impact of the planned intervention on the interdisciplinary team involved, and the second related to my learning objectives within the M.S.W. program of study.

Objectives for the intervention

(1) To facilitate improvement in the team's ability to work together, within the framework of providing an optimal level of service to clients.

(2) To help team members deal with ambiguity, change, conflict and complexity inherent in the work situation, in a way which promotes progress for both the team and service delivery.

Objectives for learning

In completing this practicum I hoped to acquire a greater understanding and working knowledge of the value, structure and dynamics of interdisciplinary teams, and how to promote improved team functioning within existing program and organizational constraints.

The specific skills I hoped to acquire and develop were:

(1) an ability to complete an assessment of need in team development,

(2) an ability to plan and implement an effective approach to team development which would be appropriate to the time, setting, and circumstances,

(3) an ability to facilitate interdisciplinary discussions in a manner which would promote growth and learning and enhance team development,

(4) an ability to evaluate the results of the intervention in a meaningful and accurate way, and

(5) an ability to re-define the situation and make observations regarding ways in which the intervention could have been strengthened, and ways in which it could be used for other situations.

3. OUTLINE OF THE REPORT

This introductory chapter has briefly stated the rationale

and objectives for this practicum. Chapter Two consists of a selective literature review with the purpose of formulating a theoretical and conceptual framework on which to base the intervention. This includes:

a) a definition of team and a distinction between types of teams,

b) a discussion of the value of the interdisciplinary team approach in general, and in particular as it relates to Geriatric Psychiatry,

c) an exploration of the nature of teams in terms of structure, internal dynamics and external relations, and

d) a discussion of the rationale for intervention.

Chapter Three focusses on the planning and implementation of the team development intervention carried out in this practicum. The first section, designing the intervention, consists of:

a) a review of team development efforts discussed in the literature,

b) a review of theories relevant to the planning and implementation of a team development intervention -- including stages of team development, adult education theory, group theory and change theory,

c) a discussion of the role of facilitator in team development, and the validity of this role for social

work, and

d) based on the above, the presentation of a framework for team development.

The second section of Chapter Three consists of a description and discussion of the team development program carried out in this practicum, utilizing a model for planned change as a framework for the process. It should be noted at this point that in order to ensure confidentiality for the team members who were involved in this practicum, certain aspects of the actual intervention will not be described or discussed in detail. Where necessary, issues will be discussed in general terms rather than directly related to this particular team's issues.

Chapter Four provides a descriptive evaluation of the team development intervention in relation to the stated objectives. Results obtained from various evaluation measures are reported and discussed.

Chapter Five provides a summary and overall conclusions to the practicum report.

CHAPTER TWO

LITERATURE REVIEW

1. OVERVIEW

A review of the literature has been completed in an attempt to gain an understanding of (1) the nature of interdisciplinary teams, (2) the dynamic processes involved in teamwork, and (3) the role of the facilitator in improving the team's ability to work together. The purpose and goals of this practicum were based on a theoretical framework derived from a variety of sources. In addition to literature on teamwork and the interdisciplinary team approach to service delivery, there is a consideration of relevant concepts selected from adult education theory, group work theory and organization theory.

2. TEAMWORK

A. Defining team

The concept of teamwork, in both its theoretical and its practical aspects, has been receiving increasing attention in the literature during the past two decades. Brill (1976) perceives teamwork as a dynamic concept in the process of development and change, and provides a definition which includes principles basic to all teamwork:

> "A team is a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate, and consolidate knowledge, from which plans are made, actions determined and future decisions influenced." (p.22)

The "meeting together to communicate, collaborate, and consolidate knowledge" (i.e. the process of teaming) is seen by this writer as a crucial element in the concept of teamwork, and one that requires more careful attention. This element is addressed by Francis and Young (1979) in their discussion of an approach to improve work groups. Francis and Young point out that an effective team will attempt to skillfully combine the individual talents of its members with a positive team spirit to achieve results. They offer this definition of a team:

> "An energetic group of people who are committed to achieving common objectives, who work well together and enjoy doing so, and who produce high quality results." (p.8)

The study of interdisciplinary teams adds another dimension to the concept of teamwork. The interdisciplinary team concept requires not only that the above characteristics of teams be addressed, but in addition that the nature and interaction of the various disciplines represented on the team be taken into consideration.

It would be helpful at this point to differentiate the types of teams utilized in the helping professions. Bailey (1984)

describes four levels or types of teams:

1. Level one, **unidisciplinary,** in which one group of professionals deals with clients in an autonomous fashion:

2. Level two, **multidisciplinary,** in which different professionals meet as a group for diagnostic or planning purposes, but each discipline remains independent and is affected very little by contributions from other team members;

3. Level three, **interdisciplinary,** in which accomplishment of the outcome depends upon contributions from each discipline and an interactive effort among all professionals on the team; and

4. Level four, **transdisciplinary,** which is characterized by a joint team approach, staff development regarding the expertise of individual team members, and role release, in which roles and responsibilities are shared by more than one member. (Bailey, p.19)

Bailey notes that interactions, tasks, and problems in team functioning may differ depending upon the level or type of team, thus suggesting the importance of considering these distinctions when planning a team development intervention.

For the purpose of this practicum I have chosen to utilize the term **interdisciplinary team** because I believe it most accurately reflects the most necessary and effective form of

interaction for a Geriatric Psychiatry setting.

B. The team as a group

The nature and process of teamwork can be more fully understood by the application of principles from group theory. It is my sense that the study of teams ought to address not only the abilities and contributions of each member, but also the individual characteristics and personal needs of each member as well as the nature of interactions between members. These considerations would be consistent with those taken into account in group theory, which stresses the importance of individual needs and interaction patterns (Gibb, 1964; De Lamater, 1974). These points are reflected in the definition offered by Gibb (1964):

> "The term functional group refers to two or more organisms interacting, in the pursuit of a common goal, in such a way that the existence of many is utilized for the satisfaction of some needs of each." (p.25)

Viewing the interdisciplinary team as a task-oriented, problem solving group allows the incorporation of a wide base of theory and knowledge into the relatively new study of teamwork. Variables such as group development, composition, structure, individual needs, interaction patterns, environment and task are all important considerations in the analysis of teams and teamwork. While it is beyond the scope of this report to attempt a major review of group theory

literature, it is helpful to look at some specific areas which are relevant to the team as a group.

Shaw (1976), in his review of data obtained from empirical studies of groups, provides a useful summary of **plausible hypotheses**, some of which are directly relevant to the study of teams:

1. Groups usually produce more and better solutions to problems than do individuals working alone. (p. 78)
2. Individuals contribute differently to the group product, depending upon the particular other individuals in the group. (p. 233)
3. High-cohesive groups are more effective than low-cohesive groups in achieving their respective goals. (p. 234)
4. Other things being equal, groups composed of members having diverse, relevant abilities perform more effectively than groups composed of members having similar abilities. (p. 235)
5. On difficult tasks, group performance is facilitated to the extent that group members can freely communicate their feelings of satisfaction (or dissatisfaction) with the group's progress toward goal achievement. (p. 331)
6. Goal clarity and goal-path clarity are positively related to the motivational characteristics and the

efficiency of group members. (p. 333)

7. Homogeneous group goals facilitate effective group functioning, whereas heterogeneous group goals hinder effective group functioning. (p. 333)

(Selected from statements of plausible hypotheses, Shaw, 1976)

While some aspects of group theory will be incorporated into this study of teams and team building, the application does have one potential limitation which warrants discussion. Whereas in group theory (particularly in regard to therapy groups) individual growth and self-actualization are usually viewed as the ultimate goal of the group process, the ultimate goal of interdisciplinary teams is the accomplishment of a particular task i.e. efficient and effective service delivery. It is arguable that the individual needs of team members, although crucial in the process and output of the team, are of necessity seen as secondary to the overall purpose and objectives of the team. Bales (1953) developed an equilibrium hypothesis in which he viewed the accomplishment of task and group cohesiveness as two opposing forces which had to be balanced by the group. He hypothesized that groups tend to fluctuate back and forth between task and socioemotional activities, and that attention to one leads to a deterioration of the other.

In contrast to Bales, other models of group development proposed by Bennis and Shepard (1956) and Tuckman (1965) emphasize the importance of the interaction between task and socioemotional activities of the group. Both models place considerable emphasis on the socioemotional dimension, while still identifying task accomplishment as the final stage of group development. In his discussion of the relationship between task and interaction effectiveness, Bass (1960) points out that each is influenced by the other. He cites studies which demonstrate that group productivity is affected by group harmony, morale and process, and also indicates that successful or unsuccessful accomplishment of task will have an impact on interaction effectiveness.

The socioemotional activities of the group may be particularly important for women who tend to place a great deal of importance on relationships in the process of achieving the group task (Shaw, 1976; Aries, 1976; Gilligan, 1982; Schaef, 1985).

With regard to the individual needs of group or team members, Schein (1965) concludes that groups have both formal and informal functions, and that they can serve the needs of both the organization and its individual members. Schein defines the formal, organizational functions as " those which pertain to the accomplishment of the organiz-

ation's basic mission...the tasks which are assigned to the group and for which it is officially held responsible". (p.70) In addition, Schein points out that the group can fulfill a number of psychological, personal functions for its members: a) an outlet for affiliation needs; b) a means of developing, enhancing, or confirming a sense of identity and maintaining self-esteem; c) a means of establishing and testing reality; d) a means of increasing security and a sense of power , and e) a means of getting some job done which members need to have done. (Schein, 1965, p.70)

For the purpose of this practicum, the interdisciplinary team will be viewed as a task-oriented group, and intervention will be based on the hypothesis that the team needs to be involved in both task and socioemotional (interactive) activities in order to achieve maximum effectiveness.

C. The team approach

Use of teams in the human services

In the 1960's there was an emergence of literature which emphasized the importance of the group or team concept in organization and management theory.For example, McGregor (1960) noted the significance of unity of purpose and collaboration in a highly effective management team (pp.228-

229), and Likert (1961) identified the characteristics of the "ideal" effective work group (pp.166-169). Since that time, as discussed by Brill (1976), Horwitz (1970), and Valletutti and Christoplos (1977), the importance of interdisciplinary teams in the human services has become more evident in many sectors. The team approach is increasingly chosen in health care, rehabilitation services and family intervention, and has in fact been mandated in the field of special education in the United States (the Education for All Handicapped Children Act, 1975, as discussed in Courtnage and Smith-Davis, 1987).

The growing use of interdisciplinary teams in the human services emerges from two societal trends -- increased specialization, and holism. With improved technology and increased knowledge regarding the complexity of client systems, there has been a tendency towards specialization in the human services. The result has often been a fragmentation of service delivery in which the client seeks help from various professionals and agencies, none of which address the client as a complete entity. The holistic approach to service delivery stresses the importance of viewing and treating individuals as a whole, and within the context of their environment. As the needs of those seeking help are usually complex and multifaceted, it is recognized both by the providers and by the recipients of service that

in many situations no one discipline has all the knowledge or expertise required to meet the whole range of needs presented. Thus the interdisciplinary team, which utilizes the knowledge and expertise of various disciplines, is gaining increasing favour as a method for providing a holistic approach to service delivery.

As with any approach to service delivery, there are both advantages and drawbacks to the team approach. The benefits of team practice will be addressed here, and drawbacks will be discussed later in the chapter (see "potential difficulties in the team approach").

Benefits of team practice

The major assets of team practice in the human services are outlined by Brill (1976):

> 1) Demand for the services of certain specialists outstrips supply, particularly in certain areas, such as medicine, and team practice affords a medium for wider use of their expertise than does individual practice.
>
> 2) Team practice affords an opportunity for greater use of paraprofessionals in close relationship with the professionals whose core knowledge they are supporting.
>
> 3) Team practice is an experience in participatory learning for team members.
>
> 4) Team practice not only increases the effective use of specialized knowledge but also provides a more comprehensive but integrated range of service.
>
> 5) Team practice promotes focus on total problems

> rather than on segments, as well as thinking about how the parts fit together into the whole.
>
> 6) In order to coordinate specialized knowledge, teams must focus on goals that provide a necessary direction for mutual efforts, thereby producing more meaningful work.
>
> 7) The team provides a forum for examination and evaluation of ideas in light of the differing frames of reference of the various members.
>
> 8) The process of team practice possesses "emergent" qualities, which lead to self-actualization and self-renewal. It is a dynamic procedure, promoting personal and group growth.
>
> (Brill, p. 26)

Kane (1975), in her review of rationales for and against interprofessional teamwork in the literature, summarizes the rationale for teamwork in terms of benefits to the client and benefits to the professional. For the client, teamwork can facilitate coordinated and skilled service, avoidance of duplication, management of interdependent problems, a systems approach to problems, additional insights, convenience, elimination of the burden of integrating services and the potential for preventive services to be introduced along with direct services. For professionals, teamwork can provide simplified access to other professions, enhanced communication among professions, an opportunity for learning, an opportunity to practice best skills most of the time, an opportunity for less established professions to gain entry to clientele, the "shared guilt" phenomenon and the facilitation of one's own work by other professionals. (Kane, P.12)

An additional benefit of the team approach, as discussed by Fry, Lech and Rubin (1974), is synergism, or "a process by which individual pieces summed together produce an outcome which exceeds the sum of the individual parts". (p.55) This refers to the process within well-functioning teams in which the outcome achieved is superior to the sum of the individual interventions and their subsequent results. It suggests not only improved service delivery, but also a fulfilling group experience for the team members. This benefit and those discussed by Brill and Kane depict the interdisciplinary team as an effective and efficient approach to delivering a high quality, integrated service to the client system, while at the same time addressing the socioemotional aspects of the team.

The team approach in Geriatric Psychiatry

As with other client systems, the needs of the elderly are multifaceted. A complicating factor in the provision of services to elderly persons with mental health problems is the interrelationship among numerous variables which have an impact on the overall status of the older adult. The study of aging emphasizes the need for unity of the sciences -- biochemistry, physiology, psychology, sociology, and ecology --rather than compartmentalization of their respective areas of knowledge and expertise.

It is becoming increasingly evident that services to the elderly must encompass a multidisciplinary, holistic approach to assessment and treatment. The mental health problems of older adults cannot be separated from the total person, nor can the persons be separated from their total environment. As discussed by Thomae (1980), process-centered approaches to the study of aging place individuals within the context of their personal history and their situation. They address numerous factors including loss of roles, decreased economic resources, loss of significant others, housing and transportation problems, health and pharmacological problems, sensory or cognitive deficits, decreased mobility, and the resultant loss of independence, lack of participation in meaningful activities, and social isolation (Thomae, 1980, pp.293-295). These physiological, psychological, social, emotional and environmental factors are so intertwined that they often affect each other in a cyclical pattern, making it difficult to detect and treat the primary problem. Assessment and treatment of the elderly with mental health problems, to be effective, must necessarily focus on more than one variable in this cycle. It is also important for teams working with this population to recognize the strengths and positive chararateristics (e.g. knowledge, experience, coping skills) which the elderly bring to their current situation.

As summarized by Busse and Pfeiffer (1977, p.169) and Gatz, Smyer, Lawton and Powell (1980, pp.8-9), the needs of the aged mentally ill have not been adequately met by traditional mental health programs or services to the elderly. This group is characterized by a high rate of institutionalization and custodial care, as well as a great deal of neglect in the community. In recognition of the special needs of this population, the field of Geriatric Psychiatry has evolved in recent years. The goals of a geriatric psychiatry program, simply stated, are:

1) to assist the elderly person in achieving his optimum potential in physical and mental functioning;
2) to maximize the individual's self-esteem, integrity, dignity and quality of life; and
3) to minimize intrusive treatments and institutionalization, and facilitate reintegration into their community and social network (Seven Oaks General Hospital Planning Document,1983).

Towards the accomplishment of the above-stated goals, a geriatric psychiatry program utilizes a combination of treatment modalities. These include milieu therapy, medical treatment, nursing intervention, individual counselling and

psychotherapy, family and group therapy, pharmacotherapy, and behaviour management. Occupational, physical and recreational therapies are also a vital part of a geriatric psychiatry program. In recognition of the intermingling of biopsychosocial factors and the need for a number of disciplines to address these factors, the interdisciplinary team approach is favoured for assessment and intervention.

The importance of an effective interdisciplinary team approach in geriatric services is summarized by Skelton (1986):

> "To contribute the maximum benefit to our aged patients we must practice as interdisciplinary team members. The therapeutic team consists of professionals, trained in complementary disciplines, who function interactively to ensure the optimum expression of skills and to assist the elderly to find the most acceptable solutions to their problems. There is no place for individual philosophies, or personal and professional jealousies, which may override or distort this fundamental goal." (p.22)

This statement also reflects a recognition of the important role that socioemotional factors within the team play in the accomplishment of task, with the suggestion that poor team functioning as reflected in "individual philosophies, or personal and professional jealousies" may "override or distort" accomplishment of task.

Organization Theory as it relates to the team in the hospital setting

As discussed by Horwitz (1970), Beckhard (1974a), Likert (1961) and Knowles (1970), the relationship between workers and the organization is an important determinant of morale and effectiveness. Likewise, the existence and functioning of an interdisciplinary team is greatly affected by the nature of the organization within which it practices. Likert, in developing patterns of management based on human relations theory, stated that:

> "the leadership and other processes of the organization must be such as to ensure a maximum probability that in all relationships with the organization, each member, in the light of his background, values, desires and expectations, will view the experience as supportive and one which builds and maintains his sense of personal worth and importance". (Likert, 1961, p.103)

In discussing the team approach to care of the elderly, Rao (1977) also noted the important role of the organization:

> "In developing and facilitating a healthy, integrated relationship of the team of different health care professionals in the care of the elderly, the role of the managers or administrators is of supreme importance. The creation of a suitable functional environment, the coordination of interdepartmental and interdisciplinary activities, and the knitting of cohesive relationships requires great tact and wisdom.... Under suitable conditions, the productivity of the team can be greatly enhanced." (p.96)

The characteristics of innovative organizations as described by Knowles (1984) are viewed by this writer as compatible

with the development and enhancement of an interdisciplinary team approach. Some of these include flexibility, multiple linkages based on functional collaboration, a willingness to take risks, emphasis on personnel and resource development, relevant participation by all those affected, and an open, multi-directional flow of communication in which feelings are allowed to be expressed. (Knowles, p.100)

The hospital setting is one which depends heavily upon the interdisciplinary team approach, but this does not negate the possibility of conflicts arising. Coe (1970), in discussing hospitals as professional bureaucracies, states:

> "They are designed to be most efficient where tasks are both uniform, requiring a highly formalized administrative authority, and non-uniform, demanding a high degree of professional autonomy....hospitals have a hierarchy of positions and clearly marked, formal channels of communications, along with an elaborate set of codified procedures for the conduct of affairs of the organization. Concommitantly, the structure of the hospital is permeated with professional persons in several disciplines, each of whom retains a degree of autonomy with respect to work within his area of expertise.....thus as organizations, hospitals tend to be both resistant to innovations, yet at the same time, uniquely suited to permit such changes." (p.8)

The professional bureaucracy model shows how a hospital combines formality and informality, rigidity and flexibility, and centralization and decentralization in its structure in order to be responsive to both its internal and

external objectives. As noted by Coe, this organizational structure of hospitals provides both barriers to, and opportunities for change and innovation. The implications for interdisciplinary team practice are that the organization defines the team, its members and its tasks, and also sets the parameters within which the team must operate. Organizational characteristics such as structure, formal and informal lines of communication, goals, and power and authority with regards to decision-making are all influential in the development and ongoing functioning of the team.

Within the interdisciplinary team, individual professionals have a degree of autonomy with regards to their input with the client system. However, considerable coordination of the efforts of all team members is required in order to ensure effective and efficient service delivery. This coordination of team effort requires structural flexibility, open communication, participatory decision-making, and goal congruence. As discussed by Brill (1976) and Ducanis and Golin (1979), among others, difficulties often arise in meeting these requirements both within the team itself and in the team's relationship with the parent organization. Some of these difficulties would have to be kept in mind when planning and implementing a team development intervention, and so are noted here briefly:

1) While teamwork emphasizes professional autonomy and democratic process, the team must still function within an organization which is bureaucratic.

2) The goals of individual professionals on the team may be in conflict with the goals of other disciplines, and/or the goals of some or all team members may differ significantly from certain goals of the organization.

3) Although the team concept implies that each member participates equally in the decision-making process, in reality participation is determined to a large extent by personal characteristics, interdisciplinary perceptions, and relative status in the organization. (For example, in the hospital where the medical model prevails, the physician and psychiatrist may exercise veto power even when there is consensus among other team members).

4) Lines of communication between team members and between the team and the parent organization are often blurred or poorly defined due to the complexity of the structure.

The potential difficulties listed above suggest that it is important for the team to develop an awareness of the organization's characteristics and the impact that these

have on the development and ongoing functioning of the team.

3. POTENTIAL DIFFICULTIES IN THE TEAM APPROACH

A. Desired characteristics of teams

As discussed previously, two functions must be addressed by the interdisciplinary team:

(1) the **task (or service delivery) function,** which refers to the accomplishment of the team's goals, and

(2) the **team (or group maintenance) function,** which refers to those internal processes by which the team accomplishes its task. There is evidence in the literature to indicate that if certain conditions are achieved within the team process, there will be a positive impact on task accomplishment (service delivery).

Beckhard (1974b) postulated that a productive and effective team with high morale would have more energy to put into patient care because less energy would be needed for team maintenance and coping with interpersonal problems of its members. He listed six dimensions in team productivity and effectiveness which provide a good basis for discussion:

1) Clarity of objectives and mission: The goals and objectives of the team should be specific,

clearly articulated, and shared by all team members.

2) Good decision-making and problem-solving processes: All team members should develop skills which will allow the team to arrive at a "best" decision which is supported by all team members.

3) Clear role expectations: There should be open discussion leading to an understanding of the roles of each team member, realistic expectations regarding each member's contribution, and an awareness of overlapping roles.

4) Norms that support the task: Ground rules are needed to help team members achieve the team's objectives. These norms include sharing of information critical to the treatment plan as well as sharing anxieties or concerns regarding individual performance.

5) Concern for each other's needs: To the degree that there is a norm of concern for each team member's needs, the team is able to function more effectively and more energy is thus available for patient care.

6) Optimizing resources for growth: To the degree that the team makes use of its various resources to contribute to the knowledge and effectiveness of each member, team functioning as a whole will be enhanced. (Beckhard, 1974, pp.95-98)

Garner (1982), in discussing staff development in skill areas related to team functioning, suggests that the three processes of communication, cooperation and coordination are essential to effective team functioning. Drawing on small group behaviour research, Garner stresses the importance of the group process in teams: that each member should be valued and respected, should be given significant weight in the decision-making process, and should be able to communicate openly and derive satisfaction from the group process

(pp. 116-118). Garner supports the view expressed by Beckhard that when the team goals and the means of achieving these goals are clearly stated and accepted by all members, this will have a positive impact on morale and task orientation on the part of the team members.

Chartier et al (1984), in addressing the need for interdisciplinary education, stress and expand upon the need for clear role expectations. They cite three factors which are crucial to this process: a) well-established levels of collaboration; b) good professional identity on the part of individual team members; and c) mutual recognition of the competence of each team member (pp.13-15) Their study showed the importance of each team member being conscious of, and secure in, what they can contribute to the task as a result of their knowledge and skills, and being able to communicate this effectively to the other team members. This ability allows for an improved understanding of the unique contributions and capabilities of each team member, and allows the team to specify what can be expected from each member in their collaborative effort.

B. Drawbacks in team practice

The desired characteristics of teams discussed above and the benefits of team practice outlined earlier in this chapter present the more positive, ideal side of teamwork. In

reality, there can be many negative or less desirable aspects of teamwork as well. Brill (1976) sees the following as the major liabilities, or "problems", in team practice:

> 1) Participatory democracy tends to be cumbersome and slow-moving, and team practice, in so far as it is a democratic form of operation, may partake of these characteristics.
>
> 2) In team practice, there is frequently less contact with the client or consumer of the service, as workers are operating in the interest <u>of</u> him, rather than <u>with</u> him.
>
> 3) There are major problems of communication in teams, which limit the effectiveness of the work.
>
> 4) Teamwork often seems to lead to greater rather than less fragmentation of service.
>
> 5) Team meetings are often more time-consuming for busy specialists than are consultation and referral outside the team framework.
>
> 6) The tensions that exist between various disciplines and the lack of clear definitions of boundaries of knowledge and expertise often make teamwork extremely difficult.
>
> 7) Problems in role definition are very great, and overlap is frequent.
>
> 8) Some workers on all levels in human services are not only not committed to teamwork but are poorly equipped for it.
>
> 9) The team situation fosters undesirable competition.
>
> 10)Differences in status among team members and inequities in regard for service frequently make team practice difficult. (Brill, pp. 26-27)

Another area of concern, as discussed by Abramson (1984), is the issue of collective responsibility in interdisciplinary collaboration, and how this relates to each professional's

value system and ethical commitments. To the extent that this issue is not dealt with, difficulties may arise in the team's decision-making process. Kane's (1975) list of rationales against teamwork in the literature contains the same points identified by Brill and Abramson, as well as one other. She notes that for the professional, teamwork may mean isolation from colleagues, less professional stimulation and evaluation by those outside the profession (Kane, p.12). However, Kane also points out that the arguments presented against teamwork tend to concentrate on characteristics of the malfunctioning team unit, suggesting that many of these drawbacks may be avoided by well-functioning teams. This viewpoint appears to be the underlying philosophy of Valletutti and Christoplos (1977), who advocate the training of professionals toward goals of interdisciplinary cooperation as a means of maximizing the benefits and minimizing the drawbacks of interdisciplinary team practice. (pp.1-7)

C. Potential Barriers to effective team functioning

While there appears to be a general consensus about the benefits of a well-functioning interdisciplinary team, and also about the characteristics which contribute to team effectiveness, a search of the literature also yields information about potential barriers to effective team functioning. As a general statement, each of the elements

which is believed to contribute to effective functioning also has the potential of becoming a source of conflict or dysfunction.

In order to promote effective team processes and collaboration towards task accomplishment, it is necessary that these potential sources of conflict be recognized and dealt with. As noted by Fry, Lech and Rubin (1974) and Lowe and Herranan (1978), failure to deal with conflict or dysfunction within the team or in the team's interaction with its external environment may be easier in the immediate sense, but in the long run it will have a negative impact on both staff morale and service delivery.

The sources of conflict and/or dysfunction can be grouped into four broad categories: 1) organizational/environmental climate; 2) role expectations; 3) the profile of individual team members; and 4) communication and collaboration processes.

1) Organizational/environmental climate

Any effort to enhance team effectiveness must incorporate an understanding and evaluation of the interface between the team and the organization. Some of the difficulties the team may experience in relation to the organization and its external environment have been presented earlier in this

paper in the discussion of the team in the hospital setting. These include goal congruence, communication and decision-making processes, and professional autonomy. Other aspects of the environment to be considered include the formal and informal linkages between the team, the organization and the community, the physical location of the team within the organization, and the perceptions and expectations of those outside the team.

One potential pitfall is identified by Pray (1969) in his discussion of academic teams, and is applicable to other settings as well. Pray notes that an interdisciplinary team may receive so much attention that other members of the organization may feel neglected, and that this is especially true when the team concept is first introduced. He suggests that "a simultaneous emphasis on the contributions and importance of other departments...can forestall the potential growth of professional jealousy" (Pray, 1969, p.94). Blake and Mouton (1965), in their "Six-Phase Approach to Organization Improvement", also note that although team training is an essential phase it is necessary to keep this within the context of the total organization. They see the team as the "fundamental building block of an organization", but emphasize that the primary goal of organization improvement efforts is "to change patterns of relationships between people and groups or between a group and the organization so

that more effective problem-solving and greater production effort can occur throughout the entire organization" (Blake and Mouton, 1965, pp.170-178).

2) Role expectations

Members of interdisciplinary teams are expected to co-ordinate their activities through cooperation and collaboration. This involves a process of working together, based on an understanding of the professional skills and knowledge of each team member, and how these relate to the accomplishment of goals. Difficulties may arise in the areas of role definition, role conflict and role overlap.

Role definition is an important determinant in effective team functioning. **Role clarity** exists when team members have a clear understanding of their own areas of expertise and responsibility as well as those of other team members. **Role ambiguity** can result when expectations are not clearly defined and/or communicated. Interdisciplinary studies have shown that there is often little congruence between the way a profession defines its own roles and the way others define them (Kane, 1975, p.22). Failure to achieve role clarity can result in an underutilization of the team's individual and collective skills.

Role conflict can occur under a variety of circumstances. As

discussed by Fry, Lech and Rubin (1974), the existence of multiple role expectations is a critical factor affecting the members of most groups. **Role conflict** can arise when there is incompatibility between the expectations of self and others (e.g. being asked to limit treatment to medical needs when one believes in a holistic approach), or when two or more members of the team or organization place demands on the individual which are inconsistent and thus in conflict. Another source of conflict can be **role overload,** or the extent to which an individual is capable of meeting multiple demands and expectations. (Fry, Lech and Rubin, 1974, p.35) Studies have found that role conflict is positively related to job dissatisfaction, tension and anxiety, propensity to leave, lack of confidence in the organization, and inability to influence decision making. (Rahim, 1986, p.45) Rahim suggests that role conflict need not necessarily be reduced or eliminated, but rather that it should be managed to increase organizational effectiveness.

Role overlap is to be expected in interdisciplinary team practice because of some of the commonalities of philosophy, goals, knowledge base and skills among the various disciplines. Due to rapidly increasing knowledge in the human services and adoption of the holistic approach to service delivery, the boundaries between disciplines are fluid rather than rigid, and are being continually redefined.

While a certain amount of role overlap may be desirable and beneficial to client care, failure to clearly delineate the unique contributions to be made by each team member can have a negative impact on the team and ultimately on service delivery. Professionals may feel threatened by overlapping roles and fear a loss of status on the team, resulting in defensiveness, territoriality, and a resistance to sharing information. (Kane, 1975; Lowe and Herranen, 1978) If left unaddressed, role overlap can also result in independent and parallel functioning, and unneccessary duplication of work.

3) The profile of individual team members

A study of interdisciplinary team functioning and proposal for team development would not be complete without consideration of the team members as individuals. Each team member enters the team with his or her own personality, values, interests, attitudes and ways of thinking and working. Group theory tells us that if openness and satisfaction are to be achieved, all team members need to be valued, accepted and respected (Horwitz, 1970). The behavioural sciences provide a background for considering the personal characteristics of individual team members and appreciating their differences. Kiersey and Bates (1984) focus on this viewpoint in their discussion of different character and temperament types:

> "People are different in fundamental ways. They **want** different things; they have different motives, purposes, aims, values, needs, drives, impulses, urges. Nothing is more fundamental than

> that. They **believe** differently: they think, cognize, conceptualize, perceive, understand, comprehend, and cogitate differently. And of course,manners of acting and emoting, governed as they are by wants and beliefs, follow suit and differ radically among people." (p.2)

The importance of respecting the individual as a necessary factor in the accomplishment of organizational goals is also recognized in organizational development and management theory. For example, Peters and Waterman (1982), in their study of America's best-run companies, found the theme of respect for the individual to be most pervasive. They note the fundamental lessons from the excellent companies researched:

> "Treat people as adults. Treat them as partners; treat them with dignity; treat them with respect. Treat **them** -- not capital spending and automation -- as the primary source of productivity gains." (Peters and Waterman, 1982, p.238)

Of the eight basic principles for excellence in companies identified by Peters and Waterman, two relate directly to employees as individuals: Principle Four, Productivity through people -- creating in **all** employees the awareness that their best efforts are essential and that they will share in the rewards of the company's success; and Principle Eight, Simultaneous loose-tight properties -- fostering a climate where there is dedication to the central values of the company combined with tolerance for all employees who accept those values (Peters and Waterman, summary of

principles).

Other studies have looked at individual workers in terms of personal needs, and the factors which can lead to job satisfaction or dissatisfaction. Herzberg (1968), drawing on a sample of 1,685 employees at different levels in various settings, found that the growth or **motivator** factors that lead to extreme job satisfaction are achievement, recognition for achievement, the work itself, responsibility, and growth or advancement. The avoidance or **hygiene** factors that lead to extreme job dissatisfaction include company policy and administration, supervision, interpersonal relationships, working conditions, salary, status and security. (p.57)

Another factor to be considered, particularly when looking at newly-formed teams, is what has motivated the individual to become a part of that team. A combination of some of the motivator and hygiene factors listed above is likely. As discussed by Sarason (1972), members are attracted to new settings because they believe they will have an opportunity to work and develop in ways superior to those in their old setting. Problems can arise when they encounter similar conflict, controversy and disruption in their new settings. Sarason emphasizes that if the positive characteristics of groups in new settings (i.e. high enthusiasm, sense of

mission, the stimulation of novelty, the challenge of personal and professional growth, and anticipation of the consequences of success) are to remain intact, there must be an attempt to prevent the problems from obscuring them:

> "...dealing at the outset with problems and issues that exist or may exist is not a panacea but it is far more productive than denial, silence, and clichés about virtue and an untroubled future." (Sarason, 1972, p.80)

Interacting with the characteristics of team members as individuals, members of a team, and employees of an organization are factors related to their professional background. Brill (1976) provides a "Cross-section of a Team Member" (see Appendix 1) which, in addition to the factors discussed above, includes reference to both generalist and specialist knowledge. She describes generalist knowledge and skill of individual workers as that which they hold in common with other team members and makes it possible for them to work on an interdisciplinary team. In discussing specialist knowledge and skill Brill notes that "professions not only differ in the essential components of practice -- values, knowledge and skill -- they also exist in a hierarchy, with the older, more established ones...possessing major status and the more recent ones... possessing lesser status." (p.38) Dependent upon the maturity and openness of team members, differences in professional background and relative status can be either an asset or a source of conflict or dysfunction within the team.

4) Communication and collaboration processes

It is an expectation that members of an interdisciplinary team will cooperate and collaborate with others in order to accomplish team tasks. For this to occur, knowledge and skill in effective communication and the processes of group problem-solving and decision-making are essential. Most professionals in the human services have a degree of knowledge and ability in these areas related to direct service to the client system, but frequently attention must be drawn to the need to develop these processes within the team itself.

Wise, Beckhard, Rubin and Kyte (1974) point out that flexibility, mutual support and open communication need to be established as norms of the team. They note four factors which affect communication and information flow within the team and between the team and its environment:

a. **geographical and architectural factors** -- which includes a consideration of location, access, and barriers to quick and open communication;

b. **formal lines of authority and status** -- the best sources of information to solve a problem will vary with the problem: is participation in terms of frequency, order or content limited to **formal** lines?

c. **the degree to which participants feel free** to

participate, challenge and express opinions; and

d. **leadership** -- depending upon the situation and the problem to be solved, different people can and should assume leadership, allowing for many **acts** of leadership rather than one leader. (Wise et al, p.37)

A fifth factor, noted by Makay and Gaw (1975), can be added to the above list:

e. **an atmosphere of trust** -- this allows for clarity, openness and honesty in communicaton. (p.220)

Makay and Gaw summarize the conditions which ought to prevail if dialogic interpersonal communication is to take place:

1. Involvement and a felt need to communicate.
2. Atmosphere of openness, freedom and responsibility.
3. Mutual trust and respect.
4. Sincerity and honesty in attitude toward communication.
5. Appreciation of individual differences and uniqueness.
6. Acceptance of disagreement and conflict with a desire for resolution.
7. A willingness to admit error and allow for persuasion.
8. Dealing with issues and values.
9. Effective feedback and use of feedback.
10. A positive attitude for understanding and learning.

(Makay and Gaw 1975, p.144)

Makay and Gaw suggest as well the importance of an honest (as opposed to vicious) sense of humour, particularly in dealing with situations which may lead to angry or defensive communications. (p.220)

Gibb (1970) notes that perceived or anticipated threat in a group setting may result in defensive communication. He found that defensive climates are characterized by evaluation, control, strategy, neutrality, superiority and certainty, while supportive climates are characterized by description, problem orientation, spontaneity, empathy, equality and provisionalism. (p.301) Although Gibb acknowledges that other interacting factors determine the degree of perceived threat, he feels it is important to be aware of, and avoid, behaviours that lead to a defensive climate. He concludes that

> "arousing defensiveness interferes with communication and thus makes it difficult -- and sometimes impossible -- for anyone to convey ideas clearly and to move effectively toward the solution of therapeutic, educational or managerial problems." (Gibb, 1970, pp.306-307)

Decision-making and problem-solving are complex processes entered into by all interdisciplinary teams. They occur both within the team and at the interface between the team and the organization, and are influenced as well by the client group and community forces. Chase, Wright and Ragade (1981) applied general systems theory concepts to an analysis of decision-making in an interdisciplinary team, and found that this approach was useful not only in auditing treatment plans but also in providing a means by which to evaluate strengths and weaknesses in team functioning. (pp.213-214)

Rubin, Plovnik and Fry (1975) provide a simple and useful summary of the decision-making and problem-solving processes in their program for health team development. Their problem-solving model involves five stages:

a. **assessment** --defining the problem;
b. **analysis** --generating alternatives;
c. **choice** --selecting the "best" alternative;
d. **action** --implementing the solution; and
e. **evaluation** --testing how well the solution worked, which feeds back to the assessment stage, or reassessment. (p.149)

It is noted that at each stage in the problem-solving process and in moving from one stage to the next, decisions are made. The decision-making checklist presented by Rubin, Plovnik and Fry consists of four questions to be addressed by team members:

a. What exactly are we trying to decide?
b. Who needs to be involved?
c. How are people to be involved? (i.e. directly, consulted or informed)
d. When will the decision be made? (pp.151-154)

Thibaut and Kelley (1959), in discussing group problem-solving, point out that group effectiveness can not be evaluated wholly in terms of the group's problem-solving

efforts. They emphasize the importance of an adequate understanding and acceptance of group solutions in order to ensure commitment to, and action towards, these solutions. They conclude that

> "if general participation in developing and planning a means heightens understanding of it and commitment to it, the group problem-solving process may be more economical in the long run than one that begins with the most expert thought and advice." (Thibaut and Kelley, p. 272)

Leadership in the team is also an important variable to be taken into consideration when assessing and intervening in team dynamics and functioning. Brill (1976) distinguishes three categories of leadership: designated, emergent and situational.

(a) The designated leader is selected by the organization or by the team itself to perform the leadership role. If this person is both a specialist on the team and the administrative leader, she/he may at times be in a position of experiencing role conflict.

(b) Emergent, or "natural", leaders usually arise in the process of team operation, on the basis of personal charisma, authority of Knowledge, ability to communicate, and ability to use the system. If both a designated and an emergent leader are present, their ability to collaborate with each other is essential for effective team functioning.

(c) Situational leadership occurs when the leader changes with the situation, dependent upon skill and knowledge in a particular area. This type of leadership is increasingly used as the team matures and is able to fully utilize the capacities of all team members. (Brill, 1976, pp. 90-91)

Communication, decision-making, problem-solving and team leadership are all very complex processes which, if handled poorly can have a negative impact on the team and its effectiveness, but if developed can promote optimum team functioning.

D. Conflict in teamwork

In the preceding discussion there are numerous references made to the potential areas of difficulty or conflict which may exist both within a team and between the team and its environment. As dealing with conflict can occupy a considerable amount of time and energy on the part of the team, it is an essential issue to be explored for the purpose of this practicum.

The nature of conflict

Rahim (1986) defines conflict as "an interactive state manifested in disagreements, differences, or incompatibility within or between social entities, i.e. individual, group,

and organization". (p.21) He classifies conflict on the basis of its source and also on the basis of the organizational levels at which it occurs. The types of conflict and conditions which lead to them are described as follows:

1. **Affective conflict,** which occurs when feelings and emotions are incompatible;
2. **Conflict of interest,** which occurs when two social entities compete for scarce resources;
3. **Conflict of values,** which occurs when values or ideologies on certain issues differ;
4. **Cognitive conflict,** which occurs when two interacting social entities become aware that their thought processes or perceptions are incongruent;
5. **Goal conflict,** which occurs when a preferred outcome or an end-state of two social entities is inconsistent;
6. **Substantive conflict,** which occurs when the members of a group disagree on their task or content issues. (Rahim, 1976, pp.15-16)

The levels at which conflict may occur in the organization are described by Rahim as:

1. **Intrapersonal** -- when a member is required to perform certain tasks and roles which do not match his or her expertise, interests, goals or values;
2. **Interpersonal** -- conflict between two or more members of the same or different hierarchical levels or

units;

3. **Intragroup** -- incompatibilities or disagreements among members of a group, between two or more subgroups within a group, or between some or all members of a group and its leader(s); and

4. **Intergroup** -- conflict between two or more units or groups within an organization. (pp.16-17)

Positive functions of conflict

The occurrence of conflict within a team is natural and is not necessarily a disruptive force. As discussed by Deutsch (1969), Petelle (1970) and Fisher (1980), conflict can be a positive force which serves several functions in the process of social interactions. Deutsch distinguishes between constructive and destructive conflict, stating

> "a conflict clearly has destructive consequences if the participants in it are dissatisfied with the outcomes and all feel they have lost as a result of the conflict. Similarly, a conflict has productive consequences if the participants all are satisfied with their outcomes and feel that they have gained as a result of the conflict."
> (Deutsch, 1969, p.10)

Deutsch also distinguishes between manifest and underlying conflict, and notes that

> "manifest conflict often cannot be resolved more than temporarily unless the underlying conflict is dealt with or unless it can be disconnected and separated from the underlying conflict so that it can be treated in isolation." (pp.10-11)

The positive functions of conflict can be summarized as follows:

--it prevents stagnation, stimulates interest and curiosity, and is the medium through which problems can be aired and solutions arrived at (Deutsch,1969, p.19)

--it generates and promotes discussion, and is a stimulant to group interaction and increased participation by under-involved members;

--it aids cohesiveness in a group and provides an outlet for hostility;

--it performs a catalytic function in developing the social organization of the group (Fisher, 1980, pp.236-239)

--it is highly valuable in achieving consensus and also promoting commitment to decisions made by a group, because it forces the group to discuss issues and options more fully before making a decision (Fisher, p.146)

--it can be the prime agent which brings groups or individuals together, thus establishing communication where none existed before;

--it can be an indicator of group stability in that the more intimate and secure the group, the more frequent and intense the conflict will be; and

--it can encourage inquiry, promote objectivity, and sharpen analysis (Petelle, 1970, pp.145-147)

Managing conflict

Rahim (1986) differentiates styles of handling conflict based on the two dimensions of concern for self and concern for others. The five styles are integrating, obliging, dominating, avoiding and compromising. (pp.18-19) Rahim notes that although the integrating or problem-solving style is generally accepted as the best for dealing with interpersonal conflict, each of the styles can be appropriate under certain circumstances. (p.78)

Fisher promotes the use of "conflict management", not to necessarily resolve or limit conflict, but to deal with it as a normal and ongoing interactive process. He describes conflict management as "the interaction sequences developed by a group to deal with social conflict and consistently used by the group when social conflict occurs". (p.237)

Given the above, managing conflict would appear to be an essential skill to be developed by a team in order to promote and utilize the beneficial aspects of conflict and minimize its potentially destructive impact.

4. RATIONALE FOR INTERVENTION

A. The Autotherapeutic Model

As discussed earlier in this chapter, the two functions which must be addressed by the interdisciplinary team are the task function and the group maintenance function, and these functions are interrelated. Both the internal characteristics and processes of the team and the nature of its external environment will have an impact on the team's effectiveness in accomplishing these two functions.

Fry, Lech and Rubin (1974) provide a useful model which incorporates both the internal and external characteristics of the team, and relates process to outcome. They view the health team as an autotherapeutic organism operating within a given life space (See Appendix 2). Their theory is that if a team learns to communicate, manage, support, grow and problem-solve, there will be less anxiety and thus more energy available for patient care. This results in improved health care delivery which in effect "re-charges the team battery", resulting in an autotherapeutic, self-renewing cycle. Alternately, if the team fails to develop these skills, there is more anxiety and less energy available for patient care, resulting in a "draining of the team's battery" and a negative spiral.(Fry et al, pp.28-29)

B. Training for teamwork

The frequency and quality of interactions between professionals is crucial to their understanding of each other and will not only influence their participation on the team, but as noted above will also have a substantial impact on service delivery. In order to prevent disruptive conflict and unnecessary duplication of service, a great deal of maturity and flexibility is required by team members. If each discipline's roles and expertise are known and accepted, it will become possible to allocate tasks and responsibilities on the basis of what would be in the best interests of the client system. However, it is only when individual team members are confident in their own professionalism as well as that of their teammates that they will be willing to let go of territorial tendencies and promote overall team effectiveness through negotiation and collaboration.

Unfortunately, professional training does not usually prepare individuals to work interactively as members of interdisciplinary teams. As noted by Garner (1982) professionals in most disciplines have usually received initial training in skills related to teamwork (e.g. communication skills, problem-solving and decision-making), but the

quantity and quality of their experiences will vary greatly, and little training is provided in understanding and supporting colleagues in other disciplines. (pp.75-76) Schein (1972) notes that one drawback in professional education is that it trains professionals to think of themselves as autonomous experts, rather than training them to take part in the interdisciplinary problem-solving efforts required to solve society's increasingly complex problems (p.39). Chartier et al (1984) note the need for professionals to have a strong professional identity and the ability to specify their thinking with regards to their own discipline, as well as to broaden their perspective regarding other disciplines (p.13). Williams et al (1978), in a study of social workers and nurses in hospital settings, found that before and during professional training students had little to no contact with members of the other discipline. As professionals they had a high degree of contact with each other, for example in joint interviews, care planning, meetings and case conferences, but they had received little preparation for this type of interdisciplinary interaction (p.317-318).In the work setting, as noted by Garner (1982), most inservice training focusses on what professionals do to and with the client system, rather than on how they work together.

Professionals who have been inadequately trained for

interdisciplinary practice may lack not only the skills but also the attitudes required for effective teamwork. The success of interdisciplinary teamwork depends a great deal on the attitudes or mind-set of individual team members [Brill (1976), Falck (1977), Garner (1982)]. Falck summarizes the major attitudes required for successful interdisciplinary practice:

> 1) Thorough commitment to the profession's values and ethics, and belief in the usefulness of one's own profession.
>
> 2) Belief in a holistic approach to client problems.
>
> 3) Recognition of the interdependency of practice.
>
> 4) Recognition of the expertise of colleagues and others. (Falck, 1977, p.36)

If the above attitudes and related teamwork skills are not acquired during professional training, then it becomes a team task to ensure they are developed. Falck comments on the importance, and also the difficulty, of this task:

> "Interdisciplinary practice is a form of behavior that must be specifically learned, and involves persons who make mutual adaptations to each other's differences around such variables as profession, method, use of knowledge, skill, and professional goal. Interdisciplinary practice is a special case of polyvariate adaptation. It poses the problem of individuation and groupness within the same social framework." (p.36)

C. The need for a change agent

Although team members may become aware of interprofessional, interpersonal or intergroup difficulties, there is still a strong motivation to maintain the status quo and resist change. Ends and Page (1977) note that most adults tend to resist change for a variety of reasons, including inertia, the influence of past experience, the influence of the person's self-concept, the risk of failure and the perception of psychological advantage or disadvantage. (p.75) In addition to the above, for interdisciplinary teams a major reason for resistance to change may be a perceived lack of time to address issues not obviously and directly related to service delivery. Thus teams may continue to function less than optimally rather than address their need for change or growth.

In view of the tendency of individuals and teams to resist change, Francis and Young (1979), Schein (1972) and Schon (1983) discuss the need for a catalyst --someone who is willing to intervene in the status quo and promote change, and who also has an idea of how to accomplish this change effectively. A change agent can be instrumental in helping the team achieve a "self-renewing cycle" as discussed in the Autotherapeutic Model (see p. 50).

As defined by Schein (1972), planned change "involves the learning of new concepts and ideas, new attitudes and values, and new patterns of behavior and skills" (p.75). In the case of interdisciplinary teamwork, planned change can take the form of team building or team development in which the change agent plays a role in facilitating optimal team functioning. As identified by Kolb and Frohman (1970), planned change involves a series of activities to be carried out by the change agent. These are scouting, entry, diagnosis, planning, action, evaluation and termination. For a discussion of the Kolb-Frohman Model for Planned Change and how it was used in this practicum, please refer to Chapter Three.

5. Summary

This chapter has reviewed the literature in an attempt to gain a clearer understanding of the importance, nature and dynamics of interdisciplinary teams. Both benefits and drawbacks in team practice were reviewed, as well as potential barriers to effective team functioning both within the team and in its external environment. The nature of conflict and the management of conflict in teamwork was explored. Finally, a rationale for intervention was presented, based on the "Autotherapeutic Model", the lack of training for teamwork, and the need for a change agent.

CHAPTER THREE

INTERVENTION

1. DESIGNING THE INTERVENTION

While numerous studies have investigated specific aspects of group or team functioning (e.g. communication patterns, decision-making, group effectiveness), or reviewed areas of concern (e.g. conflict management, role conflict), there has been relatively little written about actual attempts to design, implement and evaluate team development interventions. In this section there will be a review of team development efforts discussed in the literature, and a review of theories relevant to the planning and implementation of a team development intervention -- stages of team development, adult education theory and group theory. There will also be a discussion of the role of facilitator in team development. Finally, based on the above, the framework for team development designed for this practicum will be presented.

A. Organizational Development

In the past two decades team development has become one of the most respected and frequently employed organizational development strategies, with a widespread belief that it is

effective in improving both internal team processes and team productivity [DeMeuse and Liebowitz (1981), Dyer (1977)]. However, lack of experimental rigor has led to questions about the effectiveness and the appropriateness of team development interventions [Woodman and Sherwood (1980), DeMeuse and Liebowitz (1981)]. For example, Woodman and Sherwood (1980) found little research that supported a direct causal link between team development and behavioural changes. Boss and McConkie (1981) describe a team development intervention which appeared to be highly successful for the team involved in the short run, but in the long run proved to be extremely negative and divisive for the organization in which it took place. This example highlights the importance of designing interventions in the context of the total organization over the long term.

Although there appears to be little empirical evidence supporting the efficacy of team development interventions, there continues to be considerable theoretical and anecdotal support for this strategy. The problems stem from two sources: 1) methodological problems (including inadequate controls and inadequate measures of change) which lead to ambiguous interpretations of results, and 2) a continuing lack of clarity regarding the conceptual definition and operationalization of team development interventions [DeMeuse and Liebowitz (1981), Hughes et al (1983)]. The

methodological problems will be discussed further in Chapter Four. The conceptualization and operationalization of team dvelopment interventions will be addressed here.

In the literature, efforts to intervene in, and improve, team functioning are referred to as team building, team development, or team improvement. There has been little attempt made to differentiate between the different conditions and approaches implied by these terms, and they are often used interchangeably [Blake and Mouton (1975), Dyer (1977), Ends and Page (1977), Liebowitz and DeMeuse (1982)]. In this discussion the actual terms used by the various writers will be used in describing their work. Further reflection on these terms and the approaches they imply will be presented in the planning of the intervention used in this practicum.

1. Historical Overview

Team development activities began to emerge in the late 1950's with the application of behaviour science theory to management practice and organizational development, and began to increase rapidly in these areas in the late 1960's and early 1970's. Initial efforts focussed on training at the management level, often utilizing the T-Group method or laboratory training in the hope that the results of such interventions would have a positive impact on the whole

organization (Schein and Bennis, 1965). Gradually it became evident that these methods and the focus on management as the unit of training were not sufficient to effect organizational change, and there was a move towards involving the whole work group or team in development efforts [Blake and Mouton (1965), Galbraith (1973), Dyer (1977), Ends and Page (1977)].

The 9,9 approach to organizational improvement developed by Blake and Mouton (1965) and based on their Managerial Grid is an example of an intervention strategy aimed initially at management but also incorporating team training as an essential phase. The primary goal of their approach is "to change **patterns** of relationships between people and groups or between a group and the organization so that more effective problem-solving and greater production effort can occur throughout the entire organization" (p. 170). Their method involves six phases which may occur successively, simultaneously, or in different order depending upon the circumstances:

> Phase One, Learning to apply behavioural science theory of solving problems of work in a human laboratory;
>
> Phase Two, Team Training, initiated at the top and continued on downward through the organization to aid vertical linking;
>
> Phase Three, Horizontal Linking, with a focus on intergroup problem-solving;
>
> Phase Four, Setting organization improvement goals;

> Phase Five, Implementing planned change through direct intervention, often utilizing a neutral moderator who can participate throughout the organization to aid individuals, teams and the organization as a whole to achieve identified goals; and
>
> Phase Six, Stabilization and Replanning, with an effort to ensure that the changes brought about in earlier phases are able to withstand the pressures towards regression. (Blake and Mouton, 1965, pp. 171-183)

The ultimate goal of the approach developed by Blake and Mouton is the attainment of Team Management or 9,9 on the Managerial Grid. This exists when "production is from integration of task and human requirements into a unified system of interplay toward organizational goals" (p.173).

More recent literature on the use of team building in organizations addresses such areas as task-focussed approaches (Davidson, 1985), devising team building activities within the organizational constraints of time and expense (Newman, 1985; Miller and Phillips, 1986), and utilizing knowledge about team roles and behavioural styles to build high-performance organizational and management teams (Jacobsen-Webb, 1985; Harris, 1986).

For a comprehensive review of 36 studies of team development interventions published from 1960 through 1980, the reader is referred to DeMeuse and Liebowitz (1981).

2. Team Development in the Human Services

A review of the literature yields relatively few examples of team development interventions in the human services in recent years, despite the fact that the use of teams is so widespread in this area. However there are some efforts which have attempted to address this approach, and these will be described briefly.

Rubin, Plovnick and Fry (1975) developed a program for health team development aimed at improving the coordination of care. They state that team development "consists of activities aimed at helping the team to minimize the energy spent on problems arising from having to work together and maximize the energy devoted to accomplishing its task" (Rubin, Plovnick and Fry, 1975, p.7). They view team development as a planned maintenance activity to prevent breakdowns in team functioning. Based on the belief that team development is an essential activity for all teams, they designed a series of modules for structured sessions focussing on essential elements of team effectiveness and specific problem areas which a team might encounter. The essential or basic modules for team development presented by Rubin, Plovnick and Fry are diagnosis of team functioning, goal setting, setting priorities, role negotiations, role definition, decision-making and planning for future develop-

ment. The optional or problem-specific modules include bringing new members on board, running better meetings, leadership, norms, interacting with the rest of the organization, and getting feedback from the patient population (pp. 8-10). While providing a useful overview of team process issues and specific guidelines for task-oriented sessions, the proposed program may be viewed as somewhat artificial and directive to team members who present with their own issues, perceptions, and ways of doing things.

Margolis and Fiorelli (1984) discuss an approach to facilitating interdisciplinary teamwork in the rehabilitation services. They do not prescribe a model or method for intervention, but rather they discuss four constructs which they believe can promote interdisciplinary cooperation. These are a) understanding the unique perceptual field of each discipline, b) reducing interdisciplinary defensiveness, c) collaboratively developing ideas, and d) encouraging two-way rather than one-way communication (pp.14-16). They also discuss the inevitability and desirability of conflict, and how it can be used to enhance cooperation (pp.16-17).

Berry and Greenacre (1986) describe an interdisciplinary team intervention of a slightly different nature. Their intervention, which occurred in a health care setting, was initiated by discontent and dissatisfaction among nurses on

an interdisciplinary team. The nurses felt undervalued and lacking in control, and cited blurring of roles, skills and tasks among team members as problematic. The intervention, which spanned a year and a half, began with a discipline-specific support group but eventually involved an expectations survey of all team members and finally a presentation to the whole team by the nursing component. Berry and Greenacre noted that this intervention not only promoted an increased assertiveness and sense of competency among the nurses, but also allowed the unit as a whole to effect structural and organizational changes. They concluded that this process (i.e. initiation of intervention by a dissatisfied sub-group of the team) was a very helpful one for the nursing staff, however they did not indicate whether the remainder of the team felt equally positive about the approach.

B. Theoretical Framework for Team Development

1. Stages of team development

When planning and implementing a team development intervention it is important to consider at which stage the team is in its own development, in order to ensure that the intervention will be appropriate and meaningful. As noted by Bailey (1984) and Lowe and Herranan (1981), teams are

involved in an ongoing process of changing, growing and learning, and different types of problems are generated at different stages of team development. Lowe and Herranen provide a six-stage developmental model of team process, and identify tasks and problems characteristic of each stage. Briefly, these stages are: 1. Becoming Aquainted, 2. Trial and Error, 3. Collective Indecision, 4. Crisis, 5. Resolution, and 6. Team Maintenance (Lowe and Herranen, 1981, pp.2-4) (see Appendix 3). Bailey points out that an analysis of the stage at which a team is functioning in terms of organization and/or process will be instructive not only to the person who is designing an intervention, but also to the team itself in trying to understand its own behaviour.

Francis and Young (1979) discuss four stages of team development and the tasks, processes and behaviours which are characteristic of each stage. These are:

Stage One -- Testing

At this stage, members are finding their own place in the group, discovering the attitudes, values and styles of other members, and developing relationships. Interactions tend to be at a superficial level, with members remaining polite, impersonal and guarded.

Stage Two -- Infighting

During this stage, members begin sorting out personal

relationships of power and influence. Issues of leadership and control are being confronted and worked through.

Stage Three -- Getting Organized

At this stage there is a commitment to work together as a team, and the emphasis is on the work of the team, the contributions of each member and task effectiveness. There is greater understanding and sharing of information and ideas among members.

Stage Four -- Mature Closeness

This stage is characterized by informality, good rapport and close bonds among members. Roles have been identified and each person's contribution is distinct and valued. Steps have been taken to clarify the team's role and contribution in the organization, and to gain the recognition and support needed from the organization. (Francis and Young, 1979, pp.9-11)

Francis and Young note that these stages are not static and that a team may, at any given time, be engaged in tasks and processes which are characteristic of different stages. The stages discussed by Francis and Young and the "Team Development Wheel" which summarizes these stages (see Appendix 4) provided a useful framework for an ongoing assessment and evaluation in this practicum. (The results obtained from the use of the "Team Development Wheel" will be discussed in

Chapter Four.)

Of special interest for the purpose of this practicum is a consideration of the characteristics of new teams. As summarized by Abelson and Woodman (1983), a team that has just been formed usually has some or all of the following characteristics:

> 1. There is considerable confusion as to roles that team members must assume.
>
> 2. There is confusion as to the social relationships among members of the team.
>
> 3. Individuals have some assets or competencies relative to the team's purpose. However, some people may be unaware of how their skills or knowledge relate to group goals. Perhaps more importantly, some individuals may be unaware of (or may not value) the competencies of others, or may not appreciate their relationship to group goals. This is particularly likely to occur on multidisciplinary teams.
>
> 4. While there may be some understanding of short-range goals (e.g. why the group was brought together), understanding of long-range goals is likely to be more elusive (e.g. implementing and evaluating a treatment plan).
>
> 5. In the absence of established norms, there is considerable confusion about group processes: how the team will operate, how decisions will be made, and so on.
>
> 6. Team members (and particularly leaders) do not pay much early attention to social relationships, being more likely to focus initially on the task.
>
> (Abelson and Woodman, 1983, p.128)

While most of the above characteristics have already been described in the previous chapter as potential barriers to the effective functioning of any team, it is instructive to

note that these may be particularly salient for newly-formed teams.

The important elements of team development in the human services are consistent with those discussed in the organizational and management context. They include application of group behaviour concepts, team development as a change strategy, problem-solving and decision-making, role clarification, understanding of self and others, effective communication, interpersonal and inter-group conflict management, and working towards organizational goals. In addition to these elements, it is important to note that team development is, for the most part, viewed as an ongoing process which must continue to be addressed throughout the life of a team.

2. Adult education theory

As noted by Francis and Young (1979, p.8), team building involves "collective learning" on the part of team members. In view of this association between team development and learning, and the fact that members of interdisciplinary teams are adults, it is appropriate to take into consideration some principles of adult learning theory in the planning of a team development intervention. The success of any attempt to promote learning and growth among adults will

depend to a large extent on the ability of the facilitator to recognize and respect the characteristics of adult learners [Brundage and Mackeracher (1980), Cross (1981), Kay (1977), Knowles (1984)]. For the purpose of this practicum, it was helpful to look at the characteristics of adult learners and their implications for facilitators of adult learning discussed by Knowles (1984) in his "Andragogical Model":

> 1) **The need to know:** Adults need to know why they need to learn something before undertaking to learn it. Facilitators can raise the level of awareness of the need by providing real or simulated experiences in which the learners discover for themselves the gaps between where they are now and where they want to be.
>
> 2) **The learner's self-concept:** Adults have a self-concept of being responsible for their own decisions, and they have a need to be seen and treated by others as being capable of self-direction. Adult educators have to work at creating learning experiences in which adults are helped to become self-directing learners.
>
> 3) **The role of the learner's experience:** Adults come into an educational activity with a great volume and quality of experience, and thus the richest resources for many kinds of learning reside in the adult learners themselves. Adult educators should place greater emphasis on experiential techniques such as group discussion, simulation exercises, problem-solving activities, case study methods, and also on peer-helping activities.
>
> 4) **Readiness to learn:** Adults become ready to learn those things they need to know and be able to do in order to cope effectively with their real-life situations. In timing adult learning experiences, it is important to be aware of the developmental tasks associated with developmental stages.
>
> 5) **Orientation to learning:** Adults are life-,

> task-, or problem-centered in their orientation to learning. Adults learn new knowledge, understanding, skills, values and attitudes most effectively when they are presented in the context of application to real-life situations. Learning projects are an effective way of organizing adult educational programs.
>
> 6) **Motivation:** While adults are responsive to some external motivators (better jobs, promotions, higher salaries), the most potent motivators are internal pressures (increased job satisfaction, self-esteem, quality of life). The adult educator should attempt to remove barriers to motivation, such as inaccessibility of opportunities or resources, time constraints, and programs that violate principles of adult education.
>
> (Knowles, 1984, pp.55-60)

The above principles and implications of adult learning theory (summarized in Appendix 5) provided a helpful guideline in the planning and implementation of the team development intervention carried out in this practicum.

In addition to being adult learners, team members are also professionals involved in the process of lifelong learning. Lifelong learning refers to "the process by which individuals continue to develop their knowledge, skills and attitudes over their lifetimes" (Howe, 1977, p. 259). Jarvis (1983), in discussing professional education, notes that it is important for professionals to try, change and modify their attitudes, knowledge, skills and critical awareness in order to keep abreast of all developments and effectively serve their clients. The interdisciplinary team has been identified as a good learning environment in which ongoing

professional development can occur (Larsen, undated).

Experiential learning can be a valuable source of learning and ongoing development for professionals. Such methods as simulations, exercises, group discussions, role playing and case studies have all been described as useful [Kolb (1984), Walter and Marks (1981)]. The importance of experiential learning is highlighted by Rogers (1969):

> "...the only learning which significantly influences behaviour is self-discovered, self-appropriated learning. Such self-discovered learning, truth that has been personally appropriated and assimilated in experience, cannot be directly communicated to another." (p. 153)

As with lifelong learning and continuing professional education, team development should be an ongoing process which fosters the development of attitudes and skills which will allow the team to adapt readily to change.

3. Group Theory

As dicussed in Chapter Two, the team can be viewed as a task-oriented group. It is therefore useful to consider some principles of group development in the planning of a team development intervention. Dimock (1970), in discussing the facilitation of change in group development, states:

> "The success of a projected change is enhanced if the worker is well accepted by the group and there is a high level of trust among the members. Real needs and feelings are most likely to be expressed

> and dealt with in groups where people can be open and honest in their behavior." (p. 4)

Dimock summarizes the assumptions for facilitating change in a group as follows:

> 1. Those people affected by a change should be involved in making that change.
>
> 2. The group --its standards and norms -- should be the focus of change.
>
> 3. Change is more easily effected by reducing the forces against change than by strengthening the forces for it.
>
> 4. Resistance to change is normal and can be expected.
>
> 5. Change in one aspect of a group's life will produce a strain in other aspects.
>
> 6. Change must be a continuous process if any one change is to succeed.
>
> 7. Trust, acceptance and open communication enhance change possibilities.
>
> (Dimock, 1970, pp;4-5)

The importance of trust noted by Dimock is also highlighted by Golembiewski and McKonkie (1975). They propose that low defensiveness, high self-confidence and high feelings of competence and efficacy are promoted by high trust, and that these characteristics are most likely to lead to positive learning outcomes. Conversely, low trust leads to high defensiveness, low self-confidence and low feelings of competence and efficacy, which lead to negative learning outcomes (p.157). In view of the above, it is apparent that a team development intervention would have to aim for the

promotion of an atmosphere of trust in order to achieve maximum benefit.

The above assumptions in relation to group development and the importance of trust were integrated with the principles of adult education and organization development in my effort to design an intervention which would be responsive to the unique needs and characteristics of the team involved in this practicum.

Although the importance of group dynamics and group development principles are recognized, it is also important for the purpose of this practicum to make a distinction between team development and group therapy. Fawcett Hill (1962) identifies the need to pay attention to group development and group dynamics in a way that minimizes problems and maximizes potential, but stresses that group-oriented considerations should not obscure the particular purpose of the group. He states that "a good group is one where the process, or communication, problems are adequately handled and the potential of the members realized, so that the learning...is enhanced." (Fawcett Hill, 1962, p.21)

Thompson and Kahn (1970) note that in groups where the aim is primarily educational rather than therapeutic, the group processes that take place serve as an educational tool in

that they are used to develop and elucidate the topics being discussed (p. 42). In relating morale to group effectiveness Beckhard (1974b) emphasizes that the goals of a team improvement effort are greater productivity and increased motivation toward improved task performance -- and not high morale in itself. He notes that "happiness and feelings of comfort, while desirable, are not possible at all times, nor are they a necessary condition for achieving high productivity" (p. 98). However Beckhard does note further that the satisfaction derived from achieving task goals does have a high correlation with productivity (as discussed in Chapter Two).

Walter and Marks (1981) distinguish five types of learning experience and the patterns of objectives and purposes for each type. These types are:

> **Education,** which is characterized by an emphasis on objectives in the cognitive domain. Objectives in the affective domain may be addressed but are pursued with much less intensity than the cognitive objectives.
>
> **Training,** which is characterized by an emphasis on objectives in the psychomotor domain and generally results in participants being able to perform some specific skill or set of skills in an improved manner.
>
> **Professional development,** which is more complex and involves a combination of cognitive, affective and psychomotor objectives. There is a need to create broad awareness and insights for the participant about the personal significance of the skills, attitudes and behaviours being addressed.
>
> **Personal growth,** which is oriented toward increas-

> ing participants' understanding of some aspect of their lives as well as their ability for self-management. It is directed towards helping adequately functioning individuals to become more effective, and there is an emphasis on the affective domain.
>
> **Therapy**, which involves participants whose dysfunction is sufficiently great to motivate the use of more intense and comprehensive methods. Therapy is primarily remedial rather than preventive or developmental.
>
> (Walter and Marks, 1981, pp.240-242)

Walter and Marks note that, in most cases, more than one of the above types is needed to describe a given learning experience. The important point is that both the facilitator and the participants should be in agreement about the purpose and nature of the group experience. Dyer (1977) also comments on the distinction between training and therapy, noting that they are closely entwined, such that training can occur in a therapy group and training-focussed groups can have therapeutic value. Because of this, Dyer also stresses the importance of clarifying at the outset what the purpose of the program is and what the facilitator's role will be (p.239).

C. Role of Facilitator

Based on the principles and assumptions presented in this chapter, I perceived my role as facilitator of team development as a combination of elements derived from organization and team development, adult education and group work. Due to

the nature of team development, my intent was to incorporate activities related to subject matter (i.e. role of resource person) with activities related to group dynamics (i.e. role of group facilitator).

A combination of roles

The variety of roles performed by a facilitator during the course of a team development program are discussed by Baker (1979) and Beer (1976). These roles, and the activities they involve, are as follows:

1. **Facilitator,** creating an environment appropriate for the intervention and guiding the participants through the entire process.

2. **Data gatherer,** collecting and feeding back the information needed for diagnostic as well as evaluative purposes.

3. **Process consultant,** aiding the group in critiquing its own group processes.

4. **Change agent,** serving as a catalyst in helping the group members to increase their mutual trust, communication, shared responsibility, and problem-solving

ability.

5. **Resource person,** providing team members with information based upon her/his experience.

6. **Trainer,** conducting lectures, mini-sessions, and experiences to improve the group's skills in specific areas identified as requiring attention.

In keeping with the roles outlined above, I perceived my tasks to include the promotion of a climate of trust and acceptance, the encouragement of open communication, the stimulation of further inquiry and confrontation of issues, the introduction of theory and background information as required, and the summary and synthesis of discussions.

Although I anticipated playing all of the above roles at some point during the team development program, I chose to refer to my role simply as that of **facilitator** because this role would be consistent throughout the program and would also be consistent with both an adult education and a group work approach.

Intervention Modes and Techniques

In order to accomplish the above tasks, a combination of the

intervention modes described by Blake and Mouton (1975) was seen as appropriate. These intervention modes are:

1. cathartic team building
2. catalytic team building
3. team building by confrontation
4. prescription-based team building, and
5. theory-based team building (pp.105-120).

For a brief summary of these intervention modes, what they involve, and the circumstances under which they should be used, please refer to Appendix 6. Blake and Mouton indicate that while intervention based on theories and principles is the most likely to result in effective overall teamwork, it is often useful or even necessary to use the other intervention modes to facilitate conditions conducive to discussion at the theoretical level (pp.127-128).

Numerous techniques, ranging from specific exercises addressing identified problem areas to overall programmed team development, can be utilized in a team development program. Techniques include didactic, experiential, and group process facilitation. Sources which provide useful examples and guidelines for intervention techniques include Rubin, Plovnick and Fry (1975), Walter and Marks (1981), and Pfeiffer and Jones (1972-1980). In a team development program it is appropriate to utilize a variety of techniques

in order to provide a wide range of learning experiences. This not only accommodates the different learning characteristics of each team member, but also allows for tailoring the technique to fit each task or purpose.

Social worker as facilitator

In planning and implementing a team development program, I viewed the role of facilitator as a valid one for myself as a social worker. The knowledge, values and skills common to the social work profession lend themselves very well to the types of activity involved in the role of change agent or facilitator of team development [Studt (1968), Wax (1968), Patti and Resnick (1972), Abramson (1984)]. This point is elaborated upon by Abramson (1984):

> "The very definition of collaboration implies consensus, cohesion, negotiation, and common understanding about team goals, roles and procedures. Social work as a profession values mediation, cooperation, mutual respect and participation and coordination. Furthermore, social workers are often seen as the affective leaders of interdisciplinary teams because of their knowledge and skills in small group theory, communication and tension reduction. Finally, social workers often see themselves as being responsible for maintaining the collectivity, almost as if the group is another client system." (p.41)

Further to the above, the ecological perspective utilized by social workers in assessment and intervention (Germaine, 1979) is congruent with the perspective required in planning

and implementing a team development strategy. In addition, the social work profession's respect for self-determination, personal growth and self-actualization is compatible with the principles of adult education and group development upon which team development is based.

For the team development intervention in this practicum it was important not only for myself to feel comfortable in the role of facilitator based on my knowledge, experience and skills, but also for the team members to accept and trust me in this role(Dimock, 1970; Golembiewski and McKonkie, 1975). I believe my credibility in this role was promoted by my training as a social worker and my experience as a team member and group facilitator, and was further enhanced by my experience in a program of Geriatric Psychiatry similar to that in which the team members were involved.

Facilitator as Learner

In addition to the roles of the facilitator discussed above, my role in this intervention was that of learner. In designing and implementing the team development program as a practicum requirement, my purpose was to embark on a learning experience that would be useful and valid not only for the team members involved but also for myself as a student. Thus my role throughout the process was that of

"facilitator-as-learner", and involved learning from the team members, their situation, and their efforts towards growth and development.

D. A Framework for Team Development

As noted earlier in this chapter, there is a general lack of clarity and consistency in the conceptual and operational definitions of team development. One of the reasons for this is that team development, to be effective, should be responsive to the characteristics, needs and organizational environment that are unique to each team. As such, it follows that no one prescribed method or model would be applicable in all situations. However, there are some models of team development and planned change which were helpful in the designing of the intervention utilized in this practicum.

Models of team development

Beer (1976), in a review of team development theories and interventions, outlined four distinct models which are based on the primary issues they treat. These are 1) the goal-setting model, 2) the interpersonal model, 3) the role model, and 4) the Managerial Grid model.

1) **Goal-setting Model.** In this type of intervention the facilitator focusses on the development of individual and group goals and the identification of factors interfering with goal attainment as the basis for team development. This model is based on the assumptions that goals influence individual and group behaviour, and that participation in setting goals increases motivation and commitment towards achieving those goals.

2) **Interpersonal Model.** In this type of intervention the facilitator attempts to create a climate which promotes mutual support and trust, open communication and sharing of feelings, and the confrontation and resolution of conflict. The assumption is that increased cooperation and group cohesiveness will enhance team effectiveness.

3) **Role Model.** In this type of intervention there is an attempt to examine and clarify role definitions and expectations of team members. This model is based on the assumption, discussed previously in Chapter Two, that if team members better understand their own roles and those of others, there will be a reduction in ambiguity and conflict and more energy will be available for task-relevant behaviours.

4) **Managerial Grid Model.** This type of intervention is based on the approach developed by Blake and Mouton (1965) which was discussed earlier in this chapter. In this approach team members discuss the differences between an "ideal" situation and their actual situation, and identify problem areas to be addressed by the team. This model differs from the first three in that it is highly structured and does not require the use of a facilitator.

While the above models and the assumptions upon which they are based can be differentiated in theory, in practice it is more likely that a combination of these approaches will be required. This is because many of the factors are inter-dependent, and improving team effectiveness will usually require attention to more than one problem area. Further, as noted earlier in this chapter, a lack of strong research data makes it difficult to determine whether certain team development models or techniques are more effective than others, or which should be applied under which circumstances. Thus, in developing the intervention for this practicum I found it helpful to become familiar with these models, but did not find it appropriate to adopt any one of them exclusively. Instead, components of the first three models i.e. goal-setting, interpersonal and role models,

were incorporated into the team development process.

Team Development as a Process

The purpose of the team development intervention utilized in this practicum was to promote and enhance cohesive team functioning, address specific areas of need and/or concern, and promote optimal team effectiveness. An attempt was made to address these goals in a manner which recognized the team members as individuals, professionals, members of the team and the organization, and adult learners. The approach was based on the philosophy that process is an important factor in the development of knowledge and skills, and that an interactive format that is responsive to the unique needs and characteristics of the team can best facilitate this process.

In planning a team development intervention a focus on process is an important one, because team development should be an ongoing process. Just as lifelong learning, which emphasizes processes and concepts more than the acquisition of facts (Parker and Rubin, 1966; Rogers, 1969), and continuing professional education, which emphasizes helping professionals plan for and adapt to change (Hutton, 1977; Larsen, undated), team development should be an ongoing process or continuum which emphasizes continuing learning,

growth and adaptation.

Parker and Rubin (1966) discuss the process of learning as an important aspect of the content being learned, and their comments are viewed as applicable to the area of team development:

> "Process...refers to all the random, or ordered, operations which can be associated with knowledge and with human activities...Processes are involved in arriving at decisions, in evaluating consequences, and in accommodating new insights... Where the stress is upon process, the assimilation of knowledge is not derogated, but greater importance is attached to the methods of its acquisition and to its subsequent utilization."
> (Parker and Rubin, 1966, p.2)

Applying this to team development, a valid intervention would be to assist the team to improve the processes whereby their existing knowledge and skills are expanded upon and utilized towards identified goals.

The importance of a process that is interactive in nature is highlighted by Schon (1983) in his theory of "reflection-in-action". Schon suggests an interactive process in which the practitioner frames the problem to be addressed, remains open to the situation's backtalk, and re-frames the problem accordingly. The backtalk includes unanticipated problems and potentials which arise, and further action is guided by an assessment and appreciation of these unexpected consequences. Each situation is viewed as unique, dynamic and

complex. This "reflection-in-action" approach is seen as consistent with the principles of group development and adult education discussed earlier, and also provides a suitable mindset for the facilitator in the interactive process of team development.

Team Development as a Continuum -- A Framework for Intervention

As discussed earlier in this chapter, the literature reflects a lack of consistency in defining team development, and there is little attempt to differentiate between the terms team building, team improvement, and team development. An exception is Lewis (1975) who differentiated between team building and team development, proposing that the former is applicable to newly formed teams and the latter is applicable to pre-existing teams. However this distinction is not systematically made in the literature, and there is a general tendency to use the terms interchangeably.

While some authors argue that there is no appreciable difference in the processes used in each approach (for example Liebowitz and DeMeuse, 1982), I would propose that there are some subtle differences in definition that should be addressed -- differences which have implications for the timing, process and techniques of an intervention.

In keeping with the theoretical concepts presented in this chapter, I found it helpful to develop a framework for intervention which involved a continuum consisting of team building, team improvement and team development. This framework or continuum (see Figure A) looks at definitions of the terms and concepts and considers some of the implications for intervention based on these definitions. There is an attempt to incorporate stages of team development (Francis and Young, 1979), intervention modes (Blake and Mouton, 1975), and types of learning experience (Walter and Marks, 1981), as well as some of the underlying principles of group and adult education theory.

It is important in reviewing this framework to be aware that the three approaches described represent a continuum of intervention, and they are not mutually exclusive. The uses, characteristics and strategies described under each approach could be interchangeable under certain circumstances, and any combination of the three approaches may be valid for a specific team. Thus, while not prescriptive in nature, the framework does allow for the development of an intervention within certain parameters.

In conceptualizing and operationalizing the team development intervention for this practicum, my thinking evolved from a

	TEAM BUILDING	TEAM IMPROVEMENT	TEAM DEVELOPMENT
Definitions of the Words	To Build: 1) to make or erect by joining parts or materials 2) to establish or strengthen 3) to form or create 4) to develop toward a maximum	To Improve: 1) to bring into a more desirable condition 2) to make good use of 3) to make better	To Develop: 1) to bring to a more advanced or effective state 2) to cause to grow or expand 3) to expand in detail
Definitions of the Concepts	"Team building involves the deliberate working through of all blockages to progress until a working group becomes an effective team." (Francis & Young, 1979, p.9)	"The goals of a team improvement effort are greater productivity and increased motivation toward improved task performance." (Beckhard, 1974, p.98)	"Team development consists of activites aimed at helping the team to minimize the energy spent on problems arising from having to work together and maximize the energy devoted to accomplishing its task. (Rubin, Plovnick & Fry, 1975, p.7)
Implications for Intervention	Implies a need for a catalyst to build awareness, cohesion, and work processes, or to promote change	Implies a need for improvement of attitudes, knowledge and skills which will promote greater collaboration, cohesion and effectiveness	Implies a wish to enhance team functioning in terms of cohesion, group processes and/or output, in order to function at an optimal level
Appropriate for	- Newly-formed teams - Teams experiencing major problems in internal dynamics or task effectiveness - Teams in crisis	- Relatively new teams which have already begun to recognize and address team process and productivity issues, but need to improve skills related to working together - Teams in flux, experiencing period of adjusting to change	Established teams that are well-grounded in team practice and functioning fairly well together in the accomplishment of tasks.
Approach	Structured, educative; cathartic and catalytic; problem-oriented	Semi-structured; experiential; confrontative; problem/task oriented	Less structured; experiential using ongoing tasks; theory-based; not problem-oriented per se
Attitude Reflected	Recognition of a need to introduce or review basic elements of teamwork	Simultaneous recognition of what team members have accomplished already and where they can potentially go as a team	Recognition that team development is an ongoing interactive process, where strengths are recognized and problems can be dealt with in a non-threatening way.

FIGURE A

team building, problem-focussed approach to a more developmental, process-focussed approach. This growth or change in perspective was influenced by several factors: 1) a review of the literature using a broad theoretical base (as opposed to limiting my search to the areas of team and organization development); 2) the characteristics of the team and its members to be involved in the practicum; and 3) the processes which took place during the actual intervention.

For the particular intervention carried out in this practicum, due to the characteristics of the team involved, a combination of all three approaches described in the continuum was felt to be necessary and appropriate. There was then the question of which terminology would be accurate when elements of all three approaches were to be used. Whereas in the proposal phase I had used the term "team building", I changed to the term "team development" for the implementation because I felt it more accurately reflected the intent of both myself as facilitator and the team members involved. Specifically, I felt it reflected a commitment to the philosophy that team development is a healthy, ongoing process.

Team Development as Planned Change

Team development is a process through which the facilitator

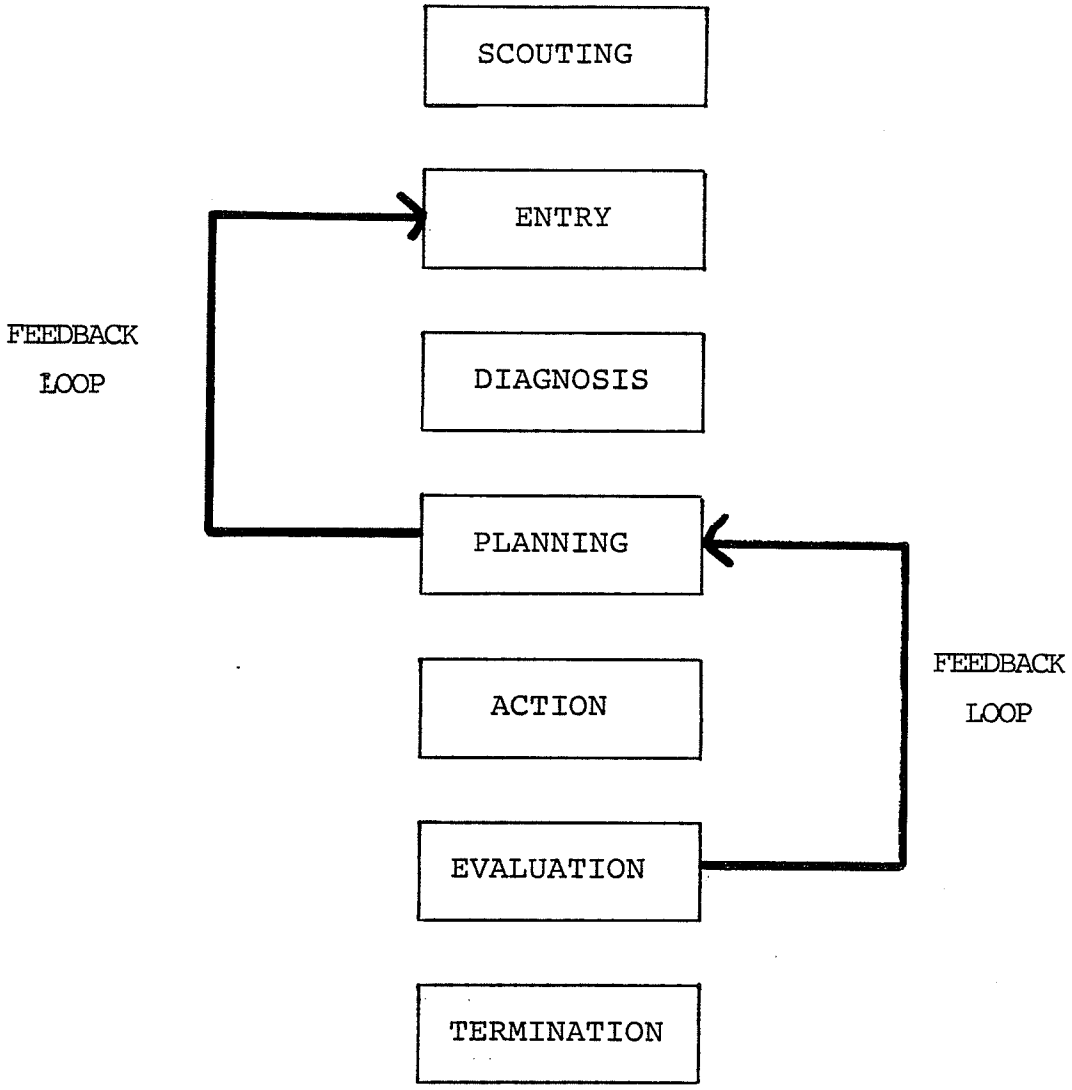
and the team members make efforts towards growth and change. In planning the intervention for this practicum it was helpful to use the Kolb-Frohman Model for Planned Change (Kolb and Frohman, 1970) as a framework for the process. The seven phases in this model are scouting, entry, diagnosis, planning, action, evaluation, and termination. Interaction and re-framing are possible in each phase, and as well are built into the process by way of two "feedback loops". (See Figure B) This model will be used to describe the team development intervention completed for this practicum, which will be described in the remainder of this chapter.

2. THE INTERVENTION -- A TEAM DEVELOPMENT PROGRAM

Phase One --Scouting

The intervention developed for this practicum was proposed for implementation in a Geriatric or Geriatric Psychiatry setting because these are the areas in which I have a good base of knowledge, experience and skill. Once the team development proposal was approved by my advisory committee I submitted a proposal to a general hospital in Winnipeg. Despite the fact that preliminary discussions had been held with various concerned parties over a period of several months, the proposal to complete the practicum within that

The Kolb-Frohman Model for Planned Change



Source: D. Kolb and A. Frohman. An Organization Development Approach to Consulting. Sloan Management Review 12 (1); Fall, 1979

FIGURE B

organization was rejected on the basis of a concern that it "would not complement effective and efficient hospital operation". At that time a decision was made not to change and re-submit the proposal to the same facility (an option suggested during informal discussions following rejection of the proposal) because it would involve some major changes in design and intent, and because it still remained highly questionable that a revised proposal would be accepted. It was therefore decided, in consultation with my advisory committee, to seek an alternate site for the practicum.

Deer Lodge Centre was identified as a possible site for this practicum because of its newly-formed Geriatric Psychiatry program, and a belief that the organizational climate would allow for receptivity.

Deer Lodge Centre is a geriatric facility with a history of much change and innovation. It first became a military convalescent facility in 1916, then served as an acute care military hospital during the two World Wars, and until recently was an active Department of Veteran Affairs hospital. Transferred from the Federal Government to the Province of Manitoba in 1983, the Centre embarked on a major redevelopment project (both physical and program expansion) designed to establish Deer Lodge Centre as a major focus of geriatric care in the province of Manitoba. Within this

climate of growth and change, support for professional development is reflected in two of the stated goals of the Centre:

> 1) to provide a teaching, learning and demonstration resource for health professionals and other health care personnel; and
>
> 2) to provide a research resource with respect to aging and care of the elderly.
>
> (Deer Lodge Centre Statement of Mission, August, 1986)

An initial, informal contact was made with a staff member who was very positive about the proposal, and indicated that in her opinion the organization was very open to research and practica being conducted in the facility. Based on this initial response contact was made with the Clinical Director and the Director of Social Work, and a meeting with these individuals was subsequently held to discuss a formal proposal. At this meeting it was decided that there was general support for the proposal in principle, and that the Clinical Director would approach the Geriatric Psychiatry department to determine their willingness to become involved.

Of significance during this phase was that, in the initial

meeting with the Clinical Director and the Director of Social Work, the concern was raised that the proposal as initially worded (i.e. a problem-oriented, team building approach) was based on an assumption that there were "problems that required fixing". It was observed that the team members might be potentially threatened or turned off by this assumption which did not appear to be a valid stance. It was through this discussion that I began to formulate more clearly a plan for ongoing team development which would acknowledge and reinforce positive aspects of team functioning and approach development in a non-threatening manner. It was with this more enlightened perspective, then, that I entered phase two.

Phase Two -- Entry

When approached by the Clinical Director with the practicum proposal, the initial response of the members of the Geriatric Psychiatry department was open and favourable. A meeting was then held between myself and four members of the department for the purpose of discussing the proposal in more depth. This meeting involved a general discussion of the team development proposal, including reasons for team development, the basic process involved, and respective roles of the team members as participants and myself as facilitator. I presented my background, expectations and

goals for the practicum experience. At this point it was made clear that the intervention was not related to supervision or performance appraisals, and that it would differ from regular staff training in that the focus would be on team issues rather than on discipline-specific or direct service issues.

Although this meeting had been intended as an exploratory meeting, the response of those present was positive and some initial, informal contracting began. The team members discussed ways in which they were developing, and also identified some areas which they felt would require attention (e.g. bringing on new team members). It was agreed that the proposed intervention would satisfy my practicum requirements as well as benefit the team members (i.e. there was a good fit between my needs and expectations and those of the team members), and the psychologist offered to obtain the required administrative approval.

Administrative approval for this practicum was obtained verbally from the Executive Director through the program psychologist, and directly in writing from the Clinical Director. Both the Clinical Director and the Director of Social Work offered to be available for consultation as required.

The team agreed to the proposed program of ten two-hour sessions to be conducted over a three-month period, mid-June to mid-September, 1987. As proposed by the team members, it was decided that in order to maximize the benefit of the experience for all concerned, sessions would not be scheduled for the weeks when individual members would be on holidays (a total of three weeks). The sessions were scheduled for 2:30 to 4:30 p.m. to accommodate the schedule of the Day Care staff whose daily program ended at 2:30.

Prior to the first session of the team development program, an effort was made to familiarize myself with the organization in general and with the Geriatric Psychiatry program in particular. This was achieved through:

1) reviewing the Deer Lodge Centre history, statement of mission, program descriptions and redevelopment plans;

2) reviewing the program proposals, program descriptions and position descriptions for the Geriatric Psychiatry program and the Day Care for the Cognitively Impaired;

3) individual discussions with team members, the Clinical Director and the Director of Social Work; and

4) participating in the Day Care program for one afternoon. This had been suggested by the activity worker during the initial planning meeting as a good way to gain an appreciation of their program and their work. I felt this was a valid activity not only as an orientation to the program but also as a method of gaining trust and acceptance and promoting my credibility with the team members involved, while at the same time giving them recognition for the work they were doing.

At the point of my entry the "team" actually consisted of the members of two different programs, the Day Care for the Cognitively Impaired and the Geriatric Psychiatry Program, which had recently been combined to form the Department of Geriatric Psychiatry. The Day Care program had been in operation since October 1986, while the Geriatric Psychiatry program began in February 1987. Neither program was fully staffed at the time the team development sessions began, but both expected to be so before the sessions ended. The team therefore consisted of a psychologist and a clinical nurse specialist in the Geriatric Psychiatry program, a home economist and an activity worker in the Day Care program, and a secretary/receptionist responsible to the department as a whole. There was also a psychiatrist involved with both

programs on a part-time basis who chose not to participate in the team development sessions.

Phase Three -- Diagnosis

Diagnosis of the team's situation and the issues to be addressed in the team development program began initially in the introductory meeting, and continued to be a focus during the first session. As this session was the first time the team had met together formally, as well as the beginning of a new experience for all present, we began by introducing ourselves and sharing our hopes, expectations and fears regarding the program. This helped to begin the process of developing trust, open communication, and bonding.

Description of the Team

Through the introductions and initial discussions several characteristics of the team became evident.

First, the team had never met together formally and had never really addressed whether or not they were in fact a "team". This was felt to be due to the fact that the Department of Geriatric Psychiatry had been so recently formed and its organizational structure had not yet been formalized. The department consisted of two separate programs, each functioning independently of

the other but with some connections in the areas of shared personnel, program planning and development, and inter-program referrals. A complicating factor was the physical location of the two programs and the difficulty that presented: "We don't really feel like a team...it's difficult when we're physically apart on two different floors."

The organizational structure of the Geriatric Psychiatry program is such that there are two teams within a department or two sub-teams within a team. Therefore, at the outset, participants addressed the question **"Are we a team?"**. Through discussion it was decided that although there were two distinct programs within which direct service was being provided, all members of the department did comprise a team for a number of reasons:

-- they had a common purpose, which was to provide programs and services to a psychogeriatric population;

-- they were required to collaborate and consolidate knowledge in order to further develop and implement their programs;

-- they had a strong community orientaton in both

programs; and

-- they felt a need to develop cohesiveness to aid interactions with the rest of the organization and the community.

Second, again due to the newness of the department, all members had been there less than one year, with the exception of one who had previously been working elsewhere in the Centre. At the time the sessions started, three staff members had not yet joined the team.

Third, all members were in transition, either personally, professionally, or a combination of both, and all were very enthusiastic about, and committed to, the department and the success of their respective programs.

Fourth, a point worth attention because it became significant during some discussions, was that all members were women and relatively young as a group in comparison with the rest of the organization.

Fifth, it became evident in the initial stages that this team had, to some degree, all six characteristics

of new teams as described by Abelson and Woodman (1983), (see p.66 of this chapter).

Finally, as the team had not had a great deal of time to work together and develop, it was not immediately possible to define whether it was multidisciplinary, interdisciplinary or transdisciplinary. I perceived the team at that point as having the characteristics of the interdisciplinary team as defined by Bailey (see Chapter Two), primarily because the lack of a full complement of staff had necessitated working closely together in order to accomplish program planning and implementation. There were also some elements of transdisciplinary functioning because most members were attempting to assume roles and responsibilities which would normally be assigned to a different discipline.

After introductions, the remainder of the first session was used to review the purpose of the program, build the agenda, and discuss the format to be followed. In order to ensure that the experience would be meaningful, and to promote both ownership of and commitment to the program, I participated in (rather than directed) the discussions about agenda and format. This involved a respect of the need to address <u>their</u> issues and preferences rather than imposing <u>mine</u>. For example, the issue of lack of clarity regarding program and

team leadership was raised during the discussion, but the team chose not to add this issue to the agenda for a future session.

Through the process of introductions and agenda-building, several concerns were raised and addressed. These were:

1) **Confidentiality.**

It was important at the outset to discuss the issue of confidentiality, so that there would be a climate conducive to expressing concerns, taking risks, learning and growing. It was established that content deemed confidential by the team members would be treated as such by all present. There was also considerable discussion regarding my request for permission to audio-tape each session for my learning purposes. The result was that team members gave permission for each session to be recorded, with the agreement that the tape could be turned off at their discretion for the purpose of confidentiality.

2) **"Prevention" vs "Treatment".**

It was identified by team members that because they were so recently formed, they had not yet experienced any problems as a team. They therefore anticipated that the team development program would be proactive rather

than reactive or remedial for them. (This stance was interesting for the team to consider in retrospect at a later stage, as it became evident that there were in fact some problem areas that needed to be addressed. However, in this initial stage of diagnosis, a generally positive outlook was taken.)

3) **Personal Risk.**

Throughout the first session there were comments which highlighted the personal risk which was perceived by participants in this team development program. For myself as facilitator, I expressed the fear that I would not adequately meet their needs and expectations as this would be my first experience facilitating team development. For the team members, there was some anxiety expressed in comments such as "are you going to analyze us all?" and "we're all being so nice ...how is this going to change?". Acknowledgement and discussion of these fears and anxieties at the outset seemed to promote a more relaxed atmosphere, although the team did remain somewhat guarded and cautious throughout the first session. This was expected and seen as normal for this stage, and in fact the team members seemed generally quite open and enthusiastic for a first session.

Phase Four -- Planning

Planning with regard to issues to be addressed and the format or techniques to be utilized was initiated in the preliminary meeting and continued throughout the team development sessions. As indicated by the feedback loops in the Kolb-Frohman model, planning is in reality a dynamic process rather than a discrete phase. In the first session issues were identified and the issue of role definitions was chosen by the team as a logical, important and non-threatening place to begin. Subsequent to that the next issue to be addressed and the desired format was chosen at the end of each session. Team members felt that it would be better to let the process "flow" rather than attempt to priorize issues at the beginning and then try to adhere to a predetermined schedule. Planning was therefore a continuous process, based on ongoing diagnosis and evaluation, which occurred throughout the entire team development program.

This approach to planning was somewhat difficult in the beginning for myself as facilitator, because it meant that the sessions could not be planned in advance, thus contributing to my anxiety about not being "adequately prepared" to deal with each issue. (This was the beginning of my internal struggle with **content vs process**, which will be discussed in Chapter Four.) However, there were benefits to using this

approach which far outweighed the difficulty.

One benefit of the ongoing planning was that the flexibility allowed for topics and issues to be addressed as they became appropriate for the team. For example, role definitions and expectations were discussed in the beginning sessions and then re-addressed in a later session after three new members had joined the team. The flexibility also allowed for discussion of issues as they arose in the session, regardless of whether it was the chosen topic for that session. In this way, sessions were able to relate to the team members' "readiness to learn" (Knowles, 1984).

Another benefit of the ongoing planning process was that it gave team members an opportunity to get to know each other better and build up their trust and confidence before addressing some of the more challenging issues (Dimock, 1970). For example, it was not until the fourth session that the team began to openly discuss some issues and events that had been problematic for them individually and as a team.

A final benefit of this approach to planning was that it allowed me to change and adjust my role and methods as both the team and myself grew and developed. In other words, it provided an opportunity for "reflection-in-action" (Schon), and as such was beneficial to the overall process.

Phase Five -- Action

The team development program consisted of ten two-hour sessions held on Wednesday afternoons over a period of four months. In recognition of the fact that this was an added-on activity for the team and that service delivery was the team's main priority, every attempt was made to accommodate the team's needs in scheduling the sessions. Consequently the first five sessions took place on a staggered schedule over June, July and August of 1987. The remaining five sessions took place on five consecutive Wednesdays in September.

During this time period the team grew in membership from the initial five to a total of eight. At the outset of the program the team consisted of the activity worker, clinical nurse specialist, home economist, receptionist and psychologist. The occupational therapist joined the fourth and subsequent sessions, and two social workers joined the sixth and subsequent sessions.

Sessions were held in the pleasant and comfortable Day Care area of Deer Lodge Centre. Round table seating arrangements, coffee, and an opportunity for informal socializing at the beginning of each session were all conducive to a climate of

comfort and sharing.

Scheduling of sessions at the end of the day had some drawbacks in that most participants were tired and some occasionally had difficulty making the transition from the direct service issues of the day to the team development issues. This was recognized as the reality for any team attempting to step back from the demands of direct service to take a look at team development. The benefit of having the sessions at the end of the day, apart from the practical matter of availability, was that at times they served as a forum for discussion of practical and professional concerns which had arisen during the day.

Team Development Sessions -- Description and Discussion

The actual content and processes of the team development sessions are summarized in Appendix 7. The first session has already been described here under Phase Three -- Diagnosis. A detailed account of the remaining sessions would be too lengthy, so an attempt will be made to highlight the points which were most important in relation to this practicum. The following areas will be reviewed: attendance, topics addressed, formats utilized, content and interaction, and my role as facilitator.

1. **Attendance.**

Attendance at the sessions remained good throughout the program and reflected a high degree of commitment to this project. In the ten sessions there were only three absences, one due to a conflicting work commitment and two due to illness. No one person missed more than one session during the time they were on staff. (Sessions were missed by members who didn't join the team until after the program started.) One member was late for one session due to a work-related emergency.

It should be noted that one scheduled session (August 26) was postponed a week at the request of the team because several members were involved with other work commitments. On another occasion some members indicated that they were very busy but had chosen to attend the session because they felt it was important.

It was also significant that for the staff of the Day Care program the sessions extended thirty to forty-five minutes beyond their working day, and they remained willing to accommodate this throughout the ten sessions.

In general, in view of the heavy demands of direct service, program planning and bringing on new staff

members, I felt attendance at the sessions was exceptionally high.

2. **Topics addressed.**

The following topics were identified during the first session as those the team wished to address: role definition, communication, decision-making, interpersonal dynamics, conflict resolution and bringing on new team members. A list of these topics was compiled and distributed to the team in the second session (see Appendix 8). It was recognized at the outset that some of these topics/issues would be included in the process of all sessions and would not need to be addressed separately (e.g. interpersonal dynamics), while others might require discussion in more than one session (e.g. role definition).

The topics chosen by the team consisted of some but not all of the topics for team development identified by Rubin, Plovnick and Fry (1975). The major difference was in approach, in that the topics were arrived at through team discussion rather than being presented as a list of options prepared by the facilitator.

While acknowledging that most issues important to teamwork are interrelated and interacting, the team

still felt it would be helpful to have one topic as the focal point for each session. As noted previously, the topic for each session was chosen at the end of the preceding session. Sessions two to nine addressed the chosen topics in the following order:

1) role definitions,

2) role perceptions and expectations -- part one,

3) communication -- part one, between the team and its external environment,

4) communication -- part two, within the team,

5) role perceptions and expectations -- part two,

6) decision-making, and

7) dealing with conflict.

In addition to the topics identified at the beginning, three other issues or themes emerged at several points during the sessions. These issues had to do primarily with the team's perception of itself within the context of the organization as a whole. Specifically, the team discussed the following issues:

1) the implications of being an all-women, informally structured team in an organization that has been traditionally run by a male-dominated hierarchical structure;

2) the implications of being "on the cutting edge" of the new image and direction being adopted by the organization; and

3) the wish to promote positive and effective rapport between this new department and the rest of the organization, and to avoid developing or contributing to an attitude of "us against them".

3. **Formats utilized.**

In order to provide a varied and meaningful learning experience, a variety of formats and techniques were used to address the above topics. In the first session I outlined a number of techniques that could be used, and it was agreed that the team members would decide what they wanted to do for each session. This was done in order to promote ownership of, and commitment to, the tasks and to avoid imposing my preferences on the team.

Over the course of the ten sessions the following formats/techniques were utilized:

- self-introductions,
- discussion,
- case study,
- review of theory,

- relating theory to practice,
- brainstorming,
- role-playing,
- simulation,
- problem-solving, and
- peer helping.

Most of the formats utilized involved collaboration among the different disciplines on the team, and as such would be anticipated to contribute to greater interdisciplinary awareness, respect, and cooperation (Margolis and Fioreli, 1984; Williams et al, 1978; Lowe and Herranen, 1981).

This team was not interested in any programmed team development exercises such as those offered by Francis and Young (1979) or Rubin, Plovnick and Fry (1975), and members were comfortable in stating their preference for their own activities. For example, when I introduced the Interprofessional Perception Scale (Ducanis and Golin, 1979; see Appendix 9) and asked if the team would like to use this exercise to look at roles, the response was in the negative. Some team members felt that the scale would only measure perceptions of other disciplines based on limited personal contact, and that this exercise would not

serve the purposes of the team. It was subsequently decided by the team to try the brainstorming method suggested by one member. This experience occurred during the second session and was, in my opinion, an important one in reinforcing that the team was in fact responsible for the process.

Of particular significance for my learning in this practicum was my observation that ownership of the task by the team members and relevancy of the task to the team's goals did appear to have a direct impact on the amount and nature of interaction. For example, in Session Eight several team members had taken the responsibility for preparing decision-making scenarios for discussion. One team member led the discussion of the scenarios which addressed real decisions regarding service delivery and other aspects of team functioning. Although other factors may have been influential, I believe this format directly contributed to the high level of participation and interaction in this session.

The use of a combination of formats and techniques in each session allowed for each topic to be approached in a number of different ways. Using this approach allowed both the team members as participants and myself as facilitator to experience a variety of opportunities

for learning and development.

4. **Content and Interaction.**

The actual content discussed and interactions which took place during the team development program were the major focus and source of learning and growth in this practicum. A chronological account of what occurred in each session can be obtained from reviewing the comments on content and interaction in Appendix 7. In this discussion I would like to comment on the content and interactions, over the course of the ten sessions, as they relate to the following parameters (presented and discussed in Chapter Two): 1) individual characteristics and needs, 2) organizational considerations, 3) team/group process, and 4) service delivery.

1) Individual characteristics and needs

It was evident from the first session that consideration of the individual characteristics and needs of team members is an important aspect of team development. As discussed previously, the issues of personal risk and confidentiality were addressed in the first session. Team members also identified early in the program that in order to function actively and effectively on the team they needed to be valued and respected

as persons as well as professionals. This included being listened to, having the opportunity to make decisions and be creative, and seeing themselves as having some impact on outcome. Some members related a current reluctance to become fully involved, citing personal characteristics and/or past experience:

> "I'm just new so I see this as a learning experience...but I don't have much to contribute yet."
>
> "Past experience has put me on my guard."
>
> "It's frustrating when somebody asks for my opinion then doesn't listen to me."
>
> "I used to run into walls [in a previous work experience] so I learned to keep quiet in order to save face. Now I'm trying to learn to express my feelings and ideas...it will take time."

Team members identified a need to get to know each other personally and professionally in order to work together effectively and provide support to each other.

Sessions Three and Seven were devoted to a discussion of role perceptions and expectations as they pertained to the different disciplines represented on the team. Through these sessions members were able to gain an appreciation of each other as professionals, and a

profile for each discipline was developed using four categories: 1) training, knowledge and skills, 2) tasks and functions, 3) personal characteristics, and 4)perceived relative status. (See Appendix 10)

It was interesting to note that the members of this team had a somewhat better understanding and appreciation of each discipline than one might expect from the literature (Kane, 1975). Their concerns and needs were more in the area of learning how the different disciplines and roles could interact effectively towards goal achievement.

An increased awareness of each other as individuals developed gradually over the entire program. One item that received considerable attention was the degree to which each individual contributed to discussions. As can be expected in any group setting, some members of the team were more vocal than others. This was addressed in the earlier sessions with the more vocal members expressing concern that they were dominating the discussions, and that they wanted to hear more ideas and opinions from the less vocal members. An attempt was made by myself as facilitator to draw out quieter members by providing support and encouragement and promoting a feeling of acceptance. Over the first

four sessions there was a reluctance to directly address this issue, and it was not until the fifth session that all members openly stated their positions and their expectations of others. In Session Five, quieter members indicated to the team that they were beginning to develop more trust in the team and were therefore gaining in confidence, but noted that it would take time for them to become completely comfortable. In later sessions quieter members began to share more of their personal, professional and work-related issues, and they received positive reinforcement from other team members for doing so.

In addition to developing an increased awareness of each other personally and professionally, the team members were also involved in adjusting to an outsider as facilitator of the sessions. Throughout the sessions the team showed concern, empathy and support for me personally and professionally in my attempt to facilitate the team development program. At one point this led to some interesting dynamics in a situation where team members were avoiding discussion of a particular issue. After some moments of tension-filled silence, one member remarked "I feel I should say something to rescue you!". When I responded that I felt no need to be "rescued", the team then had to discuss

whether or not they wanted to confront the real issue that was contributing to their tension.

2) Organizational considerations

Organizational considerations were discussed throughout all the sessions, but were specifically focussed upon in Session Four which addressed communication between the team and its external environment, and Session Six which was an orientation and general review for new members. There was a discussion of the implications of a number of organizational characteristics, including organizational structure, organizational change, formal and informal lines of communication, and physical location of the program.

In general, there was a need identified by team members to attempt to improve contacts between their department and the rest of the organization. It was felt that the relatively new programs, the new organizational philosophy that the department represented, and the somewhat isolated physical location of the programs had all contributed to a general lack of integration with the rest of the organization. After discussing the impact that this had on them personally, professionally and as a department, the team then began to discuss

ways in which they could promote a greater integration between themselves and the rest of the organization (an important phase relating to "horizontal linking" as discused by Blake and Mouton,1965).

The team development sessions provided an opportunity for team members to share feelings and frustrations related to their position in the organization, as well as a forum in which to engage in constructive and creative problem-solving in order to break down perceived barriers. An attempt was made to develop ways in which they, as a team, could promote greater organizational and community awareness of their programs and improve inter-program contacts.

In addition to considerations of the department's relationship to the organization, there were also discussions about the organization within the department itself. Due to the newness of the department and the two programs it involved, many structural and procedural details had not yet been fully defined or formalized. For example, the organizational chart had not yet been developed, leadership was informally rather than formally assigned, procedures were not fully established, and respective roles and functions were not clearly defined. Through discussion team

members came to an appreciation of both the difficulties and the opportunities presented by these factors. On the one hand, members found it sometimes difficult and frustrating to try to function without guidelines, manuals and clearcut procedures. On the other hand, consistent with the characteristics of professionals in transition described by Sarason (1972), they found more room for flexibility, innovation, creativity and change, and welcomed the opportunity to be involved in the developmental stages of new programs.

One further issue related to organizational considerations was that of orientation of new staff. The first members of the department related their experiences and identified early in the sessions the need to provide an adequate orientation for new staff members as they came on board. However, despite an awareness of this gap and an expressed desire to do something about it, no procedure had been implemented by the time new staff members were hired. This was reflected in the concern expressed by one new team member "I'm still not sure what I'm supposed to be doing here" and the response by another team member "We're still working it out". The team development program helped to address this need by focussing

attention on team issues and role definitions, and it was identified by team members that this need might not have been formally met otherwise.

3) Team/group process

In the initial stages of the team development program, team members were somewhat guarded and cautious, and interactions were for the most part kept on a polite and superficial level. Conflicts on several levels were alluded to both during and outside the sessions, but were not directly acknowledged and confronted until the fourth session. It was felt that it took approximately three sessions for the original members to develop a degree of trust and confidence that would allow them to proceed with more in-depth confrontation of issues.

Session Four, which was both cathartic and constructive, was viewed by both myself as facilitator and the team members as a turning point for the team. Increasing trust, openness and cohesion among team members was noted, as well as increased personal confidence for some members. It was interesting to note that the group process was not adversely affected by the addition of a new member, the occupational therapist, who had joined the team just prior to this

session. There was a good fit between the new member and the rest of the team, possibly related to the fact that she was previously known to them from her work elsewhere in the Centre during the previous year.

Cohesion and interaction among members remained high in the fifth session, in which open discussion, simulations and a spontaneous role-play were used to address the topic of communication within the team.

The addition of two new team members, both social workers, in the sixth session had an impact on the cohesion and level of interaction that had developed among the existing team members up to that point. As planned by the team, Session Six was used to orient the new members to the team in a non-threatening way, and to review the purpose and progress to date of the team development program. Session Seven was devoted to reviewing the respective roles of the new team members (occupational therapist and social workers) and how these fit with the roles of other team members. Although team members claimed that these sessions were useful, there was a noticeable climate of uncertainty and testing. Interactions were again more formal and guarded, although communications were generally more open and direct than they had been in the initial

stages of the program.

Sessions six and seven reflected on a small scale the impact of new members on team dynamics. New members were not yet familiar and comfortable with the team process and their respective roles, existing members were trying to adjust to new members, and there was testing on all sides. Team cohesion was temporarily diminished, and the team required a period of re-grouping.

The strain on team dynamics created by the addition of new members is seen as a normal occurrence in group process (Dimock, 1970), and it was expected that old and new members would gradually gain trust and confidence in each other, negotiate roles, and begin to develop working relationships. However, for two sessions the interaction was maintained at a non-threatening, less intense level, with more challenging issues once again being avoided. Thus the team development program temporarily lost its momentum at this point.

By the eighth session the new team members had been on board for a period of three weeks, and improved cohesion and trust level was observed in the session.

All members were actively involved in the session, and there was a greater degree of comfort in expressing opinions and opposing views. The team interacted well together in the scenarios developed by three members (two original members and one new member) to address the topic of decision-making.

Because it had been avoided by team members in choosing weekly topics for discussion, the topic for Session Nine was, by process of elimination, dealing with conflict. The initial response of team members was nervousness, avoidance and then acknowledgement of the sensitivity of this issue. The psychologist was instrumental in encouraging the team to use the team development forum in which to confront this issue. With much encouragement several team members began to review a real conflict which had occurred, how it had been dealt with, and the impact it had had on a number of team members as well as the Department as a whole. This exercise was very meaningful and relevant, and provided an opportunity for all team members to participate in the resolution of some previously unresolved issues. It promoted a high level of participation and interaction, and seemed to contribute to greater awareness and feelings of cohesiveness.

In the final session, which was an evaluation of the program, cohesion and interaction were high. There was general agreement that the sessions had been instrumental in initiating the team development process, and that there was a need for this process to continue on an ongoing basis. By this time there appeared to be a clearer separation into two teams, each focussing on specific tasks related to their respective programs. Team members were beginning to identify a need for more frequent structured meeting times in order to maintain cohesion and promote ongoing communication on matters relating to the department as a whole.

4) Service delivery

Throughout the ten sessions there was an attempt to relate process to outcome i.e. service delivery. In some ways this was a difficult task because new members had not yet been involved in direct service within the Department of Geriatric Psychiatry. Thus in many instances the relevancy of theory to practice was based on previous experience and projected involvement in direct service delivery.

Despite the above limitation, there were several sessions which were directly related to immediate

service delivery issues. These included the simulated case conference in session two, the role-play in session five, and the decision-making scenarios in session eight. In addition, the issues discussed and team interactions developed through all the sessions were perceived by team members as having a positive impact on future service delivery.

A further benefit of the team development sessions in relation to service delivery was that they provided an opportunity for team members to share information. On several occasions, through the discussions and experiential exercises, different team members became aware of resources, program information and procedures not previously known to them. They were also able to discuss ways in which they were developing services in the two programs.

5. My role as facilitator.

As discussed previously in this chapter, I anticipated my role as facilitator to involve a combination of different roles and tasks. In practice this proved to be true, and there was also an opportunity to learn from the team which roles and tasks were more relevant and helpful for them.

At different times during the team development program all five intervention modes as described by Blake and Mouton (1975, see Appendix 6) were utilized. The least used mode was prescription-based team building, because my intent was to facilitate the team's use of its own resources rather than to "give the answers". Catalytic and cathartic approaches were utilized more in the beginning sessions, where they were combined with a supportive approach in order to promote open communication in an atmosphere of trust and acceptance. In later sessions, once cohesion and interacton were higher and a good level of trust had been developed, there was a greater use of confrontation.

An attempt was made to use theory-based intervention at some point during each session in order to encourage team members to relate their experiences to theory, and to develop some systematic approaches to dealing with future issues.

In conjunction with, and related to, the above intervention modes, my roles varied throughout the ten sessions. Most frequently a combination of different roles (as outlined by Baker, 1979, and Beer, 1976) was appropriate in each session. In the initial stages the

roles of change agent and data gatherer were more prominent, and the roles of facilitator and process consultant were consistently used throughout the program.

Although I initially felt the need to focus more attention on the roles of resource person and trainer, the responses of team members to these roles indicated that these were not as useful for their purposes. For example, when handouts outlining theory on the topics of communication (Appendix 11) and decision-making (Appendix 12) were used, there was very little response or interaction generated by them. An exception to this was the use of definitions regarding roles in teamwork (see Appendix 13), which was helpful in providing some common terminology for further discussion. In retrospect, these were likely useful in that they provided information about teams that was new, whereas other handouts merely summarized information that was already known to most members.

Further observations regarding my role as facilitator will be discussed in Chapter Four.

Phase Six -- Evaluation

Two kinds of evaluation occurred during the time-frame of this practicum: these were formative evaluation and summative evaluation. Methods included questionnaires, descriptive data, and ongoing self-evaluation using a chart to plot progress.

The types and methods of evaluation used and a discussion of results will be the focus of Chapter Four.

Phase Seven -- Termination

Anticipation of, and planning for, termination is a necessary function for a facilitator in this kind of situation. Throughout the program an attempt was made to promote the team's ownership of the process so that dependency on myself as facilitator would not develop. In the later sessions, as team members became more comfortable and interacted more readily, I gradually decreased my degree of involvement in addition to changing the nature of my involvement as previously discussed. An attempt was made to encourage team members to develop some plans which would provide opportunities for ongoing team development. This was done primarily through the use of questions, such as "How can your team deal with this concern over the long term?"

and "How are you going to promote ongoing communication among yourselves?".

It was recognized by team members that the team development program offered a forum for discussion of issues that might otherwise have been ignored. By the sixth session it was identified by team members that the program was meeting a need that would have to be met on an ongoing basis, and discussions began regarding iniating bi-weekly team meetings following termination of the program.

As planned at the outset, termination occurred after the tenth session which involved a summary and evaluation of the team development program. There was some difficulty with termination for all participants because caring relationships had developed over the five month period, and we had experienced growth and change together. In order to postpone the inevitable, the team members invited me to attend their first "official" meeting and I accepted the invitation. Their intent and willingness to assume responsibility for their own ongoing team development was highlighted by their emphasis that I was being invited back as a guest, not as a facilitator.

Summary

This chapter has provided a theoretical and conceptual framework for team development, and a description and discussion of the actual team development program carried out in this practicum. Chapter Four will provide an evaluation of this intervention in terms of impact on the team and on my learning.

CHAPTER FOUR

EVALUATION

Evaluation refers to "the systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs" (Rossi and Freeman, 1982, p.20). Two types of evaluation are possible: **formative**, an ongoing evaluation which supplies information directly pertinent to a particular program, and assists in making adjustments required while the program is in progress; and **summative**, an evaluation conducted at the end of a program to assess results or outcomes (Scriven, 1967; Tripodi, 1983).

With regard to educational programs, the purpose of evaluation is "to make judgments about effectiveness of the educational activity so that the conclusions can be used to improve the educational activity" (Knox, 1976, p.104). In this practicum, formative evaluation was used in an ongoing attempt to ensure that the intervention was responsive to the needs of the team members. A summative evaluation was conducted to assess the effectiveness of the intervention in achieving its objectives.

As mentioned in Chapter Three, the literature discusses a

number of methodological problems which make it difficult to accurately evaluate team development interventions. Some of the difficulties include inadequate controls, variable lengths and duration of sessions, inconsistency in size and composition of teams, inadequate measures of change, and questionable generalizability of laboratory results to intact working groups (Woodman and Sherwood, 1980; DeMeuse and Liebowitz, 1981; Eden, 1985; Hughes et al, 1983). Although it was not the intent of this practicum to conduct rigorous research regarding the outcome of the team development intervention, a review of these methodological difficulties was useful in my attempt to develop measures for evaluation.

In order to obtain as complete and accurate an evaluation as possible, a number of techniques and measures were utilized. In recognition of the time constraints for team members, and in an attempt to make the evaluation efforts meaningful rather than intrusive or burdensome, techniques and measures were selected for their ease of use, simplicity, minimal time requirement, and relevancy to the task.

Quantitative data was obtained through the use of attendance records, rating scales completed at the end of each team development session, and a pre- and post-intervention questionnaire. Qualitative data was obtained through the use

of audio-taping and process recording of each session, observations and perceptions of team members' behaviours -- including level and quality of participation and interactions -- for the duration of the intervention, and ongoing verbal and non-verbal feedback from team members.

A final session focussing on summary and evaluation of the program provided verbal feedback regarding the team members' perceptions of the experience. As well, a written evaluation form elicited feedback regarding the content, format and facilitation of the sessions. An informal follow-up contact five months after the program ended strengthened the evaluation process.

In this chapter, each of the above evaluative measures and the results obtained from them will be described and discussed in relation to the objectives for the intervention.

Objectives for the intervention re-stated

As presented in Chapter One, the objectives for the intervention were:

(1) to facilitate improvement in the team's ability to work together, within the framework of providing an optimal level of service to clients; and

(2) to help team members deal with ambiguity, change, conflict and complexity inherent in the work situation, in a way which promotes progress for both the team and service delivery.

In order to make systematic observations of a concept, it is necessary to develop **operational definitions** i.e. to translate the concepts into variables which are measurable (Tripoldi, 1983). The above-stated objectives involve two concepts -- team functioning (the team's ability to work together), and service delivery. For the purpose of this practicum, the operational definitions of these objectives are as follows:

1. Team functioning

Team functioning will be operationally defined and measured in terms of the following variables:

(a) **role clarity,** defined as each team member's perceptions and expectations regarding her own knowledge, skills and behaviours within the team, and those of other members;

(b) **communication,** defined as the expression of ideas, opinions and concerns to team members, even when there is disagreement;

(c) **use of team resources,** defined as the

perceived degree of utilization of each team member's special knowledge, skills and expertise;

(d) **personal effectiveness,** defined as each team member's perception of how her contributions are accepted and utilized by the team as a whole; and

(e) **collaboration,** defined as the ability of the team to work together towards the accomplishment of common goals.

2. Service delivery

For the purpose of this practicum, service delivery will be defined as the quality and effectiveness of service to the client population as perceived by team members.

Pre- and post-intervention questionnaire

1. Description

The questionnaire for team members was designed to elicit information about selected variables and to determine if any change occurred in these variables over the course of the team development intervention. It was pre-tested by three of my colleagues from different disciplines, and their recommendations regarding clarity and content were incorporated in a revised form (see Appendix 14). The questionnaire was

administered prior to the first team development session and at the end of the final session.

One of the drawbacks in the use of this questionnaire for this particular setting is that pre- and post-intervention measures are available for only half of the team members . The secretary, who had joined the team just one week prior the sessions, was able to answer some of the questions, but found the majority of them not applicable to her work. The three new members who joined the team mid-way through the sessions had no basis on which to complete a pre-intervention questionnaire. The forms were given to them as part of their orientation to the team development program, but they did not complete one until after the program was finished. Thus, in most cases, this questionnaire was only able to provide comparative data for four team members.

Another drawback in the use of the questionnaire was that for this particular team there had been very little experience with direct service at the outset of the program, so questions related to service delivery were not applicable in all cases.

2. Results

Results obtained from the questionnaire for team members are presented in Appendix 15.

Questions 1 and 2 were designed to obtain information about role clarity on the team. Of five respondents, three showed a change from somewhat clear to very clear regarding their roles on the team, and one showed a change from somewhat unclear to very clear regarding clarity of other team members' roles. In the post-intervention only questionnaire, one member remained somewhat unclear regarding respective roles of team members, while the other two were somewhat and very clear.

Question 3 was designed to measure degree of comfort with overlapping roles. As noted earlier in the description of the team, members appeared at the outset to be comfortable with role overlap because it was a necessity due to their lack of full staffing. This was reflected in the responses to question 3 in which no changes were noted from the pre- to the post-test.

Questions 4 and 5 were designed to measure the perceived degree of comfort with which team members communicate with each other. Of the five original team members, two noted improvement in comfort both in communicating with and confronting other team members. It is interesting to note that at the end of the program four members were only somewhat comfortable in confronting others, and two (new)

members remained somewhat uncomfortable in doing so.

Questions 6 and 7 were designed to measure the perceived use of team resources in general, and each respondent's perception of how her individual knowledge, skills and expertise were being utilized by the team. Four out of four respondents indicated improvement in the use of team resources, and three out of five respondents indicated improvement in the team's utilization of their expertise. Only one member felt that team resources were being fully utilized, and one new member felt her skills and expertise were being used only a little by the team.

Question 8 was designed to measure the degree of perceived personal effectiveness in four major task areas: assessment, care planning, treatment and program planning. There was some improvement noted by some members in all of the areas, with the most significant improvements in the areas of being listened to with regard to treatment and program planning, and feeling ideas were accepted by others in assessment and treatment. It is notable that new team members' responses indicate, in all but two situations, that they usually or always have the opportunity to express themselves, feel others are listening to them, and feel their ideas are accepted by others.

Question 10 was designed to measure perceived effectiveness of team collaboration in the accomplishment of nine specific activities. As noted earlier, some of these activities did not exist at the time of the pre-test, and therefore no comparison can be made. However, in the instance of case conferencing, this activity was initiated as a result of the team development program so this is reflected as an improvement. Perceived improvement was noted in the areas of establishing care plans, case conferencing and ongoing treatment.

Of particular interest in the responses to question 10 was the perception in five responses that effectiveness of team collaboration had declined during the course of the team development program. These changes in perception were noted in the areas of case conferencing, sharing of client-related information, sharing of knowledge, perspective and expertise, and liaison with the community. It is also interesting to note that the team was perceived by new members as generally less effective in collaboration as compared to the ratings of original members. Possible reasons for these results will be suggested in the discussion of findings.

Questions 9, and 11 attempt to elicit information regarding service delivery. Question 9 is a direct question regarding perceived quality of service in general. Two of four

respondents reflected a perceived improvement in quality of service in general. In the post-test, all respondents with the exception of one new member felt the quality of service being provided was good or excellent.

Question 11 was designed to obtain information about the perceived effectiveness of the team in meeting specific needs of clients. This section was very difficult for team members to respond to in view of the newness of the programs and the fact that very few clients had been served by the program by the time this practicum took place. Improvement in some areas was noted, but in view of the circumstances this question had little usefulness or validity for this particular team.

Questions 12 and 13 did not relate to any specific variables, rather were intended to obtain more information regarding how team members felt about their work experience in general. Question 12 shows a considerable increase in identification of factors which sometimes make it difficult for team members to do their job as well as they would like to. It is notable that in the post-test the responses of new members indicate a generally higher degree of difficulty with these perceived constraints. Potential reasons for this will be explored in the discussion of findings.

Question 13 asked members to rate their current and previous levels of job satisfaction, for the purpose of assessing whether a correlation existed between job satisfaction and the other variables being measured. However, due to the fact that all members of the team were new, this was not an appropriate or useful question for this particular team.

Question 14 is an open question designed to determine whether there is a perceived need for improvement in team functioning and/or service delivery, and if so, in what areas. Responses are recorded in Appendix 15.

Team Development Wheel

1. Description

The "Team Development Wheel" (see Appendix 16) was used as a measure by which team members could rate their perceptions of how the team was developing. It was completed by all team members at the end of each session. In the first session team members initially felt they could not complete the rating scale because they had not had any experience together as a team. After some discussion they decided to complete the scale on the basis of their perceptions of the session, and this continued throughout the program.

Each team member received one scale on which she charted and

dated her perceptions at the end of each session. Thus at the end the program, each participant's "wheel" provided a visual representation of how the team had developed, in her perception, over the course of the team development program.

2. Results

Positions on the graph were assigned corresponding numbers in order to obtain a numerical rating from each team member for each session. Ratings from 0 to 2.9 represented Stage One -- "Testing", from 3 to 5.9 represented Stage Two -- "Infighting", from 6 to 8.9 represented Stage Three -- "Getting Organized" and from 9 to 11.9 represented Stage Four -- "Mature Closeness". Ratings of each member for each session are depicted in chart form in Appendix 17.

For each session the average and the range of responses was calculated to determine if any patterns emerged. Where an individual respondent indicated more than one rating for a session, all responses were included in the average. Although it is recognized that this is a very crude analysis of the data, it is nevertheless seen as useful to look at the patterns of responses, particularly as they compare to results of other measures.

There were four sessions in which the range of responses all fell within the same stage of team development. These were:

Session One, in which all but one response indicated that the team was at Stage One, Testing; Sessions Two and Three, in which all but one respondent perceived the team to be at Stage Three, Getting Organized; and Session Ten, in which all but one respondent placed the team in the fourth stage of Mature Closeness.

In the other sessions there was great variability in the perceptions of team members, with a wide range of responses. However, using averages for each session, it is possible to arrive at some general indications as to where the team felt it was in terms of development over the course of the program. These were:

Stage One -- Testing Session 1

Stage Two -- Infighting Session 5

Stage Three -- Getting Organized Sessions 2,3,4,6,7, 8 and 9

Stage Four -- Mature Closeness Session 10.

It is significant to note that only five out of a total of seventy-five responses were located within Stage Two on the chart. In retrospect, it appears that the labelling of this stage as "Infighting" may have caused team members to avoid this depiction of the team because of its potentially negative connotations. It would likely have been more

helpful for team members and more useful for analysis to have chosen or devised a scale in which terms were neutral rather than emotionally-laden (mature closeness implying "good" and infighting implying "poor" functioning rather than open acceptance of different stages in the team's growth and development).

Despite the limitations of the "Team Development Wheel" noted above, it was useful as a formative measure for the purposes of the team -- it allowed members to gauge their progress, it promoted increased awareness of various aspects of team functioning, and it illustrated that teams can move back and forth between stages which are neither static nor mutually exclusive.

Record of attendance

A record of attendance was maintained throughout the program. As discussed in Chapter Three, attendance remained high throughout the entire program, with only two absences due to illness and one absence due to a conflicting work requirement.

Recording of sessions

An audio-tape of each session was made, with the permission of team members, for my purposes in learning and planning subsequent sessions. After each session the tape was

reviewed, and extensive process recording was completed.

Transcribing the tapes from each session was helpful in that it allowed me to pick up on themes and concerns that emerged in the sessions, and relate these back to the team in later sessions (formative value). It was also helpful in that it helped me to determine which of my interventions as facilitator had the greatest and least impact in terms of response, discussion generated, awareness, and self-initiation. In this way it was instructive to me in my attempt to be responsive to the needs of the team (as referred to earlier in Chapter Three.

Ongoing observation

In addition to process recording of each session, I noted my observations and perceptions of individual and team development throughout the program. This included observations regarding the level and quality of participation, the nature of interactions, and indicators of trust and cohesion.

Some of these ongoing observations are included in the summaries of each session (see Appendix 7). These observations, combined with process recording and data obtained from other measures, were very helpful in evaluating the effectiveness of the team development program.

Evaluation Questionnaire and Feedback

An evaluation questionnaire (see Appendix 18) was left with team members after the final session, to be completed anonymously in order to promote freedom of expression. All questionnaires were returned.

The questionnaire was useful in obtaining the team members' evaluation of the team development program and the effectiveness of the facilitation of the program. Responses to the questionnaire are recorded in Appendix 19.

Verbal feedback from team members throughout the program and during the final session was most valuable in my effort to do an ongoing and final evaluation of the intervention. At times verbal feedback highlighted the fact that the sessions promoted individual growth:

> "My confidence is low because I got knocked down so many times in the past. It has improved in these sessions."

Other comments affirmed the value of the intervention in terms of team functioning and service delivery:

> "You have to make people feel that they belong. You get the work done better if you share information, respect each other and feel comfortable."

"It would have taken a lot longer to develop this much cohesion, communication between members."

"The more feedback we receive, the more we feel supported...this gives greater confidence in doing the job."

"Time constraints prohibit team-building interactions unless you force yourselves to set time aside."

DISCUSSION OF FINDINGS

The use of several different kinds of measures was helpful in the evaluation of this intervention because it allowed for comparison of results, perceptions and observations.

One of the major areas in which the team felt the program was effective was that of improving role clarity. This finding was confirmed by questionnaire results, evaluation questionnaire results, and verbal feedback from team members.

Questionnaire results and verbal feedback indicated that the program was effective in promoting improved use of the team's resources. The same measures also indicate improvement in perceived personal efficacy in terms of direct

service delivery and program planning.

Some interesting findings appear in question 10 in the pre- and post-intervention questionnaire, in which five responses indicate a decrease in perceived effectiveness (collaboration). In looking at verbal feedback and the stated intentions of team members for future action, it would appear that one explanation might be an increased awareness and greater expectations for the team. In discussing what the ideal should be, team members may have become less satisfied with the reality and more motivated to change. Another possible explanation might be that as the program progressed the team had more involvement in direct service, and may have become more acutely aware of the need to collaborate.

In the same question on team effectiveness with regard to collaboration, it was also interesting to note that the new team members' perceptions were of a lower level of effectiveness. As in the above, this could be related to higher expectations and increased involvement in direct service. However, in view of some of the verbal feedback, it is also possible that the new members felt team issues were being worked through and wanted to concentrate more on service delivery issues.

As with the responses to question 10, the responses to question 12 which indicate increases in perceived barriers or constraints to job performance may also be related to increased awareness and/or increased involvement for direct service.

As noted earlier, the questionnaire did not yield data regarding impact on service delivery. Verbal feedback did, however, indicate that team members felt their improved cohesion and communication would have a positive impact on service delivery in the long run.

In general, the rough measures obtained from the "Team Development Wheel" were supported by observations made by myself as facilitator and by team members in their verbal feedback. The one major exception to this was their reluctance to cite their stage of development as "Infighting", even though other indicators showed that they were in this stage.

Finally, results obtained through many of the measures lend support to the premise of this practicum regarding the connection between socioemotional (team) functions and service delivery (task) functions. Both verbal and written comments reflect the interrelationship between these two functions, and the need to address both in the daily routine

of work as well as in team development programs. This connection is perhaps best illustrated in the responses to question 14. This question requested respondents to give comments and suggestions regarding team functioning and service delivery in two separate sections. However, the responses in both sections contain both team functions and task functions, suggesting that from the team members' perspective these two functions are inseparable.

Follow-up contact

An informal contact with team members five months after the intervention indicated that the motivation and enthusiasm present at that time has been sustained. Meetings are being held on a regular basis within each program to address program and service-delivery issues. In addition, meetings for the entire team are being scheduled approximately once a month for the purpose of maintaining the level of communication and cohesion they had achieved in the team development program.

It is possible that much of what occurred during and subsequent to the team development program might have occurred naturally over time, without any intervention. However, responses of team members indicate that thay perceived this process to be facilitated and accelerated by the intervention. My observations also suggested that,

without a facilitator, certain issues might have remained unresolved for a long time, and have a detrimental effect on team functioning and service delivery.

In summary, in view of the responses to the questionnaires and the verbal feedback received, and the fact that the team development program was instrumental in the initiation of several new team processes, the objectives for the intervention in this practicum were met. It was not possible, however, to demonstrate as clear a link between socio-emotional functions and task functions as had been anticipated.

EVALUATION OF LEARNING EXPERIENCE

To summarize my learning objectives for this practicum, I had hoped to gain an increased awareness of the structure and dynamics of interdisciplinary teams, and acquire skills in assessing, planning , facilitating and evaluating a team development program (see Chapter One). In the final analysis, these objectives have been met.

While a review of the literature greatly increased my understanding of team development, group dynamics, and adult education principles, by far the greatest contribution to my learning came from the members of the team. It was their

interactions, responses and feedback that allowed me to learn and grow in the new role I had assumed for the practicum.

As I had anticipated, the role of facilitator was a consistent one throughout all ten sessions, and was often used in combination with other roles. However, I had not anticipated that the team would so clearly identify this as my major role. For example, in Session Five one member commented "this is a therapy group, isn't it", and the team agreed that there were some elements of "group work" in the sessions. Another example occurred in Session Nine when a team member encouraged the others to "take this opportunity of a competent facilitator to discuss this issue".

As noted briefly in Chapter Three, the major learning for myself was in the area of emphasis on process rather than content. Although I had been prepared for this approach on a theoretical level, in the initial stages I found it somewhat more difficult to actually carry through on a practical level. At the outset I thought the team's expectations of me, (probably my own expectations of myself), would be much more focussed on the roles of trainer and resource person. To that end, I felt the need to offer theoretical background and prescription-based interventions, and to enter each session with the expectation that a certain amount of

content would be covered. Within a few sessions however, it became evident through verbal and non-verbal responses that this approach was not necessary or even desirable for this particular team.

What was most relevant for this team appeared to be the working through of their own issues with the assistance of a catalyst and facilitator. In later sessions I became more comfortable in letting go of my perceived role of trainer and focussing more on the other roles. In other words, I directed less attention to content and focussed my energy on facilitating the process. The relevant content was then able to emerge from the team's actual involvement in the process.

Carl Rogers might have suggested that my initial need to "impose" content reflected a lack of trust in the learners (team members). However, I feel it was not so much a lack of trust in the team members as it was a lack of experience and confidence in myself as a facilitator/educater.

The use of an interactive, process-oriented approach appears to have been most useful and appropriate for this team. If a prescribed team development model had been used, it is possible that the real issues may not have been confronted because the process wouldn't have evolved in the same way. As the process did develop, team members showed greater

levels of confidence, trust and cohesion. There was also a greater use of humour rather than silence to broach more difficult subjects and to release tension.

There are two examples which illustrate the increased comfort and trust level in the team, and the fact that people need to be ready to deal with issues. One occurred in the last session when one member acknowledged to the others:

> "I wasn't completely up front in the first few sessions ---I was just feeling my way around."

Another example occurred in the ninth session after the team had just discussed at length a conflict which had occurred and had considerable impact on the team. When I noted that in earlier sessions they had told me there was no conflict, the response (accompanied by much laughter) was "We lied!". The fact that the team was able to openly share this and work on problem-solving together seems to validate the approach used in this intervention.

In summary, this practicum did meet my learning objectives in terms of gaining knowledge and developing certain skills. However, as remarked by the team members involved in this practicum, I also feel that this experience was, for myself, just the beginning.

CHAPTER FIVE

CONCLUDING REMARKS

The intervention described in this practicum report involves the planning, implementation and evaluation of an interdisciplinary team development program.

The objectives of the intervention were:

(1) to facilitate improvement in the team's ability to work together, within the framework of providing an optimal level of service to clients; and

(2) to help team members deal with ambiguity, change, conflict and complexity inherent in the work situation, in a way which promotes progress for both the team and service delivery.

Verbal and written evaluations of the team development program were generally very positive. There was a general consensus among team members that this was a valuable experience for them, and that it would be a valid activity for all interdisciplinary teams to undertake. There was also a consensus that even though this program had helped to improve their functioning as a team, they saw it as "just the beginning".

At the end of the tenth session team members were highly motivated to carry through with a number of activities discussed in the sessions, including case conferencing, regular information-sharing meetings within each program, and scheduled meetings for the entire team in order to maintain the rapport and cohesiveness that had developed. A follow-up contact five months later indicated that the momentum had been maintained, and meetings were being held as planned. The team also noted that there has been a turnover of two of their eight members since the team development program terminated. In my opinion this reinforces the need for ongoing team development, as there will always be the need for the team to adapt to changes.

The team development program implemented in this practicum took place in a Geriatric Psychiatry setting. Having completed the program, I feel it would be equally applicable to interdisciplinary teams in most human service settings. The framework for team development would be applicable in most settings because it relies on an interactive process. Thus it can be used to address the unique characteristics of a particular team, while at the same time dealing with the common characteristics of team structure and dynamics.

The flexibility and responsiveness of the approach used in this practicum appeared to be most beneficial for this team.

However, depending upon individual characteristics and preferences, other teams might want more structure built in to the program. The framework presented would allow for the use of more directed experiences if required/requested by a particular team.

The intervention confirmed the premise that professionals do have the basic knowledge and skills required for teamwork (i.e. interpersonal communication, decision-making, problem-solving), but they do need to develop increased awareness and skills regarding how to apply these in the team setting.

The use of a model for planned change was helpful for the purpose of this practicum because it provided a focus for the intervention and highlighted the importance of remaining aware of the team in its context. Interactions among team members and verbal feedback supported the premise that team development must be implemented within the context of the needs of team members as individuals, the team as a whole, service delivery, and the external environment including the organization and the community.

Quantitative and qualitative data indicated that there was improvement in cohesion and collaboration as a result of this intervention. As well, verbal feedback from team members supported the premise presented in the Autothera-

peutic Model. However, the connection between team functioning and service delivery could not be substantiated by objective data in this intervention. Stricter measures of service delivery variables and an intervention with a more established team might yield stronger results in this area.

The need for a catalyst or change agent to intervene in the status quo was validated in both written and verbal evaluations of the program. In my observations, this was particularly important in helping the team to confront and deal with difficult issues. The team development program provided a supportive environment in which team members could address problem areas and deal with them in a constructive manner.

As a note of interest, the avoidance of conflict evident in the initial stages of the program may have been due in part to the fact that it was a team comprised totally of women. It is possible that the team members were avoiding confrontation of certain issues in order to maintain relationships on the team (Gilligan, 1982; Schaef, 1985). It would be interesting to see a similar program conducted with an all-male or mixed-gender team to see if any differences occurred in this interaction pattern (note Aries, 1976).

This practicum was an excellent learning experience which

allowed me to achieve my stated objectives as follows:

(1) I did acquire a greater understanding and working knowledge regarding a) the value, structure and dynamics of interdisciplinary teams, and b) how to promote improved team functioning within existing program and organizational constraints.

(2) I was able to develop skills in:
a) assessment of need,
b) planning and implementation of an effective approach to team development which was appropriate to the time, setting and circumstances,
c) an ability to facilitate interdisciplinary discussion in a manner which promoted growth and learning and enhanced team development,
d) a beginning attempt to evaluate results in a meaningful and accurate way, and
e) an ability to re-define the situation and make observations regarding ways in which the intervention could be strengthened, both on an ongoing basis and for application in other settings.

In conclusion, this practicum experience was a beneficial one both for myself and for the team members involved.

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APPENDIX 1

CROSS-SECTION OF A TEAM MEMBER

The Individual as a Team Member

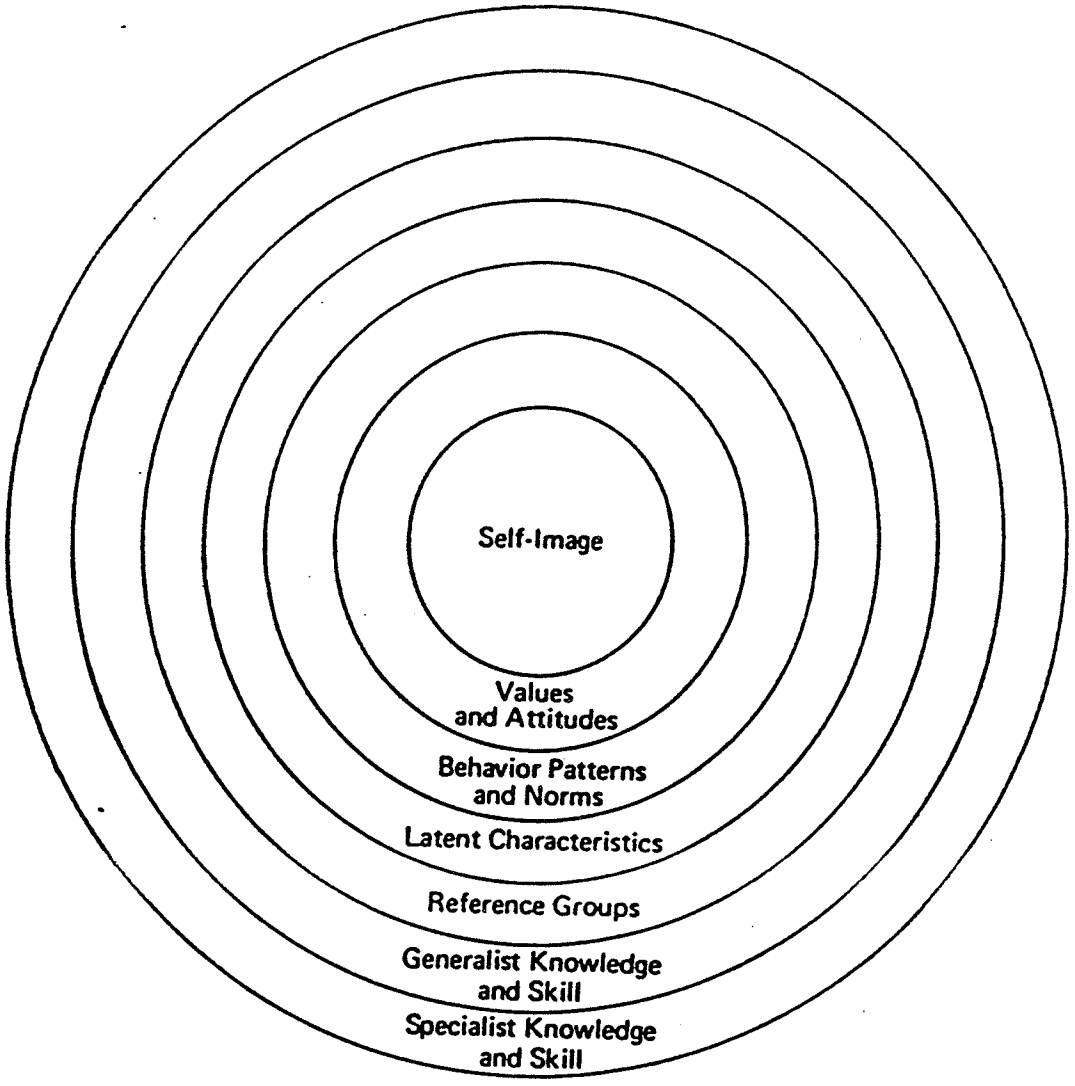


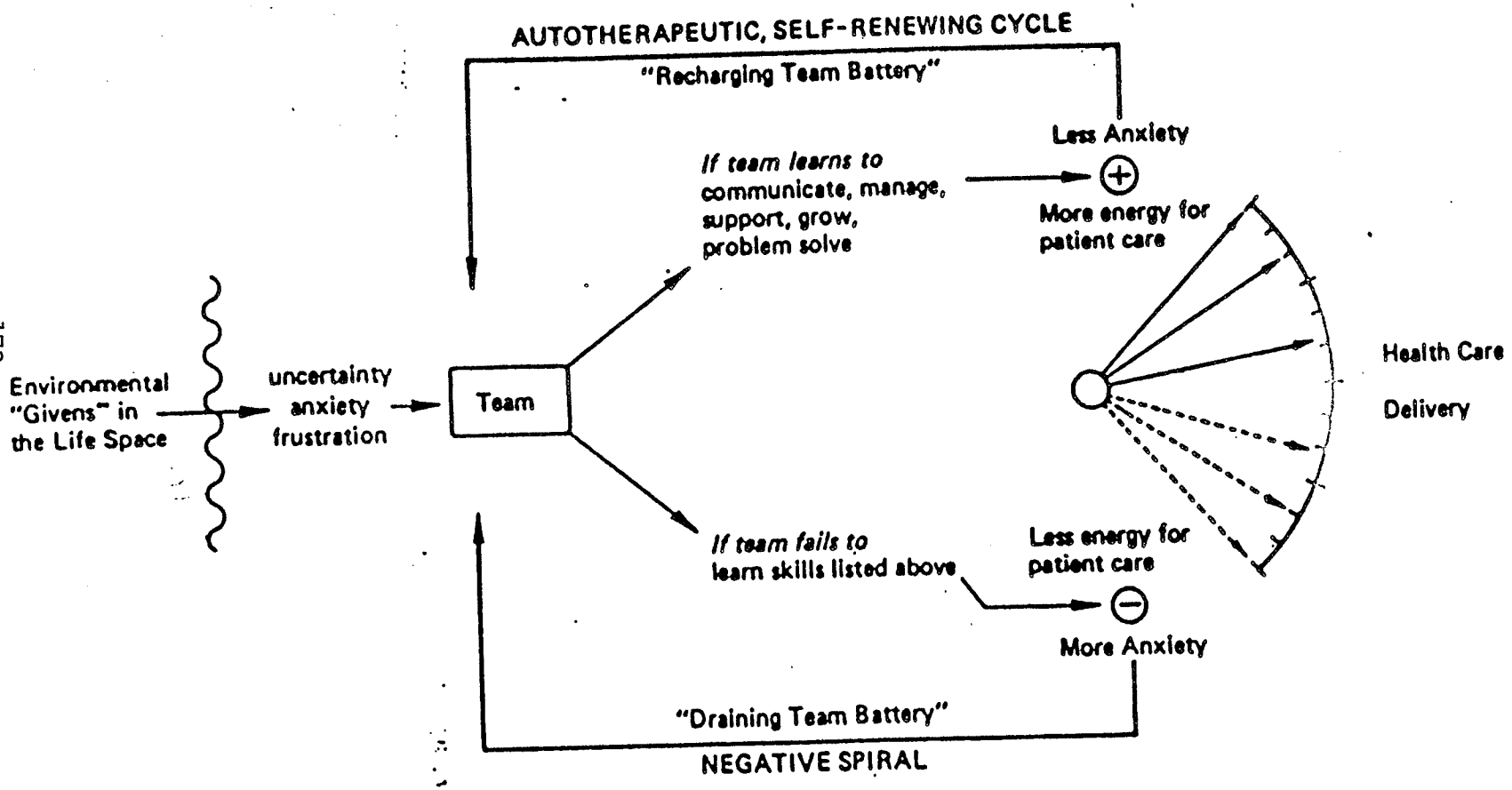
Figure 2. Cross-Section of a Team Member

Source: Brill (1976)

APPENDIX 2

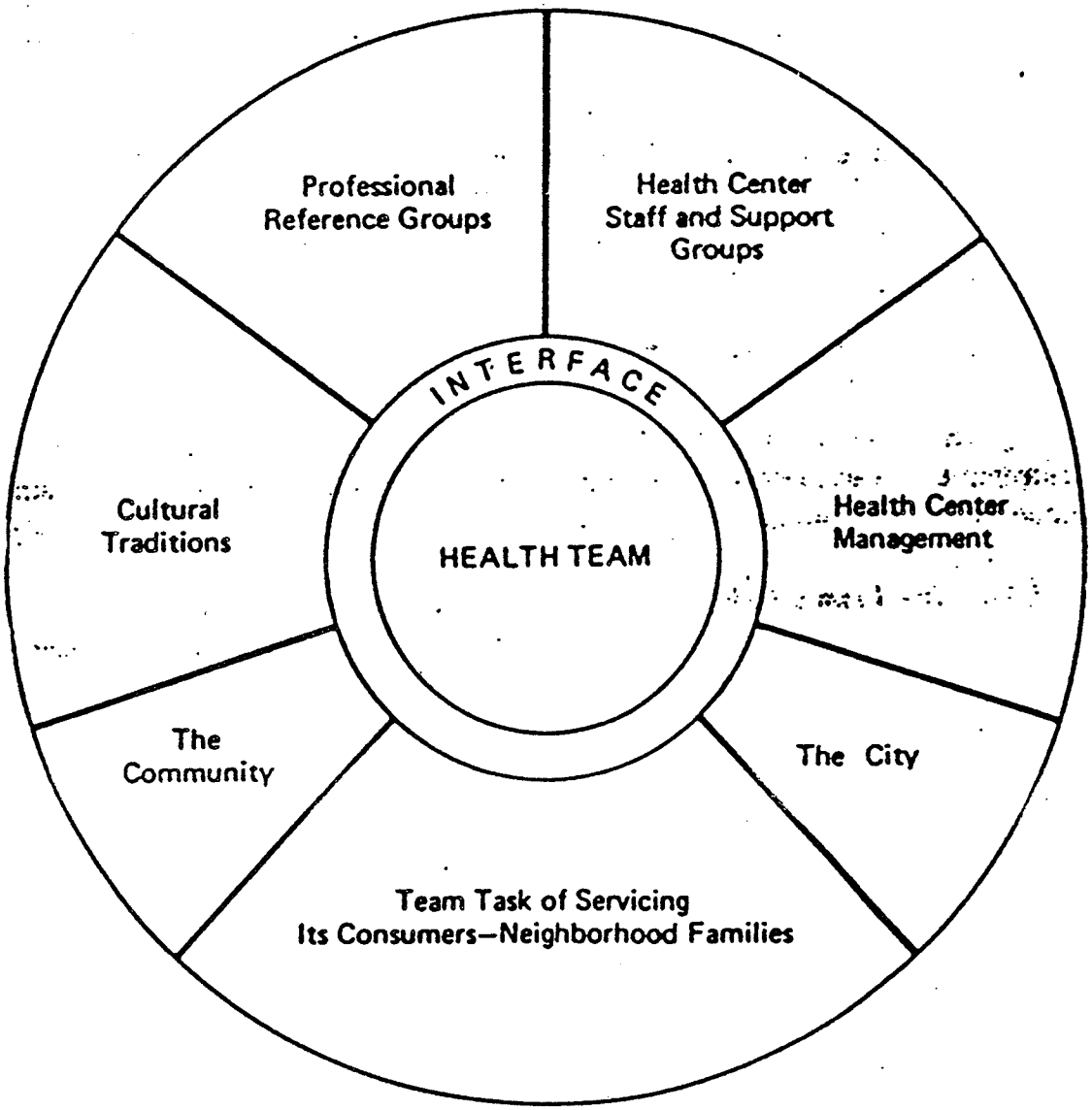
AUTOTHERAPEUTIC MODEL

Figure 2–1. The Health Team as an Autotherapeutic Organism



SOURCE: FRY, LECH & RUBIN (1994)

Figure 2-2. The Life Space of a Health Team



APPENDIX 3

TEAM DEVELOPMENT ROLE MODEL

TEAM DEVELOPMENTAL ROLE MODEL

- a dynamic, developmental process
- stages are not static or predetermined
- the timing is different for each situation, dependent upon setting, personalities, stresses etc.

STAGE 1 "BECOMING ACQUAINTED"

- superficial, polite and impersonal interactions
- each member struggling to find place on team
- low group productivity, minimal conflict

STAGE 2 "TRIAL AND ERROR"

- emerging confidence in individual roles
- testing boundaries, seeking allies, proving self
- jealous guarding of turf; little team communication and collaboration
- increasing role ambiquity, conflict, overlap of responsibilities and parallel play
- team productivity minimal, but individual goals may be achieved

STAGE 3 "COLLECTIVE INDECISION"

- attempt to minimize conflict and maintain equilibrium
- assumption of shared responsibility and pseudoconsensus decision-making
- no norm of accountability, little or weak leadership, little accomplished
- discontent, helplessness, low morale; members not listening to each other
- role conflict continues, but is not directly dealt with → covert anger
- team and individual productivity low
- scapegoating may arise when one frustrated individual makes a unilateral decision and the team doesn't support this

STAGE 4 "CRISIS EVENT"

- may be internal or external
- team forced to face issue of collective indecision and begins to delineate more definitive roles and responsibilities
- guilt, open expression of anger, depression, and recognition of conflict
- individual members assume major responsibilities for the ongoing care of patients, but team productivity remains low

STAGE 5 "RESOLUTION"

- growth toward maximal team functioning
- flexible, open communication
- shared responsibility for decision-making
- shared accountability for carrying out team tasks
- high group and individual productivity, collaboration and satisfaction

* a fragile state, easily threatened by stress, crisis, or other changes.

- evaluation of overall group productivity includes:

- how effective is the team?
- how efficient is the team?
- what has the team produced in terms of maximum patient care and best use of resources?

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APPENDIX 4

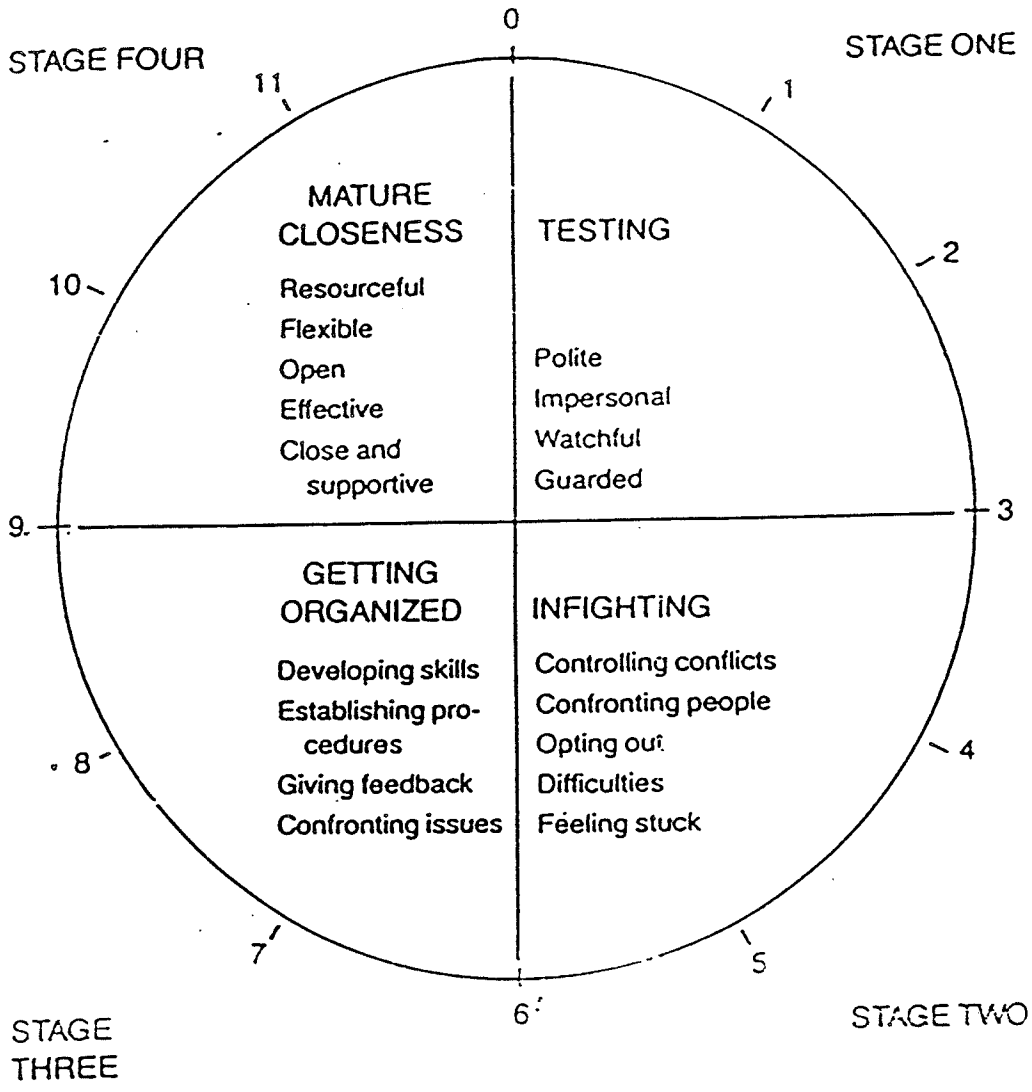
TEAM DEVELOPMENT WHEEL

TEAM DEVELOPMENT WHEEL

Name

Date

Instructions: Place a mark on the circumference of the wheel to represent the present status of your team.



SOURCE: FRANCIS AND YOUNG (1979)

APPENDIX 5

CHARACTERISTICS AND IMPLICATIONS OF ADULT LEARNING THEORY

M. KNOWLES.

Table H-1
Characteristics and Implications of Adult Learning Theory

There are a number of implications contained in the learning theory utilized in the Executive Course that flow from the identified characteristics of adult learners. These characteristics and their implications have been developed by Malcolm S. Knowles.

Characteristics of Adult Learners	Implications for Adult Learning	Implications For Presentors
Self Concept: The adult learner sees himself as capable of self-direction and desires others to see him the same way. In fact, one definition of maturity is the capacity to be self-directing.	• A climate of openness and respect is helpful in identifying what the learners want and need to learn.	Presentors recognize participants as self-directing . . . and treat them accordingly.
	• Adults enjoy planning and carrying out their own learning exercises.	The presentor is a learning reference for the participants rather than a traditional instructor; presentors are, therefore, encouraged to "tell it like it is" and stress "how I do it" rather than tell participants what they should do.
	• Adults need to be involved in evaluating their own progress toward self-chosen goals.	The presentor avoids "talking down" to participants who are experienced decision-makers and self-starters. The presentor instead tries to meet the participants' needs.
Experience: Adults bring a lifetime of experience to the learning situation. Youths tend to regard experience as something that has happened to them, while to an adult, his experience is him. The adult defines who he is in terms of his experience.	• Less use is made of transmittal techniques; more of experiential techniques.	As the adult is his experience, failure to utilize the experience of the adult learner is equivalent to rejecting him as a person.
	• Discovery of how to learn from experience is key to self-actualization.	
	• Mistakes are opportunities for learning.	
	• To reject adult experience is to reject the adult.	
Readiness-to-Learn: Adult developmental tasks increasingly move toward social and occupational role competence and away from the more physical developmental tasks of childhood.	• Adults need opportunities to identify the competency requirements of their occupational and social roles.	Learning occurs through helping participants with the identification of gaps in the learner's knowledge.
	• Adult readiness-to-learn and teachable moments peak at those points where a learning opportunity is coordinated with a recognition of the need-to-know.	No questions are "stupid"; all questions are "opportunities" for learning.
	• Adults can best identify their own readiness-to-learn and teachable moments.	
A problem-centered time perspective: Youth thinks of education as the accumulation of knowledge for use in the future. Adults tend to think of learning as a way to be more effective in problem solving today.	• Adult education needs to be problem-centered rather than theoretically oriented.	The primary emphasis in the course is on students learning rather than on teachers teaching.
	• Formal curriculum development is less valuable than finding out what the learners need to learn.	Involvement in such things as problems to be solved, case histories, and critical incidents generally offer greater learning opportunity for adults than "talking to" them.
	• Adults need the opportunity to apply and try out learning quickly.	

SOURCE: Knowles (1984)

APPENDIX 6

INTERVENTION MODES

These basic processes are

Intervention mode	Key words	Indicated when
Catharsis	Emotional release	Pent-up feelings are blocking thought and action; 'immobilizing tensions' are barriers to constructive action
Catalysis	Strengthen perception	Poor communication has resulted in pluralistic ignorance about what's going on
Confrontation	Value identification	Values, often hidden, are having negative effects and must be brought into focus before the causes of problems can be worked on
Prescription	Giving answers	There is impasse, hopelessness, or despair, and yet immediate action is imperative to avoid further negative consequences
Theory	Concept based insight	Team members are ready to diagnose and to solve problems systematically, using pertinent theory as the basis for contending with future problems

SOURCE: Blake and Mouton (1975)

APPENDIX 7

TEAM DEVELOPMENT PROGRAM

SESSIONS I - X

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
I June 29/87 All Present	Introductions Discussion of Purpose and format of sessions Agenda building	Group Theory: Makay & Gaw Shaw Gibb Dimock Thibout & Kelly Adult Education Theory: Knowles Brundage & Mackeracher Cross, Kay - recognition of each individual Sarason, Brill, Horwitz, Kiersey & Bates - begin building atmosphere of trust and open communication Golembiewski & Mc Conkie - agenda and process appropriate for this specific team - promote task ownership & commitment Organization/ Team Development Lowe & Herranen Francis & Young Brill, Argyris	- self-introduction of all present, including personal and professional background and expectations of team development sessions - agenda was built through open discussion about what topic areas should be addressed	- promoted sharing (of self and others) - facilitated building climate of trust - participated in agenda-building, recognizing their issues and not imposing mine supportive rather than confrontative - facilitator - process consultant - data gatherer	- discussed issue of confidentiality obtained permission to tape sessions; discussed team's option to turn off tape as necessary. - discussion about stages of team development, how they see themselves as a team - psychologist and nurse most actively involved in the discussion, and recognized same. - as they had little history as a team, members decided to use the interactions during each session as the basis on which to complete the "Team Development Wheel", after each session.	- somewhat guarded and cautious; recognition of anxieties, need to test out each other and the sessions - generally seemed open and enthusiastic for a first session - this was the first time they had ever met together as a "team".

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
II July 8/87 All Present	Role Definitions	Abelson & Woodman Brill Kane Wise, Beckhard, Rubin & Kyle Rubin, Plovnick, & Fry Williams et al Lowe & Herranen - role definition - role clarity - role conflict - role overlap	1) use of case study compiled and presented by one team member to have a simulated case conference and identify their interaction as a team. 2) discussion of concepts related to roles	-prepared handout with issues related to role definition for discussion purposes -noted nature and frequency of interactions in discussion and gave feedback re same -provided feedback from questionnaire items -suggested use of Interprofessional Perception Scale to look at roles for next session; suggestion rejected by members, who proposed an alternate format (ie. brainstorming) - process consultant - resource person - data gatherer	-good participation in case conference, 2 more actively involved than the rest -some members were able to share information regarding program and procedure not known by all members -discussed how to promote involvement of all members -alluded to conflict but avoided discussion of very real role conflicts which had occurred; discussed role overlap and potential conflict in general -members identified the importance of looking after personal needs for recognition, respect, etc. in order to promote maximum involvement	-helpful exercise because roles on the team had not been clearly defined, and many procedures had not been well established -use of case study was helpful in bringing to light areas which need attention regarding roles and procedures related to service delivery -team identified a need to develop good rapport and mechanisms now, before their caseload demands increase -more open, beginning to explore issues; not yet ready to deal openly with conflict - may need to increase comfort level first

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
III July 27/87 All Present 1 late due to an emergency	Role Perceptions and Expectations Part I clinical nurse specialist home economist activity worker receptionist psychologist	Interdisciplinary Role Perceptions: Mc Broom Kane Valletutti & Christoplos Chartier et al Organization Theory: Blake & Mouton Rao Likert Gender Issues: Schaef Gilligan Aries	Brainstorming: addressed each discipline present: a) others gave their perceptions & expectations b) person in that discipline responded, clarified and expanded c) general discussion d) results recorded on flip chart	-facilitated discussion, promoted further inquiry and clarification -wrote items on flip chart (later organized and printed out the information and distributed to team) - facilitator - data gatherer	-through discussion, it was discovered that characteristics could be grouped into four categories: - training, knowledge & skills - tasks & functions - personal characteristics - relative status -other themes emerged repeatedly throughout the discussion, ie. - gender issues - "we v.s. them" issues - organizational change -team members stated the exercise was very helpful and suggested we return to a more expanded discussion of roles when new team members (1 O.T., 2 S.W.) are on board	-generally polite and mutually supportive climate -team felt comfortable with this approach - no confrontation - few surprises - active participation -this exercise probably provided recognition and validation for some members, clarification for others * the perceptions and expectations of each discipline seemed somewhat better than what one might expect in view of the literature

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
IV August 12/87 All Present first meeting for O.T. who just joined team	Communication Part I Between the Team and its External Environment	-Principles of communication Makay & Gaw Barriers to effective Communication Gibb Wise, Beckhard, Rubin & Kyte -Organizational Change Coe -Multiple linkages, horizontal linkages Knowles Blake & Mouton Pray	Communication between the team and the organization chosen by the team for today's session because "it's probably the most innocuous" - catharsis - discussion - peer-helping - problem-solving	- perceptive of their anxiety and tension - encouraged release and confrontation of issue - responsive to their concerns; promoted trust and comfort level by offering to turn off tape - flexible (ie, had something prepared for session but addressed their needs rather than pursuing my own agenda) - facilatator - change agent [met separately with new member (O.T.) to discuss purpose of sessions]	- Psychologist and Nurse stated they were holding back because they didn't want to dominate the interaction - much reluctance to speak; high level of tension noted; improved once tape turned off - addressed real concerns re communications between the program and the rest of the organization; impact this has had on them personally, professionally and as a program; began by venting feelings but moved to discussion of developing strategies to promote change/improvement	- benefitted from catharsis - increasing trust, openness and cohesion - attempting to understand environment and look for positive ways of dealing with conflict - breakthrough for personal confidence, comfort level - may take this long for team to acknowledge/admit problems - good fit between new member and rest of team; previously known to each other as had worked elsewhere in Deer Lodge Centre for one year - expressed wish to engage in constructive problem-solving in order to break down perceived barriers - issue of confidentiality and loyalty to Deer Lodge Centre very important

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
V August 19/87 All Present, but personal and work stresses noted by several members prior to session	Communication Part 2 Within the Team	Interpersonal and small group communication Gibb Fisher Dealing with interpersonal conflict Rahim Resistance to Change: Ends & Page' Francis & Young Schein Schon	- open discussion - use of real-life example involving 3 team members - spontaneous role-play initiated by a team member	- encouraged use of real example to discuss this issue; introduced topic of conflict resolution - related importance of communication back to team trust and cohesion and service delivery - provided feedback from questionnaires and references to communication in earlier sessions - summarized, provided background information, encouraged confrontation of issues - used handout and review of some theory to facilitate discussion; - not well received, my need more than theirs - facilitator - change agent - resource person - trainer	- continuation of last session, felt it had been a turning point; where to go from here? - returned to issue of degree of participation by each member; finding it somewhat difficult to address and resolve, but did discuss it - somewhat less interactive perhaps due to personal stresses but beginning to share more on a personal level and discussion generally more free-flowing - looked at structure of the department and how this promotes and inhibits effective communication - beginning plans to welcome and incorporate two new S.W. beginning next week	- team identified elements of group therapy in session; not seen as threatening by members - beginning to have greater trust, which allowed for more open and honest confrontation of issue of degree of participation by different members - good session for individual growth for some members; increased understanding/insight for others, as each expressed current perceptions, feelings and expectations

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
VI September 2/87 one person absent due to another work committment session was delayed one week as three members had other work commitments - first session for two new S.W. who had just joined team	1) Introduction and Orientation for two new members 2) Review of progress to date and outstanding issues	Autotherapeutic Model Fry, Lech & Rubin - Role definitions - team-building as an on-going process, within the context of service delivery Team members as individuals (See Session I)	- discussion, sharing of information and expectations - review of theory autotherapeutic model, team members as individuals	- brief review of material and issues previously covered - facilitated exchange of information, ideas and feelings - had to re-focus as team not really addressing concerns expressed by new members met separately with two new members (S.W.) to discuss purpose of sessions - facilitator - process consultant - resource person	- considerable uncertainty on the part of new staff regarding their roles and how they fit into the team; existing team members had been "doing it all" - discussion of organizational structure of team; leadership is unofficial ---> allows for flexibility and innovation, but also creates uncertainty when there are no guidelines	- Team expressed desire to welcome and orient new staff but unsure how to proceed - New staff feeling unsure of roles, functions -- no formal way of addressing this within the team - Some polarization noted between existing team and three new team members - Session somewhat less helpful for those who had attended previous sessions, but did help to introduce new members to sessions in a non-threatening way - Members noted several times throughout session that, had it not been for this practicum, they would not have gotten together to discuss issues raised today, ie. there is no meeting time set aside, and no extensive orientation

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
VII September 9/87 1 person absent due to illness	Role Perceptions and Expectations Part 2 New Members	See Session III Also: Group theory re adjusting to new members - Dimock	Brainstorming use of flip chart to record discussion of OT and SW roles and how these can be incorporated into existing team practice discussion re period of adjustment	- facilitated discussion; encouraged further inquiry and inferences from discussion - recorded results of discussion re O.T. and S.W. roles and printed out for team - data gatherer - facilitator	- interaction less spontaneous than usual; less active participation in discussion - one new member shared perceptions re how she had initially felt she was being tested out by team, and now feels accepted - commitment to topic seemed minimal, even though team had chosen it and stated it was very useful	- new members not quite familiar and comfortable yet - existing members trying to adjust to new ones - testing on all sides; team cohesion in flux; need period of re-grouping

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
VIII September 16/8 All Present	Decision-Making	Decision Making: Kubin, Plovnick and Fry Fisher Chase et al Interdisciplinary Collaboration: Margolis & Fiorelli Larsen Williams et al Valletutti & Christoplos Organizational Change: Schein Coe Using on-going tasks and relevant processes: Knowles Schon Parker & Rubin	- simulation of real situations developed by three team members - one team member assumed responsibility for presenting scenarios and coordinating the discussion - members discussed how they would go about making these decisions; relating theory to practice - problem-solving related to specific decisions	- minimal involvement as interaction very good - asked questions to clarify points made - after discussion of scenarios, used handouts on problem-solving and decision-making to summarize process they had used; related theory to what had actually occurred in their discussions - resource person - process consultant	- high level of participation, even from quieter members - scenarios covered questions regarding: 1) delivery of service to clients 2) at what level in the organization do certain decisions get made? 3) how do decisions get made within the team? who has the authority, responsibility? 4) strategies for introducing change within the program, the organization, and the community - several decisions were actually made during the discussions	- members more comfortable in expressing opposing views, cohesion and trust level are improving - high level of participation, probably due to two factors: 1) members had ownership of, and responsibility for, scenarios and discussion; two scenarios developed were directly relevant to service delivery and other team tasks 2) increased comfort on my part in stepping back, allowing team members to take responsibility for process

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
IX September 23/87 One absentee due to illness	Dealing with Conflict	Fisher Brill Lowe & Herranen Bailey Petelle Deutsch Rahim - sources of conflict - positive aspects of conflict - conflict management	- general discussion - working through of real example on conflict brought forward by members - Psychologist very instrumental in encouraging team to use this forum in which to confront this issue - peer-helping - problem-solving	- attempted to introduce topic in a non-threatening way - encouraged identification of positive functions of conflict in addition to negative effects - drew out members who were reluctant to speak about real issues - utilized both an educative role, in providing theoretical background re conflict as well as facilitative role, both confrontative and supportive - facilitator - change agent - resource person	- initial response was nervousness, tension, avoidance, and acknowledgement of sensitivity of topic area - attempts to "rescue" facilitator - with encouragement, began to review a real conflict which had occurred, how it had been dealt with, and the impact it had had on a number of team members as well as the program	- in preparation for this session, I was preparod to address the area of conflict from the theoretical perspoctive if team members waren't ready to confront real issues - use of real example made the discussion very meaningful and relevant to the team; it promoted a high level of discussion and sharing, and was a valid use of time - facilitative skills, ability to remain calm, flexible and responsive to individual and team needs was most crucial in this session

SESSION	TOPIC	THEORETICAL BACKGROUND	FORMAT/PROCESS	MY ROLE/ INVOLVEMENT	CONTENT/INTERACTION	COMMENTS & ASSESSMENTS
X September 30/8 All Present	Review Evaluation and Closure	Group Work Theory Organizational Development re: termination phase Kolb & Frohman	- reviewed issue of confidentiality - discussion re value of the sessions in terms of team cohesiveness and service delivery - evaluation by verbal and written feedback	- primarily sought feedback from team re the value of the intervention - acknowledged risk taken and commitment made by team members, expressed appreciation for their participation	- content focussed on summing up what had occurred in the sessions discussing the degree to which it had been helpful, and formulating a plan to continue team meetings on a regular basis - group cohesion strong - high level of interaction - reviewed issue of confidentiality	- generally positive, mutually appreciative of experience - some difficulty with closure because relationships had developed

APPENDIX 8

LIST OF TOPICS

FOR TEAM DEVELOPMENT SESSIONS

MULTIDISCIPLINARY TEAM DEVELOPMENT

TOPIC AREAS

The following topic areas for dicussion in team development sessions were identified in the first session. It was recognized that some aspects of many or all of these topic areas would likely be addressed in each session, but that it would be useful to choose one topic as the focus for each session. The topics are not listed in any order of priority as it was decided to priorize on a weekly basis.

ROLE DEFINITION
- discipline-specific
- where do you belong? (individual, profession, program, Centre)

COMMUNICATION
- within the team
- in D.L.Centre
- with the community

DECISION-MAKING
- how are decisions made?
- who is involved?
- spheres of influence

INTERPERSONAL DYNAMICS
- getting to know each other
- learning how to help each other cope with/reduce stress

CONFLICT RESOLUTION
- dealing effectively with conflict from various sources
- may overlap all other areas

BRINGING ON NEW TEAM MEMBERS
- providing support
- providing good orientation
- incorporating in team

APPENDIX 9

INTERPROFESSIONAL PERCEPTION SCALE

Figure 3-6 Interprofessional Perception Scale

Answer the following items in relation to Your Own Profession

Persons in this profession:	How Would You Answer?		How Would Other Health Professionals Answer?		How Would Other Health Professionals Say You Answered?	
	TRUE	FALSE	TRUE	FALSE	TRUE	FALSE
1. Are competent	☐	☐	☐	☐	☐	☐
2. Have very little autonomy	☐	☐	☐	☐	☐	☐
3. Understand the capabilities of other professions	☐	☐	☐	☐	☐	☐
4. Are highly concerned with the welfare of the patient	☐	☐	☐	☐	☐	☐
5. Sometimes encroach on other professional territories	☐	☐	☐	☐	☐	☐
6. Are highly ethical	☐	☐	☐	☐	☐	☐
7. Expect too much of other professions	☐	☐	☐	☐	☐	☐
8. Have a higher status than other professions	☐	☐	☐	☐	☐	☐
9. Are very defensive about their professional prerogatives	☐	☐	☐	☐	☐	☐
10. Trust others' professional judgments	☐	☐	☐	☐	☐	☐
11. Seldom ask others' professional advice	☐	☐	☐	☐	☐	☐
12. Fully utilize the capabilities of other professions	☐	☐	☐	☐	☐	☐
13. Do not cooperate well with other professions	☐	☐	☐	☐	☐	☐
14. Are well trained	☐	☐	☐	☐	☐	☐
15. Have good relations with other professions	☐	☐	☐	☐	☐	☐

Source: Ducanis and Golin (1979)

Figure 3-5 Interprofessional Perception Scale

Answer the following items in relation to this profession:

Persons in this profession:	How Would You Answer?		How Would They Answer?		How Would They Say That You Answered?	
	TRUE	FALSE	TRUE	FALSE	TRUE	FALSE
1. Are competent	☐	☐	☐	☐	☐	☐
2. Have very little autonomy	☐	☐	☐	☐	☐	☐
3. Understand the capabilities of your profession	☐	☐	☐	☐	☐	☐
4. Are highly concerned with the welfare of the patient	☐	☐	☐	☐	☐	☐
5. Sometimes encroach on your professional territory	☐	☐	☐	☐	☐	☐
6. Are highly ethical	☐	☐	☐	☐	☐	☐
7. Expect too much of your profession	☐	☐	☐	☐	☐	☐
8. Have a higher status than your profession	☐	☐	☐	☐	☐	☐
9. Are very defensive about their professional prerogatives	☐	☐	☐	☐	☐	☐
10. Trust your professional judgment	☐	☐	☐	☐	☐	☐
11. Seldom ask your professional advice	☐	☐	☐	☐	☐	☐
12. Fully utilize the capabilities of your profession	☐	☐	☐	☐	☐	☐
13. Do not cooperate well with your profession	☐	☐	☐	☐	☐	☐
14. Are well trained	☐	☐	☐	☐	☐	☐
15. Have good relations with your profession	☐	☐	☐	☐	☐	☐

APPENDIX 10

SUMMARY OF ROLE DESCRIPTIONS

ACTIVITY WORKER

Training/Knowledge/Skills

-diverse backgrounds
-past image of "babysitter" and "busy-work"
-generally perceived as doing games, cooking, handicrafts
-now focus on therapeutic approach
-new and developing area in terms of roles and standards

Tasks/Functions

-education and re-education of clients and caregivers re abilities
-develops programs for activities and functions
-plans and carries out activities for the purpose of:
  promoting client awareness of abilities
  developing self-esteem, confidence
  developing leisure skills
  improving motivation
  promoting creative retirement
-recording/reporting
-supervising volunteers

Personal Characteristics

-versatile, flexible
-creative
-kind, understanding
-good listener--getting to know what people like
-patient
-organized
-high energy, happy, willing to "be there"
-ability to be objective, open-minded
-ability to motivate

Status

-low status, not viewed as a profession
-insights and recommendations may be disregarded due to above e.g. A.W. usually has good rapport and trusting relationship with client, and can share different perception of social skills, but other professionals often don't see this

CLERK-TYPIST/RECEPTIONIST

Training/Knowledge/Skills

-knowledge of medical terminology, grammar, etc.
-knowledge and understanding of staff and programs

Duties

-typing
-ordering supplies
-phone and in-person reception
-record-keeping,filing

Personal characteristics

-"people person"
-communicator
-able to relate to clients, team, D.L.Centre and community
-organized
-efficient
-dependable

Status

-crucial to running of the program
-helps: professionalism
administration
public relations
time factor

HOME ECONOMIST/ FAMILY STUDIES	PROGRAM COORDINATOR
Training/Knowledge/Skills	
-knowledge re nutrition, family dynamics, theories of family -knowledge of whole life-span, developmental stages from pre-conception to death -knowledge of budgets and financial management, and counselling skills re same -skill in working with clilents and caregivers	-management skills -knowledge of policies and procedures -knowledge of budgets and financial management
Tasks/Functions	
-counselling clients and caregivers in the areas of nutrition, financial management, family dynamics and developmental stages -front-line person to deal with problems in the client system	-administrative tasks -development of policies and procedures related to program -participate in the development and implementation of ongoing programs -communicate and problem-solve with client system, staff facility, MHSC, and community
Personal Characteristics	
-good communicator -people-oriented -diverse in skills	-ability to communicate and be assertive -organized
Status	
-lower status and pay (related to being a female-dominated, helping profession)	-lower status related to discipline and to gender in a male-dominated facility based on the medical model

NURSE

Training/Knowledge/Skills

- -diverse training, not strictly medically-based
- -knowledge about diagnoses, diseases, medications, resources
- -use of assessment scales and tools

Tasks/Functions

- -direct service to client: helping/caregiver
  assessment
  counselling
  education
- -with team and community: share knowledge re clients
  reference/resource person
  provide consultation & education
  public relations
- -research

Personal Characteristics

- -open and warm communicator
- -understanding, tolerant
- -flexible, broad-minded
- -supportive

Status

- -relative lack of status

OCCUPATIONAL THERAPIST

Knowledge/Training/Skills

- -physiology, body mechanics
- -group dynamics
- -adaptive activities

Tasks/Functions

- -cognitive assessment and re-training
- -assessments for appliances, aids
- -A.D.L. assessments, management, and rehabilitation
- -perceptual assessments and training
- -adapting homes for accessibility
- -group facilitation
- -patient education

Personal Characteristics

- -ability to motivate
- -supportive and sensitive
- -good communication skills
- -ability to relate well to other disciplines

Status

- -status dependent upon the organization, the program and the team
- -often have to counterract an oversimplified perception that others have of their profession

PSYCHOLOGIST

Training/Knowledge/Skills

- -expert clinician
- -trained in different treatment modalities: individuals
  couples
  families
  groups
  organizations
- -knowledge and skill re numerous therapeutic approaches
- -knowledge of psychological theories

Tasks/Functions

- -assessment of functioning: cognitive
  emotional
  personality
  neuropsychological
- -extensive counselling and psychotherapy
- -client advocacy
- -teaching: clients
  families
  staff
- -reference/resource person
- -consulting, assisting in problem-solving (sometimes the object of unrealistic expectations re "performing miracles"
- -case management, report-writing
- -research
- -administrative functions (related to position rather than to discipline)

Personal Characteristics

- -supportive, understanding, patient, tolerant
- -objective
- -flexible
- -"people person"
- -assertive, diplomatic
- -ability to be confrontational with staff
  with client system

Status

- -higher status on team and in facility, but lower than medical staff
- -appears to be dependent upon gender in this organization

SOCIAL_WORKER

Knowledge/Training/Skills

- -generalist training
- -knowledge of resources
- -deal with relationships and group dynamics
- -liaison with other workers

Tasks/Functions

- -assessment and counselling --psychosocial
  - --individual
  - --couples
  - --family
  - --groups
- -group facilitation --conferences
  - --family conferences
  - --therapeutic groups
- -crisis intervention
- -resource finding, referral
- -practical assistance
- -counselling and referral related to financial and legal concerns
- -patient education
- *roles overlap with those of many other disciplines

Personal_Characteristics

- -empathy
- -communication skills
- -patience
- -high tolerance for frustration

Status

- -status usually dependent upon individual personality and the organization

APPENDIX 11

COMMUNICATION

NOTES ON COMMUNICATION

for discussion purposes

Factors which affect information flow:

1. geographical and architectural factors
   - -location
   - -access
   - -barriers to quick and open communication

2. formal lines of authority or status
   - -is participation in terms of frequency, order, or content limited to formal lines?
   - -best sources of information to solve a problem will vary with the problem

3. degree to which participants feel free to participate, challenge, and express opinions

4. leadership
   - -many acts of leadership rather than one leader
   - -depending upon the situation and the problem to be solved, different people can and should assume leadership

5. atmosphere of trust
   - -allows for clarity, openness and honesty in communication

Some important elements of communication

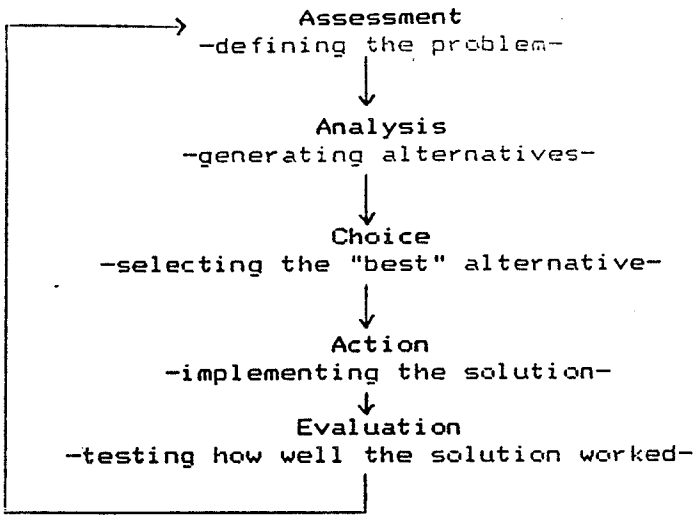
- -active listening
- -feedback
- -self-disclosure
- -constructive conflict
- -sense of humour
- -non-verbal communication

APPENDIX 12

DECISION-MAKING AND PROBLEM-SOLVING

EFFECTIVE PROBLEM-SOLVING AND DECISION MAKING

Problem-solving model



*At each stage in the problem-solving process and in moving from one stage to the next, decisions are made.

Decision making checklist

1. What exactly are we trying to decide?
   - -which stage of problem-solving are we in?
   - -is every one in agreement about this?

2. Who needs to be involved?
   - -who has valid and necessary inputs into the assessment, the generation of alternatives, etc.?
   - -who must be involved in the implementation, and therefore needs to understand and be committed to the decision?

3. How are people to be involved?
   - a)directly i.e. actually make the decisions
   - b)consulted i.e. involved before the decision is made so that they can give needed information and opinions
   - c)informed i.e. informed of the decision made

4. When will the decision be made?
   - -one person should be identified from the beginning as the one "in charge" of making sure that the decision gets made by a certain time.

SOURCE: Rubin, Plovnick and Fry (1975)
Improving the Coordination of Care
pp 149-155

APPENDIX 13

ROLE DEFINITIONS

ROLE DEFINITIONS IN TEAMWORK

Members of multidisciplinary teams are expected to coordinate activities through cooperation and collaboration. This involves a process of working together with shared goals and philosophy, and an understanding of the professional and individual skills, knowledge and characteristics of each other.

Important aspects of role definition:

ROLE EXPECTATIONS

- internal and external
- each member strives to maintain congruence between her internal values and ideas and expectations from external sources
- based on your previous experience, both personal and professional, what are your expectations about how you should behave on this team?
- what do others on the team expect of you?
- what do you expect of them?

ROLE DEFINITION

- role clarity is the condition where team members have a perfectly clear understanding of their job responsibilities and those of others
- role ambiguity can result when expectations are not clearly defined and communicated
- interdisciplinary studies have shown that there is often little congruence between the way a profession defines its own roles and the way others define them
- are the roles of your team members clearly defined and communicated?

ROLE CONFLICT

- between self and others e.g. being asked to limit treatment to medical needs when you believe in a holistic approach
- between several others i.e. when two or more other team members make demands on you that are inconsistent, and thus in conflict
- role overload i.e. multiple demands and expectations being placed on you, to the extent that you can't meet them all and thus experience conflict

ROLE OVERLAP

-is likely to occur in multidisciplinary teams utilizing a holistic approach to service delivery
-team members often have similar knowledge base, expectations and goals for patient care, and the differences in what they have to offer may not be delineated
-a certain amount of role overlap may be desirable and beneficial to patient care
-if not addressed, role overlap can have some negative effects on the team and ultimately on service delivery, e.g.
  defensiveness
  territoriality
  fear of loss of status
  resistance to sharing information
  independant and parallel functioning/ unnecessary duplication of work

ROLE NEGOTIATION

-teams are not static--they have the capacity for growth, change and self-renewal. Therefore roles are subject to constant negotiation that is never completely finalized.
-role negotiation requires great flexibility on the part of the team and its individual members

Purpose in addressing roles in team development:

-to promote a greater understanding of each team member's roles and how they are interlocked

-to provide an opportunity for inter-professional discussion about expectations and feelings

-to deal with frustrations, uncertainties, and actual or potential conflicts in a supportive atmosphere

-to promote optimal service delivery by the effective use of all team members' roles

APPENDIX 14

PRE- AND POST-INTERVENTION QUESTIONNAIRE

QUESTIONNAIRE FOR TEAM

Date_____

Please circle responses

1. Is it clear to you what your role is on this team?

not at all clear	somewhat unclear	neutral	somewhat clear	very clear

2. Are the roles of all other team members clear to you?

not at all clear	somewhat unclear	neutral	somewhat clear	very clear

3. How comfortable are you with overlapping roles?

very uncomfortable	somewhat uncomfortable	neutral	somewhat comfortable	very comfortable

4. How comfortable are you in communicating your ideas, opinions and concerns to other team members?

very uncomfortable	somewhat uncomfortable	neutral	somewhat comfortable	very comfortable

5. How comfortable are you in confronting other team members when you are in disagreement with them?

very uncomfortable	somewhat uncomfortable	neutral	somewhat comfortable	very comfortable

6. To what extent are the knowledge, skills and expertise of all team members being utilized in your program?

not at all	a little	somewhat	quite a bit	fully

7. To what extent are <u>your</u> knowledge, skills and expertise being utilized in your program?

not at all	a little	somewhat	quite a bit	fully

8. For each of the following program activities, please indicate how often:

A. Assessment

A1. You have the opportunity to express your opinion.

never rarely sometimes usually always

A2. You feel others are listening to you.

never rarely sometimes usually always

A3. Your ideas are accepted by others.

never rarely sometimes usually always

B. Care planning

B1. You have the opportunity to express your opinion.

never rarely sometimes usually always

B2. You feel others are listening to you.

never rarely sometimes usually always

B3. Your ideas are accepted by others.

never rarely sometimes usually always

C. Treatment

C1. You have the opportunity to express your opinion.

never rarely sometimes usually always

C2. You feel others are listening to you.

never rarely sometimes usually always

C3. Your ideas are accepted by others.

never rarely sometimes usually always

D. Overall Program Planning

D1. You have the opportunity to express your opinion.

never rarely sometimes usually always

D2. You feel others are listening to you.

never rarely sometimes usually always

D3. Your ideas are accepted by others.

never rarely sometimes usually always

9. In your opinion, what is the quality of the service currently being received by program participants?

poor somewhat satisfactory satisfactory good excellent

10. In your opinion, how effective is your current use of the multidisciplinary team approach in terms of the following:

a) assessment

poor somewhat satisfactory satisfactory good excellent

b) establishing care plans

poor somewhat satisfactory satisfactory good excellent

c) case conferencing

poor somewhat satisfactory satisfactory good excellent

d) ongoing treatment

poor somewhat satisfactory satisfactory good excellent

e) sharing of client-related information among team members

poor somewhat satisfactory satisfactory good excellent

f) sharing of knowledge, perspective and expertise among team members

poor somewhat satisfactory satisfactory good excellent

g) liaison with family/significant others

poor somewhat satisfactory satisfactory good excellent

h) liaison with involved community services

poor somewhat satisfactory satisfactory good excellent

i) discharge planning

poor somewhat satisfactory satisfactory good excellent

11. In your opinion, to what degree is your team meeting the needs of program participants in the following areas:

a) medical/physical health

not at all a little somewhat quite a bit greatly

b) emotional well-being

not at all a little somewhat quite a bit greatly

c) social functioning

not at all a little somewhat quite a bit greatly

d) mental health

not at all a little somewhat quite a bit greatly

e) support and information to family

not at all a little somewhat quite a bit greatly

f) access to community services

not at all a little somewhat quite a bit greatly

12. Do any of the following factors make it difficult for you to do your job as well as you would like to?

a) insufficient training or experience in specific treatment modalities?

never rarely sometimes often always

b) problems in team functioning?

never rarely sometimes often always

c) the physical environment of the program?

never rarely sometimes often always

d) program structure and policies?

never rarely sometimes often always

e) other? _____

_____

_____

13. a)How would you rate your current level of job satisfaction?

very dissatisfied | somewhat dissatisfied | neutral | somewhat satisfied | very satisfied

b)How would you have rated your level of job satisfaction 6 months ago?

very dissatisfied | somewhat dissatisfied | neutral | somewhat satisfied | very satisfied

14. Do you have any other comments or suggestions?

a) regarding ways in which your team functioning could be improved?

_____

_____

_____

b) regarding ways in which your service delivery could be improved?

_____

_____

_____

c) other? _____

_____

_____

_____

THANK YOU.

APPENDIX 15

RESULTS OF PRE- AND POST-INTERVENTION QUESTIONNAIRE

QUESTIONNAIRE FOR TEAM

1. Is it clear to you what your role is on this team?

Scale 0 to 4

0 = not at all clear; 4 = very clear

Pre-test	Post-test	Change	Post-test Only
3	3	-	
3	4	+1	3
3	4	+1	4
4	4	-	1
3	4	+1	

2. Are the roles of all other members clear to you?

Scale 0 to 4

0 = not at all clear; 4 = very clear

Pre-test	Post-test	Change	Post-test Only
3	3	-	
3	3	-	3
3	3	-	4
4	4	-	1
1	4	+3	

3. How comfortable are you with overlapping roles?

Scale 0 to 4

0 = very uncomfortable; 4 = very comfortable

Pre-test	Post-test	Change	Post-test Only
4	4	-	
-	-	-	3
3	3	-	3
4	4	-	3
2	2		

4. How comfortable are you in communicating your ideas, opinions, and concerns to other team members?

Scale 0 to 4

0 = very uncomfortable; 4 = very comfortable

Pre-test	Post-test	Change	Post-test Only
4	4	-	
3	3	-	4
3	4	+1	4
3	3	-	4
1	3	+2	

5. How comfortable are you in confronting other teammembers when you are in disagreement with them?

Scale 0 to 4

very uncomfortable — very comfortable

Pre-test	Post-test	Change	Post-test Only
3	3	-	
-	-	-	1
2	3	+1	4
3	3	-	1
2	3	+1	

6. To what extent are the knowledge, skills and expertise of all team members being utilized in your program?

Scale 0 to 4

not at all — fully

Pre-test	Post-test	Change	Post-test Only
3	4	+1	
-	-	-	3
2	3	+1	3
2	3	+1	2
1	3	2	

7. To what extent are your knowledge, skills and expertise being utilized in your program?

Scale 0 to 4

not at all — fully

Pre-test	Post-test	Change	Post-test Only
4	4	-	
-	3	+3	3
3	3	-	3
2	3	+1	1
2	3	+1	

8. For each of the following program activities, please indicate how often:

Scale 0 to 4

never always

1. You have had the opportunity to express your opinion.

	Pre-test	Post-test	Change	Post-test Only
Assess-ment	4	4	-	
	-	-	-	4
	3	3	-	4
	3	3	-	3
	0	2	+2	
Care-planning	3	4	+1	
	-	-	-	4
	4	4	-	4
	4	4	-	3
	2	4	2	
Treatment	3	4	+1	
	-	-	-	4
	4	4	-	4
	4	4	-	3
	2	3	+1	
Program Planning	3	3	-	
	-	-	-	3
	3	4	+1	4
	3	4	+1	2
	3	3	-	

8. For each of the following program activities, please indicate how often:

2. You feel others are listening to you.

	Pre-test	Post-test	Change	Post-test Only
Assess-ment	3	4	+1	
	-	-	-	4
	3	3	-	3
	3	3	-	4
	0	2	+2	
Care-Planning	3	4	+1	
	-	-	-	4
	3	3	-	3
	3	3	-	4
	2	3	+1	
Treatment	3	4	+1	
	-	-	-	4
	3	4	+1	4
	3	4	+1	4
	2	3	+1	
Program Planning	2	3	+1	
	-	-	-	3
	3	3	-	4
	3	4	+1	3
	2	3	+1	

For each of the following program activities, please indicate how often:

3. Your ideas are accepted by others.

	Pre-test	Post-test	Change	Post-test Only
Assess-ment	2	4	+2	
	-	-	-	3
	3	3	-	3
	3	3	-	3
	0	3	+3	

8. 3. Cont'd

	Pre-test	Post-test	Change	Post-test Only
Care-Planning	3	4	+1	
	-	-	-	4
	3	3	-	3
	3	3	-	3
	2	3	+1	
Treatment	3	4	+1	
	-	-	-	4
	3	3	-	3
	3	4	+1	3
	2	3	+1	
Program Planning	2	3	+1	
	-	-		3
	3	3	-	3
	3	4	+1	2
	3	3	-	

9. In your opinion, what is the quality of service currently being received by program participants?

Scale 0 to 4
poor excellent

Pre-test	Post-test	Change	Post-test Only
3	3	-	
-	-	-	4
3	4	+1	3
4	4	-	2
1	3	+2	

10. In your opinion, how effective is your current use of the multidisciplinary team approach in terms of the following:

Scale 0 to 4
poor excellent

	Pre-test	Post-test	Change	Post-test Only
a)	assessment			
	3	3	-	
	-	-		4
	2	3	+1	3
	3	3	-	1
	1	2	+1	
b)	establishing care plans			
	2	3	+1	
	-	-		3
	2	3	+1	3
	3	3	-	1
	1	3	2	
c)	case conferencing			
	2	1	-1	
	-	-	-	0
	N/A	3	+3	3
	2	4	+2	0
	1	1	-	
d)	ongoing treatment			
	-	2	-	
	-	-	-	2
	N/A	3	+3	3
	3	4	+1	1
	1	3	+2	
e)	sharing of client-related information			
	3	2	-1	
	-	-	-	2
	4	3	-1	3
	4	4	-	1
	1	3	+2	
f)	sharing of knowledge perspective and expertise			
	3	3		
	-	-		3
	3	3		4
	4	3	-1	1
	1	4	+3	

Pre-test	Post-test	Change	Post-test Only
g) liaison with family			
3	3	-	
-	-		3
3	3	-	2
2	4	+2	1
1	2	+1	
h) liaison with community			
3	3	-	
-	-		2
3	3	-	2
4	3	-1	1
0	1	+1	
i) discharge planning			
N/A	N/A	-	
-	-	-	2
N/A	N/A	-	2
3	3	-	N/A
2	2	-	

11. In your opinion, to what degree is your team meeting the needs of program participants in the following areas:

Scale 0 to 4
not at all greatly

Pre-test	Post-test	Change	Post-test Only
a) medical/physical health			
2	2		
-	-		2
N/A	3		N/A
2	3	+1	3
2	3	+1	
b) emotinal well being			
3	3		
-	-		3
4	4		4
3	4	+1	3
3	3		

Pre-test	Post-test	Change	Post-test Only
c) social functioning			
2	3	+1	
-	-		1
3	3		3
4	4		2
3	4	+1	
d) mental health			
3	3		
-	-		2
3	3		3
3	3		3
-	3		
e) support and information to family			
3	3		
-	-		3
N/A	3		3
3	3		3
1	3	+2	
f) access to community services			
3	3	-	
-	-		2
2	3	+1	3
3	2	-1	2
2	3	+1	

12. Do any of the following factors make it difficult for you to do your job as well as you would like to?

Scale 0 to 4
never always

Pre-test	Post-test	Change	Post-test Only
a) insufficient training or experience in specific treatment modalities			
1	2	+1	
-	-		2
1	1		1
1	2	+1	3
-	1		

Pre-test	Post-test	Change	Post-test Only
b) problems in team functioning			
1	2	+1	
-	-		1
N/A	1	+1	1
1	1	-	1
2	1	-1	
c) the physical environment of the program			
1	2	+1	
-	-	-	2
N/A	2	+2	2
2	2	-	0
1	2	+1	
d) program structure and policies			
2	1	-1	
-	-	-	3
-	2		1
2	1	-1	0
2	2	-	

e) other: still short team members organized policies and procedures at times, lack of administrative support; lack of established patient intake conferences

13. a) How would you rate your current level of job satisfaction?

Scale 0 (very dissatisfied) to 4 (very satisfied)

Pre-test	Post-test	Change	Post-test Only
4	4	-	
-	4	-	3
3	3	-	3
2	2	-	2
3	3	-	

Pre-test	Post-test	Change	Post-test Only

b) How would you have rated your level of job satisfaction 6 months ago?

N/A	N/A	-	
-	N/A	-	1
2	2	-	N/A
3	3	-	N/A
-	2	-	

14. Do you have any comments or suggestions?

a) Regarding ways in which your team functioning could be improved?

- organizing regular meetings with all team members.
- more team meetings to co-ordinate and share information, particularly with the number of part-time staff
- implementation of specific intake meetings for planning patient care
- case conferencing on a regular basis
- ongoing dialogue re program direction
- clarification of roles
- adjustments in physical environment

b) Regarding ways in which your service delivery could be improved?

- too early to tell
- having more team members will probably help
- having one office instead of two
- more team meetings
- it is very necessary that communication be kept up

- increased education to team members re field of geriatric psychiatry
- identify case managers
- formal case conferencing and goal setting

T = Team Functions (Socio emotional)

S.D. = Service Delivery (Task functions)

Note: Although question 14 divided into team and task functions, responses were mixed in both sections - Further supports inter-relationship between these two functions.

APPENDIX 16

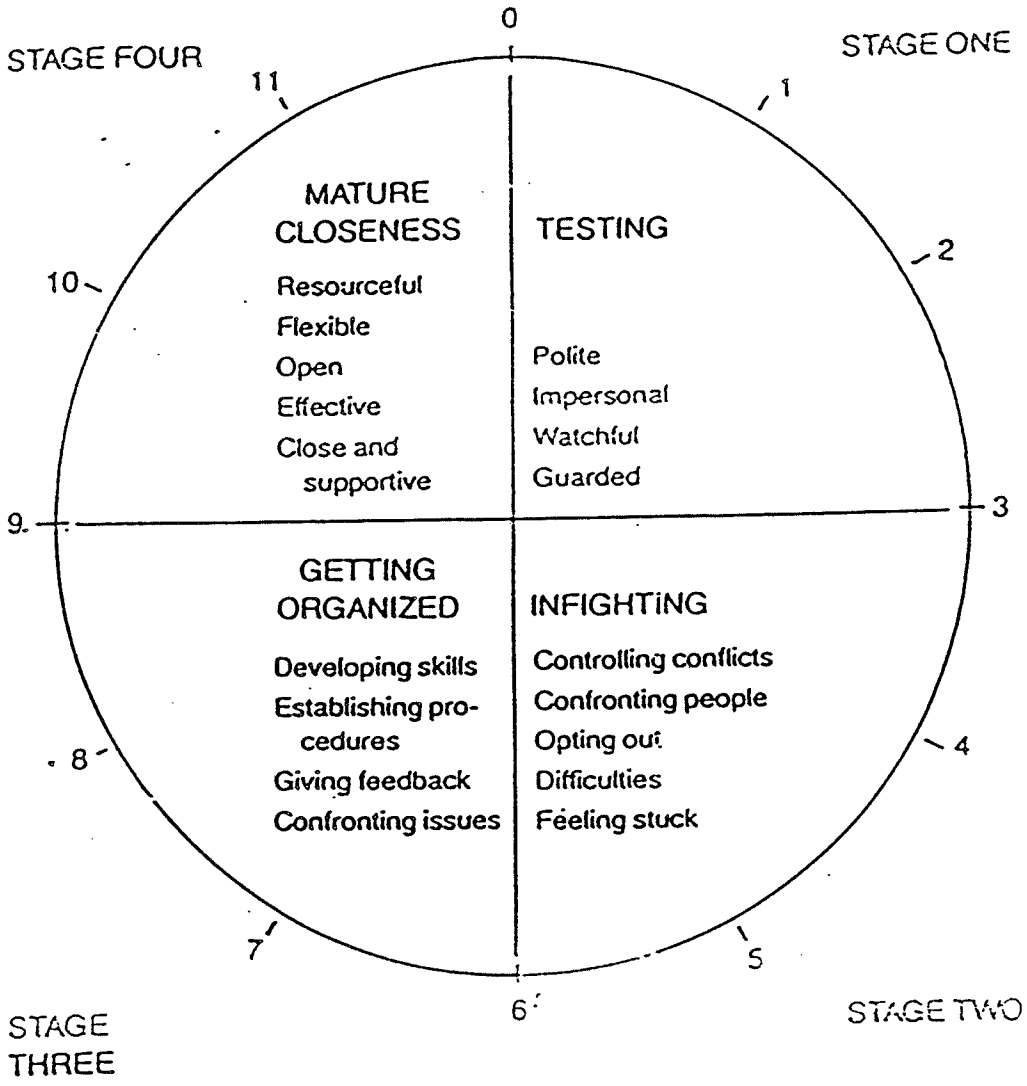
TEAM DEVELOPMENT WHEEL

TEAM DEVELOPMENT WHEEL

Name

Date

Instructions: Place a mark on the circumference of the wheel to represent the present status of your team.



APPENDIX 17

RESULTS OF TEAM DEVELOPMENT WHEEL

TEAM DEVELOPMENT WHEEL RESULTS

TEAM MEMBERS' RESPONSES

SESSION	1	2	3	4	5	6	7	8	Average Range
I	1	1	1	1	1.1				1 1 - 1.1
II	7	7.5	7	9.6	7.1				7.69 7 - 9.6
III	6.5	8.4	7.4	8.5	9.2				8 6.5 - 9.2
IV	7.75	6.9	7.1	7.4	10.6	9.1			8.14 6.9 - 10.6
V	7.3	2.9	5	8.3	2.75	8.9			5.85 2.75 - 8.9
VI	-	7.9	7.5	7.9	6.6	7	2.6 8.3	1.5 6.5	6.2 1.5 - 8.3
VII	8	9.4	-	9.4	10.2	9.5	2.8 6.5 9.1	.1 7.1	8.9 .1 - 10.2
VIII	8.25	4.5	3	10.4	9.6	9.85	.75 7.25 10.5	8.5	7.5 .75 - 10.5
IV	8.9	-	9.4	4.2	9.9 1.9	10.1	3.1 9.5	9.1	7.7 1.9 - 10.1
X	8.75	9.1	10.3	9.1	10.9	10.9	10.4	9.8	9.9 9.1 - 10.9

SCALE	STAGE	DESCRIPTION	SESSIONS AT THAT STAGE
0 - 2.9	One	"Testing"	I
3 - 5.9	Two	"Infighting"	V
6 - 8.9	Three	"Getting Organized"	II, III, IV, VI, VII, VIII, IX
9 - 11.9	Four	"Mature Closeness"	X

APPENDIX 18

EVALUATION QUESTIONNAIRE

EVALUATION OF TEAM SESSIONS

A. Content and format of the sessions:

1. Were the sessions helpful to you as a team member?

not at all helpful	somewhat helpful	very helpful

2. Were the sessions helpful in increasing your awareness of the team approach to service delivery?

not at all helpful	somewhat helpful	very helpful

3. Did the sessions address the issues that were important to you?

Yes____ No____

Please explain_____
_____
_____
_____

4. What was most useful to you in the sessions?

1)_____
_____

2)_____
_____

3)_____
_____

5. What was least useful to you in the sessions?

1)_____
_____

2)_____
_____

3)_____
_____

6. Were the sessions helpful to you in raising any questions or concerns you might have had with the team?

not at all helpful	somewhat helpful	very helpful

7. Was the format of the sessions conducive to team sharing and learning?

Yes____ No____

Please explain_____
_____
_____
_____

8. Please rank your preference of methods used in the sessions (1=most preferred, 6=least preferred)

1) discussion format	____
2) case study	____
3) decision-making scenarios	____
4) literature and background material	____
5) brainstorming	____
6) other_____	____

9. Please comment on the number, frequency and duration of the sessions:

number:	too many	just right	not enough
frequency:	too frequent	just right	not frequent enough
duration:	too long	just right	not long enough

10. Overall, how would you rate the team development sessions?

poor 1 2 3 4 5 excellent

11. Do you have any other comments or suggestions?

_____
_____
_____
_____

B. Facilitation of the sessions:

1. Was the facilitator adequately prepared for the sessions?

never rarely sometimes usually always

2. Did the facilitator provide additional information and clarification when necessary?

never rarely sometimes usually always

3. Did the facilitator promote the involvement and participation of all team members?

never rarely sometimes usually always

4. In what ways was the facilitator most helpful to you?

1)_____
_____

2)_____
_____

3)_____
_____

5. In what ways was the facilitator least helpful to you?

1)_____
_____

2)_____
_____

3)_____
_____

6. Overall, how would you rate the facilitator?

poor 1 2 3 4 5 excellent

7. Do you have any other comments or suggestions?

_____
_____
_____
_____

APPENDIX 19

RESULTS OF EVALUATION QUESTIONNAIRE

EVALUATION OF TEAM DEVELOPMENT SESSIONS

A. CONTENT AND FORMAT OF THE SESSIONS

1. Were the sessions helpful to you as a team member?

not at all helpful	0
somewhat helpful	2
very helpful	6

2. Were the sessions helpful in increasing your awareness of the team approach to service delivery?

not at all helpful	0
somewhat helpful	3
very helpful	5

3. Did the sessions address the issues that were important to you?

yes	7
no	0
no response	1

Comments: They discussed roles and role negotiation.

As we were helped to set out the session topics, it made them meaningful.

Gave me a chance to become familiar with the opinions and personalities of other members of the team.

Very real issues were addressed - very necessary.

Issues important to me in understanding what everyone does.

Sessions allowed us to work on some important issues of role blurring, role of team within overall institution, conflict resolution, which might have been more difficult to tackle outside the context of the sessions.

4. What was the most useful to you in the sessions?

The roles and functions of each member.

Identifying areas of expertise.

Made me aware of sorts of professionals' responsibilities.

Made me aware of sorts of conflict that could arise.

Communication - sharing of ideas and concerns.

Structure - direction.

Total building of group cohesiveness through role descriptions, dealing with conflict, communication.

I found all the sessions equally useful.

I enjoyed watching ways in which the facilitator directed the sessions.

Strangely, the fact that we had to sit down

as a team and find the time which we had not done before.

Getting to know other members as people and team workers - their views, etc.

Getting to know new team members.

Learning how the team defines various roles.

Getting a picture of how team fits into larger institution.

The opportunity to work through scenarios. We deliberately chose certain kinds of issues that required further discussion, yet altered them in such a way as to reduce their potential for threat for various team members. That exercise clarified a number of issues (e.g. accountability).

The increased group cohesiveness which developed particularly for new team members (our acceptance of them and their acceptance of us); I feel the sessions facilitated this goal.

5. What was least useful to you in the sessions?

It was all useful.

Some of the material distributed - I was familiar with it already.

Backtracking over events occurring in former sessions.

No response - 4

I found the parts dealing with roles somewhat redundant (especially since I wrote the job descriptions). But I do feel it helped other team members gain an understanding of the contributions other disciplines can make, and helped them in their task of defining their specific roles.

I don't feel there was anything that was not helpful.

6. Were the sessions helpful to you in raising any questions or concerns you might have had with the team?

not at all helpful	1	(Comment = not yet)
somewhat helpful	4	
very helpful	2	
no response	1	

7. Was the format of the sessions conducive to team sharing and learning?

yes	7
no	0
no response	1

Comments: The round table, the facilitator's ability to involve, her ambience set the tone.

Everyone on the team is fairly new. People have not worked together before

and in this situation the format was conducive to people sharing views.

Discussion with a good facilitator was conducive to sharing. Brainstorming re decision-making also helped with this.

Informal, flexible yet directive.

Lots of opportunity for personal sharing in examples and case studies, etc.

It was interesting to see that participants were more willing to take risks and share often personal information as rapport and cohesiveness became established.

8. Please rank your preference of methods used in the sessions.

Based on 7 responses:

most preferred: decision-making scenarios
second: brainstorming
third: case study
(equal preference) and
discussion format
least preferred: literature and background material

9. Please comment on the number, frequency and duration of the sessions:

			Comments
Number:	too many	1	- We should now continue as a team
	just right	6	
	not enough		- Maybe a few more
	no response	1	
Frequency:	too frequent	2	- Could be every 2 weeks in actual practice
	just right	6	
	not frequent enough		
Duration:	too long	3	- Too long at times
	just right	3	- Would have liked to see this done over a longer period of time.
	not long enough	1	
	no response	1	

10. Overall, how would you rate the team development sessions?

Scale 1 = poor 4 - 4 responses
1 - 5 5 = excellent 5 - 4 responses

11. Do you have any other comments or suggestions?

1 response. I felt it really helped me, as a brand new member, get to know everyone else.

B. FACILITATION OF THE SESSIONS

1. Was the facilitator adequately prepared for the sessions?

always 8

2. Did the facilitator provide additional information

and clarification when necessary?

usually	1
always	7

3. Did the facilitator promote the involvement and participation of all team members?

usually	3
always	5

4. In what ways was the facilitator most helpful to you?

Helped focus discussion, tie things together.

Able to draw everyone into the discussion.

Able to pick up the underlying meaning and connections.

Brought in quieter members.

Summarized well and kept us on track when we "wandered".

Calm, non-threatening personality or manner; able to easily elicit sharing of information most of the time.

Picked up the conversation during periods of silence.

Made me feel comfortable.

Was relaxed, informed, and flexible.

Very relaxed, informed, knowledgeable.

Provided opportunities for breaking up of silence, quiet spots.

Helped me recognize that I "wear too many hats" - colleague, friend, team member, supervisor. This would have helped in my interactions with all members of the team.

5. In what ways was the facilitator least helpful to you?

two responses -Can't think of anything
She was always helpful

6. Overall, how would you rate the facilitator?

Scale 1 = poor 4 - 1 response
1 - 5 5 = excellent 5 - 7 responses

7. Do you have any other comments or suggestions?

This type of project or exercise should be compulsory for all teams at certain points, e.g. once a year - with an outside facilitator. I think many issues would be resolved.

Although I was initially ambivalent about this project, I feel that we as a newly developing team benefitted from the experience. Would recommend it for other teams in this and other facilities.